COUNTY OF SAN MATEO
FINANCIAL ASSISTANCE PROGRAMS
January 2014 update

San Mateo Medical Center
A County System of Healthcare

Attachment A – Eligibility Summary Table

Attachment B – Overview of Financial Assistance Programs

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<Delete D-2 MCE section>

<Add D-2 ACE Limited Term section>

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Eligibility Criteria	COUNTY FINANCIAL ASSISTANCE PROGRAMS FOR UNINSURED (1)					
	Charity Care	ACE County Fee Waiver(2)	ACE County	ACE Limited Term	Discounted Health Care (DHC)	Self-Pay
Resident of San Mateo County	No	Yes	Yes	Yes	Not required	Not required
Income Limit – Federal Poverty Level (FPL)	At or below 100% FPL	At or below 138% FPL	At or below 200% FPL***	At or below 200% FPL***	At or below 400% FPL	No income limit
Asset Limit	$10,500	No asset limit***				
Annual/ Monthly Fee	None	Waived	$XX fee, payable in installments	$XX fee, payable in installments	None	Deposit required before receiving non-emergency services
Payment for Outpatient (Clinic) Visits	Not applicable	All charges waived	Co-pays; annual cap for each individual on annual fees and co-pays for services at an amount aligned with Covered CA (at or below 6.3% of income as defined by Covered California)		65% Discount	Deposit required before receiving non-emergency services; 50% discount if bill is paid within 30 days; must pay 100% after 30 days
Payment for Inpatient (Hospital) Stays and Same Day Surgeries	All charges waived	Co-pay waived; Estate recovery pursued as described in sections D	$300[1] co-pay + Estate recovery on the balance of charges (Best government payer discount rate, adjusted annually)	Tbd (to align with Covered CA cost-sharing)	Will not exceed the highest amount that SMMC receives for medical services from Medicare, Medi-Cal, Healthy Families or other government-sponsored program	Deposit required before receiving non-emergency services; 50% discount if bill is paid within 30 days; must pay 100% after 30 days
Availability of Extended Repayment Plan	All charges waived	All charges waived	N/A for Fee-waiver population, Yes, for others based on ability to pay		Yes, interest-free Based on ability to pay	
Eligibility Redetermination Period	N/A	Annually, and before inpatient stays, surgeries (County to explore shorter eligibility periods)			Applicant will be re-screened upon request	
Third Party Verification of Eligibility	??	Internal audit of at least 50 cases per quarter			None	
Appeals Process if Denied or Disenrolled		Client will be given 10 days notice prior to disenrollment from ACE and DHC. Two-step appeals process. Appeals must be filed within 60 days of notification of denial or disenrollment. A written response will be provided within 30 days of receipt.				

[1] Will revisit to align with applicable Covered CA cost-sharing

1.Uninsured applicants will be screened for Medi-Cal, Covered California and other federal/state programs prior to being screened for the County's financial assistance programs
2Waiver also applies to San Mateo County residents who are ineligible for Medi-Cal and are receiving other County public assistance, such as General Assistance and services through the County's Alcohol and Other Drug programs, Health Care for the Homeless Programs and Teen Centers.
3. Community Health Advocates (CHAs) have authority to place patients on ACE program if income is up to 225% of FPL where patient shows existence of hardship and/or chronic condition requiring regular, recurring medical treatment; 4. $250 of monetary assets per patient, calculated in AB 774
5. Care is limited to emergency care, urgent care, inpatient care, and ambulatory surgery transfers from SMMC ED.
6 Payment for Outpatient (Clinic) Visits and Inpatient (Hospital) Stays and Same Day Surgeries is not to exceed the highest amount SMMC receives for medical services from Medicare, Medi-Cal, Coverd California or other government-sponsored program.

ATTACHMENT B
OVERVIEW - FINANCIAL ASSISTANCE PROGRAMS

PURPOSE:

The purpose of this policy is to provide an overview of the Financial Assistance programs available to patients of San Mateo Medical Center (SMMC) and served through the County's ACE program. The following areas are covered in this policy:

- Application Process and Eligibility Criteria for Obtaining Financial Assistance
- Overview of Financial Assistance Programs
- Billing and Collection Practices for Patients Receiving Financial Assistance
- Appeals Process
- Notification and Posting of Financial Assistance Programs

POLICY:

SMMC's "safety net" mission is to provide a basic level of health care coverage to low-income and uninsured patients of San Mateo County regardless of ability to pay. The policy demonstrates the Board of Supervisors' strong commitment to fulfill the County's safety net mission, to treat patients fairly and with respect, and to ensure equal and appropriate medical care for all patients. San Mateo County Health System's mission to build a healthy community recognizes its responsibilities to assure the availability of healthcare for the medically indigent, as articulated in Welfare and Institutions Code Section 17000. In addition, this policy reflects the goal of establishing a financial relationship with each patient, which is built on trust, confidentiality and compassion, and that carefully balances the patient's need for financial assistance with SMMC's fiduciary responsibilities.

PROCEDURE:

A. Notice of the Right to Apply for Financial Assistance

Individuals who receive medical care at the San Mateo Medical Center or are served through the County's ACE program shall be provided a brochure detailing their right to apply for various financial assistance programs, and shall be provided with information on who to contact for an application. Copies of financial assistance policies shall be available for review.

B. Notice of the Determination of Eligibility

Individuals who apply for financial assistance will be informed in writing whether they qualify, and the basis for the determination if they are found ineligible. The document will provide information about the right to an individual eligibility review and the right to appeal a denial or discontinuance of coverage.

C. Application Process and Eligibility Criteria for Obtaining Financial Assistance

1. Financial assistance will be considered for any patient who indicates an inability to pay for medical services. An application for financial assistance will be initiated to assess the extent of financial need. The Health System and SMMC will make every effort to match the appropriate source of payment and coverage from public and private programs to help cover the patient's medical care. Whenever possible, patients should apply for financial assistance prior to the first day of service.

2. Patients seeking financial assistance from SMMC are expected to provide personal and financial information that is complete and accurate. This may include current health care benefits coverage, financial status, residency, and any other information necessary for the Health System/ SMMC to make a determination regarding the patient's eligibility for financial assistance. Patients must declare, under penalty of perjury that the information provided is true and correct. Patients applying for financial assistance must consent to verification and investigation of eligibility by County personnel, agents or contractors. This may include the obtaining and use of information and documents possessed by other public and private agencies, including, but not limited to, records of the Department of Child Support Services.

3. The Health System/ SMMC will make available the assistance of a Community Health Advocate (CHA) or Financial Counselor for patients seeking financial assistance. The CHA or Financial Counselor's mission is to match the patient with the appropriate form of financial assistance based on the patient's unique financial situation. The patient may be referred to a Benefits Analyst, or other outside contractors, for assistance in applying for Medi-Cal or other health coverage. The County will provide assistance in the primary language of the patient or patient's guarantor for, at a minimum, Limited English Proficient (LEP) clients who fall within one of the County's threshold language groups.

4. In general, patients must meet certain eligibility criteria, including residency and income <removed reference to assets> to qualify for financial assistance. Assistance is normally not available for elective or medically unnecessary cases, experimental procedures, or those highly specialized services that are typically covered by other federal and state programs. A patient's unique circumstances may be taken into consideration when determining coverage for such services.

5. At a minimum, an application for financial assistance must be renewed and updated annually and prior to inpatient stays and same-day surgeries. This is required in order to incorporate and allow consideration of any changes to a patient's financial status. The County shall determine and may modify the period of eligibility for any individual entitled to receive services covered under the financial assistance programs. Re-screening of a patient will not take place if the patient has been screened for eligibility within 90 days prior to a scheduled surgery or inpatient stay. Similar to MC clients, ACE and MCE applicants are also required to report any changes in circumstances such as income and county residency.

6. All uninsured patients who present for financial screening with incomplete verifications will be entered into One-e-App. One-E-App will retain the screening date as the date of application. Patients have 45 days from this date to provide their verifications. Patients

are given notification at the time their application is suspended in One-e-App notifying them of the date at which their application will expire and the information and documentations needed to complete their application. If they do not bring their verifications by day 45, their application will expire and they will need to reapply if they are seeking coverage. If patients provide their verifications within the 45 days and are found eligible for a financial assistance program, the balances from their previous visits from the three complete months prior to the date of application will be waived but those who are eligible for the ACE Non-Fee Waiver Program will still be responsible for their co-payments for services rendered. This retroactive coverage will not be extended if the patient was previously enrolled in coverage and notified about how to retain that coverage but did not follow through with the actions necessary to maintain continuous coverage.

7. Patients seen in the Emergency Department or other clinic location during a time when a Community Health Advocate is not available will be given a letter advising them they have 14 days to start their financial screening. Failure to start the financial screening by day 14 will result in their account being considered full pay.

8. It is desirable to determine the kind of financial assistance for which a patient is eligible as close to the time of service as possible. In some cases, it may take a substantial amount of time to investigate the patient's eligibility criteria due to the patient's limited ability or willingness to provide required information. Patient accounts which have been turned over to a collection agency and later meet the criteria for financial assistance, will be returned to SMMC's Patient Billing and Collections office.

9. The financial assistance policies do not apply to services provided by physicians or other medical providers practicing at SMMC, unless contractually obligated through a third party billing arrangement with SMMC.

D. Scope of Services

The Chief of the Health System or her/his designee shall have the authority to develop and implement policies and procedures necessary to clarify and/or adjust scope of coverage and benefits and administrative practices of the County's medical Financial Assistance Policies to track or conform with changes to State and/or federal law.

E. Overview of Financial Assistance Programs

Applied in the Following Order	General Qualifications / Income Level	Refer to:
External Government-Sponsored Programs (e.g.,. Medi-Cal, Covered California qualified health plan, Impact, CDP, PACT, CHDP, BCCTP, Healthy Kids, Medicare)	Based on specific program's guidelines and eligibility criteria	Guidelines for Medi-Cal & Government Sponsored Insurance
General Assistance/Other Public Assistance Programs - County-sponsored coverage for medically indigent adults enrolled in other public assistance programs such as General Assistance	County resident receiving General Assistance; served by a Health Care for the Homeless provider; enrollment in a County sponsored Alcohol and Other Drug Program contracted	Medically Indigent Policy - ACE Program
Youth Health Centers - County-sponsored coverage for medically indigent young adults receiving services provided at Teen Health Centers	Patients must receive sensitive services & must be ineligible for PACT or Medi-Cal Minor Consent.	Medically Indigent Policy - ACE Program
Charity Care Program - County Program that complies with the charity care mandates of Assembly Bill 774. The program is available to assist uninsured or underinsured patients with limited income of up to 100% of the federal poverty level (FPL) who are not eligible for the ACE Program, government programs, or coverage from other payors.	Not limited to San Mateo County Residents. Must have income at or below 100% of the FPL, *monetary* assets that do not exceed $250 (calculated pursuant to AB 774). Care limited to emergency care, urgent care, inpatient care and ambulatory surgery transfers from the SMMC Emergency Department. Patients receiving charity care pay no annual fees and make no co-pays.	San Mateo County Charity Care Policy

ACE Program – County-sponsored coverage for medically indigent adults who are uninsured and meet residency, income and asset requirements	County resident, income at or below 200% of federal poverty level (FPL), **Fee Waiver** - Waiver of all fees*, co-pays for County residents at or below 138%FPL, or for persons receiving General Assistance, services through the County's Alcohol and Drug programs, Health Care for the Homeless program, or services at the County's Teen Centers	Medically Indigent Policy - ACE Program
Discounted Health Care (DHC) Program – Discount for low-income adults who meet eligibility requirements	Where the patient is uninsured, he must have income at or below 400% FPL. Where patient is insured and his income at or below 400% FPL and has high medical costs, as defined, he/she will be eligible.	Discounted Health Care (DHC) Program
Self-Pay Prompt-Pay Discount – For adults who do not qualify for other programs; 50% discount for payments received within 30 days of first bill date	No income, asset and residency requirements; required to pay a deposit in advance of receiving non-emergency services	Self-Pay Prompt-Pay & Extended Repayment Plan Policy
Self-Pay Extended Repayment Plan – for adults who do not qualify for other programs; payment of full charges over an established repayment period	No income, asset and residency requirements; required to pay a deposit in advance of receiving non-emergency services	Self-Pay Prompt-Pay & Extended Repayment Plan Policy

1. External Government-Sponsored Programs

   Whenever possible, patients will be first assessed for coverage through a governmentally sponsored program such as Medi-Cal, Covered California, PACT, IMPACT, CDP, etc. Under these programs, the patient may be responsible for a share of cost or co-pay. Patients who are eligible for further financial assistance may be allowed to have specific co-pays and non-covered charges waived. For more information on this type of program, refer to the specific guidelines for Medi-Cal & other government-sponsored insurance programs.

2. Charity Care

Charity Care will be offered to uninsured patients with income levels not exceeding 100% of the FPL, and whose monetary assets, calculated pursuant to AB 774, do not exceed those set forth in this policy. Patients with incomes that are higher than 100% of the FPL, but lower than 400% of the FPL may be eligible for discounted services pursuant to the SMMC's Discounted Healthcare Policy. Patients will only be offered charity care if they are ineligible for the ACE Program or other governmental programs, or for coverage from other payors, including those having third party liability.

A patient's qualifying *monetary* assets must not exceed the $250.00 County resource limit and the resource exemptions required under AB 774. Pursuant to AB774, the first ten thousand dollars ($10,000.00) of a patient's monetary assets shall not be counted in determining eligibility, nor shall 50 percent of a patient's monetary assets over the first ten thousand dollars ($10,000.00) be counted in determining eligibility. "Monetary assets" include cash, checking account balances, savings account balances, money market fund balances, certificates of deposits, annuities, stocks, bonds, or mutual funds that are not part of a retirement or deferred compensation plan qualified under the Internal Revenue Code, or non qualified deferred –compensation plan.)

3. Medically Indigent Healthcare (W&I Section 17000) - ACE Program

   a. The ACE Program is a County-sponsored program that subsidizes health care to medically indigent adults and fulfills the County's obligation under Section 17000 of the California Welfare and Institutions Code. Patients must be residents of San Mateo County with income at or below 200% of federal poverty level (FPL)[2]. Patients must pay an annual or monthly fees as established in the ACE sections following this overview and are aligned with the premium requirements of persons at similar income levels who are eligible to obtain subsidized coverage through the federal Affordable Care Act offerings administered by Covered California, as well as copays for inpatient stays and same day surgeries, and other services. Each individual participating in ACE shall be required to pay no more that 6.3% of income as defined by Covered California of their annual income per year out of pocket for copayments, fees, and charges.

   b. Fee Waiver - All outpatient fees, co-pays and charges will be waived for patients who are San Mateo County residents with incomes at or below 138% FPL. For inpatient stays and/or same day surgeries, such patients shall not be responsible for any copayment but the County shall be entitled to pursue estate recovery on the balance owed by applying the discount that matches the best government payer.

[2] CHAs are vested with the authority to place patients who have incomes up to 225% of the FPL on the ACE Program in cases where the patients have established that denial of such relief would give rise to hardship for the patient. Further, CHAs may consider the presence of chronic medical conditions for which regular, recurring medical treatment is needed in making such determinations.

c. Patients ineligible for Medi-Cal or other private/public health coverage and qualify for other County-sponsored public assistance programs – via enrollment in an Alcohol and Other Drug program that contracts with the San Mateo County Health System, as a recipient of Health Care for the Homeless (HCH) services, or in receipt of General Assistance in San Mateo County-will be eligible for the ACE Program if income and county residency requirements are met.
d. Patients at the Teen Health Centers in Daly City and Redwood City are eligible for County assistance if they receive sensitive services not covered by the Medi-Cal Minor Consent program or Family PACT.
e. For inpatient stays and/or same day surgeries, the County shall be entitled to pursue estate recovery on the balance owed by applying the discount that matches the best government payer.

1. Discounted Health Care (DHC) Program

   The DHC Program offers a discount to SMMC patients who qualify with income at or below 400% of FPL and who lack third party health insurance coverage or who have such coverage but who also bear "high medical costs (as defined in this policy). Patients who qualify receive a discount rate for the scope of services provided in the ACE Program. This discount rate will be adjusted annually and may be applied to non-covered charges, denied charges, co-pays, and deductibles.

2. Self-Pay Prompt-Pay Discount and Extended Repayment Plan

   a. Patients who are not covered under a commercial insurance or governmentally sponsored program, and do not qualify for the ACE or Discounted Health Care programs, may elect to receive the self-pay prompt-pay discount. This allows the patient to receive a 50% discount off full charges if the bill is paid within 30 days of the initial billing date. This discount is set at a rate that ensures the San Mateo Medical Center (SMMC) is adequately reimbursed for the cost of care provided to the patient. This discount does not apply to co-pays, deductibles, but may be applied to non-covered, denied charges, or Medi-Cal share of cost responsibility.

   b. Patients who are responsible for their entire bill and cannot elect to take the Self-Pay Prompt-Pay Discount may make arrangements to pay off the bill over an extended amount of time without interest. The extended amount of time granted is based on the total amount to be repaid and the patient's current financial status. There are no discounts allowed under this program.

E. Billing and Collection Practices for Patients Receiving Financial Assistance

1. SMMC is committed to a minimum of 90 days billing prior to assigning a self-pay account to a bad debt collection agency. The County is committed to complying with all the provisions of AB 774 (Health and Safety Code §127425) and will not refer matters to collection where payment plans are in negotiation. Information regarding income and asset status should be provided as soon as possible.

2. The San Mateo Medical Center's billing and collections department will adhere to SMMC's values and mission as a "safety net" institution.

3. An interest-free extended repayment plan will be made available by the San Mateo Medical Center in all appropriate cases based on each individual's ability to pay.

4. Patient statements will contain information indicating that the patient may be eligible for financial assistance as well as contact information for further assistance.

F. Appeals Process

1. Notice of the Right to Eligibility Review and Appeal

   Every individual who has been disenrolled, or has been denied eligibility, or who wishes to request a waiver or reduction of co-pays, fees or charges shall have the right to a two-step appeals process that allows the individual to present evidence of eligibility or argue special circumstances based on inability to pay. The first appeal step is an "individual eligibility review" (IER) to appeal any financial and non-financial issues relating to ACE Program eligibility. The second appeal step shall be before the "eligibility and financial review committee" (EFRC).

   Every individual who has been disenrolled, or has been denied eligibility, or who is assessed co-pays, fees or charges shall receive written notice of (1) the denial, discontinuance or charges; (2) the right to have the denial, discontinuance, or fees, co-pays and charges reviewed through the IER process based on ability to pay; and (3) a specific description of the appeals process and timelines. An individual who can demonstrate inability to pay shall be entitled to a reversal of the County's initial determination on eligibility, fees, co-pays or charges.

2. Step-One Appeal: Individual Eligibility Review (IER)

   a. Timeline for Step-One Application

   Individuals may appeal a disenrollment or denial decision within 60 days of the receipt of a written notice indicating the disenrollment or denial. Individuals who wish to request a waiver or reduction of fees, co-pays or charges may do so within 60 days of receipt of a bill for the fees, co-pays or charges. Notice of the right to appeal shall accompany such bills. Individuals are to complete a Request for Individual Eligibility Review (IER) form and submit the form to the Chief Financial Officer or his/her designee within 60 days of the written notice.

   b. Content of Request for Individual Eligibility Review

   In completing the Request for IER form, individuals must provide specific information supporting their appeal. The specific information needs to support a case that the

individual has special circumstances demonstrating an inability to pay which justifies a reversal of the initial County decision to deny or disenroll, or of the County's decision to assess charges. Such information may include unusual and extraordinary expenses over and above the actual cost of necessities of life.

c. Individual Eligibility Review Decision-Maker

The IER shall be decided by the Chief Financial Officer or his/her designee, who has not been directly responsible for the preliminary determination. This individual shall consider all special facts and circumstances supporting the applicant's claim of eligibility or claim of inability to pay, including the actual costs of necessities of life in San Mateo County.

d. Timeline for Decision

The Chief Financial Officer or his/her designee shall make a written decision to affirm or reverse the initial County determination within 30 days after receipt of all requested documents. If the decision is to reverse the initial County determination, then the applicant shall receive specific notice of the decision and information relating to the rights and benefits associated with the decision. If the decision is to affirm the initial County determination, then the written decision shall provide the reason for the decision and also include a description of the applicant's Step-Two Appeal rights, including a form to complete the appeal. If there is no decision within 30 days, the applicant has the right to an immediate review by the Eligibility and Financial Review Committee.

3. Step-Two Appeal: Eligibility and Financial Review Committee (EFRC)

a. Timeline for Step-Two Application

Individuals may appeal the decision of the IER to the EFRC within 60 days of the receipt of the decision letter. Individuals may initiate an appeal by completing a pre-provided appeal form and submitting it to the Chief Financial Officer or his/her designee.

b. Content of Appeal

Upon notice of appeal, the original Request for Individual Eligibility Review form and all documentation, in addition to the new appeal form will be forwarded to the EFRC for consideration. Individuals are free to supplement this form with any other information that supports their position, including inability to pay information.

c. Eligibility and Financial Review Committee

The EFRC shall consist of three individuals: the Chief of the Health System or his/her designee (other than the IER decision-maker), the San Mateo Medical Center Chief Financial Officer or his/her designee and a public member to be chosen by the County Manager and Health System Chief. The applicant has the right to appear before the EFRC, to present testimony including the sworn testimony of witnesses, and to bring an

attorney. An electronic record of the proceedings will be obtained at the applicant's request.

d. Timeline for Decision

The EFRC shall make a written decision to affirm or reverse the IER determination within 30 days after receipt of requested documents. If the decision is to reverse the initial County determination, then the applicant shall receive specific notice of the decision and information relating to the rights and benefits associated with the decision. If the decision is to affirm the IER determination, then the written decision shall provide the reason for the decision.

4. Anytime Request for Eligibility and Financial Review

Any individual may request an eligibility and financial review at any time if their circumstances change. If the Chief Financial Officer or his/her designee receives such a request, it shall be processed under the same timelines and rules specified above.

G. Periodic Board Reports

Periodically, program, eligibility and appeal data shall be submitted to the Board of Supervisors for review and consideration.

H. Notification and Posting of Financial Assistance Programs

1. SMMC will publicly post information on its financial assistance programs. This includes the distribution of pamphlets and letters, public notices in visible locations where there is a high volume of patient registrations, information contained on the SMMC web site, and statements on patients' bills indicating the availability of financial assistance. Pursuant to AB 774 (Health and Safety Code §127410(a)) such information must be provided in the language of the applicant for, at a minimum, LEP clients in the threshold language groups in San Mateo County.

2. Upon request, SMMC will make available its financial assistance policies. In addition, posted information will include the types of financial assistance available and SMMC's contact for further information about these policies and how to apply for financial assistance

CHARITY CARE POLICY

POLICY: San Mateo Medical Center ("SMMC") offers a Charity Care Program consistent with the changes to the California Health and Safety Code made by Assembly Bill No. 774 (AB774). It is the policy of SMMC to initially provide care, to the extent possible, under the County of San Mateo's Access and Care for Everyone (ACE) Program, third party coverage, and other government programs, before considering Charity Care.

The Charity Care Program is available to assist uninsured patients with limited income of up to one hundred percent (100%) of the Federal Poverty Level (FPL) and who are not eligible for the ACE Program, government programs, or coverage from other payors, including those having third party liability.

This Policy applies to emergency care, urgent care, in-patient care and ambulatory surgery transfers from the SMMC Emergency Department.

DESCRIPTION: The procedure describes the process to identify and secure all available third party coverage and reimbursements from government programs, and to make available the Charity Care program to self pay patients who are ineligible for other forms of financial assistance and who meet the income limitation requirements set forth in this policy.

It is the intent of the SMMC that this policy shall comply with all federal, state, and local regulations. If any regulation, current or future, conflicts with this policy, the regulation will supersede this policy.

I. CHARITY CARE:

A. Definition of Charity Care:

Charity Care will be offered to uninsured patients with income levels not exceeding 100% of the FPL, and whose monetary assets, calculated pursuant to AB 774, do not exceed those set forth in this policy. Patients with incomes that are higher than 100% of the FPL, but lower than 400% of the FPL may be eligible for discounted services pursuant to the SMMC's Discounted Healthcare Policy.

A patient's qualifying *monetary* assets must not exceed $250.00 at the time of service, as defined in AB 774. Pursuant to AB774, the first ten thousand dollars ($10,000.00) of a patient's monetary assets shall not be counted in determining eligibility, nor shall 50 percent of a patient's monetary assets over the first ten thousand dollars ($10,000.00) be counted in determining eligibility. "Monetary assets" include cash, checking account balances, savings account balances, money market fund balances, certificates of deposits, annuities, stocks, bonds, or mutual funds that are not part of a retirement or deferred compensation plan qualified under the Internal Revenue Code, or non qualified deferred –compensation plan.).

B. Charity Care Application Process:

Patient must comply in a timely manner with screening process by providing all required information on other coverage, and must fully cooperate in pursuing third parties who may be liable for incurred health care expenses.

Patient must apply for government coverage programs for which he or she may be eligible. Patients who do not cooperate in the application process will not be eligible for Charity Care.

Patient must complete an application for Charity Care and provide required verifications as follows:

a. Most recent 3 months of patient's pay stubs before the date of the Charity Care application or last income tax return.
b. Last 3 months of statements relating to all financial assets from date of Charity Care application.

Patients eligible for Charity Care will receive free services within the scope of services set forth in Section IC of this policy.

C. Scope of Charity Care

Medical care provided under this Policy shall be limited to emergency care, urgent care, inpatient care and ambulatory surgery transfers from the SMMC Emergency Department.

D. Collect existing Insurance and Third Party Payer Information

Patients are interviewed to collect demographic, financial and existing insurance information used in the determination of federal, state and county program eligibility.

- Commercial HMO/PPO
- Medicare
- Medi-Cal and Medi-Cal Special Programs
- Covered California
- Healthy Kids,
- Slip and Falls/Third Party
- Auto Accidents
- Injuries at work

E. Refer Patients for County and State Programs Referrals based on:

- Provider referral
- Patient's request as a result of information provided
- Eligibility
- Worker's determination at time of registration or admission.

F. Distribution of Governmental Program Applications

Uninsured patients will be provided with information on the applicant process for government programs, such as the Medi-Cal Program, Covered California, the County's ACE program. This information will be provided prior to discharge if the patient has been admitted or made available to patients receiving emergency or outpatient care.

Community Health Advocates ("CHAs") will track and identify patients who were previously referred to apply for Medi-cal and have a Medi-Cal application pending. These patients will not be provided another government application but will be encouraged to follow through with the pending application.

Notice of the Health System's/ SMMC's ACE Policy, as well as its Charity Care and Discounted Health Care policies, will be clearly and conspicuously posted in locations that are visible to the public, including, but not limited to all of the following:

- Emergency department registration
- Outpatient registration sites
- Billing office
- Admissions office

CHAs and the SMMC Finance Department Admitting and Business Office staff will provide patients with a written notice that shall contain information about availability of the SMMC's Charity Care and Discounted Health Care Policies, including information about eligibility, as well as contact information for an office from which the person may obtain further information about these policies. The notice shall be provided to patients who receive and may be billed for emergency department care, outpatient care or inpatient care.

Patients who have not been screened for a public health coverage program will be referred to a CHA. If the CHA determines that patient is not eligible for a public health coverage program including the Discounted Health Care Program, then the patient will be assisted with filling out the Charity Care application which will then be forwarded to the Director of Patient Access.

Patients who have been found ineligible for a public health coverage program and who receive a bill and indicate an inability to pay or requests a bill adjustment at any time within 150 days from initial issuance of a bill will be referred to the Director of Patient Access or his/her designee to review the patient's eligibility for Charity Care.

The Director of Patient Access or his/her designee will review the eligibility history of the patient's account to verify that the patient has no third party payers and has completed the eligibility process for all government programs for which they may be eligible.

If the Director of Patient Access or his/her designee determines the patient is self-pay or insured with high medical costs, the patient completes a combined application for the Charity Care and Discount Payment.

G. Assist Patients with Enrollment and Applications

Patients are referred to programs based on specific diagnosis and/or family demographics. CHAs are available by appointment or drop-in to enroll patients immediately in programs whenever possible. CHAs and patient registration staff enroll or assist patients to apply for the following programs. In some cases, enrollment is processed at the point of service:

- Medi-Cal
- Covered California
- Healthy Kids
- California Children Services
- ADAP
- Well-Child-CHDP Gateway
- Family Planning-Family Planning Access, Care (PACT)
- Cancer Detection Program (CDP)
- Breast Cervical Cancer Treatment Program (BCCTP)
- Prenatal – Presumptive Eligibility Medi-Cal
- Victim of Crime Program
- 1011 Program
- ACE
- Charity Care and Discounted Healthcare

H. Charity Care and Discounted Healthcare are only available as last resorts

SMMC will exhaust all third party payer sources, linkages to third party payer sources and the ACE Program before enrolling a patient for Charity care or Discount Payment.

I. Required Verifications of Income and Assets

1. Income (one of the following):
   Most recent 3 months of patient's pay stubs before the date of application or last income tax return.

2. Assets:
   Most recent 3 months of statements from banks or other financial institutions from date of application. If a patient declines to provide assets information, he or she will then be ineligible for Charity Care and will only be evaluated for the Discounted Healthcare Program.

J. Third party coverage:

- Third party insurance information
- Auto insurance or liability information
- Denial notices for government programs
- Results of lawsuits

K. **Notification of Eligibility Determination**

1. The patient has 45 days to provide the requested verifications. If the patient fails to provide the verification in 45 days, the application is denied. If this occurs, the patient will receive a written notice that his application has been denied based on his/her failure to provide necessary verifications and what specific verifications are needed. The notice will inform patients of their right to appeal this denial and of their right to reapply.

When an application is complete, the Director of Patient Access or his/her designee first evaluates the patient for Charity Care. If the patient is ineligible for Charity Care, the patient is evaluated for the Discounted Health Care program.

3. When an application is complete, the Director of Patient Access or his/her designee makes a determination of eligibility and notifies the patient and the Business Office.

L. Notification to Patient

1. Approval

Inpatient**:** The SMMC Patient Access Financial Counselor will complete the insurance revisions of the accounts and refer account balances to the business

office for appropriate adjustments. The patient will receive a new statement reflecting the revised patient liability amount.

Outpatient: The SMMC Patient Access Financial Counselors will complete insurance revisions of the accounts. Patient will receive a new statement reflecting the revised patient liability amounts.

2. Denial

The Director of Patient Access or his/her designee completes the eligibility determination portion of the application. The Director of Patient Access or his/her designee provides the patient with a copy of the denial notification and the information of the appeals process.

M. Eligibility Appeals Process

1. Patient may appeal the denial of Charity Care and must submit written request within 60 business days of receiving their denial determination to the Patient Access Manager. The patient must submit the following items:

- Copy of complete application
- Statement setting forth the basis of the appeal
- Send to:
  San Mateo Medical Center
  Director of Patient Access
  222 W. 39th Avenue
  San Mateo, CA 94403

ATTACHMENT D-1
SAN MATEO COUNTY MEDICALLY INDIGENT POLICY
(ACE PROGRAM-SECTION 17000)

PURPOSE:

The purpose of this policy is to set forth the County's program to address its legal obligations pursuant to Welfare and Institutions Code section 17000 et. seq. to "relieve and support" the resident medically indigent population. The County refers to this program as the Access and Care for Everyone (ACE) Program. This policy outlines the specifics of the ACE program, including scope of services, eligibility requirements, verification, enrollment, appeals and waiver process.

POLICY:

It is the policy of the County to provide health care to its incompetent, poor and indigent residents, in accordance with Section 17000 of the Welfare and Institutions Code. The objectives of this program are to optimize community health by focusing on prevention and proactive health management, provide an equitable and uniform method of payment for health services, and empower patients to take an active role in their own care.

PROCEDURE:

A. Notice of the Right to Apply for ACE Program

Individuals who receive medical care at the San Mateo Medical Center shall be provided a brochure detailing their right to apply for various financial assistance programs, including the ACE Program, and shall be provided with information on who to contact for an application. Copies of this policy and other financial assistance policies shall be available for review.

B. Populations Eligible for ACE Scope of Services

1. County residents who have been screened and enrolled in the following public assistance programs are eligible for the ACE Program.
   - Persons receiving General Assistance in San Mateo County who are ineligible for Medi-Cal, Covered California or other public or private health coverage
   - Persons receiving services through the County's Alcohol and Other Drug programs who are ineligible for Medi-Cal, Covered California or other public or private health coverage
   - Persons who are receiving services through the County's Healthcare for the Homeless (HCH) program who are ineligible for Medi-Cal, Covered California or other public or private health coverage

- Persons under 19 years of age who are receiving services at a San Mateo County Youth Health Center and who are ineligible for PACT, Medi-Cal Minor Consent, Covered California or other public or private health insurance coverage

These eligible populations shall receive an ACE Program enrollment form and brochure explaining that they are not required to pay the Program's annual fee, co-pays, charges or liens.

2. County resident adults who are not eligible for full-scope or share-of-cost Medi-Cal coverage, Covered California, Medicare or other public or private health coverage and who meet the income and asset criteria for ACE enrollment described in the next section.

3. County resident adults who are not eligible for full-scope or share-of-cost Medi-Cal coverage, Covered California, Medicare or other public or private health coverage, who meet clinical criteria to receive services through the County's Behavioral Health and Recovery Services programs, and have income or assets that are above the thresholds described in the next section. The Chief of the Health System or her/his designee shall develop guidelines for establishing the client's financial responsibilities for participation in the ACE program.

C. ACE Program Eligibility Criteria

1. Applicants must declare under penalty of perjury that they meet the requirements for eligibility as defined below. Applicants have the ability to appeal a denial or disenrollment decision pursuant to the Appeal Process set forth in section M below.

   a. Residency Requirement

      1. Applicants must be residents of San Mateo County. Residency is based on an applicant's actual place of residence and demonstrable intent to reside in the County.
      2. If an adult immigrant applicant has a valid visa issued with a duration of less than one year, he or she is not eligible for ACE.
      3. An applicant with a valid Multiple Entrance visa issued for longer than one year is also not eligible for ACE if the current entrance period has not expired.
      4. ACE participants are required to report any changes in residency/address within ten days of when the change occurs.

   b. Income Criteria

      1) Income must be equal to or lower than 200% of the Federal Poverty Level (FPL). This level is updated annually. Designated Community Health Advocates (CHAs) are vested with the authority to place patients who have incomes up to 210% of the FPL on the ACE Program in cases where the patients have

established that denial of such relief would give rise to hardship for the patient. Further, CHAs may consider the presence of chronic medical conditions for which regular, recurring medical treatment is needed in making such determinations. These designated Community Health Advocates may exercise the same discretion with respect to patients with incomes up to 225% of the FPL. The Chief of the San Mateo County Health System or his or her designee has developed and implemented a process for CHAs and CHA Supervisors/Managers to apply in considering whether to place individuals with incomes between 200% and 225% of FPL on the ACE Program. Said process shall be set forth in writing and made available to all ACE Program applicants, and shall include, among other factors deemed appropriate by the Chief of the San Mateo County Health System, a consideration of the patient's income and expenses, as well as the presence of chronic conditions for which regular, recurring medical treatment is needed. In addition, any individuals with income above 200% FPL who can demonstrate that denial of eligibility would give rise to a hardship may appeal their denial through the process described in section M.

2) Income is defined as total or gross cash receipts, wages and salaries, before taxes and from all sources. It also includes regular payments from Public Assistance, Social Security, Unemployment and Workers' Compensation, strike benefits, training stipends, alimony, child support, military family allotments or other regular support from an absent family member or someone not living in the household, pensions, insurance or annuity payments, dividend income, interest, rents, royalties, estates, and trusts. The following Social Security income will be counted: Survivor's, Retirement Survivor's Disability Income (RSDI), Federal Retirement, Federal Disability, and State Disability Insurance (SDI). The following Social Security income will not be counted: Supplemental Security Income (SSI) and State Supplemental Payment (SSP).

3) Income may be offset with deductions for business or farming expenses and should not include food or rent received in lieu of wages.

4) Applicants are required to apply for unemployment benefits if potential eligibility is assessed by the Community Health Advocate during the course of the health coverage application process.

5) ACE participants are required to report any changes in income within ten days of when the change occurs.

c. Identity Verification

1) Applicants must provide an acceptable proof of identity.

2. Patients who are recipients of third party liability payment funding (e.g., Medicare, full-scope or share of cost Medi-Cal, Covered California, private insurance, or any other state, federal public or private health care coverage or reimbursement or compensation for medical expenses through a third party source, including, for example, from the proceeds of a lawsuit) are not eligible for the ACE Program.

3. Every individual who has been disenrolled, or has been denied eligibility, or who wishes to request a waiver or reduction of co-pays, fees or charges shall have the right to an appeals process that allows the individual to present evidence of eligibility or argue special circumstances based on inability to pay. This appeals process is more fully described in section M of this Policy.

   Every individual who has been disenrolled, or has been denied eligibility, or who is assessed co-pays, fees or charges shall receive written notice of (1) the denial, discontinuance or charges; (2) the right to have the denial, discontinuance, or fees, co-pays and charges reviewed through the IER process based on ability to pay; and (3) a specific description of the appeals process and timelines. An individual who can demonstrate inability to pay shall be entitled to a reversal of the County's initial determination on eligibility, fees, co-pays or charges.

4. Patients may be ineligible for or lose coverage for the ACE Program for the following reasons:

   - Patients who were denied Medi-Cal, Covered California or other benefits due to lack of reasonable cooperation
   - Patients who fail to apply for Medi-Cal, Covered California or any other third party coverage when requested to do so.
   - Patients holding non-resident visas with a duration of less than one year. An applicant with a valid Multiple Entrance visa issued for longer than one year is also not eligible for ACE if the current entrance period has not expired.
   - Patients who fail to provide requested information.
   - Patients who fail to cooperate with an ACE audit.
   - Patients providing materially incorrect or false eligibility information. In such cases, the patient my be terminated immediately from the ACE Program and billed retroactively for all ACE Program services during the period of time in which the information was incorrect or false.
   - Patients who fail to pay ACE fees, co-pays and charges.
   - Patients who enter the United States for the purpose of obtaining medical care.

D. Verification Process

1. In order to qualify for the ACE Program, patients must satisfy eligibility requirements including family income, assets, and residency. The patient must declare, under penalty of perjury, that the information provided is true and correct. Patients applying for the ACE Program must consent to verification and/or investigation of eligibility by County personnel, agents or contractors. Such investigation/verification may include the

obtaining and use of information and documents possessed by other public and private agencies, including but not limited to records of the Department of Child Services.

2. The Health System/ San Mateo Medical Center will request proof of income and residence. Proof must be timely and dated within the last 45 days. Proof of identity is also required. These requirements can be satisfied in the following ways:

   a. Proof of Residency

      1) Car registration
      2) Voter registration
      3) California driver's license or ID card
      4) Employment record including offer letter, pay stubs, lay-off notice, employment or registration contract with an employment service, employer affidavit
      5) Rent or mortgage receipt. If the receipt is from a relative, the applicant must have that relative complete and sign the form, *Statement of Rent Receipt,* from a relative.
      6) Utilities bill – if not in patient's name, the bill should be accompanied by a signed statement from a relative or non-relative landlord
      7) Listing in the city directory or phone book that can be verified
      8) Principal property ownership document or property tax bill
      9) Membership record in a religious institution that reflects patient's address
      10) Student identification
      11) School records
      12) Recent marriage license, divorce decree, or evidence of domestic partnership issued in the State of California (within the last 45 days)
      13) Recent court documents showing the applicant's current address (within the last 45 days)
      14) Insurance documents
      15) Police record from a California law enforcement agency (within the last 45 days)
      16) Documents from a homeless shelter or other public or community service agency indicating that the applicant is receiving services from the agency
      17) Adoption record (within the last 45 days)
      18) Medical record except San Mateo Medical Center (within the last 45 days)
      19) Voided personal check with pre-printed address
      20) Other proof of residency – other third party documents verifying residency of applicant can be provided

   b. Proof of Income

      1) Unemployment – employer's records; EDD records; UIB check; layoff notice; training program records; training stipends; union records.
      2) Earnings – pay stubs; employer's wage record; state and/or federal income tax return; EDD records; employee W-2 form; farm business records; an employer statement, preferably on the employer's letterhead, or name of company stated on

letter, including name of person employed, signature of employer, date of letter, pay frequency and gross amount.

3) Person receiving income can write an affidavit if there is no alternative manner to document income. This letter should include: claimant's name and signature; date of letter; how much employee is paid; date, frequency and source of payment; declarations that (1) the information provided is true and correct (2) there is no other form of income documentation available, and (3) the employee understands the county/state may verify the information provided.
4) Self-Employment – recent tax returns/business records; receipts for goods and services; last year's federal income tax return including Schedule C; last three months net profit and loss statement; beneficiary's statement when expenses cannot be verified; signed statement from business associates; statement from institutions where checks are deposited/cashed.
5) Unearned Income – Social Security Administration (SSA) award letter, official correspondence from SSA, bank statement showing SSA deposit, Veterans Administration (VA) check, VA award letter; public assistance; worker's compensation award notice; workers' compensation check; alimony; child support check; itemized statement from child support agency; SDI check; government and private pension checks; insurance/annuities checks, correspondence; bank statements verifying interest income; rents; dividends; royalties; estates and trusts; military and child support allotment or other regular support from an absent family member or someone not living in the household.
6) Other proof of income – other third party documents verifying income of applicant can be provided

c. Proof of Identity

1). Acceptable identification documents in order of priority:
   a. California Driver's License or California DMV identification card
   b. US Passport or other US federal government identification
   c. Other state driver's license or DMV identification card
   d. Photo in SMMC's E Clinical Works (ECW)
   e. Foreign government identification document (consular ID card, passport, national ID Card, or national voter card).

2) If documents listed above are not available, other acceptable documents, in order of priority include:
   a. Birth Certificate
   b. Social Security Card
   c. Medicare Card
   d. Medi-Cal Card
   e. Health Plan of San Mateo card
   f. Bank card with Photo ID
   g. Two signed affidavits attesting to the identification of the patient photo identification from both parties who signed them.

The County may request different or further forms of documentation for verification of identity, residency, income or assets in cases where the genuineness and/or validity of the provided documents is reasonably questioned or where the provided documents raise further questions as to eligibility.

3. The Health System/ San Mateo Medical Center may utilize third party verification services including the use of credit reports, IEVS, State Income Tax Bureau, MEDS, CDS/CalWIN, DMV and property clearances.

4. Patient eligibility for the ACE Program will be reviewed, at a minimum, annually and prior to inpatient stays and same-day surgeries. This is required in order to incorporate any changes to a patient's financial status. The County shall determine and may modify the period of eligibility for any individual entitled to receive services covered under financial assistance programs. Re-screening of a patient will not take place if the patient has been screened for eligibility within 90 days prior to a scheduled surgery or inpatient stay.

E. Notice of the Determination of Eligibility

Individuals who apply for the ACE Program will be informed in writing if they qualify. The enrollment confirmation or notice of of ineligibility will be provided to the applicant either at time of application or within 45 days after receipt by the County of a complete applicant and it shall provide information about the right to an individual eligibility review, the right to appeal a denial or discontinuance of coverage, and the bases upon which an individual eligibility review and/or an appeal can be based.

F. Scope of Services

1. The ACE Program scope of services is similar to that under Medi-Cal except that inpatient and outpatient care, pharmaceuticals and supplies are provided at San Mateo Medical Center or, at an approved outside contracted provider site.

2. The ACE Program does not cover cosmetic surgery, pregnancy-related services, Family Planning, impotence/infertility, non-medically necessary services, mental health services other than limited outpatient mental health services provided within primary care settings, emergency medical transport, emergency care and treatment at other facilities, unauthorized care or services received at other facilities, long term care, experimental or investigational treatments or therapies, non-emergent dental, and certain prescriptions such as vitamins, some pain medications and tranquilizers, etc. Notwithstanding the foregoing limitations, the Chief of the San Mateo County Health System has authorized the Eligibility and Financial Review Committee (EFRC) (described in Section M) to consider appeals regarding whether to cover otherwise non-covered services in cases where the ACE Program beneficiary can establish by appropriate evidence that the service in question is medically necessary. The EFRC will enlist additional expertise, as needed, to consider these types of appeals.

3. Certain state programs, such as Family PACT (Family Planning), Cancer Detection Program (CDP) and IMPACT (Prostate Cancer services), provide specific coverage and have the same income eligibility criteria as the ACE Program. If the patient meets the specific program eligibility criteria, these programs will be used to cover the specific services rather than covering these services by the ACE program.

4. The ACE Program will not cover outpatient procedures or admissions deemed not medically necessary. The patient may elect to have the procedure, but will be billed in full for services provided. An advance deposit will be required.

G. Pre-Authorization

Pre-authorization is required for outside specialty care, scheduled admissions, ambulatory surgeries, and certain outpatient procedures. Without pre-authorization, the patient may be liable for payment.

H. Co-pays

Co-pays will be charged for outpatient, inpatient stays and same day surgeries. The co-pay amounts for such services shall be described in the ACE Program brochure provided to each eligible patient, and are subject to change from time to time, as determined by the San Mateo County Board of Supervisors.

I. Charges and Estate Recovery for Inpatient Stays and Same Day Surgeries

In addition to co-pays of $300[3], the County may pursue estate recovery from patients' estates for a portion of the balance of the cost of inpatient stays/same day surgeries, in accordance with applicable state and federal laws. Patients who wish to avoid estate recovery may arrange a payment plan with the County for the balance of these costs due. Patients may be required to complete documentation that authorizes estate recovery action by the County.

The Chief of the San Mateo County Health System has developed and implemented a policy for estate recovery of ACE Program patients. Estate recovery will be based on the outstanding balance of billed costs (or any amounts otherwise recoverable) for inpatient and/or same day surgery services provided under the ACE Program. This policy shall be made available to all ACE Program applicants and participants.

J. Annual Processing Fee, Co-Pays and Charges

[3] This is the co-payment amount as of October 1, 2008 and it is subject to change in the future by action of the County Board of Supervisors. This copayment amount will be revisited to align with the copayments charged under Covered California plans for persons of similar income levels.

1. Each patient enrolled in the ACE Program pays an annual processing fee of $XXX.[4] However, the payment of the annual fee shall not be a condition precedent to medical services. In accordance with Welfare and Institutions Code section 16804.1(a), no patient shall be denied medical services for non-payment of the annual fee. There will be no cancellation fee. Patients who are able and willing to pay the entire $XXX annual fee at the time of enrollment will receive two "ACE Bucks." Each ACE Buck can be redeemed in lieu of one outpatient visit copayment at SMMC during the patient's program year. Patients who are unable to pay the entire $XXX annual fee at the time of enrollment will be offered the opportunity to pay this amount in installments over the course of the program year. The Chief of the San Mateo County Health System or his or her designee shall have the authority to develop and implement installment payment plans for the annual ACE processing fee. The annual ACE processing fee may be fully or partially waived where the patient can show that payment of the fee would constitute a hardship. The Chief of the San Mateo County Health System has developed and implemented a process for consideration of applications to waive, as a hardship, a patient's ACE Program annual processing fee. This process is made available to all ACE Program applicants, and includes, among other factors deemed appropriate by the Chief of the San Mateo County Health System, a consideration of the patient's income and expenses, as well as the presence of chronic conditions for which regular, recurring medical treatment is needed.

2. Patients are responsible for co-payments for selected services, and discounted charges for inpatient stays and same day surgeries, payable at the time of service.

3. An interest-free extended repayment plan will be made available by the San Mateo Medical Center to all patients based on each individual's ability to pay. The Chief of the San Mateo Health County Health System shall develop a policy to ensure that Health System/ SMMC staff take affirmative steps to ask patients whether they require extended repayment plans, based on individuals' ability to pay, to develop repayment agreements consistent with individuals' ability to pay, and to ensure that accounts are not referred to Revenue Services unless the patients fail to comply with a repayment agreement and fail to contact the County within 30 days of such failure to discuss and arrange alternative arrangements that are reasonably satisfactory to the County.

K. Notification of Enrollment, Denial of Enrollment or Disenrollment

1. Patients will receive a program brochure informing them of the ACE Program's annual processing fee, co-payments, payment requirements for inpatient stays and same day surgeries, scope of services and San Mateo County Clinic site locations.

2. Patients will be informed of a denial of enrollment in the ACE Program within 45 days of submission of a complete application for enrollment. Patients shall be

[4] The current processing fee of $240 per year was established on October 1, 2008, and it is subject to change in the future by action of the County Board of Supervisors. We expect to align the enrollment fee with the premiums assigned by Covered California to an individual with income similar to that of ACE non-Fee Waiver participants.

informed of disenrollment in the ACE Program in person or by mail at least 15 days prior to disenrollment, unless it is due to fraud or misrepresentation which will result in immediate disenrollment. Denial of enrollment or disenrollment can be due to failure to meet or prove eligibility requirements, change of circumstances, or the patient's request for disenrollment.

3. Patients can dispute a denial of enrollment or disenrollment through the Appeal Process set forth in Section M below.

L. Waiver of Co-Pays and Annual Fees and Annual Out-of-Pocket Cap

1. The ACE Program's annual processing fee, co-pays and charges will be waived (except as described in #2 below) for the following San Mateo County residents:

   a. Patients with income at or below 138% of the Federal Poverty Level.
   b. Persons receiving General Assistance ineligible for Medi-Cal or Covered California who meet income and county residency requirements for the Fee Waiver Program.
   c. Persons receiving services through the County's Alcohol and Other Drug programs not eligible for Medi-Cal or Covered California and meeting the income criteria who meet income and county residency requirements for the Fee Waiver Program.
   d. Persons receiving services through the County's Health Care for the Homeless program not eligible for other public or private coverage who meet income and county residency requirements for the Fee Waiver Program.
   e. Persons receiving services at a San Mateo County Teen Center who are ineligible for PACT or Medi-Cal Minor Consent, Covered California or other public or private coverage who meet income and county residency requirements for the Fee Waiver Program.
   f. Persons for whom payment of the ACE Program's annual processing fee is found by the Chief of the San Mateo County Health System to constitute a hardship, as set forth in Section J of this Policy, provided, however, that such waiver shall only fully or partially exempt the patient from paying the annual processing fee and shall not affect the obligation to make co-payments.
   g. Persons who are unable to pay as determined through the appeals process set forth in Section M of this Policy.

2. For the eligible populations outlined in #1 above, the County shall pursue estate recovery from patients' estates for the balance of the cost of inpatient stays/same day surgeries, which shall be billed at the highest SMMC government reimbursement rate for similar services. Patients who wish to avoid estate recovery may arrange a payment plan with the County for the balance of these costs.

3. The eligibility for this waiver must be reassessed annually, at a minimum. This is required in order to incorporate any changes to a patient's financial status. The County shall determine and may modify the period of eligibility for any individual entitled to receive services covered under financial assistance programs.

4. The eligible populations outlined in #1 above shall receive an ACE Program enrollment form and brochure explaining the annual fees, co-pays, charges, and estate recovery program.

5. Each ACE participant, regardless of whether he or she qualifies for a waiver of copayments or annual fees, shall be responsible only for payments up to a maximum of 6.3 percent (6.3% of income as defined by Covered California) of their income per calendar year of program processing or membership fees, copayments and charges. After an ACE participant incurs out-of-pocket expenses totaling 6.3 percent (6.3% of income as defined by Covered California) of their income in a calendar year for program processing or membership fees, copayments or charges, the individual shall not be liable for any additional program processing or membership fees, copayments or charges in that same calendar year. Notwithstanding the foregoing, the County shall retain the right to pursue estate recovery on inpatient and same-day surgery charges that exceed an ACE participant's annual out-of-pocket liability of 6.3 percent (6.3% of income as defined by Covered California) of their annual income.

M. Appeals Process

1. Notice of the Right to Eligibility Review and Appeal

In addition to the hardship review processes discussed above, every individual who has been disenrolled, or has been denied eligibility, or who wishes to request a waiver or reduction of ACE Program co-pays, fees or charges shall have the right to an appeals process that allows the individual to present evidence of eligibility and/or argue special circumstances based on inability to pay for medical services or ACE Program co-payments or fees.

Every individual who has been disenrolled, or has been denied eligibility, or who is assessed co-pays, fees or charges shall receive written notice of (1) the denial, discontinuance or charges; (2) the right to have the denial, discontinuance, or fees, co-pays and charges reviewed through the appeals process; and (3) a specific description of the appeals process, timelines, and bases for appeal. In particular, individuals will be informed that those who can demonstrate, by a preponderance of the evidence, an inability to pay for medical care, shall be entitled to a reversal of the County's initial determination on eligibility, fees, co-pays or charges, regardless of income level.

2. Delegation to Chief of the San Mateo County Health System to Develop Appeals Process

The Chief of the San Mateo County Health System has developed and implemented procedures for considering appeals and for issuing timely decisions on appeals. Such procedures are in writing and can be made available to all ACE Program applicants, provide appellants the opportunity to appear in person before the decisionmaker(s) and to provide documentary and testimonial evidence in support of their appeal. Such procedures also provide that individuals may appeal a disenrollment or denial decision

within 60 days of the receipt of a written notice indicating the disenrollment or denial. They also provide that individuals who wish to request a waiver or reduction of fees, co-pays or charges may do so within 60 days of receipt of a bill for the fees, co-pays or charges. Notice of the right to appeal shall accompany such bills. These procedures also clearly identify the various bases for appeal and the documentation and/or information required to be provided in connection with an appeal.

The procedures provide that the County shall make a written decision to sustain or deny the appeal within 30 days after receipt of all documents/information required to be submitted in support of the appeal. If the decision is to grant the appeal, then the applicant shall receive specific notice of the decision and information relating to the rights and benefits associated with the decision. If the decision is to deny the appeal, then the written decision shall provide the reason for the decision.

3. Anytime Request for Eligibility and Financial Review

Any individual may request an eligibility and financial review at any time if their circumstances change. If the Chief Financial Officer or his/her designee receives such a request, it shall be processed under the same timelines and rules specified above.

N. Periodic Board Reports

Periodically, program, eligibility and appeal data shall be submitted to the Board of Supervisors for review and consideration.

ATTACHMENT D-2
ACE Limited Term

PURPOSE:

The purpose of this policy is to describe the ACE Limited Term program, which is the program that the County will administer for residents who have eligibility for subsidized coverage through the Covered California, but did not enroll in this coverage during the designated Open Enrollment period. Covered California is California's health benefits exchange, which furthers the Affordable Care Act's expansion of health coverage to residents meeting citizenship requirements and distributes federal subsidies available to make coverage affordable for those with incomes up to 400% of the Federal Poverty Level (FPL).

This policy outlines the specifics of the ACE Limited Term program, including scope of services, eligibility requirements, verification, enrollment, appeals and waiver process. The term of coverage for the ACE Limited Term program will end on or before December 31st of the year in which the applicant enrolled. Participants will be offered assistance to enroll in a Covered California plan during the Open Enrollment period to effectuate coverage by January 1st of the following year.

POLICY:

The objective of this program is to adapt the County's indigent care program to the new offerings available through California's implementation of the federal health reform law. This program allows the County to continue to meet its Section 17000 responsibilities while learning how best to maximize the benefits of the federal health reform law for San Mateo County residents and administer local Financial Assistance Policies in a manner that uses County resources as a safety net for those without other support.

PROCEDURE:

D. Notice of the Right to Apply for ACE Limited Term Program

Individuals who are uninsured and seeking affordable health coverage through the Health Coverage Unit hotline, website or community outreach, including those who receive medical care at the San Mateo Medical Center (SMMC) shall be provided a brochure detailing their right to apply for various financial assistance programs, including the ACE Limited Term Program, and shall be provided with information on who to contact for an application. Copies of this policy and other financial assistance policies shall be available for review.

E. Populations Eligible for ACE Limited Term Scope of Services

The County population eligible for the ACE Limited Term program consists of County resident adults who are not eligible for full-scope no cost or share-of-cost Medi-Cal coverage

and who meet the income and residency criteria for ACE Limited Term enrollment described in the next section.

F. ACE Limited Term Program Eligibility Criteria

1. Applicants must declare under penalty of perjury that they meet the requirements for eligibility listed below. Applicants may appeal a denial or disenrollment decision pursuant to the Appeal Process set forth in section L below.

   a. Residency Requirement

      1. Applicants must be residents of San Mateo County. Residency is based on an applicant's actual place of residence at the time that program enrollment is sought and demonstrable intent that existed at that time to reside indefinitely in the County.
      2. ACE Limited participants are required to report any changes in residency/address within 10 days of when changes occur.

      Proof of Residency can be satisfied through one of the following documents:

      1) Car registration
      2) Voter registration
      3) California driver's license or ID card
      4) Employment record including offer letter, pay stubs, lay-off notice, employment or registration contract with an employment service, employer affidavit
      5) Rent or mortgage receipt. If the receipt is from a relative, the applicant must have that relative complete and sign the form, *Statement of Rent Receipt*, from a relative.
      6) Utilities bill – if not in patient's name, the bill should be accompanied by a signed statement from a relative or non-relative landlord
      7) Listing in the city directory or phone book that can be verified
      8) Principal property ownership document or property tax bill
      9) Membership record in a religious institution that reflects patient's address
      10) Student identification
      11) School records
      12) Recent marriage license, divorce decree, or evidence of domestic partnership issued in the State of California (within the last 45 days)
      13) Recent court documents showing the applicant's current address (within the last 45 days)
      14) Insurance documents
      15) Police record from a California law enforcement agency (within the last 45 days)
      16) Documents from a homeless shelter or other public or community service agency indicating that the applicant is receiving services from the agency
      17) Adoption record (within the last 45 days)
      18) Medical record except San Mateo Medical Center (within the last 45 days)
      19) Voided personal check with pre-printed address
      20) Other proof of residency – other third party documents verifying residency of applicant can be provided

b. Income Criteria

1) Income must be equal to or lower than 200% of the Federal Poverty Level (FPL). The FPL level is updated annually by the federal government.

2) Income is defined as total or gross cash receipts, wages and salaries, before taxes and from all sources. It also includes regular payments from Public Assistance, Social Security, Unemployment and Workers' Compensation, strike benefits, training stipends, alimony, child support, military family allotments or other regular support from an absent family member or someone not living in the household, pensions, insurance or annuity payments, dividend income, interest, rents, royalties, estates, and trusts. The following Social Security income will be counted: Survivor's, Retirement Survivor's Disability Income (RSDI), Federal Retirement, Federal Disability, and State Disability Insurance (SDI). The following Social Security income will not be counted: Supplemental Security Income (SSI) and State Supplemental Payment (SSP).

3) Income may be offset with deductions for business or farming expenses and should not include food or rent received in lieu of wages.

4) Applicants are required to apply for unemployment benefits if potential eligibility is assessed by the Community Health Advocate during the course of the health coverage application process.

5) ACE participants are required to report any changes in income within ten days of when the change occurs.

c. Screening for Potential Medi-Cal Eligibility

1) There is no asset limit for eligibility for the ACE Limited Term program. However, clients who may qualify for Medi-Cal are required to fully participate in the Medi-Cal application process as a condition of verifying eligibility for ACE Limited Term.

2) Community Health Advocates will assist participants in gathering verification information (including asset verifications) to facilitate the Medi-Cal application process.

d. Identity Verification

1) Applicants must provide an acceptable proof of identity.

2. Every individual who has been disenrolled, or has been denied eligibility shall have the right to an appeals process that allows the individual to present evidence of eligibility. This appeals process is more fully described in section L of this Policy.

   Every individual who has been disenrolled, or has been denied eligibility shall receive written notice of (1) the denial, discontinuance or charges; (2) the right to have the denial or discontinuance reviewed; and (3) a specific description of the appeals process and timelines.

3. Patients may be ineligible for or lose coverage for the ACE Limited Term program for the following reasons:

   - Patients who were denied Medi-Cal, Covered California or other benefits due to lack of reasonable cooperation
   - Patients who fail to apply for Medi-Cal, Covered California or any other third party coverage when requested to do so.
   - Patients holding non-resident visas.
   - Patients who fail to provide requested information.
   - Patients who fail to cooperate with an ACE or ACE Limited Term audit.
   - Patients providing materially incorrect or false eligibility information. In such cases, the patient my be terminated immediately from the ACE Limited Term Program and billed retroactively for all ACE Limited Term program services during the period of time in which the information was incorrect or false.

D. Verification Process

1. In order to qualify for the ACE Limited Term program, patients must satisfy eligibility requirements including family income, and residency. The patient must declare, under penalty of perjury, that the information provided is true and correct. Patients applying for the ACE Limited Term program must consent to verification and/or investigation of eligibility by County personnel, agents or contractors. Such investigation/verification may include the obtaining and use of information and documents possessed by other public and private agencies, including but not limited to records of the Department of Child Support Services.

2. The Health System/ San Mateo Medical Center will request proof of income, and residence. Proof must be timely and dated within the last 45 days. This requirement can be satisfied in the following ways:

   a. Proof of Residency may be satisfied by the presentation of bona fide documents such as those listed in Section F.1.a. of this Attachment. The County may request different or further forms of documentation when the genuineness and/or validity of the documents provided is reasonably questioned or when the documents presented raise further questions regarding the eligibility of the applicant.

   b. Proof of Income may be satisfied by the presentation of bona fide documents such as those listed below. The County may request different or further forms of documentation when the genuineness and/or validity of the documents provided is

reasonably questioned or when the documents presented raise further questions regarding the eligibility of the applicant

1) Unemployment – employer's records; EDD records; UIB check; layoff notice; training program records; training stipends; union records.
2) Earnings – pay stubs; employer's wage record; state and/or federal income tax return; EDD records; employee W-2 form; farm business records; an employer statement, preferably on the employer's letterhead, or name of company stated on letter, including name of person employed, signature of employer, date of letter, pay frequency and gross amount.
3) Person receiving income can write an affidavit if there is no alternative manner to document income. This letter should include: claimant's name and signature; date of letter; how much employee is paid; date, frequency and source of payment; declarations that (1) the information provided is true and correct (2) there is no other form of income documentation available, and (3) the employee understands the county/state may verify the information provided.
4) Self-Employment – recent tax returns/business records; receipts for goods and services; last year's federal income tax return including Schedule C; last three months net profit and loss statement; beneficiary's statement when expenses cannot be verified; signed statement from business associates; statement from institutions where checks are deposited/cashed.
5) Unearned Income – Social Security Administration (SSA) award letter, official correspondence from SSA, bank statement showing SSA deposit, Veterans Administration (VA) check, VA award letter; public assistance; worker's compensation award notice; workers' compensation check; alimony; child support check; itemized statement from child support agency; SDI check; government and private pension checks; insurance/annuities checks, correspondence; bank statements verifying interest income; rents; dividends; royalties; estates and trusts; military and child support allotment or other regular support from an absent family member or someone not living in the household.
6) Other proof of income – other third party documents verifying income of applicant can be provided

c. Proof of Identity may be satisfied by the presentation of bona fide documents such as those listed below. The County may request different or further forms of documentation when the genuineness and/or validity of the documents provided is reasonably questioned or when the documents presented raise further questions regarding the eligibility of the applicant

1) California Driver's License or California DMV identification card
2) US Passport (expired ones are acceptable) or other US federal government identification
3) Certificate of Naturalization
4) Certificate of U.S. Citizenship
5) Other state driver's license or DMV identification card
6) School Identification card with a photograph
7) U.S. Military I.D. Card or draft record
8) U.S. Military dependent identification card
9) A U.S. passport (issued with limitation)

10) Certificate of Degree Of Indian Blood or other U.S. American Indian/Alaska Native Tribal document
11) U.S. Coast Guard Merchant Mariner Card
12) Three or more confirming documents, such as employee ID cards, high school or college diplomas, marriage licenses, divorce decrees, and property deeds/titles
13) For people with disabilities who live in a residential care facility, and Affidavit signed by the facility's director or administrator
14) Two signed affidavits attesting to the identification of the patient with photo identification from both parties who signed them.
15) Other documents as determined by the California Department of Health Care Services (DHCS)

*Note: As required by DHCS, the original copies of the documents must be provided in person. No photo copies accepted. Expired identity documents are acceptable proof of identify.

3. The Health System/ San Mateo Medical Center may utilize third party verification services including the use of credit reports, IEVS, State Income Tax Bureau, MEDS, CDS/CalWIN, DMV and property clearances.

4. Patient eligibility for the ACE Limited Term program will be reviewed, at a minimum, annually and prior to inpatient stays and same-day surgeries. This is required in order to incorporate any changes to a patient's financial status. The County shall determine and may modify the period of eligibility for any individual entitled to receive services covered under financial assistance programs. Re-screening of a patient need not take place if the patient has been screened for eligibility within 90 days prior to a scheduled surgery or inpatient stay.

E. Notice of the Determination of Eligibility

Individuals who apply for the ACE Limited Term program will be informed in writing if they qualify. The enrollment confirmation or notice of ineligibility will be provided to the applicant either at time of enrollment or within 45 days after receipt by the County of a complete application and it shall provide information about the right to an individual eligibility review, the right to appeal a denial or discontinuance of coverage, and the bases upon which an individual eligibility review and/or an appeal can be based.

F. Scope of Services

1. The ACE Limited Term program scope of services is similar to that under Medi-Cal except that inpatient and outpatient care, pharmaceuticals and supplies are provided at San Mateo Medical Center or, at an approved outside provider site to which San Mateo Medical Center refers patients. Specialty behavioral health services are provided at an approved contracted provider authorized by the Health System's Behavioral Health and Recovery Services division. Emergency services provided outside the San Mateo Medical Center are not included.

2. The ACE Limited Term program does not cover cosmetic surgery, pregnancy-related services, family planning, impotence/infertility, non-medically necessary services,

unauthorized non-emergency care or services received at other facilities except for emergency care and treatment, long term care over 30 days, experimental or investigational treatments or therapies, gender reassignment surgery, non-emergent dental, and certain prescriptions such as vitamins, some pain medications and tranquilizers, etc.

3. Certain state programs, such as Family PACT (Family Planning), Cancer Detection Program (CDP) and IMPACT (Prostate Cancer services), provide specific coverage and have the same income eligibility criteria as the ACE Limited Term Program. If the patient meets the specific program eligibility criteria, these programs will be used to cover the specific services rather than the ACE Limited Term program.

4. The ACE Limited Term program will not cover outpatient procedures or admissions deemed not medically necessary. The patient may elect to have the procedure, but will be billed in full for services provided. An advance deposit will be required.

G. Pre-Authorization

Pre-authorization is required for outside specialty care, scheduled admissions, ambulatory surgeries, and certain outpatient procedures. Without pre-authorization, the patient may be liable for payment.

H. Monthly Fees and Co-pays

Co-payments for services are established to align with the cost-sharing required through a Covered California plan for individuals with incomes between 139% and 200% FPL. Because individuals in this income group are eligible for cost-sharing credits to increase the actuarial value of a plan, the cost-sharing for this program is aligned with that of the applicable level Covered California plan.

The cost-sharing will be further defined as more details about Covered California's cost-sharing for persons in this income range are specified.

I. Charges and Estate Recovery for Inpatient Stays and Same Day Surgeries

The County may pursue estate recovery from patients' estates for a portion of the balance of the cost of inpatient stays/same day surgeries, to the extent authorized and/or not prohibited by applicable federal and state laws. Patients who wish to avoid estate recovery may arrange a payment plan with the County for the balance of these costs due. Patients may be required to complete documentation that authorizes estate recovery action by the County.

J. Program Duration

Individuals eligible for the ACE Limited Term program have eligibility for federally subsidized coverage through Covered California but failed to enroll in such coverage during the Open Enrollment period. The ACE Limited Term program will not cover services beyond the end of any calendar year in which a participant is enrolled. Instead, participants will be encouraged to pursue enrollment in a Covered California plan during open enrollment

to achieve a coverage effective date of January 1 of the following year. The Health System will offer clients assistance to successfully secure such coverage. ACE Limited Term program eligibility will end no later than December 31st of the year in which program enrollment is effectuated.

K. Notification of Enrollment, Denial of Enrollment or Disenrollment

1. Patients who are enrolled in ACE Limited Term will receive a program brochure informing them about the program's benefits and guidelines. Participants will NOT receive any type of ID card.

2. Patients will be informed of a denial of enrollment in the ACE Limited Term program within 45 days of submission of a complete application for enrollment. Patients shall be informed of disenrollment in the ACE Limited Term program in person or by mail at least 15 days prior to disenrollment, unless it is due to fraud or misrepresentation which will result in disenrollment on at least five days prior notice. Denial of enrollment or disenrollment can be due to failure to meet or prove eligibility requirements, change of circumstances, or the patient's request for disenrollment.

3. Patients can dispute a denial of enrollment or disenrollment through the Appeal Process set forth in Section L below.

L. Appeals Process

1. <u>Notice of the Right to Eligibility Review and Appeal</u>

Every individual who has been disenrolled, or has been denied eligibility shall have the right to an appeals process that allows the individual to present evidence of eligibility and/or argue special circumstances.

Every individual who has been disenrolled, or has been denied eligibility shall receive written notice of (1) the denial, discontinuance or charges; (2) the right to have the denial, or discontinuance reviewed through the appeals process; and (3) a specific description of the appeals process, timelines, and basis for appeal. In particular, individuals will be informed that those who can demonstrate, by a preponderance of the evidence, an inability to pay for medical care, shall be entitled to a reversal of the County's initial determination on eligibility.

2. <u>Delegation to Chief of the San Mateo County Health System to Develop Appeals Process</u>

The Chief of the San Mateo County Health System or his or her designee has developed and implemented procedures for considering appeals and for issuing timely decisions on appeals. Such procedures are in writing and can be made available to all ACE Limited Term program applicants.

Such procedures provide appellants the opportunity to appear in person before the decisionmaker(s) and to provide documentary and testimonial evidence in support of their appeal. Such procedures also provide that individuals may appeal a disenrollment

or denial decision within 60 days of the receipt of a written notice indicating the disenrollment or denial. These procedures shall also clearly identify the various bases for appeal and the documentation and/or information required to be provided in connection with an appeal.

The procedures shall provide that the County shall make a written decision to sustain or deny the appeal within 30 days after receipt of all documents/information required to be submitted in support of the appeal. If the decision is to grant the appeal, then the applicant shall receive specific notice of the decision and information relating to the rights and benefits associated with the decision. If the decision is to deny the appeal, then the written decision shall provide the reason for the decision.

4. Anytime Request for Eligibility and Financial Review

Any individual may request an eligibility and financial review at any time if their circumstances change. If the Chief Financial Officer or his/her designee receives such a request, it shall be processed under the same timelines and rules specified above.

M. Periodic Board Reports

Periodically, program, eligibility and appeal data shall be submitted to the Board of Supervisors for review and consideration.

ATTACHMENT E
DISCOUNTED HEALTH CARE (DHC) PROGRAM

PURPOSE:

The purpose of this policy is to describe the Discounted Health Care (DHC) Program, including scope of services, eligibility requirements, verification, enrollment and appeals process.

POLICY:

It is the policy of the San Mateo Medical Center to offer a discount to low-income and uninsured patients who do not qualify for the County's ACE Program or other financial assistance, in compliance with the legal requirements of AB 774. This policy represents the County's discounted healthcare policy, and is one of several policies and programs that demonstrate SMMC's "safety net" mission to provide a basic level of health care coverage to low-income and uninsured patients.

PROCEDURE:

A. Notice of the Right to Apply for DHC Program

Individuals who receive medical care at the San Mateo Medical Center ("SMMC") shall be provided a brochure detailing their right to apply for various financial assistance programs, including the DHC Program, and shall be provided with information on who to contact to apply for the program.. Copies of this policy and other financial assistance policies shall be available for review.

B. Notice of the Determination of Eligibility

Individuals who apply for the DHC Program will be informed in writing whether they qualify, and if they do not qualify, the reasons for the determination. The letter will provide information about the right to an individual eligibility review and the right to appeal a denial or discontinuance of coverage.

C. Definition of Discount

1) The Discounted Health Care (DHC) Program offers a discount to patients who meet the eligibility criteria and want to pay their share of the bill, but are unable due to their financial situation, to pay the entire amount that would otherwise be due. The self-pay portion of a patient's bill may include all billed charges or non-covered charges, denied charges, and deductibles.

2) The County Board of Supervisors sets the discount rate for the DHC Program but, pursuant to State law, it will not exceed the highest amount of payment that SMMC would receive for providing the medical services in question from Medicare, Medi-Cal,

Healthy Families or any other government sponsored program of health benefits in which SMMC participates.

G. Eligibility Criteria

SMMC Patients whose family income is at or below 400% of the Federal Poverty Level, are eligible for the DHC Program if they:

- lack third party coverage from a health insurer, a health care service plan, Medicare or Medi-Cal (or some other government sponsored health program); whose injuries are not compensable for purposes of workers compensation, automobile insurance, or other insurance as determined and documented by SMMC; and who do not qualify for the ACE program or other financial assistance.
- Possess third party coverage but also qualifies as a "patient with high medical costs."
    - For purposes of this policy, a "patient with high medical costs" is a patient who does not receive a discount from SMMC as a result of that patient's third party coverage.
    - For purposes of this policy, "high medical costs" means either:
        - Annual out-of-pocket costs incurred by the individual at SMMC that exceed 10 percent of the patient's family income during the pervious twelve months; or
        - Annual out-of-pocket expenses for medical care that exceed 10% of the patient's family income
    - SMMC may require documentation to establish the out-of-pocket medical expenses paid by a patient and/or a patient's family in order to determine eligibility for the DHC Program.

H. Scope of Services

The DHC Program will provide the same scope of services covered by the County's ACE Program for services provided by San Mateo Medical Center.

F. Pre-Authorization

Pre-authorization is required for outside specialty care, scheduled admissions, ambulatory surgeries, and certain outpatient procedures. Without pre-authorization, the patient may be liable for payment.

G. Extended Payment Plan

Patients can defer charges by completing a lien against property that the guarantor may possess or acquire in the future. However, patients will not be required to complete liens against their primary residences. Patients eligible for the DHC Program are eligible to enter into an extended payment plan with the County of San Mateo to allow for the payment of the discounted price for medical care provided at SMMC over time. The County will not charge interest on any balance subject to a discounted payment plan. The SMMC's Chief Executive Officer or his/her designated representative will negotiate the terms of an extended payment plan with patients in all appropriate cases and may require appropriate information from the patient in negotiating the terms of such an agreement.

H. Application Process

1. The DHC Program will be considered for any patient who indicates an inability to pay for medical services. In general, patients must meet certain eligibility criteria, including low income and a lack of third party coverage and/or high medical costs to qualify for the DHC Program. The patient's unique circumstances may be taken into consideration.

2. Patients applying for the DHC Program are expected to provide personal and financial information that is complete and accurate. This may include data regarding current health care benefits coverage, financial status/income, and any other information necessary for the SMMC to make a determination regarding the patient's eligibility. The patient must declare, under penalty of perjury, that the information provided is true and correct.

3. Patients applying for the DHC Program must consent to the use of third party verification services including the use of credit reports, IEVS, State Income Tax Bureau, MEDS, CDS/CalWIN, DMV and property clearances.

4. SMMC will make available to patients a Community Health Advocate (CHA) or Financial Counselor whose mission is to match the patient with the appropriate form of financial assistance based on the patient's unique financial situation. The County will provide assistance in the primary language of the patient or patient's guarantor for, at a minimum, those Limited English Proficient clients who fall into one of the County's threshold language groups.

5. DHC Program enrollment must be renewed and updated for each inpatient stay, and, at a minimum, annually, for outpatient visits. This is required in order to incorporate any changes to a patient's eligibility status. The County shall determine and may modify the period of eligibility for any individual entitled to receive services covered under financial assistance programs. Re-screening of a patient will not take place if the patient has been screened for eligibility within 90 days prior to a scheduled surgery or inpatient stay.

6. There is no limit to the time, either prior to or after receiving medical care, in which a determination for the DHC Program can be made. Whenever possible, patients should apply for the program prior to the first day of service. However, in some cases, it may take a substantial amount of time to investigate a patient's eligibility due to the patient's limited ability or willingness to provide required information.

7. Patient accounts which have been turned over to a collection agency and later meet the criteria for the DHC Program, will be returned to SMMC's Patient Billing and Collections office.

8. Approval for the DHC Program must follow SMMC's level of signature authority.

9. This policy does not apply to services provided by physicians or other medical providers practicing at SMMC, unless contractually obligated through a third party billing arrangement with SMMC.

I. Verification Process

1. In order to qualify for the DHC Program, patients must satisfy eligibility requirements including income and coverage status or high medical costs. The patient must declare, under penalty of perjury, that the information provided is true and correct. Patients applying must consent to verification and/or investigation of eligibility by County personnel, agents or contractors. Such investigation/verification may include the obtaining and use of information and documents possessed by other public and private agencies, including, but not limited to, records of the Department of Child Support Services.

2. SMMC will request proof of third party health insurance coverage (or lack thereof), income and, when relevant, medical expenses. Proof must be timely and valid for the last 45 days (or longer period of time, when applicable). This requirement can be satisfied in the following ways:

Proof of Income

1) Unemployment – employer's records; EDD records; UIB check; layoff notice; training program records; training stipends; union records.
2) Earnings – pay stubs; employer's wage record; state and/or federal income tax return; EDD records; employee W-2 form; farm business records; an employer statement, preferably on the employer's letterhead, or name of company stated on letter, including name of person employed, signature of employer, date of letter, pay frequency and gross amount.
3) Person receiving income can write an affidavit if there is no alternative manner to document income. This letter should include: claimant's name and signature; date of letter; how much employee is paid; date, frequency and source of payment; declarations that (1) the information provided is true and correct (2) there is no other form of income documentation available, and (3) the employee understands the county/state may verify the information provided.
4) Self-Employment – recent tax returns/business records; receipts for goods and services; last year's federal income tax return including Schedule C; last 3 months net profit and loss statement; beneficiary's statement when expenses cannot be verified; signed statement from business associates; statement from institutions where checks are deposited/cashed.
5) Unearned Income – Social Security Administration (SSA) award letter, official correspondence from SSA, bank statement showing SSA deposit, Veterans Administration (VA) check, VA award letter; public assistance; worker's compensation award notice; workers' compensation check; alimony; child support check; itemized statement from child support agency; SDI check; government and private pension checks; insurance/annuities checks, correspondence; bank statements verifying interest income; rents; dividends; royalties; estates and trusts; military and child support allotment or other regular support from an absent family member or someone not living in the household.
6) Other proof of income – other third party documents verifying income of applicant can be provided

Proof of Insurance Coverage

Medi-Cal/Medicare databases
Letter from employer stating status of employer-sponsored health insurance

J. Notification of Enrollment or Disenrollment

1) Patients will receive a program brochure informing them of the DHC Program's terms and conditions, scope of services and San Mateo Medical Center Clinic site locations.

2) Patients will be informed of disenrollment in the DHC Program in person or by mail at least 10 days prior to disenrollment, unless it is due to fraud or misrepresentation which will result in immediate disenrollment. Disenrollment can be due to failure to meet or prove eligibility requirements, change of circumstances, or the patient's request for disenrollment.

3) Patients can dispute a disenrollment through the appeals process set forth in Section K.

K. Appeals Process

1. Notice of the Right to Eligibility Review and Appeal

Every individual who has been disenrolled, or has been denied eligibility, or who wishes to request a waiver or reduction of co-pays, fees or charges shall have the right to a two-step appeals process that allows the individual to present evidence of eligibility or argue special circumstances based on inability to pay. The first appeal step is an "individual eligibility review" (IER) to appeal any financial and non-financial issues relating to DHC Program eligibility. The second appeal step shall be before the "eligibility and financial review committee" (EFRC).

Every individual who has been disenrolled, or has been denied eligibility, or who is assessed co-pays, fees or charges shall receive written notice of (1) the denial, discontinuance or charges; (2) the right to have the denial, discontinuance, or fees, co-pays and charges reviewed through the IER process based on ability to pay; and (3) a specific description of the appeals process and timelines. An individual who can demonstrate inability to pay shall be entitled to a reversal of the County's initial determination on eligibility, fees, co-pays or charges.

2. Step-One Appeal: Individual Eligibility Review (IER)

a. Timeline for Step-One Application

Individuals may appeal a disenrollment or denial decision within 60 days of the receipt of a written notice indicating the disenrollment or denial. Individuals who wish to request a waiver or reduction of fees, co-pays or charges may do so within 60 days of receipt of a bill for the fees, co-pays or charges. Notice of the right to appeal shall accompany such bills. Individuals are to complete a Request for Individual Eligibility Review (IER) form and submit the form to the Chief Financial Officer or his/her designee within 60 days of the written notice.

b. Content of Request for Individual Eligibility Review

In completing the Request for IER form, individuals must provide specific information supporting their appeal. The specific information needs to support a case that the individual has special circumstances demonstrating an inability to pay which justifies a reversal of the initial County decision to deny or disenroll, or of the County's decision to assess charges. Such information may include unusual and extraordinary expenses over and above the actual cost of necessities of life.

c. Individual Eligibility Review Decision-Maker

The IER shall be decided by the Chief Financial Officer or his/her designee, who shall consider all special facts and circumstances supporting the applicant's claim of eligibility or claim of inability to pay, including the actual costs of necessities of life in San Mateo County.

d. Timeline for Decision

The Chief Financial Officer or his/her designee shall make a written decision to affirm or reverse the initial County determination within 30 days after receipt of all requested documents. If the decision is to reverse the initial County determination, then the applicant shall receive specific notice of the decision and information relating to the rights and benefits associated with the decision. If the decision is to affirm the initial County determination, then the written decision shall provide the reason for the decision and also include a description of the applicant's Step-Two Appeal rights, including a form to complete the appeal. If there is no decision within 30 days, the applicant has the right to a review by the Eligibility and Financial Review Committee.

3. Step-Two Appeal: Eligibility and Financial Review Committee (EFRC)

a. Timeline for Step-Two Application

Individuals may appeal the decision of the IER to the EFRC within 60 days of the receipt of the decision letter. Individuals may initiate an appeal by completing a pre-provided appeal form and submitting it to the Chief Financial Officer or his/her designee.

b. Content of Appeal

Upon notice of appeal, the original Request for Individual Eligibility Review form and all documentation, in addition to the new appeal form will be forwarded to the EFRC for consideration. Individuals are free to supplement this form with any other information that supports their position, including inability to pay information.

c. Eligibility and Financial Review Committee

The EFRC shall consist of three individuals: the Chief Financial Officer or his/her designee (other than the IER decision-maker), the Health System Chief or his/her designee and a public member to be chosen by the County Manager's Office. The applicant has the right to appear before the EFRC, to present evidence including the

sworn testimony of witnesses and to bring an attorney. An electronic record of the proceedings shall be obtained at the applicant's request.

d. Timeline for Decision

The EFRC shall make a written decision to affirm or reverse the IER determination within 30 days after receipt of requested documents. If the decision is to reverse the initial County determination, then the applicant shall receive specific notice of the decision and information relating to the rights and benefits associated with the decision. If the decision is to affirm the IER determination, then the written decision shall provide the reason for the decision.

4. Anytime Request for Eligibility and Financial Review

Any individual may request an eligibility and financial review at any time if their circumstances change. If the Chief Financial Officer or his/her designee receives such a request, it shall be processed under the same timelines and rules specified above.

L. Periodic Board Reports

Periodically, program, eligibility and appeal data shall be submitted to the Board of Supervisors for review and consideration.

M. Billing and Collections Practices

A. SMMC is committed to a minimum of 90 days billing prior to assigning a self-pay account to a collection agency. The County is committed to complying with all the provisions of AB 774 (Health and Safety Code §127425) and will not refer matters to collection where payment plans are in negotiation.

B. At the time that SMMC initially bills a patient who has not provided proof of third party insurance coverage, SMMC will provide the patient with a notice that includes information about SMMC's charity care and discounted payment policies. This notice will include information about program eligibility, the availability of interest-free extended payment plans for qualified patients, and contact information for a SMMC employee or office from which the patient can obtain further information.

C. Also as part of the initial billing of patients who have not provided evidence of third party health insurance coverage at the time that the care is provided or at discharge, SMMC will provide a notice that includes the following:

- A statement of charges for services rendered by SMMC
- A request that the patient inform SMMC if the he/she has health insurance coverage, Medicare, Medi-Cal, Healthy Families, or other coverage
- A statement that if the patient does not have third party health insurance coverage, the patient may be eligible for Medicare, Healthy Families, Medi-Cal, California Children Services, or charity care
- A statement indicating how a patient may obtain an application for Medi-Cal and Healthy Families and that SMMC will provide these applications

- Information about the SMMC's DHC and Charity Care Programs, including a statement that if a patient lacks or has inadequate health insurance, and meets certain low and moderate income requirements, the patient may qualify for the DHC or Charity Care Programs and the name and telephone number of a SMMC employee or office to contact for information about SMMC's DHC and Charity Care Programs.

D. As noted, an interest-free extended repayment plan will be made available by SMMC to all patients eligible for the DHC Program based on each individual's ability to pay.

E. The SMMC's billing and collections department will adhere to SMMC's values and mission as a "safety net" institution, and it will conduct all billing and collections activities in compliance with applicable provisions of law

ATTACHMENT F
SELF-PAY PROMPT-PAY DISCOUNT AND EXTENDED REPAYMENT POLICY

PURPOSE:

The purpose of this policy is to extend a discount off full charges to self-pay patients who pay their bill in full in a timely manner, or to allow an extended non-discounted interest-free repayment plan. The purpose of this discount is to encourage patients to quickly and conveniently resolve their obligation to San Mateo Medical Center (SMMC), reduce future Medical Center expenses related to account follow-up, and lower the amount of bad debt write-off related to self-pay accounts.

POLICY:

The self-pay prompt-pay discount will be applied against full charges and set at a rate that ensures SMMC is adequately reimbursed for the cost of care provided to the patient.

PROCEDURE:

1. Self-pay patients will be required to make a deposit before non-emergency services are provided. For outpatient clinic visits and related ancillary services, the deposit is $25 if the patient has not been screened for financial assistance, and $100 if the patient has been screened and coded as a self-pay patient. For inpatient stays and surgeries, the deposit is $550 if the patient has not been screened for financial assistance, and $750 if the patient has been screened and coded as a self-pay patient.

2. A discount of 50% off full charges will be extended to a self-pay patient if payment is received within 30 days of the first bill date. This discount ensures SMMC is adequately reimbursed for the cost of care provided to the patient. Patient is responsible for full charges if discounted amount is not received.

3. The self-pay prompt-pay discount applies to billed charges that are incurred by self-pay patients and non-covered charges that are incurred while covered under a third party plan. The discount also applies to the share-of-cost responsibility while covered under the Medi-Cal program only in those months when patients did not meet their share of cost. It does not apply to co-payments, co-insurance, deductibles, or annual fees.

4. If a self-pay patient applies for other coverage and is subsequently denied, the patient will be re-coded from “pending” status to self-pay retroactive to the initial application date. The self-pay prompt pay discount will apply if the patient makes payment within 30 days of the first bill date after being re-coded to self-pay. The patient must provide proof of coverage denial to be eligible for the discount. The discount will not apply if the patient was denied coverage due to lack of cooperation.

5. The extended repayment plan can be applied to all or a portion of billed charges that are determined to be the patient’s responsibility. Extended repayment plans are interest-free and

will be made available by the San Mateo Medical Center to all patients based on each individual's ability to pay.

6. The extended repayment plan is utilized when the patient is unable to make a full payment within the normal billing cycle timeframe for a self-pay patient. A Community Health Advocate (CHA) or Revenue Services account representative will determine the number of months and amount of installment payments. All extended repayment plans must have the prior approval of a supervisor or manager. Patients defaulting on an extended re-payment plan may be referred to Revenue Services for follow-up bad debt collection.

Appeals Process

1. Notice of the Right to Eligibility Review and Appeal

   Every individual who has been disenrolled, or has been denied eligibility, or who wishes to request a waiver or reduction of co-pays, fees or charges shall have the right to a two-step appeals process that allows the individual to present evidence of eligibility or argue special circumstances based on inability to pay. The first appeal step is an "individual eligibility review" (IER) to appeal any financial and non-financial issues relating to program eligibility. The second appeal step shall be before the "eligibility and financial review committee" (EFRC).

   Every individual who has been disenrolled, or has been denied eligibility, or who is assessed co-pays, fees or charges shall receive written notice of (1) the denial, discontinuance or charges; (2) the right to have the denial, discontinuance, or fees, co-pays and charges reviewed through the IER process based on ability to pay; and (3) a specific description of the appeals process and timelines. An individual who can demonstrate inability to pay shall be entitled to a reversal of the County's initial determination on eligibility, fees, co-pays or charges.

2. Step-One Appeal: Individual Eligibility Review (IER)

   a. Timeline for Step-One Application

   Individuals may appeal a disenrollment or denial decision within 60 days of the receipt of a written notice indicating the disenrollment or denial. Individuals who wish to request a waiver or reduction of fees, co-pays or charges may do so within 60 days of receipt of a bill for the fees, co-pays or charges. Notice of the right to appeal shall accompany such bills. Individuals are to complete a Request for Individual Eligibility Review (IER) form and submit the form to the Chief Financial Officer or his/her designee within 60 days of the written notice.

   b. Content of Request for Individual Eligibility Review

   In completing the Request for IER form, individuals must provide specific information supporting their appeal. The specific information needs to support a case that the individual has special circumstances demonstrating an inability to pay which justifies a reversal of the initial County decision to deny or disenroll, or of the County's decision to

assess charges. Such information may include unusual and extraordinary expenses over and above the actual cost of necessities of life.

c. Individual Eligibility Review Decision-Maker

The IER shall be decided by the Chief Financial Officer or his/her designee, who shall consider all special facts and circumstances supporting the applicant's claim of eligibility or claim of inability to pay, including the actual costs of necessities of life in San Mateo County.

d. Timeline for Decision

The Chief Financial Officer or his/her designee shall make a written decision to affirm or reverse the initial County determination within 30 days after receipt of all requested documents. If the decision is to reverse the initial County determination, then the applicant shall receive specific notice of the decision and information relating to the rights and benefits associated with the decision. If the decision is to affirm the initial County determination, then the written decision shall provide the reason for the decision and also include a description of the applicant's Step-Two Appeal rights, including a form to complete the appeal. If there is no decision within 30 days, the applicant has the right to a review by the Eligibility and Financial Review Committee.

3. Step-Two Appeal: Eligibility and Financial Review Committee (EFRC)

a. Timeline for Step-Two Application

Individuals may appeal the decision of the IER to the EFRC within 60 days of the receipt of the decision letter. Individuals may initiate an appeal by completing a pre-provided appeal form and submitting it to the Chief Financial Officer or his/her designee.

b. Content of Appeal

Upon notice of appeal, the original Request for Individual Eligibility Review form and all documentation, in addition to the new appeal form will be forwarded to the EFRC for consideration. Individuals are free to supplement this form with any other information that supports their position, including inability to pay information.

c. Eligibility and Financial Review Committee

The EFRC shall consist of three individuals: the Chief Financial Officer or his/her designee (other than the IER decision-maker), the Health System Chief or his/her designee and a public member to be chosen by the County Manager's Office. The applicant has the right to appear before the EFRC and bring an attorney.

d. Timeline for Decision

The EFRC shall make a written decision to affirm or reverse the IER determination within 30 days after receipt of all requested documents. If the decision is to reverse the initial County determination, then the applicant shall receive specific notice of the

decision and information relating to the rights and benefits associated with the decision. If the decision is to affirm the IER determination, then the written decision shall provide the reason for the decision.

4. Anytime Request for Eligibility and Financial Review

   Any individual may request an eligibility and financial review at any time if their circumstances change. If the Chief Financial Officer or his/her designee receives such a request, it shall be processed under the same timelines and rules specified above.

Periodic Board Reports

Periodically, program, eligibility and appeal data shall be submitted to the Board of Supervisors for review and consideration.