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MARINHEALTH MEDICAL CENTER

HOUSEWIDE ADMINISTRATIVE MANUAL

FINANCIAL ASSISTANCE, CHARITY CARE, AND LOW-INCOME UNINSURED POLICY

I. POLICY

A. It is the policy of MarinHealth Medical Center to provide charity care (financial assistance) to the low-income uninsured or underinsured persons to whom we provide services in our community. This policy includes services which are furnished on an emergency basis. It is imperative that the notification of availability, determination, reporting, and tracking of charity care are in concert with our not-for-profit mission and our community obligation.

B. Confidentiality of information and individual dignity will be maintained for all that seek charitable services. Personal health information will be maintained consistent with HIPAA and other medical confidentiality obligations.

C. Patients who do not qualify for charity care, but are uninsured, may qualify for the Uninsured Patient Discount set forth in the current medical center policy.

D. Authority for decision making with regard to this policy and the progression to formal debt collection is granted to the Director for Patient Financial Services and/or an individual with such authority at a higher level or rank in the medical center including the Executive Director for Revenue Cycle, Chief Financial Officer and other personnel granted this authority for coverage when the Director for Patient Financial Services is not available.

II. PURPOSE

The purpose of this policy is to define the eligibility criteria for charity care services and to provide administrative and accounting guidelines to assist with the identification, classification, and reporting of patient accounts as charity care.

III. GENERAL INFORMATION

A. Background/ Scope

As required by law, MarinHealth Medical Center must provide patients with information regarding charity care and other discounts during the patient intake process. There are five (5) regulatory components to this policy:

1. Partial and/or full charity care will be based on the individual's ability to pay as defined by Federal Poverty Income Guidelines and the medical center income criteria.
2. Payment liability from financially qualified persons shall be established to the highest of various government payment rates for comparable health services. This rate is established to be the in-effect Medicare rate.

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3. Debt collection activities include providing such qualified persons with interest-free, extended payment plans for repaying the medical center for incurred services.
4. Provide HCAI with notice of this policy.
5. Reimburse overcharges to persons that should not have been collected under the law, with interest.

B. Definitions

1. **"Patient's family"**:
   a. For patients 18 years of age and older, the family includes the patient's spouse, registered domestic partner, and dependent children under 21 years of age whether living at home or not.
   b. For patients under 18 years of age, the family includes the patient's parent, caretaker relatives, and other children (under 21 years of age) of the parent or caretaker relative. [H&S §127400(h)]
   c. For patients 18 years of age or older, the definition of "patient's family" has been expanded to include dependent children of any age if those children are disabled
   d. For patients under 18 years of age or who are 18 to 20 years of age and are a dependent child, the definition of "patient's family has been expanded to include other dependent children of the patient's parents or caretaker relatives if those other children are disabled
2. **"Charity Care"** means "free care"
3. **"Federal Poverty Level" (FPL)**: the poverty guidelines updated periodically in the Federal Register by the U.S. Department of Health and Human Services [H&S §127400(b)].
4. **"Self-pay patient"**: A patient who does not have third-party coverage from a health insurer, health care service plan, Medicare, or Medicaid/ Medi-Cal, and whose injury is not a compensable injury for Worker's Compensation, automobile insurance, or other insurance as determined and documented by medical center. Self-pay patients may include charity care patients. [H&S §127400(f)].
5. **"Uninsured patient"**: this term is not defined in the law. The terms 'uninsured" and "self-pay" are synonymous for the individuals who meet the criteria for charity care.
6. **"Discount payment"** means "any charge for care that is reduced but not free"
7. **"Patient with high medical cost"** is a person whose family income does not exceed the FPL percent if that individual does not receive a discounted rate from the medical center as a result of his or her third-party coverage. [H&S §127400(g)]
8. For purposes of determining whether a patient has "high medical costs," "out-of-pocket" costs and expenses means "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"

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9. **"High medical cost"** means annual out-of-pocket costs incurred anywhere by the patient or the patient's family that exceed 10% of the family's income for the prior 12-month period or patient's current family income net of any applied write-offs or discounts already applied.
10. The words **"persons" and "patients"** are used interchangeably in this policy.
11. **"Primary Language"** of MarinHealth Medical Center's service area means 5% or more of MarinHealth Medical Center's local population who speaks the language.
12. **"Charitable Event"**. MarinHealth Medical Center considers any reimbursement less than 25% of cost to be charitable event.
13. **"Medical Debt"** means a debt owed by a consumer to a person whose primary business is providing "medical services, products or devices," or to that person's agent or assignee, for the provision of medical services, products, or devices. Medical debt includes, but is not limited to, medical bills that are not past due or that have been paid.
14. "**Medical service, product, or device"** does not include cosmetic surgery, but does include, without limitation, all of the following:
    a. Any service, drug, medication, product, or device sold, offered, or provided to a patient by licensed health care facilities or providers.
    b. Initial or subsequent reconstructive surgeries, and follow-up care deemed necessary by the attending physician and surgeon
    c. Initial or subsequent prosthetic devices, and follow-up care deemed necessary by the attending physician and surgeon.
    d. A mastectomy.

C. Requirements

1. DETERMINING ELIGIBILITY
    a. Eligibility Qualifications

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1) A low-income uninsured patient is eligible for Charity Care consideration based on meeting the family income eligibility criteria as established by MarinHealth Medical Center's Federal Poverty Income Guideline. Full charity care (no payment) is for all patients at 400% or less of the FPL. MarinHealth Medical Center has established the FPL limit at a rate higher than that required by law. This level is referred to as the criteria in this policy.
2) **No Consideration of Assets:** The Medical Center will no longer consider a patient's monetary assets when determining that patient's eligibility for discount payment or charity care.
3) **Other Forms of Income Documentation:** The Medical Center may accept other forms of documentation of income but shall not require those other forms.
4) If a patient does not submit an application or documentation of income, the Medical Center may presumptively determine that a patient is eligible for charity care or discounted payment based on information other than that provided by the patient or based on a prior eligibility determination.
5) **Cannot Require Discount Payment Patients to Apply for Health Coverage:** The Medical Center will not require a patient to apply for Medicare, Medi-Cal, or other coverage before the patient is screened for, or provided, discount payment.
6) **No Application Deadlines:** The Medical Center will not impose time limits for charity care or discount payment applications. The Medical Center also will not deny eligibility based on the timing of a patient's application.
7) Insured patients with limited coverage or who have exhausted their benefit coverage may qualify for charity care or discount payment according to the criteria.
8) Insured patients with high medical costs may qualify for charity care or discount payment according to the criteria.
9) Insured patients with high deductible plans may qualify for charity care or discount payment according to the criteria.
10) The Medical Center will not furnish information regarding a medical debt to a consumer credit reporting agency.
11) The Medical Center will not commence civil action against a patient for nonpayment of medical debt before 180 days after initial billing.

b. Testing for Eligibility

1) The medical center shall test for the entire family income and not solely the patient's income.
2) The medical center shall include all sources of income including income from other sources such as cash payments to patient or patient's family.

c. Contracting with Other Organizations to Determine Eligibility

1) The medical center may enter into contracts/memorandums of understanding which accept the formal screening by other nonprofit organizations that serve populations in need of healthcare services but do not have the means to pay for services. These organizations shall not include organizations that have eligibility criteria that are more liberal than that which the medical center has in effect at the time services are rendered.

2. LIMITING EXPECTED REIMBURSEMENT

a. The maximum expected billing amount for patients who qualify for charity care or discount payment who do not have insurance coverage shall be the full in effect allowable Medicare rate for the service (s) as calculated in accordance with Medicare payment rules. [H&S §127405(d)]

b. For any patient who has coverage under a third-party insurance plan, that contract shall establish the billing rate except when the Medicare payment is less. [H&S §127400(c) and §127405(d)] See example.

c. Negotiations with insurance carriers involving inferred contractual relationships for insured patients not under contract with MarinHealth Medical Center will be conducted by Contracting department at MarinHealth Medical Center.

1) Although MarinHealth Medical Center may agree to the terms of the negotiations with insurance companies, an inferred contractual relationship is not representative of a patient “under contract” with MarinHealth Medical Center.

2) MarinHealth Medical Center considers any reimbursement less than 25% of cost to be charitable event. Any care provided to a presumptive or actual case of COVID-19 is provided at an amount no greater than what the patient would have otherwise been required to pay if the care had been provided by an in-network provider. All unreimbursed amounts are a form of patient financial assistance and determined as the difference between gross hospital charges and hospital reimbursement.

d. Please note that “***No health care service plan, insurer, or any other person shall reduce the amount it would otherwise reimburse a claim for medical center services because a medical center has waived, or will waive, collection of all or a portion of a patient’s bill for medical center services in accordance with the medical center’s charity care of discount payment policy, notwithstanding any contractual provision***.” [H&S § 127444]

3. LIMITED DEBT COLLECTION ACTIVITIES

a. Notice Prior to Commencing Collection Activities

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1) The medical center, or any assignee of a medical center debt, including a collection agency must provide the patient with a clear and conspicuous notice that includes the required language from the various practice acts and a statement that nonprofit credit counseling services may be available in the area.

b. Collection Practices

No Consideration of Patient Assets for Debt Recovery Determinations: In determining the amount of a debt it may seek to recover from patients who are eligible under its charity care or discount payment policy, the Medical Center will only consider income and not monetary assets.

1) **No liens on any real property for collections:** Wage garnishments and liens on any real property owned by the patient will not be used as a means of collecting unpaid hospital bills by the Medical Center, assignees that affiliates or subsidiaries of the Medical Center, collection agencies, debt buyers and other assignees that are not subsidiaries or affiliates of the Medical Center.
2) The medical center includes an extended payment plan to allow payment of the discounted price over time. The medical center and the patient may negotiate the terms of the payment plan. The medical center will not charge interest on the extended payment plan debt.
3) An extended payment plan may be negotiated with the patient if the patient fails to make all consecutive payments during a 90-day period. Prior to declaring an extended payment plan inoperable the patient must be:
    i. Contacted or attempted to be contacted by telephone (last known number)
    ii. Given notice in writing that the plan may be inoperable (last known address)
    iii. Informed that there is an opportunity to re-negotiate the payment plan.
4) Until the payment plan is declared inoperable, no report may be made to a consumer credit reporting agency and no civil action may commence. Any advancing of debt for collection or reporting requires the approval of each patient by the Director of Patient Financial Services. Advancing of debt collection shall occur after 150 days of an inoperable payment plan.
5) Credit reporting shall not occur until after 180 days of the payment plan being inoperable.
6) **Two Types of Permissible Reimbursements from Patient or Guarantor:** The Medical Center may require a patient or guarantor to pay the hospital the entire amount of any reimbursement sent directly to the patient or guarantor by a third-party payer for the Medical Center's

services. 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 Medical Center may require the patient or guarantor to reimburse the Medical Center for the related health care services rendered up the amount reasonably awarded for that purpose.

7) **5-Year Record Retention for Money Owed to the Hospital:** The Medical Center will maintain all records relating to money owed to the Medical Center by a patient or a patient's guarantor for 5 years, including, but not limited to, all of the following:
    a) Documents related to litigation filed by the Medical Center
    b) A contract and significant related records by which the Medical Center assigns or sells medical debt to a third party,
    c) A list, updated at least annually, of every person, including the person's name and contact information, that is either a debt collector to whom the Medical Center sold or assigned medical debt or retained by the Medical Center to pursue litigation for debts owed by patients on behalf of the Medical Center.
8) **Contracts with Assignees and Debt Buyers Must Require 5-Year Record Retention:** Any contract entered into by the Medical Center related to the assignment or sale of medical debt must require the assignee or buyer (and any subsequent assignee or buyer) to maintain records related to litigation for five years.
9) **Changed Relevant Lookback Date for Policy's Application to the Time the Patient was First Billed:** The Medical Center will not deny a patient's financial assistance that would be available under the Medical Center's policy published on the HCAI's website at the time the patient was first billed by the Medical Center.

4. PROVIDING WRITTEN NOTICE

a. Charity Care Information Provided at Patient Intake

1) Except in the case of emergency services, MarinHealth Medical Center shall provide patients with information regarding charity care and discount payments during the patient intake process.
2) MarinHealth Medical Center shall also provide patients with contact information for a MarinHealth Medical Center employee or office from which the patient may obtain further information about charity care and discount payments. The information provided shall be in the primary language(s) of MarinHealth Medical Center's service area and in a manner consistent with all applicable federal and state laws and regulations.

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b. Charity Care Information Provided at all other times

1) MarinHealth Medical Center shall provide patients with information regarding charity care and discount payments during the intake process, or at any other time upon patient request.
2) MarinHealth Medical Center shall provide uninsured patients with the MarinHealth Medical Center charity care application form (Attachment A in English or Attachment B in Spanish), the "Statement of Financial Condition", immediately upon patient request.
3) The information provided shall be in the primary language(s) of MarinHealth Medical Center's service area and in a manner consistent with all applicable federal and state laws and regulations.

c. Public Notice and Posting

1) Public notice of the availability of assistance through this policy should be made through each of the following means:
    i. Posting notices in a visible manner in locations where there is a high volume of inpatient or outpatient admitting/registration. Notices must be posted in at least the emergency departments, billing offices, admitting offices, and medical center outpatient service settings.
2) Posted notices shall be in languages reflecting that spoken in the service area is 5% or more of the populations speak this language. Posted notices shall contain the following information:
    i. A statement indicating that MarinHealth Medical Center has a financial assistance policy for low-income uninsured patients who may not be able to pay their bill and that this policy provides for full or partial charity care write-off.
    ii. Identification of a medical center contact phone number that the patient can call to obtain more information about the policy and about how to apply for assistance.

d. Include policy information on bills and statements sent to patients indicating:

1) If the patient meets certain income requirements the patient may be eligible for a government-sponsored program or qualify for charity care or discount payment from MarinHealth Medical Center. The income requirements shall be stated on the notice.
2) Notification to the patient that emergency physicians are required to have a discount policy to uninsured and high medical cost patients which may have different eligibility criteria than that of the medical center but at least at 400% of the FPL.

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3) A medical center phone number which patients may call for further information.
4) Posting notice of the availability of assistance and a contact phone number on MarinHealth Medical Center's web site.
5) Providing a document outlining the types of financial assistance available to uninsured patients.

5. REIMBURSING OVERCHARGES
   a. If the medical center has mistakenly over collected from a patient for their portion who qualifies for charity care or discount payment the patient will be reimbursed the principle plus interest calculated at the same rate as stated in California Civil Code §685.010 which is currently 10% per annum.
   b. This clause shall not apply if the overpayment is $5 or less. In this case the medical center shall furnish credit equal to the amount of $5 or under for a period of 60 days. Interest shall accrue beginning on the date payment by the patient is received from the medical center.

6. NOT AVAILABLE FOR CHARITY CARE
   a. Charity care and discounts provided by this policy are generally not available for "elective procedures". The application of this policy does not apply to any portion of a patient's services because of the transfer of a patient to another facility that bills for services under a different Tax Identification Number.
   b. The medical center will make every effort to locate a charitable organization that MarinHealth Medical Center is aware of or has a relationship with to furnish elective procedures.

IV. PROCEDURES

A. Eligibility Criteria

1. Charity Care Application
   a. A low-income uninsured medical center patient who indicates the financial inability to pay a bill for a medically necessary service shall be evaluated for charity care assistance.
   b. The MarinHealth Medical Center standardized application form, shown as the "Financial Assistance" form (Attachment A or B), will be used to document each patient's overall financial situation. This application should be available in the primary language(s) of MarinHealth Medical Center's service area.
   c. The "Financial Assistance Program Worksheet" (see Attachment C) is completed to aid MarinHealth Medical Center in determining the amount and type of charity care for which the patient may be eligible.
   d. If an uninsured medical center patient does not complete the application form within 30 days of delivery, MarinHealth Medical Center will notify the patient

that the application has not been received and will provide the patient an additional 45 days to complete the application. If the application form is subsequently submitted it will be accepted.

e. The patient must make every reasonable effort to furnish the medical center with documentation of income. The documentation requirements are on the form.
f. The patient must attest in writing that the information they are furnishing to the medical center is accurate.
g. Denials for charity care or discount payment can be made by the Director of Patient Financial Services.
h. Once a determination has been made, a “Notification Form” (see Attachment D Sample Letter) will be sent to each applicant advising him or her of the facility’s decision.
i. The amount and frequency of medical center bills may also be considered.
j. The data used in making a determination concerning eligibility for charity care should be verified to the extent practical in relation to the amount involved.

2. Presumptive Charity Care:
    a. Financial assistance may be granted in the absence of a completed application in situations where the patient does not apply but other available information substantiates a financial hardship. Examples of these exceptions where documentation requirements are waived include, but are not limited to:
        1) An independent credit-based financial assessment tool indicates indigence;
        2) An automatic financial assistance determination of 100% assistance is applied in the following situations provided other eligibility criteria are met:
            i. Patient has an active Medicaid plan
            ii. Patient is eligible for Medicaid,
            iii. or patients with current active Medicaid coverage will have assistance applied for past dates of service.”
            iv. Patient is deceased”
        3) Determination of patient financial assistance eligibility by PFS Director
        4) Presumptive eligibility tools may not be used for indigent Medicare patients

3. Full Charity Care:
    a. The basic standard for full charity care write-off will be 400% of the most recent Family Federal Poverty Income Guidelines (Attachment B). Periodic updates to the FPL by the federal government will be adopted by the medical center and will not require a revision to this policy.

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4. Denied Patient Days and Non-Covered Services – All Payors:
    a. 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) Services provided to Medicaid beneficiaries with restricted Medicaid (i.e., patients that may only have pregnancy or emergency benefits, but receive other hospital care)
        2) Medicaid-pending accounts
        3) Medicaid or other indigent care program denials
        4) Charges related to days exceeding a length-of-stay limit
        5) Medicaid claims (including out of state Medicaid claims) with “no payment””
        6) Any service provided to a Medicaid eligible patient with no coverage and no payment
    b. Any unreimbursed charges from non-covered or denied services from any payor, such as charges for days beyond a length-of-stay limit, exhausted benefits, balance from restricted coverage, Medicaid-pending accounts, and payor denials are considered a form of patient financial assistance at MarinHealth Medical Center. Charges related to these denials/non-covered amounts written off during the fiscal year are reported as uncompensated care.

5. High Medical Cost Patients:
    a. The annual out-of-pocket costs incurred anywhere by the patient or the patient’s family that exceed the lesser of 10% of the family’s income for the prior 12-month period or 10% of the family’s current income net of any applied write-offs or discounts already applied will trigger this qualification, insurance premiums are ***not*** considered in this calculation:
        1) MarinHealth Medical Center will multiply the Family Income as determined in Section O of this policy by 10%.
        2) MarinHealth Medical Center will determine the patient’s Allowable Medical Expenses according to the limiting formula.
        3) MarinHealth Medical Center will compare 10% of the Family Income as determined in the total amount of the patient’s Allowable Medical expenses. If the total of the Allowable Medical Expenses is greater than 10% of the Family Income, then the patient meets the High Medical Cost qualification.

6. Eligibility for Insured Patients

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a. A patient who is insured but has "high medical costs" and who is at or below 400% of the federal poverty level (FPL) is eligible to apply for charity care.
b. Charity care applies to the portion of the bill that is the patient's responsibility, including co-payments, co-insurance and deductibles.
c. MarinHealth Medical Center will determine the patient's Allowable Medical Expenses according to the limiting formula.
d. A patient's family is defined as a patient's spouse, domestic partner, and dependent children under 21 years of age. For patients under 18 years of age, the family is defined as their parent(s), caretaker relatives, and other children under 21 years of age of the parent or caretaker relative.
e. If a patient has been assigned Medi-Cal share of cost, the share of cost amount will be eligible for charity care.
f. Patients who do not qualify for Financial Assistance may be eligible to receive discounts based on the prompt payment discount policy.

7. Eligibility Period:
   a. Approvals for MARINHEALTH MEDICAL CENTER Financial Assistance for patients who complete the application process will be applied for 6 months forward from the approval date and retroactively to open accounts.

8. Homeless Patients:
   a. Emergency room patients without a payment source may be classified as charity if they do not have a job, mailing address, residence, including temporary residence, or insurance. Consideration must also be given to classifying emergency-room-only patients who do not provide adequate information as to their financial status. In many instances, these patients are homeless and have few resources to cover the cost of their care.

9. Collection Agency:
   a. If a collection agency identifies a patient who meets MarinHealth Medical Center's charity care eligibility criteria, the patient account may be considered charity care, even if they were originally classified for collection or as a bad debt. Collection agency patient accounts ***meeting charity care criteria*** should be returned to MarinHealth Medical Center's billing office and reviewed for charity care eligibility.

10. Special Circumstances:
    a. Deceased patients without an estate or third-party coverage will be eligible for charity.
    b. Patients who are in bankruptcy (filed but an open case) or completed bankruptcy in the past three (3) months may be eligible for charity.

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11. Governmental Assistance:
    a. In determining whether each individual qualifies for charity care, other county or governmental assistance programs should also be considered. Many applicants are not aware that they may be eligible for assistance such as Medi-Cal, the Healthy Families Program, Victims of Crime, California Children Services or the Affordable Care Act benefit plans.
    b. MarinHealth Medical Center should assist the individual in determining if they are eligible for any governmental or other assistance.
    c. Persons eligible for programs such as Medi-Cal, but whose eligibility status is not established for the period during which the medical services were rendered, may be granted charity care for those services. MarinHealth Medical Center may make the granting of charity contingent upon applying for governmental program assistance. This may be prudent, especially if the particular patient requires ongoing services.

12. Time Requirements for Determination:
    a. While it is desirable to determine the amount of charity care for which a patient is eligible as close to the time of service as possible. In some cases, eligibility is readily apparent and a determination can be made before, on, or soon after the date of service. In other cases, it can take investigation to determine eligibility, particularly when the patient has limited ability or willingness to provide needed information. At any time if a patient sends confirming information and the application that demonstrate qualification for charity care then charity care will be indicated.
    b. Every effort should be made to determine a patient's eligibility for charity care. In some cases, a patient eligible for charity care may not have been identified prior to initiating external collection action. Accordingly, any collection agency will be made aware of the policy on charity care. This will allow the agency to refer back to MarinHealth Medical Center patient accounts that may be eligible for Charity Care.
    c. After 150 days of no response from a patient to formally determine eligibility, the account may proceed to debt collection. If the patient was initially identified as probable charity care and the patient has no public or private record to locate the patient (e.g. homeless with no residence) the case may be classified as charity care. The Director of Patient Financial Services will use appropriate judgment to differentiate charity care based on the criteria in lieu of a bad debt determination.

13. Application Denied:
    a. No financial assistance is granted under this policy. However, if patient is self-pay, the patient may be eligible according to the prompt pay discount policy.

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14. Appeals:
    a. In the event of a dispute over the application of this policy, a patient may seek review from MarinHealth Medical Center's Director of Patient Financial Services. The patient may also follow the medical center's complaint policy. The patient will be informed of any decision in writing.

15. Definition of Income:
    a. Annual family earnings and cash benefits from all sources before taxes, less payments made for alimony and child support.
    b. Proof of earnings may be determined by annualizing year-to-date family income, giving consideration for current earning rates.

16. Who Can Grant Charity Care Write-offs:
    a. Director of Patient Financial Services or Executive Director of the Revenue Cycle, or someone in a higher position may approve charity write offs.

17. Reimbursement to Patients
    a. Any amount collected from a patient in excess of the amount due under this policy will be reimbursed to the patient at an annual interest rate of 10 percent.

18. Roles and Responsibilities:
    a. Procedures must be adopted that clearly address the various responsibilities in the determination of charity care. This includes documentation of any contact with the patient, provision of information, and assistance to the patient making the determination of charity care eligibility, and notifying the patient.

19. Recordkeeping:
    a. Records relating to potential charity care patients must be readily accessible. MarinHealth Medical Center must maintain information regarding the number of uninsured patients who have received service, the number of financial assistance applications completed, the number approved, the estimated dollar value of the benefits provided, the number denied, and the reasons for denial.
    b. In addition, notes relating to charity application and approval or denial should be entered on the patient's account.

20. Submission to the California Department of Health Care Access and Information HCAI (formerly known as OSHPD):
    a. Beginning January 1, 2008, and biennially thereafter (every two years) by January 1, MarinHealth Medical Center shall forward copies of this policy to

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the California Department of Health Care Access and Information (HCAI). Submission of the policy shall be done consistent with the manner prescribed by HCAI.

21. Application of Policy:
    a. This policy does not create an obligation to pay for any concurrent charges or services not billed by MarinHealth Medical Center at time of service. MarinHealth Medical Center includes a notice regarding the Emergency Physician discount policy requirement. This policy does not apply to services provided within MarinHealth Medical Center by other physicians or other medical providers including Anesthesiologists, Radiologists, Medical Hospitalists, Pathologists, etc.

22. Notification of Emergency Physicians Fair Pricing Policies:
    a. In accordance with state law, the medical center provides notice to persons regarding the obligation of emergency physicians to have a discount payment policy for the uninsured and high-cost patients whose incomes are at or below at least 400% of the FPL. This policy may be different than the medical center's policy for discounts. The maximum fee may be different than that of the medical center. Emergency physicians are not required to offer an extended payment plan but if they do the plan must be interest free.

23. Access to Healthcare During a Public Health Emergency
    a. An Access to Healthcare Crisis must be proclaimed by [hospital leadership/ approved by the board of directors] and attached to this patient financial assistance document as an addendum.
    b. An Access to Healthcare Crisis may be related to an emergent situation whereby state/ federal regulations are modified to meet the immediate healthcare needs of MarinHealth Medical Center community during the Access to Healthcare Crisis. \
    c. During an Access to Healthcare Crisis MarinHealth Medical Center may "flex" its patient financial assistance policy to meet the needs of the community in crisis. These changes will be included in the patient financial assistance policy as included as an addendum.
    d. Patient discounts related to an Access to Healthcare Crisis may be provided at the time of the crisis, regardless of the date of this policy (as hospital leadership may not be able to react quickly enough to update policy language in order to meet more pressing needs during the Access to Healthcare Crisis)

V. AGE SPECIFIC CONSIDERATIONS NA

VI. EQUIPMENT NA

Originated By	Business Office
Origination Date	12/2002
Current Review Date(s)	02/2018, 2/2019, 12/2021, 02/2022
Current Revision Date(s)	12/2015, 2/2018, 02/2022, 12/2024

VII. APPENDICES AND ATTACHMENTS

Appendices and Attachments	Title
Attachment A	Statement of Financial Conditions (English)
Attachment B	Statement of Financial Conditions (Spanish) Declaracion de Situacion Financier
Attachment C	Financial Assistance Worksheet
Attachment D	Sample Letter
Attachment E	Physician Groups Not Covered by Financial Assistance Policy

VIII. AUTHORITY, REFERENCES, APPROVAL, DISTRIBUTION

A. Replaces: Charity Care, Financial Assistance and Low Income Uninsured #1115.9
New Title: Financial Assistance, Charity Care and Low Income Uninsured #1115.09.1

B. Authority/ Reference

1. California Health & Safety Code §127400(g)
2. California Health & Safety Code §127405
3. California Civil Code §685.010

C. Originators and Authors

Department or Function	Name	Title	Date
Originating Departments Business Office			12/2002
Latest Author Patient Financial Services	Nanette Harris	Director, PFS	2/2022

D. Reviewed or Revised By

Department, Committee or Function	Subject Matter Experts Name	Title	Date
Hospital Administration	Lee Domanico	CEO	2/2016
Revenue Cycle	Bernadette Jensen	Exec. Dir., Revenue Cycle	10/2016
Patient Financial Services	Nanette Harris	Director, Patient Financial Services	03/16/2022
Finance	Eric Brettner	CFO	04/05/2022

E. APPROVED

Originated By	Business Office
Origination Date	12/2002
Current Review Date(s)	02/2018, 2/2019, 12/2021, 02/2022
Current Revision Date(s)	12/2015, 2/2018, 02/2022, 12/2024

Department, Committee or Function	Name	Title	Date
Policy & Procedure Committee	Lillian Chan, FACHE	Chair, Policy & Procedures Committee	04/21/2022
Medical Executive Committee	NA		
Finance Committee of the Board	Joe Euphrat	Chair, Finance Committee	052/26/2022
Hospital Board of Directors	Andrea Schultz	Chair, Board of Directors	06/07/2022