SANTA CLARA VALLEY MEDICAL CENTER
CHARITY AND DISCOUNT POLICY

POLICY: To provide comprehensive financial screening for all Santa Clara Valley Medical Center patients who are self pay, under-insured and do not qualify for the Ability to Pay Program or Valley Care for possible reductions to their hospital charges.

PURPOSE: To ensure qualified patients who fall at or below 350% of the Federal Poverty Level have Fair Pricing of their hospital charges.

PROCEDURE:

SECTION I: DEFINITIONS, INCLUDING MEANING OF WORDS, AND EFFECT OF SECTION HEADINGS

A. As used in this policy, unless otherwise apparent from the context:

1. "Beneficiaries" means those persons certified eligible for services.

2. "The County" means the County of Santa Clara.

3. "Board of Supervisors" means the Board of Supervisors of the County of Santa Clara.

4. "Department of Revenue" means the Santa Clara County department responsible for the collection activity for SCVMC's accounts.

5. "Federal poverty level" means the poverty guidelines updated periodically in the Federal Register by the United States Department of Health and Human Services.

6. "Family" means a) for persons 18 years of age and older; spouse, domestic partner and dependent children under 21 years of age, whether living at home or not, b) for persons under 18 years of age; parent, caretaker relatives and other children under 21 years of age of the parent or caretaker relative.

7. "Ability to Pay Program" (APD) refers to a program for those individuals that reside in Santa Clara County and receive services provided by Santa Clara Valley Medical Center, who lack other health care coverage, have no linkage to other health care coverage and whose income is at or below 350% of the Federal Poverty Level and who have limited assets.

8. "Valley Care" refers to a program for Santa Clara County residents who are United States (U.S.) citizens, have U.S. national status, or immigrants who can demonstrate lawful permanent, continuous residency in the U.S. for at least five years and receive services provided by Santa Clara Valley Medical

Center, who lack other health care coverage, have no linkage to other health care coverage and whose income is at or below 200% of the Federal Poverty Level.

9. "Charity" patients are those patients who are self pay or underinsured, who have received emergency services and are at or below 100% the Federal Poverty Level and have limited assets.

10. "Discount" patients are those patients who are self pay or underinsured, who are at or below 350% the Federal Poverty Level.

11. "Program" means the Charity and Discount programs.

12. "Emergency Services" means service 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.

13. "Hospital" means Santa Clara County Valley Medical Center (SCVMC).

14. "Ambulatory Surgery" means services provided in the operating room but the patient stay is anticipated to be less than 24 hours.

15. "Short Stay" means a patient stay where the patient occupies a bed on one of the inpatient units for purposes of delivering a medical procedure but the stay is anticipated to be less than 24 hours.

16. "Inpatient Admission" means a patient stay where, at the time of admission, the patient is anticipated to occupy an inpatient bed for more than 24 hours.

17. "Self Pay" means patients that do not have third-party coverage from a health insurer, health care service plan, Medicare, or Medicaid, and whose injury is not a compensable injury for purposes of workers' compensation, automobile insurance, Victim-Witness Assistance Program, or other insurance as determined and documented by the hospital.

18. "Underinsured" means a patient who has medical coverage, but is responsible for a significant part of their expenses.

19. "High medical costs" means a person whose family income does not exceed 350% of the Federal Poverty Level if the patient does not receive a discounted rate from the hospital as a result of his or her third-party coverage. For the purposes of this policy high medical cost is defined as:

a. Annual out-of-pocket costs incurred by the patient at SCVMC that exceed 10% of the patient's family income in the prior 12 months.
b. Annual out-of-pocket expenses that exceed 10% of the patient's family income, if the patient provides documentation of his or her medical expenses paid by him or her or the patient's family in the prior 12 months.

20. "Monetary Assets" means resources owned and controlled by the applicant and his/her family, which are convertible to cash or held as cash as defined by the State of California in AB774 – Fair Pricing Policy.

21. "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 does not meet spend-down criteria.

22. 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 II: COUNTY POLICY

It is the intent and purpose of Santa Clara Valley Medical Center:

A. To organize and administer this Policy of Fair Pricing pursuant to California AB774.

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

C. To provide that responsible parties shall reimburse the County for their health care services to the fullest extent possible, provided that reimbursement does not jeopardize their future minimum self-maintenance or security.

SECTION III: GENERAL ELIGIBILITY PROVISIONS

A. This policy applies only to services provided at Santa Clara Valley Medical Center.

B. This policy applies to services provided on or after January 1, 2007.

C. 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.

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

E. It is the intent of this program not to duplicate medical services that may be available elsewhere, for which an individual applicant is eligible. Services that are covered by other federal and/ or other funding sources for which an individual applicant is eligible, such as, but not limited to Medicare, Medicaid (including those with a share of cost), Worker's Compensation, third party liability plans, contracted commercial insurances, Victim-Witness Assistance Program, and other State/Federal funding programs will not be eligible for discounts under this policy.

F. Persons will be screened for eligibility for all other available medical coverage, including Federal, State, or local programs. Applicants who are not eligible for any other coverage or program will then be screened for eligibility to participate in this Policy.

G. Persons who may qualify for other coverage, including Federal, State, and local programs must apply and comply with the application process for such programs before they will be considered for the Program.

H. Persons must apply for the Program no later than 150 days from receipt of first bill.

I. Person must provide require documentation and/or verification within 10 business days unless other arrangements have been mutually agreed on by both SCVMC and the applicant.

J. Applicants or recipients subject to an adverse decision regarding eligibility medical benefits may appeal the decision. (See Attachment 1).

SECTION IV: ELIGIBILITY REQUIREMENTS

Charity Program

To qualify for this program, the patient must meet the following minimum requirements:

A. Income and Resource:

1. Family Income, including one-twelfth of 50% of monetary assets over $10,000, is at or below 100% of the Federal Poverty Level (FPL). Current

pay stubs and/or the most recent Income Tax return(s) may be required to substantiate reported Family Income.

2. Individuals whose monetary assets disqualify them from the Charity Program may qualify for the Discount Program. 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. Monetary assets do not include retirement, deferred compensation plans qualified under the Internal Revenue Code, or non-qualified deferred compensation plans. The first $10,000 of a patient's monetary assets will not be counted in determining eligibility, nor shall 50% of the monetary assets over $10,000.

B. Uninsured/Self Pay or Underinsured:

1. Patient must not have, or be eligible for, any third-party coverage from a health insurer, health care services plan, Medicare or Medicaid, and the injury must not be a compensable injury for purposes of workers compensation, automobile insurance, Victim-Witness Assistance Program, or other liability insurance;

Or

2. Patient with High Medical Costs. Patient does not receive a discounted rate from the hospital as a result of his or her third-party coverage, and

   a. The annual out-of-pocket medical costs incurred by the patient at the hospital that exceed 10% of the patient's family income during the prior 12 months, or
   b. The annual out-of pocket expenses that exceed 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 12 months.

C. Other Restrictions

1. Coverage limited to emergency services provided at SCVMC

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Discount Program

To qualify for this program, the patient must meet the following minimum requirements:

A. Income and Resource:

1. Family Income is at or below 350% of the Federal Poverty Level (FPL). Current pay stubs and/or the most recent Income Tax return(s) may be required to substantiate reported Family Income.

2. Individuals whose monetary assets disqualify them from the Charity Program may qualify for the Discount Program. Individuals may reapply in subsequent months and gain access to the Charity Program if, in the interim period, they have "spent-down" to within the asset limits.

B. Uninsured/Self Pay or Underinsured:

1. Patient must not have, or be eligible for, any third-party coverage from a health insurer, health care services plan, Medicare or Medicaid, and the injury must not be a compensable injury for purposes of workers compensation, automobile insurance, Victim-Witness Assistance Program, or other liability insurance; or

2. Patient with High Medical Costs. Patient does not receive a discounted rate from the hospital as a result of his or her third-party coverage, and

   a. The annual out-of-pocket medical costs incurred by the patient at the hospital that exceed 10% of the patients family income during the prior 12 months, or
   b. The annual out-of pocket expenses that exceed 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 12 months.

C. Other Restrictions
1. Coverage limited to services provided at SCVMC

SECTION V: PROCEDURES

A. Individuals may apply for the Charity and Discount Program at the time of scheduling a visit, time of visit, or within 150 days of receipt of first billing for services provided on or after 1/1/07. Applications will be completed through an interview process with a representative from SCVMC.

B. Eligible persons may be required to make a written statement and provide verification of all money and income which the Family, as defined by AB774, Article 3, Section 127400(h), receives or is entitled to receive. in order to compute the Family Income.

C. Eligible persons may be required to make a written statement and provide verification of all money that could qualify as a monetary asset, i.e. savings accounts, bonds, stocks, etc when consideration is being made for a Charity Discount.

D. Patients will be notified at time of application of status of application, i.e. approved or denied whenever possible, i.e. patient provides all required information. If patient is unable to provide all information at time of application patient will have 10 working days to provide required information unless otherwise agreed to by both parties. If information is not received by SCVMC with 10 working days or agreed upon timeframe, application will be denied. Patient may reapply if the date is still within 150 days of first billing.

E. Patient is responsible for ensuring they have provided a valid mailing address. If SCVMC receives returned mail as a result of the patient providing a bad address the application for services will be denied and eligibility denied or rescinded.

F. Each eligible beneficiary will be subject to a review of their income and resources every six (6) months and upon every inpatient admission, ambulatory surgery or short stay to determine continuing eligibility under this policy.

G. In determining eligibility for the Charity Care Program, the hospital will review the patient's family income and monetary assets excluding retirement or deferred compensation plan(s). The first $10,000 of a patient's monetary assets shall not be counted nor shall 50% of the patient's monetary assets over the first $10,000 for the purposes of determining eligibility. Monetary assets will be divided by 12 and added to the monthly income to determine the FPL qualifying level. If the patient's income is equal to or less than 100% of the FPL and the services are emergency services the patient will be assessed a co-payment based on the type of emergency service received, i.e. emergency room visit, emergency inpatient admission or emergency ambulatory surgery.

H. In determining eligibility for the Discount Program, the hospital will review the patient's family income only. The hospital shall limit expected payment for services it provides to the patient to the highest rate paid by a Government payer. The hospital shall negotiate and establish a payment plan with the patient.

I. Utilization of other healthcare 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, Medicaid, Limited Services Medicaid, Medicare, CHAMPUS, Victim-Witness

Protection Program, and/or employer sponsored health insurance plans before applicant is considered for the Charity or Discount Programs.

J. If available, the patient and/or his or her guarantor must apply for employer sponsored insurance plans, provided that the premium expense to the beneficiary does not exceed 10% of their monthly gross income.

SECTION VI: EXCLUSIONS

A. Patients who are covered by an insurance that is a contracted plan with Santa Clara Valley Medical Center, including Medicaid, will not qualify for further discounted services under this Policy.

B. Only services provide at Santa Clara Valley Medical Center will be covered by the Discount or Charity Programs.

C. Charity Program covers only emergency services provided at Santa Clara Valley Medical Center.

D. Any individual who is discovered to have willfully misrepresented his/her assets, income or residency for the purpose of becoming eligible for Charity or Discounted services will be denied eligibility for the period in question, will be liable for all charges billed by SCVMC, and may not reapply for 90 days.

E. Any person who transfers their monetary assets up to six (6) months of the date of service in order to qualify for the Charity Program will only be considered for the Discount program.

F. No requirement of this section or of any other section of this Policy shall in any way prevent the receipt of emergency services.

SECTION VII: PATIENT RESPONSIBILITY

A. Once qualified for a Charity or Discount program, the patient or his/her guarantor will pay the agreed upon portion of their charges within a mutually agreed upon time frame.

B. The negotiated payment plan agreed to may include a deposit amount and/or a transfer of the account to the County's Department of Revenue for monthly payments.

C. Payments must be made per the terms of the negotiated payment plan for the account to remain in good standing with the County.

D. Co-payments and/or deposits are due at the time of the visits. A $25 billing fee will be charged. Exception: Emergency Services.

E. No requirement in this section or of any other section of this policy shall in any way prevent the receipt of emergency services to individuals.

Charity Program:

A. Patients will be assessed a co-payment based on the type of emergency services received, i.e. emergency room visit, emergency ambulatory surgery, emergency inpatient admission.

Discount Program:

A. Patients will be required to pay the lesser of total charges or the amount that would be paid by highest government payer. Exception: Visits at a Federally Qualified Health Center (FQHC). Services provided at a FQHC clinic will be assessed a co-payment.
B. Deposits and co-payments for elective services are required at the time of visit.

SECTION VIII: CHARGES

A. All charges for care at SCVMC shall be in accordance with a schedule of charges adopted and/or amended from time to time by the Board of Supervisors.

SECTION IX: 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 SCVMC. The statement will be mailed monthly to the patient/guarantor with the current balance due noted.

B. Co-payments and deposits are due at the time of service or a $25.00 billing fee will be added. Patients who qualify for the Charity or Discount Programs are required to pay the agreed amount on a regular payment schedule.

C. The "Amount Due" as shown on the patient's statement shall be paid by the patient or responsible party to SCVMC on the date indicated on the bill, unless a payment plan has been negotiated. In which case, payments will be made in accordance with the negotiated payment plan.

SECTION X: 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. Accounts requiring collection activity will be handled by the Department of Revenue.

C. Collection practices to recover amounts owed to SCVMC from patients who have been determined eligible for the Charity or Discount program shall be consistent with AB774.

SECTION XI: CLAIMS AGAINST THE ESTATE OF DECEDENT FOR REIMBURSEMENT FOR CARE

A. The County may assert 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 or Discounted Program, and/or (b) if a judgment by a court of law has been granted for approved discounted claims as described under California AB774.

B. The County 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. The County 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 XII: REIMBURSEMENT FOR APPROVED CLAIMS

A. Approved rate schedules will be kept on file and made available to the Public upon request.

SECTION XIII: ELIGIBILITY APPEALS

Individuals subject to an adverse decision affecting eligibility shall have the right to appeal that decision (See Attachment 1).

SECTION XIV: REFUNDS

Refunds to patients for payments or co-payments shall be made with interest calculated using SCVMC's current operating interest rate pursuant to the refund policy set forth in California AB774. (See Attachment 2)

ATTACHMENT 1

APPEAL PROCESS

Eligibility Appeal

A. The first appeal of an adverse Charity or Discounted program decision is to be directed to the Patient Business Services Manager – Customer Service. The appeal shall be in writing whenever possible and the respective decision of the reviewing person shall be rendered within 30 days.

B. If dissatisfied with the first level appeal decision a final appeal may be filed in writing to the Administrative Offices – Dept of Appeals, at P.O. Box 5280 San Jose, CA 95128 within 15 days of the first level appeal decision.

ATTACHMENT 2

REFUND POLICY

A. Payments and co-payments will only be refunded when:

B. 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 amount paid. The program will refund the difference between the amount paid and the revised amount.

C. The patient has paid the full estimated payment amount and then due to a change in program eligibility (e.g., patient becomes eligible for Medicaid), 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.

D. 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.

E. Patients who are deemed eligible for a Charity or Discounted Program and who made an over-payment, and have no previous balances as described in (d) above, will be refunded with interest calculated using SCVMC's current operating interest rate and in accordance to California AB774.