COUNTY OF SAN MATEO

County Manager's Office

DATE: November 7, 2005
BOARD MEETING DATE: November 15, 2005
SPECIAL NOTICE/HEARING: None
VOTE REQUIRED: Majority

TO: Honorable Board of Supervisors

FROM: John L. Maltbie, County Manager

SUBJECT: County Financial Assistance Programs for Provision of Healthcare to Uninsured Patients of the San Mateo Medical Center

RECOMMENDATION:
Adopt a Resolution approving standards of aid specified in the following Financial Assistance Programs for the provision of healthcare to uninsured patients of the San Mateo Medical Center:

1. WELL Program for medically indigent residents of San Mateo County as mandated under Section 17000 of the California Welfare and Institutions Code;
2. Discounted Health Care (DHC) Program for low-income residents; and
3. Prompt-Pay Discount and Extended Repayment policy for self-pay patients.

VISION ALIGNMENT:
Commitments: Ensuring Basic Health and Safety for All; and Responsive, Effective and Collaborative Government.
Goals 5 and 20: Residents have access to healthcare and preventative care; and Government decisions are based on careful consideration of future impact, rather than temporary relief or immediate gain.

These financial assistance programs contribute to these commitments and goals by ensuring that the County meets its legal mandate and exercises fiscal responsibility in providing healthcare to its medically indigent residents, and that all patients seeking healthcare services at the San Mateo Medical Center will be screened for available health insurance programs and provided with payment assistance based on each person's ability to pay.

BACKGROUND

A. Legal Requirements – Indigent Healthcare

Under Section 17000 of the California Welfare and Institutions Code, counties are mandated to provide health care to their uninsured medically indigent residents. To implement the general duty language of Section 17000 to "relieve and support" the medically indigent, Section 17001 requires that the Board of Supervisors of each county "adopt standards of aid and care for the indigent and dependent poor of the county." San Mateo County has fulfilled this Section 17001 obligation by creating the Wellness, Education, Linkage, Low-Cost (WELL) Program in July 1996, and using the WELL Program eligibility requirements as a basis for Section 17000 eligibility.

B. Existing Financial Assistance Programs

The County currently pays for two broad categories of uninsured patients:

- Patients who qualify for services under the County's Section 17000 mandate (WELL Program); and
- Uninsured patients who may not qualify under Section 17000 but who cannot afford the full cost of their care. In the hospital industry, care for these patients is often called "charity care."

1. WELL Program for Medically Indigent (Section 17000) - Patients in the first category who do not qualify for other insurance programs such as Medi-Cal, are covered under the WELL Program. A self-declaration process is used to determine eligibility. Individuals verbally provide information and sign a self-declaration form, and 5% of applicants are randomly selected as part of a WELL audit that verifies residency, income and assets. Requests for proof of eligibility are limited.

There are approximately 13,000 WELL patients. Individuals who qualify for WELL are charged an annual fee and co-pays for visits. For more costly procedures requiring hospital stays and surgeries, individuals are responsible for co-pays plus full charges that can be deferred by signing a lien. To qualify for WELL, an individual must:

- Be a resident of San Mateo County
- Have income at or below 200% of the federal poverty level (FPL)
- Have assets that do not exceed $2,000 per family unit member (excluding one vehicle and principal residence)

Patients who are enrolled in other County public assistance programs, such as General Assistance and Alcohol/Other Drug treatment programs, receive care covered under the WELL scope of services. All fees, co-pays and charges are waived for these populations.

2. Self-Pay Patients - Uninsured patients who do not qualify under the County's Section 17000 mandate are categorized as "self-pay" and are responsible for full charges. The only financial assistance available to self-pay patients is a 50%

discount if a bill is paid within 30 days. Delinquent accounts deemed uncollectible are written off as bad debt.

DISCUSSION

A. Growth in General Fund Contribution to Medical Center

The General Fund contribution to the San Mateo Medical Center (SMMC) has doubled from $28 million in FY 1999-2000 to $56 million in FY 2004-05. The current leadership at SMMC has made significant progress in managing the growth in costs in recent years, but more can be done to further manage the County's contribution and bring more predictability to the financial relationship between the County and SMMC. It is anticipated that growth in health care costs will continue, so it is important that the County find ways to improve the screening process and tracking of costs for its financial assistance programs.

B. Issues with Self-Declaration Process

A major problem with the self-declaration process is that it is so unexacting in its requirements that the Medical Center could potentially be providing services to patients who would otherwise not qualify for the WELL Program meant for the County's medically indigent residents. In fact, an audit conducted by the Controller's Office estimated that 20% of WELL members selected as part of an audit sample were non-residents and/or did not meet eligibility criteria. With a full screening and documentation process, SMMC may encourage the uninsured, who could be non-residents and/or exceed income and asset limits, to explore other providers other than SMMC. SMMC currently provides over 90% of the charity care in San Mateo County, care that can be shared with other hospitals in the county.

C. Full Screening and Verification Pilot Study

In May 2005, a County Medically Indigent Healthcare Work Group with representatives from the San Mateo Medical Center, Health Department, Human Services Agency, County Manager's Office, Revenue Services (Employee and Public Services), Controller's Office, and County Counsel, completed a report and made recommendations toward creating a long-term financially viable business model for providing healthcare to the County's medically indigent population. As part of the FY 2005-06 budget, your Board approved the implementation of recommendations made by this County work group, which include a full screening and verification process that would be conducted on a pilot basis from October 2005 through March 2006. All uninsured applicants would be screened for eligibility in Adult Medi-Cal, the WELL Program, and other programs using the One-e-App web-based application screening tool. Applicants would be required to provide proof of residency, income and assets.

The full screening and verification process using the modified One-e-App tool (that now includes Adult Medi-Cal and WELL) has begun at the Daly City, South San Francisco, and Fair Oaks clinics, as well as 14 community-based sites that are already utilizing One-e-App for the Children's Health Initiative. If the Board

approves the changes to the financial assistance programs that have been proposed in this report, further modifications to One-e-App will be made and rolled out to the remaining County clinics in January.

Results from the pilot will be used to develop a Memorandum of Understanding (MOU) with the Medical Center for the provision of care to the medically indigent Section 17000 population, as well as to explore the possibility of a proposed ordinance or other approaches to address the provision of and payment of charity care in the county. These will be developed as part of next year's budget process.

D. Issues with Existing Financial Assistance Programs

The existing programs also provide no financial assistance to low-income residents who make more than 200% of FPL and have more assets. These residents may not qualify under Section 17000 but cannot afford the full cost of their care. Currently these residents would be considered self-pay patients, and the only discount available to them would be 50% for paying their bills within 30 days. The County would not consider these residents as "indigent" under its Section 17000 mandate, but could choose to provide some level of financial assistance to this population. In the hospital industry, care for these patients is often called "charity care."

The existing approach also provides inadequate information to the County about the "self-pay" patient pool. Neither SMMC nor Employee and Public Services (the department that provides collection services for self-pay patients) collects information on their income and asset levels; therefore, it is difficult to estimate what portion of these patients could be considered charity care and what the expected costs for care might be. The only way to develop better estimates is to perform full financial screening for all patients.

RECOMMENDATIONS

Proposed changes include adjusting WELL Program eligibility requirements, creating a full waiver for those making less than 100% FPL with low assets, and creating a discount for WELL inpatient stays and same day surgeries. Changes also include the creation of the Discounted Health Care (DHC) Program, and altering the process for admitting self-pay patients seeking non-emergency services. These proposed changes are discussed below and a chart of each financial assistance program with proposed changes is included in Attachment A. An overview of these programs can be found in Attachment B.

1. Medically Indigent Healthcare Policy - WELL Program (Attachment C)
2. Discounted Health Care (DHC) Program (Attachment D)
3. Self-Pay Prompt Pay Discount and Extended Repayment Plan (Attachment E)

1. Changes to WELL Program for Medically Indigent:

- Waiver of all fees, co-pays and charges for applicants with income at or below 100% of FPL and asset limit of $2,000 per family unit member (excluding one vehicle per adult)

- Inclusion of principal residence in calculation of assets – applicants who own a

home in San Mateo County would not be considered “indigent” and would not qualify for the WELL Program; these applicants could qualify for the Discounted Health Care (DHC) program or can appeal the denial or disenrollment from WELL. An individual’s ability to pay, including income, assets, expenses, and other relevant information, will be considered in reaching a decision regarding an appeal. Data gathered from recent WELL applicants indicate that 95% of those eligible for WELL do not own their homes.

- Creation of a 65% discount for hospital stays and same day surgeries – this rate reflects the Medicare discount rate which is adjusted annually. There is currently no discount provided to indigent patients for inpatient stays and same day surgeries. Patients can choose to defer payment of these discounted charges by signing a lien, or can request an interest-free extended repayment plan based on each person’s ability to pay.

2. Creation of Discounted Health Care (DHC) Program:

- Creation of a 50% discount for San Mateo County residents with income at or below 400% of FPL and asset limit of $15,000 per family (excluding one vehicle per adult and principal residence)
- Patients can request an interest-free extended repayment plan based on each person’s ability to pay.

3. Requirement of Deposit from Self-Pay Patients for Non-Emergency Services

- Patients who are not eligible for the WELL and DHC Programs will be coded as Self-Pay and will be required to make a deposit before receiving non-emergency services
- Self-pay patients will still receive a 50% discount for bills paid within 30 days, and can request an interest-free extended repayment plan based on each person’s ability to pay.

FISCAL IMPACT:

There is no fiscal impact for adopting these financial assistance programs. The true fiscal impact is unknown at this time. Results from the screening and verification pilot will be evaluated to determine the fiscal impact of these changes to standards of aid, and will be used to begin the development of a Memorandum of Understanding (MOU) with the Medical Center for the provision of care to the medically indigent Section 17000 population. The FY 2005-06 Budget includes $1.1 million for conducting the screening and verification pilot study.

Attachments

Attachment A – Eligibility Summary Table
Attachment B – Overview of Financial Assistance Programs
Attachment C – Medically Indigent Healthcare – WELL Program
Attachment D – Discounted Healthcare (DHC) Program
Attachment E – Self-Pay Prompt Pay and Extended Repayment Plan

ATTACHMENT A

Eligibility Criteria	COUNTY FINANCIAL ASSISTANCE PROGRAMS FOR UNINSURED *			
	WELL Full Waiver	WELL Indigent Program	Discounted Health Care (DHC)	Self-Pay
Resident of San Mateo County	Yes **	Yes	Yes	Residency not required
Income Limit – Federal Poverty Level (FPL)	At or below 100% FPL	At or below 200% FPL	At or below 400% FPL	No income limit
Asset Limit	$2,000 per family member, excluding one vehicle per adult	$2,000 per family member, excluding one vehicle per adult	$15,000 per family, excluding one vehicle per adult and principal residence	No asset limit
Annual Fee	Waived	$250 annual fee, Payable after first visit	None	Deposit required before receiving non-emergency services
Charges for Outpatient (Clinic) Visits	All charges waived	Co-pays	50% of charges Discount rate adjusted annually	Deposit required before receiving non-emergency services; 50% discount if bill is paid within 30 days; must pay 100% after 30 days
Charges for Inpatient (Hospital) Stays and Same Day Surgeries	All charges waived	$550 co-pay + 35% of charges (Medicare discount rate, adjusted annually) Option to defer charges by signing lien for 35% of charges interest-free	50% of charges Discount rate adjusted annually	Deposit required before receiving non-emergency services; 50% discount if bill is paid within 30 days; must pay 100% after 30 days
Availability of Extended Repayment Plan	All charges waived	Yes, interest-free Based on ability to pay (Will review assets, income, expenses, other relevant information)		
Eligibility Redetermination Period	Annually, and before inpatient stays and surgeries (County to explore shorter eligibility periods)			Applicant will be re-screened upon request
Third Party Verification of Eligibility	20% of eligible applicants and After 6 months of eligibility			None
Appeals Process if Denied or Disenrolled	Applicant/patient will be given 10 days notice prior to disenrollment from WELL and DHC programs. Applicant/patient can file an appeal form within 60 days of notification of denial or disenrollment. A written response will be provided regarding the disposition of the appeal within 30 days of receipt First Level Review – Patient Access Manager Second Level Review – WELL Oversight Committee			

* 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 receiving other County public assistance, such as General Assistance and services through the County's Alcohol and Other Drug programs and Teen Centers.

RESOLUTION NO. _____

BOARD OF SUPERVISORS, COUNTY OF SAN MATEO, STATE OF CALIFORNIA

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RESOLUTION AUTHORIZING THE ADOPTION AND EXECUTION OF THREE FINANCIAL ASSISTANCE HEALTH CARE POLICIES: 1) WELL PROGRAM; 2) DISCOUNTED HEALTH CARE PROGRAM; AND, 3) SELF-PAY PROMPT PAY AND EXTENDED REPAYMENT PLAN

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RESOLVED, by the Board of Supervisors of the County of San Mateo, State of California, that

WHEREAS, Welfare and Institutions Code section 17000 et. seq. require counties to adopt standards of aid to serve the medically indigent resident population; and

WHEREAS, County Ordinance Code section 2.64.050 requires the County to adopt policies and procedures regarding health service programs, including Welfare and Institutions Code section 17000 et. seq. policies; and

WHEREAS, in May 2005, a County Medically Indigent Healthcare Work Group completed a report and made recommendations toward creating a long-term financially viable business model for providing healthcare to the County's medically indigent population; and

WHEREAS, as part of the FY 2005-2006 budget, the Board approved the implementation of the recommendations which include a full screening and verification process conducted as part of a pilot program to be completed in March 2006; and

WHEREAS, by adopting this resolution and implementing the financial assistance policies, further modifications can be made to the pilot program; and

WHEREAS, results from the pilot program will be presented to the Board, including any recommendations to modify the three financial assistance policies referenced herein; and

WHEREAS, there has been presented to this Board for its consideration and acceptance, three financial assistance polices, namely 1) Well Program; 2) Discounted Health Care and 3) Self-Pay Prompt-Pay Discount and Extended Repayment Plan and desires to adopt these policies to be implemented by the County

NOW THEREFORE, IT IS HEREBY DETERMINED AND ORDERED that the three financial assistance polices, namely 1) Well Program; 2) Discounted Health Care and 3) Self-Pay Prompt-Pay Discount and Extended Repayment Plan be adopted and implemented.

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ATTACHMENT B

SUBJECT:	OVERVIEW - FINANCIAL ASSISTANCE PROGRAMS
DEPARTMENT:	FINANCIAL SERVICES: PATIENT ACCESS
AUTHOR:	CHIEF FINANCIAL OFFICER

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). 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. 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 the Medical Center's fiduciary responsibilities.

PROCEDURE:

A. <u>Application Process and Eligibility Criteria for Obtaining Financial Assistance</u>

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. 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 San Mateo Medical Center (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 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. SMMC will make available 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. Efforts will be made to provide assistance in the primary language of the patient or patient's guarantor.

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 and highly specialized services, but a patient's unique circumstances can be taken into consideration.

5. At a minimum, an application for financial assistance must be renewed and updated annually. 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 the financial assistance programs.

6. 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 the Medical Center's Patient Billing and Collections office.

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

B. Overview of Financial Assistance Programs

Applied in the Following Order	General Qualifications / Income Level	Refer to:
External Government-Sponsored Programs (ex. 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; enrollment in a County sponsored Alcohol and Other Drug Program contracted with the Human Services Agency	Medically Indigent Healthcare Policy - WELL Program
Teen 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 Healthcare Policy - WELL Program
WELL 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); **Financial Hardship Waiver** - Waiver of all fees, co-pays and charges for County resident, income at or below 100%FPL, asset limit of $2,000 per family unit member (excluding one vehicle per adult)	Medically Indigent Healthcare Policy - WELL Program
Discounted Health Care (DHC) Program – 50% discount for low-income adults who meet residency, income and asset requirements	County resident, income at or below 400% FPL, asset limit of $15,000 per family (excluding one vehicle per adult and principal residence)	Discounted Health Care (DHC) Program
Self-Pay Prompt-Pay Discount – For adults who do not qualify for other programs; 50% discount for payments received within 30 days of first bill date	No income, asset and residency requirements; required to pay a deposit in advance of receiving non-emergency services	Self-Pay Prompt-Pay & Extended Repayment Plan Policy
Self-Pay Extended Repayment Plan – for adults who do not qualify for other programs; payment of full charges over an established repayment period	No income, asset and residency requirements; required to pay a deposit in advance of receiving non-emergency services	Self-Pay Prompt-Pay & Extended Repayment Plan Policy

1. External Government-Sponsored Programs

   Whenever possible, patients will be first assessed for coverage through a governmentally sponsored program such as Medi-Cal, 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. Medically Indigent Healthcare (W&I Section 17000) - WELL Program

   a. The WELL 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) and asset limit of $2,000 per family unit member (excluding one vehicle per adult). Patients must pay an annual fee, charges for inpatient stays and same day surgeries, and co-pays unless they qualify for other County-sponsored programs or a full waiver due to financial hardship. For more information on the WELL program, refer to the Ethics, Rights and Responsibilities chapter policy titled: 1.54 WELL Program Eligibility.

   b. All fees, co-pays and charges will be waived for patients who qualify for other County-sponsored public assistance programs. The County subsidizes the Medical Center for the care of these patients within the scope of services provided in the WELL Program. Patients must be enrolled in an Alcohol and Other Drug program that contracts with the San Mateo County Human Services Agency or in receipt of General Assistance in San Mateo County. In addition, 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. For more information on this type of program, refer to the Ethics, Rights and Responsibilities chapter policy titled: 1.54 WELL Program Eligibility.

   c. Financial Hardship Waiver - All fees, co-pays and charges will be waived for patients who are San Mateo County residents with income at or below 100% FPL and asset limit of $2,000 per family unit member (excluding one vehicle per adult).

3. Discounted Health Care (DHC) Program

   The DHC Program offers a discount to San Mateo County residents who qualify with income at or below 400% of FPL and asset limit of $15,000 per family (excluding one vehicle per adult and principal residence). Patients who qualify receive a discount rate of 50% for the scope of services provided in the WELL Program. This discount rate will be adjusted annually and may be applied to non-covered charges, denied charges, co-pays, deductibles, and the share-of-cost responsibility while covered under the Medi-Cal program. For more information on this type of program, refer to the Financial Services Patient Access department policy titled: Discounted Health Care (DHC) Program.

4. 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 WELL 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 or share of cost, but may be applied to non-covered or denied charges. For more information on this type of program, refer to the Financial Services Patient Billing department policy titled: Self-Pay Prompt- Pay Discount and Extended Repayment.

    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. For more information on this type of program, refer to the Financial Services Patient Billing department policy titled: Self-Pay Prompt-Pay Discount and Extended Repayment.

C. Billing and Collection Practices for Patients Receiving Financial Assistance

1. The Medical Center is committed to a minimum of 90 days billing prior to assigning a self-pay account to a bad debt collection agency. 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 the Medical Center's values and mission as a "safety net" institution.

3. An interest-free extended repayment plan will be made available to all patients 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.

D. Appeals Process

Patients will be informed of disenrollment from the County's financial assistance programs 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.

Applicants or patients on financial assistance may appeal a denial or disenrollment decision by completing an appeal form and submitting it to the Patient Access Manager within 60 days of notice of denial or disenrollment. The Patient Access Manager and WELL Oversight Committee will review appeals. The applicant shall receive a written response as to the determination of the appeal within 30 working days after the appeal form is received.

E. 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.

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

ATTACHMENT C

1.54

SUBJECT:	MEDICALLY INDIGENT HEALTHCARE POLICY - WELL PROGRAM
CHAPTER:	ETHICS, RIGHTS, AND RESPONSIBILITIES
AUTHOR:	PATIENT ACCESS MANAGER

PURPOSE:

The purpose of this policy is to describe the scope of services provided to the County's medically indigent population through the WELL (Wellness, Education, Linkages, Low-Cost) Program. This policy specifies WELL scope of services, eligibility requirements, verification, enrollment, and appeals processes and requirement for waiving the annual processing fee, co-pays and charges.

POLICY:

It is the policy of San Mateo County to offer its low-income and uninsured residents a basic level of health care to fulfill the County's obligation to provide medical services to the medically indigent population under Section 17000 of the Welfare and Institutions Code. This health care is to be provided through the WELL Program. The objectives of this program are to optimize patient health by focusing on prevention and proactive health management, reduce per-patient expenditures by reducing inappropriate usage, 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. Populations Eligible for WELL Scope of Services

1. The following medically indigent populations, who have been screened and enrolled in other public assistance programs, are eligible for the scope of services provided through the WELL Program. All WELL fees, co-pays and charges are waived for these populations:
   - Persons receiving General Assistance in San Mateo County
   - Persons receiving services through the County's Alcohol and Other Drug programs
   - Persons under 19 years of age who are receiving services at a San Mateo County Teen Center and who are ineligible for PACT or Medi-Cal Minor Consent coverage

2. Adults who meet the residency, income and asset criteria for WELL enrollment described in the next section, are eligible for the scope of services provided through the WELL Program with payment of an annual processing fee, co-pays and charges.

B. Eligibility Criteria

1. In general, the WELL Program is designed to cover the medically indigent adult population residing in San Mateo County who meet the WELL Program's income and assets requirements and are not eligible for full-scope or share-of-cost Medi-Cal coverage, Medicare or other public or private health coverage. A patient between the ages of 19 and 21 may be eligible for the WELL Program if he/she has been denied Medi-Cal or is only eligible for restricted scope Medi-Cal services.

2. The patient must declare under penalty of perjury that he/she is a resident of San Mateo County and meets the requirements for eligibility as defined below.

   a. Residency Requirement

      Patients must be residents of San Mateo County. Residency is based on patient's actual place of residence and demonstrable intent to reside.

   b. Income Criteria

      1) Income must be equal to or lower than 200% of the Federal Poverty Level. This level is updated annually.

      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, private pensions, insurance or annuity payments, dividend income, interest rents, royalties, estates, and trusts.

      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

      1) Persons who have assets in excess of $2,000 per family unit member are not 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 principal residence and other real property, as well as any personal property that is available and easily liquidated. This includes checking and savings accounts, stocks, bonds, retirement accounts (IRAs, 401K, 403B, etc.) and life insurance.

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

3. Patients who are recipients of third party liability payment funding (e.g., Medicare, full-scope Medi-Cal, share-of-cost responsibility while covered under the Medi-Cal program, private insurance, Healthy Families, Healthy Kids or any other state, federal public or private health care coverage) are not eligible for the WELL Program.

4. Special cases that do not meet the above criteria may still be eligible for WELL Program coverage if approved by a member of the SMMC Administration.

5. Patients may be ineligible or lose coverage for the WELL Program for the following reasons:

   a. Patients who were denied Medi-Cal or other benefits due to lack of cooperation
   b. Patients who fail to apply for Medi-Cal or any other third party coverage when requested to do so.
   c. Patients holding visas issued for less than one year.
   d. Patients who fail to provide requested information.
   e. Patients who fail to cooperate under a WELL audit.
   f. Patients providing incorrect or false eligibility information. In this instance the patient will be terminated immediately from the WELL Program and billed retroactively for all prior year's services that were covered by the WELL Program.
   g. Patients who fail to pay WELL fees, co-pays and charges.

C. Verification Process

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

2. San Mateo Medical Center will request proof of income, assets, 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

      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) Property ownership document or property tax bill
      9) Membership record in a religious institution
      10) Student Identification
      11) School records
      12) Recent marriage, divorce, or evidence of domestic partnership issued in the state of California (within the last 3 months)
      13) Recent court documents showing the applicant's current address (within the last 3 months)
      14) Insurance documents
      15) Police record from a California law enforcement agency (within the last 3 months)
      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 3 months)
      18) Medical record except San Mateo Medical Center (within the last 3 months)
      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; employee W-2 form; farm business; 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 are no other ways 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

c. Proof of Assets

1) Tax records
2) Bank Accounts – bank statement dated month or prior month of application; written statement from the bank on bank stationery; current teller verification.
3) Life Insurance – copy of policy showing face value and cash surrender value; written statement from the insurance company showing face value and cash surrender value
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 assets – stock certificates; letter from broker; other property of value
7) Other proof of assets – other third party documents verifying assets of applicant can be provided

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

4. Patient eligibility for the WELL Program will be reviewed, at a minimum, annually. 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.

D. Scope of Services

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

2. The WELL Program does not cover cosmetic surgery, pregnancy-related services, Family Planning, impotence/infertility, non-medically necessary services, mental health services, 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.

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

4. The WELL 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.

E. Liens for Inpatient Stays and Same Day Surgeries

Co-pays will be charged for all inpatient stays and same day surgeries. In addition to co-pays, WELL patients must pay 35% of full charges for medical care and treatment. Patients can defer charges by completing a lien against property that the guarantor may possess or acquire in the future. The lien will secure 35% of full charges for medical care and treatment provided. If the patient is a minor, the minor's parent or guardian must sign the lien. Patients who choose not to sign a lien to defer charges will be billed for co-pays and 35% of full charges.

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. Billing

1. Each patient enrolled in the WELL Program pays an annual processing fee. This fee is payable at the time of the first service or renewal and is non-refundable.

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. Patients may have to pay a higher co-payment if billing becomes necessary.

3. An interest-free extended repayment plan will be made available to all patients based on each individual's ability to pay.

H. Notification of Enrollment or Disenrollment

1. Patients will receive a program brochure informing them of the WELL 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 disenrollment in the WELL 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.

I. Appeals Process

1. Patients will be given a notification of their right to appeal with notification of denial or disenrollment.

2. Applicants may appeal a denial or disenrollment decision by completing an appeal form and submitting this to the Patient Access Manager within 60 days of notice of denial or disenrollment. The Patient Access Manager and WELL Oversight Committee will review appeals. The applicant shall receive a written response as to the determination of the appeal within 30 working days after the appeal form is received.

J. Waiver of Co-Pays and Annual Fees

1. Fees, co-pays and charges will be waived for patients who are San Mateo County residents with income at or below 100% of the Federal Poverty Level and do not have qualifying assets that exceed $2,000 per family unit member (excluding one vehicle per adult).

2. The annual WELL processing fee, co-pays and charges are waived for these populations:
   - Persons receiving General Assistance
   - Persons receiving services through the County's Alcohol and Other Drug programs
   - Persons receiving services at a San Mateo County Teen Center who are ineligible for PACT or Medi-Cal Minor Consent coverage

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

Implementation: 1/83

Reviewed and approved by:	Date:
RI Function Leader	5/02, 11/02
Director, Patient Financial Services	9/03, 4/04, 10/04
Patient Services Supervisor	10/04
Patient Access Manager	7/05
Chief Financial Officer	4/04, 10/04, 7/05
Chapter Chair	4/04, 11/04
Medical Executive Committee	5/04
Hospital Board	7/96, 6/04

ATTACHMENT D

SUBJECT:	DISCOUNTED HEALTH CARE (DHC) PROGRAM
DEPARTMENT:	FINANCIAL SERVICES: PATIENT ACCESS
AUTHOR:	CHIEF FINANCIAL OFFICER

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 WELL Program for the medically indigent or other financial assistance. This policy represents the County's discounted healthcare policy, and is one of several policies and programs that demonstrate the Medical Center's "safety net" mission to provide a basic level of health care coverage to low-income and uninsured patients.

PROCEDURE:

1. Definition of Discount

   A. The Discounted Health Care (DHC) Program offers a 50% discount to patients who meet the eligibility criteria for residency, income and assets and want to pay their share of the bill, but are unable due to their financial situation. The self-pay portion of a patient's bill may include all billed charges or non-covered charges, denied charges, deductibles, or the share-of-cost responsibility while covered under the Medi-Cal program.

   B. The County Board of Supervisors sets the discount rate for the DHC Program.

2. Eligibility Criteria

   San Mateo County residents whose income is at or below 400% of the Federal Poverty Level, do not qualify for the WELL program or other financial assistance, and do not have assets that exceed a total of $15,000 per family (excluding one vehicle per adult and principal residence), qualify for the DHC Program.

3. Scope of Services

   The Discounted Health Care (DHC) Program will provide the same scope of services covered by the County's WELL Program. 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.

4. Application Process

A. 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 residency, income and assets tests to qualify for the DHC Program. The patient's unique circumstances may be taken into consideration.

B. Patients applying for the DHC Program 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 Medical Center 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.

C. 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.

D. 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. Efforts will be made to provide assistance in the primary language of the patient or patient's guarantor.

E. 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 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.

F. 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.

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

H. Approval for the DHC Program must follow the Medical Center's level of signature authority.

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

5. Verification Process

A. In order to qualify for the DHC Program, patients must satisfy eligibility requirements including residency, income and assets. 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.

B. San Mateo Medical Center will request proof of residency, income and assets. Proof must be timely and valid for the last 45 days. This requirement can be satisfied in the following ways:

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) Property ownership document or property tax bill
9) Membership record in a religious institution
10) Student Identification
11) School records
12) Recent marriage, divorce, or evidence of domestic partnership issued in the state of California (within the last 3 months)
13) Recent court documents showing the applicant's current address (within the last 3 months)
14) Insurance documents
15) Police record from a California law enforcement agency (within the last 3 months)
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 3 months)
18) Medical record except San Mateo Medical Center (within the last 3 months)

19) Voided personal check with pre-printed address
20) Other proof of residency – other third party documents verifying residency of applicant can be provided

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; employee W-2 form; farm business; 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 are no other ways 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 Assets

1) Tax records
2) Bank Accounts – bank statement dated month or prior month of application; written statement from the bank on bank stationery; current teller verification.
3) Life Insurance – copy of policy showing face value and cash surrender value; written statement from the insurance company showing face value and cash surrender value
4) Property excluding 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 assets – stock certificates; letter from broker; other property of value
7) Other proof of assets – other third party documents verifying assets of applicant can be provided

6. Notification of Enrollment or Disenrollment

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

B. 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.

C. Patients can dispute a disenrollment through the appeals process.

7. Appeals Process

A. Applicants may appeal a denial or disenrollment decision by completing an appeal form and submitting this to the Patient Access Manager within 60 days of notice of denial or disenrollment. The Patient Access Manager and WELL Oversight Committee will review appeals. The applicant shall receive a written response as to the determination of the appeal within 30 working days after the appeal form is received.

B. Patients will be given a notification of their right to appeal with notification of denial or disenrollment.

8. Billing and Collections Practices

A. The Medical Center is committed to a minimum of 90 days billing prior to assigning a self-pay account to a bad debt collection agency. Information regarding residency, income and asset status should be provided as soon as possible.

B. An interest-free extended repayment plan will be made available to all patients based on each individual's ability to pay.

C. The San Mateo Medical Center's billing and collections department will adhere to the Medical Center's values and mission as a "safety net" institution. An extended repayment plan will be made available to patients who qualify.

D. Patient statements will contain information indicating that the patient may be eligible for financial assistance and who to contact for further information.

9. Notification of Availability

A. The Medical Center will publicly post information regarding the availability of the discount provided through the Discounted Health Care (DHC) Program. 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 Medical Center's web site, and statements on patient's bills indicating the availability of financial assistance.

B. Upon request, the Medical Center will make available its financial assistance policies. In addition, posted information will include the Medical Center's contact for further information about this policy.

ATTACHMENT E

SUBJECT:	SELF-PAY PROMPT-PAY DISCOUNT AND EXTENDED REPAYMENT POLICY
DEPARTMENT:	FINANCIAL SERVICES: PATIENT BILLING
AUTHOR:	CHIEF FINANCIAL OFFICER

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 the Medical Center 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.

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 the Medical Center 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 (i.e., O/P Medicare Drugs). It does not apply to co-payments, co-insurance, share-of-cost, deductibles, or annual fees.

4. 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 to all patients based on each individual's ability to pay.

5. 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.