Title of Policy/Procedure

SAN JOAQUIN GENERAL HOSPITAL CHARITY POLICY

POLICY: To provide comprehensive financial screening for all San Joaquin General Hospital patients who are unfunded, under-insured and do not qualify in the Patient Financial Responsibility Policy for possible reductions to their Hospital Charges.

PURPOSE: To ensure qualified patients who fall at or below the 400% of the Federal Poverty Guidelines have Fair Pricing of their hospital charges, as required by AB1020.

PROCEDURE:

SECTION I: DEFINITIONS, INCLUDING MEANING OF WORDS, AND EFFECT OF SECTION HEADINGS

A. As used in this policy, unless otherwise apparent from the context:

1. "Beneficiaries" means those persons certified eligible for services.

2. "Board of Supervisors" means the Board of Supervisors of the County of San Joaquin.

3. "California Healthcare Indigent Program" (CHIP) refers to those individuals that reside in San Joaquin County, who lack other health care coverage, and have virtually no income or assets.

4. "Charity" patients are those patients who are uninsured or underinsured and who would experience financial hardship if required to pay the bill, or a portion of the bill.

5. "County Medical Indigent Program" (CMIP) and Medical Assistance Program (MAP), mean the health care program providing coverage for eligible MIA and CHIP patients, as required by §17000 of the W&I Code.

6. "Discounts" means the reduction of billed charges to the amount of the highest government payer.

7. "Emergency Services" means any service required for the alleviation of severe pain or the immediate diagnosis and treatment of severe medical conditions, which, if not immediately diagnosed and treated, would lead to disability or death.

8. "Hospital" means San Joaquin General Hospital (SJGH).

9. "Medically Indigent Adult" (MIA) refers to those individuals that reside in San Joaquin County, who lack other health care coverage, and meet certain financial criteria.

10. "Medically Necessary" or "Medical Necessity" means a service which is reasonable and necessary to protect life, to prevent significant illness or significant disability or to alleviate severe pain.

11. "Monetary Assets" refers to resources owned and controlled by the applicant and his/her family, which are convertible to cash or held as cash as defined by the State of California in AB774 – Fair Pricing Policy.

12. "Provider" refers to any individual, group, business, or institution that delivers health care service or supplies.

13. "Self-Pay" refers to those patients that are uninsured and not covered by any government or commercial insurance and are responsible for their own medical expenses.

14. "Service Area" means the area surrounding SJGH where the primary patient population resides. This area will be considered when pre-determining eligibility for adjustments under this Policy. The service area will not be considered when reviewing eligibility for adjustments in this Policy when Emergency Services have been provided.

15. "Spend Down" means the procedure by which a beneficiary reduces his/her liquid resources (assets) to below guideline limitations. Any voluntary transfer of assets for the purpose of qualifying does not meet spend-down criteria.

16. "High Medical Costs" 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.

17. "Underinsured" patients have medical coverage but are responsible for a significant part of their expenses and their payer is not contracted with SJGH.

18. Articles and section headings, when contained herein, shall not be deemed to govern, or modify or in any manner affect the scope, meaning or intent of the provisions of any article or section.

SECTION II: COUNTY POLICY

It is the intent and purpose of the Board of Supervisors:

A. To organize and administer this Policy of Fair Pricing for San Joaquin General Hospital patients that complies with AB1020.

B. Provide Discounted, Medically Necessary outpatient and inpatient services to residents of the eligible service area in compliance with California law, including but not limited to California AB774 and SB1276, and Federal law, subject to the requirements of this policy.

C. No requirement in this section or of any other section of this policy shall in any way prevent the receipt of acutely and Medically Necessary services to individuals.

D. To reduce charges for only those medical services not provided by other entities and / or programs for which the individual is eligible.

E. To provide that responsible parties shall reimburse the County for their health care services to the fullest extent possible, provided that reimbursement does not jeopardize their future minimum self-maintenance or security.

F. To prioritize the provision of inpatient hospital services at San Joaquin General Hospital according to medical need.

G. To provide Medically Necessary services at San Joaquin General Hospital to the fullest extent practical and consistent with good practice.

H. Provide charity to financially qualified low income, uninsured, and underinsured patients who meet specified criteria.

SECTION III: GENERAL ELIGIBILITY PROVISIONS

A. This policy does not apply to cash assistance, burials, or grave maintenance.

B. Names, addresses and all other information concerning the circumstances of any individual for whom or about whom information is obtained are confidential and shall be safeguarded as required by applicable state and federal law. No disclosure of any information obtained by a representative, agent or employee of the County in the course of discharging his or her duties shall be made, directly or indirectly, except as required by law.

C. An eligible person is entitled to receive benefits without regard to age, race, color, religion, political affiliation, national origin, marital status, or sexual orientation.

D. It is the intent of this program not to duplicate medical services that may be available elsewhere, for which an individual applicant is eligible. Services that are covered by other federal and/ or other funding sources for which an individual applicant is eligible, such as, but not limited to Medicare, Medi-Cal, Worker's Compensation, third party liability plans, contracted commercial insurances, and other State/Federal funding programs will not be eligible for discounts under this policy.

E. Persons will be screened for eligibility to the CMIP program outlined in the Patient Financial Responsibility Policy. Applicants who are not eligible for MAP or CMIP programs will then be screened for eligibility to participate in this Policy.

F. Applicants or recipients subject to an adverse decision regarding eligibility of medical benefits shall have an appeal process available (See Attachment 2).

SECTION IV: ELIGIBILITY REQUIREMENTS

To qualify for this program, the patient must:

A. Reside in the Hospital's service area. Except for those patients who receive Emergency Services starting from or through the Emergency Department will be deemed to have satisfied the residence requirement.

B. Income and Resource:

1. Individuals whose monetary assets as defined in AB774 Chan that exceed $5,000 of a qualified amount will not be eligible for a Charity adjustment. Individuals may gain access to benefits if they have "spent-down" to within the asset limits.

2. Family Income, as determined by current pay stubs and/or the most recent Income Tax return(s) will not exceed 400% of FPL.

3. Utilization of other healthcare coverage – Each eligible beneficiary will be encouraged to take all actions necessary to obtain any other available health care coverage for which he/she may be eligible including, but not limited to, Medi-Cal, Limited Services Medi-Cal, Medicare, CHAMPUS, Victims of Crime, and/or other State funded programs. If a patient applies, or has a pending application for, another health coverage program at the same time that he or she applies for charity care, neither application shall preclude eligibility for the other program.

4. Each eligible person shall make a written statement of all money and income which he/she receives or is entitled to receive and estimated incomes of all his/her kindred of the degree of spouse, child or parent in order to compute the Family Income.

5. Each eligible person shall make a written statement to all money that could qualify as a monetary asset, i.e. Savings Accounts, Bonds, Stocks that he/she has in their name when consideration is being made for a Charity adjustment.

C. No requirement of this section or of any other section of this Policy shall in any way prevent the receipt of acute, medically necessary services.

D. Each eligible beneficiary will be subject to a periodic review of their income and resources, at least every 180 days, to determine continuing discounts under this policy.

E. Any individual who is discovered to have willfully misrepresented his/her assets, income or residency for the purpose of becoming eligible for Charity or Discounted services will be denied eligibility for the period in question and will be liable for all charges billed by SJGH and may not reapply for 90 days.

F. A patient who is uninsured, and who does not have third party coverage from a health insurance service plan, Medicare, or Medi-Cal and whose injury is not a compensable injury for purposes of workman's compensation, an automobile insurance, or other insurance and who is at or below 400% of the Federal Poverty Level, (FPL) is eligible to apply for the hospital's Charity Care. The FPL is outlined in Attachment 1.

G. A patient who is insured but has high medical costs, as defined in AB774 Chan, and who is at or below 400% of the Federal Poverty Level, (FPL) as contained in AB1020, may also be eligible and can apply for the hospital's Charity Care. High medical costs shall include all charges to patients covered by third party insurance, including those charges that were discounted by the third-party insurance. High medical costs also include any annual out-of-pocket costs incurred by the individual at the hospital that exceed 10 percent of the patient's family income in the prior 12 months. This would also apply to the portion of the bill that is the patient's responsibility, including co-payments, deductibles and non-covered services by the non-contracted insurance carrier.

H. This Policy will also provide consideration to those patients that do not qualify for CMIP but are responsible for a significant portion of their hospital bill, as a result of a catastrophic medical event, and are l residents of the Hospital's service area.

I. In determining eligibility for a Charity Care Adjustment, the hospital will review the patient's family income and monetary assets excluding a patient's retirement or deferred compensation plan(s). The first $10,000 of a patient's monetary asset shall not be counted, nor shall 50% of the patient's monetary assets over the first $10,000 for the purposes of determining eligibility. A sliding fee schedule will be used to determine the patient's portion of their billing, as indicated in Attachment 1.

J. In determining eligibility for an individual who is over assets for charity and has high medical costs, the hospital will review the patient's family income only. The hospital shall limit expected payment for services it provides to the patient to the highest rate paid by a Government payer (e.g. Medicare or Medi-Cal). The hospital shall establish and negotiate a payment plan with the patients.

K. Individuals who do not qualify under this Policy may apply for a Catastrophic Adjustment as described in the Patient Financial Responsibility Policy. In addition, individuals who do not qualify under this policy due to income and request financial assistance will be forwarded to Administration for review on a case-by-case basis.

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. The reason for presumptive eligibility will be reflected in the alias (transaction) code used to adjudicate the patient's claim. Additional notes may be included. Examples of these exceptions where documentation requirements are waived include, but are not limited to:

- An independent credit-based financial assessment tool indicates indigence.
- An automatic financial assistance determination of 100% assistance is applied in the following situations provided other eligibility criteria are met:
    - Patient has an active Medi-cal plan
    - Patient is eligible for Medi-cal or, patients with current active Medi-cal coverage will have assistance applied for past dates of service
    - Patient is deceased.
- Determination of patient financial assistance eligibility by the Deputy Finance Director – Patient Financial Services.

L. Non-covered and denied services provided to Medi- Cal eligible beneficiaries are considered a form of charity care. Medi-cal 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:

- Services to Medi-cal beneficiaries with restricted Medi-cal (i.e. patients that may only have pregnancy or emergency benefits, but receive other hospital care.)
- Medi-cal pending accounts
- Medi-cal or other indigent care program denials
- Charges related to days exceeding a length-of-stay limit
- Medi-cal claims (including out-of-state Medicaid claims) with 'no payment'
- Any service provided to a Medi-cal eligible patient with no coverage and no payment.

SECTION V: PATIENT RESPONSIBILITY PAYMENTS

A. Once qualified for a Charity adjustment, the patient or his/her guarantor will pay the agreed upon portion of their charges within a mutually agreed upon time frame.

B. The hospital will negotiate a "reasonable payment plan" with each patient who qualifies for a Charity.

C. The payment plan agreed to may include a deposit amount and then regular monthly payments that are reasonable and within the means of the patient/guarantor.

D. Agreed upon payments must be made as scheduled for the account to remain in good standing with the County.

SECTION VI: CHARGES

A. All charges for care at SJGH shall be in accordance with a schedule of charges adopted and/or amended from time to time by the Board of Supervisors.

B. No person shall be entitled to medical care and treatment as an inpatient or outpatient, except to the extent entitled by virtue of this policy or by law. Financial screening must occur prior to determining eligibility for this program.

C. The time, manner, source and amount of payments due from each eligible beneficiary or family seeking aid shall be established prior to receiving care, when applicable.

SECTION VII: BILLING

A. A written bill or statement will be made available to each beneficiary or his/ her legally responsible relative or legal representative or other person for whom financial responsibility has been established for services rendered at SJGH.

The statement will be mailed monthly to the patient/guarantor with the current balance due noted.

B. Patients having third party insurance coverage will be required to assign benefits to the County of San Joaquin, SJGH. The third-party carriers will be billed to the full extent of their liability. Co-pays as directed by their insurance coverage are due at the time of service. Patients who qualify for a charity are required to pay the agreed amount on a regular payment schedule.

C. The liability indicated on the patient's statement shall be due on a regular basis to SJGH from the patient or responsible party.

SECTION VIII: COLLECTIONS

All obligations established pursuant to this policy shall become delinquent if not paid when due and appropriate action shall be taken for their collection.

A. Collection practices to recover liabilities due to SJGH from patients who have been granted a Charity adjustment shall be consistent pursuant to California AB774.

B. While San Joaquin General Hospital 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. San Joaquin General Hospital 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, San Joaquin General Hospital will reverse the account out of bad debt and document the respective discount in charges as charity care.

C. Prior to selling patient debt to another party, reporting adverse information to credit agencies or bureaus, or commencing civil action against the patient for non-payment, the Hospital or its assignee must wait 180 days following the first post-discharge statement sent to the patient.

D. Before assigning a bill to collections, or selling patient debt to a debt buyer, SJGH must provide the patient with both:

   a. An application for SJGH's charity care and financial assistance;
   b. Notice including the dates of service of the bill that is being assigned to collections, the name that the entity that the bill is being.

SECTION IX: CLAIMS AGAINST THE ESTATE OF DECEDENT FOR REIMBURSEMENT FOR CARE

A. SJGH may assert a claim against the estate of the decedent or against any recipient of the property of that decedent by distribution or survival, if; (a) the patient did not qualify for a Charity, and/or (b) if a judgment by a court of law has been granted for approved discounted claims as described under California AB774.

B. SJGH may not assert a claim where there is a surviving spouse, or where there is a surviving child who is under the age of 21 or who is blind or permanently and totally disabled, within the meaning of the Social Security Act. SJGH may waive its claim, in whole or in part, if it determines that enforcement of the claim would result in substantial hardship to other dependents of the deceased individual against whose estate the claim exists.

SECTION X: REIMBURSEMENT FOR APPROVED CLAIMS

A. Approved rate schedules will be kept on file and made available to the Public upon request.

B. Providers, in accepting adjustments under this Policy, shall agree to accept the adjusted amount as a payment in full and will not attempt to collect from the beneficiary for the difference, if any, between the charged amount and the discounted amount.

SECTION XI: ELIGIBILITY APPEALS

Individuals subject to an adverse decision affecting eligibility shall have available an appeal process to afford them due process in seeking relief from such decisions. (See Attachment 2)

SECTION XII: REFUNDS

Refunds to patients for payments or co-payments shall be made with a 10.0% interest on overpayments made by a patient who qualified for a charitable adjustment pursuant to the refund policy set forth in California AB774. (See Attachment 4)

SECTION XIII. NOTICE OF POLICY

This policy shall be submitted to the Department of Health Care Access and Information (HCAI) in accordance with the procedures set by HCAI. Notice of this policy shall also be

posted on the official SJGH website with a link to the policy as well as in public locations at SJGH including:

- Emergency Department;
- Patient Financial Services;
- Admissions Office;
- Other hospital outpatient settings

ATTACHMENT 1

CHARITY ADJUSTMENT CRITERIA

A. Eligibility for the Charity Adjustment will be based on Medical Necessity, residence to the service area (excluding Emergency services), Family Income up to 400% of the current Federal Poverty Level guidelines, posted annually to the Federal Register, and liquid assets up to $5,000 of the qualifying amounts.

B. Patient Responsibility after Charity Adjustment:

≤ 200% of the current FPL: Free Care

201 – 250% of the current FPL:

Clinic Visit: $60.00 per visit
ER: $100.00 per visit
OP Surgery: $300.00 per visit
Inpatient: $300.00 per day, not to exceed $2,000.00, or a 3-year payment arrangement

251 – 300% of the current FPL:

Clinic Visit: $60.00 per visit
ER: $100.00 per visit
OP Surgery: $300.00 per visit
Inpatient: $300.00 per day, not to exceed $3,000.00, or a 3-year payment arrangement

301 – 400% of the current FPL:

Clinic Visit: $60.00 per visit
ER: $100.00 per visit
OP Surgery: $300.00 per visit
Inpatient: $300.00 per day, not to exceed $4,000.00, or a 3-year payment arrangement

ATTACHMENT 2

APPEAL PROCESS

SJGH recognizes that there may be extraordinary circumstances or disputes, which may warrant an appeal of the financial assistance determination. In such cases, a written description of the nature of the extraordinary circumstances or dispute should be forwarded to the attention of the SJGH Manager of Admitting at P.O. Box 1020, Stockton, California, 95201. The decision of the reviewing person shall be rendered within 30 days of receipt of the appeal request.

Upon receipt, the Manager of Admitting will review the request and will approve, deny or make a recommendation toward approval based upon the limits established in the procedure.

A. Appeals to denied applications shall be directed to the Manager of Admitting.

   i. If the denial is reversed, the Manager of Admitting shall send the patient an appeal acceptance letter, stating the reasons(s) for the acceptance. The Manager of Admitting will update the patient account in accordance with the approval procedures stated above.

   ii. If the denial is upheld, the Manager of Admitting will send the patient an appeal denial letter stating the reason(s) for the denial.

B. If the appellant is dissatisfied with the decision of the Manager of Admitting, he/she may file a formal appeal in writing to the Revenue Cycle Director within 30 days of the decision of the Manager of Admitting.

C. If the appellant is dissatisfied with the decision of the Revenue Cycle Director, he/she may file a formal appeal in writing to the Chief Financial Officer (CFO) within 30 days of the decision of the Revenue Cycle Director.

D. If the appellant is dissatisfied with the decision of the Chief Financial Officer (CFO), he/she may file a formal appeal in writing to the Chief Executive Officer (CEO) within 30 days of the decision of the CFO.

ATTACHMENT 3

SAN JOAQUIN COUNTY MEDICAL CHARITY PROGRAM RESIDENCY POLICY

A. It is the policy of the County of San Joaquin and San Joaquin General Hospital as a Public Hospital that all applicants must meet the residency requirements established herein to be eligible for Program participation.

B. Residence in the SJGH service area is a requirement for eligibility. Each applicant will be asked to provide evidence that he/she is a resident of the service area. Documentation/verification of information given by the applicant may be requested. Those persons determined to have residence in another service area will be referred back to that location to receive their medical services.

C. Residence is the place where one remains when not called elsewhere for labor or other special or temporary purpose, and to which he/she returns in seasons of repose. It can be established by physical presence and intent to reside in the service area. Intent to reside will be evaluated according to but not limited to the following criteria:

- Applicant's last out of county address
- Length of time lived at last out-of-county address
- Arrival date of applicant to California
- Arrival date of applicant in service area
- Reason for the applicant's presence in service area
- Length of time applicant expects to live in San Joaquin County
- Living arrangements in San Joaquin County
- Has applicant sought or obtained employment locally
- Location of applicant's personal property
- Whether applicant owns, rents or maintains a place of residence outside of San Joaquin County.
- Whether applicant has a spouse or dependent children residing outside of San Joaquin County
- Whether applicant is registered to vote in San Joaquin County
- Whether applicant received aid from another county in the month of application

D. Severity of medical need shall not be a consideration in determining County of residency.

E. Decisions regarding residency claims of applicants will be based on the responses to questions derived from the above criteria and satisfactory proof of residence in the County. Other pertinent information will also be evaluated.

F. Adverse residency decisions will be rendered when the responses do not support a reasonable expectation that the applicant intends to permanently reside in San Joaquin County. Where it is clear that an applicant is attempting to establish residency for the purpose of obtaining free or reduced cost medical care for medical conditions that predate the claim of residency in San Joaquin County, the applicant will not be granted eligibility.

G. Applicants will be advised of their appeal rights. Applicants denied on the basis of non-resident status are ineligible for the entire month of application. Assistance will be provided to those who do not qualify under this policy to locate/be directed to facilities in their place of residence, including other countries.

H. Eligible recipients of San Joaquin County's General Assistance Program shall generally be presumed to have met the residency requirements of CMIP. However, this in no way prevents the eligibility clerk from requesting documentation of residency, as deemed necessary.

I. Regardless of place of residency, no patient who has received Emergency care, whether in the Emergency Department, or in the Hospital, if admitted through the Emergency Department, will be denied access to adjustments listed in the policy.

ATTACHMENT 4

REFUND POLICY

Payments and co-payments will only be refunded when:

A. The patient has paid the full estimated payment liability amount and due to a change in financial status during the eligible months, the revised payment liability is less than the estimated amount. The program will refund the difference between the estimated amount and the revised amount.

B. The patient has paid the full estimated payment amount and then due to a change in program eligibility (e.g., patient becomes eligible for Medi-Cal) the patient's liability is less. In this case, the program will refund the patient's full liability, except for any co-payments or share of cost.

C. In all cases any patient's account with a possible refund due will be screened for balances owed to the Hospital on other accounts, as well as accounts belonging to family members. If any account exists with a balance owed, the refundable amount will be applied first to those accounts, prior to making any refund to the patient.

D. Patients who are deemed eligible for a Charity adjustment and who made an overpayment, and have no previous balances as described in (c) above, will be refunded with an added 10% interest rate in accordance to California AB774.

Author: Patient Financial Services, Patient Access Services
References: California AB774, California SB1276, California Hospital Association,

Approval:
(Revised 9/12/23 dm)