I. PURPOSE

A. San Joaquin General Hospital (the "Hospital" or SJGH) provides Charity Care and self-pay discounts adhering to the requirements of state law. The intent of this Medical Financial Assistance Policy (the "Policy") is to satisfy applicable federal and state laws and regulations; all provisions should be interpreted accordingly.

B. A significant objective of San Joaquin General Hospital is to provide care for patients in times of need. San Joaquin General Hospital provides Charity Care and a Discount Payment Program as a benefit to the communities we serve. To this end, San Joaquin General Hospital is committed to providing charity to low income, uninsured, and underinsured patients who meet a specified criterion. All patients will be treated fairly, with compassion and respect. The following topics are covered by this policy:

a) Definitions
b) County Policy
c) Medical Financial Assistance
d) Charity Program
e) Financial Assistance Discount Payment Program
f) Hospital Collections Process

II. DEFINITIONS

A. Board of Supervisors: The Board of Supervisors of the County of San Joaquin.

B. Charity Care: Any medically necessary impatient or outpatient hospital service provided to a patient, who has income below 400% of the current FPL and who has been deemed ineligible for other government assistance programs. Charity Care is defined as free care.

C. Discounted Payment: Any charge for care that is reduced to the amount of the highest government payer but not free.

D. Emergency and Medically Necessary: Any hospital inpatient, outpatient, or emergency that is not entirely cosmetic, for patient comfort and/or convenience. A service which is reasonable and necessary to protect life, to prevent significant illness or significant disability or to alleviate severe pain.

Commented [LS1]: Definition of Charity Care.

Commented [LS2]: Definition of Discount Payment.

E. High Medical Costs: 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 and exceed the lesser of: (a) ten percent (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 twelve (12) months (whether such expense were incurred or paid inside or outside of the Hospital) or (b) the annual out-of-pocket costs incurred by the individual at the hospital that exceed 10% of the patient's current Family Income or Family Income in the prior twelve (12) months.

Commented [LS3]: Definition of High Medical Costs

F. Self-Pay: Those patients that are uninsured and not covered by any government or commercial insurance and are responsible for their own medical expenses.

G. Underinsured: Patients that have medical coverage but are responsible for a significant part of their expenses and their payer is not contracted with SJGH.

H. Beneficiaries: Persons certified eligible for services.

I. California Healthcare Indigent Program (CHIP): Individuals that reside in San Joaquin County, who lack other health care coverage, and have virtually no income or assets.

J. Medically Indigent Adult (MIA): Individuals that reside in San Joaquin County, who lack other health care coverage, and meet certain financial criteria.

K. County Medical Indigent Program (CMIP) and Medical Assistance Program (MAP): Health care programs providing coverage for eligible MIA and CHIP patients, as required by §17000 of the California Welfare and Institutions W&I Code.

L. Provider: Any individual, group, business, or institution that delivers health care service

M. Spend Down: 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.

III. COUNTY POLICY

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

1. To organize and administer this Policy of Fair Pricing for San Joaquin General Hospital patients.

2. Provide Discounted, Medically Necessary outpatient and inpatient services to residents of the eligible service area in compliance with California and Federal law, subject to the requirements of this policy.

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

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

5. To provide that responsible parties should reimburse the County for their health care services, if reimbursement does not jeopardize their future minimum self-maintenance or security.

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

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

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

IV. APPLICABILITY OF THIS POLICY

A. This Policy applies to all emergencies and other medically necessary care provided by the Hospital or a substantially related entity working in the Hospital. This Policy applies only to charges for Hospital services and is not binding upon other providers of medical services who are not employed or contracted by Hospital to provide medical services, including physicians who treat Hospital patients on an emergency, inpatient or outpatient basis. Physicians not covered by this Policy who provide services to patients who are uninsured or cannot pay their medical bills due to high medical costs may have their own financial assistance policies to provide assistance. The Hospital is not responsible for the administration of any financial assistance program offered by the Hospital's non-employed medical staff physicians or such physicians' billing practices.

B. Financial assistance policies must balance a patient's need for financial assistance with the Hospital's broader fiscal stewardship. Financial assistance through discount payment and Charity Care programs is not a substitute for personal responsibility. It is the patients' responsibility to actively participate in the financial assistance screening process and where applicable, contribute to the cost of their care based upon their ability to pay. Outside debt collection agencies and the Hospital's internal collection practices will reflect the mission and vision of the Hospital.

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

D. 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 while discharging his or her duties shall be made, directly or indirectly, except as required by law.

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

F. It is the intent of this program not to duplicate medical services that may be available elsewhere, for which an individual applicant is eligible.

G. Applicants who are not eligible for MAP or CMIP programs will then be screened for eligibility to participate in this Policy.

H. Applicants who are denied eligibility of these programs shall have an appeal process available (See Attachment 2).

V. ELIGIBILITY REQUIREMENTS

A. Income and Resource

1. Family Income, as determined by current pay stubs and/or the most recent Income Tax return(s) will not exceed 400% of FPL. Family Income includes all persons 18 years of age and older, spouse, domestic partner and dependent children, whether living at home or not; and (2) persons under 18 years of age, parent, caretaker relatives, and other children of the parent or caretaker relative.

2. Utilization of other healthcare coverage – Each eligible beneficiary will be encouraged but not required 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 similar State programs. If a patient applies or has a pending application for another health coverage program while he or she applies for charity care, neither application shall preclude eligibility for the other program.

3. 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.

4. 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.

5. 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.

Commented [LS4]: •Definition of Family
•Use of only current pay stubs and tax returns; no monetary assets.
•400% FPL

Commented [LS5]: Encouraged but not required to obtain any other available health coverage for which the patient is eligible.

6. 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 program.

7. A patient who is insured but has high medical costs and who is at or below 400% of the Federal Poverty Level, (FPL) may also be eligible and can apply for the hospital's Charity Care program. 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.

8. This Policy will also provide consideration to those patients that do not qualify for charity or discounted payment but are responsible for a significant portion of their hospital bill, because of a catastrophic medical event.

9. To provide a discount for patients with high-cost medical expenses, 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.

10. Individuals who do not qualify under this Policy may apply for a Catastrophic Adjustment. 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.

11. Financial assistance may be presumptively granted in the absence of a completed application in situations where the patient does not apply but other available information supports a financial hardship. The reason for presumptive eligibility will be reflected in the alias (transaction) code used to determine the outcome of settling the patient's claim. Additional notes may be included. Examples of these exceptions where documentation requirements are waived include, but are not limited to:

Commented [LS6]: Presumptive eligibility without application for charity.

a) An independent credit-based financial assessment tool indicates indigence.

b) An automatic financial assistance determination of 100% assistance is applied in the following situations provided other eligibility criteria are met:

c) Patient has an active Medi-Cal plan

d) Patient is eligible for Medi-Cal or, patients with current active Medi-Cal coverage will have assistance applied for past dates of service

e) Patient is deceased.

f) Determination of patient financial assistance eligibility by the Deputy Finance Director – Patient Financial Services.

g) 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:

(1) 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.)

(2) Medi-Cal pending accounts

(3) Medi-Cal or other indigent care program denials

(4) Charges related to days exceeding a length-of-stay limit

(5) Medi-Cal claims (including out-of-state Medicaid claims) with 'no payment'

(6) Any service provided to a Medi-Cal eligible patient with no coverage and no payment.

VI. 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 may waive or reduce Medi-Cal and Medicare cost-sharing amounts as part of its charity care program or discount payment program.

Commented [LS7]: Waiving Medi-Cal/Medicare cost sharing as a part of charity program.

C. The hospital will negotiate a "reasonable payment plan" with each patient who qualifies for Charity which takes into consideration the patient's family income and essential living expenses.

D. 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.

E. A health savings account held by the patient or the patient's family may be considered when negotiating payment plans.

Commented [LS8]: Health Savings Account may be considered when negotiating payment plans.

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

G. If the hospital and patient cannot agree on the payment plan, the hospital shall create a reasonable payment plan, where monthly payments are not more than 10% of the patient's monthly family income, excluding deductions for essential living expenses.

VII. 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 the payments due from each eligible beneficiary or family seeking aid shall be established prior to receiving care, when applicable.

VIII. 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.

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

C. 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 charity are required to pay the agreed amount on a regular payment schedule.

Commented [LS9]: May require assignment of third party payments to SJGH.

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

IX. COLLECTIONS

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

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

C. 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 to SJGH the 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. The Hospital will not impose time limits for applying for charity or discounted payment nor will it deny eligibility based on the timing of a patient's application.

Commented [LS10]: Financial Assistance may be obtained any time during the collection process.

D. The hospital will not report adverse information about a patient's hospital debt to a consumer credit reporting agency.

Commented [LS11]: Will not report adverse information about hospital debt to collection agency.

E. 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 must find the patient ineligible for financial assistance and must wait 180 days following the first post-discharge statement sent to the patient.

F. The sale of any real property owned by the patient is prohibited.

Commented [LS12]: The sale of real property is not allowed to pay off hospital debt.

G. Liens on any real property owned by the patient are prohibited.

Commented [LS13]: Liens on real property is prohibited.

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

1. An application for SJGH's charity care and financial assistance.
2. 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.

I. SJGH may declare 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.

J. 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.

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.

XI. ELIGIBILITY APPEALS

A. Individuals denied eligibility for charity or discount payment shall have available an appeal process to afford them due process in seeking relief from such decisions.

XII. REFUNDS

A. 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).

B. The hospital is not required to reimburse a patient if: (1) it has been five years or more since the patient's last payment to hospital/debt buyer, or (2) the patient's debt was sold before January 1, 2022, in accordance with the law at the time.

Commented [LS14]: Patient Reimbursement over five year since last payment.

XIII. NOTICE OF POLICY

A. 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:

1. Emergency Department;
2. Patient Financial Services;
3. Admissions Office;
4. Other hospital outpatient settings

XIV. 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

XV. 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.

XVI. 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.

XVII. 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 with California AB774.

Author: Patient Financial Services, Patient Access Services
Approval:
(Revised 12/31/2024)