MemorialCare

SUBJECT:	**Financial Assistance**	
The following MemorialCare affiliates have adopted this: ☒ Policy & Procedure or ☐ Policy (only) or ☐ Procedure (only)	☐ MemorialCare Shared Services ☒ Long Beach Medical Center ☒ Miller Children's & Women's Hospital Long Beach ☒ Orange Coast Medical Center ☒ Saddleback Medical Center ☒ MemorialCare Medical Foundation ☐ Seaside Health Plan ☐ Memorial Medical Center Foundation ☐ Saddleback Memorial Foundation	REFERENCE: FP-236 PAGE: 1 OF: 10 EFFECTIVE: 1/1/2025
MANUAL:	MC/Finance-Purchasing	
OWNER:	Finance Department	

I. POLICY

A. The purpose of this Policy is to set forth the process for providing financial assistance for services provided by MemorialCare Health System (MHS) hospitals to patients who have limited or no means to pay the full billed charges for their care. This Policy is applicable to each hospital MHS operates (an MHS hospital).

B. MHS offers financial assistance to qualified low-income patients unable to pay for services provided by an MHS hospital, to the extent that the hospital services provided are not covered or reimbursed by any state or federal government program such as Medicare, Medicaid, Medi-Cal, Managed Medi-Cal or other government-sponsored low-income assistance programs or any other third-party payer.

C. Regardless of a patient's ability to pay or eligibility under this Policy, MHS hospitals will provide emergency medical care to all individuals to the extent the MHS hospital is reasonably able to do so.

D. Financial Assistance may be applied to uninsured patients, as well as the patient liability for patients with insurance, including charges determined uninsured for the hospital stay, coinsurance, copayment, deductible amounts, and other liabilities for medically necessary hospital services.

E. Eligibility for this form of charity is determined according to the patient's income in relation to Federal Poverty Level (FPL) requirements as determined under Section III(A) - Eligibility.

II. DEFINITIONS

A. **Automatic Predictive Scoring Tool (APST**): an electronic payment assistance ranking score that estimates the patient's Federal Poverty Level (FPL) percentage and assists in evaluating and determining eligibility criteria.

B. **Federal Poverty Level (FPL)**: the poverty guidelines updated periodically in the Federal Register by the United States Department of Health and Human Services under authority of subsection (2) of Section 9902 of Title 42 of the United States Code.

C. **Financial Assistance Program:** the MHS hospital Financial Assistance Program available to patients unable to pay for their care for any services provided by an MHS hospital.

D. **Full Financial Assistance:** free care where the patient is not expected to pay anything at all. i.e., "charity care" under Health and Safety Code Section 127400.5(a).

E. **High Medical Costs:** 1. Annual out-of-pocket medical expenses that exceed the lesser of 10% of the patient's current family income or family income in the prior 12 months; or
2. Annual out-of-pocket expenses that exceed 10% of the patient's family income, if the patient provides documentation of the patient's medical expenses paid by the patient or the patient's family in the prior 12 months. For purposes of this policy, "out-of-pocket" costs and expenses mean any expenses for medical care that are not reimbursed by insurance or a health coverage program, such as Medicare copays or Medi-Cal cost sharing.

F. **Household or Patient's Family:** 1. For persons 18 years of age and older, spouse, domestic partner and dependent children of any age, whether living at home or not. 2. For persons under 18 years of age, parent, caretaker relatives, and other dependent children of any age of the parent or caretaker relative.

G. **Household Income or Patient's Family Income:** the wages and fringe benefits in the form of money, property or services. Generally, gross income includes everything received as payment for personal services, such as federal taxable wages, self-employment income, Social Security Income, retirement or pension income, investment income, rental and royalty income.

H. **Insured Patient**: a patient who has a third-party payer for all or a portion of their medical expenses.

I. **Partial Financial Assistance or Low-Income Financial Assistance (LIFA):** the patient does not qualify for Full Financial Assistance (free care) but is eligible for a discount and may be expected to pay only a portion of the bill. i.e., "discount payment" under Health and Safety Code Section 127400.5(b).

J. **Patient:** the party who is financially responsible for the services provided.

K. **Presumptive Eligibility for Full Financial Assistance:** the patient's current balance is eligible for Full Financial Assistance for the current services based on information MHS has obtained or assessed without looking to the patient to provide all of the information required by the usual application process. Determination may include reliance on a prior determination by MHS, information supplied by another caregiver of the patient, or a general assessment of information available to MHS.

L. **Supplemental Security Income (SSI)**: benefits paid monthly to people with limited income and resources who are disabled, blind, or age 65 or older.

M. **Unable to Bill**: the patient received services, but MHS is not able to bill the patient due to missing or inaccurate information, no contract, etc.

N. **Uninsured or Self-Pay Patient:** a patient who does not have third-party coverage from a health insurer, health care service plan, Medicare, or Medicaid, and whose injury is not a compensable injury for purposes of workers' compensation, automobile insurance, or other insurance as determined and documented by the hospital.

III. PROCEDURE

A. Eligibility – Patients are responsible for making every effort to provide sufficient information that is reasonable and necessary for MHS to make a determination for full or partial financial assistance.

1. **Presumptive Eligibility for Full Financial Assistance:** MHS recognizes that a portion of the insured and uninsured patient population may not be well-equipped to engage in the traditional financial assistance application process. In certain instances, where the required information is not provided by the patient, MHS may make reasonable assumptions based on the Automated Predictive Scoring Tool (APST) to qualify patients for Full Financial Assistance. MHS will assign a patient's current balance to presumptive eligibility without a Financial Assistance Program application if MHS can reasonably determine that (i) the patient's estimated household income is less than or equal to 250% of the current FPL guidelines or (ii) one of the following situations applies:

   a) The patient is eligible for another indigent care qualified program such as Medi-Cal, Managed Medi-Cal, Medicaid, or other government-sponsored low-income assistance program. Non-covered and denied services provided to Medicaid-eligible beneficiaries are considered a form of charity care. Medicaid beneficiaries are not responsible for any forms of patient financial liability and all charges related to services not covered, including all denials, are charity care. Examples may include, but are not limited to:
      (1) Denied inpatient services.
      (2) Denied outpatient services, including Emergency Room services.
      (3) Non-covered services.
      (4) Denied treatment authorizations.
      (5) Charges related to days exceeding a length-of-stay limit.
   b) Denials due to coverage restrictions, including Medi-Cal Restricted Aid Codes (i.e., patients that may only have pregnancy or emergency benefits, but receive other hospital care).
   c) Medicaid-pending accounts.
   d) Out-of-state Medicaid claims with "no payment" (i.e., out-of-state Medicaid claims that cannot be billed due to the lack of a provider agreement with the applicable state).
   e) The patient is disabled and has an SSI case referred to the disability examiner.
   f) The patient is deceased and there is no identifiable estate or estate shows insolvency.
   g) The patient is homeless.
   h) The patient has been declared bankrupt by a Federal Bankruptcy Court within the last year or is declared bankrupt at any point during the collection process.
   i) Unable to bill for services provided by an MHS hospital.

2. **Full Financial Assistance:**

   a) Eligible patients will qualify for Full Financial Assistance if both of the following are true:
      (1) The patient is a Self-Pay Patient or a patient with High Medical Costs; and
      (2) The patient's household income is less than or equal to 250% of the current FPL guidelines.
   b) The required documentation of the patient's household income will be limited to recent pay stubs or income tax returns. The patient's monetary assets will not be considered in determining eligibility for Full Financial Assistance.

3. **Partial Financial Assistance:**
   a) Eligible patients will qualify for Low-Income Financial Assistance (LIFA) if the following requirements are met:
      (1) The patient is a Self-Pay Patient or a patient with High Medical Costs;
      (2) The patient's household income is less than or equal to 400% of the current FPL guidelines; and
      (3) The patient does not qualify for Full Financial Assistance.
   b) Documentation of the patient's household income shall be limited to recent pay stubs or income tax returns. Monetary assets will not be considered.
   c) In all cases that a patient qualifies for LIFA rather than Full Financial Assistance, the patient will not be charged more than "amounts generally billed" by MHS for emergency or other medically necessary care. The "amounts generally billed" are calculated as follows:
      (1) If the services are not covered by a third-party payer, the LIFA - qualified patient's payment obligation will be 100% of the total expected payment (including co-payment and deductible amounts) that the Medicare program would have paid for the service if the patient was a Medicare beneficiary, or 20% of billed charges if the service provided is not covered under the Medicare program. The payment obligation shall not exceed 100% of total charges.
      (2) If the services are covered by a third-party payer, and the LIFA- qualified patient is responsible for only a portion of billed charges, the patient's payment obligation will be the difference of:
         (a) 100% of the total expected payment (including co-payment and deductible amounts) that the Medicare program would have paid for the service if the patient was a Medicare beneficiary, and the third-party payer's payment for services.
         (b) If the third-party payer's payment for services is greater than the expected payment from Medicare, a refund is not applicable.

B. Financial Assistance Qualification/Other Eligible Circumstances
   1. Financial Assistance Program qualification is determined after the patient establishes eligibility or financial need according to criteria contained in the policy.
      a) Patients with pending applications for a government-sponsored health coverage program are also eligible to apply for the Financial Assistance Program.
      b) Eligibility for financial assistance shall be determined solely by the patient's ability to pay as determined in accordance with this Policy and shall not be based in any way on age, gender, sexual orientation, ethnicity, national origin, veteran status, disability or religion.
      c) In evaluating all factors pertaining to a patient's clinical, personal and demographic situation, and alternative documentation (including information that may be provided by other charitable organizations), patients with limited information for application or the absence of patient financial data available to MHS does not preclude eligibility for financial assistance.
      d) If a patient does not submit an application or documentation of income, MHS may determine a patient is eligible for LIFA or Full Financial Assistance by making reasonable

assumptions regarding the patient's household income.

2. Financial assistance may be denied when the patient or other financially responsible party does not meet the Financial Assistance Program requirements.
3. In the event of a dispute regarding eligibility or qualification for financial assistance, a patient may submit a written request for reconsideration to the Vice President of MHS Patient Financial Services Department (PFS).

C. Applying for Financial Assistance

1. Patients may apply for financial assistance from an MHS hospital by submitting a completed Financial Assistance Program application.
   a) The Financial Assistance Program application form may be submitted prior to service, during a patient stay, or after services are completed and the patient has been discharged.
   b) There is no time limit for submitting an application for LIFA or Full Financial Assistance and no denial of eligibility based on the date of submission of the application.
   c) Each MHS hospital will provide assistance with completion of an application for the Financial Assistance Program as needed and will also provide guidance and/or direct assistance to patients as necessary to facilitate completion of government low-income program applications when the patient may be eligible.
   d) In the case of patients who have submitted an incomplete application, the MHS Hospital will:
      (1) Notify the patient in writing that their Financial Assistance Program application is incomplete, including the list of outstanding items and information; and
      (2) Offer assistance with completion of the application.
2. As part of the Financial Assistance Program application, the patient must provide sufficient documentation of income in the form of:
   a) Recent tax returns (tax returns which document a patient's income for the year in which the patient was first billed or 12 months prior to when the patient was first billed); or
   b) Recent paystubs (paystubs within a 6-month period before or after the patient is first billed by the MHS hospital, or in the case of preservice, when the application is submitted).
3. Patients applying for financial assistance will be mailed a written notice approving or denying financial assistance within 10 business days from the date the MHS hospital receives a completed application with all necessary documentation.
4. The MHS hospital relies on the fact that information presented by the patient is complete and accurate. Provision of financial assistance does not eliminate the right to bill, either retrospectively or at the time of service, for all services when fraudulent, inaccurate or incomplete information has been given. In addition, the MHS hospital reserves the right to seek all remedies, including but not limited to civil and criminal damages from those who have provided false, inaccurate or incomplete information in order to qualify for the Financial Assistance Program.
5. It is recognized that the need for financial assistance is a sensitive and deeply personal issue for recipients. MHS hospital personnel will maintain the confidentiality of all requests, information and funding for patients who seek or receive financial assistance.
6. Once qualification for the Financial Assistance Program is determined, such determination

will remain in effect for a period of 6 months. After 6 months, the patient will need to reapply for consideration under the Financial Assistance Program and the MHS hospital will determine if the patient continues to qualify for financial assistance upon the patient's submission of information reasonably required. Discounts under the Financial Assistance Program will only apply to hospital services for which financial assistance was requested and approved, and other hospital services provided within 6 months following such approval, unless otherwise determined by the MHS hospital in their sole discretion.

D. Billing and Collection Practices

1. If a patient qualifies for discounted payments under the LIFA program, the MHS hospital will negotiate with the patient to create an extended payment plan, taking into consideration the patient's family income and essential living expenses and, if applicable, may also consider the patient's health savings account. If the MHS hospital and the patient are unable to agree on an extended payment plan, the MHS hospital will create a reasonable payment plan in which monthly payments do not exceed 10% of the patient's family income in a month, less essential living expenses. "Essential living expenses" means expenses for any of the following: rent or house payment and maintenance, food and household supplies, utilities and telephone, clothing, medical and dental payments, insurance, school or childcare, child or spousal support, transportation and auto expenses, including insurance, gas and repairs, installment payments, laundry and cleaning, and other extraordinary expenses. All extended payment plans will be interest-free.
2. In the event that a patient qualifying for financial assistance under this Policy fails to make payment in full on their remaining patient liability balance, the MHS hospital, in its sole and exclusive discretion, may use any or all appropriate means to collect the outstanding balance (either directly or through an outside collection agency) while in compliance with California Civil Code Section 1788.145, and California Health and Safety Code 127400 et seq. Prior to commencing any collection activities, the MHS hospital or an outside collections agency seeking to collect the debt on behalf of the MHS hospital will provide the patient with a written notice summarizing the patient's rights pursuant to the Hospital Fair Pricing Policies law, the California Rosenthal Fair Debt Collection Practices Act, and the Federal Fair Debt Collection Practices Act.
3. The MHS hospital and any outside collections agency shall not use for collections activities any information regarding documentation of income that the MHS hospital receives from the patient as part of the financial assistance eligibility process.
4. Patients in the process of qualifying for government financial assistance or the MHS hospital Financial Assistance Program will not be assigned to collections prior to 120 days from the date of initial post-discharge billing. If a patient is attempting to qualify for eligibility under the MHS hospital's Financial Assistance Program and is attempting in good faith to settle an outstanding bill with the MHS hospital by negotiating an extended payment plan or by making regular partial payments of a reasonable amount, the MHS hospital shall not send the unpaid bill to any collection agency or other assignee, unless that entity has agreed to comply with guidelines outlined in California Health and Safety Code Section 127400 et seq. Insured or uninsured patients, who at the sole discretion of the MHS hospital are reasonably cooperating to settle an outstanding hospital bill by making regular and reasonable payments towards their outstanding hospital bill, will not be sent to an outside collection agency if doing so would negatively impact the patient's credit. Patients who communicate that they have an appeal for coverage of services pending will not be forwarded to collections until the final determination of that appeal is made.
5. Any extended payment plan may be declared no longer operative after 90 consecutive days

without payment. Before declaring the extended payment plan no longer operative, the MHS hospital shall make a reasonable attempt to contact the patient by telephone and to give notice in writing that the extended payment plan may become inoperative, and of the opportunity to renegotiate the extended payment plan. For purposes of this paragraph, the notice and telephone call to the patient may be made to the last known telephone number and address of the patient. Prior to the extended payment plan being declared inoperative, the MHS hospital shall attempt to renegotiate the terms of the defaulted extended payment plan, if requested by the patient. The MHS hospital shall not report adverse information to a consumer credit reporting agency at any time or commence a civil action against the patient or responsible party for nonpayment at any time within 180 days after the initial post-discharge billing or prior to the time the extended payment plan is declared to be no longer operative.

6. The MHS hospital will make reasonable efforts (as further described in 26 C.F.R. Section 501 (r)-6(a) to determine whether an individual is eligible for financial assistance before engaging, either directly or indirectly, in any of the following collections actions:; commencing a civil action against the patient; or requiring a payment before providing non-emergency care because of outstanding bills for previously provided care. In no event will the MHS hospital use wage garnishments or liens on real property owned, in part or completely, by the patient as a means of collections.
7. Authority. The Patient Financial Services Department will act as the final authority in determining that the MHS hospital has made reasonable efforts to determine whether a patient qualifies for financial assistance and that MHS may therefore advance patient debt for collection and therefore engage in the above-described collection actions.
8. Discovery of Patient Financial Assistance Eligibility During Collections - While MemorialCare strives to determine patient financial assistance as close to the time of service as possible, in some cases further investigation is required to determine eligibility. Some patients eligible for financial assistance may not have been identified prior to initiating external collection action. MemorialCare collection agencies shall be made aware of this possibility and are requested to refer back patient accounts that may be eligible for financial assistance. When it is discovered that an account is eligible for financial assistance, MemorialCare will reverse the account out of bad debt and document the respective discount in charges as charity care.

E. Reimbursements

1. Reimbursements from Patient.
   a) If a patient receives a legal settlement, judgment, or award under a liable third party action that includes payment for health care services or medical care related to the injury, the patient or guarantor must reimburse the MHS hospital for the related health care services rendered up to the amount reasonably awarded for that purpose.
   b) A patient or guarantor must pay the MHS hospital the entire amount of any reimbursement sent directly to the patient or guarantor by a third-party payer for the MHS hospital's services.

2. Reimbursements from MHS.
   a) If a patient qualifying for financial assistance under this Policy makes a payment to an MHS hospital in excess of the amount the patient is determined to be responsible for, the overpayment amount, including interest accrued at a rate of 10% per annum beginning on the date the overpayment is received, shall be promptly refunded to the patient within 30 days. The MHS hospital is not required to reimburse the patient or pay

interest if the amount due to the patient is less than $5.00, but will give the patient a credit for that less than $5.00 amount due for at least 30 days from the date the amount is due.

b) Notwithstanding the above, no reimbursement is due to a patient if (i) it has been five years or more since the patient's last payment to the MHS hospital or a debt buyer, or (ii) the patient's debt was sold before January 1, 2022, in accordance with state law in effect at that time.

F. Third-Party Providers Emergency physicians who provide emergency medical services at any MHS hospital are required by law to provide discounts to insured and uninsured patients whose family income is at or below 400% of the FPL. Physicians providing care at MHS hospitals are independent practitioners and are not employees or agents of MHS hospitals. MHS hospitals do not provide patient financial assistance for the professional fees charged by physicians and other third- party providers for their services, even if those services were rendered at an MHS hospital. However, to the extent third-party physician providers are contracted to provide medically necessary services at an MHS hospital, such third-party providers may be bound by this Policy. Attachment A, which may be updated from time to time, lists the third-party providers at each MHS hospital obligated to comply with this Policy. This Policy shall not apply to any other third-party providers.

G. Exclusions and Limitations on Elective Procedures. MHS retains the right to prospectively deny financial assistance in connection with pre-scheduled elective, non-emergent, non-medically necessary, surgical or cosmetic surgical patients, or international non-emergent, non-medically necessary surgical patients, based on MHS's need to judiciously allocate its financial and clinical resources unless otherwise approved in advance.

H. Written Notification of MHS Hospital Discount Payment and Charity Care Policies. Each MHS hospital shall provide all of its patients with a written notice of its hospital discount payments and charity care policies in compliance with, among other things, the requirements set forth in California Health and Safety Code Section 127410.

I. Posting of MHS Hospital Policy. Each MHS hospital shall clearly and conspicuously post its policy for financially qualified and self-pay patients in locations visible to the public, including, but not limited to, the emergency department, billing and admissions offices, and other outpatient settings, including observation units.

J. Obtaining a Copy of Policy and Attachment A. This Policy and Attachment A are prominently displayed on each MHS hospital's internet site at www.memorialcare.org/guides-tools/financial-assistance. A Patient may also call or visit the Admitting Department of any MHS hospital or contact a Patient Financial Services representative at 877.323.0043 to request a paper copy free of charge.

IV. ATTACHMENT A

The following is a list of the categories of third-party providers covered by this policy. Provider types *not* appearing on this list and who provide emergency or medically necessary care are not covered by this policy, although they may honor it at their sole discretion.

MemorialCare Locations	Third-party providers at each MHS hospital obligated to comply with this Policy
Long Beach Medical Center 2801 Atlantic Avenue Long Beach, CA 90806	Anesthesiologists Pathologists Radiologists Emergency Physicians NICU Physicians PICU Physicians Breast Imaging Physicians
Miller Children's & Women's Hospital Long Beach 2801 Atlantic Avenue Long Beach, CA 90806	Anesthesiologists Pathologists Radiologists Emergency Physicians NICU Physicians PICU Physicians
Orange Coast Medical Center 18111 Brookhurst Street Fountain Valley, CA 92708	Anesthesiologists Radiologists Pathologists Emergency Physicians NICU Physicians Breast Imaging Physicians Cardiac Surgery Physicians
Saddleback Medical Center 24451 Health Center Drive Laguna Hills, CA 92653	Pathologists NICU Physicians Emergency Physicians Breast Imaging Physicians