I. PURPOSE OF THIS POLICY

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 SJGH is to provide care for patients in times of need. The Hospital provides Charity Care and a Discount Payment Program as a benefit to the communities we serve. To this end, SJGH 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 USED IN THIS POLICY

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

B. Federal Poverty Level: The measure of the Federal Poverty Level (FPL) shall be made by reference to the most up to date Health and Human Services Poverty Guidelines for the number of people in the patient's Family or household. HHS Poverty Guidelines are updated periodically in the Federal Register by the United States Department of Health and Human Services under authority of subsection (2) of Section 9902 of Title 42 of the United States Code and are available here: at https://aspe.hhs.gov/poverty-guidelines or per request from the Hospital's patient financial services at 209-468-6679.

C. 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.

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

E. 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.

F. EMTALA: The Hospital complies with the requirement of the Emergency Medical Treatment and Active Labor Act (EMTALA), Section 1867 of the Social Security Act. There is nothing contained in this policy, which will preclude such compliance. This is a federal law that requires anyone coming to an emergency department to be stabilized and treated, regardless of their insurance status or ability to pay.

G. 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. A patient who has high medical costs and who is at or below 400% of the FPL may also be eligible and can apply for the Hospital's Charity Care and Discount Payment program.

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

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

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

K. Emergency Physician: Per Health & Safety Code § 127405 (a)(1)(B), an emergency physician, as defined in Section 127450, who provides emergency medical services in a hospital that provides emergency care is also required by law to provide discounts to uninsured patients or patients with high medical costs who are at or below 400 percent of the FPL. Physicians providing care at SJGH are independent practitioners and are not employees or agents of SJGH. SJGH does not provide patient financial assistance for the professional fees charged by physicians and other third- party providers for their services, even if those services were rendered at SJGH.

III. COUNTY POLICY

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

1. To organize and administer this Policy of Hospital Fair Pricing for SJGH patients.

2. Provide Discounted, medically necessary outpatient and inpatient services in compliance with California and Federal law, and 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 ensure 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 SJGH according to medical need.

7. To fully provide medically necessary services at SJGH to an extent practical and consistent with good practice.

8. Provide charity care or discounted care 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. This Policy applies only to charges for Hospital services and does not cover 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 through Charity Care and Discount Payment 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 other governmental assistance programs will 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. 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. 2) 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)] Family Income shall not exceed 400% of FPL and is documented as follows:

a) Charity Care Income Requirements: Current pay stubs and/or the most recent Income tax return(s).

b) Discount Payment Income Requirements: Income tax returns for the year in which the patient was first billed or 12 months prior to when the patient was first billed, or paystubs within a 6-month period before or after the patient is first billed by the hospital.

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 income for the purpose of becoming eligible for charity care or discounted services will be denied eligibility for the period in question and will be liable for all charges billed by SJGH.

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 FPL is eligible to apply for the Hospital's Charity Care and Discount Payment program.

7. A patient who is insured but has high medical costs and who is at or below 400% of the FPL may also be eligible and can apply for the Hospital's Charity Care and Discount Payment 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 the Charity Care and Discount Payment program but are responsible for a significant portion of their hospital bill, because of a catastrophic medical event.

9. To provide a discount for patients, 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:

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:

1. Patient has an active Medi-Cal plan
2. Patient is eligible for Medi-Cal or, patients with current active Medi-Cal coverage will have assistance applied for past dates of service

c) Patient is deceased.

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

e) 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 discount payment 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 and Discount Payment program.

C. The Hospital will negotiate a "reasonable payment plan" with each patient who qualifies for a discounted payment 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.

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

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 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 Hospital. 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 discount payment plan are required to pay the agreed amount on a regular payment schedule.

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. While the 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. The Hospital's 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, the 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.

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

D. Prior to selling patient debt to another party or commencing civil action against the patient for non-payment, the Hospital must find the patient ineligible for the Charity Care and Discount Payment program and must wait 180 days following the first post-discharge statement sent to the patient.

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

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

G. 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 Discount Payment program.

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.

H. 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 Care or Discount Payment, and/or (b) if a judgment by a court of law has been granted for approved discounted claims as described under California AB774.

I. 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 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. If a patient qualifying for financial assistance under this Policy makes a payment to the Hospital in excess of the amount the patient is determined to be responsible for, the overpayment amount, including interest accrued at a rate of 10% per annum beginning on the date the overpayment is received, shall be promptly refunded to the patient within 30 days. The Hospital is not required to reimburse the patient or pay interest if the amount due to the patient is less than $5.00, but will give the patient a credit for that less than $5.00 amount due for at least 30 days from the date the amount is due. (See Attachment 3).

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.

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

B. Notices shall be posted in languages where a patient population of 5% or 1,000 individuals is determined through an annual review of the language demographic information collected during the registration process. Currently, notices are published in English and Spanish. A telephone number will be available for persons with questions to inquire about the Hospital's Charity Care and Discount Payment program.

C. Additional Resources: The Health Consumer Alliance ("HCA") is a resource available to patients to help them understand the billing and payment process, as well as Covered California and Medi-Cal Presumptive Eligibility. HCA offers free assistance over-the-phone or in-person. For more information, visit the Health Consumer Alliance website at https://healthconsumer.org.

D. Shoppable Services: In compliance with the No Surprise Billing Act (Title 45 section 180.60 of the Code of Federal Regulations), please see the Hospital's tool of shoppable services available at https://www.sanjoaquingeneral.org/SJGH Price Transparency/

XIV. ATTACHMENT 1

DISCOUNT PAYMENT ADJUSTMENT CRITERIA

Eligibility for the Discount Payment adjustment will be based on medical necessity, and Family Income up to 400% of the current FPL guidelines, posted annually to the Federal Register.

Patient Responsibility after Charity Care and Discount Payment adjustment:

≤ 200% of the current FPL: Free Care

201 – 250% of the current FPL:

Clinic Visit	$60.00 per visit	
Emergency Services	$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	
Emergency Services	$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	
Emergency Services	$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

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. If a patient qualifying for financial assistance under this Policy makes a payment to the Hospital in excess of the amount the patient is determined to be responsible for, the overpayment amount, including interest accrued at a rate of 10% per annum beginning on the date the overpayment is received, shall be promptly refunded to the patient within 30 days. The Hospital is not required to reimburse the patient or pay interest if the amount due to the patient is less than $5.00 but will give the patient a credit for that less than $5.00 amount due for at least 30 days from the date the amount is due.

D. 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.

Author: Patient Financial Services, Patient Access Services
Approval:
(Revised 12/31/2025)