SAN MATEO COUNTY HEALTH
SAN MATEO MEDICAL CENTER

Financial Assistance Policy

Last Revised
January 2025

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FINANCIAL ASSISTANCE PROGRAMS POLICY OVERVIEW

Policy Statement

It is the policy of San Mateo Medical Center (SMMC) to provide medical services to all individuals, regardless of their ability to pay, and to provide financial assistance to eligible patients who are uninsured, underinsured, ineligible for third-party assistance or have low income.

Patients presenting with an emergency medical condition will be provided with emergency medical services and care without regard to their ability to pay or their financial status. The financial screening process will begin prior to discharge, but only after a Medical Screening Examination (MSE) has occurred.

It is the intent of the SMMC policy to comply with all federal, state, and local regulations. If any regulation, current or future, conflicts with this policy, the regulation will supersede this policy. SMMC's financial assistance practices and adherence to hospital billing and collection laws, are reflective of SMMC's commitment to complying with fair billing and pricing policies as established by the California Hospital Fair Pricing Act, Health and Safety Code §127400 et al., and the Fair Debt and Collections Act, 15 U.S.C.1692.

Purpose

San Mateo Medical Center (SMMC) provides emergency, outpatient, and inpatient, diagnostic, and therapeutic services across multiple locations. In recognition of this, SMMC must adhere to a comprehensive Financial Assistance Policy, which serves to define criteria applied to assess a patient's unique financial situation as it relates to healthcare services provided by SMMC. Further, it is within the scope of this policy, to explain roles and responsibilities, and provide basic guidance for key patient financial activities performed by those persons and parties involved in the financial matters related to clinical services rendered by SMMC.

The SMMC Financial Assistance Policy has been developed to maintain fiscal viability while providing quality customer service, respect and to ensure equal and appropriate access to medical care for all patients, while assuming consistent and transparent handling of patient accounts. Such a policy is necessary to support the understanding for all parties involved in these often-complex patient financial matters. This policy directly assists patients by reducing the uncertainty of their financial responsibilities while also helping to keep SMMC financially viable so that we may continue to carry out our mission of delivering excellent patient care.

FINANCIAL ASSISTANCE PROGRAMS CHARTS

Overview Chart

Applied in the Following Order	Description	General Qualifications
External Government-Sponsored Programs	Medi-Cal, Covered California, Improving Access, Counseling and Treatment Program (IMPACT), Every Woman Counts (EWC), Breast and Cervical Cancer Treatment Program (BCCTP), and Medicare	Based on specific program's guidelines and eligibility
Access and Care for Everyone (ACE) Program	County sponsored coverage for medically indigent adults who meet program requirements	County resident, uninsured, income at or below 200% of Federal Poverty Level (FPL)
Charity Care Program	Complies with the charity care mandates of the California Hospital Fair Pricing Act; This program is available to assist uninsured or underinsured patients who are not eligible for other government programs.	Not limited to San Mateo County residents. Must have household income at or below 138% of Federal Poverty Level (FPL). All SMMC services are covered except for prescription benefits. Patients receiving charity care pay no annual fees or copayments.
Discounted Health Care (DHC) Program	Provides a 65% discount of total charges – not to exceed the amount of payment the hospital would expect to receive from Medi-Cal or Medicare	Uninsured and underinsured patients whose household income is at or below 400% of the Federal Poverty Level (FPL)
HCH/FH Sliding Fee Discount Program	Offers a sliding fee scale ($0-30) for patients experiencing homelessness or who are farmworkers	Patients experiencing homelessness or are farmworkers and their dependents whose household income is under 200% FPL
Self-Pay Prompt-Pay Discount	Provides a 50% discount for payments received within 30-days of first bill date; for patients who do not qualify for other programs	No income or residency requirement; required to pay deposit in advance of receiving non-emergent services
Self-Pay Extended Repayment Plan	Allows for payment of full charges over an established repayment period, not to exceed 24 months; for patients who do not qualify for other programs	No income or residency requirement; required to pay deposit in advance of receiving non-emergent services

San Mateo County Health Coverage Programs for Adults Chart

Eligibility Criteria	No Cost Medi-Cal	Share of Cost[1] Medi-Cal	ACE	Temporary ACE	ACE Excess Income with Chronic Disease	Kaiser Community Health Care Program (CHCP)	Covered California (CC)	DHC[2]	Self-Pay	Charity Care
Residency Requirement	California	California	San Mateo Co.	San Mateo Co.	San Mateo Co.	Kaiser Service Area	California	None	None	None
Age	No limit	No limit	21 and above	21 – 64	21 and above	0 – 64	No limit	No limit	No limit	No limit
Income Limit Federal Poverty Limit (FPL)	0 – 138% 0 – 213% for pregnant women[3]	138.01% – Up[3]	138.01% – 200%	138.01% – 200%	200.01% – 225%	138.01% – 300%	138.01 – 400% or higher[4]	0 – 400%	No limit	0 – 138%
Asset Limit	No Asset Limit	No Asset Limit	No Asset Limit	No Asset Limit	No Asset Limit	No Asset Limit	No Asset Limit	No Asset Limit	No Asset Limit	No Asset Limit
Immigration / Citizenship Requirements	None	None	None	Lawfully present immigration status required	None	None	Lawfully present immigration status required	None	None	None
Other Requirements	None	Must have linkage to be eligible. Linkage includes: • Under 21 years old • Pregnant women • Parents of children living with them who are under 21 • 65+ years old • Blind • Disabled	Must not be eligible for No Cost or Share of Cost[1] Medi-Cal.	Must not be eligible for No Cost or Share of Cost[1] Medi-Cal. Must not be eligible for a CC Special Enrollment Period.	Must not be eligible for No Cost or Share of Cost[1] Medi-Cal. Must not be eligible for a CC Special Enrollment Period. Must be experiencing a financial hardship and have a chronic condition.	Must not be eligible for No Cost Medi-Cal. Must not be eligible for a CC Special Enrollment Period. May only apply during open enrollment or during a special enrollment period.	Must not be eligible for No Cost Medi-Cal. May only apply during open enrollment or during a Special Enrollment Period.	None	None	None

[1] A Share of Cost (SOC) is the amount of money an individual is responsible to pay towards their medical-related services, supplies, or equipment before Medi-Cal will begin to pay.
[2] DHC charges will not exceed the highest amount that SMMC receives for medical services from Medicare, Medi-Cal, or other government-sponsored programs.
[3] Income limits are higher for children 0 – 18. See Poverty Guidelines for 2024 chart for details.
[4] Consumers at 400% FPL or higher may receive a federal premium tax credit to lower their premium to a maximum of 8.5% of their income based on the second-lowest cost Silver plan in their area. Click this link to review the chart.
[5] Metal tier Platinum-level plans cover 90% of health care costs; Gold plans cover 80%; Silver plans cover 70%; and Bronze plans cover 60%. Plans in higher metal categories have higher monthly premiums with lower out-of-pocket costs when medical care is needed.

SAN MATEO COUNTY HEALTH: FINANCIAL ASSISTANCE POLICY

Eligibility Criteria	No Cost Medi-Cal	Share of Cost[1] Medi-Cal	ACE	Temporary ACE	ACE Excess Income with Chronic Disease	Kaiser Community Health Care Program (CHCP)	Covered California (CC)	DHC[2]	Self-Pay	Charity Care
Monthly / Annual Fee	None	None	$360/yr.	$360/yr.	None	None	Monthly premium varies based on metal tier selected [5]	None	None	None
Payment for Outpatient Visits	None	Share of Cost[1]	$15	$15	$15	None	Varies based on metal tier selected[5]	65% discount varies[2] Deposit requested	Varies - patients have 30 days from the bill date to receive a 50% discount; they must pay 100% after 30 days. Deposit requested	None
Payment for Inpatient Stays & Same Day Surgeries	None	Share of Cost[1]	$300 co-pay	$300 co-pay	$300 co-pay	None	Varies based on metal tier selected[5]	65% discount Varies[2] Deposit requested	Varies - patients have 30 days from the bill date to receive a 50% discount; they must pay 100% after 30 days. Deposit requested	None

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SAN MATEO COUNTY HEALTH: FINANCIAL ASSISTANCE POLICY

Eligibility Criteria	No Cost Medi-Cal	Share of Cost[1] Medi-Cal	ACE	Temporary ACE	ACE Excess Income with Chronic Disease	Kaiser Community Health Care Program (CHCP)	Covered California (CC)	DHC[2]	Self-Pay	Charity Care
Interest-Free Repayment Plan Available Based on Ability to Pay	Not applicable	Yes	Yes	Yes	Yes	Not applicable	Not applicable	Yes	Yes	Not applicable
Prescriptions	None	Share of Cost[1]	$7	$7	$7	None	Varies based on the metal tier selected[5]	65% discount	50% discount	Not Covered
Enrollment Coverage Period Restrictions / Retroactive Coverage	Once the application is approved, coverage begins the first day of the month the application was submitted. Retro coverage is available up to three months prior to the coverage effective date.[6]	Once the application is approved, coverage begins the first day of the month the application was submitted. Retro coverage is available up to three months prior to the coverage effective date.[6]	Once the application is approved, coverage begins the first day of the month the application was submitted. SMMC may waive bills in the three months prior to the coverage effective date.	Only available AFTER CC open enrollment has closed. It always ends 12/31 of the current year. SMMC may waive bills in the three months prior to the coverage effective date, but not before the end of the CC open enrollment period.	Once the application is approved, coverage begins the first day of the month the application was submitted. SMMC may waive bills in the three months prior to the coverage effective date.	Once the application is approved, coverage begins the first day of the following month. SMMC may waive bills in the three months prior to the coverage effective date.	First day of the month following plan selection SMMC may waive bills in the three months prior to the coverage effective date.	Limited to 6 months from the date of service	Not applicable	Limited to 6 months from the date of service

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SAN MATEO COUNTY HEALTH: FINANCIAL ASSISTANCE POLICY

Eligibility Criteria	No Cost Medi-Cal	Share of Cost[1] Medi-Cal	ACE	Temporary ACE	ACE Excess Income with Chronic Disease	Kaiser Community Health Care Program (CHCP)	Covered California (CC)	DHC[2]	Self-Pay	Charity Care
How to Apply	Benefits Cal, SSApp or CalHEERS	Benefits Cal, SSApp or CalHEERS	HCU_ SMC_Health App	HCU_ SMC_HealthApp	Excess Income/Chronic Disease Application and HCU_SMC_HealthApp	E-mail – see instructions	CalHEERs	HCU_ SMC_Health App or SMMC Financial Assistance Program Application	None	SMMC Financial Assistance Program Application

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NOTIFICATION AND POSTING OF FINANCIAL ASSISTANCE PROGRAMS

Individuals who receive medical services at the San Mateo Medical Center (SMMC) shall be provided an understandable written notice detailing their right to apply for various financial assistance programs and shall be provided with information regarding the application process. SMMC will make available a plain language written financial assistance policy detailing discount payments and charity care for financially qualified patients.

SMMC will clearly and conspicuously post information about its financial assistance programs in locations that are visible to the public, including, but not limited to all the following:

- The California Department of Health Care Access and Information (HCAI) website
- Emergency Department registration
- Clinic and Outpatient registration
- Patient Financial Services
- Business Services
- Admitting Department
- Long-Term Care registration
- Same Day Surgery Unit registration
- SMMC website

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

All notices and postings of financial assistance programs will be made available in English and languages other than English. The languages to be provided shall be determined in a manner similar to that required pursuant to Section 12693.30 of the Insurance Code.

APPLICATION PROCESS FOR OBTAINING FINANCIAL ASSISTANCE

1. Uninsured patients will be given a written notice about the availability of financial assistance and the qualifying criteria, along with an application for financial assistance as soon as practical. The notice and application will be provided to patients at the time of service if the patient is conscious and able to receive written notice. If the patient is not able to receive it at the time of service, the notice and application will be provided during the discharge process. If the patient is not admitted, the written notice and application will be provided when the patient leaves the facility. If the patient leaves the facility without receiving the written notice, the hospital will mail the notice and application to the patient within 72 hours of providing service.

2. SMMC will make every effort to determine a patient's eligibility for financial assistance as soon as possible. The financial assistance program application must be submitted within 6 months from the date of service. Any applications received 6 months after the date of service will be considered on a case-by-case basis.

3. If a patient applies, or has a pending application, for another health coverage program while the patient applies for Charity Care or the Discounted Health Care program, neither application shall preclude eligibility for the other program. Collection activity will be postponed while applications for health coverage or other sources of payment are still pending.

4. Financial assistance will be considered for any patient who indicates an inability to pay for medical services. SMMC will make available the assistance of HCU staff to determine the appropriate financial assistance program and to initiate the application.

   HCU is charged with matching the patient with the appropriate financial assistance program based on the patient's unique financial situation. Patients must be screened for ACE eligibility before being enrolled in the Charity Care or Discounted Health Care programs.

5. HCU staff will aid in the primary language of the patient or patient's guarantor. When staff do not speak the patient's preferred language, they will make use of the contracted interpreter services language line to ensure good communication.

6. SMMC will make reasonable efforts to determine whether a patient is eligible for financial assistance based on prior eligibility for financial assistance or the use of third-party data to identify financially eligible patients, or through notification and processing of applications as specified in 16 C.F.R. 1-501(r)-6(c)(2) and (3). When eligibility is determined based on prior eligibility, it will be documented by a note in Invision/OAS Gold and a new application and verifications will not be required.

7. Patients seeking financial assistance from SMMC are expected to make reasonable efforts to provide personal and financial information that is complete and accurate. Patients applying for financial assistance must consent to verification and investigation of eligibility by SMMC staff, agents, or contractors. To determine eligibility, SMMC may request different or additional forms of documentation for verification of income, identity, or residency in cases where the genuineness and/or validity of the provided documents is reasonably questioned or where the provided documents raise further questions as to eligibility.

8. At any point that patients provide their information, they will be assessed for eligibility and assisted with the corresponding health program enrollment. Patients are encouraged to make reasonable efforts to provide their information in a timely manner to maximize the coverage benefit to the patient.

9. Patients must meet certain eligibility criteria, depending on the program, including being uninsured or underinsured and meeting residency and income requirements to qualify for financial assistance. A patient's unique circumstances may be taken into consideration when determining coverage for such services.

10. Once patients have applied for or been enrolled in a financial assistance program, they are required to report within 10 days any changes in circumstances that will affect their eligibility for the program, such as income, insurance/health coverage status and county residency.

11. At a minimum, an application for financial assistance must be renewed and updated annually and prior to an inpatient stay, same-day surgery and/or infusion therapy. This is required to incorporate and allow consideration of any changes to a patient's financial status. SMMC shall determine and may modify the period of eligibility for any individual entitled to receive services covered under the financial assistance programs.

12. All uninsured patients who present for financial screening with incomplete verifications will be provided with a list of required verifications to complete their application. Prior to determining eligibility for the SMMC financial assistance programs, required verifications must be presented.

13. All applications will be made available in English and languages and languages other than English. The languages to be provided shall be determined in a manner similar to that required pursuant to Section 12693.30 of the Insurance Code.

14. The financial assistance policies apply to services provided by physicians or other medical providers practicing at SMMC, unless contractually obligated through a third-party billing arrangement with SMMC which permits services to be separately billed from SMMC provider services. SMMC emergency room providers are contract providers who bill the professional component of the visit separately from SMMC providers. They are also required by law to provide discounts to uninsured patients and/or patients with high medical costs whose household income is at or below 400% FPL.

15. A list of providers who deliver medically necessary care at SMMC and are covered by the Financial Assistance policy can be found here – Find a Doctor - San Mateo Medical Center (smchealth.org)

16. The Health Coverage Unit (HCU) and/or a patient registration staff may enroll or assist patients to apply for the following state and local programs. In some cases, enrollment is processed at the point of service. Patients are referred to some programs based on specific diagnosis. In addition, San Mateo County Certified Enrollment Counselors (CECs), who are County Health or community-based organization staff, assist with enrollments in some of the public health coverage programs listed below such as ACE, Covered California and Medi-Cal. CECs are trained and certified on the eligibility and enrollment processes by the Department of Health Care Services, Covered California, and HCU.
    a. Access and Care for Everyone (ACE)
    b. AIDS Drug Assistance Program (ADAP)
    c. California Children's Services (CCS)
    d. Charity Care
    e. Covered California
    f. Discounted Health Care (DHC)
    g. Every Woman Counts (EWC)
    h. HCH/FH Sliding Fee Scale
    i. Improving Access Counseling and Treatment Program (IMPACT)
    j. Medi-Cal
        i. Modified Adjusted Gross Income (MAGI) Medi-Cal

ii. Non-MAGI
iii. Breast Cervical Cancer Treatment Program (BCCTP)
iv. Newborn Gateway Presumptive Eligibility (NGPE)
v. Children Presumptive Eligibility (CPE)
vi. Hospital Presumptive Eligibility (HPE)
vii. Presumptive Eligibility for Pregnant Women (PE4PW)
viii. Medi-Cal Access Program (MCAP)
ix. Medi-Cal County Inmate Program (MCIP)
x. Medi-Cal Presumptive Eligibility for Pregnant Women
xi. Tuberculosis Medi-Cal
xii. Working Disabled Program (WDP)
xiii. County Children's Health Insurance Program (CCHIP)

k. Ryan White
l. Victim of Crime Program

Individuals who apply for financial assistance will be informed in writing regarding their eligibility status, and the basis for determination. The notice will provide information about the right to an individual eligibility review, the right to appeal a denial or discontinued coverage and their right to reapply. If the denial is for failure to provide required verifications, the notice will also include information about which specific verifications are needed to complete the application process.

Assets

None of the financial assistance programs covered by this policy has an asset limit.

Household Size

An applicant's household size is an important factor for determining eligibility for the SMMC's financial assistance programs. Income eligibility is based on the Federal Poverty Level (FPL), and you need the number of people in a household to determine the FPL.

The financial assistance programs follow MAGI Medi-Cal guidelines in establishing who counts in a household. MAGI household size guidelines provide for both tax filer rules and non-filer rules. Tax-filer rules establishes that the household consists of the tax-filer and all individuals expected to be claimed as a tax dependent. If the tax filer is married, the spouse is always counted unless they are living apart and filing taxes separately. Non-filer rules dictate that household size consists of the individual, plus their spouse and children under the age of 19 (if a full-time student, under age 21). Both tax-filer and non-filer rules add to the household size the number of children expected for any pregnant household member.

The MAGI Household Flow Chart shows which individuals are counted in the composition of the household. Click this link for the MAGI Medi-Cal Household Flow Chart.

Identity

Applicants must provide proof of identity when applying for a health coverage program. The applicant may provide any one document from the lists below. Even if the document has expired, it is still an acceptable verification.

Proof of Identity

Acceptable identification documents in order of priority:

- California driver's license or California DMV identification card
- U.S. passport or other U.S. federal government identification
- Other state driver's license or DMV identification card
- Photo in SMMC's eClinicalWorks (eCW)
- Foreign government identification document (consular ID card, passport, national ID card, or national voter card).

If documents listed above are not available, other acceptable documents, in order of priority include:

- Birth certificate
- Social Security card
- Medicare card
- Medi-Cal card
- Health Plan of San Mateo card
- Bank card with photo ID
- Two signed affidavits attesting to the identification of the patient photo identification from both parties who signed them.

Income

The SMMC financial assistance programs follow MAGI Medi-Cal guidelines when determining countable income, non-countable income, and allowable deductions. Refer to this job aid provided by Centers for Medicare & Medicaid Services (CMS) for more detailed information than the information below.

Income Counted

Income is defined as total or gross cash receipts, wages, salaries and bonuses, before taxes and from all sources. It includes self-employment income, tips and gratuities, regular payments from Social Security, Unemployment Compensation, strike benefits, training stipends, alimony, 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, capital gains/losses, interest, tax refunds, rents, royalties, estates, and trusts.

The following Social Security income will be counted: Retirement, Survivor's, Disability Income (RSDI), Federal Retirement, and Federal Disability.

Income Not Counted

The following Social Security income will not be counted: Supplemental Security Income (SSI) and State Supplemental Payment (SSP).

Other income that will not be counted include child support received, workers compensation, gifts and inheritances, child tax credit payments, military allowances, veteran's benefits and portion of scholarships, awards, fellowships used for education purposes, state disability insurance (SDI) and public assistance payments.

Deductions

Income may be offset with the following deductions: education expenses; business expenses of reservists, performing artists and fee-basis government officials; health savings account

contributions; moving expenses; deductible part of self-employment tax; self-employed, simple and qualified deduction; self-employed health insurance deduction; penalty on early withdrawal of savings; alimony paid; IRA deduction; student loan interest; tuition and fees; and domestic production activities.

Proof of Income

Income verification documentation for Charity Care and ACE must be dated within the last 90 days, except for tax returns, award letters or other proof of irregular income which can exceed the 90 days. For the Discounted Health Care program, income verifications must be dated within a 6-month period before or after the patient is first billed by the hospital, or when there haven't been any visits, within 6-months prior to the application submission date. For DHC, tax returns, award letters or other proof of irregular income can exceed the 6-months. Applicant must provide proof of all forms of income for each household member.

- Unemployment – employer's records; EDD records; UIB check; layoff notice; training program records; training stipends; union records.

- 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.

- Affidavit - 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

- 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.

- Unearned Income – Social Security Administration (SSA) award letter, official correspondence from SSA, bank statement showing SSA deposit; alimony; government and private pension checks; insurance/annuities checks, correspondence; bank statements verifying interest income; rents; dividends; royalties; estates and trusts; military or other regular support from an absent family member or someone not living in the household.

- Other proof of income – other third-party documents verifying income of applicant can be provided

Insurance/Health Coverage Status

Governmentally Sponsored Programs and Third-Party Payers

Patients must be screened and enrolled in governmentally sponsored programs such as Medi-Cal, Medicare, Covered California, IMPACT, EWC, etc. and/or provide all available third-party payer information prior to being enrolled in a SMMC financial assistance program. The applicant's eligibility for some of these programs, but not all, may preclude their eligibility for the SMMC financial assistance programs. Under some of 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 waived.

Patients must make reasonable efforts to comply in a timely manner with the screening process by providing all required information regarding any other coverage and in pursuing third parties who may be liable for incurred health care expenses. Patients who do not cooperate in the application process could be found ineligible for financial assistance programs.

Information Regarding Third-Party Payers

Third-party insurance is a form of liability insurance purchased by an insured (first party) from an insurer (second party) for protection against the claims of another (third party). The patient is responsible for their charges, regardless of who is at fault for their injury or illness, but SMMC will bill to the third-party payor as a courtesy to the patient. Automobile and Worker's Compensation insurance is one of the most common types of third-party insurance.

Proof of Insurance Coverage

Insurance/health coverage status is determined by asking applicants for information and by checking available systems to confirm information. Examples of acceptable verifications of insurance coverage are as follows:

- eCareNext
- Medi-Cal/Medicare
  databases HPSM
  HealthTrio
- Verbal or electronic confirmation from health insurance company
- Letter from employer stating status of employer-sponsored health insurance

Additional Sources of Information Regarding Insurance/Health Coverage Status

- Auto insurance or liability information
- Notices regarding eligibility for government
  programs
- Results of lawsuits

Out-of-Pocket Medical Expenses

SMMC may require documentation to establish the out-of-pocket medical expenses that the applicant is financially responsible for to determine eligibility for the DHC program.

Residency

Only the ACE program has a San Mateo County residency requirement. San Mateo County residency may be self-declared.

When San Mateo County residency is questionable, the verifications listed below can satisfy the residency requirement.

Proof of Residency

- Car registration
- Voter registration
- California driver's license or ID card
- Employment record including offer letter, pay stubs, lay-off notice, employment or registration contract with an employment service, employer affidavit
- Rent or mortgage receipt
- Utilities bill
- Listing in the city directory or phone book that can be verified
- Principal property ownership document or property tax bill
- Membership record in a religious institution that reflects patient's address
- Student identification
- School records
- Recent marriage license, divorce decree, or evidence of domestic partnership issued in the State of California
- Recent court documents showing the applicant's current address
- Insurance documents
- Police record from a California law enforcement agency
- Documents from a homeless shelter or other public or community service agency indicating that the applicant is receiving services from the agency
- Adoption record
- Medical record
- Voided personal check with pre-printed address
- Other proof of residency – other third-party documents verifying residency of applicant can be provided

APPEALS PROCESS

Any individual who has been disenrolled, or has been denied eligibility, or who wishes to request a waiver or reduction of fees or other patient responsible balances, shall have the right to an appeal and to receive a written eligibility determination notice or statement. The written eligibility determination notice or statement* shall include the (1) the denial and/or discontinuance reason; (2) the right to have the denial, discontinuance, or fees, co- pays and charges reviewed through the Step-One appeal, Individual Eligibility Review (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, or charges.

In addition, any individuals with income above the various Financial Assistance Program's income limit who can demonstrate that denial of eligibility would give rise to a hardship, may appeal their denial. This process allows the individual to present additional information to support eligibility according to the SMMC Financial Assistance Policy.

Individuals have the right to a second level appeal to review the decision of the IER. The instructions for filing the Step-Two appeal are included in the Step-One IER denial notice.

*The billing statement will not include information about a denial/discontinuance reason, but it will include information about the right to appeal and the process to do so.

Step-One Appeal: Individual Eligibility Review (IER)

Timeline for Step-One Appeal Application

Individuals may appeal a disenrollment or denial decision for any SMMC Financial Assistance Program within 60 days of 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 6 months of the date of service. Notice of the right to appeal shall be included in SMMC billing statements. Individuals are to complete an appeal request and submit it with supporting documentation to the HCU Appeals Coordinator, 801 Gateway Blvd., Ste. 100, South San Francisco, CA 94080 or e-mail it to: info-hcu@smcgov.org..

Content of Request for Individual Eligibility Review

In completing the appeal request, individuals must provide their identifying information (name and date of birth, or medical record number, or ACE policy number) and a statement about the reason for the appeal. They should include specific information which supports a case that the individual has special circumstances demonstrating an inability to pay which justifies a reversal of the initial decision made by SMMC to deny or disenroll, or of SMMC's decision to assess charges. Such information may include unusual and extraordinary expenses over and above the actual cost of necessities of life.

Individual Eligibility Review Decision-Maker

The IER shall be decided by the HCU Manager, who has not been solely responsible for the preliminary determination. This individual shall consider all special facts and circumstances supporting the applicant's claim of eligibility or claim of inability to pay. This includes, among other factors deemed appropriate by the Chief of San Mateo County Health, a consideration of the client's income and expenses, the presence of chronic conditions for which regular, recurring medical treatment is needed and, the actual costs of necessities of life in San Mateo County.

Timeline for Decision

The HCU Manager shall make a written decision to affirm or reverse the initial County determination within 30 days after receipt of all requested documents. If the decision is to reverse the initial County determination, then the applicant shall receive a 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 include a description of the applicant's Step-Two Appeal rights, including a form to complete the appeal. If there is no decision within 30 days, the applicant has the right to an immediate review by the Eligibility and Financial Review Committee.

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

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 HCU Appeal Coordinator.

Content of Appeal

Upon notice of appeal, the original appeal request and all documentation, in addition to the Step-Two 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.

Eligibility and Financial Review Committee and Decision-Making Process

The EFRC shall consist of three individuals: the County Health Chief or his/her designee (other than the IER decision-maker), the San Mateo Medical Center Chief Financial Officer or his/her designee and a public member to be chosen by the County Manager and County Health Chief. The applicant has the right to appear before the EFRC, to present testimony including the sworn testimony of witnesses, and to bring an attorney. An electronic record of the proceedings will be obtained at the applicant's request. The EFRC shall consider all written materials and testimony provided and will also enlist additional expertise, as needed, to consider the appeal request.

Timeline for Decision

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

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 HCU 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.

FRAUD

San Mateo County Health has an established process to conduct follow up on clients who are suspected of providing false information to make themselves eligible for SMMC financial assistance programs. County Health staff are instructed to report via e-mail any suspected client fraud to the HCU Fraud Referral Coordinator. The HCU Fraud Referral Coordinator checks all available systems to confirm the client's residency, income, and other client eligibility information. They also contact the client to request documentation to confirm program eligibility. If the requested documentation is not submitted, the client is disenrolled from the financial assistance program but is provided with an opportunity to appeal the decision.

For purposes of this Financial Assistance Policy, health care fraud is defined as "the knowing and willful executing, or attempt to execute, a scheme or deceit to defraud a health care insurance or benefit program, or to obtain by fraudulent means any benefit or payment from the program".

Clients are provided with an "Important Reminders" flyer upon enrollment in a financial assistance program which describes fraud and instructs clients how to update information provided on their application. The flyer includes this information:

- You are required to report changes to the following information within 10 days of change:
  - Income
  - Address/Phone Number
  - Family size – Adding or removing a family member (e.g., Birth, Marriage, Adoption)
  - Immigration status
  - Other health coverage (e.g., employer sponsored or private insurance)

- Providing false information on your application **will result in disenrollment** from your coverage program. You may be billed for past services.

- Some examples of false information include:
  - You don't live in San Mateo County **BUT** you claim to live with a relative or other individual who lives in San Mateo County.
  - You report no income **BUT** you work.
  - You only report one job **BUT** you have other jobs that you did not report on the application.
  - You claim you are single or separated **BUT** you are married and living with your spouse.
  - You currently have an active VISA issued for less than one year **BUT** you state you are a San Mateo County resident.
  - You used another person's information to obtain coverage.

- Willful misrepresentation of information to obtain health coverage is **grounds to report to appropriate agencies**.

- If you previously reported inaccurate information or need to update information on your application, please update it by contacting the appropriate agency or HCU at **650-616-2002** or via e-mail Info-HCU@smcgov.org.

CHARITY CARE

Description

The Charity Care program is SMMC's program to provide access to care for patients who are unable to pay for themselves and meet certain financial criteria. It is designed to provide a consistent and uniform evaluation of the patient/guarantor ability to pay the outstanding medical balances.
The Charity Care program is consistent with the changes to the California Hospital Fair Pricing Act and other applicable state and federal laws.

Scope of Services

The scope of services eligible for Charity Care includes all SMMC services except for prescription benefits. The specific visits approved for Charity Care will be covered without charge to the patient.

Eligibility Criteria

Charity Care will be considered for all patients who are financially responsible for a balance due at SMMC that doesn't qualify for payment by other payers, including the ACE program, other governmental programs and other third-party liability payers. The patient will be approved for Charity Care if their household income does not exceed 138% FPL, and only after efforts have been exhausted to enroll the patient into an appropriate health coverage program.

Application Process

Patients must complete an application for Charity Care and provide required income and identity verifications. The application must be submitted within 6 months of the date of service. Any applications received after more than 6 months will be considered on a case-by-case basis.
HCU staff evaluate the patient for health coverage eligibility. If the patient does not qualify for any other health coverage programs, then the patient is evaluated for Charity Care eligibility and an eligibility determination is made.

HCU staff provide the patient with a Charity Care eligibility determination form, either in-person or by mail, and updates the patient's account accordingly. The eligibility determination form includes information about the patient's right to appeal and instructions on how to do so. If the patient is ineligible for Charity Care, the patient is then evaluated for the Discounted Health Care program.

ACCESS AND CARE FOR EVERYONE (ACE) PROGRAM

Description

The ACE program is a County-sponsored program that subsidizes health care to medically indigent adults and fulfills the County's obligation under Section 17000 of the California Welfare and Institutions Code. The ACE program includes the following categories:

ACE Program

Patients who qualify for the ACE program must pay an annual participation fee and co-payments for selected services.

Temporary ACE Program

The Temporary ACE program is for County residents who meet income and citizenship and/or satisfactory immigration status requirements for subsidized coverage through Covered California but did not enroll in this coverage during the designated Covered California Open Enrollment period or any applicable Special Enrollment Periods (SEP).

Temporary ACE program coverage will end no later than December 31st of the year in which a participant is enrolled. Instead, participants will be encouraged to pursue enrollment in a Covered California plan during open enrollment to achieve a coverage effective date of January 1st of the following year. San Mateo County Certified Enrollment Counselors will offer clients assistance to successfully secure such coverage.

Patients who qualify for the Temporary ACE program must pay an annual participation fee and co-payments for selected services.

ACE Excess Income Program

The ACE Excess Income program was established to assist applicants with incomes over the ACE program limits but because of a chronic medical condition and financial hardship, may be eligible for this program.

Patients who qualify for the ACE Excess Income program must pay co-payments for selected services. They are not charged an annual participation fee.

Scope of Services

The ACE program scope of services is similar to Medi-Cal's except that inpatient and outpatient care, pharmaceuticals and supplies are provided at San Mateo Medical Center or at an approved outside contracted provider site. For more detailed information about ACE scope of services, please refer to the San Mateo County ACE Participant Handbook.The ACE program does not cover cosmetic surgery, pregnancy-related services, family planning, impotence/infertility, mental health services other than limited outpatient mental health services provided within primary care settings, substance use 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.

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

The ACE program will not cover outpatient procedures or admissions deemed a non-covered benefit. The patient may elect to have the procedure but will be billed in full for services provided. An advance deposit will be required.

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.

Eligibility Criteria

Applicants must declare under penalty of perjury that they meet the requirements for eligibility as defined below.

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. San Mateo County residency may be self-declared.

Applicants with an active visa that is issued for less than one year do not meet the residency criteria. An applicant with a multiple entrance visa issued for longer than one year (often issued for 10 years)

also does not meet the residency criteria if the most recent date of entry stamp is dated within the previous six months.

Income Criteria

The current ACE Federal Poverty Level (FPL) guidelines are posted on the San Mateo County Health – Health Insurance webpage and are updated annually.

ACE
Income must be between 138.01% - 200% FPL.

Temporary ACE
Income must be between 138.01% - 200% FPL.

ACE Excess Income
Income must be between 200.01% - 225% FPL.

Insurance/Health Coverage Status

To qualify for the ACE program, applicants must be uninsured. Applicants who are recipients of third-party liability payment funding are NOT eligible for the ACE program. Third-party liability payment funding includes Medicare, full-scope Medi-Cal (with or without a share of cost), Covered California, private insurance, or any other state, federal, public, or private health care coverage or reimbursement or compensation for medical expenses through a third-party source, including, for example, from the proceeds of a lawsuit.

Applicants may be denied for ACE coverage if they refuse to apply for state or federal programs for which they may be eligible.

Other Requirements

- **Temporary ACE** – Requires citizenship and/or lawfully present status.
- **ACE Excess Income** – Requires a financial hardship AND a chronic medical condition for which regular, recurring medical treatment is needed.

Ineligibility Criteria

Reasons for Ineligibility or Losing Coverage

- Denied Medi-Cal, Covered California or other benefits due to lack of reasonable cooperation
- Failed to apply for Medi-Cal, Covered California or any other third-party coverage when requested to do so
- No longer a county resident
- No longer meets income eligibility criteria
- Failed to provide requested information
- Failed to cooperate with an ACE audit
- Provided materially incorrect or false eligibility information –
  - In such cases, the patient may be terminated immediately from the ACE program and billed retroactively for all ACE program services during the period of time in which the information was incorrect or false.
- Have an active visa issued for less than a one-year period

Annual Participation Fee, Co-pays, Charges

Annual Participation Fee

Each client enrolled in the ACE program and the Temporary ACE program is charged an annual participation fee of $360. However, the payment of the annual fee shall not be a condition precedent to medical services. In accordance with Welfare and Institutions Code section 16804.1(a), no patient shall be denied medical services for non-payment of the annual fee. There will be no cancellation fee.

Clients who are able and willing to pay the entire $360 annual participation fee at the time of enrollment will receive three "ACE Bucks". Each ACE Buck can be redeemed in lieu of one outpatient visit copayment at SMMC during the client's program year.

Clients who are unable to pay the entire $360 annual participation fee at the time of enrollment will be offered the opportunity to pay this amount in installments over the course of the program year. The Chief of San Mateo County Health or his or her designee shall have the authority to develop and implement installment payment plans for the annual ACE participation fee.

The annual ACE participation fee may be fully or partially waived when the client can show that payment of the fee would constitute a hardship. This waiver shall only fully or partially exempt the client from paying the annual participation fee and shall not affect the obligation to make co-payments. The eligibility for this waiver must be reassessed annually, at a minimum. This is required to incorporate any changes to a client's financial status. Clients who are experiencing homelessness (PEH) and farmworkers and their dependents who meet ACE eligibility criteria, will have their ACE participation fee waived upon enrollment. The ACE participation fee may also be waived via the Appeals process.

The Chief of the San Mateo County Health has developed and implemented an Appeals process for consideration of requests to waive, as a hardship, a client's ACE program annual participation fee. This process is made available to all ACE program Applicants.

Co-Payments

ACE, Temporary ACE and ACE Excess Income clients are responsible for co-payments for selected services payable at the time of service. Co-payments for services are established to align with the cost-sharing required through a Covered California plan for individuals with incomes between 138.01% and 200% FPL. In addition, since Temporary ACE patients are eligible for cost-sharing credits to increase the actuarial value of a plan, the cost-sharing for this group is aligned with that of the applicable level Covered California plan.

The co-pay amounts for such services shall be described in the ACE Participant Handbook provided to each eligible client, and are subject to change from time to time, as determined by the San Mateo County Board of Supervisors.

Cost-sharing for the major types of services are as follows:

Primary Care MD Visit	$15
Emergency Dental Visit	$15
Emergency Oral Surgery provided by a physician in a clinic	$100
Specialty Care MD Visit	$15
Other Practitioner Visit	$15
Laboratory For lab-only visit. Does not apply if the lab service is part of an inpatient stay, outpatient visit, emergency room visit or ambulatory surgery.	$15
Behavioral Health Visit	$15 (within primary care)
Outpatient Drug Therapy Services	$15
X-ray	$25
Imaging (CT, PET, MRI)	$50 - CT $150 - MRI
Rx (generic/ brand/ non-preferred/specialty)	$7
Urgent Care/ ER	$40 - Urgent Care $75 - ER
Outpatient Surgery	$150
Ambulatory Surgical Center Services (Same Day Surgery)	$300
Outpatient Ancillary Procedures	$150
Inpatient Hospitalization	$300
Short Term Skilled Nursing Care	$300
Durable Medical Equipment	Actual cost - items that cost less than $10 $10 - items that cost $100 or less $20 - items that cost more than $100 $150 - CPAP/BIPAP machines
Orthotic and Prosthetic Devices	Actual cost - items that cost less than $10 $10 - items that cost $100 or less $20 - items that cost more than $100
Medical Supplies	Actual cost - items that cost less than $10 $10 - items that cost $100 or less $20 - items that cost more than $100

Home Health Care Services	$5 - each home health visit Medical supplies, equipment, or appliances associated with home health visits are included.
Vision	$15 - Pair of eyeglasses $15 - Set of contact lenses Coverage limit: $150 every two years
Acupuncture	$15
Chiropractic Services	$15
Occupational, Speech and Physical Therapy	$15
Podiatry Services	$15
Audiology (Hearing)	$15
Respiratory Therapy	$15
Out-of-pocket maximum	$1,000

Estate Recovery Process

The ACE Estate Recovery process requires that County Health seek repayment for inpatient stays and same day surgeries from the estates of certain deceased ACE participants. Repayment only applies to benefits received by these participants on or after their 55th birthday and who own assets at the time of death. If a deceased participant owns nothing when they die, nothing will be owed.

For ACE participants who died **on or after January 1, 2017:** (See Changes to Estate Recovery effective January 1, 2017, due to Legislation SB 833)

- Repayment will be limited only to estate assets subject to probate that were owned by the deceased participant at the time of death.
- Repayment will be limited to payments made, including for nursing facility services, home and community-based services, and related hospital and prescription drug services received when the participant was an inpatient in a nursing facility or received home and community-based services.

For ACE participants who died prior to January 1, 2017:

- Repayment will be sought from all assets owned by the deceased participant at the time of death.

This ACE Estate Recovery process is based on the Medi-Cal Estate Recovery Program and it has been modified to apply to the ACE program.

- In addition to your co-payment and subject to restrictions of SB 833 above, for inpatient hospital stays and same-day surgeries, the County will pursue estate recovery from your estate for the balance of the cost of the hospital stays or same-day surgeries.
    - This balance will be billed to your estate at a discounted rate.
    - This means that the County will file a claim on your estate when you pass away to cover those costs.

- Regardless of what is owed, the County will never collect more than the assets owned by the participant at the time of his/her death.
- Patients may be required to complete documentation that authorizes estate recovery action by the County.
- If you want to avoid estate recovery, you may arrange a payment plan with the San Mateo Medical Center's Billing for the balance of these costs.
    - For more information, call San Mateo Medical Center Billing at 650-573-2525.

Annual Out-of-Pocket Cap

ACE participants shall only be responsible for out-of-pocket expenses totaling up to 6.3 percent of their income in a calendar year, including program participation fees, copayments, and charges. After an ACE participant incurs the maximum out-of-pocket amount, the individual shall not be liable for any additional program participation fees, copayments, or charges in that same calendar year. Notwithstanding the foregoing, the County shall retain the right to pursue estate recovery on inpatient and same-day surgery charges that exceed an ACE participant's annual out- of-pocket liability of 6.3 percent (6.3%) of their annual income.

Notification of Enrollment or Disenrollment

Patients will receive an ACE program handout and Participant Handbook explaining the ACE program's annual participation fee, co-payments, payment requirements for inpatient stays and same day surgeries, scope of services, estate recovery program and San Mateo County Clinic site locations.

Patients will be informed of disenrollment from the ACE program by mail at least 15 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.

DISCOUNTED HEALTH CARE (DHC) PROGRAM

Description

This program offers a discount to patients who do not have insurance or have insurance but have high medical costs and meet certain moderate-income requirements. Patients who do not qualify for the County's ACE program or other financial assistance may be assessed for the Discounted Health Care (DHC) program consistent with the California Hospital Fair Pricing Act and other applicable state and federal laws.

Scope of Services

The DHC program will provide a discount to patients who meet the program eligibility criteria. A patient may receive a discount on the amount due for qualified services rendered only at San Mateo Medical Center and/or clinics. This discount rate may be adjusted annually.The County Board of Supervisors sets the discount rate for the DHC program but, pursuant to State law, it will not exceed the highest amount of payment that SMMC would receive for providing the medical services in question from Medicare or Medi-Cal. The discounted rate is currently 65% of total charges.

Eligibility Criteria

The DHC Program offers a discount to SMMC patients who meet these criteria:

1. Household income is at or below 400% of the Federal Poverty Level
2. Uninsured or possess third party coverage but qualifies as having "high medical costs".
    a. For purposes of this policy, "high medical costs" means annual out-of-pocket expenses for medical care that exceed the lesser of 10% of the patient's current family income or family income in the prior 12 months.

Coverage Period

The DHC Program's coverage period will be for a duration of one year. The coverage start date will be the first day of the month in which the application is submitted. The coverage end date will be the last day of the 12th month of coverage.

Coverage may be applied retroactively to visits for up to six months after the date of service. Retroactive coverage will not affect the program's coverage end date. A refund of previously paid balances will not be considered, even when applying DHC coverage retroactively.

HEALTHCARE FOR THE HOMELESS/FARMWORKER HEALTH (HCH/FH) SLIDING FEE DISCOUNT PROGRAM (SFDP)

Description

The SFDP program offers patients who are experiencing homelessness (PEH) and farmworkers and their dependents whose incomes are below 200% FPL. This policy represents the Healthcare for the Homeless/Farmworker Health (HCH/FH) federal requirement to ensure that all PEH and farmworkers and their dependents can access San Mateo Medical Center services regardless of ability to pay.

Scope of Services

The SFDP program will provide a discounted rate for all services provided by San Mateo Medical Center. A schedule of discounts will be adjusted annually to align with the Federal Poverty Level (FPL) and will be reviewed and approved annually by the HCH/FH Board. The discounted rate is $0 for patients with household incomes at or below 100% FPL, and ranges between $20-30 for patients whose household incomes are between 101-200% FPL.

San Mateo County Health Care for the Homeless Farmworker Health (HCH/FH) Program

(HRSA 330 Program/FQHC)

Sliding Fee Discount Schedule 2025

Monthly Income Thresholds by Family Size for Sliding Fee Discount Policy

Poverty Level*	0-100%	101-138%	139-175%	176-200%	>200%
Family Size					
1	$1,304	$1,800	$2,282	$2,608	$2,609
2	$1,763	$2,432	$3,084	$3,525	$3,526
3	$2,221	$3,065	$3,886	$4,442	$4,443
4	$2,679	$3,697	$4,689	$5,358	$5,359
5	$3,138	$4,330	$5,491	$6,275	$6,276
6	$3,596	$4,962	$6,293	$7,192	$7,193
7	$4,054	$5,595	$7,095	$8,108	$8,109
8	$4,513	$6,227	$7,897	$9,025	$9,026
For each additional person add:	$458	$633	$802	$917	$917
Patient Cost	No Charge	$20	$25	$30	No sliding fee discount**

* Based on 2025 HHS Poverty Guidelines (Poverty Guidelines | ASPE)
** Reduced payments may be available through other state or locally funded discount programs

Eligibility Criteria

The SFDP program offers a discount to SMMC patients experiencing homelessness and farmworkers and their dependents who can demonstrate that their household income is at or below 200% FPL. If a patient cannot provide documentation/proof of income, they must provide a signed self-declaration of their income.

The SFDP program is a last resort program, and clients should only be enrolled if they refuse or are ineligible to participate in Medi-Cal or other FAP program.

BILLING AND COLLECTION PRACTICES

The SMMC's Patient Financial Services (PFS) department is responsible for billing and collection of services rendered at the hospital and clinics. SMMC may employ contracted billing vendors and collection agencies. The PFS department and billing vendors will adhere to SMMC's values and mission as a "safety net" institution and is committed to providing emergency services and medical treatment to patients regardless of their ability to pay. SMMC will conduct all billing and collections activities in compliance with applicable provisions of law, including without limitation California Health and Safety Code §127400 et al., Assembly Bill No's. 774 (AB774), 1020 (AB1020), 532 (AB532), Senate Bill 1276 (SB1276) and the Fair Debt and Collections Act. Unless otherwise specified, this policy does not apply to physicians or other medical providers whose services are not included in a hospital bill generated and submitted by SMMC (i.e. does not apply to emergency room physicians, hospitalists, etc.).

General Guidelines

1. SMMC will make every effort to confirm valid insurance coverage information and to assist patients with financial assistance. SMMC may bill the patient or guarantor for their balance due after the insurance pays, or for total charges if applicable.
2. SMMC is required to provide an estimate of charges prior to services being rendered and a written notice of financial assistance options. Financial assistance information may be provided at the time of service, during discharge, or within 72 hours post hospital or clinic visit.
3. SMMC will send a statement of charges and balance due within 10 business days of the date of service. The total charges billed may not include all charges associated with a visit. SMMC may employ contracted physicians and allied professionals who may bill separately. Patients are notified in advance of receiving services when a separate billing may occur.

4. Patients treated at SMMC with a group health plan or health insurance coverage is considered out-of-network. Out-of-network plans usually do not cover the entire out-of-network cost, leaving the patient with higher costs than if they had been seen by an in-network provider. Billing patients for this high cost for out of network services is considered "balance billing". An unexpected balance bill is called a surprise bill and prohibited by state law. SMMC does not balance bill patients and will waive these fees as applicable.

5. SMMC will adhere to applicable laws by ensuring patients with high-cost medical bills, including deductibles, and co-insurance amounts are afforded an opportunity to be assessed for financial assistance, discounts, and payment plans.

Self-Pay Patients

1. Uninsured patients will receive a Good Faith Estimate (GFE) prior to a scheduled non-emergent visit, during the registration process, or within 72 hours post admit and upon request. The GFE will provide the patient the expected cost for services provided and will not exceed a $400.00 variance. Final charges exceeding a $400.00 variance will be adjusted and the patient will not be held responsible.

2. An uninsured patient may be required to pay a deposit before receiving non-emergency or elective services. If the patient has not been screened for financial assistance, the deposit is $150 for outpatient clinic visits and related ancillary services and $550 for inpatient stays and surgeries. If the patient has been deemed ineligible for other coverage, thereby coded as a self-pay patient, the deposit is $100 for outpatient clinic visits and related ancillary services and $750 for inpatient stays and surgeries. If the patient is later found to be eligible for a health program or becomes active on an insurance plan, the patient's deposit will be refunded.

3. Patients who have been coded self-pay will receive a notice that includes the following:
   a. A statement of charges for services received at SMMC
   b. A request that the patient inform SMMC if he/she has health insurance coverage
   c. A statement that if the patient does not have health insurance coverage, he/she may be eligible for Medicare, Medi-Cal, Covered California, California Children's Services program, other state- or county-funded health coverage or charity care
   d. A statement indicating how a patient may apply for a financial assistance program and that the hospital will provide the application
   e. A statement that if the patient does not indicate coverage by a third-party payer or requests a discounted price or charity care, then the hospital shall provide an application for financial assistance programs to the patient
      i. This application shall be provided prior to discharge if the patient has been admitted or to patients receiving emergency or outpatient care.
   f. Information about the SMMC's Financial Assistance Programs, including a statement that if a patient lacks or has inadequate health insurance, and meets certain low- and moderate-income requirements, the patient may qualify for the ACE, DHC or Charity Care programs and the contact information for HCU for information about these programs
   g. A statement that if a patient applies, or has a pending application, for another health coverage program at the same time that the patient applies for a hospital charity care or discount payment program, neither application shall preclude eligibility for the other program.
   h. The Health Consumer Alliance (HCA) offers free in-person and phone assistance at (888) 804-3536 to help people who are struggling to get or maintain health coverage, resolve problems with their health plans and hospital bills, and provide information about Covered California and Medi-Cal presumptive eligibility. The internet address for Health Consumer Alliance is https://healthconsumer.org. Patients may also contact Legal Aid for assistance at (650) 558-0915 or visit https://www.legalaidsmc.org.
   i. The internet address for the hospital's list of shoppable services

4. Patient accounts will be updated to reflect the current responsible payer including any newly determined financial assistance or health insurance. Patients will receive a new statement reflecting any revised patient liability amount.

Self-Pay Prompt Pay Discount

SMMC extends a 50% discount off balances due from patients when remitted within 30 days of the first bill date. This includes Medi-Cal Share of Cost when the Share of Cost exceeds total charges. It does not apply to discounted charges, co- payments, co-insurance, deductibles, or participation fees. This discount ensures SMMC is adequately reimbursed for the cost of care provided to the patient. The patient is responsible for full charges if the discounted amount is not received timely.

If a self-pay patient applies for other coverage and is subsequently denied, the patient will be re-coded from a "pending" status to self-pay, retroactive to the initial application date. The Self-Pay Prompt-Pay discount will apply if the patient pays 50% of charges within 30 days of the first bill date after being recoded to self-pay.

Extended Payment Policy

SMMC provides an extended, "reasonable payment plan" to patients who do not elect to take the Self-Pay Prompt-Pay discount. The extended payment plan can be applied to all or a portion of billed charges that are determined to be the patient's responsibility. Extended payment plans are interest-free and will be made available by SMMC to all patients based on their ability to pay. SMMC and the patient will negotiate the terms of the payment plan and take into consideration the patient's family income and "essential living expenses". If SMMC and the patient cannot agree on a payment plan, SMMC will use the following definitions to create a payment plan.

Definitions

"Reasonable payment plan" means monthly payments that are not more than 10 percent of a patient's family income for a month, excluding deductions for essential living expenses.

"Essential living expenses" means, expenses for any of the following: rent or house payment and maintenance, food and household supplies, utilities and telephone, clothing, medical and dental payments, insurance, school or childcare, child or spousal support, transportation and auto expenses, including insurance, gas, and repairs, installment payments, laundry and cleaning, and other extraordinary expenses.

The extended payment plan is utilized when the patient is unable to make a full payment within the normal billing cycle timeframe. An SMMC account representative will determine the number of months and amount of installment payments. The extended amount of time granted is based on the total amount to be repaid and the patient's current financial status. All extended payment plans must have the prior approval of a PFS supervisor or manager.

Patients defaulting on an extended payment plan may be referred to SMMC's contracted collection agency for follow-up.

Waiving Balances Due to Financial Assistance Program Eligibility

SMMC is committed to serving our patients and may waive account balances when the following criteria are met.

Patients may have SMMC visit fees waived for up to three months prior to becoming eligible for the ACE program, Kaiser Community Health Care program or Covered California. If they are San Mateo County

residents and their household income is less than 200% FPL, they will be eligible to have their open balance waived for SMMC services received in the three months prior to their coverage effective date. This is similar to the Medi-Cal policy of allowing for retroactive coverage for up to three complete months prior to the month of application.

The Medi-Cal application date will be honored and considered as the SMMC's Financial Assistance Program's application date. If the Medi-Cal application is denied, that applicant may be evaluated for eligibility for SMMC's Financial Assistance Programs. If eligible, the Medi-Cal application date will be used to determine the effective date of eligibility for the SMMC's financial assistance program. Since the ACE program does not allow for retroactive effective dates prior to the first date of the month of application, patient visits will be waived retroactively as far back as three months prior to the month of the Medi-Cal application date.

Collection Practices

SMMC is a safety net hospital whose mission requires that healthcare be provided for individuals regardless of their insurance status or ability to pay. The mission of SMMC is to focus and emphasize a devotion to providing the best possible healthcare for those who may be experiencing adverse circumstances. These circumstances mostly revolve around problems with financial payments, insurance plans, or health conditions. SMMC will make every effort to work with patients, guarantors, and insurance plans to resolve outstanding balances before referring an account to a collection agency. SMMC will make every reasonable effort to obtain valid insurance information from the patient to ensure proper billing.

SMMC will not refer matters to collection when payment plans are in negotiation or established. However, patients who have committed to an established payment plan and default on the agreement may be sent to collections. Collection agencies may pursue a property lien for unpaid debts but may not use liens on primary residences as a means of collecting unpaid hospital bills.

SMMC will not refer patients to collections who are actively pursuing financial assistance or pending an eligibility determination for a governmental program. Additionally, SMMC will retract any collection account upon notice of verified insurance information. Patient accounts that are in dispute or which have been turned over to a collection agency sooner than 180 days shall be removed from collections and returned to SMMC's Patient Financial Services office.

SMMC shall reimburse patients any amount paid in excess of the amount due, including interest. Interest owed by the hospital to the patient shall accrue at the rate set forth in Section 685.010 of the Code of Civil Procedure, beginning on the date payment by the patient is received by the hospital. However, a hospital is not required to reimburse the patient or pay interest if the amount due is less than five dollars ($5.00). The hospital shall refund the patient within 30 days.

1. SMMC will send three (3) or more statements to patients and will allow a minimal of 180-day billing cycle prior to assigning an unpaid balance amount to a collection agency.
    a. Prior to forwarding a bill for collections or selling the bill to another entity, SMMC will provide patients with a written notice called a goodbye final letter that includes the following information:
        i. The date(s) of service of the bill that is being assigned to collections or sold;
        ii. The name of the entity to which the bill is being assigned or sold;

iii. A statement informing the patient how to obtain an itemized hospital bill from the hospital;
iv. The name and plan type of the health coverage for the patient on record with the hospital at the time of services or a statement that the hospital does not have that information;
v. An application for the hospital's charity care and financial assistance;
vi. The date or dates the patient was originally sent a notice about applying for financial assistance, the date or dates the patient was sent a financial assistance application, and, if applicable, the date a decision on the application was made.

2. SMMC will only send patient accounts to a collection agency when the collection agency agrees to adhere to all state and federal laws pertaining to fair collection of debt, as well as those pertaining to charity and discount care. That includes the SMMC Financial Assistance Policy, the California Hospital Fair Pricing Act, the Rosenthal Fair Debt Collection Practices Act, the federal Fair Debt Collection Practices Act, and the tax regulations at 26 C.F.R. §§ 1.501(r)-1, *et seq*.

SMMC Policy Review & Approval Grid	
Origination Date:	Last Review Date:
Reviewed and approved by:	Date:
Manager, Patient Access	1/25
Manager, Patient Financial Services	1/25
Manager, HCU	1/25
Revenue Cycle Governance Council	1/25
Chief Financial Officer	1/25, FINAL
Date & Submission By: 2025-1, Kathy Van Kirk-Supervisor HCU	
NOTE(s):	