

Title: AD – Patient Financial Assistance Policy			
Policy Level	☒	System Level – Sets expectations for all JMH employees	
	☐	Entity Level – Sets expectations for employees in <u>multiple departments</u> within one or more entities	
	☐	Department Level – Sets expectations for employees in <u>only one</u> department at one or more sites	
Department	☐		
Entity(ies)	☐	Concord Medical Center (CMC)	☐ Walnut Creek Medical Center (WCMC)
	☐	Physician Network (PN)	☐ Behavioral Health Center (BHC)
Document Type	☐ Policy ☐ Procedure ☒ Policy and Procedure		

I. Purpose:

To set forth clear criteria and a fair process for providing financial assistance to patients who (i) require Medically Necessary Hospital Services and (ii) have limited or no means to pay for such care. This Policy is designed to comply with the California Hospital Fair Pricing Law (California Health & Safety Code § 127400 et seq.), California Fair Debt Collection Practices Act (California Civil Code 1788 et. seq.), United States Internal Revenue Code Section 501(r) and guidance from the United States Department of Health and Human Services Office of Inspector General regarding financial assistance to uninsured and underinsured patients.

Definitions:

Designated Languages: The Designated Languages are English, Spanish, and any other language that is spoken by more than 1,000 patients (including inpatients and outpatients) receiving care at a John Muir Health [JMH] Hospital in a twelve-month period as measured in the most recent language survey conducted by the JMH Community Health Improvement Department. Such assessment shall be conducted and documented at least every three years upon request from JMH Finance.

Family: (1) For persons 18 years of age and older, spouse, domestic partner, as defined in Section 297 of the Family Code, and dependent children under 21 years of age, or any age if disabled, consistent with Section 1614(a) of Part A of Title XVI of the Social Security Act, whether living at home or not.

(2) For persons under 18 years of age or for a dependent child 18 to 20 years of age, inclusive, parent, caretaker relatives, and parents or caretaker relatives' other dependent children under 21 years of age, or any age if disabled, consistent with Section 1614(a) of Part A of Title XVI of the Social Security Act.

Healthcare Emergency: The JMH Chief Financial Officer or his/her designee may designate a "Healthcare Emergency" under this Policy when he/she determines in his/her discretion that extraordinary, urgent circumstances warrant a temporary expansion of financial assistance under this Policy.

Hospital Service: A Hospital Service is a service that (i) is furnished by a JMH Hospital in an inpatient or hospital-licensed outpatient setting and (ii) billed by a JMH Hospital. The term does not include (i) separately billable professional services of physicians or advanced practice professions or (ii) services furnished by any person or facility outside of a licensed hospital.

Medically Necessary: A Medically Necessary service is one that (i) is absolutely necessary to treat or diagnose a patient, (ii) could adversely affect the patient's condition if withheld, and (iii) is not considered an elective or cosmetic intervention or treatment. Services performed within the hospital are presumed to be medically necessary unless the referring provider provides an attestation that the hospital services at issue were not medically necessary.

Reasonable Payment Plan: A Reasonable Payment Plan is one that incorporates monthly payments to the Hospital that are not more than 10 percent of a patient's Family income for a month (after Essential Living Expenses have been deducted from such income) and precludes any interest charge on the unpaid balance. "Essential Living Expenses" means, for purposes of this definition, expenses for any of the following: rent or house payment and maintenance, food and household supplies, utilities, and telephone, clothing, medical and dental payments, insurance, school or childcare, child or spousal support, transportation and auto expenses, including insurance, gas, and repairs, installment payments, laundry and cleaning, and other extraordinary expenses.

Self-Pay Patient: A patient who (i) has a Family income at or below 400% of the Federal Poverty Guidelines (FPG) and (ii) lacks third-party coverage for the specific Hospital Services furnished. A patient who has third-party coverage for certain Hospital Services will qualify as Self-Pay for those Hospital Services falling outside the scope of the patient's coverage (including, without limitation, non-covered Hospital Services, denied days, denied stays). By contrast, a patient lacking general health insurance coverage will fail to qualify as Self-Pay if he or she has specific source of payment for the condition giving rise to Hospital Services (e.g., worker's compensation, automobile insurance).

Underinsured Patient: A patient who has (i) Family income at or below 400% of the FPL; (ii) third-party coverage for the Medically-Necessary Hospital Service furnished (*i.e.*, is not a Self-Pay Patient with respect to the Medically-Necessary Hospital Service furnished); and (iii) has aggregate out-of-pocket medical expenses from all sources in the prior twelve (12) months that exceed 10% of the lesser of the projected value of the patient's current Family income or the Family's actual income over the prior 12 months.

Financially Qualified Patient: An uninsured patient or a patient with high medical costs after insurance that are at or below 400% of the Federal Poverty Level as defined in subdivision (b) of Section 127400.

Charity Care: Means free care. Uninsured patients or patients with high medical costs who are at or below 400 percent of the federal poverty level, as defined in subdivision (b) of Section 127400, shall be eligible for participation under a hospital's charity care policy.

Discounted payment: Means any charge for care that is reduced but not free. A discount payment policy shall include an extended payment plan to allow payment of the discounted price over time. The policy shall provide that the hospital and the patient shall negotiate the terms of the payment plan and take into consideration the patient's family income and essential living expenses. A hospital may also consider the availability of a patient's health savings account held by the patient or the patient's family. If the hospital and the patient cannot agree on the payment plan, the hospital shall use the formula described in subdivision (i) of Section 127400 to create a reasonable payment plan. JMH will use this definition for denying charity applications for family income exceeding 400% of federal poverty guidelines and set payment arrangements in determination letter to patient.

II. **Policy:**

General Scope: This policy is designed to provide assistance to patients who (i) require Medically Necessary Hospital Services, (ii) have a Family income of 400% or less of the current FPL and (iii) are either Self-Pay Patients or Underinsured Patients. This policy and the financial screening criteria will be applied consistently to all cases throughout JMH. Any decisions made under this Policy, including the decision to grant or deny financial assistance, shall be based on an individualized determination of financial need and shall not take into account race, color, national origin, citizenship, religion, creed, gender, sexual preference, age, or disability.

A. **Exclusions:** This policy addresses financial assistance only for Medically Necessary Hospital Services. It explicitly excludes (i) Hospital Services that are not Medically Necessary, (ii) services other than Hospital Services, and (iii) separately billable professional services furnished in the Hospital (even when they are Medically Necessary). Finally, this policy will not apply if the patient or other responsible party (i) fails to provide information listed in this policy after reasonable requests by JMH, and (ii) provides false information about financial eligibility.

B. Professional Services:

1. **General:** As noted above, this Policy does not provide financial assistance for separately billable services of physicians and advanced practice professionals who furnish care in the Hospital. Rather, such professionals independently choose whether they wish to offer financial assistance (and, if so, the terms under which such assistance will be offered). JMH will maintain a list of each credentialed physician and advanced practice professional practice who furnishes care in the Hospital ("Practitioner List") and separately indicate for each identified practice whether he or she has agreed to be bound by the terms of the policy. The Practitioner List shall be updated quarterly, indicate the date on which it was last updated, and be made available online and in any location where this Policy is posted or in hard copy without charge. The list will be available once a request is submitted to The Director of Patient Financial Services, or the Executive Director Revenue Cycle, 5003 Commercial Circle, Concord, CA 94520.

It should be noted, however, that an emergency physician who provides emergency medical services in a JMH (or non-JMH) Hospital is required to provide discounts to uninsured patients or patients with high medical costs who have a Family income at or below 400% of the Federal Poverty Level. This is true regardless of whether the emergency physician or his or her practice has agreed to specifically be bound by this policy.

- C. **Limitation on Charges:** A Financially Qualified Patient or Underinsured Patient receiving Medically Necessary Hospital services shall be asked to pay no more than the greater of Medicare or Medi-Cal payment for the service furnished. Per the terms of this policy however, no patients found eligible for Financial Assistance will be billed any charges for Eligible Services while covered under this policy.

III. Procedure:

A. Communication of Financial Assistance Policy

1. Patients will be provided a brochure and plain language summary detailing our Financial Assistance Policy in the Designated Languages indicating the following: (i) the assistance offered under this policy, (ii), the eligibility criteria for assistance, (iii) how to apply for assistance, (iv) the web site address and physical location to obtain by mail a free copy of this policy and a financial assistance application form, (v) contact information (including telephone number and physical location) of the office or department where a patient can receive assistance with the application process, (vi) the fact that those eligible for assistance under this policy cannot be charged more than the Medicare fee-for-service allowable for Medically-Necessary Hospital Service; (vii) the fact that this policy, the plain language summary, and the application form are available in the Designated Languages.

2. The brochure and plain language summary will be given to patients in the Designated Languages at the time of service when such patients (i) are in the Admitting Department, Emergency Department, Patient Registration, Patient Financial Services or other outpatient Hospital settings where patients may be billed for Hospital Services even though not admitted and (ii) do not appear to have third-party coverage.
3. A notice will be posted in the Designated Languages in conspicuous places throughout the Hospital, including the Admitting Department, Emergency Department, Patient Registration, Patient Financial Services, or other outpatient Hospital settings where patients may be billed for Hospital Services even though not admitted.
4. The brochure and plain language summary will also be available in the Designated Languages on the John Muir Health website.
5. Patients shall receive information about this policy in their billing statements and collection action letters.
6. Other venues may be used to educate and inform the patient and physician population of the availability of the Patient Financial Assistance program as deemed appropriate.

B. Determining Eligibility

1. **Patients without Third-Party Coverage:**
 - a. If the patient does not indicate coverage by a third-party payer, or requests financial assistance, the patient should be screened for eligibility for the Medi-Cal program, provided an application for the Medi-Cal program, the Healthy Families program, coverage offered through the California Health Benefits Exchange, California Children's Services (CCS), or other state or county-funded health coverage program before the patient leaves the Hospital. The patient also shall be provided with a referral to Health Consumer Center, Bay Area Legal Aid, 1735 Telegraph Ave, Oakland, CA 94612; (855) 693-7285, <http://healthconsumer.org/index.php?id=446>, or other agency as applicable.
 - b. Completing an application for these programs is not a requirement to be screened and approved for Financial Assistance if the patients meet the other eligibility criteria.
 - c. All uninsured patients will be offered an opportunity to complete a Patient Financial Assistance Application. The form is available in each of the Designated Languages. The Patient Financial Assistance Application will be used to determine a patient's eligibility for local, state, and federal governmental programs as well as assistance under this Policy. A patient seeking assistance under this Policy must complete the Application, and

Family income will be verified. The eligibility screening will be performed by JMH or its designee. It is the patient's responsibility to cooperate with the information gathering process.

2. An applicant must provide documentation of income limited to timeframe of when patient is first billed or twelve (12) months prior to when the patient was first billed. Documentation of income shall be (i) income tax returns, or (ii) recent pay stubs [recent pay stubs are pay stubs within a six (6) month period before or after the patient is first billed by the hospital, or in the case of pre-service, when the application is submitted]. Documentation of income submitted to JMH in applying for financial assistance under this Policy will not be used for collection activities.
 - a. JMH will review Patient Financial Assistance Applications monthly for approval.
 - b. A patient without third-party coverage (and ineligible for coverage under State, County, and other programs), will be entitled to free Medically Necessary Hospital Services under this Policy if the sum of the following is at or below 400% of the FPL:

Patient's Family income will be based on documentation outlined in section 2 above, for each Family Member.

- c. Balances approved will be submitted for an adjustment/reduction to a transaction code assigned to Patient Financial Assistance and will follow the signature authority pursuant to the JMH Write-Off Guidelines.
 - d. John Muir Health runs a file through a nationally recognized tool, Experian, on all Self-Pay (uninsured) balances prior to sending a patient's account to Bad Debt. The file uses the patient's Social Security Number and demographic information to pull their FPG [Federal Poverty Guideline] score. For all Self-Pay balances for Medically Necessary Hospital Services that indicate a Family income of 400% or less, a file is generated and reported to John Muir Health. Upon validation that the patient does not have Medi-Cal, 100% of the balance is adjusted/reduced to Presumptive Charity.

For patients that present as homeless without an active address and who do not provide enough information to pull their FPG score, the balance of their account will be written off to Presumptive Charity.

3. Patients with Third-Party Coverage.

- a. Patients with third-party coverage who have significant out-of-pocket medical costs will be screened to determine whether they qualify as Underinsured Patients. Upon patient request for financial assistance, the patient will be informed of the criteria to qualify as an Underinsured Patient under this Policy and the need to provide evidence of expenses for any medical services rendered at other providers in the past twelve months. It is the patient's decision as to whether he or she wishes to apply. However, the Hospital will ensure that all information pertaining to the Financial Assistance Policy was provided to the patient.
- b. A Patient seeking assistance under this Policy must complete the Patient Financial Assistance Application. Family income will be verified.
- c. The eligibility screening under this policy will be performed by JMH or its designee. It is the patient's responsibility to cooperate with the information gathering process. JMH will review Patient Financial Assistance Applications monthly for approval.
- d. JMH will waive any out-of-pocket fees for Medically-Necessary Hospital Services furnished to an Underinsured Patient if the patient is at or below 400% of the Federal Poverty Guidelines and patient has out-of-pocket medical expenses in the prior twelve (12) months that exceeds 10% of the lesser of the projected value of the patient's current Family income or the Family's actual income over the prior 12 months.
 - i. An applicant must provide documentation of income limited to timeframe of when patient is first billed or twelve (12) months prior to when the patient was first billed. Documentation of income shall be (i) income tax returns, or (ii) recent pay stubs [recent pay stubs are pay stubs within a six (6) month period before or after the patient is first billed by the hospital, or in the case of pre-service, when the application is submitted]. Patients with insurance are required to provide (iii) evidence of out-of-pocket medical expenditures relevant to determining whether a patient is an Underinsured Patient. Documentation of income submitted to JMH in applying for financial assistance under this Policy will not be used for collection activities.
 - ii. Information of Health Savings Account [H S A] funds the patient/family may have available to use for health care expenses.
- e. Balances approved will be submitted for adjustment/reduction to a transaction code assigned to Patient Financial Assistance and will follow the signature authority pursuant to the JMH Write-Off Guidelines.

C. Review Process:

1. Requirements above will be reviewed and consistently applied throughout JMH in making a determination on each patient case.
2. Information collected in the Patient Financial Assistance Application may be verified by JMH. The patient's signature on the Patient Financial Assistance Application will certify that the information contained in the form is accurate and complete.
3. Any patient, or patient's legal representative, who requests charity or discounted care under this policy shall make every reasonable effort to provide JMH with documentation of income and all health benefits coverage. Failure to provide information could result in a denial of financial assistance.
4. In the case of Inpatient Hospital Services, The Patient Financial Assistance Application will be required each time the patient is admitted and is valid for the current admission plus retroactive application for any previous owning Hospital Services. In the case of outpatient Hospital Services, the Patient Financial Assistance Application must be submitted every six months.
5. Patients will be notified in writing of approval or reason for denial of financial assistance as well as their appeal rights. (See the section for Appeals/ Reporting Procedures.) Such notification shall be made in Designated Languages.
6. Specific payment responsibility amounts for discounts will require the episode of care or treatment plan to be determined and priced to enable accuracy of Federal healthcare program reimbursement reporting. For Underinsured Patients, it may be necessary to wait until a payer has processed the claim to determine patient financial responsibility.
7. Medicare program patient liability amounts will be treated with no discrimination and will move forward to collection processes to first collection agency where efforts are continued to collect from the patient. Upon 120 days, if not collected, the account will be returned to JMH for adjustment to zero for inclusion to Medicare Cost Report process as defined by federal regulations.
8. Medi-Cal approval to state program uses 400% of federal poverty guidelines. Share of Cost amounts that are not paid by the patient will be considered qualified for financial assistance by merit of being approval to the program for the services. Share of cost by the Medi-Cal program are self-pay and can be considered in the application process.

D. Patient Billing And Collection Practices:

1. Patients who have not provided proof of coverage by a third-party at or before care will be provided a statement of charges for Hospital Services ("Statement of Charges"). The Statement of Charges will include (i) a statement of charges for the Hospital Services furnished, (ii) a request to provide the Hospital with health insurance or third-party coverage information, and (iii) a copy of the Summary. The Statement will also indicate that if the patient does not have health insurance coverage, he or she may be eligible for Medi-Cal, HealthyFamilies Program, coverage offered through the California Health Benefit Exchange, California Children's Services, other government-funded health coverage, or financial assistance under this policy. Finally, the Statement shall indicate that (i) the Hospital will provide applications for such coverage and assistance, (ii) the telephone and physical address where such applications can be obtained, and (iii) the telephone and contact information for the local consumer assistance center at the community Legal Services Office.
2. Before being sent to collections, the patient will receive a handoff letter detailing the accounts that will be sent to collections and their options for payment before this occurs. The letter will specify (i) the dates of service for the underlying care, (ii) the entity that will be pursuing collections, (iii) how to obtain an itemized bill from the hospital, (iv) entity that will pursue collections, (v) the health coverage for the patient on record at the time of service (or absence of coverage), (vi) the Hospital's application for financial assistance, (vii) the date or dates on which the patient was previously provided information to apply for financial assistance, and (viii) the date of determination on any prior applications for assistance.
3. Hospital or its contracted collection agencies must send a notice specifying the following at least thirty (30) days before commencing a collection action:

Collection activities the Hospital or contracted collection agency may take and the likely timeline within which they would be undertaken. This information will be included in the handoff letter that is sent before the patient's account is sent to collections. Patients may request information regarding the Patient Financial Assistance Policy orally or in writing, and a Patient Financial Assistance Application will be provided to the patient. Written correspondence with the patient shall be in the Designated Language.
4. If a patient is attempting to qualify for assistance under this Policy and is attempting in good faith to settle any outstanding bill, the Hospital shall not send the unpaid bill to any collection agency or other assignee unless that entity has agreed to comply with this policy. In either event, the patient will be given a reasonable opportunity to complete the application process before further collection action is undertaken.

5. If a patient has a pending appeal for coverage of the Medically Necessary Hospital Service by a third-party payer and makes reasonable efforts to keep JMH updated, JMH shall suspend any collection action until completion of the appeal or failure by the patient to provide timely updates regarding the appeal.

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

6. Patients are required to promptly report to JMH any change in their financial information.
7. Information regarding the patient's Family income shall not be used in support of collection efforts.
8. Prior to deferring or denying medically necessary care due to non-payment of prior bills, JMH must provide written notice that Financial Assistance is available for those who qualify.
9. The Single Business Office is the department at JMH with authority to determine whether the Hospital has made reasonable efforts to assess whether a patient is eligible for assistance under this policy before commencing collection actions.
10. Prior to commencing collection activities against a patient who is eligible for financial assistance under this Policy, the Hospital and our contracted collection agencies will provide a notice (i) containing a statement that non-profit credit counseling may be available, (ii) incorporating a summary of the patient's rights, and (iii) a further statement as follows: "State and Federal law require debt collectors to treat you fairly and prohibit debt collectors from making false statements or threats of violence, using obscene or profane language, and making improper communications with third parties, including your employer. Except under unusual circumstances, debt collectors may not contact you before 8:00 AM or after 9:00 PM. In general, a debt collector may not give information about your debt to another person other than your attorney or spouse. A debt collector may contact another person to confirm your location or to enforce a judgment. For more information about debt collecting activities, you may contact the Federal Trade Commission by telephone at 1 877-FTCHELP or online at www.ftc.gov. The foregoing notices shall also be included in any communication with the patient indicating the start of collection activities may occur.

11. Neither JMH nor its contracted collection agencies will impose wage garnishments or liens on real property. This requirement does not preclude JMH from pursuing reimbursement from third-party settlements or other legally responsible parties. Agencies that assist the Hospital and may send a statement to the patient must sign a written agreement that they will adhere to the Hospital's standards regarding collections from patients.

The agency must also agree to:

- a) Not report adverse information to a consumer credit reporting agency. They may also not commence civil action against the patient for non-payment at any time prior to 180 days after initial billing.
- b) Suspend any extraordinary collection efforts if patient has submitted a pending Financial Assistance Application.
- c) Not place liens on real property.
- d) Adhere to all requirements as identified in the California Hospital Fair Pricing Act Health & Safety Code Section 127400 et seq., Internal Revenue Code 501(r), and the California Fair Debt Collection Practices Act (California Civil Code 1788 et. seq.).
- e) Comply with the definition and application of a Reasonable Payment Plan, as defined in the Definition Section above.

12. In the event that a patient is overcharged an amount that is greater than \$5.00, the Hospital shall reimburse the patient the overcharged amount with interest at 10%, (Article XV, Section 1 of the California Constitution), calculated from the date the overpayment is identified. JMH is not required to refund the patient payments if it has been five [5] years or more since the last payment to the hospital, hospital assignee, in accordance with state law in effect at the time of the debt, and if before January 1, 2022. Refunds are due to patient within 30 days of completed determination.

13. A patient shall not be denied financial assistance that would be available pursuant to the policy published on the Hospital's website at the time the patient was first billed.

E. Appeals Reporting Procedures:

Responsibility: Patient Financial Services

1. In the event of a dispute or denial, a patient may seek review from the Director of Patient Financial Services. The Hospital CFO or their designee will review a second-level appeal.
2. This policy, the Summary, and the Patient Financial Assistance Application shall be provided to the Department of Health Care Access and Information (DHCAI) at least biennially on January 1. If significant revisions are made between biannual filings, an interim filing shall be made.
3. If no significant revision has been made by JMH since the policies and financial information form was previously provided, DHCAI will be notified that there has been no significant revision.
4. In reporting data relating to charity and discounted care, only those write-offs and discounts provided under this Policy shall count towards calculation of “community benefit” on the Form 990 filed by JMH.

F. Healthcare Emergency. During a Healthcare Emergency, the JMH Chief Financial Officer or his/her designee may temporarily amend the terms of this Policy in order expand the availability of financial assistance. Any such amendments will be documented in writing with specificity as to the effective date and termination date (it being understood that establishment and documentation of the termination date might occur in a subsequent notice if not known as of the effective date). JMH shall make reasonable efforts under the circumstances to communicate to the public the terms and duration of any such amendment. It is understood, however, that the demands of the emergency may not permit communication through all of the channels described in Section III.A and other portions of this Policy. Within ten (10) days of implementing material temporary amendments to this Policy under this subsection, the JMH Chief Financial Officer or his/her Designee shall provide written notice to the Chair of the JMH Board and the Chair of the JMH Finance Committee summarizing the terms, effective date, and termination date (if known) of any such amendment.

IV. Patient/Family Education

Provided through publication of this policy on the JMH website, direct education from JMH designees, and posted information as outline in this Policy.

V. Documentation: N/A

Reference/Regulations:	
California Hospital Fair Pricing Law (Health & Safety Code § 127350 et seq.), United States Internal Revenue Code Section 501 (r), California Fair Debt Collection Practices Act (California Civil Code 1788 et. seq.), AB2297	
Supersedes:	
Primary Sponsor Name & Title:	
Gretta Senegal, Director Revenue Cycle Hospital and Physician Billing	
Owner(s) Name & Title:	
Gretta Senegal, Director Revenue Cycle Hospital and Physician Billing	
Record of Review Dates	
List Stakeholder, Committee, Medical Staff, etc. Reviews: (with approval dates)	
Jeff Smith, Controller September 2025	
Origination Date:	December 2006

Record of Approval Dates - System or Entity Level Documents		
PPRC: Direct to Board		
JMPN: Direct to Board		
MEC - BHC: N/A	MEC - WC: N/A	MEC - CC: N/A
System Performance Huddle:	Direct to Board	Board 12/06, 11/09, 02/12, 1/16, 3/25/20, 10/27/21, 9/21/22, 7/26/23, 9/24/25