COUNTY OF SAN MATEO
FINANCIAL ASSISTANCE PROGRAMS
June 2011 update

Eligibility Criteria	COUNTY FINANCIAL ASSISTANCE PROGRAMS FOR UNINSURED *					
	Charity Care	**MCE**	**ACE County Fee Waiver**	**ACE County**	**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 133% FPL		At or below 200% FPL***	At or below 400% FPL	No income limit
Asset Limit	$250 of monetary assets per patient, calculated per AB 774)[1]	No asset limit****	$2,000 per family member, excluding one vehicle per adult	$2,000 per family member, excluding one vehicle per adult	No asset limit	No asset limit
Annual Fee	None	Waived		$240 annual fee, payable in installments	None	Deposit required before receiving non-emergency services
Payment for Outpatient (Clinic) Visits	Care limited to emergency care, urgent care, inpatient care, and ambulatory surgery transfers from SMMC ED	All charges waived		Co-pays, annual cap for each individual on annual fees and copays for services of 5% of income	Not to exceed the highest amount SMMC receives for medical services from Medicare, Medi-Cal, Healthy Families or other government-sponsored program	Deposit required before receiving non-emergency services; 30% 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 waived as described in sections D-1 and D-2		$300 co-pay; Estate recovery on the balance of charges (Best government payer discount rate, adjusted annually)	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; 30% 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		Yes, interest-free Based on ability to pay (Will review assets, income, expenses, other relevant information)		
Eligibility Redetermination	Annually, and before inpatient stays and surgeries				Applicant will be re-screened upon	

San Mateo Medical Center
A County System of Healthcare

Attachment A – Eligibility Summary Table
Attachment B – Overview of Financial Assistance Programs
Attachment C – Charity Care Program
Attachment D – Medically Indigent Healthcare – Access and Care for Everyone (ACE) -County Program
Attachment D-2 – Medicaid Coverage Expansion (MCE) Program
Attachment E – Discounted Healthcare (DHC) Programs
Attachment F – Self-Pay Prompt Pay and Extended Repayment Plan

* Uninsured applicants will be screened for Medi-Cal and other state and federal programs prior to being screened for the County's financial assistance programs ** Waiver 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. *** Community Health Advocates (CHAs) have authority to place patients on ACE program if income is up to 210% of FPL where patient shows existence of hardship and/or chronic condition requiring regular, recurring medical treatment; CHA Supervisors/Managers have authority to place patients on ACE program if income is up to 225% of FPL. *** ACE Coverage Initiative population that is "grandfathered" into the ACE program in accordance with Low Income Health Program requirements is included in this category. ****MCE does not have an asset limit, as required by the terms established by the Federal and State governments

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, asset ownership 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, income and assets tests, 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.

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 will receive written notification in advance of their application expiration date to notify

them of the date at which their application will expire and the information needed to complete the application process. 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, the retroactive coverage period for previous visits will be three complete months prior to the date of application.

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, Impact, CDP, PACT, CHDP, BCCTP, Healthy Kids, Healthy Families)	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 with th Hlth St i li ibl f	Medically Indigent Policy - ACE Program
Youth Health Centers - County-sponsored coverage for medically indigent teens 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 **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), asset limit of $2,000 per family unit member (excluding one vehicle per adult); asset limit only applies to ACE County; **Fee Waiver** - Waiver of all fees*, co-pays for County residents at or below 133%FPL, asset limit of $2,000 per family unit member (excluding one vehicle per adult) or for persons receiving General Assistance, services through the County's Alcohol and Drug programs,	Medically Indigent Policy - ACE Program
Medicaid Coverage Expansion (MCE) – Program established by 2010 Medi-Cal1115 waiver as a precursor to Medi-Cal expansion under federal health reform.	County adult resident (between age 19 and 64), income at or below 133% of federal poverty level (FPL), meets Federal documentation/ citizenship and identity requirements under DRA, no asset limit	Special Terms and Conditions for California 1115 Medi-Cal waiver, November 2, 2010
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	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	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, 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] and asset limit of $2,000 per family unit member (excluding one vehicle per adult)[3]. Patients must pay an annual fee of $240.00 (which may be paid in installments throughout the patient's membership year), charges for inpatient stays and same day surgeries, and co-pays. Each individual participating in ACE shall be required to pay no more that five percent of their annual income per year out of pocket for copayments, annual 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 133% FPL and who have assets of $2,000 or less per family unit member (excluding one vehicle per adult) . 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.

c. All outpatient fees, co-pays and charges will be waived for patients who are 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.

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.

4. Medicaid Coverage Expansion Program: MCE

The MCE Program is health coverage program that, among other things, makes health care available to low income individuals between the ages of 19 and 64. To qualify, patients must be residents of San Mateo County, be United States citizens or Nationals, or be lawful permanent residents (LPRs) with five or more years of legal permanent residency in the United States, not be eligible for coverage through full scope no cost or full scope share of cost Medi-Cal, and have incomes that are at or below 133% of FPL. There is no asset limit for the MCE Program. Patients do not pay an enrollment fee or copayments for services. For inpatient stays and/or same day surgeries, the patient shall not be responsible for any copayment but the County shall be entitled (and may be required) to pursue estate recovery to the extent set forth in applicable laws.

5. 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.

6. 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, copays 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 Deputy County Manager 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.

5. State Fair Hearing for MCE Participants

Participants seeking eligibility in the MCE program may file a request for a State fair hearing to appeal an adverse eligibility decision after exhaustion of the EFRC appeal process described 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

Attachment C 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, ACE-Coverage Initiative (ACE-CI 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 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
- Healthy Families, Healthy Kids, Young Adults, and Workers
- Slips and Falls/Third Party
- Auto Accidents
- Injuries at Work

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

- Physician 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, the Healthy Families Program, 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 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 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 a CHA to review the patient's eligibility for Charity Care or discounted health care.

The CHA 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 CHA 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
- Medicaid Coverage Expansion (MCE)
- Healthy Families
- 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
- ACE-Coverage Initiative
- Charity Care and Discounted Healthcare

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

CHAs must 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

1.1.1 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.

2 When an application is complete, the CHA first evaluates the patient for Charity Care. If the patient if ineligible for Charity Care, the patient is evaluated for the Discounted Healthcare program.

3 When an application is complete, the CHA makes a determination of eligibility and notifies the patient and the Business Office.

L. Notification to Patient

1. Approval

Inpatient**:** The 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 Financial Counselor will complete insurance revisions of the accounts. Patient will receive a new statement reflecting the revised patient liability amounts.

2. Denial

The CHA completes the eligibility determination portion of the application. The CHA 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
Patient Access Manager 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 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 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 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 or Medi-Cal Minor Consent 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.

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

2 County resident adults who are not eligible for full-scope or share-of-cost Medi-Cal coverage, 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

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.

b. Income Criteria

1) Income must be equal to or lower than 200% of the Federal Poverty Level (FPL). This level is updated annually. 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. CHA Supervisors/Managers 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 shall develop and implement 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.

c. Assets Criteria[4]

1) Applicants who meet the residency and income requirements above and who have assets equal to or below $2,000 per family unit member are eligible for coverage. A family unit refers to a married couple or domestic partners living together and their minor children or to a single parent living with minor children. For example, a married couple living together and having two minor children would count as a

(4) member family unit. A relative who is living in the household but is not part of the family unit is counted as a separate family unit.

2) Assets include the applicant's equity interest in real property. Other than real property that is an applicant's primary residence.

3) Assets also include property that is available and easily liquidated, including, but not limited to, checking and savings accounts, stocks, bonds, retirement accounts (IRAs, 401K, 403B, etc.) and the surrender value of life insurance policies.

4) One vehicle per adult is exempt from the assets limit.

d. 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, , 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. Patients who voluntarily drop employer-provided health insurance who are determined to have an ability to afford such coverage shall be subject to a three month waiting period before they are eligible for ACE Program benefits.

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, copays 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 or other benefits due to lack of reasonable cooperation Patients who fail to apply for Medi-Cal 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 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, assets, 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 Assets

1) Tax records

2) Bank Accounts – bank statement dated the month or prior month of application; written statement from the bank on bank stationery; current teller verification.

3) Life Insurance –written statement from the insurance company dated within the last 45 days of the application date showing the cash surrender value of the policy and the name of the policy owner.

4) Property including principal residence – current year's property tax statement; loan payment; receipts for expenses or insurance

5) Vehicle registration or proof of ownership (one vehicle per adult is exempt)

6) Other insurance cash surrender value – written statement from the insurance company dated within the last 45 days of the application date showing the cash surrender value of the policy and the name of the policy owner.

7) Other assets – stock certificates; letter from broker; other property of value

8) Other proof of assets – other third party documents verifying assets of applicant may be provided

d. 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.

1 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.

2 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 letter will be provided to the applicant 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 or his or her designee shall develop and implement a process for SMMC personnel to apply in considering 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. Said process shall be set forth in writing and made available to all ACE Program applicants and beneficiaries.

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 temporarily cover patients.

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[5], 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 or his or her designee shall develop and implement 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 in writing and shall be made available to all ACE Program applicants and participants.

J. Annual Processing Fee, Co-Pays and Charges

1 Each patient enrolled in the ACE Program pays an annual processing fee of $240.[6] 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 $240 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 $240 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 or his or her designee shall develop and implement a process for consideration of applications to waive, as a hardship, a patient's ACE Program annual processing fee. 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.

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 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 133% of the Federal Poverty Level and do not have qualifying assets that exceed $2,000 per family unit member (excluding one vehicle per adult).

b. Persons receiving General Assistance ineligible for Medi-Cal.

c. Persons receiving services through the County's Alcohol and Other Drug programs and ineligible for Medi-Cal.

d. Persons receiving services through the County's Health Care for the Homeless program not eligible for other public or private coverage.

e. Persons receiving services at a San Mateo County Teen Center who are ineligible for PACT or Medi-Cal Minor Consent coverage.

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 I 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.

M. Appeals Process

1. Notice of the Right to Eligibility Review and Appeal

In addition to the hardships reviewed by the County as described above, 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, copays 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 or his or her designee shall develop and implement procedures for considering appeals and for issuing timely decisions on

appeals. Such procedures, which shall be in writing and made available to all ACE Program applicants, shall provide appellants the opportunity to appear in person before the decision maker(s) and to provide documentary and testimonial evidence in support of their appeal. Such procedures shall 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 shall 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 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.

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 Medicaid Coverage Expansion Program (Medi-Cal 1115 Waiver Program)

PURPOSE:

The purpose of this policy is to describe the Medicaid Coverage Expansion (MCE) program, which is the County's coverage program implementing provisions of the Medi-Cal 1115 waiver negotiated by the State of California and the federal government and concluded on November 2, 2010. This policy outlines the specifics of the MCE program, including scope of services, eligibility requirements, verification, enrollment, appeals and waiver process.

POLICY:

The objective of this program is to prepare for the expansion of Medi-Cal under federal health reform, in January 2014 through the earlier development and implementation of a locally managed health coverage program for the population that will become newly eligible for Medi-Cal under federal health reform.

PROCEDURE:

D. Notice of the Right to Apply for MCE 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 MCE 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 MCE Scope of Services

The County population that eligible for the MCE program consists of County resident adults who are not eligible for full-scope or share-of-cost Medi-Cal coverage and who meet the income and residency criteria for MCE enrollment described in the next section and who are United States citizens or nationals or Qualified Eligible Immigrants, as defined herein.

F. MCE 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

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. 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 133% 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.

c. Screening for Potential Medi-Cal Eligibility

1) There is no asset limit for eligibility for the MCE 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 the MCE.

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 to meet requirements of this program's eligibility criteria related to U.S. Citizens, U.S. Non-Citizen Nationals or Qualified Eligible Immigrant

2) Applicants must meet one of the following criteria to qualify for MCE:

i. United States Citizen
ii. United States Non-Citizen National
iii. Legal Permanent Resident (LPR) with at least 5 years of LPR status in the US
iv. Other qualified immigrant statuses as determined by the California Department of Health Care Services

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 MCE program for the following reasons:

- Patients who were denied Medi-Cal or other benefits due to lack of reasonable cooperation
- Patients who fail to apply for Medi-Cal or any other third party coverage when requested to do so.
- Patients holding non-resident visas.
- Patients whose LPR status is terminated.
- Patients who fail to provide requested information.

 Patients who fail to cooperate with an MCE audit.

 Patients providing materially incorrect or false eligibility information. In such cases, the patient my be terminated immediately from the MCE Program and billed retroactively for all MCE 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 MCE 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 MCE 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. 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.

d. Proof of U.S. Citizenship, U.S. Non-Citizen Nationals or Qualified Eligible Immigrant Criteria Status 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) U.S. Citizenship Or U.S. Non-Citizen National
   i. U.S. Passport issued without limitation (expired ones are acceptable)
   ii. Certificate of Naturalization
   iii. Certificate of U.S. Citizenship
      1 Certification of Report of Birth
      2 Report of Birth Abroad of a U.S. Citizen
   vi. State Department Certification of Birth
   vii. U.S. Citizen Identification Card
   viii. American Indian Card
      1 Northern Marianas Card
      2 Final adoption decree showing a U.S. place of birth
   xi. Proof of adoption of a child born outside U.S. and in the legal custody of the U.S. Citizen parent
   xii. Proof of U.S. civil service employment before June 1, 1976
   xiii. U.S. military service record showing a U.S. place of birth
   xiv. U.S. hospital record established at the time of the person's birth*
   xv. Life, health, or other insurance record*
   xvi. Religious record recorded in the U.S. within 3 months of birth showing U.S. place of birth and birth date or age
   xvii. Early school record showing a U.S. place of birth, date of admission, birth date, names and places of birth of parents
   xviii. Federal or State census record that shows the applicant's age and U.S. citizenship or place of birth
   xix. Seneca Indian tribal census record*
   xx. Bureau of Indian Affairs Navajo Indians tribal census record*
   xxi. U.S. State Vital Statistics birth registration notification*
   xxii. An amended U.S. public birth record (amended more than 5 years after the person's birth)*
   xxiii. Statement signed by doctor or midwife present at the birth*
   xxiv. Roll of Alaska Natives from the Bureau of Indian Affairs
   xxv. Admission papers from a nursing or skilled care facility, or other institution that shows a U.S place of birth
   xxvi. Medical record (not an immunization record)*
   xxvii. Two signed adults affidavits attesting to the U.S. citizenship. Both adults must have proof of their identity own identity and U.S. citizenship, and only one of them may be related to the MCE applicant
   xxviii. Other documents as determined by the California Department of Health Care Services

   *Must be dated at least 5 years before the first MCE application and show a U.S. place of birth.

2) Legal Permanent Resident (LPR) with at least 5 years of LPR status in the US
   i. United States Citizenship and Immigration Services (CIS) Form I551
   ii. I-94 with a Current I-551 stamp

iii. Foreign Passport with a Current I-551 stamp

iv. U.S. Legal Permanent Resident Alien Card (Green Card)

v. Other documents as determined by the California Department of Health Care Services

*Note: Verifications must not be expired.

3) Other qualified immigrant statuses as determined by the California Department of Health Care Services

i. Documents as determined by the California Department of Health Care Services

Certain forms of documentation listed above for establishing citizenship or qualified immigrant status must meet criteria presently set forth in section 435.407 of Title 42 of the Code of Federal Regulations.

1 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.

2 Patient eligibility for the MCE 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 MCE Program will be informed in writing if they qualify. The letter will be provided to the applicant 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 MCE 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. 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 contracted network are included.

2 The MCE 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.

1 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 MCE Program. If the patient meets the specific program eligibility criteria, these programs will be used to temporarily cover patients.

2 The MCE 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-payments for services are waived for participants enrolled in the MCE program.

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. Annual Processing Fee, Co-Pays and Charges

1 Enrollment fees are waived for participants of the MCE program.

2 Copayments for services are waived for participants of the MCE program.

K. Notification of Enrollment, Denial of Enrollment or Disenrollment

1. Patients who are enrolled in MCE will receive a program brochure informing them about the MCE Program's benefits and guidelines. MCE enrollees will also receive an MCE ID card and informing materials from the Health Plan of San Mateo.

2. Patients will be informed of a denial of enrollment in the MCE Program within 45 days of submission of a complete application for enrollment. Patients shall be informed of disenrollment in the MCE 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. Notice of the Right to Eligibility Review and Appeal

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

The Chief of the San Mateo County Health System or his or her designee shall develop and implement procedures for considering appeals and for issuing timely decisions on appeals. Such procedures, which shall be in writing and made available to all MCE Program applicants, shall incorporate all federal and state mandated provisions for appeals in connection with the MCE, including those set forth in Part 431 of Title 42 of the Code of Federal Regulations. Such procedures shall provide appellants the opportunity to appear in person before the decision maker(s) and to provide documentary and testimonial evidence in support of their appeal. Such procedures shall 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.

3. State Fair Hearing for MCE Participants

Participants seeking eligibility in the MCE program may file a request for a State fair hearing to appeal an eligibility decision after exhaustion of the EFRC process described in Section B.

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 for an application. 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."

a
- 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.

b
- 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

c
- 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.

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, copays 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

1. 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.

2. 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.

3. 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. A statement of charges for services rendered by SMMC

b. A request that the patient inform SMMC if the he/she has health insurance coverage, Medicare, Medi-Cal, Healthy Families, or other coverage

c. 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

d. A statement indicating how a patient may obtain an application for Medi-Cal and Healthy Families and that SMMC will provide these applications

e. 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.

1 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.

2 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, copays 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.

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