

**SAN JOAQUIN GENERAL HOSPITAL
PATIENT FINANCIAL RESPONSIBILITY POLICY**

SECTION 1. DEFINITIONS, INCLUDING MEANING OF WORDS, AND EFFECT OF SECTION HEADINGS

- A. As used in this policy, unless otherwise apparent from the context:
1. "Board of Supervisors" means the Board of Supervisors of the County of San Joaquin.
 2. "Hospital" means San Joaquin General Hospital (SJGH).
 3. "Medically Indigent Adult" (MIA) refers to those individuals that reside in San Joaquin County, who lack other health care coverage, and meet certain financial eligibility criteria.
 4. "California Healthcare Indigent Program" (CHIP) refers to those individuals that reside in San Joaquin County, who lack other health care coverage, and have virtually no income or assets.
 5. "Self-pay" refers to those patients that are uninsured and not covered by any government or commercial insurance and are responsible for their own medical expenses.
 6. "Underinsured" patients have medical coverage, but are responsible for a significant part of their medical expenses.
 7. "Charity" patients may be uninsured or underinsured patients who would experience financial hardship if they were required to pay their bill.
 8. "County Medically Indigent Program" (CMIP) means the health care program under which the eligible MIA and CHIP patients are covered, as required by § 17000 of the W&I Code.
 9. "Beneficiaries" means those persons certified eligible for services under CMIP.
 10. "Emergency Services" means any services required for the alleviation of severe pain or the immediate diagnosis and treatment of severe medical conditions which, if not immediately diagnosed and treated, would lead to disability or death.
 11. "Medically Necessary" or "Medical Necessity" - A service is medically necessary or a medical necessity when it is reasonable and necessary to protect life, to prevent significant illness or significant disability or to alleviate severe pain.
 12. "Spend-Down" means the procedure by which a beneficiary reduces his/her liquid resources (assets) to below guideline limitations. Any voluntary transfer

of assets for the purpose of qualifying for CMIP services does not meet spend-down criteria.

13. "Provider" refers to any individual, group, business, or institution that delivers health care services or supplies.
14. "Assets" refers to resources owned and controlled by the applicant, which are convertible to cash or held as cash as defined by and in conformity with Medical Eligibility Manual, Chapter 2, as may be amended from time to time.
15. Articles and section headings, when contained herein, shall not be deemed to govern or modify or in any manner affect the scope, meaning or intent of the provisions of any article or section.

SECTION 2. COUNTY POLICY

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

- A. To organize and administer San Joaquin County's §17000 medical care obligations through the CMIP.
- B. Provide medically necessary outpatient and inpatient services to those residents of San Joaquin County who are eligible to receive them pursuant to W&IC §17000, and subject to the requirements of this policy.
- C. No requirement in this section or of any other section of this policy shall in any way prevent the receipt of acutely & medically necessary services to those individuals who are eligible for CMIP services under W&IC §17000 and the provisions of this policy.
- D. To restrict CMIP coverage to those medical services not provided by other entities and/or programs for which the individual is eligible.
- E. To provide that those able and liable to do so shall reimburse the County for CMIP health care services to the fullest extent they are able to do so, at the time of service or in the future, to the extent that would not jeopardize their future minimum self maintenance or security.
- F. To prioritize the provision of inpatient hospital services at San Joaquin General Hospital according to medical need.
- G. To provide medically necessary services at San Joaquin General Hospital to the fullest extent practical and consistent with good medical practice.
- H. To become the payer of last resort, unless otherwise required by law.
- I. Those persons determined to have lawful residence outside San Joaquin County will be referred back to that County/State/Country to receive their medical services.

SECTION 3. RESPONSIBILITY FOR ADMINISTRATION OF THE WELFARE AND INSTITUTIONS CODE W&IC §17000 MEDICAL CARE OBLIGATIONS

The County of San Joaquin's obligation to provide medical services pursuant to W&IC §17000 shall operate under the direction of the Director of the San Joaquin County Health Care Services Agency.

SECTION 4. GENERAL ELIGIBILITY PROVISIONS

- A. The medical aid and care governed by the provisions of this policy shall not be construed as to apply to cash assistance, burials, or grave maintenance, which are provided for through other programs.
- B. Names, addresses and all other information concerning the circumstances of any individual for whom or about whom information is obtained are confidential and shall be safeguarded as required by applicable state and federal law. No disclosure of any information obtained by a representative, agent or employee of the County in the course of discharging his or her duties shall be made, directly or indirectly, other than in the administration of the CMIP program, or as required by law.
- C. An eligible person under Section 5 herein is entitled to receive benefits without regard to race, color, religion, political affiliation, national origin, marital status, or sexual preference.
- D. It is the intent of this program not to duplicate medical services that may be available elsewhere, for which an individual applicant is eligible. The program scope of medical services set forth in this policy shall therefore not include those services that are covered by other federal and/or funding sources for which an individual applicant is eligible, such as, but not limited to, prenatal care during pregnancy, end-stage renal disease, organ transplants, breast/cervical/prostate cancer, Limited Medi-Cal, or other insurance.
- E. Applicants or recipients subject to an adverse decision regarding eligibility of medical benefits shall have an appeal process available (See Attachment4).

SECTION 5. ELIGIBILITY REQUIREMENTS

- A. To be eligible for CMIP, every person shall meet all of the following requirements:
 - 1. Residence - Must legally reside in the State and the County wherein the application is made within the requirements of Federal and State law. A continuous 30-day period of residence in the County is required; however, satisfactory proof must be presented as to residence. 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 (See Attachment 5).
 - 2. Income and Resources - Must have income and resources, which do not exceed the income and resource criteria for eligibility for services, pursuant to

the Financial Eligibility requirements as established and/or amended from time to time (See Attachment 1).

- a. Individuals whose assets exceed the \$10,000 amount allowed by Medi-Cal guidelines (excluding primary residence and one car) will not be eligible as MIA or CHIP under CMIP during the month of application. Individuals may reapply in subsequent months and gain access to benefits if, in the interim period, they have "spent-down" to within the asset limits.
 - b. Sources of income excluded in calculating a patient's income are SSI and AFDC.
 - c. Exclusion of assets shall be in conformity with current Medi-Cal guidelines, as amended from time to time.
 - d. Utilization of other health care coverage - Each eligible beneficiary must agree 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 Medi-Cal, Medicare, CHAMPUS, Victims of Violent Crimes, and/or employer sponsored insurance plans; provided that the premium expense to the beneficiary does not exceed 20% of their monthly gross income.
 - e. Affidavit - Each eligible beneficiary shall make a written statement under oath, affirmation or penalty of perjury, of all money and income which he/she receives or is entitled to receive each month, the nature, location and estimated value of all property, real and/or personal, in which he/she has or claims an interest, and the names, places of residences and estimated incomes of all his/her kindred of the degree of spouse, child or parent.
 - f. Spend-Down - A patient may retroactively spend-down his/her liquid assets for medical purposes. The spend-down payment should be paid to the Hospital for any outstanding balances in order to become eligible for CMIP services.
3. Individuals who lawfully reside in San Joaquin County may apply for eligibility whenever medical care is required which falls within the scope of services as defined by SJGH. Application for eligibility will only be considered up to 30-days following the month of service or discharge.
 4. No requirement of this section or of any other section of this policy shall in anyway prevent the receipt of acute medically necessary services to those individuals who are eligible for CMIP services under W&IC §17000 and the provisions of this policy.
 5. Each eligible beneficiary will be subject to a periodic review of their income and resources, at least annually, to determine continuing coverage under CMIP.
 6. Any individual who is discovered to have willfully misrepresented his/her assets, income or residency for the purpose of becoming eligible for CMIP services will

be denied eligibility for the period in question, will be liable for all charges billed by SJGH or paid by CMIP, and may not reapply for 90 days.

SECTION 6. TRANSFER OF PROPERTY FOR THE PURPOSE OF QUALIFYING

- A. No person shall be certified as eligible for benefits who has made a voluntary transfer of property for the purpose of qualifying for CMIP.
- B. Retroactively, an individual shall be considered ineligible if he/she willfully misrepresents his/her income, aid in kind, personal or real property valuation.

SECTION 7. CO-PAYMENTS

- A. Co-payments are required (See Attachment 2).
 - 1. Each eligible CMIP recipient may be required to make a co-payment for services. The co-payments set forth in Attachment 2, as amended from time to time by the Board of Supervisors, are incorporated herein by this reference as though herein in full.
 - 2. Co-payments shall not be used to deny or delay emergency services, or medically necessary services that cannot be safely re-scheduled.
 - 3. Co-payments may be established for the purpose of controlling inappropriate utilization by beneficiaries.

SECTION 8. 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, whether 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.
- D. The criteria set forth in this policy and its attachments, as amended from time to time, as well as applicable law and reputations, will be used to determine an eligible beneficiary's co-payment amount.

SECTION 9. CATASTROPHIC CHARITY ADJUSTMENTS

- A. Self pay or underinsured patients may qualify for a Catastrophic Charity Adjustment if they are able to demonstrate financial hardship should they be required to pay the full amount of their bill for health care services. If eligible (see Attachment 3), an adjustment would be made to the patient's balance of the hospital charges in

accordance with the schedule provided in Attachment 3. This adjustment will provide consideration to those patients that do not qualify for CMIP, but are responsible for a significant portion of their hospital bill, as a result of a catastrophic medical event.

SECTION 10. BILLING

- A. Upon request, 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. 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 dictated by their insurance coverage, are due at time of service. Patients that are not eligible for CMIP and do not have other funding will be considered "self-pay" and are required to pay for their non-emergency services prior to receiving them.
- C. The liability indicated on the patient's statement shall be due to SJGH from the patient or responsible party.

SECTION 11. COLLECTION

- A. Collection practices to recover liabilities due to SJGH for medical services shall be consistent with established collection practices.
- B. All obligations established pursuant to this policy shall become delinquent if not paid when due, and appropriate action shall be taken for their collection.

SECTION 12. CLAIMS AGAINST THE ESTATE OF DECEDENT FOR REIMBURSEMENT FOR CARE

- A. SJGH may claim against the estate of the decedent or against any recipient of the property of that decedent by distribution or survival, an amount equal to the payments for the health care services received by the decedent. SJGH may not claim where there is a surviving spouse, or where there is a surviving child who is under age 21 or who is blind or permanently and totally disabled, within the meaning of the Social Security Act. SJGH may waive its claim, in whole or in part, if it determines that enforcement of the claim would result in substantial hardship to other dependents of the deceased individual against whose estate the claim exists.

SECTION 8. 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 reimbursement from the CMIP, shall agree to accept the reimbursement amount as payment in full and will not attempt to collect from the beneficiary the difference, if any, between the charged amount and the reimbursement amount.

SECTION 9. ELIGIBILITY APPEALS

Individuals subject to an adverse decision affecting eligibility or co-payments shall have available an appeal process to afford them due process in seeking relief from such decisions (See Attachment 4).

SECTION 10. REFUNDS

Refunds to patients for payments or co-payments shall be made in conformity with the refund policy as outlined in Attachment 7.

ATTACHMENT 1

MAXIMUM FINANCIAL ELIGIBILITY

Financial eligibility for services in the San Joaquin County Medically Indigent Services Program shall be determined by considering:

A. Medically Indigent Adult (MIA) eligibility is as follows:

1. Gross income greater than \$100 per month and which does not exceed 300% of the Federal Poverty Level, as reported in the Federal Register and updated by SJGH annually each May, would qualify as MIA. The current Medi-Cal Income In Kind standards will be used to calculate the MIA beneficiary gross income for co-payment calculation.
2. Other Coverage: Individuals will not be eligible as an MIA that are covered by or have access to another program, such as services not covered by Emergency or Limited Medi-Cal or another medical plan (e.g., health insurance, Workers' Compensation, homeowners' or automobile insurance for an injury, etc.), provided that the premium expense to the beneficiary does not exceed 20% of their monthly gross income.
3. Assets: Individuals whose assets exceed \$10,000 (excluding primary residence and one car) will not be eligible as an MIA during the month of application.
4. Co-payment for services will be established using the income table below:

(Based on 300% of Federal Poverty Level, as reported in the Federal Register and updated by SJGH annually each May).

Family Size	Monthly Maximum Income	Co-payment Structure Monthly Income Not To Exceed		
		A	B	C
1	\$2,328	\$1,164	\$1,746	\$2,328
2	\$3,123	\$1,562	\$2,342	\$3,123
3	\$3,918	\$1,959	\$2,939	\$3,918
4	\$4,713	\$2,357	\$3,535	\$4,713
5	\$5,508	\$2,754	\$4,131	\$5,508
6	\$6,303	\$3,152	\$4,727	\$6,303
7	\$7,098	\$3,549	\$5,324	\$7,098
8	\$7,893	\$3,947	\$5,920	\$7,893
9	\$8,688	\$4,344	\$6,516	\$8,688
10	\$9,483	\$4,742	\$7,112	\$9,483

5. The co-payment schedule, as it corresponds to the table above, is as follows:

	<u>A</u>	<u>B</u>	<u>C</u>
Clinic	\$0	\$10	\$20
ER	\$0	\$25	\$40
Pharmacy (Per Rx)	\$0	\$5	\$10
Inpatient (Per Day)	\$0	\$100	\$250

B. California Healthcare Indigent Program (CHIP) eligibility is as follows:

1. If an applicant meets the MIA eligibility qualifications, except that they have a monthly income of less than \$100 and they have no assets, they would be considered eligible for CMIP under the California Healthcare Indigent Program (CHIP), and they would be assigned to the co-payment Schedule A. The current Medi-Cal In Kind standards will be used to calculate the CHIP beneficiary gross income for the co-payment calculation.

ATTACHMENT 2

CO-PAYMENT REQUIREMENTS

1. Each eligible CMIP recipient may be required to make a co-payment for services. In an unusual case of financial hardship, the County will consider individual need and the amount or means of payment.
2. Co-payment rates for services are required as outlined in Attachment 1.
3. Collection Procedure
 - a. The failure to make a co-payment at the time of service shall not prevent the receipt of emergency medical services or acute medically necessary services.
 - b. The failure to make a co-payment at the time of service will, however, result in the cancellation of outpatient clinic services where the patient can safely be rescheduled.
 - c. The appropriate co-payment amount will be requested and is due and payable prior to the delivery of service. If a patient asserts an inability to pay:
 1. Clinic/Emergency Room visits:
 - a. The patient will be evaluated by a nurse or health care provider. If the medical team evaluates the patient's condition as an emergency, the patient will be treated and the co-payment will be assessed and billed. If the patient is evaluated as non-emergent, he/she will be given a new appointment.
 2. Hospital Admission:
 - a. Patients may make a deposit and pay the amount in full prior to discharge. Patients unable to pay the full amount at the time of discharge may execute a Payment Plan according to established hospital procedures.

CATASTROPHIC CHARITY ADJUSTMENTS

A. Self Pay or underinsured patients may qualify for catastrophic charity adjustments if they are able to demonstrate financial hardship if required to pay their entire bill, and their gross monthly income is within the table set forth below:

(Based on 400% and 500%, respectively, of Federal Poverty Level, as reported in the Federal Register and updated by SJGH annually each May).

	Family Size	Monthly Maximum Income	
		Adjustment Factor 1	Adjustment Factor 2
	1	\$3,104	\$3,880
	2	\$4,164	\$5,205
	3	\$5,224	\$6,530
	4	\$6,284	\$7,855
	5	\$7,344	\$9,180
	6	\$8,404	\$10,505
	7	\$9,464	\$11,830
	8	\$10,524	\$13,155
	9	\$11,584	\$14,480
	10	\$12,644	\$15,805

The charity adjustment factor, as it corresponds to the table above, is as follows:

If the Patient Balance Is greater than or equal to:	\$5,000	\$10,000	\$25,000	\$50,000
Adjustment Factor 1:	30%	40%	50%	60%
Adjustment Factor 2	20%	30%	40%	50%

ATTACHMENT 4

APPEAL PROCESS

1. Eligibility Appeal:

- a. First appeal is to the CMIP Supervisor, and if the appellant is dissatisfied with the decision of the supervisor, he/she may then appeal to the Patient Access Manager. Each appeal shall be oral and informal, and the respective decision(s) of such review person shall be rendered as promptly as possible.
- b. Second, if the appellant is dissatisfied with the decision of the Patient Access Manager, he/she may file a formal appeal, in writing, to the CMIP Director (The Hospital's Financial Manager), within 15 days after the decision of the Patient Access Manager. The CMIP Director shall hold a hearing within 15 days after the filing of such an appeal, and shall promptly notify the appellant of the time and place. Within 15 days after the conclusion of the hearing, the CMIP Director will prepare written findings of fact, which shall constitute his decision. A copy of the decision will promptly be mailed or otherwise delivered to the appellant.
- c. If the appeal to the CMIP Director involves the suspension, or termination of CMIP eligibility or an increase in the co-payment liability, the person's eligibility and/or co-payment liability shall remain the same pending disposition of his or her appeal.
- d. Pending an appeal, no one will be denied medically necessary services.

2. Co-Payment Appeals

1. Patients who wish to appeal their co-payment amount may do so by:
 - a. Discussing the Clerk's decision with the Patient Access Manager located in the Admitting area during normal business hours.
 - b. If dissatisfied with the Patient Access Manager's decision, a patient may file a first level appeal by writing to the CMIP Director at P. O. Box 1020, French Camp 95231 within 15 days of the first adverse finding.
 - c. If dissatisfied with the CMIP Director's decision, a patient may file a final appeal by writing to the Hospital Director at P. O. Box 1020, French Camp 95231 within 15 days of the CMIP Director's decision.

ATTACHMENT 5

SAN JOAQUIN COUNTY MEDICALLY INDIGENT SERVICES PROGRAM RESIDENCY POLICY

1. It is the policy of CMIP that all applicants must meet the residency requirements established herein to be eligible for Program participation.
2. Lawful residence in San Joaquin County is a requirement for CMIP eligibility. Each applicant for CMIP eligibility will be asked to provide evidence that he/she is a lawful resident of San Joaquin County. Documentation/verification of information given by the applicant may be requested. Those persons determined to have lawful residence in another county will be referred back to that county to receive their medical services.
3. County 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 County of San Joaquin. 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-country address
 - arrival date of applicant in California
 - arrival date of applicant in San Joaquin County
 - reason for the applicant's presence in San Joaquin County
 - 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.
2. Severity of medical need shall not be a consideration in determining County of residency.
3. Decisions regarding residency claims of applicants will be based on the information given in response to questions derived from the intent to permanently reside criteria and satisfactory proof of lawful residence in the County. Other pertinent information will also be evaluated. Adverse residency decisions will be rendered when the responses to these questions do not support in total or substantial part, a reasonable expectation that the applicant is legally present and intends to permanently reside in the San Joaquin County. Where it is clear that an applicant is not lawfully resident in the County and/or 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.

4. Applicants will be advised of their appeal rights. Applicants denied CMIP eligibility on the basis of non-resident status are ineligible for the entire month of application. If the application is initiated on or after the twenty- third of the month, the applicant shall be ineligible for the month following the month of application as well.
5. 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 if a compelling reason exists.

REFUND POLICY

1. Payments or co-payments will only be refunded when:
 - a. The patient has paid the full estimated co-payment liability amount and due to a change in financial status during the eligible months, the revised co-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 co-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. If a patient fails to apply for CMIP on a timely basis or fails to timely complete the necessary application and is required to make a deposit or purchase drugs, CMIP will not authorize a refund.