



HEALTHCARE ACCESS PROGRAM

POLICY SUMMARY:

The County of Santa Clara Health System (hereinafter, the “County”) supports enhancing access to affordable healthcare. The County therefore offers discounted Medically Necessary Services or Supplies to eligible low-income and moderate-income Self-Pay and High Medical Cost patients through this Healthcare Access Program (also known as the Patient Financial Assistance Policy or “Financial Assistance”). A short overview of the policy follows. Patients should review the full policy for complete program information and contact a County Financial Counselor at (866) 967-4677 (Monday to Friday, 8am to 5pm) with any questions.

- Self-Pay patients are patients who do not have third-party coverage from a health insurer, healthcare service plan, Medicare, or Medi-Cal, whose injury is not a compensable injury for purposes of workers’ compensation, automobile insurance, or other insurance, and who are not eligible for health insurance or other third-party coverage for Medically Necessary Services or Supplies provided by the County.
- High Medical Cost patients are either (1) patients who have themselves incurred annual out-of-pocket healthcare costs from the County that exceed the lesser of 10% of their current Family Income or Family Income in the prior 12 months, or (2) patients whose Family has paid any medical provider for healthcare 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 members in the prior 12 months.
- Self-Pay and High Medical Cost patients who are County Residents and who have Family Incomes at or below 400% of the Federal Poverty Level are eligible for 100% discounted Medically Necessary Services or Supplies from County healthcare providers.
- Self-Pay and High Medical Cost patients who are County residents and who have Family Incomes above 400% but below 450%, 550%, or 650% of the Federal Poverty Level are eligible for discounts for Medically Necessary Services or Supplies from County healthcare providers of 70%, 50%, or 25%, respectively. A patient who qualifies for a partial discount may ask the County to set up a long-term, interest-free payment plan to allow the patient to pay the discounted price over time.
- The Federal Poverty Levels change annually. The 2022 Federal Poverty Levels referenced in this policy are listed in Attachment A.
- Eligible patients qualify for Financial Assistance for a one-year period, except if there is a material change to their eligibility before that year ends. Patients must notify the County of material changes to their eligibility (such as changes to their income, eligibility for health insurance or other coverage for healthcare services, family composition, and/or medical expenses) within sixty (60) days or at the next point of service, whichever is earlier. The County reserves the right to reverify a patient’s eligibility at any time.

- Eligible patients must make all reasonable efforts to submit a completed Financial Assistance Application (or qualify for Presumptive Enrollment for Discount Care) in compliance with this policy within 180 days of being sent their initial billing statement for a particular Episode of Care and the accompanying Healthcare Access Program Notice. If the patient does not submit a completed Financial Assistance Application (or qualify for Presumptive Enrollment for Discount Care) in compliance with this policy within 180 days of being sent their initial billing statement for a particular Episode of Care and qualify for Financial Assistance, the patient's account may be sent to collections as described in the Patient Debt Collection Policy attached as Attachment B. The Revenue Cycle Director or their designee has discretion to deny eligibility if the patient fails to provide information that is reasonable and necessary for the County to make an eligibility determination. The Revenue Cycle Director or their designee may determine a patient's eligibility for Financial Assistance after this 180-day period upon a showing of good cause, as described later in this Policy.
- Generally, Self-Pay and High Medical Cost patients who are Non-County Residents are not eligible for non-emergency healthcare services in Santa Clara County facilities. In those facilities where there is excess capacity, Non-County Residents may receive non-emergency healthcare services. Non-County Residents who do receive Medically Necessary Services or Supplies at County facilities and who are Self-Pay or High Medical Cost patients are eligible to receive a 100% discount for that specific Episode of Care (as defined below) if they have Family Incomes at or below 400% of the Federal Poverty Level.

DEFINITIONS:

1. **Patient's Family or Family:** For patients age eighteen (18) and older, the Patient's Family includes the patient, the patient's spouse or domestic partner, and dependent children under age twenty-one (21), whether living at home or not. For patients under age eighteen (18), the Patient's Family includes the patient's parents or caretaker relatives, and other children of the parents or caretaker relatives under age twenty-one (21).
2. **County Resident:** A County Resident is a person who lives in Santa Clara County.
3. **Non-County Resident:** A Non-County Resident is a person who does not live in Santa Clara County.
4. **Family Income:** Family Income includes gross annual income of all members of the Patient's Family, minus any payments made for alimony or child support.
5. **Self-Pay Patient:** A Self-Pay Patient is a patient who does not have third-party coverage from a health insurer, healthcare service plan, Medicare, or Medi-Cal, whose injury is not a compensable injury for purposes of workers' compensation, automobile insurance, or other insurance, and who is not eligible for health insurance or other third-party coverage for Medically Necessary Services or Supplies provided by the County. Self-Pay Patients include, without limitation: (a) patients who qualify for a government insurance program but receive services that are not covered under such program and (b) patients whose benefits are exhausted prior to or during the provision of services.
6. **High Medical Cost Patient:** A High Medical Cost Patient is a patient who:
 - a. Has a third-party source of payment for healthcare services (i.e., is not a Self-Pay Patient), and

- b. Either:
 - i. Owes the County for annual out-of-pocket healthcare costs for themselves that exceed the lesser of 10% of the Patient's current Family Income or Family Income in the prior twelve (12) months, or
 - ii. Paid, or has one or more Family members who paid, annual out-of-pocket medical expenses to any healthcare provider 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 members in the prior 12 months.

These healthcare expenses may include a copayment, coinsurance, deductible, or other amount due from an insured patient under the patient's health insurance plan.

- 7. **Presumptive Enrollment for Discount Care:** A patient may be determined eligible for the Healthcare Access Program based upon patient-specific socio-economic information gathered from market sources. Patients who are homeless or who expire while receiving services, and who have neither a source of funding nor a responsible party or estate, may be determined eligible for Financial Assistance even if they did not complete a Financial Assistance Application. The Patient Access Director or the Revenue Cycle Director or their designee will review such instances and make a determination on a case-by-case basis.
- 8. **Medically Necessary Service or Supply:** A Medically Necessary Service or Supply is a medical service and/or supply that is necessary to treat or diagnose a medical condition, the omission of which could adversely affect the health of the patient. The following services are not generally considered to be Medically Necessary Services or Supplies and therefore are not generally covered by this policy:
 - a. Reproductive endocrinology and infertility services;
 - b. Cosmetic services or plastic surgery services;
 - c. Vision correction services, including LASEK, PRK, conductive keratoplasty, Intac's corneal ring segments, custom contoured C-CAP;
 - d. Patient-initiated ambulance transportation; and
 - e. Lifestyle medications, as defined by the Santa Clara Valley Medical Center (SCVMC) Pharmacy and Therapeutics Committee.

The County reserves the right to change this list of generally non-covered services and/or supplies. In rare situations, for example, upon the recommendation of a physician or participating provider, the County Chief Medical Officer or their designee may approve one of these services or supplies as a Medically Necessary Service or Supply for a specific patient. The decision of the County Chief Medical Officer or their designee is final.

- 9. **Episode of Care:** For purposes of this policy, Episode of Care means:
 - a. In the inpatient setting, Medically Necessary Services or Supplies received between the date of an admission and the date of discharge associated with that admission; or

- b. In the emergency department setting or outpatient setting, an individual visit to receive Medically Necessary Services or Supplies.

PROCEDURE:

A. Eligibility for Financial Assistance

1. To receive Financial Assistance under this policy, a patient must apply for Financial Assistance by either submitting a complete Financial Assistance Application or qualifying for Presumptive Enrollment for Discount Care.
 - a. Eligible patients must make all reasonable efforts to submit a completed Financial Assistance Application (or qualify for Presumptive Enrollment for Discount Care) in compliance with this policy within 180 days of being sent their initial billing statement for a particular Episode of Care and the accompanying Healthcare Access Program Notice. If the patient does not submit a completed Financial Assistance Application (or qualify for Presumptive Enrollment for Discount Care) in compliance with this policy within 180 days of being sent their initial billing statement for a particular Episode of Care and qualify for Financial Assistance, the patient's account may be sent to collections as described in the Patient Debt Collection Policy attached as Attachment B. The Revenue Cycle Director or their designee has discretion to deny eligibility if the patient fails to provide information that is reasonable and necessary for the County to make an eligibility determination.
 - b. Immediately after this time period of 180 days, and in any event before final judgment has been entered in a civil collection action relating to a patient's unpaid bill, the Revenue Cycle Director or their designee may determine said patient's eligibility for Financial Assistance upon a showing of good cause. Along with their completed Financial Assistance Application, the patient must submit a statement in writing explaining why they did not apply for Financial Assistance within the required 180-day timeframe. The Revenue Cycle Director or their designee may request additional information from the patient to substantiate the good cause request. Examples of circumstances in which the patient may be able to demonstrate that good cause exists include, but are not limited to: the County inadvertently gave the patient incomplete or inaccurate information about the Healthcare Access Program or government-based health coverage options; the patient's physical, mental, educational, or linguistic limitations prevented the patient from submitting a completed Financial Assistance Application within the 180-day timeframe; and/or the patient had a serious illness, or there was a death or serious illness in the patient's immediate family, that prevented the patient from submitting a completed Financial Assistance Application within the 180-day timeframe.
2. Patients must provide true, accurate, and complete information when applying for Financial Assistance, including necessary supporting documentation, as requested by the County. Patients may be determined ineligible for Financial Assistance if they provide false or incomplete information during the application process.
3. Patients must provide one of each of the following types of documents with their Financial Assistance application:
 - a. Proof of identity (for example, a driver's license, passport, government-issued ID card, work or school ID card, or birth certificate plus other ID, such as gym or Costco membership);

- b. Proof of income (for example, pay stubs or income tax returns); and
 - c. Proof of residency (for example, a rental contract/lease, mortgage statement, utility bill, vehicle registration, driver’s license, declaration of homelessness, or letter of support from a person with whom the applicant is living and proof of residency for that person).
 - d. Any patient seeking to qualify for Financial Assistance under part (b)(ii) of the definition of “High Medical Cost Patient” above must also submit documentation of medical expenses that they and/or their Family members paid in the prior 12 months.
4. Different levels of Financial Assistance are available to eligible patients based on their Family Income, as listed in the table below and Attachment A to this Policy.

Amount of Financial Assistance Available to County Residents Who Are Either Self-Pay Patients or High Medical Cost Patients Based on Family Income

FAMILY INCOME	Amount of Write Off of Amounts Due from Patient For Medically Necessary Services or Supplies
Family Income at or below 400% of the Federal Poverty Level	100% Charity Care write off
Family Income between 401-449% of the Federal Poverty Level	70% Charity Care write off
Family Income between 450 – 549% of the Federal Poverty Level	50% Charity Care write off
Family Income between 550 – 649% of the Federal Poverty Level	25% Charity Care write off

The 2022 Federal Poverty Levels are listed in Attachment A.

For patients who are not able to complete an application or provide all necessary documentation, the Health System may develop and rely on a tool to presumptively enroll patients into the Healthcare Access Program based on existing enrollment in programs such as homeless services, the Women, Infants and Children (WIC) program, the Supplemental Nutrition Assistance Program (SNAP, also commonly known as food stamps), and certain subsidized housing.

- 5. Patients who do not have health insurance (or another third-party source of payment for Medically Necessary Services or Supplies) will be screened to determine if they are eligible for any state, federal, and/or County health programs, and/or any other third-party source of payment. The County will make all reasonable efforts to obtain information from patients about whether private or public health insurance or sponsorship may fully or partially cover the charges for care rendered by the County. When patients contact the Patient Access Department about available financial assistance options, the County will also take steps to help them complete

applications for Medi-Cal, other government-funded healthcare coverage, and the Healthcare Access Program, as applicable. If a patient applies, or has a pending application, for another health coverage program at the same time that the patient applies for Financial Assistance, neither application shall preclude eligibility for the other program.

6. Patients seeking Financial Assistance must apply for all health insurance (or other third-party sources of payment for Medically Necessary Services or Supplies) for which they are eligible, unless the County Revenue Cycle Director or their designee exempts the patient from the requirement, as described below.
7. A patient's failure to make every reasonable effort to obtain health insurance (or another third-party source of payment for Medically Necessary Services or Supplies) may be grounds for denial of Financial Assistance.
8. The Revenue Cycle Director or their designee may exempt from this requirement patients who could reasonably suffer negative immigration consequences under federal rules such as the final rule on "Inadmissibility on Public Charge Grounds," 84 Fed. Reg. 41,292 (Aug. 14, 2019). For example, adult patients age 21 and over who are seeking lawful permanent residence and who have the following immigration statuses may not be required to apply for federally-funded health insurance: (1) patients granted parole into the United States for at least one year, (2) patients granted withholding of deportation or removal, (3) patients granted conditional entry prior to April 1, 1980, (4) Cuban-Haitian entrants, or (5) patients with SSI-linked Medi-Cal since before August 22, 1996.
9. Eligible patients may receive Financial Assistance for Medically Necessary Services or Supplies from County healthcare providers. Patients are not entitled to Financial Assistance for services that are not Medically Necessary Services or Supplies or for separately billed physician professional fees or ambulance transportation not requested by the County. In those rare circumstances when referral outside of the County health system is necessary, the County Chief Medical Officer or designee may approve Financial Assistance for Medically Necessary Services and Supplies secured from outside of the County health system.

B. Scope of Financial Assistance for County Residents

1. Financial Assistance for County Residents generally extends for a one-year period starting on the earlier of the first day of the month in which the patient submitted their completed Financial Assistance Application or qualified for Presumptive Enrollment for Discount Care, or the first day of the Episode of Care to which the patient's completed Financial Assistance Application or Presumptive Enrollment for Discount Care relates, except if there is a material change to the patient's eligibility before that year ends (such as qualifying for third-party coverage from a health insurer or another third-party source of payment for Medically Necessary Services or Supplies). The Revenue Cycle Director or their designee also has discretion to provide additional discounts upon a showing of good cause.
2. Patients must reapply for Financial Assistance annually as appropriate, either by submitting a Financial Assistance Renewal Application or by requalifying for Presumptive Enrollment for Discount Care.
3. Patients must notify the County of material changes to their eligibility (such as changes to their income, eligibility for health insurance or other coverage for healthcare services, family composition, or medical expenses) within sixty (60) days of when the changes occur or at the next point of service, whichever is

earlier. The County reserves the right to reverify a patient's eligibility at any time.

4. If a patient fails to timely notify the County of any material change to their eligibility, their Financial Assistance may be retroactively terminated starting on the date the material change took effect.

C. Scope of Financial Assistance for Non-County Residents

1. Self-Pay and High Medical Cost patients who are Non-County Residents are generally not eligible for non-emergency healthcare services in Santa Clara County facilities. In those facilities where there is excess capacity, Non-County Residents may receive non-emergency healthcare services.
2. Non-County Residents who do receive Medically Necessary Services or Supplies at County facilities and who are Self-Pay or High Medical Cost patients are eligible to receive a 100% write-off on those services if their Family Incomes are at or below 400% of the Federal Poverty Level.
3. Qualifying Non-County Residents may only qualify for Financial Assistance for a specific Episode of Care, not on an ongoing, one-year basis. The Revenue Cycle Director or their designee has discretion to provide additional discounts upon a showing of good cause.

D. Payment Plans

1. A patient who qualifies for a partial discount under this policy may ask to set up a long-term, interest-free payment plan with the County to allow payment of the discounted price over time.
2. The County and the patient will negotiate the terms of the payment plan. In negotiating the terms of a reasonable payment plan with the patient, the County will take into consideration the patient's Family Income and essential living expenses. "Essential living expenses" means expenses for 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.
3. If the County and the patient cannot agree on the terms of a payment plan, the County will use the formula described in subdivision (i) of California Health and Safety Code section 127400 to create a reasonable payment plan consisting of monthly payments that are not more than 10 percent of a patient's Family Income for a month, excluding deductions for essential living expenses.

E. Appeals

1. The County will issue a decision within 30 days of receiving a patient's completed Financial Assistance Application. The decision will include instructions on how a patient may appeal the denial and the timeline for appealing.
2. A patient who is denied Financial Assistance may appeal the denial in writing. An appeal must contain the basis for the appeal and the requested relief. Appeal forms are available online at <https://health.sccgov.org/healthcare-access-program> or by contacting Patient Access at (877) 967-4677.

3. Appeals must be received at the address below within thirty (30) days of the denial:

County of Santa Clara Health System Patient Business Services
5750 Fontanoso Way, 1st Floor
San José, CA 95138
Attention: Revenue Cycle Director

4. The Revenue Cycle Director will decide all initial appeals within thirty (30) days of receiving the appeal forms.
5. If the Revenue Cycle Director or their designee affirms the initial denial, a patient may submit a second written appeal. Any second appeal must be received by the County of Santa Clara Health System's Chief Financial Officer at the address listed below within thirty (30) days of the initial appeal denial:

County of Santa Clara Health System Finance Department
2325 Enborg Lane, Suite 360B
San José, CA 95128
Attention: Chief Financial Officer

6. The Chief Financial Officer will decide all second appeals within thirty (30) days.
7. The decision on any second appeal will be final.

F. Reporting Procedures

1. The Financial Assistance policy and attachments will be provided to the Department of Health Care Access and Information (HCAI) at least biennially on January 1, or whenever a significant revision is made.
2. In the event no significant revision has been made since the previous submission, HCAI will be notified that no significant revision has occurred.

POLICY BACKGROUND:

This policy is intended to comply with the following laws:

- California Hospital Fair Pricing Policies (HFFP) law, Cal. Health & Saf. Code § 127400 *et seq.*
- California Emergency Physician Fair Pricing Policies (EPFPP) law, Cal. Health & Saf. Code § 127450 *et seq.*

This policy constitutes the County's Charity Care program. This policy will be consistently applied to all County patients.

This policy applies only to Medically Necessary Services or Supplies from County healthcare providers. A current list of County medical healthcare providers is available through the following "Find A Provider" pages: <https://www.scvmc.org/find-provider> (Santa Clara Valley Medical Center), <https://och.sccgov.org/find-provider> (O'Connor Hospital), and <https://slrh.sccgov.org/find-provider> (St. Louise Regional Hospital). A list of the County hospitals and clinics is available at: <https://www.scvmc.org/find-health-center>.

Patients are hereby notified that emergency physicians, as defined in California Health and Safety Code section 127450, who provide emergency medical services at County facilities, are required by law to provide discounts to Self-Pay Patients and High Medical Cost Patients who

are at or below 400% of the Federal Poverty Level.

For a list of the County of Santa Clara Health System's shoppable services, please visit <https://www.scvmc.org/patients-visitors/services/shoppable-servicesestimate-potential-charges>.

This Policy does not waive or alter any contractual provisions or rates negotiated by and between the County and a third-party payer, nor does it provide discounts to non-contracted third-party payers or other entities that are legally responsible to make payment on behalf of a beneficiary, covered person, or insured. This Policy does not permit the routine waiver of deductibles, co-payments, and/or co-insurance imposed by insurance companies for patients who do not qualify for Financial Assistance.

RESPONSIBILITY:

Questions about the implementation of this policy should be directed to the Patient Access Director at: 770 South Bascom Avenue, San José, CA 95128 or (866) 967-4677.

This Financial Assistance policy supersedes the following now-null policies: VMC#924.0 Sliding Scale; HHS#735.0 Ability to Pay Determination (APD) Program; O'Connor Hospital #4765025 Financial Assistance Policy; and St. Louise Regional Hospital #5424657 Financial Assistance Policy.

This Financial Assistance Policy was last updated on December 8, 2022.

Attachment A

2022 Federal Poverty Levels Chart

2022 FEDERAL POVERTY LEVELS							
Size of Household	100% Discount*	70% Discount		50% Discount		25% Discount	
	Up to 400% FPL	401%	449%	450%	549%	550%	649%
1	\$4,530	\$4,531	\$5,096	\$5,097	\$6,228	\$6,229	\$7,361
	\$54,360	\$54,361	\$61,154	\$61,155	\$74,744	\$74,745	\$88,334
2	\$6,103	\$6,104	\$6,866	\$6,867	\$8,391	\$8,392	\$9,917
	\$73,240	\$73,241	\$82,394	\$82,395	\$100,704	\$100,705	\$119,014
3	\$7,677	\$7,678	\$8,636	\$8,637	\$10,555	\$10,556	\$12,474
	\$92,120	\$92,121	\$103,634	\$103,635	\$126,664	\$126,665	\$149,694
4	\$9,250	\$9,251	\$10,406	\$10,407	\$12,718	\$12,719	\$15,031
	\$111,000	\$111,001	\$124,874	\$124,875	\$152,624	\$152,625	\$180,374
5	\$10,823	\$10,824	\$12,176	\$12,177	\$14,881	\$14,882	\$17,587
	\$129,880	\$129,881	\$146,114	\$146,115	\$178,584	\$178,585	\$211,054
6	\$12,397	\$12,398	\$13,946	\$13,947	\$17,044	\$17,045	\$20,144
	\$148,760	\$148,761	\$167,354	\$167,355	\$204,544	\$204,545	\$241,734
7	\$13,970	\$13,971	\$15,716	\$15,717	\$19,208	\$19,209	\$22,701
	\$167,640	\$167,641	\$188,594	\$188,595	\$230,504	\$230,505	\$272,414
8	\$15,543	\$15,544	\$17,486	\$17,486	\$21,371	\$21,372	\$25,257
	\$186,520	\$186,521	\$209,834	\$209,835	\$256,464	\$256,465	\$303,094



DATE: December 8, 2022

TO: County of Santa Clara Health System
Executive Leadership Group

FROM: René G. Santiago, Deputy County Executive and
Director, County of Santa Clara Health System

DocuSigned by:
René G. Santiago
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SUBJECT: Patient Debt Collection Policy

REFERENCES: Cal. Health & Safety Code, §§ 127400–127462
Cal. Civ. Code, §§ 1788–1788.33
15 U.S.C. §§ 1692–1692p
CSCHS Policy #715.0 (Healthcare Access Program)

DEFINITIONS:

1. **Patient:** For purposes of this policy, Patient includes any individual who received health care items and/or services from CSCHS and, if not the same person, their Guarantor.
2. **Guarantor:** The individual who has accepted financial responsibility for payment of a Patient Debt.
3. **Patient Debt:** The amount that a Patient owes CSCHS for health care items and/or services.
4. **DTAC:** The County of Santa Clara's Department of Tax and Collections, which collects Patient Debt on behalf of CSCHS.
5. **Financial Assistance:** A full or partial discount on a Patient Debt authorized by CSCHS under the terms of the CSCHS Financial Assistance Policy.
6. **CSCHS Policy #715.0 or CSCHS Financial Assistance Policy:** A separate policy describing CSCHS's Financial Assistance program, also known as the Healthcare Access Program (HAP), which offers discounts on health care items and/or services provided by CSCHS to certain eligible Patients with low or moderate incomes. The CSCHS Financial Assistance Policy is available online at: <https://health.sccgov.org/healthcare-access-program>. Individuals may also obtain a copy of the CSCHS Financial Assistance Policy by calling the CSCHS Patient Access Department at (866) 967-4677 (8am to 5pm, Monday to Friday).

BACKGROUND:

The purpose of this policy is to define standards and practices for the collection of Patient Debt owed to the County of Santa Clara Health System (CSCHS).

POLICY:

It is the policy of CSCHS to bill Patients in a manner that is accurate, timely, and consistent with applicable laws and regulations, including, but not limited to, applicable provisions of the California Health and Safety Code, the California Civil Code, and the United States Code.

PROCEDURE:

Responsible Party

Action

CSCHS Patient Business Services

1. Under the authority of the CSCHS Chief Financial Officer, CSCHS will pursue payment for Patient Debts owed for health care items and/or services provided by CSCHS, including by designating unpaid amounts as bad debt and referring such amounts to DTAC for collection. Collection actions will be undertaken at CSCHS's and DTAC's discretion and will comply with all applicable state and federal laws and regulations, including the California Hospital Fair Pricing Policies law (California Health and Safety Code, sections 127400 *et seq.*), the Emergency Physician Fair Pricing Policies law (California Health and Safety Code, sections 127450 *et seq.*), the Rosenthal Fair Debt Collection Practices Act (California Civil Code, sections 1788 *et seq.*), and the federal Fair Debt Collection Practices Act (United States Code, Title 15, sections 1692 *et seq.*).
2. CSCHS will obtain a written agreement from DTAC that DTAC will adhere to this Policy in its entirety. The written agreement will not be construed to create a joint venture between CSCHS and DTAC, or otherwise to allow CSCHS governance of DTAC.
3. Before referring a Patient Debt to DTAC, CSCHS will do all of the following:
 - a. Make all reasonable efforts to obtain from Patients information about whether private or public health insurance or sponsorship may

fully or partially cover the charges for care rendered by CSCHS.

- b. Provide Patients who do not indicate health care coverage by a third-party payer, or who request a discounted price or charity care, with an application for the Medi-Cal program or other state- or county-funded health coverage programs.
- c. Inform Patients of their financial responsibilities by mailing Patients at least four (4) account statements for the services rendered at CSCHS.
- d. Inform Patients of available financial assistance options by providing notice of the CSCHS Financial Assistance Policy and application on or soon after the date(s) of service, at the time of billing, and at least 30 days before referring a Patient Debt to DTAC.
- e. Take steps, when Patients contact the CSCHS Patient Access Department about available financial assistance options, to help those Patients complete applications for Medi-Cal, other government-funded healthcare coverage, and the Healthcare Access Program, as applicable.
- f. Send Patients a notice—otherwise known as the “Goodbye Letter”—at least 60 days before referring a Patient Debt to DTAC. This notice will include:
 - i. The date(s) of service of the bill that is being referred to DTAC;
 - ii. DTAC’s full name and address;
 - iii. A statement informing the Patient how to obtain an itemized bill from CSCHS;
 - iv. The name and type of health coverage

for the Patient on record with CSCHS at the time of service, or a statement that CSCHS does not have that information;

v. A copy of the CSCHS Financial Assistance application; and

vi. The date(s) the Patient was originally sent a notice about applying for Financial Assistance, the date(s) the Patient was originally sent an application for Financial Assistance, and, if applicable, the date that CSCHS made a decision on the Patient's application for Financial Assistance.

g. Wait at least 180 days after initial billing before referring a Patient Debt to DTAC.

4. Once the steps listed in paragraph (3) above are complete, CSCHS may refer the Patient Debt to DTAC to pursue one or more of the following collection actions:

a. Engage in standard collection efforts, including, but not limited to, the use of billing statements, written correspondence, and phone calls;

b. Commence civil action against the Patient in a manner that complies with all applicable laws. By way of a written interagency agreement, CSCHS will ensure that DTAC does not commence a civil action against a Patient if that Patient has a pending appeal for coverage of the items or services for which they received a bill from CSCHS (as defined in California Health and Safety Code, section 127426, subdivision (b)), until a final determination of that appeal is made, if the Patient makes a reasonable effort to communicate with CSCHS and DTAC about the progress of any pending appeals. A pending appeal includes health plan grievances, independent medical reviews conducted by the Department of Managed

Health Care or Department of Insurance, Medi-Cal fair hearings, and Medicare appeals, which are described in California Health and Safety Code, section 127426, subdivision (b).

5. By way of a written interagency agreement, CSCHS will ensure that with any document indicating that the commencement of collection activities may occur, DTAC will send the Patient a notice containing a plain language summary of the Patient's rights pursuant to the Hospital Fair Pricing Policies law, the Rosenthal Fair Debt Collection Practices Act, and the federal Fair Debt Collection Practices Act, which will include a statement that nonprofit credit counseling services may be available in the Patient's area, consistent with Health and Safety Code section 127430; and that in the first written communication to the Patient, DTAC will provide a copy of the Goodbye Letter and a statement that more than 180 days have passed from the date the Patient was initially billed for the medical services that are the basis of the debt, that DTAC may file a lawsuit against the patient to collect the debt, and that DTAC will not report adverse information to a credit reporting agency.
6. CSCHS will not engage in any of the following collection actions:
 - a. Report adverse information about a Patient Debt to a consumer credit reporting agency or credit bureau;
 - b. Sell a Patient debt to a debt buyer;
 - c. Defer or deny, or require a payment before providing, medically necessary care because of a Patient's nonpayment of one or more bills for previously provided care;
 - d. Foreclose on a Patient's real property;
 - e. Attach or seize a Patient's bank account or other personal property; or
 - f. Use wage garnishments or a lien on a primary

residence as a means of collecting unpaid hospital bills from a Patient found eligible for Financial Assistance.

7. Any Patient may ask to set up an interest-free payment plan for payment of a Patient Debt.
 - a. In negotiating the terms of a payment plan with the Patient, CSCHS will take into consideration the Patient's family income and living expenses.
 - b. If CSCHS and a Patient who has qualified for Financial Assistance cannot agree on the payment plan, CSCHS will use the formula and definitions described in subdivision (i) of California Health and Safety Code section 127400 to create a reasonable payment plan consisting of monthly payments that are not more than 10 percent of a Patient's family income for a month, excluding deductions for essential living expenses.
 - c. A payment plan may be declared inoperative after the Patient's failure to make all consecutive payments due during a 90-day period.
 - d. Before declaring a payment plan inoperative, CSCHS will:
 - i. Make reasonable attempts to contact the Patient by telephone, give notice in writing that the payment plan may become inoperative, and inform the Patient of the opportunity to try to renegotiate the terms of the defaulted payment plan.
 - ii. At the Patient's request, attempt to renegotiate the terms of the defaulted payment plan.
 - e. CSCHS will not commence a civil action against

a Patient for nonpayment prior to the time the payment plan is declared inoperative.

8. CSCHS will not use pay stubs, income tax returns, or documentation of assets obtained from Patients during the Financial Assistance application process for collection activities.
9. In the event that the CSCHS Revenue Cycle Director or their designee reviews an application for Financial Assistance submitted more than 180 days after initial billing, the CSCHS Revenue Cycle Director or their designee will request that DTAC pause collection activities, including staying civil actions, until the CSCHS Revenue Cycle Director or their designee has rendered a decision on the application. In the event that a patient is found eligible for Financial Assistance after civil action has commenced, CSCHS will work with DTAC to dismiss the lawsuit with prejudice.
10. Nothing in this Policy precludes CSCHS or DTAC from pursuing third party liability in a manner consistent with applicable laws.

Patients

1. Patients should direct questions about this policy to CSCHS Patient Business Services. Patients may reach CSCHS Patient Business Services by phone at (408) 885-7470 (8am to 4:30pm, Monday to Friday) or in person at 770 S. Bascom Ave, San Jose, CA 95128 (8am to 4:30pm, Monday to Friday).
2. Patients should make all reasonable efforts to promptly respond to billing statements and related communications from CSCHS and DTAC.
3. Patients should make all reasonable efforts to inform CSCHS if they have health insurance coverage, Medicare, Medi-Cal, or other third-party coverage that might pay for all or some of the health care items and/or services received at CSCHS.
4. Patients are encouraged to review the CSCHS Financial Assistance Policy and, if they believe they are eligible for

Financial Assistance, complete and submit a Financial Assistance application as soon as possible. Patients may review the full CSCHS Financial Assistance Policy and download a copy of the CSCHS Financial Assistance application at <https://health.sccgov.org/healthcare-access-program>. Patients may also contact the CSCHS Patient Access Department at (866) 967-4677 (8am to 5pm, Monday to Friday) with any questions about the Financial Assistance policy.

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