COUNTY OF SAN MATEO

County Manager's Office

DATE: December 8, 2005
BOARD MEETING DATE: December 13, 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 improvement of the appeals process, 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.
   - Patients can choose to defer charges by signing a lien

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.

4. **Appeals Process**
   - A two-step appeals process will be put in place. The first step will be an Individual Eligibility Review conducted by the Medical Center's Chief Financial Officer or his/her designee. The second step is the appeal to the Eligibility and Financial Review Committee consisting of a public member selected by the County Manager, a representative from the Medical Center, and a representative from the County Manager's Office.

A Financial Assistance Policy Review group will be part of the process to review future changes to standards of aid for recommendation to the Board. This group will include a community member and representatives from the Medical Center, Health Department, Human Services Agency, and County Manager's Office.

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 Fee 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 Option to defer charges by signing lien for 50% of charges interest-free	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 Option to defer charges by signing lien for 50% of charges interest-free	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. Two-step appeals process. Appeals must be filed 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 Step – Request for Individual Eligibility Review Second Step – Appeal to Eligibility and Financial Review 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 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 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

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
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). 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. Notice of the Right to Apply for Financial Assistance

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, 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 if they qualify. 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. 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.

D. 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; ineligible for other public/private health coverage	Medically Indigent 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 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); **Fee 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 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.

   b. All fees, co-pays and charges will be waived for patients who qualify for other County-sponsored public assistance programs and are ineligible for Medi-Cal or other private/public health coverage. 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.

   c. Fee 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, and deductibles.

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, 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. 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 by the San Mateo Medical Center within a year of the adoption of the financial assistance policies 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.

F. Appeals Process

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

   Every individual who has been disenrolled, or has been denied eligibility, 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 WELL Program eligibility. The second appeal step shall be before the "eligibility and financial review committee" (EFRC).

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

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

a. Timeline for Step-One Application

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

b. Content of Request for Individual Eligibility Review

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

c. Individual Eligibility Review Decision-Maker

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

d. Timeline for Decision

The Chief Financial Officer or his/her designee shall make a written decision to affirm or reverse the initial County determination within 30 days after the Request for Individual Eligibility Review form has been received. 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 Deputy County Manager or his/her designee and a public member to be chosen by the County Manager's office.

d. Timeline for Decision

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

4. Anytime Request for Eligibility and Financial Review

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

G. Periodic Board Reports

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

H. Notification and Posting of Financial Assistance Programs

1. SMMC will publicly post information on its financial assistance programs. This includes the distribution of pamphlets and letters, public notices in visible locations where there is a high volume of patient registrations, information contained on the SMMC web site, and statements on patients' bills indicating the availability of financial assistance.

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
SAN MATEO COUNTY MEDICALLY INDIGENT POLICY
(WELL 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 Wellness, Education, Linkages, Low-Cost (WELL) Program. This policy outlines the specifics of the WELL 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 WELL 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 WELL 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 WELL Scope of Services

1. County residents who have been screened and enrolled in the following public assistance programs are eligible for the WELL 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 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

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

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

C. WELL 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. 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, 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) 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 principal residence and other real property. Under no circumstance does the County expect a patient to foreclose on their principal place of residence in order to pay for medical care. To the extent this is a concern for patients who are ruled ineligible for the WELL Program solely as a result of home ownership, the patient may raise this issue as a special consideration in appealing their eligibility denial, pursuant to the appeal process outlined in Section M.

3) Assets also include personal 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 life insurance.

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

2. 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, or any other state, federal public or private health care coverage) are <u>not</u> eligible for the WELL Program.

3. Every individual who has been disenrolled, or has been denied eligibility, or who wishes to request a waiver or reduction of co-pays, fees or charges shall have the right to 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 WELL Program eligibility. The second appeal step shall be before the "eligibility and financial review committee" (EFRC).

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

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

   - Patients who were denied Medi-Cal or other benefits due to lack of cooperation
   - Patients who fail to apply for Medi-Cal or any other third party coverage when requested to do so.
   - Patients holding visas issued for less than one year.
   - Patients who fail to provide requested information.
   - Patients who fail to cooperate under a WELL audit.
   - 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 WELL Program services during the period of time in which the information was incorrect or false.

- Patients who fail to pay WELL fees, co-pays and charges.

D. Verification Process

1. In order to qualify for the WELL 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 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 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) Principal 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 three months)
      13) Recent court documents showing the applicant's current address (within the last three months)
      14) Insurance documents
      15) Police record from a California law enforcement agency (within the last three 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 three months)
      18) Medical record except San Mateo Medical Center (within the last three 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 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 – 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.

E. Notice of the Determination of Eligibility

Individuals who apply for the WELL Program will be informed in writing if they qualify. The letter will provide information about the right to an individual eligibility review and the right to appeal a denial or discontinuance of coverage.

F. Scope of Services

1. The WELL Program scope of services is similar to those covered by 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 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.

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 WELL Program brochure provided to each eligible patient.

I. Charges and Liens for Inpatient Stays and Same Day Surgeries

In addition to co-pays, WELL patients must pay 35% of full charges for medical care and treatment for inpatient stays and same day surgeries. 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.

J. Annual Processing Fee, Co-Pays and Charges

1. Each patient enrolled in the WELL Program pays an annual processing fee of $250. 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.

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 by the San Mateo Medical Center within a year of the adoption of this policy to all patients based on each individual's ability to pay.

K. 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 Appeal Process set forth in Section M below.

L. Waiver of Co-Pays and Annual Fees

1. The WELL Program's annual processing fee, co-pays and charges will be waived for the following San Mateo County residents:

   a. Patients 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).
   b. Persons receiving General Assistance ineligible for Medi-Cal.
   c. Persons receiving services through the County's Alcohol and Other Drug programs not eligible for Medi-Cal.
   d. Persons receiving services at a San Mateo County Teen Center who are ineligible for PACT or Medi-Cal Minor Consent coverage.
   e. Persons who are unable to pay as determined through the appeals process.

2. 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.

3. The eligible populations outlined in #1 above shall receive a WELL Program enrollment form and brochure explaining the fact that they are not required to pay an annual fee, co-pays, charges or liens.

M. Appeals Process

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

   Every individual who has been disenrolled, or has been denied eligibility, 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 WELL Program eligibility. The second appeal step shall be before the "eligibility and financial review committee" (EFRC).

   Every individual who has been disenrolled, or has been denied eligibility, or who is assessed co-pays, fees or charges shall receive written notice of (1) the denial, discontinuance or charges; (2) the right to have the denial, discontinuance, or fees, co-pays and charges reviewed through the IER process based on ability to pay; and (3) a

specific description of the appeals process and timelines. An individual who can demonstrate inability to pay shall be entitled to a reversal of the County's initial determination on eligibility, fees, co-pays or charges.

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

a. Timeline for Step-One Application

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

b. Content of Request for Individual Eligibility Review

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

c. Individual Eligibility Review Decision-Maker

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

d. Timeline for Decision

The Chief Financial Officer or his/her designee shall make a written decision to affirm or reverse the initial County determination within 30 days after the Request for Individual Eligibility Review form has been received. 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 Deputy County Manager or his/her designee and a public member to be chosen by the County Manager's office.

   d. Timeline for Decision

   The EFRC shall make a written decision to affirm or reverse the IER determination within 30 days after the appeal has been received. 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.

N. Periodic Board Reports

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

ATTACHMENT D
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 WELL Program 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:

A. Notice of the Right to Apply for DHC 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 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 if they qualify. 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 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, and deductibles.

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

D. 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.

E. Scope of Services

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

Patients can defer charges by completing a lien against property that the guarantor may possess or acquire in the future. The lien will secure 50% 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 50% of full charges.

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 residency, income and assets tests 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 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.

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

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 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.

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 the Medical Center's Patient Billing and Collections office.

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

9. 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.

I. Verification Process

1. 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.

2. 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:

   <u>Proof of Residency</u>

   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
   10) Student identification
   11) School records
   12) Recent marriage, divorce, or evidence of domestic partnership issued in the state of California (within the last three months)

13) Recent court documents showing the applicant's current address (within the last three months)
14) Insurance documents
15) Police record from a California law enforcement agency (within the last three 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 three months)
18) Medical record except San Mateo Medical Center (within the last three 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 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 Assets

1) Tax records
2) Bank Accounts – bank statement for the 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

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 County 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 WELL Program eligibility. The second appeal step shall be before the "eligibility and financial review committee" (EFRC).

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

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

   a. Timeline for Step-One Application

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

   b. Content of Request for Individual Eligibility Review

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

   c. Individual Eligibility Review Decision-Maker

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

   d. Timeline for Decision

   The Chief Financial Officer or his/her designee shall make a written decision to affirm or reverse the initial County determination within 30 days after the Request for Individual Eligibility Review form has been received. 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 Deputy County Manager or his/her designee and a public member to be chosen by the County Manager's office.

d. Timeline for Decision

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

4. Anytime Request for Eligibility and Financial Review

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

L. Periodic Board Reports

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

M. Billing and Collections Practices

A. 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 by the San Mateo Medical Center within one year of adoption of this policy 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.

ATTACHMENT E
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 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). 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 met their share of cost. It does not apply to co-payments, co-insurance, 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 by the San Mateo Medical Center within one year of adoption of this policy 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.

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 WELL Program eligibility. The second appeal step shall be before the "eligibility and financial review committee" (EFRC).

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

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

a. Timeline for Step-One Application

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

b. Content of Request for Individual Eligibility Review

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

c. Individual Eligibility Review Decision-Maker

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

d. Timeline for Decision

The Chief Financial Officer or his/her designee shall make a written decision to affirm or reverse the initial County determination within 30 days after the Request for Individual Eligibility Review form has been received. 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 Deputy County Manager or his/her designee and a public member to be chosen by the County Manager's office.

d. Timeline for Decision

The EFRC shall make a written decision to affirm or reverse the IER determination within 30 days after the appeal has been received. 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.