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|--|-------------------------------------|---|-------------------------------------|------------------------------------|
| <b>Title: AD – Patient Financial Assistance Policy</b> |                                     |   |                                     |                                    |
| <b>Policy Level</b>                                    | <input checked="" type="checkbox"/> | System Level – Sets expectations for all JMH employees  |                                     |                                    |
|  | <input type="checkbox"/>            | Entity Level – Sets expectations for employees in <u>multiple departments</u> within one or more entities |                                     |                                    |
|  | <input type="checkbox"/>            | Department Level – Sets expectations for employees in <u>only one</u> department at one or more sites     |                                     |                                    |
| <b>Department</b>                                      | <input type="checkbox"/>            |   |                                     |                                    |
| <b>Entity(ies)</b>                                     | <input checked="" type="checkbox"/> | Concord Medical Center (CMC)  | <input checked="" type="checkbox"/> | Walnut Creek Medical Center (WCMC) |
|  | <input type="checkbox"/>            | Physician Network (PN)  | <input checked="" type="checkbox"/> | Behavioral Health Center (BHC)     |
| <b>Document Type</b>                                   | <input type="checkbox"/>            | Policy  | <input type="checkbox"/>            | Procedure                          |
|  | <input checked="" type="checkbox"/> | 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 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 JHM Finance.

**Family:** For patients 18 years of age or older, a patient's family is defined as his or her (i) spouse or domestic partner (as defined in Section 297 of the California Family Code) and (ii) dependent children under 21 years of age (whether or not living at home). For persons under 18 years of age, a patient's family is defined to include (i) parent(s) or caretaker relative(s) and (ii) other children under 21 years of age of the parent or caretaker relative.

**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.

**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 child care, 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 Level ("FPL") 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 a specific source of payment for the condition giving rise to Hospital Services (e.g., worker's compensation, automobile insurance, and third-party liability).

**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 annualized value of the patient's current Family income or the Family's actual income over the prior 12 months.

## 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 FPL and (iii) are either Self-Pay Patients or Underinsured Patients. This policy and the financial screening criteria must 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, (ii) provides false information about financial eligibility, or (iii), fails to make reasonable effort to apply for and receive government-sponsored insurance benefits for which he or she may be eligible.

### 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 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 on line 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.
- 2.** 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 Self-Pay Patient or Underinsured Patient receiving Medically Necessary Hospital services shall be asked to pay no more than the greater of Medicare 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 our 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 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. 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 application period is 240 days from the date of the first patient statement. The eligibility screening will be performed by JMH or its designee. It is the patient's responsibility to cooperate with the information gathering process. Patient-specific information will be provided to the County and State in accordance with County and State guidelines for eligibility determinations.
2. An applicant must provide the following in order to be considered for financial assistance under this policy: (i) the most recent income tax return filed by each member of the Family (or certification that no return has been filed for the family member), (ii) wage statements covering the most recent 3 months for each Family member (or (iii) three most recent statements for each bank account or investment account maintained by a Family member (if the applicant wants to be considered for free care as opposed to merely discounted care), (iv) evidence of out-of-pocket medical expenditures relevant to determining whether a patient is an Underinsured Patient, (v) proof of rent or mortgage payments for the last three months, and (vi) a release permitting JMH or its agents or representatives to contact third-parties to validate the accuracy and completeness of documents submitted. Documentation of income and assets submitted to JMH in applying for financial assistance under this Policy will not be used for collection activities.
  - a. All potentially-eligible patients must apply for assistance through State, County and other governmental programs before JMH financial assistance will be considered under this Policy. Financial assistance will be provided under this policy only upon receipt by JMH of a copy of the denial. Failure

to comply with the application process or provide required documents can be considered in JMH's determination. 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:
    - 1) Patient's Family income (as validated by its most recent filed Federal tax return and most recent three months of paycheck stubs from each Family Member); and
    - 2) Patient's monetary assets (assets that are readily convertible to cash, such as bank accounts and publicly traded stock) after excluding (i) the first \$10,000 of monetary assets (liquid assets) and (ii) 50% of a patient's monetary assets (liquid assets) above the first \$10,000. Retirement accounts and IRS-defined deferred-compensation plans (both qualified and non-qualified) are not considered monetary assets and are excluded from consideration.
  - c. Balances approved will be submitted for write-off to a transaction code assigned to Patient Financial Assistance, and will follow the signature authority pursuant to the JMH Write-Off Guidelines. Any recoveries to an account will be identified and steps taken to ensure the diminished assistance is reflected appropriately in the general ledger.
  - d. John Muir Health runs a file through a nationally recognized tool, Experian, on all Self-Pay 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 FPL 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 written off to Presumptive Charity.
3. Patients with Third-Party Coverage.
- a. Patients with third-party coverage who nonetheless 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 must insure 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. Applications may not be submitted more than 240 days following the first patient statement date. 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 level and patient has out-of-pocket medical expenses in the prior twelve (12) months that exceeds 10% of the lesser of the annualized value of the patient's current Family income or the Family's actual income over the prior 12 months.
  - 1) Patient's Family income (as validated by its most recent filed Federal tax return and most recent three months of paycheck stub from each Family Member); and
  - 2) Patient's monetary assets (assets that are readily convertible to cash, such as bank accounts and publicly-traded stock) after excluding (i) the first \$10,000 of monetary assets (liquid assets) and (ii) 50% of a patient's monetary assets (liquid assets) above the first \$10,000. Retirement accounts and IRS-defined deferred-compensation plans (both qualified and non-qualified) are not considered monetary assets and are excluded from consideration.
- e. Balances approved will be submitted for write-off to a transaction code assigned to Patient Financial Assistance, and will follow the signature authority pursuant to the JMH Write-Off Guidelines. Any recoveries to an account which has qualified and was absorbed under the Assistance adjustment code to ensure the diminished assistance is reflected appropriately in the general ledger.

### 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. A waiver or release may be required authorizing the Hospital to obtain account information from a financial or commercial institution or other entity that holds or maintains the monetary assets to verify their value. 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 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 Hospital Services up to six months prior to the current admission. In the case of outpatient Hospital Services, the Patient Financial Assistance Application must be submitted every six months.
5. Patient 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 liability 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 adjudicated the claim to determine patient financial liability.

#### 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, or 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: (i) collection activities the Hospital or contracted collection agency may take and (ii) 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.
  4. 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.
  5. 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.
  6. 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.
  7. Patients are required to report to JMH any change in their financial information promptly.
  8. Information regarding the patient's Family income shall not be used in support of collection efforts.
  9. 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 and wait at least 240 days from the date of the post-discharge notice.
  10. The Single Business Office is the department at JMH with final 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.
  11. 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 and 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](http://www.ftc.gov)." The foregoing notices shall also be included in any communication with the patient indicating the start of collection activities may occur.

12. Neither JMH nor its contracted collection agencies will impose wage garnishments or liens on primary residences. This requirement does not preclude JMH from pursuing reimbursement from third-party liability 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 or 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 primary residences.
  - 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.
13. 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 10% interest (Article XV, Section 1 of the California Constitution) calculated from the date the overpayment is identified.

## 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 Executive Director of Revenue Cycle will review a second-level appeal.
2. This policy, the Summary, and the Patient Financial Assistance Application shall be provided to the Office of Statewide Health Planning and Development (OSHPD) 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, OSHPD 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 to 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: N/A if not applicable

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

V. Documentation: N/A

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|--|---------------|
| <b>Reference/Regulations:</b>  |               |
| 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.) |               |
| <b>Supersedes:</b>   |               |
| <b>Primary Sponsor Name &amp; Title:</b>   |               |
| Chris Pass - Chief Financial Officer   |               |
| <b>Owner(s) Name &amp; Title:</b>  |               |
| Chris Pass - Chief Financial Officer   |               |
| <b>Record of Review Dates</b>  |               |
| <b>List Stakeholder, Committee, Medical Staff, etc. Reviews: (with approval dates)</b>   |               |
|  |               |
| <b>Origination Date:</b>   | December 2006 |

|  |                      |  |
|--|----------------------|--|
| <b>Record of Approval Dates – System or Entity Level Documents</b> |                      |  |
| <b>PPRC:</b> Direct to System Performance Huddle/Board             |                      |  |
| <b>JMPN:</b> Direct to System Performance Huddle/Board             |                      |  |
| <b>MEC – BHC:</b> N/A  | <b>MEC – WC:</b> N/A | <b>MEC – CC:</b> N/A   |
| <b>System Performance Huddle:</b>                                  | 9/15/22              | <b>Board</b> 12/06, 11/09, 02/12, 1/16, 3/25/20, 10/27/21, 9/21/22 |