HEALTH CARE FOR THE HOMELESS/FARMWORKER HEALTH PROGRAM (HCH/FH)
Co-Applicant Board Meeting
Human Services Agency | 400 Harbor Blvd. (Bali Room) Belmont
August 11, 2016, 9:00 A.M - 11:00 A.M.
AGENDA

A. CALL TO ORDER	Robert Stebbins	**9:00 AM**
B. CLOSED SESSION		
1. No Closed Session this meeting		
C. PUBLIC COMMENT		**9:02 AM**
Persons wishing to address items on and off the agenda		
D. CONSENT AGENDA		**9:05 AM**
1. Meeting minutes from July 21, 2016		**TAB 1**
2. Program Calendar		**TAB 2**
E. BOARD ORIENTATION		
1. No Board Orientation items this meeting.		
F. REGULAR AGENDA		
1. Consumer Input- NHCHC 2016 Conference de-brief	Tay Deldridge	**TAB 3** 9:10 AM
2. Board Ad Hoc Committee Reports	Committee Members	**9:20 AM**
i. Transportation		
ii. Health Navigation		
iii. Board Composition		
3. HCH/FH Program QI Report	Frank Trinh	**9:30 AM**
4. HCH/FH Program Director's Report	Jim Beaumont	**TAB 4** 9:35 AM
5. HCH/FH Program Budget/Finance Report	Jim Beaumont	**TAB 5** 9:43 AM
6. Grant Conditions	Jim Beaumont	**TAB 6** 9:50 AM

i. Action Item- Request to Approve Form 5B letter submission
ii. Action Item- Request to Approve Form 5A change
iii.Action Item- Request to Approve Billing & Collections - **Appropriate SMMC policies attached, used caution when printing large document that includes 147 pages**
iv. Update

7. Strategic Plan	Jim Beaumont	**TAB 7 10:05 AM**

i. Action Item- Request to Approve Report
ii. Update

8. Request to Approve DSHII application submission	Jim Beaumont	**TAB 8 10:15 AM**

i. Action Item- Request to Approve

Remainder of documents for the following item will be provided by Monday 8/8/16 at 9 a.m. (as Tab 9A)

9. Request to Approve Draft SAC application submission	Jim Beaumont	**TAB 9 10:22 AM**

i. Action Item- Request to Approve Policy

10. Request to Approve Credentialing and Privileging	Jim Beaumont	**TAB 10 10:40 AM**

i. Action Item- Request to Approve C&P list

11. Quarterly report on Contractors- 2nd Quarter	Linda/Elli	**TAB 11 10:45 AM**

Meetings are accessible to people with disabilities. Individuals who need special assistance or a disability-related modification or accommodation (including auxiliary aids or services) to participate in this meeting, or who have a disability and wish to request an alternate format for the agenda, meeting notice, or other documents that may be distributed at the meeting, should contact the HCH/FH Program Coordinator at least five working days before the meeting at (650) 573-2966 in order to make reasonable arrangements to ensure accessibility to this meeting and the materials related to it. The HCH/FH Co-Applicant Board regular meeting documents are posted at least 72 hours prior to the meeting and are accessible online at: http://www.sanmateomedicalcenter.org/content/Co-ApplicantBoard.htm.

    12. Discussion on Board Member- Eric Brown   Robert Stebbins   **10:53AM**

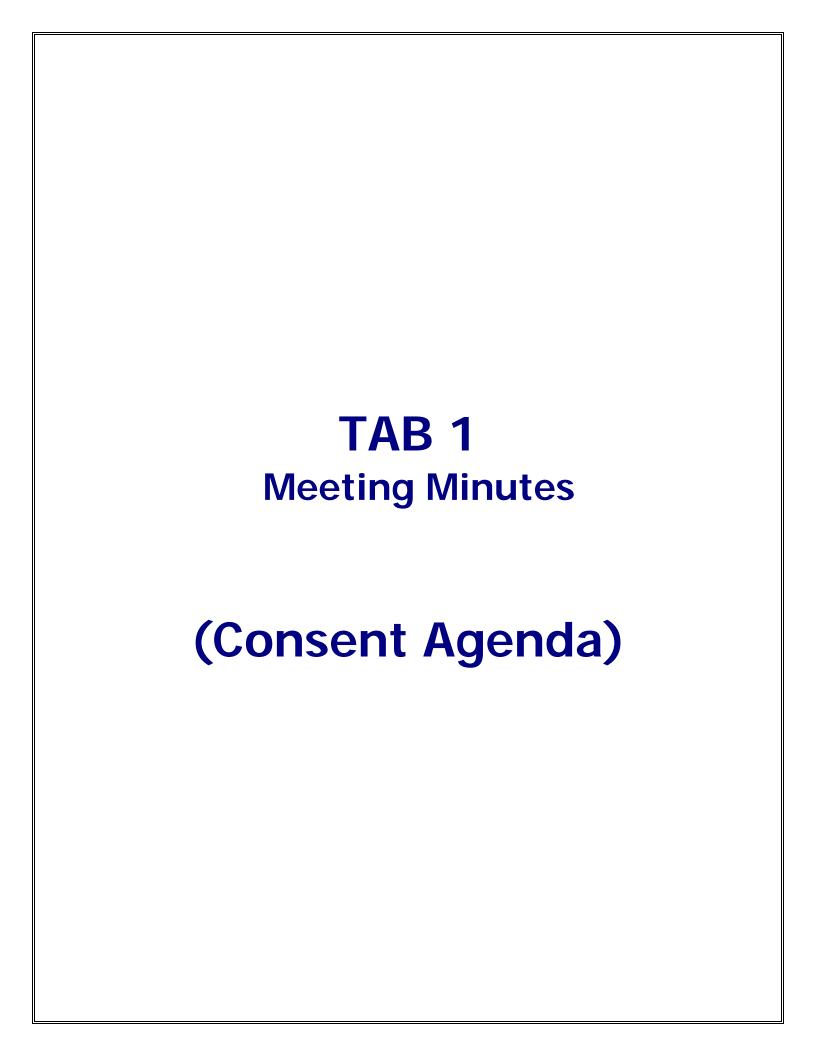**G. OTHER ITEMS**
    1. Future meetings – every 2nd Thursday of the month (unless otherwise stated)
        i. Next Regular Meeting – September 8, 2016; 9:00 A.M. – 11:00 A.M.
          Fair Oaks Clinic- Redwood City

H. ADJOURNMENT   Robert Stebbins   **AM**

TAB 1
Meeting Minutes

(Consent Agenda)

Healthcare for the Homeless/Farmworker Health Program (Program)
Co-Applicant Board Meeting Minutes
July 21, 2016 ; 9:00-11:00 a.m.

First Step for Families Shelter- San Mateo

<u>Co-Applicant Board Members Present</u>
Robert Stebbins, Chair
Brian Greenberg
Paul Tunison, Vice Chair
Theresa Sheats
Christian Hansen
Molly Wolfes
Julia Wilson
Steve Carey
Tayischa Deldridge
Jim Beaumont, HCH/FH Program Director (Ex-Officio)

<u>County Staff Present</u>
Frank Trinh, HCH/FH Medical Director
Glenn Levy, County Counsel
Elli Lo, Management Analyst
Linda Nguyen, Program Coordinator
Brian Eggers, Center on Homelessness, H.S.A.

<u>Members of the Public</u>

Absent: Eric Brown, Daniel Brown, Kathryn Barrientos

ITEM	DISCUSSION/RECOMMENDATION	ACTION
Call To Order	Robert Stebbins called the meeting to order at 9:02 A.M. Everyone present introduced themselves.	
Regular Agenda Public Comment	No Public Comment at this meeting. Dr. Frank Trinh commented on new staff added to Street Medicine effort to expand services/hours.	
Regular Agenda Consent Agenda	All items on Consent Agenda (meeting minutes from April 26 meetings and the Program Calendar) were approved. Please refer to TAB 1, 2	Consent Agenda was <u>MOVED</u> by Paul <u>SECONDED</u> by, Theresa and APPROVED by all Board members present.
Board Orientation:	No Board Orientation for this meeting.	
Regular Agenda Consumer Input	<u>National health Care for Homeless Conference 2016:</u> Discussion on various workshops attended by staff and Board members: data quality, data sharing and Respite challenges. Presentations by Elli Lo, Linda Nguyen and Paul Tunison. <u>National Advisory Council on Migrant Health</u> Discussion on nominating someone for open position for council. Molly will consider applying.	

	National Consumer Advisory Board Elects Local Leader Our own Board member PaulTunison, waselected as a member to serve a 2 year term of National Consumer Advisory Board. Attached is a press release from NHCHC . *Please refer to TAB 3, 4, 5 on the Board meeting packet.*	
Transportation *Sub-committee reports* *Steve, Molly, Christian*	Sub-committee will gather data on transit and work with Molly and Christian. • Discussion on transportation options such as Uber or MV transit. • Christian was volunteered to serve on sub-committee.	Program staff- inquire with Brian Eggers on transit
Board orientation Sub-committee reports Brian, Dan, Molly	Chair of committee reported that 2 applications (Dentist and EPA advocate) were given to possible applicants, have not heard back from.	
Patient Navigator Sub-committee reports Tay, Julia, Kat	No report, will convene after meeting	
Regular Agenda QI Committee report	Dr. Trinh gave oral report: • Patient Satisfaction surveys are being collected for analysis • Outcome measures discussed during last QI Committee meeting were Hyper tension and Diabetes. These reports are only from first quarter, so small sample size, will review again after second quarter for further analysis. • Discussion on outreach to male farmworkers, as data shows lower numbers of male farmworkers served compared to females.	
Regular Agenda: HCH/FH Program Directors report	Report included: • Update on Grant Conditions, staff working on, most due August 26th , see attachment • Update on Proposals and Contracts • Service Area Competition efforts • Upcoming Operational Site Visit • HRSA Supplemental Funding (DSHII) *Please refer to TAB 6 on the Board meeting packet.*	Add to next agenda- SAC report for approval, DSHII grant approval,

Regular Agenda: HCH/FH Program *Budget & Financial Report*	Report included: • Some proposals are still under review that include CORA, Project WeHOPE, and Daly city Youth Health Center. • Current levels of activity indicate that virtually all of the contracted funds from previous contractors will be expended • Expenditures to date total $990,000. • See attachment for expense summary *Please refer to TAB 7 on the Board meeting packet.*	Staff- email Board ideas to spend remainder of funds.
Request to Approve- Medical Director Job Description	One of the Federal Program Requirements is ensuring adequate Key Management Staff and support that meet the Health Center Program's requirements. The Operational Site Visit (OSV) Report from the March 2015 OSV found we did not meet the Key Management Staff Requirement and we received a subsequent grant condition on the requirement. Based on the OSV Report comments, we are finalizing the Medical Director's job description that reflects delineation of tasks, duties and responsibilities. Attached to this Action Request is a copy of the Medical Director job description **Action item: *Request to Approve*** *Please refer to TAB 8 on the Board meeting packet.*	Motion to Approve Medical Director Job Description <u>MOVED</u> by Paul <u>SECONDED</u> by, Theresa and APPROVED by all Board members present.

Request to Approve- Contracts policy	The Co-Applicant Board has the responsibility to establish general policies for the program, as well as the services to be delivered and overall approval of the budget. In April, 2015, this Board approved a revised Policy & Procedure for HCH/FH Program Contract Oversight. During the March 2015 Operational Site Visit (OSV), it was noted that there had not been a formal determination on the contracts and MOUs that had been approved by the Board were sub-recipient agreement or contracts. This was noted in the OSV Report issued in August 2015, and it resulted in a grant condition for the Contractual Affiliation Agreements Program Requirement (#10). Attached is a DRAFT revised HCH/FH Contract Oversight Policy & Procedure. It had been revised to provide for the Board to make a determination in the process of approval on whether an agreement is a contract or a sub-recipient agreement. There are no other changes to the Contract Oversight Policy & Procedures. We have also attached the current Contract Oversight Policy & Procedures, last revised and approved by the Board on April 9, 2015, and a redline version of the current Policy & Procedures showing the requested changes. Please see attachments **Action item: *Request to Approve*** *Please refer to TAB 9 on the Board meeting packet.*	Motion to Approve Contracts Policy <u>MOVED</u> by Julia <u>SECONDED</u> by,Paul and APPROVED by all Board members present.
Strategic Plan Update	Strategic Plan efforts/discussion started in October of 2015 and continued with a Strategic Plan Retreat on March 17, 2016 with the help of consultants Rachel Metz and Pat Fairchild. The Three Year Strategic Plan report 2016-2019 was finalized at the last June 9, 2016 meeting. This report summarizes current staff efforts to implement the plan. There has been some progress on Goals 1 and 2: Respite Care, investigating a homeless navigator position and improving the ability to assess on-going needs for homeless and farmworkers via improving data and collaborations with other departments. *Please refer to TAB 10 on the Board meeting packet.*	
Adjournment	Time _10:45 a.m._____	Robert Stebbins

TAB 2
Program Calendar
(Consent Agenda)

Health Care for the Homeless & Farmworker Health (HCH/FH) Program
2016 Calendar (*Revised August 2016*)

EVENT	DATE	NOTES
• Board Meeting (August 11, 2016 from 9:00 a.m. to 11:00 a.m.) • Service Area Competition Grant Application prep & submission	August	@ Human Services Agency- Belmont
• Board Meeting (September 8, 2016 from 9:00 a.m. to 11:00 a.m.) • Nominations for Chair & Vice -Chair • QI Committee meeting	September	@ Fair Oaks Clinic- Redwood City
• Board Meeting (October 13, 2016 from 9:00 a.m. to 11:00 a.m.) • Elections of Chair & Vice- Chair • Operational Site Visit October 4-6 • Providers Collaborative meeting	October	
• Board Meeting (November 10, 2016 from 9:00 a.m. to 11:00 a.m.) • QI Committee meeting	November	
• Board Meeting (December 8, 2016 from 9:00 a.m. to 11:00 a.m.) •	December	

Conference calendar 2016	
NHCHC Fall regional training	September 22-23; Louisville, KY
NW Regional Primary Care Assoc.	Oct 15-18 ; Denver, Colorado
Int'l Street Medicine Symposium	October 20-22; Geneva, Switzerland
Primary Care Assoc. & HCCN Conf.	November 14-16; Pasadena, CA
Nat'l Center for Health in Public Housing	November 15- 15; Chicago, IL

TAB 3
Consumer Input
NHCHC 2016
De-brief

Health Care for the Homeless 2016 Conference

Tayischa Deldridge

Pre Conference institute

Medical respite care: Positioning your program for success

Presenters: Donna Biederman,DrPH, MN,RN, Assistant Professor Brandon Clark MBA Chief Executive Officer Honora Englander MD FACP Assistant Professor of Medicine,He ry Fader JD Attorney Jessie Gaeta MD CMO, Carrie Harnish LMSW Jennifer Nelson-Seals, MSHRM Rebecca S. Ramsay,BSN Caitlin Synovec

This institute was put together by the RCPN Respite Care Providers Network Steering Committee

The key points were effective models for respite care:

- An overview of different respite care models.

- How to successful y develop a respite program.

- Being in a relationship with your hospital discharge teams. What model is right for your area? How to Access funding. (Who pays for the beds).

- Educating local agency on the need for respite care.

Respite care connects to EPA/RFHC, for the lack of respite care in San Mateo County. The need for respite beds for San Mateo county homeless is great.

I gained knowledge on the different models and services provided by respite care facilities in different states. The institute helped me to understand the base foundation and structure of a respite care. What worked and what didn't. What major challenges they faced and how they were able to overcome them. After attending, I know we can have a success shelter based respite care in East Palo Alto. I would like to visit a shelter based respite in the future.

TAB 4
Director's
Report

DATE: August 11, 2016

TO: Co-Applicant Board, San Mateo County Health Care for the
               Homeless/Farmworker Health (HCH/FH) Program

FROM: Jim Beaumont, Director
               HCH/FH Program

SUBJECT: DIRECTOR'S REPORT

Program activity update since the July 21, 2016 Co-Applicant Board meeting:

1. Grant Conditions

   As noted in last meeting's Director's Report 7-Day update, on July 19, 2016, we received NOA 15-04 lifting the grant condition for Program Requirement #16 – Scope (Form 5B-Sites).

   Subsequently, we had a further phone conversation with our Project Officer, who requested a follow-up letter from the Board. That item is elsewhere on today's agenda.

   On August 02, 2016, Program submitted documents on the grant condition for Program Requirement #5 – After Hours Coverage. We are awaiting further response on this condition.

   Program continues to move forward in addressing the remaining grant conditions, some of which have Board action requested elsewhere on today's agenda. A copy of the current Grant Condition Status Report is attached to this report.

2. Proposals & Contracts

   Program continues to work with CORA, Daly City Youth Health Center and Project WeHOPE on developing final contracts for their proposals. We have a meeting scheduled with WeHOPE on Wednesday, August 10, 2016, have had follow-up telephone conversation with CORA on Friday, August 05, 2016 and are expecting additional information from Daly City Youth Center the week of August 8th.

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3. Service Area Competition (Base Grant Application)

We continue working with HFS Consulting on preparation of our Service Area Competition (SAC) application, and elsewhere on today's agenda is a package of the current draft SAC application documents. The Co-Applicant Board has the responsibility to approve Program grant applications. With the submission deadline on August 31, 2016, this application does not coincide well with Board meetings. Therefore, as with last year, the agenda item today will ask for the Board's guidance and approval of intent to submit the SAC application as substantially represented by the draft documents. This would be followed by a full, formal approval of the final actual SAC application at the September Board meeting. The alternative would be to schedule a Special meeting of the Board for very late in August to obtain Board approval of the applications once it is all finalized and is ready for submission.

4. Operational Site Visit

Based on conversations with our Project Officer, our Operational Site Visit (OSV) is now tentatively set for October 4-6, 2016. The HRSA contractor who organizes the OSV visits is working with those dates in putting together the OSV consultant team.

We expect the OSV Team to want to schedule a meeting with the Co-Applicant Board during their visit, and that it generally is beneficial for there to be some attendance of Board members at the Entrance and Exit Conferences for the visit. Therefore, we are advising Board members of the dates and requesting they do their best to keep that window of time available. It appears that both the Health System Chief (Louise Rogers) and the SMMC CEO (Dr. CJ Kunnappilly) will be available during that time.

5. Care/Case Management System

A Request for Information (RFI) was issued July 14, 2016, with a closing date of August 17, 2016. A RFI is, as the name implies, a request for potential vendors to provide information about how their systems/services/application might address the stated need. Generally, they help to clarify the direction and specifics of a subsequent Request for Proposals (RFP). Program had ensured that the various potential vendors we had identified in this area have all been informed of the RFI.

Also on the automation front, the project list (AKA "Open Season") for FY 17/18 and FY 18/19 is already in the process of being built. As we have two projects potentially pending (Care/Case Management System and the DSHII project), we have not submitted anything new.
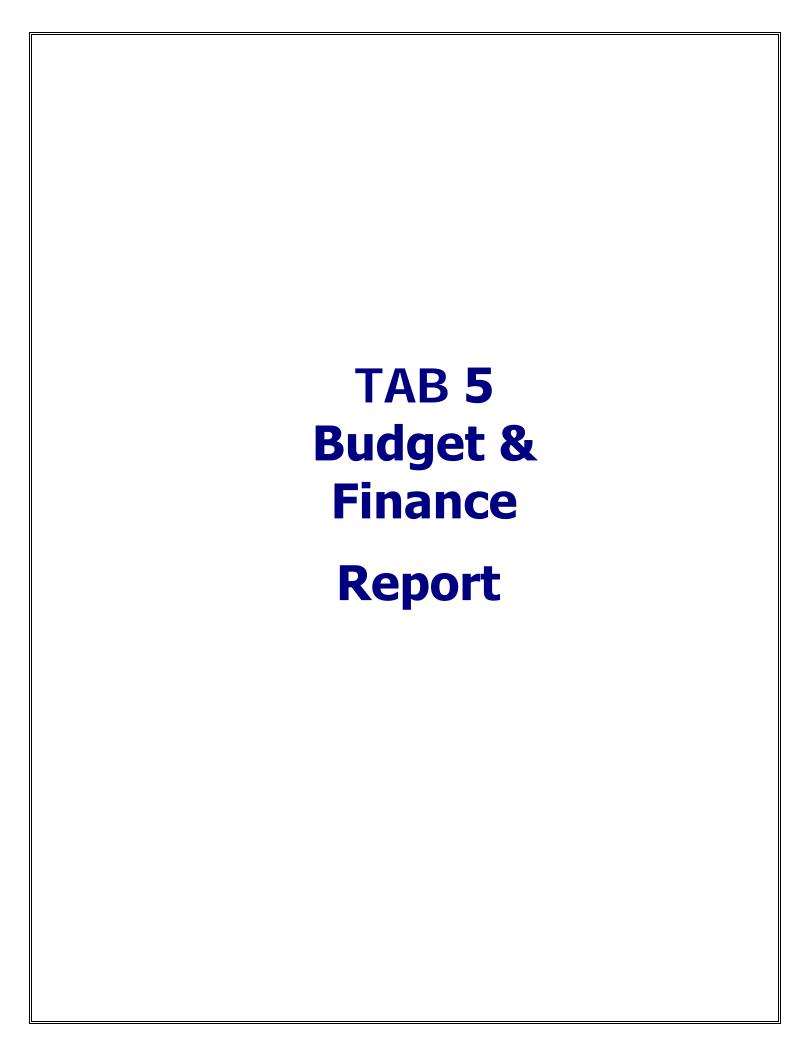
6. Seven Day Update

Attachment:
Grant Condition Status Report

Grant Conditions - Status Report	for upcoming August 11, 2016 Co-Applicant Board Meeting		
Requirements	**Required Action**	**Upcoming Due Date**	**Current Status**
2. Required and Additional Services	Document Form 5A, Revise as necessary; tracking referred servcies; multi-lingual information	**08/26/16** - 120-day Condition Response	**08/11/16 -** Submitting change for Board approval in August meeting.
3. Staffing	Much similar to current corrective efforts. ADD: "Agreement" with SMMC on doing C&P for HCH/FH. Some newer possible minor details. Actual approval activity by Co-Applicant Board?	**08/26/16** - 120-day Condition Response	**08/11/16 -** Privileging Report brought to Board for approval. Details of submission addressing previous grant condition provided to Project Officer.
5. After Hours Coverage	Must develop "adequate" policy & procedures (their test had some failures); multi-language information & signage.	**08/02/16** - 120-day Condition Response	**8/2/16-** Submitted After Hours Script and policy
6. Hospital Admitting Privileges	Policy on Hospital Admitting and tracking of patients.	**08/26/16** - 120-day Condition Response	Reviewing SMMC policies.
7. Sliding Fee Scale	Define income & household; update annually, re-evaluate every three years; everyone can opt for the SFDP; contractors must also have SFDP; [policy/procedure on waiving fees (no one denied care) - being done in Billing & Collections policy.]	**08/26/16** - 120-day Condition Response	**07/15/16 - Resubmitted as requested.** **07/06/16 - Revised SFDP Policy submitted. 06/09/16 - Board approved revised Sliding Fee Discount Program Policy.**
9. Key Management Staff	Finalize Director's job description; develop a Medical Director's job description, insure sufficient infrastructure support (fiscal/HR/budget/etc.)	**08/26/16** - 120-day Condition Response	**7/21/16- Board Approved Medical Director job description.**
10. Contractural Affiliation Agreements	Co-Applicant Board must review and approve all agreements; document a determination of contractor/sub-recipient status for every agreement; include minority, women-owned, etc. provisions in procurement.	**08/26/16** - 120-day Condition Response	**7/21/16- Board Approved Revised Policy (for sub-recipient determination)**
13. Billing and Collections	Enroll in Medicare or justify not doing it; see SFDP-policies to insure eligibility is not a barrier to servcie, develop P&P on fees, fee structure, self-declaration of income specific to populations	**08/26/16** - 120-day Condition Response	**08/11/16 -** Sample policies up for approval at August Board meeting.
14. Budget	Budget to show all costs/income, including overhead, indirect and system support; monthly financial statement for current month & YTD for GY budget (including system costs & revenues).	**03/31/16** - Change Request Response	**06/30/16 - Met, grant condition lifted.** **03/31/16 - Change Request Submission.** **01/14/16 - Board approved budget.**
16. Scope of Service	Review/confirm Form 5A; remove RFHC (?); separate clinics by suite numbers (?); use suite numbers at Coastside (?); delete duplicate mobile van; update annually.	**07/06/16** - Change Request Response.	**08/11/16 -** Letter for submission on August meeting agenda for Board approval. **07/29/16** - Project Officer requests letter from Board on special population access. **07/19/16 - Met. Condition lifted.** **07/06/16 - Scope document update submitted.** Request to approve updated Form 5A & 5B in April Board meeting.

Potential Conditions Resolved Prior to Issuance of Conditions

8. Quality Improvement Pan	Include measures across the scope of project; review utilization and quality; address negative trends		
17. Board Authority	Board approve single audit report		Request to accept Financial Audit report was approved on 4/26/2016 Board Meeting

TAB 5
Budget & Finance

Report

DATE: August 11, 2016

TO: Co-Applicant Board, San Mateo County Health Care for the Homeless/Farmworker Health (HCH/FH) Program

FROM: Jim Beaumont, Director
HCH/FH Program

SUBJECT: HCH/FH PROGRAM BUDGET and FINANCIAL REPORT

Expenditures to date – through July 31, 2016 – total just over $1,130,000.   .

This is a very difficult month in which to provide any significant update for financials. With much of the County financial staff focused on year-end activities, along with attempting to collect the data so early in the month (August 5th is before the month-end close), it is all but impossible to get an accurate tally of the expenditures for July. We have incorporated salary & benefits for July as reported in the County system, and have added in the contract/MOU expenditures approved during July which may not have been posted yet.

Based on the above, we project total expenditures to be around $2,030,000 for the grant year, based on current activity and approved contracts (including estimates for expenditures by new contractors) out of our awarded grant of $2,373,376.00. This is an increased rate of expenditures primarily driven by significant contract activity. Current levels of activity indicate that virtually all of the contracted funds from previous contractors will be expended. Some of the new contracts for 2016 may not have sufficient time left in the year to fully maximize the expenditures up to the contract maximum.

Overall, as we move forward with decision for this grant year – the proposals still under review and consideration, new efforts resulting from the Strategic Planning process, additional staffing, etc. – there currently appears to be approximately $340,000 in unobligated funding. Based on the expectation of typical growth for Base Grant funding for GY 2017 (and not including any Expanded Services funding), and the continuation of current efforts, we project a similar amount of unobligated funding for GY 2017.

Attachment:
GY 2016 Summary Report

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Details for budget estimates	Budget	To Date	Projection for	Projected for GY 2017
	[SF-424]	(07/31/16)	GY (+~24 wks)	
Salaries				
Director				
Program Coordinator				
Medical Director				
Management Analyst				
new position, misc. OT, other, etc.				
	697,262	204,231	370,000	395,000
Benefits				
Director				
Program Coordinator				
Medical Director				
Management Analyst				
new position, misc. OT, other, etc.				
	417,915	91,987	165,000	205,000
Travel				
National Conferences (1500*4)			6,000	9,000
Regional Conferences (1000*5)		8,871	9,000	7,500
Local Travel		974	1,250	1,500
Taxis		1,356	2,000	4,000
Van			1,200	3,000
	16,000	11,201	19,450	25,000
Supplies				
Office Supplies, misc.	7,000	3,987	10,500	10,500
	7,000	3,987	10,500	10,500
Contractual				
Current 2016 contracts	561,425	379,453	650,000	775,000
Current 2016 MOUs	433,300	406,154	675,000	675,000
---unallocated---	168,474			
	1,163,199	785,607	1,325,000	1,450,000
Other				
Consultants/grant writer		27,215	75,000	75,000
IT/Telcom		3,849	8,000	12,000
New Automation			50,000	25,000
Memberships		2,000	4,000	5,000
Training		1,250	2,500	2,000
Misc (food, etc.)		1,356	2,500	2,500
	72,000	35,670	142,000	121,500
TOTALS - Base Grant	2,373,376	1,132,683	2,031,950	2,207,000
HCH/FH PROGRAM TOTAL	2,373,376	1,132,683	2,031,950	2,207,000
PROJECTED AVAILABLE	BASE GRANT		341,426	343,004
				based on est. grant of $2,550,004

TAB 6
Request to Approve

Form 5B letter
Form 5A change
Billing & Collections

DATE: August 11, 2016

TO: Co-Applicant Board, San Mateo County Health Care for the
           Homeless/Farmworker Health (HCH/FH) Program

FROM: Jim Beaumont, Director
           HCH/FH Program

SUBJECT: REQUEST FOR THE BOARD TO TAKE ACTION TO APPROVE HCH/FH
           PROGRAM TO SUBMIT A LETTER TO HRSA FOR FORM 5B – SITES IN
           RESPONSE TO SCOPE GRANT CONDITION

Under the Bylaws Article 3.E, the Board has the authority and responsibility to set the scope
and availability of services to be delivered by and the location and hours of operation of the
Program. This responsibility is also represented by HRSA Program Requirement #16 – Scope
of Project. This Requirement was found to be out of compliance in the Operational Site Visit
(OSV) Report received August 2015 for the site visit of March 10-12 2015.

On July 6, 2016, per instruction as provided by our Project Officer, Program submitted a
Correction Requested document listing each of the individual address changes and Scope Site
Discussion document.

On July 20, 2016, per instruction as provided by our Project Officer, HCH/FH must submit a
letter indicating
- sites listed on Form 5B – Scope of Project are accessible and serving homeless and
  farmworker patients in San Mateo County
- homeless and farmworker patients are being seen at the sites listed on Form 5B

In order to submit the identified information above, governing Board action is required. The
request is for the Board to take such action as to approve the letter submission to HRSA.

Approval of this item requires a majority vote of the Board members present.

ATTACHED: FORM 5B SITE OF SERVICE LETTER TO HRSA

San Mateo Medical Center
A County System of Healthcare

August 11, 2016

Health Resources & Services Administration
Bureau of Primary Health Care
Submitted via Email

RE: Response to Change Request, Tracking Number 00195586, on Corrected Scope of
Project Documentation (Requirement #16)

This submission follows instruction as provided by our Project Officer to address the
outstanding issues with the grant condition for our Scope Requirement.

HCH/FH locates health care and enabling services at key sites throughout the service area to
provide convenient access for homeless people and farmworkers through our network of
County-operated and contracted services. Per PIN 2008-01, the HCH/FH sites listed on Form
5B meet the definition and statements of a service site. All the sites listed on Form 5B are
open and accessible to all homeless and farmworker patients in San Mateo County. Actual
visit numbers for the homeless and farmworkers for 2015 can be provided for any and every
site on Form 5B upon request.

Please feel free to contact me with any additional questions or concerns.

Jim Beaumont, Director
HCH/FH Program

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DATE: August 11, 2016

TO: Co-Applicant Board, San Mateo County Health Care for the
Homeless/Farmworker Health (HCH/FH) Program

FROM: Jim Beaumont, Director
HCH/FH Program

SUBJECT: REQUEST FOR THE BOARD TO TAKE ACTION TO APPROVE HCH/FH
PROGRAM UPDATES FOR FORMS 5A – SERVICES

Under the Bylaws Article 3.E, the Board has the authority and responsibility to set the scope
and availability of services to be delivered by the Program. This responsibility is also
represented by HRSA Program Requirements #2 – Required and Additional Services.

Environmental Health Services is currently listed in Column II. Formal Written
Contract/Agreement under the Additional Services section. In reviewing the services provided
by San Mateo County Health System's Environmental Health Division, we found that services
match HRSA's service descriptor of environmental health services. Since Environmental
Health Division is under San Mateo County Health System, Environmental Health Services
should be listed in Column I. Direct under the service delivery method. We have drafted an
updated Form 5A – Services to add this reference.

Nutrition service is currently listed in both Column I. Direct and Column III. Formal Written
Referral Arrangement under the Additional Services section. Since we have not found an
external, not-paid-for-referral for Nutrition services by San Mateo County Health System,
Nutrition services listed in Column III. Formal Written Referral Arrangement should be
removed. We have drafted an updated Form 5A – Services to add this reference.

In order to make or request the identified change above on the official HRSA documents,
governing Board action is required. The request is for the Board to take such action as to
approve the draft updated version of Form 5A- Services for submission to HRSA.

Approval of this item requires a majority vote of the Board members present.

Attachments:
HCH/FH Form 5A

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Board of Supervisors: Carole Groom • Don Horsley • Dave Pine • Warren Slocum • Adrienne Tissier
Health System Chief: Louise Rogers • **San Mateo Medical Center CEO:** Chester Kunnappilly
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www.sanmateomedicalcenter.org

Self Updates: Services details

H80CS00051: SAN MATEO COUNTY HEALTH SERVICES AGENCY, San Mateo, CA

Grant Number: H80CS00051   BHCMIS ID: 091140   Project Period: 11/1/2001 - 12/31/2016

Budget Period: 1/1/2016 - 12/31/2016

Required Services

Service Type	Column I. Direct (Health Center Pays)	Column II. Formal Written Contract/Agreement (Health Center Pays)	Column III. Formal Written Referral Arrangement (Health Center DOES NOT pay)
General Primary Medical Care	X	X	
Diagnostic Laboratory	X	X	
Diagnostic Radiology	X	X	
Screenings	X	X	
Coverage for Emergencies During and After Hours	X	X	
Voluntary Family Planning	X	X	
Immunizations	X	X	
Well Child Services	X	X	
Gynecological Care	X	X	
Obstetrical Care			
Prenatal Care	X	X	
Intrapartum Care (Labor & Delivery)	X	X	
Postpartum Care	X	X	
Preventive Dental	X	X	
Pharmaceutical Services	X	X	
HCH Required Substance Abuse Services	X	X	X
Case Management	X	X	X
Eligibility Assistance	X	X	
Health Education	X	X	
Outreach	X	X	
Transportation	X	X	
Translation	X	X	

Additional Services

Service Type	Column I. Direct (Health Center Pays)	Column II. Formal Written Contract/Agreement (Health Center Pays)	Column III. Formal Written Referral Arrangement (Health Center DOES NOT pay)
Additional Dental Services	X	X	
Behavioral Health Services			
Mental Health Services	X	X	
Optometry	X		
Environmental Health Services	X		
Occupational Therapy	X		
Physical Therapy	X		
Nutrition	X		
Additional Enabling/Supportive Services			X

Speciality Services			
	Service Delivery Methods		
Service Type	Column I. Direct (Health Center Pays)	Column II. Formal Written Contract/Agreement (Health Center Pays)	Column III. Formal Written Referral Arrangement (Health Center DOES NOT pay)
Podiatry	X		
Psychiatry	X		
Ophthalmology	X		
Cardiology	X	X	
Dermatology	X	X	
Gastroenterology	X		
Other - Orthopedics	X		
Other - Hepatology	X		
Other - Neurology	X		

Close Window

DATE: August 11, 2016

TO: Co-Applicant Board, San Mateo County Health Care for the
Homeless/Farmworker Health (HCH/FH) Program

FROM: Jim Beaumont, Director
HCH/FH Program

SUBJECT: REQUEST FOR THE BOARD TO TAKE ACTION TO APPROVE HCH/FH
BILLING & COLLECTION POLICY

The HCH/FH Co-Applicant Board, as the governing board of the Program, has the
responsibility and authority to create policies regarding Billing 7 Collection. The Program is
currently under a grant condition which includes having these policies established.

As with the Credentialing & Privileging Policies, the Board and Program may utilize as
Program policy, the billing & collection policies of the San Mateo Medical Center, as long as
they meet the minimum requirements for such policies as established by the Health Services &
resources Administration (HRSA). On review of the SMMC Policies, Program believes that,
with the exception of the determination to waive fees, the SMMC policies conform to those
required by HRSA.

Included with the policy is a Fee Waiver Application form, and the policy designates the
HCH/FH Director to make the fee waiver determinations in the best interest of the program.

This request is for the Board to take action to approve the attached HCH/FH Billing &
Collection Policy, including the specification on the authority to make a fee waiver
determination. As part of the HCH/FH Billing & Collection Policy, the Board approves the
incorporation of the SMMC Billing & Collection Policies, with the exception of the fee waiver
determination, as specified in the HCH/FH Policy.

Approval of this item requires a majority vote of the Board members present.

Attachments:
HCH Billing & Collection Policy
SMMC Billing & Collection Policies

Board of Supervisors: Carole Groom • Don Horsley • Dave Pine • Warren Slocum • Adrienne Tissier
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SAN MATEO COUNTY

HEALTHCARE FOR THE HOMELESS/FARMWORKER HEALTH PROGRAM

Program Policy

Policy Area: Fiscal	**Effective Date:** August 11, 2016
Subject: Policy for Billing & Collection	**Approved Date: August 11, 2016** **Revision Date:**
Title of Policy: Billing & Collection Policy	

1. **Rationale or background to policy:**

The San Mateo County Health Care for the Homeless/Farmworker Health (HCH/FH) Program is committed to ensuring the homeless and the farmworker families of San Mateo County receive the health and medical services they need regardless of ability to pay. The Program also has a responsibility to remain fiscally solvent. It is the responsibility of the HCH/FH Co-Applicant Board to establish such policies and procedures for Billing & Collection as may be necessary to ensure both of those outcomes,. The HCH/FH Program expects patients to pay their outstanding balances in a timely manner. A bill for services is based on the patient's ability to pay as established by the approved HCH/FH Program Sliding Fee Scale. The HCH/FH Program, through the San Mateo Medical Center's (SMMC) fiscal policies, also provides payment plans as necessary should financial circumstances of a patient receiving services change, or if the current financial assessment does not accurately reflect the patient's ability to pay. A patient who refuses to pay his/her outstanding balance will be notified and may be subject to a Payment Plan, which may lead to termination of services if not followed.

2. **Policy Statement**:

Based on the utilization of the San Mateo Medical Center's Ambulatory Clinics and safety net services for the delivery of primary care (and other) medical services to the homeless and farmworker families, the HCH/FH Program accepts and utilizes the Billing & Collection Policies as established by SMMC, unless otherwise explicitly stated in this policy. The HCH/FH Co-Applicant Governing Board shall review on at least a biennial basis the SMMC Billing & Collection Policies to determine their continued acceptance.

The HCH/FH Co-Applicant Board has also established a Sliding Fee Discount Program and Policy (SFDP) that provides specifics on the allowable charges for services based on a patient's ability to pay (income & family size).

3. Procedures:

Once a patient's responsibility to, and ability to pay is determined, the patient is expected to pay for services based on the Sliding Fee Discount Program. Regardless of their established ability to pay, any patient who believes that they are unable to meet their financial responsibility may submit a Patient Request for Waiver of Fees (attached and hereby incorporated). The Governing Board delegates to the Director the authority to review individual Patient Request for Waiver of Fees cases and make decisions in the best interest of the HCH/FH Program.

Approved _____

_____   _____
Board Chair   Program Director

Date:_____   Date:_____

ATT: PATIENT WAIVER OF FEES APPLICATION

PATIENT WAIVER OF FEES APPLICATION

As provided for by Federal Law, I hereby request that the San Mateo County Health Care for the Homeless/Farmworker Health (HCH/FH) Program make a written determination of my request to waive my out-of-pocket fees associated with services provided to me. I verify that the information I submit is accurate and true and I authorize the HCH/FH Program to verify the information by all necessary means. I also understand that if the information which I submit is determined to be false, such determination will result in denial of approval for waiver of fees and I will be liable for any balances on my account.

> **The information requested will be held in the strictest of confidence and will be used solely for the purpose of determining waiver of health center fees**

Patient Name	Date of Birth

Address	Telephone

REASON FOR WAIVER REQUEST

Please briefly describe the hardships you are facing that are preventing you from paying for the fees associated with the services provided:

_____

_____

_____

_____

_____

_____

_____

_____

_____

SIGNATURES

PATIENT (OR GUARDIAN)	DATE

FOR STAFF USE ONLY

WAIVER OF FEES DETERMINATION

TREATING PROVIDER CONSULTED   (**CIRCLE**)   **YES / NO**

TREATING PROVIDER NAME (or Medical Director in Absence)

TREATING PROVIDER SIGNATURE   DATE

WILL FEES BE WAIVED FOR THIS PATIENT?   (**CIRCLE**)   **YES / NO**

DIRECTOR SIGNATURE   DATE

IF FEES WILL NOT BE WAIVED, PLEASE EXPLAIN RATIONALE

IF YES, PLEASE INDICATE PERCENT OR AMOUNT OF FEES (OR TOTAL/100% IF ALL) _____

IF YES, PLEASE INDICATE TIMEFRAME FOR ELIGIBILITY OF WAIVER OF FEES _____

SMMC Financial Policies

Billing & Collection

SMMC Financial Policies

Charge Master

SUBJECT: PROCEDURE CHARGE MASTER MAINTENANCE
DEPARTMENT: FINANCE: REVENUE CYCLE (CDM)
AUTHOR: HEALTH SERVICES MANAGER

San Mateo Medical Center maintains a procedure charge master of all billable charges including hospital and physician charges. Department managers are responsible for the annual review of departmental charges to assure accuracy, completeness, and appropriateness. The Data Control Unit is responsible for the maintenance of the overall procedure charge master. The following procedure is to be followed when a department manager requests an addition/change/deletion to the procedure charge master.

1.   All requests for additions/changes/deletions to the procedure charge master must be submitted on a Procedure Master Maintenance form (see attached). Up to three requests may be submitted per form. If a large number of deletions and/or price changes are being made, the department manager may submit the original procedure charge master reflecting the changes. The form is completed by the department manager as follows:

       a.   Department - The name of the hospital department submitting the request.

       b.   Revenue Center # - The four-digit revenue center number corresponding to the requesting department.

       c.   Add/Change/Delete - Check the appropriate box.

       d.   Procedure # - For changes/deletions, write the eight-digit number previously assigned to the procedure. For additions, write "New."

       e.   CPT Code - The five-digit number assigned to the service/procedure in the most current CPT manual; primarily used for physician, laboratory, radiology charges. Include modifiers if appropriate.

       f.   Effective Date - The date that the addition/change/deletion should take effect.

       g.   Current Charge - The current charge for the procedure.

       h.   Invoice Description - 25-character description of the service, supply, etc.; this descriptor appears on the hospital invoice. It should be a clear description of the service, supply, etc., provided to the patient.

1

i.   Proposed Charge - The new charge for the procedure. Charges should reflect the actual value of services provided and be based on factors such as rates charged by other providers and/or cost incurred by the hospital. Charges for materials and equipment including supplies and pharmaceuticals should be based on the hospital's mark-up formula.

j.   Technical Description - 50-character description of the service, supply, etc.; this descriptor appears in the procedure catalog. For easier reference, use common descriptors for related services, supplies, etc., e.g., I.V. Solution-1000 cc, I.V. Solution-500 cc, etc. CPT manual descriptions should be used if appropriate; a copy of the page from the CPT manual may be submitted.

k.   Professional Component - Use only if there is a professional component associated with the procedure; primarily Radiology, EEG, etc. A charge should also be indicated.

l.   Generate To/From Procedure # - Indicate only if this procedure will generate or is generated by another procedure.

m.   Justification - Indicate why addition/change/deletion is being made.

NOTE: If numerous charges are made, it is acceptable to make charges on the charge master report.

2.   The department manager is responsible for reviewing additions/changes/deletions to the department's procedure charge master with his/her director and/or administrator. If approved, the director and/or administrator should cosign the form based on the written justification.

3.   Once the form has been approved, it is submitted to the Patient Services Supervisor, Data Control, for data entry.

4.   The Patient Services Supervisor makes the appropriate additions/changes/deletions to the procedure catalog via computer functions FUP, FPC, APE, and/or CPTM.

5.   Upon completion, the Patient Services Supervisor will sign and date the form. If a new procedure was added, the supervisor will write the eight-digit procedure number on the Procedure # line of the form.   The supervisor will make a copy of the form: the original is placed in the Procedure Charge Master Binder under the appropriate department; the copy is forwarded to the department manager.

6.   If a procedure was added, the department manager will update all appropriate charge documents and advise staff accordingly.

7. Copies of the procedure charge master are generated quarterly. Departmental procedure charge master will be distributed to the appropriate department manager. The departmental procedure charge master should be kept with the departmental protocol manual.

Implementation: 03/91
Reviewed and approved by: Date:
   Administrative Council   11/97

                                                                                11/21/02

   Old number(s): 1.53 (RI chapter)
   Received for review: (date) from (committee) or (person and dept)
   NOTE(S):
   STATUS:

SUBJECT:	CHARGE DESCRIPTION MASTER (CDM) PRICING REVIEW
DEPARTMENT:	FINANCIAL SERVICES: CHARGE DESCRIPTION MASTER
AUTHOR:	DIRECTOR, REVENUE CYCLE OPERATIONS / CDM COORDINATOR

POLICY:

The CDM Coordinator at San Mateo Medical Center (SMMC) is responsible for ensuring the data integrity of the Chargemaster. This includes having documented policies and procedures for adding or updating charge amounts to line items within the CDM, as well as continual evaluation of ancillary systems containing cost information and mark-up formulas (i.e., system stress testing).

PURPOSE:

1. To provide guidelines and procedures that will ensure that:

    The charge description master for SMMC contains charges that are consistent with mark-up rates that have been approved based upon evaluations and established guidelines for SMMC. This policy must also be used in conjunction with policy LD.04.02.03 Charge Description Master (CDM) Updates in the Leadership chapter in FileNET.

2. To establish clear guidelines for the application of markup formulas for all charge codes entered by the CDM Coordinator including:

    - Professional Charges
    - Technical Charges
    - Supply Charges
    - Routine evaluation of mark-up policies used in various ancillary departments throughout the medical center to include:

        – Pharmacy
        – Laboratory (including Laboratory, Blood Bank, and Pathology)
        – Operating Room
        – Supplies used in outpatient clinic areas and procedural areas, as well as inpatient use areas

PROCEDURE:

CDM Coordinator

1. The CDM Coordinator is to follow established guidelines for adding and updating charge amounts for line items within the CDM based on approved SMMC formulas

2. To accomplish this, the CDM Coordinator will utilize the most recent download of the CDM, Craneware Toolkit ©, and all available up-to-date Medicare fee schedules to measure that all line items follow the markup formulas as outlined below:

   a. Professional charges must be 300% above the professional fee schedule
   b. Technical charges must be 300% above the Ambulatory Payment Classification (APC) fee schedule
   c. As CDM pricing reviews occur, the CDM Coordinator must always keep in mind any "across the board" increases or decreases that may have occurred during the fiscal year that may skew statistics, and that charge amounts will not be precise based on the formulas outlined above
   d. Any ancillary systems that contain cost information must be reviewed with the department director/manager to ensure that no unapproved changes have been made to the markup formulas based on this documented policy

3. Laboratory

   a. Tests performed at Reference Laboratory are 300% of the Medicare fee schedule
   b. Tests performed at Quest Diagnostics are charged at the fee schedule amount obtained from Quest without any markup applied.

4. Pharmacy contains various markups based upon the numerous products and solutions that are housed within the SMMC formulary. Pharmacy markups are as follows:

   a. Unit Dose (tabs and liquids)
      AWP + $4.00
   b. Multi-dose Container (i.e., opth, inhalers, etc).
      1) AWP x2-$10
      2) Minimum Charge $12.00
      3) If AWP is greater than $7000, charge is AWP x2.5
   c. Injectables
      1) AWP x2 + $10.00
      2) Minimum Charge $12.00
      3) If AWP is greater than $7000, charge is AWP x2.5
   d. Controlled Substances
      1) Tabs $6.00 each
      2) Solutions $6.00 each
      3) Injectables AWP x2+$10
      4) Minimum Charge $15.00

5. Materials Management/Central Processing Department (CPD) is unique as it contains only supply items that are utilized by the facility. The formula utilized by CPD is four (4) years old and should be routinely reviewed by the CFO. The approved markup formula for supply items is listed below and based on 2006 data:

ITEM COST	MARK UP
$0 - $.50	Flat $3.00
$.51 - $ 20.00	Cost plus 575%
$21 - $50	Cost plus 525%
$51 - $100	Cost plus 450%
$101 -$500	Cost plus 400%
$501 - $9.999	Cost plus 275%
Over $10K	No mark up

6. Any aberrancy in data must be reported to the Director of Revenue Cycle Operations and subsequently to the Chief Financial Officer as soon as possible. This will ensure that more intensive analysis can be performed to include gross revenue calculations and the impact on SMMC.

7. A detailed report summarizing this review, complete with recommendations for change, will be provided within ten (10) business days following the completion of the analysis. The report data should be separated by any impacted outpatient clinics, Pharmacy, CPD, Laboratory, other ancillary areas, and any Finance Departments impacted so they may adjust budgets accordingly (i.e., Decision Support/Financial Analysis, Reimbursement, Accounting, etc).

8. The CDM Coordinator will thoroughly document all findings, in electronic format, to be easily retrieved for future reference. The preference would be documentation in the Chargemaster Operations Database as well as in the designated location for all CDM work files (network drive).

9. It is important to note that all "across the board" increases that do not involve fee schedule analysis must be approved by the County Board of Supervisors prior to implementation

Reference: policy titled Charge Description Master (CDM) Review in FileNET in the
            Financial Services Department, CDM (Charge Description Master) manual

Implementation: April 2011
Reviewed and approved by: Date:
   ~~County Counsel~~
   ~~Executive Management Team~~
   ~~Hospital Board~~
   Charge Description Master Coordinator   3/11
   Director, Revenue Cycle Operations   3/11
   Chief Financial Officer   3/11
   Deputy Director, Clinical Ancillary Svcs   3/11
   Chief Operating Officer   10/11 FINAL

                                               10/17/11

Old number(s): N/A
Received for review:
NOTE(S):
STATUS:

SUBJECT: CHARGE DESCRIPTION MASTER (CDM) REVIEW

DEPARTMENT: FINANCIAL SERVICES: CHARGEMASTER

AUTHOR: DIRECTOR, REVENUE CYCLE OPERATIONS / CDM COORDINATOR

POLICY:

The CDM at San Mateo Medical Center (SMMC) is presently scheduled to perform four quarterly comprehensive reviews. The CDM Coordinator must have documented procedures in order to complete a comprehensive evaluation of the CDM at SMMC.

PURPOSE:

To provide guidelines and procedures that will ensure that:

The CDM for SMMC is evaluated at regularly scheduled intervals to ensure that coding and billing integrity is based on federal and state regulations. The CDM review will encompass a review of:

- Charge codes and HCPCS codes
- Revenue Codes
- Technical and Professional Charges
- Use of statistical codes in the CDM
- Evaluation of industry-specific best practice standards that may be implemented
- Evaluation of tools used to analyze the CDM as well as the end-user utilization of Craneware Toolkit ©

CDM Coordinator

1. The CDM Coordinator is to maintain the accuracy of all chargeable items within the Core system

2. In order to accomplish this, the CDM Coordinator will utilize the current CDM system, Craneware Toolkit © to measure all items at least on a quarterly basis based on the rules that have been pre-loaded into the software. This includes a comprehensive review of all items in the CDM including:

    a. HCPCs codes
    b. Revenue Codes
    c. Hard-coded modifiers
    d. Technical and professional charges

    e. CDM content, format, and structure
    f. Statistical chargecodes
    g. Lost or misapplied charge line items

3. Any errors in data calculation by the software must be reported to the support team or area sales representative as soon as possible so the data integrity can be maintained

4. As Medi-Cal, Medi-Cal products, and Medicare bulletins are published throughout the year, the potential impact upon the Chargemaster is frequent. These must be reviewed as soon as possible once released due to the potential for inaccurate coding/billing, as well as maintaining billing compliance integrity

5. Quarterly Medicare and Medi-Cal updates must be reviewed thoroughly prior to the CDM review to ensure that the CDM Coordinator has the most up-to-date information available

6. Analysis of separate clinical charge systems including pharmacy and lab should be reviewed to verify charging and coding accuracy. This can be completed via analysis of the dictionaries in the systems, as well as claims analysis reporting via the DSG billing system or via pre-billing from Core reports. System interface and charging irregularities may also be identified during this process

7. A written, detailed report summarizing each quarterly review, complete with findings and recommendations for improvement, will be provided within ten (10) business days following the completion of the review. The report should be separated by clinical areas and individual follow-up meetings conducted as needed.

   a. Upon completion of the report, the CDM Coordinator will meet with key SMMC personnel to ensure that findings and recommendations for change are appropriately communicated.
   b. All current findings and recommendations must be reviewed with those of previous CDM reviews to verify that recommendations are being followed (as appropriate).
   c. Edit analysis must also be conducted to ensure there are no system edits or rules in place that are improperly overriding correct coding/charging logic. thus changing codes on the billing form

      1) This would be performed by reviewing any DSG billing edits and
      2) Receivables Policy Manager edits

8. The CDM Coordinator will meet with all clinic/clinical departments upon completion of the review to address any aberrant findings. These findings may include:

   a. Services that should not be performed in that CDM setting
   b. Services that are missing from the CDM that should be performed in that specific CDM setting
   c. Errors in the CDM that identify trends of departments not working their CDM via the Craneware Toolkit © per SMMC policy LD.04.02.03 Charge Description Master (CDM) Updates in the Leadership chapter in FileNET

9. The CDM Coordinator will thoroughly document all findings, training/education provided, etc., in electronic format to be easily retrieved for future reference. The preference would be the Chargemaster Operations Database.

Implementation: April 2011
Reviewed and approved by: Date:
~~County Counsel~~
~~Executive Management Team~~
~~Medical Executive Committee~~
~~Hospital Board~~
Charge Description Master Coordinator   3/11
Director, Revenue Cycle Operations   3/11
Chief Financial Officer   3/11
Deputy Director, Ambulatory Svcs   3/11
Chief Operating Officer   11/11 FINAL

                                                              11/22/11

Old number(s): N/A
Received for review: (date) from (committee or person and dept)
NOTE(S):
STATUS:

SUBJECT: CHARGE DESCRIPTION MASTER (CDM) UPDATES

CHAPTER: LEADERSHIP (LEADERSHIP)

AUTHOR: CDM COORDINATOR

POLICY:

The charge description master update policy will be applied universally throughout San Mateo Medical Center (SMMC) without exception. This will enable a standardized process to be implemented and will promote efficiency as well as reduce disorganization of both time and communication.

PURPOSE:

The purpose of this policy is to notify users at SMMC of the correct processes for requesting updates to departmental Charge Description Masters (CDMs).

DEFINITION:

Updates: requests for new codes, requests for deletions, requests for new chargemaster departments, as well as general coding-related questions that are directed to the CDM Coordinator.

A. General Information

1. All inpatient, outpatient, and ancillary departments are required to utilize the Craneware Toolkit software for all CDM updates.

2. Updates requested via the Craneware Toolkit should be as concise and specific as possible indicating the change requested (addition, deletion, change, question), while providing as much detailed information as possible within the request.

3. The CDM Coordinator will receive and review all update requests via the Craneware Toolkit and will respond to them utilizing the Toolkit. If the change request posed is unclear in nature or requires additional clarification from the requesting department, the CDM Coordinator will contact the individual directly (via email or telephone) requesting the additional information.

4. Effective July 1, 2010, emails will no longer be an accepted form for communicating change. Any emails that are received regarding routine CDM updates will be returned to the sender via GroupWise with a reply message directing the individual that "No action will be taken regarding your CDM request sent via email. All requests for CDM updates must be sent utilizing the Craneware Toolkit."

B. New Chargemaster Department Set-Up

1. Exceptions to this policy would only include new charge master department setup requests. These cannot be submitted utilizing Craneware as the department will not exist. These requests can only be received in written format and via the pre-approved standing policy for review.

2. The Chief Financial Officer, Director of Revenue Cycle Operations, Reimbursement Director, Controller, and Financial Planning Director must determine if an additional cost center, charge master department, or other financial service transaction code should be created to accomplish what the requester is applying for.

3. Once a determination has been made affirming an additional department, a subsequent meeting will be held with the CDM Coordinator and the department requesting the new CDM. The purpose will be to obtain the data and code sets required for building both the CDM, as well as the encounter form (if applicable) for the new department.

4. Once the new department has been activated, the entire CDM must be reloaded into the Craneware Toolkit, and manager responsible for the department added into the user table with assignment responsibility for the new department.

Implementation: 8/10
Reviewed and approved by: Date:
~~Chapter Chair~~   ~~1/12~~
~~County Counsel~~
~~Executive Management Team~~
~~Medical Executive Committee~~
~~Hospital Board~~
CDM Coordinator   7/10
Director, Revenue Cycle Operations   7/10, 1/12
Chief Financial Officer   7/10 FINAL
                                                          1/11/12
Old number(s): LD.04.02.03
Received for review: (date) from (committee or person and dept)
NOTE(S):
STATUS:

SUBJECT:	SERVICE MASTER MAINTENANCE
DEPARTMENT:	FINANCIAL SERVICES: CHARGE DESCRIPTION MASTER
AUTHOR:	DIRECTOR, REVENUE CYCLE OPERATIONS / CDM COORDINATOR

POLICY:

The Chargemaster (CDM) Coordinator at San Mateo Medical Center (SMMC) is presently responsible for partial maintenance of the Service Master. The Information Services Department (ISD) is responsible for ancillary areas due to order and result pathways, etc. These procedures will provide clear guidance regarding the delegation of duties as well as additional activity that should routinely occur within the Service Master.

PURPOSE:

To provide guidelines and procedures that will ensure that:

The Service Master is the pathway in Siemens that links front-end pathways to back-end translation tables (located within Core/Invision/Siemens) for SMMC. The maintenance of the Service Master is by designated individuals based upon service area.

A. CDM Coordinator

1. The CDM Coordinator will be responsible for entering and updating the following items in the SMMC Service Master:

   a. all outpatient clinic items
   b. all supply and/or pharmacy items used within the outpatient clinic setting

2. The CDM Coordinator will also be responsible for ensuring that appropriate mechanisms are in place within the Service Master to prevent erroneous billing activity. This can be accomplished by numerous methods.

   One example is an annual review of the Service Master and the "maximum ordering quantity" field for the service being provided. To be more specific, all Evaluation and Management codes can be restricted so that the default for entry via the order-entry pathways is "1" instead of the default of "999." By implementing these additional measures, it will reduce and eliminate a large number of billing errors due to keying mistakes made by charge-entry staff.

B. ISD Analysts

1. ISD analysts are presently assigned responsibility for managing specific clinical applications within SMMC. There are currently systems that impact order entry, results, and various other pathways within Invision, as well as the application the analyst manages. The specific ISD analyst will be responsible for entering and updating the following items in the SMMC service master:

    a. all Laboratory items (including order entry pathways, results pathways and the Lab Systems)
    b. all Pharmacy items (including order entry pathways)
    c. all Radiology items (including other entry pathways, result pathways, and working with the Radiology department to ensure that the Radiology Information System is updated)

2. ISD analysts will also ensure that all interfaces are properly routing information to the appropriate system, including eClinicalWorks and Pulse Check [while this line item does not specifically apply to the Service Master, it does apply to the dictionaries that are maintained in these systems and how the order/result interface engines are operating.]

Implementation: April 2011
Reviewed and approved by: Date:
~~County Counsel~~
~~Executive Management Team~~
~~Hospital Board~~
Charge Description Master Coordinator   3/11
Director, Revenue Cycle Operations   3/11
Deputy Director, Health Information Mgmt Svcs   3/11
Chief Financial Officer   3/11 FINAL
                                                                10/12/11

Old number(s): N/A
Received for review: (date) from (committee) or (person and dept)
NOTE(S):
STATUS:

SMMC Financial Policies

Patient Access

SUBJECT: CHILDREN AND FAMILY SERVICES – REGISTRATION OF PATIENTS

DEPARTMENTAL UNIT: BUSINESS SERVICES/OUTPATIENT SERVICES

AUTHOR: BUSINESS SERVICES MANAGER

PURPOSE

Provide standardized procedures that will promote consistent registration and subsequent payment to San Mateo County Health Center for services rendered to children who are under the care and jurisdiction of Children and Family Services.

POLICY

The San Mateo County Human Services Agency, Children and Family Services, is responsible for the payment of medical bills at San Mateo County Health Center that are the result of special needs identified by members of the Human Services Agency. San Mateo County Health Center recognizes that San Mateo County Human Services Agency is the payor of last resort; however, it is the responsibility of Children and Family Services to obtain Medi-Cal eligibility and to provide San Mateo County Health Center with the required proof of eligibility stickers.

PROCEDURE

A.   RECEIVING HOME RESPONSIBILITIES – CLINIC VISITS

       1.   An authorization form will accompany each patient when they are seen in the Pediatric Clinic. The authorization form will identify each patient and provide the clinic with demographic information.

       2.   If the patient is known to have Medi-Cal benefits or private insurance at the time of service, the Medi-Cal number and/or proof of eligibility or insurance information will accompany the patient authorization form.

B.   CHILDREN AND FAMILY SERVICES RESPONSIBILITIES – EMERGENCY DEPARTMENT VISITS

       1.   If patients are brought from the Receiving Home, a treatment authorization must accompany the patient, along with any known insurance or Medi-Cal benefits information as described in A.1 and A.2.

       2.   If patients are brought in directly from a residence other than the Receiving Home, the official agent/social worker representing the patient will be

responsible for authorizing payment by Children and Family Services. The official agent will be required to sign an authorization form.

C.   HOSPITAL CLINICS AND EMERGENCY DEPARTMENT RESPONSIBILITIES

1.   Hospital Clinics and Emergency Department staff will register each patient in accordance with registration policies and procedures. All patients will be registered completely even if the patient has a current ID plate from previous visits.

2.   Clinics staff will obtain a written authorization from the official agent/social worker and attach the form to the registration materials for forwarding to the Outpatient Billing Office.

3.   All registration material will be forwarded to the Outpatient Billing Office in accordance with policies and procedures.

4.   Coding

CHAMP Checks Without Insurance or Medi-Cal POE -   D35
CHAMP Checks With Medi-Cal POE -   C20
Victims of Sexual Assault Checks – 2 Codes According to Police Department
CHDP Covered Visits -   C85
CHDP Follow-up Treatment Visits -   D86
Emergency Department Visits Without POE -   D35
Children Brought in by Foster Parents and have
       No Medi-Cal POE -   D35

The "ELG" function will be checked on all patients prior to coding to determine if Medi-Cal has already been established. If eligibility is determined in the "ELG" function, the account should always be coded C520.

D.   OUTPATIENT BILLING OFFICE RESPONSIBILITIES

1.   An alphabetical list of patients and Children and Family Services charges will be prepared and sent, on a monthly basis, to the Human Services Agency. A photocopy of all signed authorizations will accompany the list.

2.   Upon receipt from Children and Family Services of the final list of patients that clearly identifies the correct payment source, San Mateo County Health Center will provide an itemized invoice to Children and Family Services for all the patients deemed to be paid through Children and Family Services.

3. All accounts found to have other coverage will be re-coded and billed according to policies and procedures.

4. Upon receipt of the journal voucher from Children and Family Services, the Billing Office staff will post the voucher payment using procedure code 00017350 for D735 accounts and procedure code 00017368 for D736 accounts.

E. CHILDREN AND FAMILY SERVICES ACCOUNTS PAYABLE RESPONSIBILITIES

1. Children and Family Services staff will review the monthly list of visits and provide San Mateo County Health Center with proof of insurance or Medi-Cal eligibility within 14 days.

2. Children and Family Services staff will return the list after clearly indicating the payment source on the list.

3. Accounts that are determined to be the sole responsibility of Children and Family Services will be paid via journal voucher within 14 days from receipt of final invoices.

F. FOSTER CHILDREN

1. The Human Services Agency will provide San Mateo County Health Center with a list of all foster parents. When a child presents in the clinics or Emergency Department, the San Mateo County Health Center staff will verify the foster parent on the list provided. If a foster parent is not on the list, the clinic or Emergency Department staff will telephone the Shelter Home Finding Unit at 595-7636 for verification.

2. San Mateo County Health Center registration staff will list the foster parent as guarantor of payment unless the verification is obtained. When the verification is obtained, the foster parent will sign an authorization form. NOTE: Most children placed in foster homes should already have Medi-Cal benefits established.

Implementation: 1/91
Revised: 03/01
Reviewed and Approved by: Business Services   Date: 11/96, 01/98, 03/01

03/20/01

SUBJECT: CONDITIONS OF ADMISSION FORM COMPLETION

DEPARTMENT: PATIENT FINANCIAL SERVICES: ADMITTING

AUTHOR: PATIENT ACCESS MANAGER/PATIENT SERVICES
                          SUPERVISOR

PURPOSE:

To describe the actions to be taken if a Conditions of Admission form is not signed at the time of admission.

POLICY:

All patients receiving inpatient services at San Mateo Medical Center must sign a Conditions of Admission (COA) form (available in the Admitting Office). In some cases, the patient is unable to sign the Conditions of Admission at the time of admission and there is no relative or family representative available. This procedure will be followed to obtain a signature on the Conditions of Admission after the patient has been admitted to the hospital.

PROCEDURE

1. If the patient is unconscious or is otherwise unable to sign the COA form at the time of admission to the hospital or if a family member signs the COA on behalf of the patient, the Admitting staff will:

    a. Write a note on the Conditions of Admission indicating that the patient is unable to sign and the reason, e.g., unconscious, 5150, etc.

    b. Place the entire Conditions of Admission form in the patient's binder.

    c. Attach a label **(CONDITIONS OF ADMISSION <u>NOT</u> SIGNED)** to the outside of the patient's binder.

    d. Write **COA NEEDING SIGNATURE** and the patient's medical record number, name, unit and bed number in the Admission and Discharge log (A and D log).

    e. A conserved patient may not sign consent forms. If the patient is conserved, status of conservatorship can be ascertained by calling the Aging and Adult TIES line at 1-800-675-8437 24 hours per day. Admitting will fax a COA form to the conservator for signature. If conservator will not sign COA, Admitting staff will write conservator's name and "refused to sign" and the date on the form.

2. The Admitting staff will monitor the status of all patients who need to sign a COA. This will occur at least once per shift by contacting the appropriate nursing unit. When it is determined that the patient can sign the COA, the Admitting staff will go to the inpatient unit and take the COA from the patient's binder. Admitting staff will go to the patient's room and have the patient sign the COA. If the patient refuses to sign, the Admitting staff will contact the Nurse Manager and note on the COA that the patient refused to sign.

3. Once the patient has signed the COA, the Admitting staff will:

   a. Tear down the form and distribute as follows:

      1) Pink copy - Patient

      2) White copy (original) - Binder

      3) Yellow copy - Account folder (if available); if not available, put in Inpatient Billing box

   b. Remove the label from the patient's binder.

   c. Remove the label from the patient's account folder (if available).

   d. Enter Completed By and the name of the Admitting staff person who completed the Conditions of Admission form and date in the A&D log.

4. If the patient refuses to sign the COA, the Admitting staff will write "patient refused to sign" and the date on the COA form.

Implementation: 9/95
Reviewed and approved by: Date:
   Director, Administrative Services   9/95, 5/98, 4/03
   Access Manager   7/04
   Director, Patient Financial Services   7/04
   Chief Financial Officer   7/04
   Medical Executive Committee   8/04
   Hospital Board   9/04

7/20/04

SUBJECT: DISCOUNTED HEALTH CARE (DHC) PROGRAM

DEPARTMENT: FINANCIAL SERVICES: PATIENT ACCESS

SPONSOR/AUTHOR: SMMC CFO / SAN MATEO CO. MANAGER'S OFFICE

THIS POLICY REFLECTS SAN MATEO MEDICAL CENTER'S INCORPORATION OF SAN MATEO COUNTY POLICY

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 San Mateo Medical Center (SMMC) 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:

I. 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.

II. 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.

III. Definition of Discount

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

IV. 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.

V. Scope of Services

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

VI. 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.

VII. 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.

VIII. Application Process

A. The DHC Program will be considered for any patient who indicates an inability to pay for medical services. In general, patients must meet certain eligibility criteria, including residency, income and assets tests to qualify for the DHC Program. The patient's unique circumstances may be taken into consideration.

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

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

D. SMMC will make available to patients a Community Health Advocate (CHA) or Financial Counselor whose mission is to match the patient with the appropriate form of

financial assistance based on the patient's unique financial situation. Efforts will be made to provide assistance in the primary language of the patient or patient's guarantor.

E. DHC Program enrollment must be renewed and updated for each inpatient stay and, at a minimum, annually, for outpatient visits. This is required in order to incorporate any changes to a patient's financial status. The County shall determine and may modify the period of eligibility for any individual entitled to receive services covered under financial assistance programs.

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

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

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

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

IX. Verification Process

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

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

   1. Proof of Residency

       a. Car registration
       b. Voter registration
       c. California driver's license or ID card

d. Employment record including offer letter, pay stubs, lay-off notice, employment or registration contract with an employment service, employer affidavit
e. 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.
f. Utilities bill – if not in patient's name, the bill should be accompanied by a signed statement from a relative or non-relative landlord
g. Listing in the city directory or phone book that can be verified
h. Principal property ownership document or property tax bill
i. Membership record in a religious institution
j. Student identification
k. School records
l. Recent marriage, divorce, or evidence of domestic partnership issued in the state of California (within the last three months)
m. Recent court documents showing the applicant's current address (within the last three months)
n. Insurance documents
o. Police record from a California law enforcement agency (within the last three months)
p. Documents from a homeless shelter or other public or community service agency indicating that the applicant is receiving services from the agency
q. Adoption record (within the last three months)
r. Medical record except San Mateo Medical Center (within the last three months)
s. Voided personal check with pre-printed address
t. Other proof of residency – other third party documents verifying residency of applicant can be provided

2. Proof of Income

a. Unemployment – employer's records; EDD records; UIB check; layoff notice; training program records; training stipends; union records.
b. 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.
c. 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.
d. 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.

 e. 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.

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

3. Proof of Assets

 a. Tax records

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

 c. 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

 d. Property excluding principal residence – current year's property tax statement; loan payment; receipts for expenses or insurance

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

 f. Other assets – stock certificates; letter from broker; other property of value

 g. Other proof of assets – other third party documents verifying assets of applicant can be provided

X. Notification of Enrollment or Disenrollment

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

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

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

XI. Appeals Process

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

1. 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).

2. 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.

B. <u>Step-One Appeal: Individual Eligibility Review (IER)</u>

1. 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.

2. 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.

3. 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.

4. 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.

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

1. 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.

2. 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.

3. 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.

4. 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.

D. <u>Anytime Request for Eligibility and Financial Review</u>

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.

XII. Periodic Board Reports

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

XIII. 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.

Implementation: 9/05
Reviewed and approved by: Date:
    San Mateo County Manager's Office / BOS   2/06
    Chief Financial Officer   5/06
    County Counsel   5/06
    Executive Management Team   5/06
    Medical Executive Committee   6/06
    Hospital Board   7/06

                                                        4/25/06

SUBJECT:	eCW BILLING ALERTS
DEPARTMENT:	FINANCIAL SERVICES: PATIENT ACCESS
AUTHOR:	DIRECTOR, REVENUE CYCLE OPERATIONS

POLICY:

When Business Services determines from patient interaction or insurance denials that the insurance information is incorrect on a patient account, Business Services will enter a Billing Alert in eCW. When Patient Access pre-registers (confirms) a patient in eCW and there is a Billing Alert, the PSAII will read the alert and take appropriate action, including verifying eligibility, to ensure the most accurate insurance information and insurance codes are applied to each patient account.

PURPOSE:

Utilize Billing Alerts in eCW to communicate between Business Services and Patient Access when insurance coding and eligibility issues are identified on individual patient accounts. This will improve insurance information accuracy and billing processes.

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1. When Billers receive an Insurance Denial or otherwise determine the insurance is incorrect for a patient account and the correct information is known, they will update the patient's account on the front end in SMS/CORE.
2. If the information is not known, they will enter a Billing Alert in eCW. This will alert the PSAII to validate and update the patient's insurance information when pre-registering (confirming) the patient's next visit.
3. The Billing Alert entry is a free text field and may contain up to 600 characters. Staff can view the first 65 characters on the window, and the entire entry by double clicking the alert. Each message should be kept to a minimum, yet communicate the issues. Following are some sample messages to be used:

   a. Medicare HMO terminated 01/01/2011
   b. Medi-Cal HMO terminated 01/01/2011
   c. Not an (ACE, Healthy Family) member as of 01/01/2011
   d. Not a Care Advantage member as of 01/01/2011
   e. Patient has other insurance per denial (Patient has EDS per HPSM denial dated 01/01/2011)
   f. Patient has insurance (Blue Cross) primary to Medicare (MSP)

4. When the PSA is pre-registering (confirming) the visit in eCW and there is a Billing Alert, PSA will read the alert, then run HDX, visit payer web sites and/or validate insurance coverage with patient.

5. PSAII will also ensure once insurance information is validated that the information is accurately entered on the patient's visit record.
6. PSAII may choose to update the Billing Alert when eligibility is updated.

Implementation: April 2011
Reviewed and approved by: Date:
   ~~County Counsel~~
   ~~Executive Management Team~~
   ~~Hospital Board~~
   Director, Patient Access   12/11
   Director, Revenue Cycle Operations   3/11
   Chief Financial Officer   3/11
   Deputy Director, Clinical Ancillary Svcs   3/11
   Deputy Director, Ambulatory Svcs   3/11
   Chief Operating Officer   12/11 FINAL
                                        12/16/11

Old number(s): N/A
Received for review: (date) from (committee or person and dept)
NOTE(S):
STATUS:

SUBJECT:	FEDERALLY QUALIFIED HEALTH CENTER (FQHC) REGISTRATION
DEPARTMENT:	FINANCIAL SERVICES: PATIENT ACCESS
AUTHOR:	DIRECTOR, REVENUE CYCLE OPERATIONS

POLICY:

This policy will identify and establish guidelines for the appropriate registration of the various types of FQHC visits.

PURPOSE:

Provide guidelines for registration of FQHC patients, improving the accuracy of registration information, including the reduction of financial coding errors, and improving the flow of patients in the clinics and ancillary departments.

A. **HP (formerly EDS) Medi-Cal FQHC visit**

1. <u>Medi-Cal Primary (C72) FQHC 00001 (including CPSP, CHDP, and other qualified visits)</u>

    a. Eligibility status is checked through the use of HDX
    b. Patients who are not assigned to HPSM for managed care but are otherwise eligible for Medi-Cal benefits will be registered with the C72 Ins Plan Code
    c. Patients must receive Physician services during the visit
       1) The following providers, for FQHC purposes, are defined as "physicians"
          a) A doctor of medicine or osteopathy authorized to practice medicine and surgery by the State and who is acting within the scope of his/her license
          b) A doctor of podiatry authorized to practice podiatric medicine by the State and who is acting within the scope of his/her license
          c) A doctor of optometry authorized to practice optometry by the State and who is acting within the scope of his/her license
          d) A doctor of chiropractics authorized to practice chiropractics by the State and who is acting within the scope of his/her license

   e) A doctor of dental surgery (dentist) authorized to practice dentistry by the State and who is acting with in the scope of his/her license

  2) CPSP Practitioner Defined
- A comprehensive Perinatal Services Program (SPSP) practitioner as defined in California Code of Regulations (CCR), Title 22, Section 51179.7, is a physician who is either a general practice physician, family practitioner physician, pediatrician, obstetrician-gynecologist, certified nurse midwife, registered nurse, nurse practitioner, physician assistant, social worker, health educator, childbirth educator, dietician, or comprehensive perinatal health worker.

 d. FQHC services do not require a Treatment Authorization Request (TAR), but providers are required to maintain in the patient's medical record the same level of documentation that was needed for authorization approval

 e. Encounters with more than one health professional and multiple encounters with the same health professional that take place on the same day and at a single location constitute a single visit. The exception is that two visits may be billed in the following instances:

  1) When a patient – after the first visit – suffers illness or injury that requires another health diagnosis or treatment

  2) When a patient receives ADHC services or is seen by a health professional or CPSP practitioner, and also receives dental services on the same day

 f. Clinic visits at which the patient receives services "incident to" physician services (for example, a laboratory or X-ray appointment) do not qualify as reimbursable visits

  1) If a patient is given an order for ancillary services to be performed at SMMC that are "incident to" the clinic visit, those service charges are appended to the FQHC clinic visit and no new encounter is created.

  2) If a patient is given an order for ancillary services to be performed at SMMC that are not "incident to" the clinic visit, a new encounter is created for the ancillary visit and charges for those services are appended to the ancillary encounter and billed separately from the clinic visit to Medi-Cal.

2. <u>Medicare/Medi-Cal Secondary (M20/C72) FQHC 00002 (including Medicare (Palmetto) eligible patients with HP straight Medi-Cal as secondary</u>

 a. Eligibility status is checked through the use of HDX

 b. Patients who have Medicare primary and Medi-Cal secondary and are not assigned to HPSM for managed care but are otherwise eligible for Medi-Cal benefits will be registered with the M20 as primary and C72 as secondary Ins Plan Codes

 c. Patients must receive Physician services during the visit

  1) The following providers, for FQHC purposes, are defined as "physicians"

   a) A doctor of medicine or osteopathy authorized to practice medicine and surgery by the State and who is acting within the scope of his/her license

   b) A doctor of podiatry authorized to practice podiatric medicine by the State and who is acting within the scope of his/her license

   c) A doctor of optometry authorized to practice optometry by the State and who is acting within the scope of his/her license

> d) A doctor of chiropractics authorized to practice chiropractics by the State and who is acting within the scope of his/her license
> e) A doctor of dental surgery (dentist) authorized to practice dentistry by the State and who is acting with in the scope of his/her license
>
> 2) CPSP Practitioner Defined
> - A comprehensive Perinatal Services Program (SPSP) practitioner as defined in California Code of Regulations (CCR), Title 22, Section 51179.7, is a physician who is either a general practice physician, family practitioner physician, pediatrician, obstetrician-gynecologist, certified nurse midwife, registered nurse, nurse practitioner, physician assistant, social worker, health educator, childbirth educator, dietician, or comprehensive perinatal health worker.

d. FQHC services do not require a Treatment Authorization Request (TAR), but providers are required to maintain in the patient's medical record the same level of documentation that was needed for authorization approval

e. Encounters with more than one health professional and multiple encounters with the same health professional that take place on the same day and at a single location constitute a single visit. The exception is that two visits may be billed in the following instances:
  1) When a patient – after the first visit – suffers illness or injury that requires another health diagnosis or treatment
  2) When a patient receives ADHC services or is seen by a health professional or CPSP practitioner, and also receives dental services on the same day

f. Clinic visits at which the patient receives services "incident to" physician services (for example, a laboratory or X-ray appointment) do not qualify as reimbursable visits
  1) If a patient is given an order for ancillary services to be performed at SMMC that are "incident to" the clinic visit, those service charges are appended to the FQHC clinic visit and no new encounter is created.
  2) If a patient is given an order for ancillary services to be performed at SMMC that are not "incident to" the clinic visit, a new encounter is created for the ancillary visit and charges for those services are appended to the ancillary encounter and billed separately from the clinic visit to Medicare and Medi-Cal.

3. Medi-Cal Primary (C72) Dental FQHC 00003 (Pregnancy related; effective 7/1/2009)

  a. Eligibility status is checked through the use of HDX
  b. Patients who have Medi-Cal will be registered with the C72 Ins Plan Code
  c. Patients must receive Physician services during the visit
    1) The following providers, for FQHC purposes, are defined as "physicians"
      a) A doctor of medicine or osteopathy authorized to practice medicine and surgery by the State and who is acting within the scope of his/her license
      b) A doctor of podiatry authorized to practice podiatric medicine by the State and who is acting within the scope of his/her license
      c) A doctor of optometry authorized to practice optometry by the State and who is acting within the scope of his/her license

        d) A doctor of chiropractics authorized to practice chiropractics by the State and who is acting within the scope of his/her license

        e) A doctor of dental surgery (dentist) authorized to practice dentistry by the State and who is acting with in the scope of his/her license

    2) CPSP Practitioner Defined

- A comprehensive Perinatal Services Program (SPSP) practitioner as defined in California Code of Regulations (CCR), Title 22, Section 51179.7, is a physician who is either a general practice physician, family practitioner physician, pediatrician, obstetrician-gynecologist, certified nurse midwife, registered nurse, nurse practitioner, physician assistant, social worker, health educator, childbirth educator, dietician, or comprehensive perinatal health worker.

  d. FQHC services do not require a Treatment Authorization Request (TAR), but providers are required to maintain in the patient's medical record the same level of documentation that was needed for authorization approval

  e. Encounters with more than one health professional and multiple encounters with the same health professional that take place on the same day and at a single location constitute a single visit. The exception is that two visits may be billed in the following instances:

    1) When a patient – after the first visit – suffers illness or injury that requires another health diagnosis or treatment

    2) When a patient receives ADHC services or is seen by a health professional or CPSP practitioner, and also receives dental services on the same day

  f. Clinic visits at which the patient receives services "incident to" physician services (for example, a laboratory or X-ray appointment) do not qualify as reimbursable visits

    1) If a patient is given an order for ancillary services to be performed at SMMC that are "incident to" the clinic visit, those service charges are appended to the FQHC clinic visit and no new encounter is created.

    2) If a patient is given an order for ancillary services to be performed at SMMC that are not "incident to" the clinic visit, a new encounter is created for the ancillary visit and charges for those services are appended to the ancillary encounter and billed separately from the clinic visit to Medi-Cal.

B. **HPSM Managed Medi-Cal FQHC visit**

1. Medi-Cal Priamry (C20/C30)

  a. Eligibility status is checked through the use of HDX

  b. Patients who have Medi-Cal and have been assigned to HPSM as their Managed Care provider will be registered with the C20 or C30 Ins Plan Codes

  c. Patients must receive Physician services during the visit

    1) The following providers, for FQHC purposes, are defined as "physicians"

      a) A doctor of medicine or osteopathy authorized to practice medicine and surgery by the State and who is acting within the scope of his/her license

      b) A doctor of podiatry authorized to practice podiatric medicine by the State and who is acting within the scope of his/her license

      c) A doctor of optometry authorized to practice optometry by the State and who is acting within the scope of his/her license

      d) A doctor of chiropractics authorized to practice chiropractics by the State and who is acting within the scope of his/her license

      e) A doctor of dental surgery (dentist) authorized to practice dentistry by the State and who is acting with in the scope of his/her license

    2) CPSP Practitioner Defined

- A comprehensive Perinatal Services Program (SPSP) practitioner as defined in California Code of Regulations (CCR), Title 22, Section 51179.7, is a physician who is either a general practice physician, family practitioner physician, pediatrician, obstetrician-gynecologist, certified nurse midwife, registered nurse, nurse practitioner, physician assistant, social worker, health educator, childbirth educator, dietician, or comprehensive perinatal health worker.

d, FQHC services do not require a Treatment Authorization Request (TAR), but providers are required to maintain in the patient's medical record the same level of documentation that was needed for authorization approval

e. Encounters with more than one health professional and multiple encounters with the same health professional that take place on the same day and at a single location constitute a single visit. The exception is that two visits may be billed in the following instances:

    1) When a patient – after the first visit – suffers illness or injury that requires another health diagnosis or treatment

    2) When a patient receives ADHC services or is seen by a health professional or CPSP practitioner, and also receives dental services on the same day

f. Clinic visits at which the patient receives services "incident to" physician services (for example, a laboratory or X-ray appointment) do not qualify as reimbursable visits

    1) If a patient is given an order for ancillary services to be performed at SMMC that are "incident to" the clinic visit, those service charges are appended to the FQHC clinic visit and no new encounter is created.

    2) If a patient is given an order for ancillary services to be performed at SMMC that are not "incident to" the clinic visit, a new encounter is created for the ancillary visit and charges for those services are appended to the ancillary encounter and billed separately from the clinic visit to Medi-Cal.

2. Medicare CareAdvantage/Medi-Cal Secondary (H20/C20/C30)

a. Eligibility status is checked through the use of HDX

b. Patients who have Medicare and have Care Advantage as their Medicare HMO plan along with Medi-Cal secondary and have been assigned to HPSM as their Managed Care provider will be registered with the H20 as their primary Ins Plan code and C20 or C30 as their secondary Ins Plan Codes

c. Patients must receive Physician services during the visit

    1) The following providers, for FQHC purposes, are defined as "physicians"

      a) A doctor of medicine or osteopathy authorized to practice medicine and surgery by the State and who is acting within the scope of his/her license

    b) A doctor of podiatry authorized to practice podiatric medicine by the State and who is acting within the scope of his/her license

    c) A doctor of optometry authorized to practice optometry by the State and who is acting within the scope of his/her license

    d) A doctor of chiropractics authorized to practice chiropractics by the State and who is acting within the scope of his/her license

    e) A doctor of dental surgery (dentist) authorized to practice dentistry by the State and who is acting with in the scope of his/her license

   2) CPSP Practitioner Defined

    • A comprehensive Perinatal Services Program (SPSP) practitioner as defined in California Code of Regulations (CCR), Title 22, Section 51179.7, is a physician who is either a general practice physician, family practitioner physician, pediatrician, obstetrician-gynecologist, certified nurse midwife, registered nurse, nurse practitioner, physician assistant, social worker, health educator, childbirth educator, dietician, or comprehensive perinatal health worker.

  d. FQHC services do not require a Treatment Authorization Request (TAR), but providers are required to maintain in the patient's medical record the same level of documentation that was needed for authorization approval

  e. Encounters with more than one health professional and multiple encounters with the same health professional that take place on the same day and at a single location constitute a single visit. The exception is that two visits may be billed in the following instances:

   1) When a patient – after the first visit – suffers illness or injury that requires another health diagnosis or treatment

   2) When a patient receives ADHC services or is seen by a health professional or CPSP practitioner, and also receives dental services on the same day

  f. Clinic visits at which the patient receives services "incident to" physician services (for example, a laboratory or X-ray appointment) do not qualify as reimbursable visits

   1) If a patient is given an order for ancillary services to be performed at SMMC that are "incident to" the clinic visit, those service charges are appended to the FQHC clinic visit and no new encounter is created.

   2) If a patient is given an order for ancillary services to be performed at SMMC that are not "incident to" the clinic visit, a new encounter is created for the ancillary visit and charges for those services are appended to the ancillary encounter and billed separately from the clinic visit to CareAdvantage and Medi-Cal.

3. <u>Medicare /Managed Medi-Cal Secondary (M20/C20/C30)</u>

  a. Eligibility status is checked through the use of HDX

  b. Patients who have Medicare along with Medi-Cal secondary and have been assigned to HPSM as their Managed Care provider will be registered with the M20 as their primary Ins Plan code and C20 or C30 as their secondary Ins Plan Codes

  c. Patients must receive Physician services during the visit

   1) The following providers, for FQHC purposes, are defined as "physicians"

a) A doctor of medicine or osteopathy authorized to practice medicine and surgery by the State and who is acting within the scope of his/her license

b) A doctor of podiatry authorized to practice podiatric medicine by the State and who is acting within the scope of his/her license

c) A doctor of optometry authorized to practice optometry by the State and who is acting within the scope of his/her license

d) A doctor of chiropractics authorized to practice chiropractics by the State and who is acting within the scope of his/her license

e) A doctor of dental surgery (dentist) authorized to practice dentistry by the State and who is acting with in the scope of his/her license

2) CPSP Practitioner Defined

- A comprehensive Perinatal Services Program (SPSP) practitioner as defined in California Code of Regulations (CCR), Title 22, Section 51179.7, is a physician who is either a general practice physician, family practitioner physician, pediatrician, obstetrician-gynecologist, certified nurse midwife, registered nurse, nurse practitioner, physician assistant, social worker, health educator, childbirth educator, dietician, or comprehensive perinatal health worker.

d. FQHC services do not require a Treatment Authorization Request (TAR), but providers are required to maintain in the patient's medical record the same level of documentation that was needed for authorization approval

e. Encounters with more than one health professional and multiple encounters with the same health professional that take place on the same day and at a single location constitute a single visit. The exception is that two visits may be billed in the following instances:

1) When a patient – after the first visit – suffers illness or injury that requires another health diagnosis or treatment

2) When a patient receives ADHC services or is seen by a health professional or CPSP practitioner, and also receives dental services on the same day

f. Clinic visits at which the patient receives services "incident to" physician services (for example, a laboratory or X-ray appointment) do not qualify as reimbursable visits

1) If a patient is given an order for ancillary services to be performed at SMMC that are "incident to" the clinic visit, those service charges are appended to the FQHC clinic visit and no new encounter is created.

2) If a patient is given an order for ancillary services to be performed at SMMC that are not "incident to" the clinic visit, a new encounter is created for the ancillary visit and charges for those services are appended to the ancillary encounter and billed separately from the clinic visit to Medicare and Medi-Cal.

4. CHDP Visits – Managed Medi-Cal Primary (C86)

a. Eligibility status is checked through the use of HDX

b. Patients who are eligible for Medi-Cal and fall within the scope of the CHDP program will be registered using the C86 Ins Plan Code

- The Child Health and Disability Prevention (CHDP) program is responsible for overseeing a portion of the Early and Periodic Screening Diagnosis and

Treatment (EPSDT) screening requirements of the Federal Medicaid program (Medi-Cal in California). These requirements include reporting the status of selected EPSDT screening services according to Social Security Act, Section 1902 (a) (43) as amended by Section 6402 of the Omnibus Budget Reconciliation Act of 1989.

c. Patients must receive Physician services during the visit

   1) The following providers, for FQHC purposes, are defined as "physicians"

      a) A doctor of medicine or osteopathy authorized to practice medicine and surgery by the State and who is acting within the scope of his/her license

      b) A doctor of podiatry authorized to practice podiatric medicine by the State and who is acting within the scope of his/her license

      c) A doctor of optometry authorized to practice optometry by the State and who is acting within the scope of his/her license

      d) A doctor of chiropractics authorized to practice chiropractics by the State and who is acting within the scope of his/her license

      e) A doctor of dental surgery (dentist) authorized to practice dentistry by the State and who is acting with in the scope of his/her license

   2) CPSP Practitioner Defined

      • A comprehensive Perinatal Services Program (SPSP) practitioner as defined in California Code of Regulations (CCR), Title 22, Section 51179.7, is a physician who is either a general practice physician, family practitioner physician, pediatrician, obstetrician-gynecologist, certified nurse midwife, registered nurse, nurse practitioner, physician assistant, social worker, health educator, childbirth educator, dietician, or comprehensive perinatal health worker.

d. FQHC services do not require a Treatment Authorization Request (TAR), but providers are required to maintain in the patient's medical record the same level of documentation that was needed for authorization approval

e. Encounters with more than one health professional and multiple encounters with the same health professional that take place on the same day and at a single location constitute a single visit. The exception is that two visits may be billed in the following instances:

   1) When a patient – after the first visit – suffers illness or injury that requires another health diagnosis or treatment

   2) When a patient receives ADHC services or is seen by a health professional or CPSP practitioner, and also receives dental services on the same day

f. Clinic visits at which the patient receives services "incident to" physician services (for example, a laboratory or X-ray appointment) do not qualify as reimbursable visits

   1) If a patient is given an order for ancillary services to be performed at SMMC that are "incident to" the clinic visit, those service charges are appended to the FQHC clinic visit and no new encounter is created.

   2) If a patient is given an order for ancillary services to be performed at SMMC that are not "incident to" the clinic visit, a new encounter is created for the ancillary visit and charges for those services are appended to the ancillary encounter and billed separately from the clinic visit to Medi-Cal.

5. Psychology Visits – Managed Medi-Cal Primary (C25, C20 or C30) (Carve-out Mental Health Services from Managed Plan)

    a. Eligibility status is checked through the use of HDX

    b. Patients who have Medi-Cal and have been assigned to HPSM as their Managed Care provider will be registered with C25, C20 or C30 as their primary Ins Plan code

    c. Patients must receive Physician services during the visit

        1) The following providers, for FQHC purposes, are defined as "physicians"

          a) A doctor of medicine or osteopathy authorized to practice medicine and surgery by the State and who is acting within the scope of his/her license

          b) A doctor of podiatry authorized to practice podiatric medicine by the State and who is acting within the scope of his/her license

          c) A doctor of optometry authorized to practice optometry by the State and who is acting within the scope of his/her license

          d) A doctor of chiropractics authorized to practice chiropractics by the State and who is acting within the scope of his/her license

          e) A doctor of dental surgery (dentist) authorized to practice dentistry by the State and who is acting with in the scope of his/her license

        2) CPSP Practitioner Defined

          • A comprehensive Perinatal Services Program (SPSP) practitioner as defined in California Code of Regulations (CCR), Title 22, Section 51179.7, is a physician who is either a general practice physician, family practitioner physician, pediatrician, obstetrician-gynecologist, certified nurse midwife, registered nurse, nurse practitioner, physician assistant, social worker, health educator, childbirth educator, dietician, or comprehensive perinatal health worker.

    d. FQHC services do not require a Treatment Authorization Request (TAR), but providers are required to maintain in the patient's medical record the same level of documentation that was needed for authorization approval

    e. Encounters with more than one health professional and multiple encounters with the same health professional that take place on the same day and at a single location constitute a single visit. The exception is that two visits may be billed in the following instances:

        1) When a patient – after the first visit – suffers illness or injury that requires another health diagnosis or treatment

        2) When a patient receives ADHC services or is seen by a health professional or CPSP practitioner, and also receives dental services on the same day

    f. Clinic visits at which the patient receives services "incident to" physician services (for example, a laboratory or X-ray appointment) do not qualify as reimbursable visits

        1) If a patient is given an order for ancillary services to be performed at SMMC that are "incident to" the clinic visit, those service charges are appended to the FQHC clinic visit and no new encounter is created.

        2) If a patient is given an order for ancillary services to be performed at SMMC that are not "incident to" the clinic visit, a new encounter is created for the

ancillary visit and charges for those services are appended to the ancillary encounter and billed separately from the clinic visit to Medi-Cal.

6. <u>Psychiatrist Visits – Managed Medi-Cal Primary (C25,C20 or C30) (Carve-out Mental Health Services from Managed Plan)</u>

   a. Eligibility status is checked through the use of HDX
   b. Patients who have Medi-Cal and have been assigned to HPSM as their Managed Care provider will be registered with C25, C20 or C30 as their primary Ins Plan code
   c. Patients must receive Physician services during the visit
      1) The following providers, for FQHC purposes, are defined as "physicians"
         a) A doctor of medicine or osteopathy authorized to practice medicine and surgery by the State and who is acting within the scope of his/her license
         b) A doctor of podiatry authorized to practice podiatric medicine by the State and who is acting within the scope of his/her license
         c) A doctor of optometry authorized to practice optometry by the State and who is acting within the scope of his/her license
         d) A doctor of chiropractics authorized to practice chiropractics by the State and who is acting within the scope of his/her license
         e) A doctor of dental surgery (dentist) authorized to practice dentistry by the State and who is acting with in the scope of his/her license
      2) CPSP Practitioner Defined
         • A comprehensive Perinatal Services Program (SPSP) practitioner as defined in California Code of Regulations (CCR), Title 22, Section 51179.7, is a physician who is either a general practice physician, family practitioner physician, pediatrician, obstetrician-gynecologist, certified nurse midwife, registered nurse, nurse practitioner, physician assistant, social worker, health educator, childbirth educator, dietician, or comprehensive perinatal health worker.
   d. FQHC services do not require a Treatment Authorization Request (TAR), but providers are required to maintain in the patient's medical record the same level of documentation that was needed for authorization approval
   e. Encounters with more than one health professional and multiple encounters with the same health professional that take place on the same day and at a single location constitute a single visit. The exception is that two visits may be billed in the following instances:
      1) When a patient – after the first visit – suffers illness or injury that requires another health diagnosis or treatment
      2) When a patient receives ADHC services or is seen by a health professional or CPSP practitioner, and also receives dental services on the same day
   f. Clinic visits at which the patient receives services "incident to" physician services (for example, a laboratory or X-ray appointment) do not qualify as reimbursable visits
      1) If a patient is given an order for ancillary services to be performed at SMMC that are "incident to" the clinic visit, those service charges are appended to the FQHC clinic visit and no new encounter is created.

2) If a patient is given an order for ancillary services to be performed at SMMC that are not "incident to" the clinic visit, a new encounter is created for the ancillary visit and charges for those services are appended to the ancillary encounter and billed separately from the clinic visit to Medi-Cal.

Implementation: April 2011
Reviewed and approved by: Date:
~~County Counsel~~
~~Executive Management Team~~
~~Hospital Board~~
Director Revenue Cycle Operations   3/11
Chief Financial Officer   3/11
Deputy Director Ambulatory Services   3/11
Deputy Director Ancillary Services   3/11
Chief Operating Officer   10/11 FINAL
                                                          10/6/11

Old number(s): N/A
Received for review:
NOTE(S):
STATUS:

SUBJECT: MASTER TREATMENT AUTHORIZATION REQUEST (TAR)

DEPARTMENT: FINANCIAL SERVICES: PATIENT ACCESS

AUTHOR: DIRECTOR, REVENUE CYCLE OPERATIONS

POLICY:

A TAR will be initiated by the ordering provider prior to rendering services requiring a TAR. If the services are modified, a corrected TAR will be generated by the department providing the service. Each department has the responsibility to initiate a TAR for patients receiving retroactive eligibility. TARs will be monitored through a Master TAR document.

PURPOSE:

To provide a uniform method for requesting, processing, and tracking Treatment Authorization Requests (TARs) for services rendered when a TAR is required for payment

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I.   General Instructions/Process/Tracking

   A. Initial TAR Process

     1. The ordering provider will initiate the TAR: if a patient is to be scheduled or a provider places an order for a service that requires a TAR.
     2. The Patient Services Assistant II (PSA) will verify patient eligibility and ensure a TAR has been completed for the following payers:

       a. MEDI-CAL (C10, C20, C30, C70, C71, C72, C80, C91, & C95)
       b. ACE/ACE County – Inpatient Only (W10, W22, Z50, Z55)
       c. HEALTHY KIDS (O87)
       d. HEALTHY FAMILY (O92)
       e. HEALTH WORX (O97)

   B. HPSM Process

     1. <u>Inpatient</u>

       a. Admitting staff will complete the initial TAR.
       b. Admitting will log the TAR Referral Number by patient in the pre-field in the Invision system
       c. Admitting staff will deliver TARs to Case Management daily by 9:30 a.m.
       d. Case Management staff will log all TARs received from the Admitting staff daily.

    e.   Health Plan of San Mateo (HPSM) has an on-site review nurse, Monday-Thursday. There is also an HPSM ACE nurse on Tuesday and Thursday.

    f.   The unit RN case managers identify those patients who are downgraded to administrative days and direct the Case Management staff to prepare a TAR for administrative days to present to the HPSM Medi-Cal reviewers.

    g.   Admitting staff picks up all reviewed TARs from an inbox located in the Case Management office daily.

    h   .HPSM approves TAR. Case management manager is to provide a retro TAR copy to the Billing department.

    i.   Admitting will enter all approved TARs in the Invision system in the final field daily and submit to TAR Coordinator.

    j.   TAR Coordinator will submit a copy of all approved TARs to Business Services or scan

2. Outpatient

    a.   The PSA will fax the TAR to Health Plan of San Mateo (HPSM)

    b.   PSA will enter the TAR number in the Pre-Treat/Authorization Field in the Invision system.

    c.   *If the order is incomplete (i.e. there is no ICD-9 code, clinical information, no dictated note in CORE or in eCW), efforts will be made to contact the provider. If there is no response from the provider, the order will be sent back to the clinic to be completed.

    d.   HPSM approves TAR.

    e.   Department staff may then schedule patient for their appointment.

    f.   Once the approved TAR has been logged in the HPSM system, the department staff will then enter the approved TAR number in the Final Treat/Authorization Field in Invision. Departments should scan the approved TAR into eCW.

    g.   The TAR Coordinator will validate the approved TAR information in the TAR Master Log.

    h.   The TAR Coordinator will distribute the approved TARs to Billing Supervisors and their staff to bill

C. HP (EDS) Process

1. Inpatient

    a.   Admitting staff will complete the initial TAR.

    b.   Admitting will log the TAR Referral Number by patient in the pre-field in the Invision system

    c.   Admitting staff will deliver TARs to Case Management daily by 9:30 a.m.

    d.   Case Management staff will log all TARs received from the Admitting staff daily.

    e.   The San Francisco Field Office does not provide an on-site review; Case Management staff will mail all TARs with a copy of the medical record via USPS. (effective 12/09)

    f.   The unit RN case managers identify those patients who are downgraded to administrative days and direct the Case Management staff to prepare a TAR for administrative days to present to the EDS Medi-Cal reviewers.

    g. Admitting staff picks up all reviewed TARs from an inbox located in the Case Management office daily.

    h. EDS approves TAR. EDS adjudication copies: SFFO-EDS Faxed directly to SMMC Billing and Admitting.

    i.   Admitting will enter all approved TARs in the Invision system in the final field daily.

    j.   Admitting will submit a copy of all approved TARs to Business Services or scan

2. Outpatient

    a. The PSA will attach to the TAR the clinical/provider notes, x-ray report or any other information that may pertain to the service being ordered and submit the TAR to the field office in San Francisco.

    b. PSA will enter the TAR number in the Pre-Treat/Authorization Field in the Invision system.

    c. *If the order is incomplete for example there is no ICD-9 code, clinical information, no dictated note in CORE or in ECW, efforts will be made to contact the provider. If there is no response from the provider, the order will be sent back to the clinic to be completed.

    d. EDS approves TAR.

    e, Department staff may then schedule patient for their appointment.

    f.   Once the approved TAR has been logged in the EDS system, the department staff will then enter the approved TAR number in the Final Treat/Authorization Field in Invision. Departments should scan the approved TAR into eCW.

    g. The TAR Coordinator will validate the approved TAR information in the TAR Master Log.

    h. The TAR Coordinator will distribute the approved TARs to Billing Supervisors and their staff to bill.

D. Retro TAR Process

1. Each department has the responsibility to initiate retroactive TARS, and all other actions requested upon and/or after the submission of a TAR.
2. Billers receive information that a patient obtained retroactive eligibility for a service that has already been provided and that service requires a TAR
3. Business Services Staff will recode the insurance code in Invision
4. Business Services Staff will enter an activity code in Patient Accounting that will prompt the billers to delete the claim from DSG.
5. Business Services will email the department that provided the service to request a TAR and cc the TAR Coordinator
6. Departments may review the Master TAR report to identify accounts requiring a Retro TAR
7. The department that provided the service will initiate the retro TAR

8. PSAII will enter the TAR number in the Pre-Treat/Authorization Field in the Invision system.
9. The PSAII will attach the clinical/provider notes, x-ray report or any other information that may pertain to the service and submit as noted below.
10. Once the approved TAR has been logged in the HPSM/EDS system (this process normally takes at least 30 days), the department staff will then enter the approved TAR number in the Final Treat/Authorization Field in Invision. Departments should keep scan the TAR into eCw.
11. The TAR Coordinator will validate the approved TAR information in the TAR Master Log.
12. The TAR Coordinator will distribute the approved TARs to Billing Supervisors and their staff to bill. Billing will then be responsible for requesting a re-bill, billing the new claim in DSG and storing the original documents.

E. HPSM Process

1. The PSAII will provide the TARs to the TAR Coordinator.
2. HPSM will collect the Retro TARs on Tuesday and Thursday from the TAR Coordinator.

F. EDS Process
The PSA will follow the initial EDS TAR Processing Criteria

G. TAR Correction Process

In the event of a correction or a missing TAR, the billing department will send an e-mail directly to the department managers for distribution to the appropriate staff/supervisor with a cc to the TAR Coordinator. The staff will have a five day turn around to resolve the issue. In the event the department is unable to respond to a request within 5 business days, a reminder email will be sent for follow up.

H. HPSM TAR Correction Process

1. A TAR correction form will be required to justify a modification of an existing TAR. Each department is responsible for completing the form and faxing it to the appropriate division. Treatment Authorization Forms will be faxed to HPSM Health Services at **650-829-2079**
2. Common TAR errors
   a. Incorrect Provider ID Number
   b. Incorrect Procedure or Drug Code
   c. Incorrect Quantity
   d. Change of payer
   e. Adding Modifier to the Procedure
   f. Change of Date of Service

3. All TAR Correction forms must be fully completed and legible before submitting to HPSM.

I. EDS TAR Correction Process

1. A TAR correction form will be required to justify a modification of an existing TAR. Each department is responsible for completing the form and submitting it to HPSM or to EDS depending on the TAR line of business.
2. SMMC may request a TAR correction to the Medi-Cal Field office via the eTAR system or via mail to the appropriate Field Office.

II. Ordering Forms

A. To order Medi-Cal TAR Forms:

Medi-Cal Fiscal Intermediary
P. O. Box. 15600
Sacramento, CA 95852-1600

B. To order HPSM TAR Forms:

HPSM Provider Services -Shania Dupanga (SMMC Rep) 650-616-2104

Implementation: April 2011
Reviewed and approved by: Date:
   ~~County Counsel~~
   ~~Executive Management Team~~
   ~~Medical Executive Committee~~
   ~~Hospital Board~~
   Director, Revenue Cycle Operations   3/11
   Chief Financial Officer   3/11
   Deputy Director, Clinical Ancillary Svcs 3/11
   Deputy Director, Ambulatory Svcs   3/11
   Chief Operating Officer   10/11 FINAL
                                                              10/13/11

   Old number(s): N/A
   Received for review:
   NOTE(S):
   STATUS:

SUBJECT:	MEDICALLY INDIGENT POLICY (WELL PROGRAM)
DEPARTMENT:	FINANCE: REVENUE CYCLE, PATIENT ACCESS
SPONSOR/AUTHOR:	CHAPTER CHAIR / SAN MATEO CO. MANANGER'S OFFICE

**THIS POLICY REFLECTS SAN MATEO MEDICAL CENTER'S INCORPORATION
OF SAN MATEO COUNTY POLICY**

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:

I. 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.

II. Populations Eligible for WELL Scope of Services

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

1. Persons receiving General Assistance in San Mateo County who are ineligible for Medi-Cal or other public or private health coverage

2. 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

3. 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

B. 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.

III. WELL Program Eligibility Criteria

A. 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.

1. 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.

2. Income Criteria

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

b. 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.

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

3. Assets Criteria

a. 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.

     b. 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.

     c. 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.

     d. One vehicle per adult is exempt from the assets limit.

B. 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.

C. 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.

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

1. Patients who were denied Medi-Cal or other benefits due to lack of cooperation
2. Patients who fail to apply for Medi-Cal or any other third party coverage when requested to do so.
3. Patients holding visas issued for less than one year.
4. Patients who fail to provide requested information.
5. Patients who fail to cooperate under a WELL audit.
6. 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.
7. Patients who fail to pay WELL fees, co-pays and charges.

IV. Verification Process

    A. 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.

    B. 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:

        1. Proof of Residency

            a. Car registration
            b. Voter registration
            c. California driver's license or ID card
            d. Employment record including offer letter, pay stubs, lay-off notice, employment or registration contract with an employment service, employer affidavit
            e. 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.
            f. Utilities bill – if not in patient's name, the bill should be accompanied by a signed statement from a relative or non-relative landlord
            g. Listing in the city directory or phone book that can be verified
            h. Principal property ownership document or property tax bill
            i. Membership record in a religious institution
            j. Student identification
            k. School records
            l. Recent marriage, divorce, or evidence of domestic partnership issued in the State of California (within the last three months)
            m. Recent court documents showing the applicant's current address (within the last three months)
            n. Insurance documents
            o. Police record from a California law enforcement agency (within the last three months)
            p. Documents from a homeless shelter or other public or community service agency indicating that the applicant is receiving services from the agency
            q. Adoption record (within the last three months)
            r. Medical record except San Mateo Medical Center (within the last three months)
            s. Voided personal check with pre-printed address

t. Other proof of residency – other third party documents verifying residency of applicant can be provided

2. Proof of Income

a. Unemployment – employer's records; EDD records; UIB check; layoff notice; training program records; training stipends; union records.
b. 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.
c. 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.
d. 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.
e. 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.
f. Other proof of income – other third party documents verifying income of applicant can be provided

3. Proof of Assets

a. Tax records
b. Bank Accounts – bank statement dated the month or prior month of application; written statement from the bank on bank stationery; current teller verification.
c. 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

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

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

     f. Other assets – stock certificates; letter from broker; other property of value

     g. Other proof of assets – other third party documents verifying assets of applicant can be provided

C. 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.

D. 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.

V. 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.

VI. Scope of Service

A. 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.

B. 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.

C. 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.

D. 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.

VII. 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.

VIII. 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.

IX. 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.

X. Annual Processing Fee, Co-Pays and Charges

A. 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.

B. 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.

C. 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.

XI. Notification of Enrollment or Disenrollment

A. 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.

B. 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.

    C. Patients can dispute a disenrollment through the Appeal Process set forth in Section XIII below.

XII. Waiver of Co-Pays and Annual Fees

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

        1. 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).
        2. Persons receiving General Assistance ineligible for Medi-Cal.
        3. Persons receiving services through the County's Alcohol and Other Drug programs not eligible for Medi-Cal.
        4. Persons receiving services at a San Mateo County Teen Center who are ineligible for PACT or Medi-Cal Minor Consent coverage.
        5. Persons who are unable to pay as determined through the appeals process.

    B.   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.

    C.   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.

XIII. Appeals Process

    A. <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.

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

1. 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.

2. 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.

3. 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.

4. 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.

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

    1. 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.

    2. 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.

    3. 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.

    4. 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.

D. 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.

XIV. Periodic Board Reports

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

Implementation: 1/83
Reviewed and approved by: Date:
~~RI Function Leader~~   ~~5/02, 11/02~~
~~Patient Services Supervisor~~   ~~10/04~~
~~Director, Patient Financial services~~   ~~9/03, 4/04, 10/04~~
San Mateo Co. Manager's Office / BOS   7/96, 2/06
Chief Financial Officer   4/04, 10/04, 5/06
Chapter Chair   4/04, 11/04, 5/06
County Counsel   5/06
Executive Management Team   5/06
Medical Executive Committee   5/04, 6/06
Hospital Board Hospital Board   6/04, 7/06
                                                                            4/25/06

Old number(s): 1.54 (RI chapter)
Received for review: (date) from (committee) or (person and dept)
NOTE(S):
STATUS:

SUBJECT:	OUTSIDE REFERRALS (ORF)
DEPARTMENT:	FINANCIAL SERVICES: PATIENT ACCESS
AUTHOR:	DIRECTOR, REVENUE CYCLE OPERATIONS

POLICY:

All referring physicians must be added to the patient account when pre-registered or registered. If the referring physician is not in the system, the ORF code may be used. However, this policy must be followed to correct the ORF code to the new code for the physician within ten days of the visit date to allow the claim to be billed promptly.

PURPOSE:

To provide a systematic usage of the ORF physician code, and provide a means to update missing referring physician information in SMS Invision

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I.   If the referring physician is not listed in Invision, use the ORF code to complete the account registration.

II.   E-mail the Office Assistant in Business Services with as much information as possible about the missing physician, office address, telephone, fax number, etc. The Office Assistant will contact the physician's office to receive the NPI number. The Office Assistant will then reply to the e-mail with the NPI number and any other information for this physician.

III.   The department will then open a ticket by emailing the information to the ISD Help Desk, requesting the physician receive a SIEMENS number in PR DOC.

IV.   Once ISD provide staff with a Dr Number, staff will then go into Invision through the revise pathway and revise the registration entering the correct referring physician number.

V.   This process is time-sensitive and must be completed within ten days of the visit date to allow for correct billing.

Implementation: April 2011
Reviewed and approved by: Date:
~~County Counsel~~
~~Executive Management Team~~
~~Hospital Board~~
Director, Revenue Cycle Operations 3/11
Chief Financial Officer 3/11
Deputy Director, Ambulatory Svcs 3/11
Deputy Director, Clinical Ancillary Svcs 3/11
Chief Operating Officer 10/11 FINAL

10/13/11

Old number(s): N/A
Received for review:
NOTE(S):
STATUS:

SUBJECT: PAYMENT ARRANGEMENTS

DEPARTMENT: FIANANCIAL SERVICES: PATIENT ACCESS

AUTHOR: DIRECTOR, REVENUE CYCLE OPERATIONS

POLICY:

All amounts due from patients should be paid at the time services are rendered. Patients unable to pay in full will be given the opportunity to set up a payment plan. Payment arrangements should be made within ten (10) business days of discharge or as soon as possible thereafter. Payment arrangements should be set for 90 days, with a maximum of 24 months.

PURPOSE:

To provide a payment arrangement option for self-pay patients when paying for services rendered.

SCOPE:

Some patients will be required to pay some portion, if not all, of the charges for services provided by San Mateo Medical Center. In addition to quality health care (HIPAA/ EMTALA Compliance), patients of San Mateo Medical Center are entitled to financial counseling by someone who understands and who can offer possible solutions for those who cannot pay in full (PSAII). The PSAII'S role is that of patient advocate, that is, one who works with the patient and/or guarantor to find reasonable payment alternatives (including, but not limited to: Medicaid, Grant Programs, Prompt Pay Discounts, Payment Arrangements, and Charity Care). The PSAII should also become familiar with any outside companies used to assist patients with application for Medi-Cal or other state funded programs.

Suggested Performance Standard:

All patients with a patient portion amount due will be asked to pay the balance in full; patients that do not choose to pay in full will be given the opportunity to set up payment arrangements, these arrangements should be set up within 10 business days or as soon as possible thereafter.

Recommended Measurement:

Sample 10% of Self Pay Agreement forms on a monthly basis; review the accounts to ensure policy is being followed as outlined. Report findings via a gap analysis process to the Director Revenue Cycle Operations.

I.   The PSAII will check the Invision System for all related accounts – current and past due. Review the account history and activity to date, including collector notes, to determine what collection activity has taken place and advise the patient of the total amount due. If the patient/guarantor cannot pay the balance in full, consider alternative payment options.

II.   The patient will be asked to pay the balance in full. If unable to do so, the PSAII will negotiate acceptable payment alternatives. If the guarantor states that he or she cannot pay the balance in full, use the following guidelines:

    A. Offer deferral over 3 payments, with the first payment due immediately. The second payment is due in 30-days and the balance due 30-days later. Explore the possibility of credit card payments for all due balances.

    B. If the guarantor states that he or she will not be able to meet the above payment schedule, review Charity program option, then refer the patient to the Community Health Advocate or designee for consideration for possible alternatives such as enrollment/eligibility in the Medi-Cal program or other Health Coverage program.

    C. If the guarantor's application for the Medi-Cal or other Health Coverage program is rejected, determine the guarantor's ability/willingness to pay.

    D. If the guarantor meets San Mateo Medical Center's guidelines for payment arrangements, establish a payment schedule which does not exceed 24 months from date of discharge/treatment.

III.   A down payment of 50% of the estimated charges (or of the total amount due if related accounts are identified) will be collected at the time of service for hospital services. At a minimum, a down payment of $25.00 will be collected at the time of service for clinic services.

IV.   Upon final billing, the balance will be determined and payment arrangements entered on the account.

V.   A Payment Plan Agreement (see attachment) will be completed by the PSAII and a copy given to the patient/guarantor.

VI.   Repeat the agreed upon arrangement to the patient. This eliminates possible misunderstandings and reinforces the promise. Stress the importance of prompt payment.

VII. Upon completion of the Payment Plan Agreement, terms will be entered into the Invision System through (PF4) CTRCT DATA:

    A. CTRCT PER: Enter the contract period, W-Weekly (Every 7 days), B-Bi-Weekly (Every 14 days), S-Semi-Monthly (15th and Month End), and M-Monthly (Based on Contract Effective Date).

    B. CTRCT EFF DT: Enter the date one contract period prior to the first due date. (i.e. If it is a Monthly agreement and the first payment is due 12/01/10, enter 11/01/10).

    C. CTRCT AMT/METHOD: Enter the amount due each period (50.00) and the method code of A (Overpayments credited to the next payment amount due), or B

(Overpayments not credited to the next payment amount due, used only to bring account more current).

VIII. Thoroughly document your conversation in the system notes, including the name of the person making arrangements, agreed upon terms, first payment date, etc.

IX. If patient/guarantor defaults on the terms of the agreement, the agreement becomes void, any discounts will be reversed and the balance due in full. Patient should be notified that the account is subject to routine collection procedures and referral to an outside collection agency.

Implementation: April 2011
Reviewed and approved by: Date:
   ~~County Counsel~~
   ~~Executive Management Team~~
   ~~Hospital Board~~
   Director, Revenue Cycle Operations   3/11
   Chief Financial Officer   3/11
   Deputy Director, Clinical Ancillary Svcs   3/11
   Deputy Director, Ambulatory Svcs   3/11
   Chief Operating Officer   10/11 FINAL
                                                         10/6/11

   Old number(s):
   Received for review:
   NOTE(S):
   STATUS:

SAN MATEO COUNTY

HEALTH SYSTEM

Self Pay Agreement

Date: _____   Patient Name: _____

Patient Address:_____

Home phone:_____   Work phone: _____

Account(s): _____   Total Charges: _____

Final Bill Total: $_____   Down Payment Amount: $_____

Remaining Balance: $_____

Monthly Payments: $_____ for _____ months

• •

Credit Card number: _____

Expiration Date: _____

Name as it appears on the card: _____

Authorized Signature (patient): _____

By signing this Self Payment Plan Contract, I accept full responsibility for the above amount for the term specified. I understand that failure to honor the terms of this agreement will result in cancellation; any discounts will be reversed and the balance due in full and subject to referral to an outside collection agency.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

San Mateo Medical Center
A County System of Healthcare

SUBJECT: POINT OF SERVICE (POS) COLLECTIONS

DEPARTMENT: FINANCIAL SERVICES: PATIENT ACCESS

AUTHOR: DIRECTOR REVENUE CYCLE OPERATIONS

POLICY:

All amounts due from patients should be paid at the time services are rendered. Homeless patients are excluded from this policy. More importantly, patients will not be denied services if they are unable to pay their co-pay at the time of the visit.

PURPOSE:

To provide a systematic approach for collecting amounts due from patients at the point of service for services rendered, in order to improve patient's overall experience and help cash flow.

SCOPE:

One major function of the revenue cycle is identifying and minimizing potential financial risk to San Mateo Medical Center (SMMC). It is critical that staff closely monitor accounts for patients admitted to the facility with termination of benefits or substantial increase in self-pay portion. In addition, it is important that staff can identify potential patient benefits under the Federal Consolidated Omnibus Budget Reconciliation Act (COBRA), which gives individuals the right to continue insurance coverage at group rates under certain circumstances, after losing coverage under a group health plan.

Point-of-Service collections should occur at all points of service; for example, at inpatient admission, same day surgery, outpatient registration, clinics, and the Emergency Department (only after treatment, EMTALA Compliance).

I. CLINICS

    Steps A-E should be accomplished as a part of the pre-registration process. If the patient was pre-registered, begin with Step F, unless Steps A through E have not been completed.

    A. Patient is pre-registered for services

        Review the patient's pre-registered account in the computer system to determine if the patient has healthcare coverage. Staff should verify the coverage period.

B. Research open accounts and bad debt files

1. Review archive accounts and/or the computer system to determine if the patient/guarantor has other past due accounts or bad debts. Total all balances due.
2. ACE and ACE County Co-Pays: If an ACE patient has three or more visits (or amounts) where the co-pay has not been paid, the patient will not be scheduled for other appointments until co-pays have been paid.

C. Determine the patient's portion for the current visit

1. If the patient has <u>no</u> healthcare coverage, $25 will be collected toward the average clinic visit.
2. If the patient has healthcare coverage, calculate the deposit based on any deductibles/co-pays noted due from the insurance verification received via Health Care Data Exchange (HDX).
3. If the patient has <u>Medi-Cal</u>, calculate the deposit based on any Share of Cost (SOC) noted due from the insurance verification received via HDX.
4. The patient portion must include the total patient amount due of all other open past due accounts and bad debts. Compute total estimated charges minus estimated insurance coverage plus deductible, co-insurance, outstanding account balance(s) and bad debt account totals. Based on the Billing Alert in eCW, collect past balances, as well as the new balance.

D. Notify the patient

Contact the guarantor by telephone, inform them that insurance benefits have been verified, and relate the estimated <u>non-covered portion</u>. Request that the patient bring that amount when he or she arrives for service. When the patient arrives, collect the deposit and issue a receipt.

E. Document your actions

Document in the comments section of Invision all of the actions you have taken and the total patient portion to collect from the patient at the time of service.

F. Patient presents for service

1. Review the patient's pre-registered account in the computer system to view the documented patient portion to collect at point of service. If the amount is not documented complete steps A-C above.
2. If the patient has <u>Medi-Cal</u>, see C, 3 above. Any amount received will need to be obligated on the Medi-Cal website. If the patient is referred to the SMMC pharmacy, the patient will be allowed to collect medications without collecting, or obligating an SOC.

3. If the patient is self-pay and may qualify for Medi-Cal, prepare and submit a SAWS-1 form.
4. The patient portion must include the total of other open past due accounts and bad debts based on eCW Billing Alerts.

G. Request payment

1. Request payment, based on the amount calculated above.
2. If the patient/guarantor can pay, collect the payment and issue the patient/guarantor a receipt.
3. If the patient/guarantor cannot pay, make payment arrangements. Refer to the "Payment Arrangements Procedure".

H. Record the payment

Record the amount requested, amount received and any comments on the collection log. If the patient does not pay or make payment arrangements, record the reason stated by the patient for non-payment. Initial and date the log entry (or enter in account comments).

I. Document your actions

Document in the comments section of Invision all of the actions you have taken to collect the patient portion at the time of service. Indicate the amount of deposit requested, the amount collected and the amount not collected and the reason why. Indicate any payment arrangements, if the deposit was not fully collected.

II. EMERGENCY DEPARTMENT

A. Patient presents for services

When the patient is arriving for Emergency Department (ED) services, *do not request payment for services until after the patient has received medical screening (EMTALA).* Once the patient has received treatment, calculate a payment request based on the basic-level ED charge for treatment and any other past due accounts or bad debts. Total all balances due.

B. Determine the patient's portion for current visit

1. If the patient has no healthcare coverage, collect payment based on the basic level E.R. charge for treatment.
2. If the patient has healthcare coverage, calculate the deposit based on any deductibles/co-pays noted due from the insurance verification received via Health Care Data Exchange (HDX).

3. If the patient has <u>Medi-Cal</u>, calculate the deposit based on any Share of Cost (SOC) noted due from the insurance verification received via HDX.

4. The patient portion must include the total patient amount due of all other open past due accounts and bad debts. Compute total estimated charges minus estimated insurance coverage plus deductible, co-insurance, outstanding account balance(s) and bad debt account totals.

5. If the patient has <u>Medi-Cal</u>, (see B, 3 above), any amount received will need to be obligated on the Medi-Cal website. If the patient is referred to the SMMC pharmacy, the patient will be allowed to collect medications without collecting, or obligating an SOC.

6. If the patient is self-pay and may qualify for Medi-Cal, prepare and submit SAWS-1 form.

7. The patient portion must include the total of other open past due accounts and bad debts based on account review.

C. Request payment

1. Request payment, based on the amount calculated above.
2. If the patient/guarantor can pay, collect the payment and issue the patient/guarantor a receipt.
3. If the patient/guarantor cannot pay, make payment arrangements. Refer to the "Payment Arrangements Procedure".

D. Record the payment

Record the amount requested, amount received and any comments on the collection log. If the patient does not pay or make payment arrangements, record the reason stated by the patient for non-payment. Initial and date the log entry (or enter in account comments).

E. Document your actions

Document in Invision all of the actions you have taken to collect the patient portion at the time of service. Indicate the amount of deposit requested, the amount collected, and the amount not collected and the reason why. Indicate any payment arrangements, if the deposit was not fully collected.

III. SURGERY

Steps A-E should be accomplished as a part of the pre-registration process. If the patient was pre-registered, begin with Step F, unless Steps A through E have not been completed.

A. Patient is pre-registered for services

Review the patient's pre-registered account in the computer system to determine if the patient has healthcare coverage. Staff should verify the coverage period.

B. Research open accounts and bad debt files

Review archive accounts and/or the computer system to determine if the patient/guarantor has other past due accounts or bad debts. Total all balances due.

C. Determine the patient's portion for current visit

1. If the patient has <u>no</u> healthcare coverage, $2000 will be collected toward the surgery. If the patient has Discounted Health, $1000 will be collected toward the surgery.
2. If the patient has healthcare coverage, calculate the deposit based on any deductibles/co-pays noted due from the insurance verification received via Health Care Data Exchange (HDX).
3. If the patient has <u>Medi-Cal</u>, calculate the deposit based on any Share of Cost (SOC) noted due from the insurance verification received via HDX.
4. The patient portion must include the total patient amount due of all other open past due accounts and bad debts. Compute total estimated charges minus estimated insurance coverage plus deductible, co-insurance, outstanding account balance(s) and bad debt account totals. Based on the Billing Alert in eCW, collect past balances as well as the new balance.

D. Notify the patient

Contact the guarantor by telephone, inform them that insurance benefits have been verified and relate the estimated <u>non-covered portion</u>. Request that the patient bring that amount when he or she arrives for service. When the patient arrives, collect the deposit and issue a receipt.

E. Document your actions

Document in the comments section of Invision all of the actions you have taken and the total patient portion to collect from the patient at the time of service.

F. Patient presents for service

1. Review the patient's pre-registered account in the computer system to view the documented patient portion to collect at point of service. If the amount is not documented complete steps A-C above.
2. If the patient has <u>Medi-Cal</u>, see C, 3 above. Any amount received will need to be obligated on the Medi-Cal website. If the patient is referred to the SMMC pharmacy, the patient will be allowed to collect medications without collecting, or obligating an SOC.
3. If the patient is self-pay and may qualify for Medi-Cal, prepare and submit SAWS-1 form.

    4. The patient portion must include the total of other open past due accounts and bad debts based on eCW Billing Alerts.

G. Request payment

    1. Request payment based on the amount calculated above.
    2. If the patient/guarantor can pay, collect the payment and issue the patient/guarantor a receipt.
    3. If the patient/guarantor cannot pay, make payment arrangements. Refer to the policy titled: Payment Arrangements Procedure in the Patient Access folder in Financial Services..

H. Record the payment

Record the amount requested, amount received and any comments on the collection log. If the patient does not pay or make payment arrangements, record the reason stated by the patient for non-payment. Initial and date the log entry (or enter in account comments).

I. Document your actions

Document in Invision all of the actions you have taken to collect the patient portion at the time of service. Indicate the amount of deposit requested, the amount collected and the amount not collected and the reason why. Indicate any payment arrangements, if the deposit was not fully collected.

IV. ADMISSIONS

Steps A-E should be accomplished as a part of the pre-registration process. If the patient was pre-registered, begin with Step F, unless Steps A through E have not been completed.

A. Patient is pre-registered for services

Review the patient's pre-registered account in the computer system to determine if the patient has healthcare coverage, Staff should verify the coverage period.

B. Research open accounts and bad debt files

Review archive accounts and/or the computer system to determine if the patient/guarantor has other past due accounts or bad debts. Total all balances due.

C. Determine the patient's portion for current visit

    1. If the patient has <u>no</u> healthcare coverage, $2000 will be collected toward the inpatient stay. If the patient has Discounted Health, $1000 will be collected toward the inpatient stay.

2. If the patient has healthcare coverage, calculate the deposit based on any deductibles/co-pays noted due from the insurance verification received via Health Care Data Exchange (HDX).
3. If the patient has Medi-Cal, calculate the deposit based on any Share of Cost (SOC) noted due from the insurance verification received via HDX.
4. The patient portion must include the total patient amount due of all other open past due accounts and bad debts. Compute total estimated charges minus estimated insurance coverage plus deductible, co-insurance, outstanding account balance(s) and bad debt account totals. Based on the Billing Alert in eCW, collect past balances as well as the new balance.

D. Notify the patient

Contact the guarantor by telephone, inform them that insurance benefits have been verified and relate the estimated non-covered portion. Request that the patient bring that amount when he or she arrives for service. When the patient arrives, collect the deposit and issue a receipt.

E. Document your actions

Document in the comments section of Invision all of the actions you have taken and the total patient portion to collect from the patient at the time of service.

F. Patient presents for service

1. Review the patient's pre-registered account in the computer system to view the documented patient portion to collect at point of service. If the amount is not documented, complete steps A-C above.
2. If the patient has Medi-Cal, see C, 3 above. Any amount received will need to be obligated on the Medi-Cal website. If the patient is referred to the SMMC pharmacy, the patient will be allowed to collect medications without collecting, or obligating an SOC.
3. If the patient is self-pay and may qualify for Medi-Cal, prepare and submit SAWS-1 form.
4. The patient portion must include the total of other open past due accounts and bad debts based on eCW Billing Alerts.

G. Request payment

1. Request payment based on the amount calculated above.
2. If the patient/guarantor can pay, collect the payment and issue the patient/guarantor a receipt.
3. If the patient/guarantor cannot pay, make payment arrangements. Refer to the "Payment Arrangements Procedure".

H. Record the payment

Record the amount requested, amount received and any comments on the collection log. If the patient does not pay or make payment arrangements, record the reason stated by the patient for non-payment. Initial and date the log entry (or enter in account comments).

I.   Document your actions

Document in Invision all of the actions you have taken to collect the patient portion at the time of service. Indicate the amount of deposit requested, the amount collected and the amount not collected and the reason why. Indicate any payment arrangements, if the deposit was not fully collected.

Implementation: April 2011
Reviewed and approved by: Date:
~~County Counsel~~
~~Executive Management Team~~
~~Hospital Board~~
Director, Patient Access   12/11 FINAL
Director, Revenue Cycle Operations   3/11
Chief Financial Officer   3/11
Deputy Dir, Clinical Ancillary Services   3/11
Deputy Director, Ambulatory Services   3/11
                                                                1/31/12

Old number(s): N/A
Received for review:
NOTE(S):
STATUS:

HEALTH SYSTEM

Estimate for Services – Patient Amount Due

Notice To our patients:

San Mateo Medical Center is providing you with this notice of your potential amount due for the hospital/clinic service(s) you will receive. Regardless of the type of insurance or other health coverage you may have, you are ultimately responsible for paying the bill and for assuring that the financial obligations for your care are fulfilled promptly.

We are advising you that the service(s) furnished will incur an amount due from you to the Medical Center. At this time, we can provide you with the following information on the estimated amount due:

___   Estimated charges for this visit: $_____.

___   Your amount due for this visit is **_estimated_** to be $_____ , based on our
            current information about scheduled services.

___   We cannot provide you with an estimate of the amount due at this time because we do not know the exact type
            and extent of services that you may need.

*****

The actual amount due to the Medical Center may be different from any estimate that is provided above. Actual amounts will be based on the services that you receive and also subject to final determination by any Insurance or Health Coverage program.

If you are enrolled in a state medical assistance program (such as Medi-Cal), your amount may be reduced or eliminated by law.

*Your signature on the Estimate for Services Form confirms that you have been advised that charges are **_estimated_** and could be higher or lower depending on actual services received. You will be responsible for payment of any charges not included in the initial estimate.*

I have read the foregoing and understand that I will owe to the Medical Center any amount not paid by my Insurance or Health Coverage program.

_____   _____
Signature of patient or authorized representative   Date

_____   _____
Witness   Date

SUBJECT:	PRE-REGISTRATION
DEPARTMENT:	FINANCIAL SERVICES: PATIENT ACCESS
AUTHOR:	DIRECTOR, REVENUE CYCLE OPERATIONS

POLICY:

The centralized pre-registration unit will pre-register all scheduled patient visits at least three (3) days prior to the date of service. Because of the importance of correct financial coding to the billing process, only patients with verifiable coverage will be pre-registered.

PURPOSE:

To expedite the registration process, meet third-party payer requirements, and support financially sound operations. The objectives of the pre-registration process include; reducing patient wait times on the day of service, achieving the highest level of customer satisfaction, and providing patient education on financial, clinical, and logistical information

SCOPE:

The Centralized Pre-Registration Unit reports to Patient Access. The unit is comprised of a Lead Patient Services Assistant (Lead PSAII) and a staff of Patient Services Assistants (PSAII's). PSAII's are a vital link in the process of satisfying payer-specific requirements. PSAII's must be able to properly pre-register and register all types of patients, clearly communicate coverage requirements to the patient and correctly identify insurance plans.

The needs of the patient must be within the guidelines of all third party payers, with respect to certification precertification, second opinion and regulatory restrictions.

Suggested Performance Standard

- Complete registration with a 98% accuracy rate
- Obtain Managed Care and other insurance authorization 100% of the time for emergency services
- Collect all co-pay and deductibles prior to service date
- Have all forms appropriately signed 100% of the time

Recommended Measurement

- Quarterly review of registration accuracy for demographic and insurance information
- Monthly review of collection percentages
- Monthly review of payment denials resulting from absence of treatment authorization numbers

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A. Identifying Patients for Pre-Registration

Patients in the following financial classes may be pre-registered for scheduled clinic appointments and/or ancillary services:

1. Three days prior to an appointment, ISD will generate a Pre-Registration List which includes schedules for each clinic and some ancillary services sorted by financial class (or potential financial class). Two copies of the report will be printed in the Data Center. The report will be printed according to the following schedule:

    - Monday: appointments for Thursday
    - Tuesday: appointments for Friday
    - Wednesday: appointments for Saturday
    - Thursday: appointments for Monday
    - Friday: appointments for Tuesday, Wednesday

    Some pre-scheduled ancillary appointments are not currently maintained on the system. The ancillary departments will forward information regarding scheduled ancillary appointments to the Lead PSAII 2-3 days prior to the appointment.

2. The Lead PSAII will separate one copy of the report by clinic and financial class and distribute to the appropriate PSAII.

3. The prioritization of determining when patients should be pre-registered is as follows:

    a. Date of service (the closer the service date, the higher priority)
    b. Type of service (listed higher priority to lower priority)

        1) Inpatient admissions
        2) Outpatient surgeries
        3) Outpatient observation cases/special procedures
        4) Recurring accounts
        5) Outpatient ancillary visits with charges greater than $500-MRI, CT, etc.
        6) Outpatient ancillary visits with charges less than $500
4. PSAII's will be assigned to pre-register specific clinic(s); i.e., a PSAII will pre-register all of Fair Oaks Clinic on a daily basis.

5. Patients in the following financial classes will be pre-registered. In some cases eligibility must be verified prior to pre-registration.

    a. Health Plan of San Mateo (C20): the PSAII will verify eligibility & PCP information via the ELG file. If the patient does not appear in ELG, the PSAII will verify eligibility via the Medi-Cal POS or internet. If an RAF is needed (i.e., for a specialty appointment), the RAF number should be obtained from the RAF function. If the patient's appointment is approved or it is with the correct PCP, the PSAII will pre-register the patient as C20.

       If the PCP differs from the scheduled PCP or there is no RAF on file for the appointment, the PSAII will contact the PCP no later then the next day in order to obtain a RAF. If the PCP refuses to issue a RAF, the PSAII will contact the patient.

       Once the RAF is obtained, the PSAII will enter the RAF in the RAF function. The PSAII will pre-register the patient.

    b. Medi-Cal eligible Patients (C72, C80): the PSAII will verify eligibility via the Medi-Cal POS or internet. If the patient is verified as Medi-Cal eligible, the PSAII will pre-register the patient as C72 or C80. The PSAII will enter the EVC# in the comments field. If there is a health plan or other insurance involved, the PSAII will contact the PCP no later then the next day in order to obtain authorization.

    c. ACE County Patients (W/10)/Medi-Cal Pending (U15, U/16)

       1) The PSAII will check the Medi-Cal POS or internet to determine if the patient has obtained Medi-Cal eligibility. If the patient is Medi-Cal eligible, the PSAII will check the ELG file to determine if the patient has been assigned a PCP. If the patient is Medi-Cal eligible and there is no PCP assignment, the PSAII will pre-register the patient. If the patient is assigned to a PCP, the patient can be pre-registered if the scheduled visit is to a provider in the PCP's group. If the visit is with a specialist, the PSAII will contact the PCP no later then the next day in order to obtain a RAF. Once the RAF is obtained, the PSAII will enter the RAF in the RAF function and pre-register the patient.

       2) ACE County Patients (W10): if the patient is not Medi-Cal eligible and ACE County eligibility has not expired, the PSAII will pre-register the patient as ACE County (W10). If ACE County eligibility has expired, the patient should be coded F19 and referred to the Community Health Advocate so that the patient can be rescreened for a County program.

       (Note: for all ACE County patients, re-verify MICRS information for each episode)

Other option: have information default and after one-year expiration, re-verify information.

    3) Medi-Cal Pending (U15/U16): if the patient is Medi-Cal eligible, the PSAII will pre-register the patient as U15 or U16.

  d. CHDP (C86): if the patient is CHDP eligible and the appointment is for a well baby or child's health exam, the PSAII will look up the patient's prior visits in EAD. The PSAII will refer to the CHDP periodicity table to determine if the patient meets the interval criteria for a CHDP visit. If the criteria are met, the PSAII will pre-register the patient as CHDP (C86).

  e. Medicare (M20): all Medicare patients will be pre-registered as (M20). The PSAII will confirm the patient's crossover carrier if appropriate.

  f. PACT (G90): if the patient is enrolled in PACT and the appointment is for PACT services, the PSAII will pre-register the patient as PACT (G90).

  g. Insurance (I01-I99): if the patient has prior insurance information in the system, the PSAII will pre-register the patient as insurance (I01-I099).

B. Pre-registration Process

  1. In order to obtain/update and verify all demographic and insurance information, call to reach the patient via telephone and complete the following steps (see attached Pre-Registration Prep Work and Script)

  2. To pre-register a patient in Invision, the PSAII will select EAD Inquiry from the Master Menu screen. The PSAII will enter the patient's MRN or SS#. The Verify Enrollee screen will appear with the patient information displayed. The PSAII will verify that the correct patient has been selected. If this is not the correct patient, the PSAII will return to inquiry. If the correct patient does appear, the PSAII will press enter to continue.

  3. The Submenu screen will appear. The PSAII will select 02, Pre-Register Outpatient from the Registration Options menu.

  4. The Patient Demographic Info, Accident/Employer Info, Emergency Contact Info, Display Policies, Insurance Review, Commercial Insurance Data, Guarantor Info, and Final Prereg Info screens will appear in succession. All required fields are highlighted and must be entered into the system to move from screen to screen.

  5. Fill out the information as appropriate. If the patient is the guarantor and subscriber, subsequent screens will be populated with demographics from the initial screen. Insurance billing address will also default upon entering the information.

6. The Exp Arr Date field appears on the Final Prereg Info screen. The PSAII will enter the date of the patient's appointment in this field.

7. The system will automatically generate a patient number once the pre-registration has been completed.

8. Obtain treatment authorization number, if required, and enter the authorization number in the system.

9. Save all information concerning the pre-registration and select the next patient.

C. Clinic/Ancillaries Registration Process

1. The morning of the clinic, patients who have been pre-registered are listed on the schedule and given to the registration staff.

2. To access the pre-registered episode, the PSAII must do an EAD inquiry from the Master Menu using the patient's MRN (do not use the patient's name to access this inquiry).

   a. The PSAII will verify that the correct patient has been selected. The PSAII will return to the Submenu and select Option 01, Register Outpatient. The Select Case screen will appear.

   b. The PSAII will scan the Select Case screen for an "OP" in the Sts Field; this indicates a pre-registered episode. The PSAII must verify that the Adm/Reg Date & Svc correspond to that day's appointment. The PSAII will select the correct OP case.

   c. The Insurance Review screen will appear. The PSAII will verify that the patient's insurance information is correct and appropriate for that visit. If the insurance information entered at the time of pre-registration is correct, the PSAII will proceed with the registration. If the information is not correct, the PSAII will update the insurance information as necessary. Examples of incorrect information would be an ACE County (W10) patient appearing for a family planning visit; this information may not have been known at the time of pre-registration. The PSAII will update the Insurance Review screen to indicate PACT (G90).

   d. The Final Registration Info screen will appear. The required fields are carried forward from the pre-registration, as is the patient number. The PSAII will verify that the Reg Dr No & Atn Dr No is correct; the PSAII will update this information if necessary.

   e. The PSAII will press enter until the Select Form screen appears. The PSAII will generate the necessary forms such as Labels (24) that are needed for the visit.

   f. The actual registration date and time will automatically default once this function has been completed.

3. Request any co-payment, deductibles, or SOC (if applicable). See the policy titled Point of Service (POS) Collections in the Patient Access folder in Financial Services.

   NOTE: All patients identified as not having funds or resources to pay for the procedure, co-payments, deductibles, SOC, etc.; must then set up and agree to payment arrangements.

Implementation: 10/99
Reviewed and approved by: Date:
~~Business Services Manager~~   ~~10/99~~
~~Financial Services Manager~~   ~~10/99~~
~~Clinic Managers~~   ~~10/99~~
~~County Counsel~~
~~Executive Management Team~~
~~Hospital Board~~
Director, Patient Access   12/11, 2/12
Director, Revenue Cycle Operations   1/12, 2/12
Deputy Director, ISD   3/11, 212
Chief Financial Officer   3/11, 2/12
Deputy Director, Clinical Ancillary Services 3/11, 2/12
Deputy Director, Ambulatory Services   3/11, 2/12
Chief Operating Officer   4/2 FINAL
                                                              4/2/12

Old number(s): N/A
Received for review: (date) from (committee or person and dept)
NOTE(S):
STATUS:
~~**Pre-Registration Script needs to be referenced in policy (**~~

San Mateo Medical Center
Pre-Registration Prep Work & Script

Prep Work

All appointments within a one week period will require a pre-registration.

Prior to calling the patients you must complete the following steps:

1. **Print** the provider's schedule you will be pre-registering.

2. **Print** the insurance eligibility for all the patients who are on the providers' schedule. **(**This will allow you to have accurate eligibility information and the CIN# or Member ID # readily available to you when updating the patients' information**)**.

3. **Attach** the insurance eligibility to the appropriate clinic encounter form. **(**See attached samples on how to access eligibility through HDX**)**

The provider's schedule will be your cheat sheet. **Central Registration PSA's** will use these cheat sheets to complete the Pre-registered appointments.

If unable to contact patient:

Patients whom you are unable to contact should be noted in eCW in the General Notes section. Indicate the date/time you attempted to call, along with the patient's CIN# or Member ID #, associated with the patient's insurance. If the patient's phone number is disconnected or incorrect note it on the cheat sheet. **(**This information is required and vital for the Central Registration Process**)**

Now that you have completed the prep work, you can begin calling the patients by using the provider's schedule.

cont'd...

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Script and Step by Step Instruction for ECW & Invision

When you have the patient on the phone: **(Script to be followed by all who pre-reg)**

- Introduce yourself – "Hello", my name is _____ and I am calling from the San Mateo Medical Center with regards to your appointment with Dr. _____ in _____ clinic on _____ at _____ .
  (Date)   (Time)

- Let the patient know that we are doing things a little different in order to improve our patients over all visit. Tell the patient, "We are going to make your "check in" process easier by getting as much information from you right now over the phone. This will help us improve your wait time in the clinic."

- <u>Ask the patient</u>: "Will you be able to attend this appointment?"

  If "No"
  Ask – May I ask why?
  (Depending on the answer you respond to find or give a solution)
  Example: Patient wants an appointment for a future date...Let the patient know how long the wait period is for the next available appointment to see if they are still willing to reschedule. Give them the appointment line phone number if they still can not make their scheduled appointment, so the patient can reschedule the appointment themselves. - Specialty Clinic (650) 573-3982 or Medical Clinic (650)573-3962. Let the patient know they will need to press option #4, on our phone menu.

  If "Yes"
  Continue with verifying the patient's information with the patient on the phone....**"Remember"** these changes and updates must be done in CORE with the exception of the **Pharmacy Information, Race, Ethnicity and Primary Language** which **must be done first in eCW**.

- Attached are copy samples of the screens you will be using to Pre-Register. These screens are to be used as a guide when changing and updating patient information. This will allow you to complete a more accurate and efficient Pre-Registration.

- You will need to **first start changes and updates in eCW**. **Go to** the Providers schedule you will be Pre-Registering, in eCW (**#1**). **Click on** the patients' appointment then click on **Info** (**#2**). Click on the **additional info** (**#3**) to access the Pharmacy, Race, Ethnicity and Primary Language (**#4**).

- Ask the patient: What Pharmacy do you go to for your medications?
                    What is your Race and Ethnicity?
                    What is your Primary Language?

  If this information is already indicated in eCW you are expected to verbally verify this information with the patient, while you have them on the phone.

  RULE #1... "Do not"...ask the patient... "Do you still go to Walgreen's"? Ask the patient, "What Pharmacy do you go to for your medications".... If the answer is different update the information in Ecw. **This rule is expected to be followed when verifying any type of patient information!!!!!**

- Now that you have completed the changes and updates in eCW, you can now **go back to** the **Appointment Screen** and **change** the **Visit Type** to **Confirmed (#5)** this will allow you to continue with the Pre-Registration in CORE.

- Now that you have changed the **Visit Type** to **Confirmed**, **go to CORE (#6)**. Attached are screen copies to assist you when completing the Pre-Registration, in CORE. Screen copies #6 thru #10 are to assist you with navigating through the application.

  "Remember" - The key factor here is to follow the categories in sequence. If this process is not completed in sequence, the updated information you are entering will not be retained.

- You will first need to sign on to CORE (if you require assistance let me know) the next screen you should see will be the **"Master Menu"** here you are going to enter **"01" and press enter**. This will take you to the following screen **(Enter Selection Criteria).**

- **(Enter Selection Criteria)** This is where you are going to enter the patients' medical record number. After you enter the patients' medical record number press enter. This will take you back to the next screen (Verify Enrollee Screen)

  "Remember"....if the patient has multiple medical record numbers it will be expected of you to appropriately choose the correct one. You are also expected to follow the process for reporting Multiple Medical Record numbers to the Medical Records Department.

- **(Verify Enrollee Screen)** This is informational only, "verify" this is the correct patient and press enter. This will take you back to the next screen (Submenu).

- **(Submenu)** this is where you will need to select **!10** and press enter. This will take you to the next screen (Revise Menu).

- **(Revise Menu)** "Remember" – The key factor is to follow the categories in sequence. If this process is not completed in sequence, the updated information you are entering will not be retained. Here you are going to choose category **(! 01 Patient)** and press enter. This will take you back to the next screen (Pt Demographic Info).

- **(Pt Demographic Info)** This is where you will need to ask and verify **"Remember"...(RULE #1)** with the patient, while on the phone their **address**, **zip code**, if your provider needs to contact you what **phone number** can he reach you at, **CIN#**, **SS#**....if the **COA** is not completed prepare a COA...if the Notice of Privacy Practice is not completed prepare a **HIPPA** form **(**These forms will be given to the Central Registration Team along with the schedule cheat sheets**)**. After you have completed entering and verifying the information press enter. This will take you back to the (Revise Menu)

- **Revise Menu Screen** the next category you are going to click on is **(! 02 Acc/Emp Info)** here is where you will need to ask and verify **(again "RULE #1")** with the patient, while on the phone if this visit pertains to an accident, if they are a Veteran and employed, if patient is employed you will need to indicate employment information. After you have completed entering and verifying the information press enter. This will take you back to the (Revise Menu)

- **Revise Menu Screen** the next category you are going to click on is **(! 03 Emergency Contact)** here is where you will need to ask and verify**(again "RULE #1")** with the patient, while on the phone the **name, phone number and address of the individual they would like for us to call in case of an emergency.** After you have completed entering and verifying the information press enter. This will take you back to the (Revise Menu)

- **Revise Menu Screen** the next category you are going to click on is **(! 04 Insurances)** here is where you will need to ask and verify **(again "RULE #1")** with the patient, while on the phone the type of medical insurance they may have. Compare and verify**(again "RULE #1")** with eligibility printed specific to the patient. After you have completed entering and verifying the information press enter. This will take you back to the (Revise Menu)

- **Revise Menu Screen** the next category you are going to click on is **(! 05 Guarantor)** "If the patient is the responsible party for this visit", press enter.

  However, if the Guarantor is someone else besides the actual patient, you will need to verify **(again "RULE #1")** and update all that apply on this screen **Reminder:** "if the patient is a minor" the Guarantor is the parent or guardian....if this information is not updated correctly, the bill will be denied and come back to you (the user) as an error! After you have completed

entering and verifying the information press enter. This will take you back to the (Revise Menu)

- **Revise Menu Screen** the next category you are going to click on is **(! 06 Final Reg Data)** here is where you are expected to indicate the appropriate provider and the referring provider, for this visit.   After you have completed entering the information press enter. This will take you back to the (Revise Menu)

- **Revise Menu Screen** the next category you may see is **(MICRS)** here is where you will need to verify, **(again "RULE #1")** with the patient on the phone.   The patients' family size, type of employment, family's monthly gross income and source of income. After you have completed entering and verifying the information press enter. This will take you back to the (Revise Menu) press enter again.

- The next screen you should see is the Submenu Screen here is where you will enter **!40 Regenerate Documents** and press enter.

- The next screen you should see is the **Select Form Screen** here is where you will enter **!21 Labels w ID Card** and press enter. This will allow you to print your visit labels. When you have successfully printed your labels you are expected to double check the label for accuracy, ensuring this is the correct patient name, DOB, insurance code, medical record number and provider information.

SUBJECT: PRESUMPTIVE ELIGIBILITY PROGRAM COVERAGE

DEPARTMENTAL UNIT: OUTPATIENT SERVICES/BUSINESS SERVICES

AUTHOR: BUSINESS SERVICES MANAGER

PURPOSE

Grant immediate temporary Medi-Cal coverage for low-income prenatal patients that do not have health insurance for prenatal care.

POLICY

If the patient believes she is pregnant and has no health insurance coverage, the patient will be screened for the Medi-Cal Presumptive Eligibility Program once per pregnancy. The Presumptive Eligibility Program does not cover family planning, delivery, or abortion services. The patient will be informed whether she qualifies or not at the time of the financial screening during the registration process.

PROCEDURE

A.   CLERICAL STAFF RESPONSIBILITIES

1.   Patients will be screened at the clerical window upon entry into the OB/Gyn Clinic. Those patients that suspect they are pregnant and have no health insurance coverage will be given a Presumptive Eligibility application, which she will complete and present to the registration clerk.

2.   The registration clerk will review the application for completeness and assist the patient when needed.

3.   Once the application is completed, the registration clerk will compare the patient's gross family income, based on her family size, to the "Income Screening Chart." No verification of the income is necessary.

B.   ISSUING A PRESUMPTIVE ELIGIBILITY CARD

1.   If the pregnancy test is NEGATIVE, she is eligible for Presumptive Eligibility to cover that visit only. There should be no Presumptive Eligibility card issued to the patient.

PRESUMPTIVE ELIGIBILITY PROGRAM COVERAGE (Cont.)

2.   If the pregnancy test is POSITIVE, the information will be documented in the application package and the patient will be given a temporary Presumptive Eligibility care and instructions to apply for Medi-Cal (PREMED2).

3.   If the pregnancy test is POSITIVE, the information will be documented in the application package and the patient will be given a temporary Presumptive Eligibility care and instructions to apply for Medi-Cal (PREMED2).

4.   After the card is used, the patient needs to be informed that an official Medi-Cal Presumptive Eligibility card will be mailed to her in approximately one week.

5.   The Presumptive Eligibility card expires at the end of the following month if she does not apply for Medi-Cal. Once the patient applies for Medi-Cal, her Presumptive Eligibility will continue until the Welfare Department determines eligibility.

C.   FAXING THE PRESUMPTIVE ELIGIBILITY APPLICATION TO SACRAMENTO

Once the application process has been completed, the patient's eligibility will be reported to the Department of Health Services within three working days from the date the patient was determined eligible by faxing the PREMED1 form to the toll free Presumptive Eligibility Reporting Lines, fax 1-800-409-1498. The County ID number should be documented for a correct record match.

D.   FINANCIAL CODING

1.   Patients will be coded 580/500, financial class X.

2.   The ID plate will expire at the end of the following month from the date of issue.

3.   A copy of the PREMED1 will be attached to the pink copy of the superbill and green copy of the registration form and sent to Business Services.

Implementation: 10/94
Reviewed and Approved by: Business Services   Date: 11/96, 1/98, 3/01

03/20/01

SUBJECT: PATIENT EDUCATION – PATIENT REGISTRATION / FINANCIAL
             COUNSELING

FUNCTION: PATIENT EDUCATION

AUTHOR: NURSE MANAGER / BUSINESS SERVICES MANAGER

PURPOSE

To provide patient education for registration process, correct assessment of billing
classification, prevention of time delay on collection of funds.

Common registration outcome purposes are:

-      To foster compliance with the rules and regulations of the patient financial
       classification.

-      To lessen financial anxiety of patient regarding medical cost.

-      To promote accessibility to hospital system.

-      To assist the patient and guarantor in understanding the registration process and
       payment plans available.

SCOPE OF SERVICE

The Patient Service Assistant registration process is committed to providing accessible,
accountable, and clear financial education to patients and guarantors. The registration
information process is provided during clinic hours and Emergency Department hours and
through the phone for inquiries on a general basis.

TYPE OF PATIENT EDUCATION

Education may be formal or informal and occur during:

-      Telephone encounters

-      Registration time

-      Exiting clinic/Emergency Department settings

PATIENT EDUCATION – PATIENT REGISTRATION / FINANCIAL COUNSELING
(Cont.)

PROVIDERS

Patient Service Assistant clerks, Medical Office Assistant clerks, and Patient Accounts
clerical staff. These providers do not document inpatients medical records.

CONDITIONS REQUIRING PATIENT EDUCATION REGISTRATION SERVICES

All patients being served in the Outpatient Department clinics.

Implementation: 04/95
Revised: 04/98
Reviewed and approved by: Date:
   Patient/Family Education Committee   04/95, 04/98

                                                           05/16/01

SUBJECT: SCHEDULING AND FINANCIAL SCREENING
DEPARTMENT: FINANCIAL SERVICES: PATIENT ACCESS
AUTHOR: DIRECTOR REVENUE CYCLE OPERATIONS

POLICY:

Patients being scheduled for urgent Primary Care and Specialty Care appointments may pursue/complete financial screening post visit; however, failure to pursue/complete financial screening post visit may result in patients being billed full charges for an appointment. New and established patients seeking non-urgent primary or specialty care are required to either have a confirmed enrollment for coverage program or have coverage in place at the time the appointment is scheduled.

PURPOSE:

To provide a systematic approach for scheduling new and established patients for urgent and non-urgent appointments; to provide the expectations for clinical and financial screening for patients seeking primary and specialty care.

I. Urgent Primary Care and Specialty Care Appointments

A. Clinical urgency will continue to be the primary criteria used to allocate appointment capacity.

B. Staff scheduling urgent appointments for new or established patients should reinforce the expectation that patients must complete financial screening after their appointment in order to be billed appropriately for their services.

C. Failure to pursue/complete financial screening can result in patients being billed full charges for an appointment rather than receiving the discounts and/or health coverage for which they may qualify.

D. Patient notification letters have been developed for patients who are coded:

1. F19 (patients with have never completed the financial screening process)
2. F75 (patients who either started the financial screening process and failed to follow-up OR patients who have let their coverage program lapse; i.e., failed to renew)
3. U15/U16 (patients with a pending Medi-Cal application)
4. These letters emphasize that all patients, including those being seen for urgent appointments, must follow through with their screening and enrollment process or they will be responsible for the costs of their visits. It is vital that all patients receive

these notifications. The summary of clinic visits costs should also be distributed to patients so they are informed of the cost of their visits which they can be responsible for if they do not complete their screening and application process.

II. Non-Urgent Primary and Specialty Care Appointments

A. New patients seeking non-urgent primary or specialty care are required to complete financial screening with the Health Coverage Unit and have a confirmed enrollment for coverage program prior to scheduling and/or placement on a waiting list. Clinic staff may also schedule a Community Health Advocate (CHA) appointment through ECW for new uninsured patients.

B. Established patients seeking non-urgent primary or specialty care are required to have coverage in place (i.e., not lapsed) at the time of scheduled appointments. In order to minimize "churning" (i.e., lapses in coverage), clinic staff need to check financial status and coverage expiration dates at the time that appointments are being scheduled.

C. If coverage (e.g., ACE coverage period) is slated to expire within three months of the date of the appointment being scheduled, the patient should be instructed to complete coverage renewal PRIOR to scheduling for an appointment.

D. Clinic staff may schedule a CHA appointment through ECW to assist a patient in renewing his/her coverage.

Implementation: April 2011
Reviewed and approved by: Date:
~~County Counsel~~
~~Executive Management Team~~
~~Hospital Board~~
Director, Patient Access   12/11
Director, Revenue Cycle Operations   3/11
Chief Financial Officer   3/11
Deputy Director, Clinical Ancillary Svcs   3/11
Deputy Director, Ambulatory Svcs   3/11
Chief Operating Officer   12/11
                                                            12/16/11

Old number(s): N/A
Received for review:
NOTE(S):
STATUS:

SUBJECT:	TB FINANCIAL POLICY
DEPARTMENT:	PATIENT ACCESS
AUTHOR:	DIRECTOR PATIENT ACCESS/DIRECTOR PUBLIC HEALTH

POLICY:

The Health System's public health protection responsibilities require that TB treatment services are available without regard to clients' ability or willingness to pay.

At the same time, the Health System seeks to maximize third party reimbursement for all services provided, including TB services.

PURPOSE:

To ensure efficient and effective TB patient treatment and TB program management within the San Mateo County Health System communities regardless of the patient's ability or willingness to pay, or their, status/plan eligibility.

Note: *TB services provided by SMMC to Health System new hires and volunteers are addressed in a different policy within the IC Chapter.*

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1. All patients referred or presenting for TB services (which include clinical outpatient, inpatient, laboratory, radiology, pharmacy services) will be registered to allow for proper charging, insurance billing, etc.
2. Patients with health insurance will have their services billed to that insurance or program. Using the most current SMMC insurance plan list, the patient's account will be coded based on the insurance or program information identified at the time of service.
3. Financial eligibility actions will not deter or delay scheduling of prescribed TB treatment services for patients with active TB or identified contacts of patients with active TB. All uninsured patients will be referred for appropriate eligibility screening follow-up (see #6 below).
4. Patients seeking TB screening for school, work, or immigration requirements will be billed for these services on a standard fee schedule, either through their insurer or directly, depending on insurance status.
5. If a patient's insurance policy does not include SMMC as an in-network provider, the patient will be directed to receive services from an in-network provider.

6. If a patient is uninsured and appears eligible for TB Medi-Cal, a standard referral process for TB Medi-Cal will be followed. The patient will also be screened for all available public coverage programs such as regular Medi-Cal, ACE, MCE, Healthy Kids, etc. HCU will use its best efforts to complete eligibility screening and achieve successful enrollment for all patients referred.
7. If a patient does not complete required follow-up to be enrolled in a coverage/ insurance program, they will be coded E01/F75 (Public Health/Self Pay Failed to Follow-Up)
8. If a patient completes the eligibility process and is found in-eligible for a coverage/insurance program, they will be coded E01/F74, (Public Health/ Self Pay Confirmed).
9. **Decisions about billing of E01/F75 and EO1/F74 patients will be referred to a committee comprised of the TB Controller, the SMMC Manager of Billing and Collections and the Director of Public Health, Policy and Planning to determine what billing and financial follow-up action should be pursued. No bills will be sent to clients until there is a determination made by the committee. An outline for the committee's work will be incorporated into relevant SMMC policies and procedures.**

   __The committee will meet monthly.__ The meetings will be scheduled by the Director of Public Health. In advance of each meeting, the SMMC Manager of Billing and Collections will create a spreadsheet of all patients receiving TB services who are coded EO1/F75 and EO1/F74 for the prior month. This spreadsheet will include for each case: patient's name, MRN, outstanding balance owed, and a list of TB services provided. The committee will resolve all issues related to billing of any balances due for these cases, as well as other issues related to conflicts between financial goals and public health protection/treatment concerns that require joint leadership resolution. The committee will track the issues they address to determine if system or policy changes need to be made and to develop scenarios for training of staff.

10. If a patient's insurance coverage fails to include appropriate provider capacity or infrastructure to deliver TB services, the Public Health division will initiate advocacy with the insurance company to address the inadequacy of the network.
11. If Public Health staff has exerted reasonable efforts to refer insured and/or partially insured clients to an in-network provider and/or for services that are only partially covered and are unable to secure services that meet our public health protection responsibilities, patients may be referred to receive services at SMMC. The above practices for obtaining services without delay while also pursuing eligibility will be pursued.

12. If Public Health staff determine that financial responsibilities such as copayments or other cost-sharing are posing a barrier to achieving necessary patient follow-up to achieve clinical treatment and public health protection goals, they will contact the SMMC Manager of Billing and Collections in Patient Financial Services to initiate a request to stop the billing of co-payments/ other cost-sharing on a case by case basis. Public Health staff will develop a standard approach for pursuing such financial exceptions to balance the County's public health protection and financial stewardship goals, and to discharge this discretion in an equitable manner.

Implementation	09/13	
Reviewed and approved by:	Date:	
Director, Patient Access	9/13, 3/14	
Director, Public Health	9/13, 3/14	
Medical Director, TB Clinic	9/13, 3/14	
Manager, Billing and Collections	3/14	
Chief Operations Officer/*Interim* DD Ambulatory Services	9/13, 3/14	
Chief Executive Officer/*Interim* Chief Financial Officer	9/13, 3/14, FINAL	
		03/18/14
Old number(s):		
Received for review: (date) from (committee) or (person and dept)		
NOTE(S): *Collaborative Policy Draft/Revision/Review by Kirk Stone, Rita Ogden, Susan Ehrlich, SaraT Mayer, Lisa Gooze, Srija Srinivasan, Greg Labow.*		
STATUS:		

SUBJECT: UNINSURED PATIENT SCREENING PROCESS / MIA
                CHECKLIST AND SAWS1 FORM
DEPARTMENT: FINANCIAL SERVICES: PATIENT ACCESS
AUTHOR: DIRECTOR, REVENUE CYCLE OPERATIONS

POLICY:

All uninsured patients should be screened for Medi-Cal eligibility prior to, or if necessary, at
the time services are rendered. Urgent/Emergent uninsured patients must complete financial
screening after their appointment in order to be billed appropriately for their services.

PURPOSE:

To provide a systematic approach for assessing Medi-Cal linkage for uninsured patients in
order to improve patient's overall experience and support financially sound operations.

Patient Services Assistants IIs (PSAIIs) will conduct Medi-Cal linkage screening via the
Medically Indigent Adult Checklist (MIA) for all uninsured patients. If patient has Medi-Cal
linkage, the Medi-Cal SAWS-1 Form will be completed and the patient visits will be recoded to
Medi-Cal pending status. The registration staff will forward the completed SAWS-1s with MIA
Checklist attached to the Medi-Cal Mail-In Unit (Pony HSA 211) on a daily basis.

A. If the patient is uninsured, the PSAII will follow this process:

1. PSAII will screen the patient for Medi-Cal linkage with Medi-Cal's Medically
    Indigent Adult (MIA) Checklist.

2. If the patient answers yes to any of the questions on the MIA checklist a Medi-Cal
    SAWS-1 Form will be completed.

3. If the uninsured patient has no Medi-Cal linkage and is registered as F19
    (undetermined), then patient will be given 14 days to see a Community Health
    Advocate (CHA) to start the One-E-App (OeA) screening process.

4. At time of registration**,** patients coded F19 will be given a letter notifying them that
    they have 14 days to see CHA for screening and enrollment into a program.

5. If patient does not see CHA within 14 days, the patient visit will be recoded to F75
    (Self Pay - Patient Failed to Follow-Up).

6. SMMC's Self-Pay Team will follow-up with F75 coded patients to arrange a payment
    plan.

7. Patients coded F75 cannot have future visits coded as F19 by PSAII's. Patients with F75 financial codes must see CHA for rescreening. Only CHAs and Billing Staff can recode F75 accounts.

8. Daily F19 and U15 report by clinic will be forwarded to designated CHA staff for follow-up.

9. Designated <u>CHA will call patient within 7 days to screen and schedule enrollment assistance appointment.</u>

10. Once the patient starts OeA application process with CHA, then patient will have 45 days to complete the enrollment process. Patient visits are recoded to F19-F20 for patients that have applications started in OeA and F19-F10 for patients that have successfully submitted applications. *This is pending OeA-Invision interface automation.*

11. If the OeA application is not completed within 45 days, then patient visit will be recoded to F75. *This is pending OeA-Invision interface automation.*

12. The patient will also receive an SMMC bill, which will include information customized to his/her current financial code; i.e., F19 patients will have information on how to apply for health coverage programs

B. FAQ's

When do we complete an MIA checklist form?
Each time an uninsured patient answers "YES" to any of the questions on the MIA Checklist, the MIA Checklist and the SAWS-1 application form must be completed, attached, and submitted to the Medi-Cal Mail pony HSA 211 on a daily basis.

Do we always have to attach the MIA checklist to the SAWS1?
Yes, Medi-Cal will not accept a SAWS-1 without an MIA form.

If the client responds no to all questions on the MIA checklist, do I complete the SAWS-1?
SAWS-1 will only be completed if patient responds yes to one of the questions on the MIA Checklist. If the patient responds no to all the questions, the staff will provide the F19 letter to the patient. The staff should also enter comments in Invision. Staff will scan the MIA checklist in eCw.

When do we fill out the MIA Checklist/SAWS-1 under the parent's name?
If the patient who is seeking services is under the age of 21 and <u>living with the parent(s),</u> both MIA and SAWS-1 forms must be in the parent(s) name(s).

If the patient seeking services is between the ages of 18-21 and <u>does not live with a parent</u>, the MIA and SAWS-1 forms must be in the patient's name.
The age criterion for a minor is under the age of 21.

When is it required for us to enter comments in CORE?
This is at the discretion of your Supervisor; however, it would beneficial for all departments to brainstorm on what pertinent information is useful to document into CORE.

If a patient presents and states his/her health plan expired, but has no card with them, how do we proceed?
If their program has expired, the patient is uninsured. Use HDX to confirm if the plan is expired.
If yes, then follow the MIA/SAWS-1 screening process.
If no linkage, then code F75.
If there is a linkage and you filled out the MIA/SAWS-1, code U15 or U16.

When do I code the patient U15 versus U16
If the patient answers Yes to question #4 on the MIA form "Are you or anyone you are applying for disabled", then code the patient U16. If the patient answers Yes to any other question on the MIA form, code the patient U15.

Can the SAWS be used in place of the temporary prescription card?
The SAWS-1 can and should be used in place of a temp RX card at the SMMC and contracted pharmacies. They will honor it as verification that the MC application is pending for up to 90 days from the issue date. Please ask the PSAs to remind the patients to take their SAWS copy with them to the pharmacy, instead of referring them to see a Community Health Advocate for the purpose of obtaining a temporary RX card.

For families with more than one child, does a MIA Checklist and SAWS-1 need to be filled out for each child in the family?
Yes.

How long do we code patient Medi-Cal Pending before asking them to complete new form?
Code the patient Medi-Cal Pending for as long as the patient claims that it is still pending. The CHA will be following up on the application. If it is not pending any longer, the CHA will be recoding the visit.

When we send a SAW1 to Medi-Cal, how long does it take them to process the application?
Medi-Cal Benefits Analyst have up to 45 days to process a regular MC application but it can take longer (shouldn't be longer than 60 - 90 days). Medi-Cal applications with linkage due to disability can take up to a year before they are approved.

If the patient does not completely answer all questions on the SAW-1 or MIA sheet will they be returned/ denied, or does a BA review with patient?
Questions 1 - 13, plus the signature on 19 should be completely filled out (don't forget to date the SAWS-1 - very important!). If something has been missed, I don't believe that it will be returned or denied, but it is much better if the questions listed above are thoroughly filled out. If staff gives the SAWS-1 to the patient to fill out, please have staff review the form before the patient leaves to make sure that it is thoroughly filled out.

If the patient does not have coverage and they claim they have already completed their application for Medi-Cal or other programs and we cannot confirm, do we give them another form to complete? What happens if they refuse?

If they claim that their case is still pending, code it U15 and do not fill out another form. A CHA will be following up with the MC case. If it turns out it is not still pending, the CHA will be screening the patient for linkage, and if the patient has linkage, the CHA will assist the patient with MC process. If the patient has no linkage, then the CHA will assist the patient in applying for another program. If the patient says they already applied for MC and they were denied, fill out the MIA form. If patient has linkage, then fill out the SAWS-1. If patient refuses to apply for MC and has linkage, then code the visit F75 and explain to the patient that s/he will be responsible for the visit charges. If it is a non-urgent visit, the patient should not be seen. If it is an urgent visit, the patient should be seen.

If patient is coded F75 how long do we code them that?
(One week from last registration, one month from last registration)

If patient is coded F75, you should still be filling out the MIA checklist. If the answer is yes to any of the questions, you should fill out and submit the SAWS-1. Anytime you fill out the SAWS-1, you should code the patient U15 or U16. If the answer is no to all questions on the MIA and the patient was previously coded F75, then you should continue to code them F75 for all visits until they start or complete the application process with a CHA. Once that happens, you'll see the indicator code on the submenu change on the Elig/Stat line to F20 or F10, or you'll see the program enrollment code of W10, W22, Z60, or Z55.

Implementation: April 2011
Reviewed and approved by: Date:
~~County Counsel~~
~~Executive Management Team~~
~~Hospital Board~~
Director, Revenue Cycle Operations   3/11
Deputy Director, Health Information Mgmt Svcs   3/11
Chief Financial Officer   3/11
Deputy Director, Ambulatory Svcs   3/11
Deputy Director, Clinical Ancillary Svcs   3/11
Chief Operating Officer   10/11 FINAL
                                                          10/13/11

Old number(s): N/A
Received for review:
NOTE(S):
STATUS:

SUBJECT: WELL PROGRAM FORMS FILING AND RETENTION

DEPARTMENT: FINANCIAL SERVICES: PATIENT ACCESS

AUTHOR: PATIENT ACCESS MANAGER

PURPOSE:

 To ensure consistency in the filing of WELL Program forms.

POLICY:

All forms related to the WELL Program will be filed and stored in a timely manner in an area designated for WELL Program forms.

PROCEDURE:

1. All forms will be stored for a total period of three years. The most recent 18 months will be stored on-site at the clinic where enrollment took place in an easily accessible location.

2. WELL Program Self-Declaration forms will be filed by WELL enrollment date.

3. WELL Program Notification of Disenrollment/Ineligibility forms will be filed in alphabetical order separated by the year that the form was provided to the patient. These forms will also be kept on-site at the clinic where the patient was disenrolled or determined ineligible for the WELL Program.

Implementation: 6/05
Reviewed and approved by: Date:
  Patient Access Manager, Financial Svcs   5/05
  Chief Financial Officer   5/05
  County Counsel   6/05
  Medical Executive Committee   7/05
  Hospital Board   10/05

                                                                                      6/15/05

SMMC Financial Policies

Patient Financial Services

SUBJECT: BAD DEBT WRITE-OFF

DEPARTMENT: FINANCE: PATIENT FINANCIAL SERVICES

AUTHOR: MANAGER, PATIENT FINANCIAL SERVICES

POLICY:

It is the policy of San Mateo Medical Center (SMMC) to relieve patient accounts receivables using a bad debt write-off for charges that are no longer deemed collectible. Only those charges for which the patient is responsible and able to make payment, but is unwilling to do so, will be considered for a bad debt write-off.

PURPOSE:

To establish guidelines for assigning accounts to a bad debt status.

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1. Patients will be screened for third party reimbursement, including county and state programs, prior to assigning their responsibility for payment. This includes payment for full charges, co-pays, deductibles, annual fees, share-of cost (SOC), co-insurance or any non-covered charges that are related to the patient's visit.

2. SMMC will follow internally established procedures to secure payments from patients. These procedures may vary depending on the dollar value of the account and the payor. All responsible efforts will be made to establish and verify the amount that the patient is responsible for payment, the patient's correct address, and the patient's ability to pay. After these three items have been established, failure to make payments provides a reasonable assumption that the patient is unwilling to pay.

3. Whenever possible, patients will be asked to pay in advance or make a deposit for services for which they are responsible for making payment. Payments made in advance will be based on a reasonable estimation of the average charges for the specific procedure or diagnosis.

4. Patients are expected to make full payment within 90 days from the date of first billing or the date they were found to be ineligible for other third party reimbursement. In many cases, patients are not expected to pay their portion until coordination of benefits has been done. For example, patients may not be deemed responsible until payment has been received from a primary payor or until they are found to be ineligible for Medi-Cal or the county-sponsored WELL program.

5. After appropriate financial screening by a financial counselor or collector, patients may be eligible for a repayment plan that includes making multiple payments over time to pay off an outstanding balance. If the patient is approved for a repayment plan the account will be referred immediately to an outside service for follow-up and collection.

6. SMMC will utilize the services of a collection agency for collection of bad debt accounts. Once an account is referred to the collection agency, SMMC will direct all future account inquiries made by the patient to that agency.

7. A patient's account will be considered for bad debt write-off and subsequent referral to a collection agency if either of the following occurs:

   a. A patient fails to make full payment within 90 days from having been given notice of their responsible portion of the bill
   b. A patient fails to make a payment while on a repayment plan

8. Neither SMMC nor the outside service to which an account is referred will charge interest on outstanding balances.

9. WELL program inpatients are required to sign a lien approval in order to secure future payment in the event the patient fails to make full payment.

10. All bad debt write-offs will be pre-approved by a manager or higher authority within Patient Financial Services according to the level of signature required. Appropriate notes or other documentation for the account will be recorded in the Siemen's patient accounting system to justify the bad debt write-off.

11. Write off approval levels are as follows:

    12. Patient Financial Services Supervisor – up to $2,500.00
    13. Admitting and/or Patient Financial Services Manager – $2,500.00 to $10,000.00
    14. Chief Financial Officer – exceeding $10,000.00

15. If an account is inappropriately referred to the collection agency, the account will be returned immediately to SMMC for follow-up and resolution.

Implementation:	7/03	
Reviewed and approved by:	Date:	
Manager, Patient Financial Services	3/11, 4/15	
Supervisor, Patient Financial Services	4/15	
Chief Financial Officer	3/11, 4/15, FINAL	
		04/27/15
Old number(s): N/A		
Received for review:		
NOTE(S):		
STATUS:		

SUBJECT: CHDP BILLING PROCESS

DEPARTMENT: FINANCIAL SVCS: PT. FINANCIAL SVCS: PATIENT BILLING

AUTHOR: DIRECTOR, PATIENT FINANCIAL SERVICES

PURPOSE:

To detail the process for billing claims for services provided through the Child Health and Disability Prevention (CHDP) program.

POLICY:

It is the policy of San Mateo Medical Center (SMMC) to bill third party payers in accordance with applicable billing guidelines. The CHDP Program has specific guidelines for billing claims for services rendered at Federally Qualified Health Centers (FQHCs). SMMC is a designated FQHC.

FQHCs are paid an all-inclusive rate per visit. This includes a visit in which a CHDP complete health assessment is provided. Clinic visits at which a patient receives "incident to" physician services, even if delivered on a subsequent day (e.g., laboratory and radiology services, immunizations, etc.) do not qualify as billable visits.

PROCEDURE:

1. CHDP services are rendered in the Outpatient Clinics and coded C85.
2. The provider completes a PM160 Information Only form which is submitted to:

> Medi-Cal/CHDP
> PO Box 15300
> Sacramento, CA 95851-1300

3. The provider also completes a Pediatric encounter form; the charges entered on the encounter form are posted to the patient account.
4. At the time of billing, SMMC's claims processing system, DSG, will create an FQHC claim for the CHDP services via a UB92 claim form.
5. If the initial FQHC claim is denied because the patient is an HPSM member, DSG will automatically rebill the claim using a different FQHC code.
6. The Post Biller is responsible for monitoring the CHDP account. Once payment is received, any late charges posted to the CHDP account will be adjusted using transaction code 2010031 (CHDP Contractual Adjustment).
7. Accounts coded C85 that do not include a provider visit (CPT codes 99381-99384, 99391-99394), for example, immunization only services, will **not** be separately billed. The Biller will adjust the charges on this account using transaction code 2010031.

Implementation: 5/3/04
Reviewed and approved by: Date:
   Director, Patient Financial Services   10/04
   Manager, Patient Accounting   10/04
   Chief Financial Officer   10/04
   Medical Executive Committee   12/04
   Hospital Board   1/05

                                                                     10/22/04

SUBJECT: CREDIT BALANCES

DEPARTMENT: FINANCE: PATIENT FINANCIAL SERVICES

AUTHOR: MANAGER, PATIENT FINANCIAL SERVICES

POLICY:

Patient Financial Services will review accounts with credit balances and take appropriate action according to the applicable guidelines.

PURPOSE:

To define the process for resolving credit balances and overpayments and to facilitate timely refunding of any confirmed overpayments.

Note: See Attachments "Procedure for Refunding Confirmed Overpayments"
and related "DHSS CMS Forms and Instructions"

I. Credit Balance Guidelines

 A. Investigate and document findings as to why a credit balance exists.

 B. Apply credit balances to other outstanding balances owed by the patient/guarantor, starting with the oldest open account.

 C. Refund non-third-party amounts to the patient/guarantor if the patient/guarantor has no other open accounts.

 D. Refund non-patient/guarantor amounts to the third-party payor on a first-in-first-out basis, not to exceed a zero balance on the account(s).

 E. Review discounts or policy adjustments and reverse overstated or inaccurate adjustments.

 F. Process appropriate take-back (refund/rebill) documents provided by intermediaries for duplicate payments or overpayments.

 G. Process the standard quarterly Medicare Credit Balance Report as well as the Medi-Cal Credit Balance report without fail and within 30 days after the end of each quarter. The Hospital's Chief Financial Officer will retain a copy.

H. Process credit balances within 60 working days from the date the account balance appears as a credit.

I. Prepare a refund request with supporting details and submit for appropriate management approval when, after investigation, it is determined that a refund is due.

J. Release refund checks no earlier than 20 days from the date the account balance appears as a credit, to allow for all checks from third parties to clear the bank.

II. Small Balance (less than $10.00) Credit Balance

A. If the account has only an insurance payment and a contractual adjustment posting, and the credit balance is $9.99 or less, perform a contractual adjustment equal to the credit balance.

B. If the account has a credit balance of $9.99 or less and both an insurance payment and a patient payment are present on the account and the patient payment is equal to or greater than the credit balance amount, refund to the patient the amount equal to the credit balance.

C. If the account has a credit balance of $9.99 or less and includes a small balance write-off and a patient payment, reverse the small balance write-off and refund the patient any remaining balance.

D. Responsibilities

1. Areas of responsibility

    • Patient Financial Services Supervisor
    • Patient Financial Services Manager
    • Chief Financial Officer
    • Accounts Payable Staff

2. The Patient Financial Services Manager will ensure that the small credit balance write-off amount in the system tables is set at $4.99. Credit balances must not be automatically written off unless specific to Managed Care payors where a business-to-business arrangement exists. In such cases, the small credit balance amount may be set to the dollar amount specified within the arrangement and agreed upon by both parties. The Patient Financial Services Manager and the CFO will ensure that credit balances are resolved timely and accurately in a manner consistent with this Policy.

III. Processing Insurance/Patient Credit Balances

    A. Performance Standards

        1. Correctly research and resolve credit balances within 30 days 95% of the time
        2. Provide required supporting documentation and obtain necessary refund approvals 100% of the time

    B. Related Measurements

        1. Monthly review of credit balance report to determine length of time credit balances have existed
        2. Monthly review of refund requests and processing reports to determine that supporting documentation is provided and approvals obtained

IV. Procedure for Refunding Confirmed Overpayments

    A. Receive and review the Credit Balance Report

    Review the Credit Balance Report. Verify all information on the report against original documents; for example, insurance remittances, cash receipts and/or adjustment requests. Pull copies of insurance remittances and patient checks to verify accuracy of account transactions.

    B. Determine how the credit balance was created

    Research payment/adjustment history for each credit balance account to determine at which point a credit balance was created. Insure that all payments were applied to the correct account for the correct date(s) of service.

    C. Determine appropriate corrective action

    Based on the results of the credit balance research, determine the appropriate resolution from one of the following options:

        1. Transfer credit balance to another open account only if the credit is a result of patient payment. Do not transfer the credit balance if the overpayment is the result of insurance payment(s).
        2. Refund primary payor
        3. Refund secondary payor
        4. Refund patient/guarantor
        5. Reverse incorrectly posted contractual adjustment.
        6. Process overpayment as bad debt recovery
        7. Refund duplicate payment

D. Determine who should receive the refund

1. If an insurance company should receive the refund, determine which insurance company paid first on the account. If the patient/guarantor should receive the refund, research other accounts for outstanding balances due from him or her. If outstanding balances exist, apply the amount of overpayment to the oldest account with an outstanding balance due from the patient/guarantor. In some cases (such as Medicare or Medi-Cal) an adjustment claim may need to be submitted to initiate a "take-back" by the carrier or intermediary to retrieve overpaid funds. All time frames associated with such payors must be adhered to according to their regulatory or contractual arrangement with the facility.

2. A credit balance may be the result of excessive contractual adjustments posted to the account. In such cases, the contractual adjustments must be researched; copies of Remittance Advices may need to be referred to in order to rectify these accounts. The adjustment request form must be approved by the Business Services Manager.

E. Complete Refund Request Form

In cases where a refund is appropriate, complete a Refund Request Form. Attach the following documentation:

1. On-line inquiry documentation delineating all account activity
2. Photocopy of all payments posted to the account, if available
3. All documentation initiating account adjustment activity (Medicare allowances, courtesy discounts, etc.) including Payment/Allowance and Write-off forms and Account Transfer forms
4. An analysis of refund requirements, including to whom the refund should be made, mailing address of refund recipient, and amount of refund to be processed

F. Document your actions

Document in the computer system all actions taken in researching the credit balance. Include any payment transfer information, phone calls made in the research process, refund information, your initials, and the date of the refund request.

G. Obtain necessary approvals

Submit the Refund Request Form(s) to the Patient Financial Services Supervisor for approval. Refund Requests must then be approved by the Business Services Manager before being processed by the Accounts Payable Department and the checks mailed to the payee.

1. Supervisors must approve all refunds
2. Patient Financial Services Manager must signature approve refunds exceeding $1,000.00
3. Chief Financial Officer must signature approve refunds exceeding $10,000

H. Reports and Forms

1. Reports

Currently there is no automated report. Accounts are reviewed through a weekly ATB (aged trial balance) downloaded into an Excel format.

2. Forms

a. Procedure For Refunding Confirmed Overpayments (see attached)
b. Refund worksheet
c. Medicare credit balance reporting; policy and forms

Policy: Credit Balances…..Cont'd.

Implementation:	7/10		
Reviewed and approved by:		Date:	
Manager, Patient Financial Services		3/11, 4/15	
Supervisor, Patient Financial Services		4/15	
Chief Financial Officer		3/11, 5/15, FINAL	
			04/27/15
Old number(s): N/A			
Received for review:			
NOTE(S):			
STATUS:			

PROCEDURE FOR REFUNDING CONFIRMED OVERPAYMENTS
For additional information, refer to Patient Billing policy titled: Credit Balances

PROCESS / STEPS	SUPPORTING DOCUMENTATION	APPROVAL LEVEL
1. Receive and review the Credit Balance Report. Verify all report information against original documents.	N/A	N/A
2. Determine how the credit balance was created	N/A	N/A
3. Determine appropriate corrective action from one of the following:	N/A	N/A
• Transfer credit balance to another open account only if the credit is a result of patient payment. Do not transfer credit balance if the overpayment is the result of insurance payment(s).	N/A	N/A
• Refund primary payor	N/A	N/A
• Refund secondary payor	N/A	N/A
• Refund patient/guarantor	N/A	N/A
• Reverse incorrectly posted contractual adjustment	N/A	N/A
• Process overpayment as bad debt recovery	N/A	N/A
• Refund duplicate payment	N/A	N/A
4. Determine who should receive the refund	N/A	N/A
• Insurance company (determine which insurance company paid first on the account)	N/A	N/A
• Patient / guarantor (search for outstanding balances due on other accounts)	N/A	N/A
• If credit balance is the result of excessive contractual adjustments posted to the account, the adjustments must be researched. Any adjustment request form must be approved by the Business Services Manager (10K and under) or Revenue Cycle Director (above 10K)	ADJUSTMENT REQUEST FORM	SEE BULLET TO THE LEFT
5. Complete the Refund Request Form and attach the following documentation:	REFUND WORKSHEET	N/A
• On-line inquiry documentation delineating all account activity	INVISION	N/A
• Photocopies of all payments posted to the account, if available	RAs, EOP, etc.	N/A
• All documentation initiating account adjustment activity (Medicare allowances, courtesy discounts, etc.), including Payment/Allowance, Write-Off, and Account Transfer forms	N/A	N/A
• An analysis of refund requirements, including to whom the refund should be made, mailing address of refund recipient, and amount of refund to be processed	N/A	N/A
6. Document in the computer all actions taken in researching the credit balance	N/A	N/A
7. Obtain necessary approvals for refund requests in the following order:	N/A	N/A
• Patient Financial Services Supervisor: all refunds	REFUND WORKSHEET	PT FINAN SVCS SUPV
• Patient Financial Service Manager: $1,000.00 and greater	REFUND WORKSHEET	BUSINESS SVCS MGR
• Chief Financial Officer : above 10K	REFUND WORKSHEET	REVENUE CYCLE DIR

7/24/10

Policy: Credit Balances…..Cont'd.

San Mateo Medical Center
Refund Worksheet

Date: Requested by:

Patient Name:
Medical Record Number:
Patient Account Number:
Date of Service:

Total Charges:

Payments:

Date:	Amount:	Date:	Amount:
Date:	Amount:	Date:	Amount:
Date:	Amount:	Date:	Amount:

Total Payments:

Adjustments:

Date:	Amount:	Date:	Amount:
Date:	Amount:	Date:	Amount:
Date:	Amount:	Date:	Amount:

Total Adjustments:

Total Refund:

Reason For Refund:
☐ OVERPAYMENT ON **WELL** ACCOUNT   ☐ DUPLICATE PAYMENT
☐ OVERPAYMENT ON ACCOUNT   ☐ LATE CREDIT APPLIED TO ACCOUNT
☐ PAID IN ERROR   ☐ OTHER: Provide detailed explanation below:
    PT HAS MCAL AS SECONDARY - NO LIAB _____

_____

Charge to: ☐ 00502-0235 -Pt/Ins Refunds   ☐ 66750-2369 -ACE Annual Fee
              ☐ 66016-2526 Maddy Funds (No Detail)

Refund Amount: **Refund Amount:**
Refund to: **Refund to:**
Refund Address: **Refund Address:**

$1,000.00 < Approved by Supervisor : _____ **$10,000.00< Approved by Manager:** _____ **Refunds exceeding $10,000.00 must be CFO approved** _____

NOTE: (DHHS Medicare Credit Balance Report Sample Below, Use most current from
http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-Items/CMS006634.html)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB No. 0938-0600

MEDICARE CREDIT BALANCE REPORT
CERTIFICATION PAGE

The Medicare Credit Balance Report is required under the authority of sections 1815(a), 1833(e), 1886(a)(1)(C) and related provisions of the Social Security Act. Failure to submit this report may result in a suspension of payments under the Medicare program and may affect your eligibility to participate in the Medicare program.

ANYONE WHO MISREPRESENTS, FALSIFIES, CONCEALS OR OMITS ANY ESSENTIAL INFORMATION MAY BE SUBJECT TO FINE, IMPRISONMENT OR CIVIL MONEY PENALTIES UNDER APPLICABLE FEDERAL LAWS.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER

I HEREBY CERTIFY that I have read the above statements and that I have examined the accompanying credit balance report prepared by

_____   _____
Provider Name   Provider 6-Digit Number

for the calendar quarter ended_____and that it is a true, correct, and complete statement prepared from the books and records of the provider in accordance with applicable Federal laws, regulations and instructions.

(Sign) _____
Officer or Administrator of Provider

(Print) _____
Name and Title

(Print) _____
Date

CHECK ONE:
❑ Qualify as a Low Utilization Provider.
❑ The Credit Balance Report Detail Page(s) is attached.
❑ There are no Medicare credit balances to report for this quarter. (No Detail Page(s) attached.)

_____   _____
Contact Person   Telephone Number

Form CMS-838 (10/03)   INSTRUCTIONS FOR COMPLETING THIS PAGE ARE IN MEDICARE CREDIT BALANCE REPORT -
PROVIDER INSTRUCTIONS, FORM CMS-838

Policy: Credit Balances…..Cont'd.

NOTE: (DHHS Medicare Credit Balance Report Sample Below, Use most current from
http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-Items/CMS006634.html

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB No. 0938-0600

Medicare Credit Balance Report
Detail Page

Provider Name: _____
Provider Number: _____
Quarter Ending: _____
Medicare Part: _____ (Indicate "A" or "B")

Page _____ of _____
Contact Person: _____
Phone Number (____) ____ - _____

(1) Beneficiary Name	(2) HIC Number	(3) ICN Number	(4) Type of Bill	(5) Admission Date (MM/DD/YY)	(6) Discharge Date (MM/DD/YY)	(7) Paid Date (MM/DD/YY)	(8) Cost Report (Open/Closed)	(9) Amount of Medicare Credit Balance	(10) Amount of Medicare Credit Balance Repaid	(11) Method of Payment	(12) Amount of Medicare Credit Balance Outstanding	(13) Reason for Medicare Credit Balance	(14) Value Code	(15) Primary Payer (Name & Billing Address)

INSTRUCTIONS FOR COMPLETING THIS PAGE ARE IN MEDICARE CREDIT BALANCE REPORT - PROVIDER INSTRUCTIONS, FORM CMS-838

Form CMS-838 (10/03)

NOTE: (DHHS Medicare Credit Balance Report – Provider Instructions Sample Below, Use most current from
http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-Items/CMS006634.html

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Medicare Credit Balance Report – Provider Instructions

General
The Paperwork Burden Reduction Act of 1995 was enacted to inform you about why the Government collects information and how it uses the information. In accordance with sections 1815(a) and 1833(e) of the Social Security Act (the Act), the Secretary is authorized to request information from participating providers that is necessary to properly administer the Medicare program. In addition, section 1866(a)(1)(C) of the Act requires participating providers to furnish information about payments made to them, and to refund any monies incorrectly paid. In accordance with these provisions, all providers participating in the Medicare program are to complete a Medicare Credit Balance Report (CMS-838) to help ensure that monies owed to Medicare are repaid in a timely manner.

The CMS-838 is specifically used to monitor identification and recovery of "credit balances" owed to Medicare. A credit balance is an improper or excess payment made to a provider as the result of patient billing or claims processing errors. Examples of Medicare credit balances include instances where a provider is:

- Paid twice for the same service either by Medicare or by Medicare and another insurer;
- Paid for services planned but not performed or for non-covered services;
- Overpaid because of errors made in calculating beneficiary deductible and/or coinsurance amounts; or
- A hospital that bills and is paid for outpatient services included in a beneficiary's inpatient claim.

Credit balances would not include proper payments made by Medicare in excess of a provider's charges such as DRG payments made to hospitals under the Medicare prospective payment system.

For purposes of completing the CMS-838, a Medicare credit balance is an amount determined to be refundable to Medicare. Generally, when a provider receives an improper or excess payment for a claim, it is reflected in their accounting records (patient accounts receivable) as a "credit." However, Medicare credit balances include monies due the program regardless of its classification in a provider's accounting records. For example, if a provider maintains credit balance accounts for a stipulated period; e.g., 90 days, and then transfers the accounts or writes them off to a holding account, this does not relieve the provider of its liability to the program. In these instances, the provider must identify and repay all monies due the Medicare program.

Only Medicare credit balances are reported on the CMS-838.

To help determine whether a refund is due to Medicare, another insurer, the patient, or beneficiary, refer to the sections of the manual [each provider manual will have the appropriate cite for that manual] that pertain to eligibility and Medicare Secondary Payer (MSP) admissions procedures.

Submitting the CMS-838
Submit a completed CMS-838 to your fiscal intermediary (FI) within 30 days after the close of each calendar quarter. Include in the report all Medicare credit balances shown in your accounting records (including transfer, holding or other general accounts used to accumulate credit balance funds) as of the last day of the reporting quarter.

Report all Medicare credit balances shown in your records regardless of when they occurred. You are responsible for reporting and repaying all improper or excess payments you have received from the time you began participating in the Medicare program. Once you identify and report a credit balance on the CMS-838 report, do not report the same credit balance on subsequent CMS-838 reports.

Form CMS-838 (10/03)

Page 1

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
_____

Completing the CMS-838

The CMS-838 consists of a certification page and a detail page. An officer (the Chief Financial Officer or Chief Executive Officer) or the Administrator of your facility must sign and date the certification page. Even if no Medicare credit balances are shown in your records for the reporting quarter, you must still have the form signed and submitted to your FI in attestation of this fact. Only a signed certification page needs to be submitted if your facility has no Medicare credit balances as of the last day of the reporting quarter. An electronic file (or hard copy) of the certification page is available from your FI.

The detail page requires specific information on each credit balance on a claim-by-claim basis. This page provides space to address 17 claims, but you may add additional lines or reproduce the form as many times as necessary to accommodate all of the credit balances that you have reported. An electronic file (or hard copy) of the detail page is available from your FI.

You may submit the detail page(s) on a diskette furnished by your contractor or by a secure electronic transmission as long as the transmission method and format are acceptable to your FI.

Segregate Part A credit balances from Part B credit balances by reporting them on separate detail pages.

> NOTE: Part B pertains only to services you provide which are billed to your FI. It does not pertain to physician and supplier services billed to carriers.

Begin completing the CMS-838 by providing the information required in the heading area of the detail page(s) as follows:

- The full name of the facility;

- The facility's provider number. If there are multiple provider numbers for dedicated units within the facility (e.g., psychiatric, physical medicine and rehabilitation), complete a separate Medicare Credit Balance Report for each provider number;

- The month, day and year of the reporting quarter; e.g., 12/31/02;

- An "A" if the report page(s) reflects Medicare Part A credit balances, or a "B" if it reflects Part B credit balances;

- The number of the current detail page and the total number of pages forwarded, excluding the certification page (e.g., Page 1 of 3); and

- The name and telephone number of the individual who may be contacted regarding any questions that may arise with respect to the credit balance data.

Complete the data fields for each Medicare credit balance by providing the following information (when a credit balance is the result of a duplicate Medicare primary payment, report the data pertaining to the most recently paid claim):

Column   1 - The last name and first initial of the Medicare Beneficiary, (e.g., Doe, J.).

Column   2 - The Medicare Health Insurance Claim Number (HICN) of the Medicare Beneficiary.

Column   3 - The multiple-digit Internal Control Number (ICN) assigned by Medicare when the claim is processed.

_____
Form CMS-838 (10/03)   Page 2

Column   4 - The 3-digit number explaining the type of bill; e.g., 111 - inpatient, 131 - outpatient, 831 - same day surgery. (See the Uniform Billing instructions, [each provider manual has the appropriate cite for the manual].)

Columns 5/6 - The month, day and year the beneficiary was admitted and discharged, if an inpatient claim; or "From" and "Through" dates (date service(s) were rendered), if an outpatient service. Numerically indicate the admission (From) and discharge (Through) date (e.g., 01/01/02).

Column   7 - The month, day and year (e.g., 01/01/02) the claim was paid. If a credit balance is caused by a duplicate Medicare payment, ensure the paid date and ICN number correspond to the most recent payment.

Column   8 - An "O" if the claim is for an open Medicare cost reporting period, or a "C" if the claim pertains to a closed cost reporting period. (An open cost report is one where an NPR has not yet been issued. Do not consider a cost report open if it was reopened for a specific issue such as graduate medical education or malpractice insurance.)

Column   9 - The amount of the Medicare credit balance that was determined from your patient/ accounting records.

Column 10 - The amount of the Medicare credit balance identified in column 9 being repaid with the submission of the report. (As discussed below, repay Medicare credit balances at the time you submit the CMS-838 to your FI.)

Column 11 - A "C" when you submit a check with the CMS-838 to repay the credit balance amount shown in column 9, an "A" if a claim adjustment is being submitted in hard copy (e.g., adjustment bill in UB-92 format) with the CMS-838, and a "Z" if payment is being made by a combination of check and adjustment bill with the CMS-838. Use an "X" if an adjustment bill has already been submitted electronically or by hard copy.

Column 12 - The amount of the Medicare credit balance that remains outstanding (column 9 minus column 10). Show a zero ("0") if you made full payment with the CMS-838 or a claim adjustment had been submitted previously, including electronically.

Column 13 - The reason for the Medicare credit balance by entering a "1" if it is the result of duplicate Medicare payments, a "2" for a primary payment by another insurer, or a "3" for "other reasons." Provide an explanation on the detail page for each credit balance with a "3."

Column 14 - The Value Code to which the primary payment relates, using the appropriate two digit code as follows: (This column is completed only if the credit balance was caused by a payment when Medicare was not the primary payer. If more than one code applies, enter the code applicable to the payer with the largest liability. For code description, see [each provider manual has the appropriate cite for that manual].)

    12 – Working Aged
    13 – End Stage Renal Disease
    14 – Auto/No Fault

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

15 – Workers' Compensation
16 – Other Government Program
41 – Black Lung
42 – Department of Veterans Affairs (VA)
43 – Disability
44 – Conditional Payment
47 – Liability

Column 15 - The name and billing address of the primary insurer identified in column 14.

NOTE: Once a credit balance is reported on the CMS-838, it is not to be reported on a subsequent period report.

Payment of Amounts Owed Medicare
Providers must pay all amounts owed (column 9 of the report) at the time the credit balance report is submitted. Providers must submit payment, by check or adjustment bill.

- Payments by check must also be accompanied by a **separate** adjustment bill, electronic or hard copy, for all individual credit balances that pertain to open cost reporting periods. The FI will ensure that the monies are not collected twice.

- Submission of the detail information on the CMS-838 will not be accepted by the FI as an adjustment bill.

- Claim adjustments, whether as payment or in connection with a check, must be submitted as adjustment bills (electronic or hard copy). If the claim adjustment was submitted electronically, this must be shown on the CMS-838 (see instructions for column 11).

- There is a limited exception for MSP credit balances. Federal regulations at 42 CFR 489.20(h) state that "if a provider receives payment for the same services from Medicare and another payer that is primary to Medicare…" the provider must identify MSP related credit balances in the report for the quarter in which the credit balance was identified, even if repayment is not required until after the date the report is due. If the provider is not submitting a payment (by check or adjustment bill) for an MSP credit balance with the CMS-838 because of the 60-day rule, the provider must furnish the date the credit balance was received. Otherwise, the FI must assume that the payment is due and will issue a recovery demand letter and accrue interest without taking this 60-day period into consideration.

- If the amount owed Medicare is so large that immediate repayment would cause financial hardship, you may contact your FI regarding an extended repayment schedule.

Records Supporting CMS-838 Data
Develop and maintain documentation that shows that **each patient record with a credit balance** (e.g., transfer, holding account) was reviewed to determine credit balances attributable to Medicare and the amount owed, for the preparation of the CMS-838. At a minimum, your procedures should:

- Identify whether the patient is an eligible Medicare beneficiary;

- Identify other liable insurers and the primary payer;

- Adhere to applicable Medicare payment rules; and

- Ensure that the credit balance is due and refundable to Medicare.

Form CMS-838 (10/03)

Page 4

NOTE: A suspension of Medicare payments may be imposed and your eligibility to participate in the Medicare program may be affected for failing to submit the CMS-838 or for not maintaining documentation that adequately supports the credit balance data reported to CMS. Your FI will review your documentation during audits/reviews performed for cost report settlement purposes.

Provider Based Home Health Agencies (HHAs)

Provider-based HHAs are to submit their CMS-838 to their Regional Home Health Intermediary even though it may be different from the FI servicing the parent facility.

Exception for Low Utilization Providers

Providers with extremely low Medicare utilization do not have to submit a CMS-838. A low utilization provider is defined as a facility that files a low utilization Medicare cost report as specified in PRM-I, section 2414.4.B, or files less than 25 Medicare claims per year.

Compliance with MSP Regulations

MSP regulations at 42 CFR 489.20(h) require you to pay Medicare within 60 days from the date you receive payment from another payer (primary to Medicare) for the same service. Submission of the CMS-838 and adherence to CMS' instructions do not interfere with this rule. You must repay credit balances resulting from MSP payments within the 60-day period.

Report credit balances resulting from MSP payments on the CMS-838 if they have not been repaid by the last day of the reporting quarter. If you identify and repay an MSP credit balance within a reporting quarter, in accordance with the 60-day requirement, do not include it on the CMS-838; i.e., once payment is made, a credit balance would no longer be reflected in your records.

If an MSP credit balance occurs late in a reporting quarter, and the CMS-838 is due prior to expiration of the 60-day requirement, include it in the credit balance report. However, payment of the credit balance does not have to be made at the time you submit the CMS-838, but within the 60 days allowed.

Form CMS-838 (10/03)

SUBJECT:	FEDERALLY QUALIFIED HEALTH CENTER (FQHC) BILLING
DEPARTMENT:	FINANCIAL SERVICES: PATIENT BILLING
AUTHOR:	DIRECTOR REVENUE CYCLE OPERATIONS

POLICY:

This policy will identify and establish guidelines for the appropriate billing of the various types of Federally Qualified Health Center (FQHC) claims.

PURPOSE:

Outline the standard Medi-Cal eligible FQHC visit claim creation and billing life cycle

----

A. **HP (formerly EDS) Medi-Cal FQHC visit**

1. Medi-Cal Primary (C72) FQHC 00001 (including CPSP, CHDP, and other qualified visits)

    a. Day 1: Patient seen in Clinic
    b. Day 1+: Charges/Diagnosis posted to Patient Accounting
    c. Day 10+: Bill (837i) drops from Invision
        *   Professional and Technical charges drop on UB-04 claim form
    d. Day 10+: Claims load to DSG (Claims Scrubber)
        *   UB-04 (837i)
    e. Day 10+: DSG conditionally creates FQHC 00001 claim
        1) Eligible Ins Plan Code (C72)
        2) Eligible CPT code
        3) Outpatient claim
        4) Control – Duplicate claim check performed against claim history
        5) Control – Claim check against eligibility file; those claims with inappropriate eligibility for claim payer destination are placed in error for staff review
        6) Detect – Daily DSG No Load report of accounts that no FQHC claim was created
    f. Day 10+: FQHC 00001 Claim billed electronically to HP
        *   UB-04 (837i) to HP
    g. Day 25+: HP electronic remittance received (835/ARDS files)
    h. Day 25+: DSG creates appropriate payment posting file dependant on adjudication from HP
    i. Day 39+: Payer electronic remittance received (835/ARDS files)
        1) HP FQHC Paid claims:
            a) Pmt – 01010727 HP – FQHC PAYMENT
            b) Adj – 02010726 MEDI-CAL FQHC CONTRACTUAL

       2) HP FQHC Denied claims:
- 7m comment record posted with RA date, Reason code and Denied amount

    j. Day 40+: Denial Manager
- HP FQHC – Staff work denial received by biller stamp/RA date

2. <u>Medicare/Medi-Cal Secondary (M20/C72) FQHC 00002 (including Medicare (Palmetto)-eligible patients with HP straight Medi-Cal as secondary</u>

    a. Day 1: Patient seen in Clinic
    b. Day 1+: Charges/Diagnosis posted to Patient Accounting
    c. Day 10+: Bill (837i/837p) drops from Invision
    d. Day 10+: Claims load to DSG
       1) UB-04 (837i)
       2) CMS 1500 (837p)
    e. Day 10+: DSG conditionally creates FQHC 00002 claim
       1) Eligible Ins Plan Code (M20primary/C72secondary)
       2) Eligible CPT code
       3) Outpatient clinic claim
    f. Day 10+: FQHC 00002 (837i) to EDS
       1) Claim edited to paper
       2) Control – Duplicate FQHC claim check against history file
       3) Control – Claim check against eligibility file; those claims with inappropriate eligibility for claim payer destination are placed in error for staff review.
    g. Day 10+: Staff management of FQHC 00002 claim
- Staff place paper claim in tickler file until adjudication for Medicare is received

    h. Day 10+: Claims billed electronically to payers
       1) UB-04 (837i) to Palmetto
       2) CMS 1500 (837p) to Palmetto
    i. Day 25+: Payer electronic remittance received (835/ARDS files)
- Crossover claim sent to HP

    j. Day 25+: DSG creates appropriate posting file dependant on adjudication
    k. Day 25+: Staff confirm paper FQHC claim now has appropriate adjudication
- Staff print FQHC 00002 claim and attach RA; claim billed to HP

    l. Day 39+: Payer electronic remittance received (835/ARDS files)
       1) HP FQHC Paid claims
         a) Pmt – 01010727 HP – FQHC PAYMENT
         b) Adj – 02010726 MEDI-CAL FQHC CONTRACTUAL
       2) HP FQHC Denied claims
- 7m Comment record posted with RA date, Reason code and Denied amount

    m. Day 40+: Denial Manager
- HP FQHC – Staff work denial received by biller stamp/RA date

3. Medi-Cal Primary (C72) Dental FQHC 00003 (Pregnancy related; effective 7/1/2009)

   a. Day 1: Patient seen in Clinic
   b. Day 1+: Charges/Diagnosis posted to Patient Accounting
   c. Day 10+: Bill (837i) drops from Invision
       • Professional and Technical charges drop on UB-04 claim
   d. Day 10+: Claims load to DSG
       • UB-04 (837i)
   e. Day 10+: DSG conditionally creates FQHC 00001 claim
       1) Eligible Ins Plan Code (C72)
       2) Eligible CPT code
       3) Primary or Secondary Pregnancy related final diagnosis
       4) Outpatient claim
       5) Control – Duplicate claim check performed against claim history
       6) Control – Claim check against eligibility file; those claims with inappropriate eligibility for claim payer destination are placed in error for staff review
       7) Detect – Daily DSG No Load report of accounts that no FQHC claim was created
   f. Day 10+: FQHC 00003 Claim billed electronically to HP
       • UB-04 (837i) to HP
   g. Day 25+: HP electronic remittance received (835/ARDS files)
   h. Day 25+: DSG creates appropriate payment posting file dependant on adjudication from HP
   i. Day 39+: Payer electronic remittance received (835/ARDS files)
       1) HP FQHC Paid Claims
          a) Pmt – 01010727 HP – FQHC PAYMENT
          b) Adj – 02010726 MEDI-CAL FQHC CONTRACTUAL
       2) HP FQHC Denied Claims
          • 7m Comment record posted with RA date, Reason code and Denied amount
   j. Day 40+: Denial Manager
       • HP FQHC – Staff work denial received by biller stamp/RA date

B. HPSM Managed Medi-Cal FQHC visit

   1. Medi-Cal Primary (C20/C30)

      a. Day 1: Patient seen in Clinic
      b. Day 1+: Charges/Diagnosis posted to Patient Accounting
      c. Day 10+: Bill (837i/837p) drops from Invision
      d. Day 10+: Claims load to DSG
         1) UB-04 (837i)
         2) CMS 1500 (837p)
      e. Day 10+: Claims billed electronically to payer
         1) UB-04 (837i) to HPSM
         2) CMS 1500 (837p) to HPSM
      f. Day 25+: HPSM electronic remittance received (835/ARDS files)

    g. Day 25+: DSG creates appropriate payment posting file dependant on adjudication from HPSM
- Control – Weekly report ran from accounting system to verify accounts with appropriate payments

    h. Day 25+: Staff run special FQHC 00018 claim creation function within DSG system. DSG function conditionally creates FQHC 00018 claim
1) Eligible Ins Plan Code (C20,C30)
2) Eligible CPT code on "paid" professional claim
3) Outpatient claim
4) Control – Duplicate claim check performed against claim history
5) Control – Claim check against eligibility file; those claims with inappropriate eligibility for claim payer destination are placed in error for staff review
6) Detect – DSG No Load report of accounts that no FQHC claim was created

    i. Day 39+: Payer electronic remittance received (835/ARDS files)
1) HP FQHC SB1194 Paid Claims
    a) Pmt – 01010289 SB1194 FQHC PAYMENT
    b) Adj – 02010783 SB1194 FQHC CONTRACTUAL
2) HP FQHC SB1194 Denied Claims
- 7m comment record posted with RA date, Reason code and Denied amount

    j. Day 40+: Denial Manager
- HP FQHC – Staff work denial received by biller stamp/RA date

2. <u>Medicare CareAdvantage/Medi-Cal Secondary (H20/C20/C30)</u>

    a. Day 1: Patient seen in Clinic
    b. Day 1+: Charges/Diagnosis posted to Patient Accounting
    c. Day 10+: Bill (837i/837p) drops from Invision
    d. Day 10+: Claims load to DSG
1) UB-04 (837i)
2) CMS 1500 (837p)
    e. Day 10+: Claims billed electronically to payers
1) UB-04 (837i) to HPSM
2) CMS 1500 (837p) to HPSM
    f. Day 25+: Payer electronic remittance received (835/ARDS files)
    g. Day 25+: DSG creates appropriate payment posting file dependant on adjudication from HPSM
- Control – Weekly report ran from accounting system to verify accounts with appropriate payments
    h. Day 25+: Staff run special FQHC 00018 claim creation function within DSG system. DSG function conditionally creates FQHC 00018 claim
1) Eligible Ins Plan Code (H20 primary w/C20,C30 secondary)
2) Eligible CPT code on "paid" professional claim
3) Outpatient claim
4) Control – Duplicate claim check performed against claim history

      5) Control – Claim check against eligibility file; those claims with inappropriate eligibility for claim payer destination are placed in error for staff review

      6) Detect – DSG No Load report of accounts that no FQHC lcaim was created

  i. Day 39+: Payer electronic remittance received (835/ARDS files)

      1) HP FQHC SB1194 Paid Claims

         a) Pmt – 01010289 SB1194 FQHC PAYMENT

         b) Adj – 02010783 SB1194 FQHC CONTRACTUAL

      2) HP FQHC SB1194 Denied Claims

         • 7m comment record posted with RA date, Reason code and Denied amount

  j. Day 40+: Denial Manager

         • HP FQHC – Staff work denial received by biller stamp/RA date

3. <u>Medicare /Managed Medi-Cal Secondary (M20/C20/C30)</u>

  a. Day 1: Patient seen in Clinic

  b. Day 1+: Charges/Diagnosis posted to Patient Accounting

  c. Day 10+: Bill (837i/837p) drops from Invision

  d. Day 10+: Claims load to DSG

      1) UB-04 (837i)

      2) CMS 1500 (837p)

  e. Day 10+: DSG conditionally creates FQHC 00018 claim

      1) Eligible Ins Plan Code (M20 primary/C20,C30 secondary)

      2) Eligible CPT code

      3) Outpatient clinic claim

  f. Day 10+: FQHC 00018 (837i) to HP

      1) Claim edited to paper

      2) Control – Duplicate FQHC claim check against history file

      3) Control – Claim check against eligibility file; those claims with inappropriate eligibility for claim payer destination are placed in error for staff review

      4) Detect – DSG No Load report of accounts that no FQHC claim was created

  g. Day 10+: Staff management of FQHC 00018 claim

         • Staff place paper claim in tickler file until adjudication for managed care claim is received

  h. Day 10+: Claims billed electronically to payer

      1) UB-04 (837i) to Palmetto

      2) CMS 1500 (837p) to Palmetto

  i. Day 25+: Payer electronic remittance received (835/ARDS files)

         • Crossover claim sent to HPSM

  j. Day 25+: DSG creates appropriate payment posting file dependant on adjudication

  k. Day 25+: Staff confirm paper FQHC has appropriate adjudication

      1) Staff print FQHC 00018 claim and attch RA; claim billed to HP

      2) Control – Weekly report ran from accounting system to verify accounts with appropriate payments

  l. Day 39+: Payer electronic remittance received (835/ARDS files)

      1) HP FQHC SB1194 Paid Claims

         a) Pmt – 01010289 SB1194 FQHC PAYMENT

   b) Adj – 02010783 SB1194 FQHC CONTRACTUAL
  2) HP FQHC SB1194 Denied Claims
- 7m comment record posted with RA date, Reason code and Denied amount

m. Day 40+: Denial Manager
- 3)HP FQHC – Staff work denial received by biller stamp/RA date

4. <u>CHDP Visits – Managed Medi-Cal Primary (C86)</u>

 a. Day 1: Patient seen in Clinic
 b. Day 1+: Charges/Diagnosis posted to Patient Accounting
 c. Day 10+: Bill (837i/837p) drops from Invision
- Professional and Technical charges on UB-04 claim (837i)

 d. Day 10+: Claims load to DSG
- UB-04 (837i)

 e. Day 10+: DSG splits off professional detail lines onto CMS 1500 (837p)
 f. Day 10+: Claims billed to payers
  1) CMS 1500 (837i) submitted electronically to HPSM
  2) PM160 (brown form) mailed to HPSM

 g. Day 25+: Payer electronic remittance received (835/ARDS files)
 h. Day 25+: DSG creates appropriate payment posting file dependant on adjudication from HPSM
- Control – Weekly report ran from accounting system to verify accounts with appropriate payments

 i. Day 25+: Staff run special FQHC 00018 claim creation function within DSG system. DSG function conditionally crates FQHC 00018 claim
  1) Eligible Ins Plan Code (C86)
  2) Eligible CPT code on "paid" CHDP claim
  3) Outpatient claim
  4) Control – Duplicate claim check performed against claim history
  5) Control – Claim check against eligibility file; those claims with inappropriate eligibility for claim payer destination are placed in error for staff review
  6) Detect- DSG No Load report of accounts that no FQHC claim was created

 j. Day 39+: Payer electronic remittance received (835/ARDS files)
  1) HP FQHC SB1194 Paid Claims
   a) Pmt – 01010289 SB1194 FQHC PAYMENT
   b) Adj – 02010783 SB1194 FQHC CONTRACTUAL
  2) HP FQHC SB1194 Denied Claims
- 7m comment record posted with RA date, Reason code and Denied amount

 k. Day 40+: - Denial Manager
- HP FQHC – Staff work denial received by biller stamp/RA date

5. <u>Psychology Visits – Managed Medi-Cal Primary (C25, C20 or C30) (Carve-out Mental Health Services from Managed Plan)</u>

    a. Day 1: Patient seen in Clinic
    b. Day 1+: Charges/Diagnosis posted to Patient Accounting
    c. Day 10+: Bill (837i/837p) drops from Invision
       • Professional and Technical charges on UB-04 claim (837i)
    d. Day 10+: Claims load to DSG
       1) UB-04 (837i)
       2) CMS 1500 (837p)
    e. Day 10+: DSG conditionally creates FQHC 00012 claim
       1) Eligible Ins Plan Code (C25,C20 or C30)
       2) Eligible psychology CPT code CMS 1500 claim
       3) Patient Age LT 21
       4) Rendering Provider Taxonomy Code begins with "103T" (Psychologist)
       5) Outpatient claim
       6) Control – Duplicate claim check performed against claim history
       7) Control – Claim check against eligibility file; those claims with inappropriate eligibility for claim payer destination are placed in error for staff review
       8) Detect – Daily DSG No Load report of accounts that no FQHC claim was created
    f. Day 10+: FQHC 00012 Claim billed electronically to HP
       • UB-04 (837i)
    g. Day 25+: HP electronic remittance received (835/ARDS files)
    h. Day 25+: DSG creates appropriate payment posting file dependant on adjudication from HP
    i. Day 26+: Denial Manager
       • HP FQHC – Staff work denial received by biller stamp/RA date

6. <u>Psychiatrist Visits – Managed Medi-Cal Primary (C25,C20 or C30) (Carve-out Mental Health Services from Managed Plan)</u>

    a. Day 1: Patient seen in Clinic
    b. Day 1+: Charges/Diagnosis posted to Patient Accounting
    c. Day 10+: Bill (837i/837p) drops from Invision
       • Professional and Technical charges on UB-04 claim (837i)
    d. Day 10+: Claims load to DSG
       1) UB-04 (837i)
       2) CMS 1500 (837p)
    e. Day 10+: DSG conditionally creates FQHC 00013 claim
       1) Eligible Ins Plan Code (C25,C20 or C30)
       2) Eligible psychology CPT code CMS 1500 claim
       3) Rendering Provider Taxonomy Code begins with "2084P" (Psychiatrist)
       4) Outpatient claim
       5) Control – Duplicate claim check performed against claim history

6) Control – Claim check against eligibility file; those claims with inappropriate eligibility for claim payer destination are placed in error for staff review
7) Detect – Daily DSG No Load report of accounts that no FQHC claim was created

   f. Day 10+: FQHC 00013 Claim billed electronically to HP
- UB-04 (837i)

   g. Day 25+: HP electronic remittance received (835/ARDS files)

   h. Day 25+: DSG creates appropriate payment posting file dependant on adjudication from HP

   i. Day 26+: Denial Manager
- HP FQHC – Staff work denial received by biller stamp/RA date

Implementation: April 2011
Reviewed and approved by: Date:
~~County Counsel~~
~~Executive Management Team~~
~~Hospital Board~~
Director Revenue Cycle Operations   3/2011
Chief Financial Officer   3/2011 FINAL

                         10/5/11

Old number(s): N/A
Received for review:
NOTE(S):
STATUS:

SUBJECT: MEDICARE BAD DEBT

DEPARTMENT: FINANCIAL SERVICES: PATIENT BILLING

AUTHOR: BUSINESS SERVICES MANAGER

PURPOSE:

To establish consistent policies and procedures that will allow the facility to record
the cost report reimbursement benefit in the current period as allowable Medicare bad debts
are written off and qualified for inclusion in the cost report settlement.

POLICY:

Patient accounts written off to Medicare Bad Debt Expense must meet the criteria
given in the CMS Medicare Provider Reimbursement Manual.

PROCEDURE:

I. Criteria for Allowable Medicare Bad Debt

Medicare bad debt must meet all of the criteria in I. to be an "allowable bad debt" for cost
report reimbursement purposes

A. Collection Criteria

1. The collection effort on Medicare deductible and coinsurance amounts must be
   similar to the effort to collect comparable amounts from non-Medicare patients. It
   must include issuing a bill on or after discharge (or death) to the guarantor,
   subsequent bills, collection letters, and telephone calls or personal contact which
   constitutes a genuine, rather than token, collection effort. The effort may include
   using or threatening to use court action if this is used for non-Medicare accounts.
2. A collection agency must be used for Medicare as well as non-Medicare accounts.
3. Documentation of the collection efforts is required and should be supported by
   copies of the bills, letters, and collection notes for telephone and personal contact.
4. The bad debt must be related to covered services and derived from the deductible
   and coinsurance amounts.
5. Provider-based physician's professional components, charges paid on a fee
   schedule, and non-covered charges for this purpose are not a Medicare bad debt
   and cannot be considered as bad debt.

      6. Write-off timing
         a. CMS policy requires that all collection efforts cease, including those made by a primary or secondary collection agency, before the uncollected deductible and coinsurance can be claimed as a worthless or a bad debt.
         b. Indigent or medically indigent patients:
           1) Indigence or medical indigence may be established at any time.
           2) Medi-Cal eligibility proves medical indigence when Medi-Cal does not cover the deductible or coinsurance.
           3) The facility's customary method of determining indigence will be used for all cases other than Medi-Cal. A patient's signed declaration alone cannot be considered proof of indigence.
           4) There should be no other legal source of responsibility for payment.
           5) Documentation of how indigence was determined must be maintained in the file along with all backup information to substantiate the determination.

  B. Recovery Criteria

    1. Sound business judgment must establish that there is no likelihood of recovery at any time in the future.
    2. A partial payment made after write-off which is not specifically identified is to be applied proportionately to Part A Deductible and Coinsurance, Part B Deductibles and Coinsurance and Non-Covered services. The basis for allocation of partial payments is the proportionate amounts owed in each category.

II. Logs

Medicare bad debt logs *(attachment 1)* are to be maintained and updated on a monthly basis for the Medicare Audit, as well as the Reimbursement representatives' review, if the facility wishes to reduce current period bad debt expense by the amount of bad debt to be recovered from Medicare.

III. Early Out Bad Debts

  A. "Early out" refers to situations where once indigence is established, the debt may be deemed uncollectible without applying any further collection efforts.

  B. Those accounts meeting the early out criteria must follow the guidelines set by the Medicare program.

  C. These accounts must also meet the 120-day rule before they are deemed uncollectible.

IV. Collection Effort

  A. Once Medicare has paid the claim, and the remaining deductible and coinsurance amounts are known, the facility's collection effort will begin.
  B. Monthly mailings must be made to patients to confirm accounting entries on their accounts.

C. The facility's collection effort must continue for 120 days. Once 120 days of collection effort has been completed and no payment has been   received, the facility will write off the account to a collection agency.

D. Medically indigent determinations should not be assigned to the collection agency, but immediately claimed as an allowable bad debt.

E. At the time of write-off, an Accounts Receivable inquiry must be printed to show the status of the account, including all collection efforts that have taken place to date.

F. The collection agency should complete the customary collection effort and return to the facility all claims which are uncollectible.

G. The collection agency should print a status sheet of each patient's account once the collection effort is complete, and maintain an off-site copy of the status sheet as well as submit a copy to the facility.

H. If a facility sends accounts to a second collection agency, Medicare accounts must be handled consistently.

V. Recovery Effort

A. If payment application is not specified, a partial payment posted to an account will be prorated between the Part A Deductible and Coinsurance, Part B Deductible and Coinsurance, and Non-Covered Services.

B. Recoveries must be recorded on the Medicare Bad Debt Log.

VI. Documentation Requirements

The following documents must be maintained:

A. The monthly bad debt log listing patient accounts written off to a collection agency.

B. The monthly bad debt log listing recoveries made to patient accounts.

C. Collection agency's status sheets printed for each patient account, once collection effort is complete.

D. Accounts Receivable inquiry status at the time of write-off showing all collection efforts to date.

E. Accurate Medicare bad debt logs must be maintained by the Patient Financial Services office in order to maximize reimbursement.

VII. Log Format

The following guidelines provide minimum information to be accumulated:

A. Separate logs must be maintained for inpatient accounts and outpatient accounts.

B. The following information should be accumulated for write-offs:

1. Patient name
2. Patient number
3. HIC#
4. Date of discharge
5. Remittance advice date
6. Date of write-off
7. Days between first statement to the patient and write-off
8. Facility deductible
9. Facility coinsurance
10. Total deductibles and coinsurance
11. Payments toward deductibles and coinsurance
12. Net write-off

C. The total recovery amount can be netted with the total write-off amount to calculate a net write-off amount for the entry.

Implementation:
Reviewed and approved by: Date:
   Business Services Manager   7/10

7/10

ATTACHMENT 1

MEDICARE BAD DEBT LOG

ATTACHMENT 2

INVISION MEDICARE BAD DEBT REPORT

ATTACHMENT 3

COLLECTION AGENCY ACTIVITY REPORT

SUBJECT:	PATIENT BILLING CONCERNS
DEPARTMENT:	FINANCE: REVENUE CYCLE, PATIENT BILLING
AUTHOR:	DIRECTOR, PATIENT FINANCIAL SERVICES/ MANAGER, PATIENT BILLING/ MANAGER, PATIENT ACCESS

PURPOSE:

The purpose of this policy is to provide a formal mechanism for the recording, investigation, and resolution of billing concerns at San Mateo Medical Center (SMMC).

POLICY:

Patients may contact Patient Financial Services (PFS) when they have questions about charges appearing on their statement of services. Patient Financial Services staff will assist the patient by explaining the charges and/or determine what other department within SMMC is the most appropriate to assist in resolving the problem.

PROCEDURE:

1. Patient billing questions are received either through the mail, by phone or in person. If received by phone or in person, the PFS staff member dealing with the patient will document the patient's question in writing, including the date of service, the patient's contact information and the charge(s) in question.
2. Whenever possible, comments will be entered in the Patient Accounting system documenting that the patient has questions regarding the charges and the date that the patient contacted PFS.
3. If the PFS staff is unable to satisfactorily respond to the patient's question, documentation will be sent to the appropriate Department Manager indicating that a patient question has been received and requesting an explanation of the charge.
4. If a response is not received in one week, PFS will follow-up with the Department Manager.
5. The Department Manager will review the charges:

    a. If the Department Manager determines that the charge was in error, the Department Manager will notify PFS that the charge should be reversed.
    b. If the Department Manager determines that the charge was correct, he/she may decide that an adjustment is appropriate and will notify PFS to make an account adjustment.
    c. If the Department Manager decides that no adjustment is necessary, he/she will notify PFS.

6. PFS staff will notify the patient in writing once final resolution is made on the charge.

Implementation: 6/98
Reviewed and approved by: Date:
   Patient Relations Coordinator   6/98, 4/01
   Director, Patient Financial Services   10/03, 2/04
   Chapter Chair   2/04
   Medical Executive Committee   3/04
   Hospital Board   4/04

                                                           2/19/04

   Old number(s): 1.46.1, RI.01.07.01 (RI chapter)
   Received for review: (date) from (committee) or (person and dept)
   NOTE(S):
   STATUS:

SUBJECT:	SELF-PAY PROMPT-PAY DISCOUNT AND EXTENDED REPAYMENT
DEPARTMENT:	FINANCIAL SERVICES: PATIENT BILLING
SPONSOR/AUTHOR:	SMMC CFO / SAN MATEO CO. MANAGER'S OFFICE

THIS POLICY REFLECTS SAN MATEO MEDICAL CENTER'S INCORPORATION OF SAN MATEO COUNTY 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:

A. General Information

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 meet 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.

B. 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. <u>Step-One Appeal: Individual Eligibility Review (IER)</u>

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. <u>Anytime Request for Eligibility and Financial Review</u>

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.

C. Periodic Board Reports

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

Implementation: 7/03
Reviewed and approved by: Date:
   ~~Director, Patient Financial Services~~   ~~12/04~~
   ~~Manager, Patient Accounting~~   ~~12/04~~
   San Mateo County Manager's Office / BOS   2/06
   Chief Financial Officer   5/06
   County Counsel   5/06
   Executive Management Team   5/06
   Medical Executive Committee   6/06
   Hospital Board   7/06
                                         4/24/06

SUBJECT:	THIRD PARTY LIABILITY
DEPARTMENT:	FINANCE – PATIENT FINANCIAL SERVICES
AUTHOR:	MANAGER, PATIENT FINANCIAL SERVICES

POLICY:

It is the policy of San Mateo Medical Center (SMMC) to treat emergent and non-emergent conditions resulting from an accident, illness or injury, whereas, a third party payer is financially responsible.

Note: SMMC Finance-Patient Financial Services has a separate policy "Workers Compensation – Financial Responsibility"; please refer to said policy regarding patient visits resulting from a work related event. This policy is not intended to provide guidelines for Workers Compensation.

PURPOSE:

To provide guidance on billing considerations for patients whose accident, illness or injury is the responsibility of a third party payer.

BACKGOUND:

SMMC is not a contracted provider for Third Party Payer Administrators, as such; claims may not be paid directly to SMMC. Patients and/or guarantors may be required to actively engage the responsible payer to ensure timely reimbursement for services.

---

1. The registration staff will secure and enter into the registration system information regarding:
   a. The date of occurrence
   b. The responsible payer's; name, address, claim number, and adjustor contact information, if available.
2. Third party payers will be listed as the primary responsible payer on the account.
3. If the third party payer information is not available at the time of registration, the patient will be registered using his/her government insurance coverage as the primary insurance.
4. Patients having private insurance and DO NOT have the third party responsible payer information will be registered as self- pay. SMMC does not have a contract to provide follow-up non-emergent services to patients with private insurance.
5. If a patient is uninsured and does not provide third party responsible payer information, the patient will be registered as self-pay. The registration staff will adhere to uninsured registration guidelines and refer the patient to the Health Coverage Unit for program screening.

Policy: Third Party Liability…..Cont'd.

SMMC Policy Review & Approval Grid	
Origination Date: 2016-05	Last Review Date: New
Reviewed and approved by:	Date:
Manager, Patient Financial Services	5/16
Chief Financial Officer	5/16, FINAL
Date & Author/Reviewer: 2016-05, Portia Dixon, Patient Financial Services Manager	
NOTE(S):	

SUBJECT: WORKERS COMPENSATION – FINANCIAL RESPONSIBILITY

DEPARTMENT: FINANCE-PATIENT FINANCIAL SERVICES

AUTHOR: MANAGER, PATIENT FINANCIAL SERVICES

POLICY:

It is the policy of San Mateo Medical Center (SMMC) to treat emergency conditions associated with work related illness or injury and refer the patient to their; employer, workers compensation provider or claims adjustor for non-emergent follow-up

Note: For patient visits not resulting from a work related event, but is the responsibility of a third party, please see the Finance-Patient Financial Services Policy "Third Party Liability"; This policy is not intended to provide guidelines for third party payers.

PURPOSE:

To provide guidance on billing considerations for patients whose injury or accident is the result of a work related occurrence and is the responsibility of a workers compensation payer.

BACKGROUND:

SMMC is not a contracted provider for workers compensation payers.   As a result, the Medical Center will not be paid for medical services provided for accident or work-related injuries, except in the case of emergency services provided in our Emergency Department.

---

1. Patients sustaining a work-related injury may be treated in our Emergency Department for their initial medical care.

2. For follow-up medical services related to the same injury, these patients should be referred to their employer workers compensation or claims adjustor for follow-up instructions, including a list of covered care providers.

3.   The following protocol will be followed for any patient treated at SMMC for a non-emergent visit related to a work-related illness and/or injury:
    a. Register as a self-pay patient (F74) = Self pay confirmed
    b. Collect payment of $250.00 when patient is scheduled/on the day of the visit.
    c. Inform the patient they are financially responsible for their medical bills.
    d. Have patient sign the *"Self-Pay Financial Agreement" (see attached)*

SMMC Policy Review & Approval Grid	
Origination Date: 2016-05	Last Review Date: New
Reviewed and approved by:	Date:
Manager, Patient Financial Services	5/16
Chief Financial Officer	5/16, FINAL
Date & Author/Reviewer: 2016-05, Portia Dixon, Financial Services Manager	
NOTE(S):	

SAN MATEO COUNTY

HEALTH SYSTEM

SAN MATEO MEDICAL CENTER

SELF-PAY FINANCIAL AGREEMENT

Our records indicate that you and/or your dependent(s) currently **DO NOT** have health insurance coverage. SMMC offers a variety of Financial Assistance Programs (FAP) to uninsured patients based on applicant's family household size and income. You and/or your dependents may qualify for financial assistance. You must see a San Mateo County Community Health Advocate (CHA) within 14 days of receipt of this notification letter to be screened for eligibility for FAP. If you do not apply for a health program within the next 14 days, you will be responsible for today's medical bill. SMMC Policy requires a $150.00 deposit before rendering non-emergency services.

STATEMENT OF UNDERSTANDING

I understand that if I choose to be seen at SMMC, I must follow through with my screening and enrollment process or I will be responsible for 100% of all charges and a $150.00 deposit is required at the time services are rendered.

I understand that if after completion of my screening and enrollment process, I am found **NOT** eligible for any of the Financial Assistance Programs (FAP) offered at SMMC; I will be responsible for 100% of all charges.

I have read the above information and my signature below acknowledges my understanding of my financial responsibility in the event that I don't comply with my screening and enrollment process within 14 days of the receipt of this notification letter.

_____   _____
(Patient or Guarantor's signature)   (Date)

_____
(Patient's name)

San Mateo Medical Center
A County System of Healthcare

Board of Supervisors: Carole Groom • Don Horsley • Dave Pine • Warren Slocum • Adrienne Tissier
Health System Chief: Jean S. Fraser • **San Mateo Medical Center CEO:** Susan Ehrlich, MD, MPP
222 W. 39th Avenue • San Mateo, CA 94403 • **PHONE** 650.573.2222 • **CA RELAY** 711 • **FAX** 650.573.2030
www.sanmateomedicalcenter.org

SAN MATEO COUNTY
HEALTH SYSTEM

SAN MATEO MEDICAL CENTER

ACUERDO FINANCIERO PARA PERSONAS SIN SEGURO.

Nuestros archivos indican que actualmente usted y/o sus dependes **NO** tienen cobertura de salud. SMMC ofrece una variedad de Programas de Asistencia Financiera (FAP por sus siglas en Inglés) para personas sin seguro médico basado en la tamaño de la unidad familiar e ingresos del applicante. Usted y/o sus dependes podrían calificar para asistencia financiera. Usted debe visitar a un Asesor de la Salud Comunitario (CHA por sus siglas en Inglés) en los próximos 14 días de recibir esta notificación para applicar para los programas de cobertura disponibles. Si usted no aplica para uno de estos programas durante los próximos 14 días, usted será responsable de pagar la cantidad completa de la factura por la visita médica de hoy. Normas de SMMC requieren un depósito de $150.00 antes de recibir servicios que no son urgentes.

DECLARACION DE ENTENDIMIENTO

Entiendo que sí decido ser visto en SMMC, Yo debo completar mi aplicación y proceso de inscripción o yo seré responsable por el 100% de todos los cargos, y un depósito de $150.00 es requerido en el momento que los servicios son brindados.

Entiendo que sí despues de completar el proceso de aplicación e inscripción, me encuentran **NO** elegible para ninguno de los Programas de Asistencia Financiera (FAP por sus siglas en Inglés) ofrecidos por SMMC, yo seré responsable por el 100% de todos los cargos.

He leído la información anterior y al firmar declaro entendimiento de mi responsabilidad financiera en el caso que yo no cumpla con el proceso de mi aplicación e inscripción en uno de los programas disponibles de cobertura de salud dentro de los próximos 14 días de recibir esta notification.

_____   _____
(Firma del paciente o Garante)   (Fecha)

_____
(Nombre del Paciente)

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TAB 7
Request to Approve

Strategic Plan
Report

DATE: August 11, 2016

TO: Co-Applicant Board, San Mateo County Health Care for the Homeless/Farmworker
                Health (HCH/FH) Program

FROM: Jim Beaumont, Director and Linda Nguyen, Program Coordinator
                HCH/FH Program

SUBJECT: REQUEST APPROVAL OF STRATEGIC PLAN REPORT AND UPDATE

Strategic Plan efforts/discussion started in October of 2015 and continued with a Strategic Plan Retreat
on March 17, 2016 with the help of consultants Rachel Metz and Pat Fairchild.

The Three Year Strategic Plan report 2016-2019 was reviewed at the June 9, 2016 meeting, with the
Board arriving at consensus. Formal Board approval is required to finalize the report and plan. This
request is to approve the final report that is attached.

ATTACHMENT:
- Final Strategic Plan Report
- Status table with updates

San Mateo Medical Center
A County System of Healthcare

Board of Supervisors: Carole Groom • Don Horsley • Dave Pine • Warren Slocum • Adrienne Tissier
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San Mateo Healthcare for the Homeless/ Farmworker Health Program

Three- Year Strategic Plan

2016-2019

Prepared for June 9, 2016 Board Meeting

Introduction

For the past several years, the San Mateo Health Care for the Homeless/Farmworker Health (HCH/ FH) program has focused on revising its structure and policies to address requirements of its major funder, the Health Resources and Services Administration's (HRSA's) Bureau of Primary Health Care (BPHC). The staff and board committed to a strategic planning process starting in November 2015 with the intent of moving beyond focusing primarily on HRSA requirements and into developing a strategic vision for program development. The board and staff have worked together over the last six months to discuss program strengths and challenges, gaps in services for the target population, and opportunities for growth in order to inform how HCH/ FH could most effectively benefit the target population. This strategic plan is the result of that work.

Following is a brief program background and history and a description of the strategic planning process, followed by the key goals that have been established and the next steps. The HCH/FP program mission and values, the current environment in which the program operates, and the goals and strategies that were developed through this process are in the PowerPoint following this introduction. More detail on the data and interviews that informed the plan are in the documents attached.

Background/History

The Healthcare for the Homeless Program in San Mateo County was started in 1991 to provide health care to homeless, substance abusing women in East Palo Alto. The Program has grown to provide medical, dental, and behavioral health care services for the homeless throughout the County. In 2010, the Program's responsibilities broadened to include farmworkers and their families. The renamed Healthcare for the Homeless/Farmworker Health (HCH/FH) Program is a Public Health Act Section 330(g) (h) program, receiving federal funds to support and promote health care for these target populations. The HCH/FH Program also confers Federally Qualified Health Center status upon San Mateo Medical Center (SMMC).

A significant portion of medical, dental, and behavioral health care for San Mateo County's homeless and farmworker patients and families is provided by SMMC. In addition, the HCH/FH program typically conducts a Request for Proposal (RFP) process to solicit additional services to better serve the homeless and farmworker populations in San Mateo County. The first RFP process was conducted in 2010 that resulted in 6 agreements to provide medical, dental and enabling services. The current effort was initiated in October 2015, and is ongoing with a total of 15 proposals submitted.

These agreements have led to additional clinical services provided by the County's mobile health clinic, Sonrisas Community Dental Center (Sonrisas), and Ravenswood Family Health Center (Ravenswood). Additionally, community-based organizations, such as LifeMoves,

Samaritan House, Puente de la Costa Sur (Puente) and Legal Aid Society of San Mateo, plus the County's Behavioral Health & Recovery Services, provide additional health access and support services to the target populations, including care coordination, eligibility assistance, health education, legal services and coordination of care in conjunction with all of the County and private partners. In 2015, the HCH/FH Program provided services to 6,556 unduplicated patients, including 4,714 homeless and 1,947 farmworker individuals and their families.

Delivery of care and services within San Mateo County is hampered by the geographical dispersion of patients, clinics, and other providers of care and services. San Mateo County is an elongated geo-political entity, divided by a coastal mountain range that isolates Coastal populations from Bay-side services. The majority of homeless patients are located in Redwood City, San Mateo, East Palo Alto, South San Francisco, Daly City, and the coastal cities of Pacifica and Half Moon Bay. The farmworker population is centered from the Half Moon Bay area down to the southern coastal area around Pescadero. Coastal patients are frequently reluctant to leave the Coast, whether by car or bus, to obtain medical or other services "over the hill." After opening the SMMC Coastside Clinic in 2012, a steadily increasing number of homeless and farmworker patients have engaged medical and dental services, and they continue to use the behavioral health services located within the same clinic building in Half Moon Bay and at Puente. Farmworkers and their families also receive dental services through Sonrisas, and medical services through Coastside Clinic and SMMC pilot clinic in Pescadero at Puente on Thursday evenings funded by Measure A funds that started in 2015.

In October 2013 a new governance structure for the Program, the Co-Applicant Board, was created in response the Health Resources and Services Administration (HRSA) identifying that San Mateo County was now required to do so to be in compliance with Section 330 program requirements. As the governing board for the Program, the Co-Applicant Board oversees the operations of the Program, including selecting and evaluating the effectiveness of services offered, engaging in strategic planning, and monitoring and evaluating the Program's progress in meeting programmatic, quality, and financial goals.

The federal funding from HRSA for the HCH/FH Program is awarded based on a Service Area Competition (SAC). SACs are currently issued every three years (or less) for a given defined service area (whether geographic or by target population(s)). As a Section 330 program grantee, various other program grants may be applied for and granted throughout the 3-year grant cycle. Currently the program receives over $2 million in funding.

Process

<u>Needs Assessment</u>

A Needs Assessment was conducted from June through August 2015 that included patient surveys as well as Provider Surveys. A total of 429 patient surveys were disseminated at 12 service provider locations that included: Ravenswood Family Health Center, Samaritan House/Safe Harbor Shelter, LifeMoves, Puente de la Costa Sur, Mental Health Association, Saint Vincent De Paul, Public Health- Mobile Clinic, Coastside Hope and Coastside Mental Health.

The Provider Survey was conducted online via Survey Monkey with 39 service providers responding on their perceived health priorities for clients.

<u>Planning Data</u>

In December of 2015 John Snow Inc (JSI) completed a summary of data on the homeless and farmworker populations in San Mateo County (Attachment A). There are an estimated 4,000-6,000 people who are homeless in San Mateo County in a given year and approximately 1,700-2,000 individuals employed in the agricultural/farmworker industry in the County each year. If you include family members, who are also eligible for grant support, the total farmworker population is estimated at 3,740-4,400.

<u>Qualitative Analysis</u>

Between November 2015 and February 2016, a comprehensive review of existing data and planning documents was done, along with extensive qualitative research, including interviews of more than thirty people (HCH/FH board, HCH/FH staff, service providers, and other key stakeholders). This analysis resulted in a summary of needs that were presented to the HCH/FH board at the February 11, 2016 Board meeting (the accompanying paper is included as Attachment B).

Identified needs were divided into key service and system gaps. The service gaps focused on specific areas of need for the homeless and farmworker population in San Mateo. The system gaps were areas where the staff and board could grow their capacity through increases in expertise and communication and coordination with other systems, in particular coordination and alignment with the San Mateo Medical Center and Behavioral Health and Recovery Services (BHRS).

<u>Discussion and Prioritization</u>

After being presented with the initial findings, the Board was asked to go through a preliminary prioritization. Additional research was conducted in preparation for a half day board/staff retreat on March 17, 2016. The goal of the retreat was to identify key initiatives and actions for

each of the service and program and planning gaps that were prioritized. The goals, strategies, and actions in the strategic plan are based on the four goals discussed at the retreat. Strategies for expanding services were further prioritized at the May 12, 2016 board meeting.

Goals and Priorities

The HCH/FH goals that emerged from the strategic planning process are:

1) Expand health services for homeless and farmworkers,
2) Improve the ability to assess the on-going needs for homeless and farmworkers,
3) Maximize the effectiveness of the Healthcare for the Homeless and Farmworker Health Board and Staff, and
4) Improve communication about resources for the homeless and farmworkers.

Each of the goals have strategies and actions associated with them. The detail is provided on the following pages. The board further prioritized the strategies for the first goal "expand health services for homeless and farmworkers." The priority strategies are (not in order of priority):

- Increase dental services for adult farmworkers.
- Increase mental health clinical services, including psychiatry services, for homeless and farmworkers,
- Increase available respite care with wrap-around services for homeless,
- Provide wrap-around services for medically fragile, homeless seniors staying at shelters.

Goals two through four focus on building the capacity of the board and staff and the ability of the program to communicate and coordinate with other stakeholders. They detail strategies to increase the capacity of the program to collect and report on data and improve coordination in a way that allows the program to engage at a policy level. These are on-going efforts that can happen simultaneously as services are expanded, and in many cases the work is already underway.

Next Steps

The goals and priority areas set by the board will guide the HCH/FH work. The priorities establish a framework. Staff will need to develop funding proposals that follow some shared principles, such as:

- Continue to develop contract structure and language that promotes serving the most vulnerable (as opposed to the easiest to serve),
- To the extent possible, make funding decisions that look to provide equity in the amount of funding distributed to homeless and farmworkers, by the percentage of each in the county. Geographic equity between where the populations live and where the funding goes should also be considered.

- Not funding services that are covered through other programs, for example, Medi-Cal services for the homeless, unless the funds are being used strategically for start-up costs or to leverage other funding.
- Staff will continue to develop specific action plans and begin implementing while providing progress updates to the board.

Summary of Strategic Plan

The pages immediately following this introduction include:

- The mission, vision and values of the San Mateo Healthcare for the Homeless/ Farmworker Health Program,
- A Strengths, Weaknesses, Opportunities, and Threats (SWOT) analysis, and
- The agreed upon goals and strategies to reach those goals.

Background Documents

Attachment A: Planning Data, Prepared by John Snow, Inc (JSI), December 2015

Attachment B: San Mateo County Healthcare for the Homeless/Farmworker Health Program Three Year Vision Project: Initial Findings, Prepared by Rachel Metz, February 2016

White Papers Developed (not attached):

- Summary of Roles and Responsibilities of Case Management, Navigational and Community Health Worker Staff by Title and Functions, Prepared by John Snow, Inc (JSI), August 2015
- Promising Outreach and Navigation Programs, Prepared by John Snow, Inc (JSI), November 2015
- Promising Nutrition and Food Access Programs: Prepared by John Snow, Inc (JSI), January 2016
- Support and Companion Animal Programs: Prepared by John Snow, Inc (JSI), January 2016
- Medical Respite Care: Prepared by John Snow, Inc (JSI), March 2016
  Nonemergency Medical Transportation: Prepared by John Snow, Inc (JSI), March 2016

Mission

The mission of the San Mateo Health Care for the Homeless/Farmworker Health (HCH/FH) Program is to serve homeless and farmworker individuals and families by providing access to comprehensive health care, in particular, primary health care, dental health care, and behavioral health services in a supportive, welcoming, and accessible environment.

Vision

➢ The HCH/FH Program provides services that are patient centered and utilize a harm reduction model that meets patients where they are in their progress towards their goals.

➢ The HCH/FH Program lessens the barriers that homeless and/or farmworker individuals and their families may encounter when they try to access care.

➢ The HCH/FH Program provides health services in consistent, accessible locations where the homeless and farmworkers can receive timely care and have their immediate needs addressed in a supportive, respectful environment.

➢ Through its services, the HCH/FH Program reduces the health care disparities in the homeless and farmworker populations.

Values

ACCESS	Homeless and farmworker individuals and their families have full access to the continuum of health care and social services.
DIGNITY	The services provided by the HCH/FH Program are respectful, culturally competent and treat the whole person's physical health and behavioral health.
INTEGRITY	Homeless and farmworker individuals and their families are valued and considered a partner in making decision regarding their health care.
INNOVATION	Services provided by the HCH/FH Program will be targeted to respond to the needs of the homeless and farmworker individuals and their families with the outcome of making these individuals healthier and their lives more stable.

External Environment
Strengths/ Opportunities

- San Mateo is an affluent county with financial resources and extensive services.

- Healthcare Reform has increased the number of people eligible and enrolled in Medi-Cal.

- San Mateo has a history of service provision without regard to immigration status and a strong program for the low-income population not eligible for Medi-Cal (ACE).

- Homeless redesign is a priority of the County.

- HRSA funding has been increasing and allows for program flexibility

Internal Operating Environment
Strengths/ Opportunities

- San Mateo County has a strong system of medical and behavioral heath care with extensive services.

- San Mateo has great outreach teams (provided both through county and from HCH/FH funding).

- The HCH/FH Board and Staff are passionate and ready to move forward with new initiatives.

- History of service provision without regard to immigration status

- The mobile van and street outreach have been providing needed services and have been expanding.

- New service expansions in Half Moon Bay and Pescadero are increasing services offered to farmworkers.

- The HRSA funding has been increasing.

External Operating Environment
Weaknesses/ Threats

- The cost of housing is very high and income disparity is increasing.

- San Mateo County is geographically spread out and separated by a mountain range.

- County departments are siloed.

- HRSA requirements are burdensome and hard to navigate.

Internal Operating Environment
Weaknesses/ Threats

- County/SMMC services are not tailored to the unique needs of the homeless or farmworker population.

- There is limited information and understanding about the location and demographics of the farmworker population.

- The HCH/FH program is siloed from other homeless and farmworker services and does not have a communication strategy for the HCH/FH program or an inventory of the services available for the target population.

- The HCH/FH Program has a small staff and does not include clinical (beyond medical director) or service coordination staff.

- The Board consists primarily of individuals affiliated with a contracted organization and does not have representation in all desired areas of expertise.

FOUR STRATEGIC GOALS

I. Expand health services for homeless and farmworkers.

II. Improve the ability to assess the on-going needs for homeless and farmworkers.

III. Maximize the effectiveness of the HCH/FH Board and Staff.

IV. Improve communication about resources for the homeless and farmworkers.

GOAL I. Expand health services for homeless and farmworkers.

Strategies
1. Increase dental services for adult farmworkers.
2. Promote preventive dental care for homeless and farmworkers.
3. Increase mental health clinical services, including psychiatry services, for homeless and farmworkers.
4. Increase drug and alcohol support for farmworkers.
5. Increase available respite care with wrap-around services for homeless.
6. Provide wrap-around services for medically fragile, homeless seniors staying at shelters.
7. Investigate needs for homeless navigator position within San Mateo Medical Center and other hospitals.

GOAL II. Improve the ability to assess the on-going needs for homeless and farmworkers

Strategies
1. Integration and alignment of additional measureable outcomes for homeless and farmworker population with SMMC.
2. Work with partners to increase data collection capacity.
3. Strengthen collaboration with San Mateo Medical Center.

GOAL III. Maximize the effectiveness of the HCH/FH Board and Staff

Strategies
1. Increase diversity of expertise on the Board
2. Determine whether additional staff and/or consultants should be hired to complete strategies and on-going efforts.
3. Use all available resources.

GOAL IV. Improve communication about resources for the homeless and farmworkers.

Strategies
1. Elevate visibility and knowledge of HCH/FH program known within County departments and other agencies/providers serving homeless and farmworkers.
2. Develop easy to use material for homeless and farmworker providers with information about resources available.

STRATEGIC PLAN- ACTIONS	Status/Notes
Goal 1: Expand Health Services for Homeless and Farmworkers	
1. Increase mental health clinical services, including psychiatry services, for homeless and farmworkers.	
2. Increase available respite care with wrap-around services for homeless.	Staff is conducting research for Respite Services, with a Request for Information (RFI) announcement to come out soon for hire of consultant(s) to assist in this effort.
3. Provide wrap-around services for medically fragile, homeless seniors staying at shelters. *(Strategy that were added at the retreat.)*	Collecting data on senior homeless population from shelters as well as current services provided/accessible to population
4. Increase dental services for adult farmworkers.	On-going conversations with Dental Director and Fiscal
//	//
5. Investigate needs for homeless navigator position within San Mateo Medical Center and other hospitals.	Efforts are also ongoing to research the appropriate classification as well as knowledge, skills and abilities needed for Homeless Navigator position.
6. Increase drug and alcohol support for farmworkers.	
7. Promote preventive dental care for homeless and farmworkers. (Strategy that were added at the retreat.)	
Goal 2: Improve the ability to assess the on-going needs for homeless and farmworkers	
1. Integration and alignment of additional measureable outcomes for homeless and farmworker population with SMMC.	
2. Work with Partners to increase data collection capacity	Program staff has been meeting with Center on Homelessness and meeting with Department of Housing to discuss partnerships, future collaborations and data sharing options. Working with SMMC/Business Intelligence to add homeless/farmworker status to E.H.R., pursuing the Delivery System Health Information (DSHII) supplemental funding for this effort.
3. Strenghten collaboration with San Mateo Medical Center	
Goal 3: Maximize the effectiveness of the HCH/FH Board and Staff	
1. Increase diversity of expertise on the Board.	
2. Determine whether additional staff and/or consultants whould be hired to complete strategies and on-going efforts.	
3. Use all available resources.	
Goal 4: Improve communication about resources for the homeless and farmworkers.	
1. Elevate visibility and knowledge of HCH/FH program known within County departments and other agencies/providers serving homeless and farmworkers.	Program staff has been meeting with Center on Homelessness and Department of Housing to discuss partnerships and future collaborations.
2. Develop easy to use material for homeless and farmworker providers with information about resources available.	Continually updating HCH/FH Services provided table, sent to COH and DOH

TAB 8
Request to Approve
DSHII application submission

DATE: August 11, 2016

TO: Co-Applicant Board, San Mateo County Health Care for the
               Homeless/Farmworker Health (HCH/FH) Program

FROM: Jim Beaumont, Director
               HCH/FH Program

SUBJECT: REQUEST FOR THE BOARD TO TAKE ACTION TO APPROVE THE FINAL
               APPLICATION OF THE DELIVERY SYSTEM HEALTH INVESTMENT (DSHII)
               SUPPLEMENTAL FUNDING APPLICATION

In accordance with the Board's Bylaws, Article 3, Section L, the Board has the responsibility to
approve grant applications.

Program submitted a request for the full potential allotment of funding ($50,748), looking to
develop the presentation of the homeless and farmworker indicators in eCW for easy and
immediate recognition by providers when seeing a patient. We expect to here on the request
around mid-September.

This request is for the Board to approve the final DSHII application submitted on July 20, 2016.
A majority vote of the Board members present is required to approve the grant application.

ATTACHED: FINAL DSHII APPLICATION

San Mateo Medical Center
A County System of Healthcare

Board of Supervisors: Carole Groom • Don Horsley • Dave Pine • Warren Slocum • Adrienne Tissier
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www.sanmateomedicalcenter.org

Application Submitted to HRSA

Submitted to HRSA

Organization: SAN MATEO, COUNTY OF, SAN MATEO, California

Grants.gov Tracking Number: N/A

EHB Application Number: 141874

Grant Number: 6 H80CS00051-15-04

Funding Opportunity Number: HRSA-16-191

Received Date:

Total Number of Pages Submitted by the Applicant: 12

(Number of pages counted in accordance with program guidance: 3)

Table Of Contents

	Application for Federal Assistance SF-424	OMB Approval No. 4040-0004 Expiration Date 8/31/2016

* 1. Type of Submission

☐ Preapplication
☑ Application
☐ Changed/Corrected Application

* 2. Type of Application

☐ New
☐ Continuation
☑ Revision

* If Revision, select appropriate letter(s):

* Other (Specify)

* 3. Date Received:

4. Applicant Identifier:

* 5.a Federal Entity Identifier:

Application #:141874Grants.Gov #:

5.b Federal Award Identifier:

H80CS00051

* 6. Date Received by State:

7. State Application Identifier:

8. Applicant Information:

* a. Legal Name SAN MATEO, COUNTY OF

* b. Employer/Taxpayer Identification Number (EIN/TIN): 94-6000532

* c. Organizational DUNS: 625139170

d. Address:

* Street1: 222 W 39TH AVENUE
Street2:
* City: SAN MATEO
County: San Mateo
* State: CA
Province:
* Country: US: United States
* Zip / Postal Code: 94403-4364

e. Organization Unit:

Department Name: San Mateo County Health Services Agency

Division Name: Health Care for the Homeless/Farmworker Health Program

f. Name and contact information of person to be contacted on matters involving this application:

Prefix:

* First Name: Jim

Middle Name: Middle Name:

Last Name: Beaumont

Suffix:

Title:

Organizational Affiliation:
☐

* Telephone Number: (650) 573-2459

Fax Number: (650) 573-2030

* Email: jbeaumont@smcgov.org

9. Type of Applicant 1: B: County Government

Type of Applicant 2:

Type of Applicant 3:

* Other (specify):

* 10. Name of Federal Agency: N/A

11. Catalog of Federal Domestic Assistance Number: 93.224

CFDA Title: Community Health Center

* 12. Funding Opportunity Number: HRSA-16-191

* Title: Delivery System Health In

13. Competition Identification Number:

6839

Title:

Delivery System
Health Information

Areas Affected by Project (Cities, Counties, States, etc.):

See Attachment

* 15. Descriptive Title of Applicant's Project:

Health Center
Program

Project Description:

See Attachment

16. Congressional Districts Of:

* a. Applicant	CA-14	* b. Program/Project CA-14

Additional Program/Project Congressional Districts:

See Attachment

17. Proposed Project:

* a. Start Date:	11/1/2001	* b. End Date: 12/31/2016

18. Estimated Funding ($):

* a. Federal	$50,748.00
* b. Applicant	$0.00
* c. State	$0.00
* d. Local	$0.00
* e. Other	$0.00
* f. Program Income	$0.00
* g. TOTAL	$50,748.00

* 19. Is Application Subject to Review By State Under Executive Order 12372 Process?

☐ a. This application was made available to the State under the Executive Order 12372 Process for review on

☑ b. Program is subject to E.O. 12372 but has not been selected by the State for review.

☐ c. Program is not covered by E.O. 12372.

* 20. Is the Applicant Delinquent Of Any Federal Debt(If "Yes", provide explaination in attachment.)

☐ Yes   ☑ No

21. *By signing this application, I certify (1) to the statements contained in the list of certifications** and (2) that the statements herein are true, complete and accurate to the best of my knowledge. I also provide the required assurances** and agree to comply with any resulting terms if I accept an award. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties. (U.S. Code, Title 218, Section 1001)

☐ I Agree

** The list of certifications and assurances, or an internet site where you may obtain this list, is contained in the announcement or agency specific instructions.

Authorized Representative:

Prefix:		* First Name:	Jim
Middle Name:			
* Last Name:	Beaumont		
Suffix:			
* Title:			
* Telephone Number:	(650) 573-2459	Fax Number:	(650) 573-2030
* Email:	jbeaumont@smcgov.org		
* Signature of Authorized Representative:	Jim Beaumont	* Date Signed:	

FY 2016 Delivery System Health Information Investment

Supplemental Funding Opportunity

Project Description/Abstract

San Mateo Medical Center 's Healthcare for the Homeless/Farmworker Health Program (HCH/FH) locates, provides and coordinates health care and enabling services at key sites throughout the service area to provide convenient access for homeless people and farmworkers through our network of County-operated and contracted services. For County-operated primary care, the San Mateo Medical Center has implemented eClinicalWorks (eCW) at all 11 health center sites as well as mobile clinics in the HCH/FH scope. Currently, there are no apparent homeless and/or farmworker status alerts on the eCW front page or elsewhere within a typical provider workflow for immediate recognition by providers. The failure to recognize the special population status is potentially detrimental to the quality of care delivery to these patients, as there are health conditions and disparities that homeless persons and farmworkers experience disproportionately. Many homeless and farmworker patients need more intensive care, additional health education and case management services. A noticeable special alert or flag for patient's homeless and/or farmworker status in the provider workflow of eCW is a crucial to ameliorating this situation.

To address the above, we are proposing a project focused on the Health Information System Enhancements Activity Category. Specifically, we are proposing to develop the presentation of the homeless and farmworker indicators in eCW for easy and immediate recognition by providers when seeing a patient. Currently, homeless and farmworker status is recorded in the registration system, but this is not communicated to eCW. This proposal will enable electronic transfer of homeless/farmworker status to eCW and its display in a location easily seen by providers during their clinical workflow. To accomplish this, the existing interface between eCW and the registration system must be modified, and then custom programming by eCW must be undertaken to display this information in an easily accessible location for the clinical team. This feature will improve clinical decision making with patients, engage patients more actively in and improve their experience of care, and ultimately improve patient and population health outcomes.

SF-424A: BUDGET INFORMATION - Non-Construction Programs

OMB Approval No. 4040-0004

Expiration Date 8/31/2016

SECTION A - BUDGET SUMMARY						
Grant Program Function or Activity	**Catalog of Federal Domestic Assistance Number**	**Estimated Unobligated Funds**		**New or Revised Budget**		
		Federal	**Non-Federal**	**Federal**	**Non-Federal**	**Total**
Health Care for the Homeless	93.224	$0.00	$0.00	$40,050.00	$0.00	$40,050.00
Migrant Health Centers	93.224	$0.00	$0.00	$10,698.00	$0.00	$10,698.00
Total		**$0.00**	**$0.00**	**$50,748.00**	**$0.00**	**$50,748.00**

SECTION C - NON-FEDERAL RESOURCES				
Grant Program Function or Activity	**Applicant**	**State**	**Other Sources**	**TOTALS**
Health Care for the Homeless	$0.00	$0.00	$0.00	**$0.00**
Migrant Health Centers	$0.00	$0.00	$0.00	**$0.00**
Total	**$0.00**	**$0.00**	**$0.00**	**$0.00**

SF-424B: ASSURANCES, NON-CONSTRUCTION PROGRAMS

OMB Approval No. 4040-0007

Expiration Date 06/30/2014

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing
instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of
information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for
reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

**PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND
IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.**

NOTE: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the
awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances.
If such is the case, you will be notified.

As the duly authorized representative of the applicant, I certify that the applicant:

1. Has the legal authority to apply for Federal assistance and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project cost) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States and, if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standards or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standards for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C.§§1681- 1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to nondiscrimination in the sale, rental or financing of housing; (i) any other

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally-assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetlands pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clean Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended (P.L. 93-523); and, (h) protection of endangered species under the Endangered Species Act of 1973, as amended (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of

nondiscrimination provisions in the specific statute(s)under which application for Federal assistance is being made; and, (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Titles II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally-assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead-based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. 45 CFR 75, "Audits of States, Local Governments, and Non-Profit Organizations."

18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations, and policies governing this program.

19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

* SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	* TITLE
Jim Beaumont	
* APPLICANT ORGANIZATION	* DATE SUBMITTED
SAN MATEO, COUNTY OF	7/20/2016

DSHII Budget Justification & Narrative

CONTRACTUAL

Federal

Both the registration system and the Electronic Health Record are supported by contractors.
The funding will be used to specifically add the project efforts to those contracts through deta
The contract amendments wil require deliverables including the enhancement of the systems'
the data migration to eCW, and for the display enhancements necessary to provide the inforr
appropriate locations of the providers' workflow.

Cost estimates are based on current contract rates and estimated project hours.

	Non-Federal	Total
	$0	$50,748

Federal Object Class Categories

00141874: SAN MATEO, COUNTY OF

Due Date: 07/20/2016 (Due In: 0 Days)

Announcement Number: HRSA-16-191	**Announcement Name:** Delivery System Health Information Investment Supplemental Funding	**Application Type:** Revision (Supplemental)
Grant Number: H80CS00051	**Total Federal Requested Amount:** $50,748.00	**Maximum Eligible Amount:** $50,748.00

Resources ⧉

View

FY 2016 DSHII User Guide ┊ Funding Opportunity Announcement

As of 07/20/2016 04:53:14 PM
OMB Number: 0915-0285 **OMB Expiration Date:** 9/30/2016

Total Proposed Budget	Amount
Section 330 Federal funding (from Total Federal - New or Revised Budget on Section A – Budget Summary)	$50,748.00
Non-Federal funding (from Total Non-Federal - New or Revised Budget on Section A – Budget Summary)	$0.00
Total	$50,748.00

Budget Categories			
Object Class Category	Federal	Non-Federal	Total
a. Personnel	N/A	N/A	N/A
b. Fringe Benefits	N/A	N/A	N/A
c. Travel	$0.00	$0.00	$0.00
d. Equipment	$0.00	$0.00	$0.00
e. Supplies	$0.00	$0.00	$0.00
f. Contractual	$50,748.00	$0.00	$50,748.00
g. Construction	N/A	N/A	N/A
h. Other	$0.00	$0.00	$0.00
i. Total Direct Charges (sum of a - h)	$50,748.00	$0.00	$50,748.00
j. Indirect Charges	$0.00	$0.00	$0.00
k. Total Budget Specified in this application (sum of i - j)	$50,748.00	$0.00	$50,748.00

Equipment List

00141874: SAN MATEO, COUNTY OF   **Due Date: 07/20/2016 (Due In: 0 Days)**

Announcement Number: HRSA-16-191   **Announcement Name:** Delivery System Health   **Application Type:** Revision (Supplemental)
                                             Information Investment Supplemental Funding

Grant Number: H80CS00051   **Total Federal Requested Amount:** $50,748.00   **Maximum Eligible Amount:** $50,748.00

Resources 🗗

View

FY 2016 DSHII User Guide ┊ Funding Opportunity Announcement

As of 07/20/2016 04:53:19 PM
OMB Number: 0915-0285 **OMB Expiration Date:** 9/30/2016

⚠️ **Alert:**

This form is not applicable to you as you have not requested federal funds for the Equipment category in the Federal Object Class Categories form of this application.

Equipment List

00141874: SAN MATEO, COUNTY OF

Announcement Number: HRSA-16-191   **Announcement Name:** Delivery System Health
                                             Information Investment Supplemental Funding

Grant Number: H80CS00051   **Total Federal Requested Amount:** $50,748.00

Project Overview Form

00141874: SAN MATEO, COUNTY OF	**Due Date: 07/20/2016 (Due In: 0 Days)**

Announcement Number: HRSA-16-191	**Announcement Name:** Delivery System Health Information Investment Supplemental Funding	**Application Type:** Revision (Supplemental)
Grant Number: H80CS00051	**Total Federal Requested Amount:** $50,748.00	**Maximum Eligible Amount:** $50,748.00

Resources ⬏

View

FY 2016 DSHII User Guide | Funding Opportunity Announcement

As of 07/20/2016 04:53:21 PM
OMB Number: 0915-0285 **OMB Expiration Date:** 9/30/2016

Proposal Development: Assess the most effective uses of Delivery System Health Information Investment (DSHII) funding to enhance the health center's health information technology (health IT) by consulting, as appropriate, with the State Primary Care Association (PCA), consulting with a Health Center Controlled Network (HCCN), and/or reviewing the Network Guide and Health IT Resources and Tools List available on the DSHII technical assistance website. The results of the assessment should guide decision-making when developing the proposed activities and determining an appropriate budget.

Completing the Application - Step 1: Select the Activity Categories to be addressed by the DSHII proposal from the list below (minimum 1). Indicate if the proposed activities will enhance telehealth services.

Activity Categories	Select One or More	Indicate if Funds will Enhance Telehealth Services
1. Equipment and Supplies Purchases (Required if the health center does not have a certified electronic health record in use at any site)	[_]	[_]
2. Health Information System Enhancements	[X]	[_]
3. Training	[X]	[_]
4. Data Aggregation, Analytics, and Data Quality Improvement Activities	[_]	[_]

Step 2: Respond to the three required Project Narrative questions below.

Need

1. Describe the health center's need for health IT enhancements to support the transition to value-based models of care, improve efforts to share and use information to support better decisions, and/or increase engagement in delivery system transformation.

San Mateo Medical Center 's Healthcare for the Homeless/Farmworker Health Program (HCH/FH) locates, provides and coordinates health care and enabling services at key sites throughout the service area to provide convenient access for homeless people and farmworkers through our network of County-operated and contracted services. For County-operated primary care, the San Mateo Medical Center has implemented eClinicalWorks (eCW) at all 11 health center sites as well as mobile clinics in the HCH/FH scope. Currently, there are no apparent homeless and/or farmworker status alerts on the eCW front page or elsewhere within a typical provider workflow for immediate recognition by providers. The failure to recognize the special population status is potentially detrimental to the quality of care delivery to these patients, as there are health conditions and disparities that homeless persons and farmworkers experience disproportionately. Many homeless and farmworker patients need more intensive care, additional health education and case management services. A noticeable special alert or flag for patient's homeless and/or farmworker status in the provider workflow of eCW is a crucial part of the care delivery, clinical decision making and patient engagement.

Response

1. Describe the proposed health IT enhancements and how they will respond to described needs. Include details about how these enhancements will build the health center's capacity while leveraging resources available from partner organizations (including but not limited to PCAs, HCCNs, Regional Extension Centers, and state or local health information exchanges) to maximize impact.

HCH/FH is proposing health information system enhancement to develop the presentation of the homeless and farmworker indicators in eCW for easy and immediate recognition by providers when seeing a patient. Currently, homeless and farmworker status is recorded in the registration system, but this is not communicated to eCW. This proposal will enable electronic transfer of homeless/farmworker status to eCW and its display in a location easily seen by providers during their clinical workflow. To accomplish this, the existing interface between eCW and the registration system must be modified, and then custom programming by eCW must be undertaken to display this information in an easily accessible location for the clinical team. This feature will improve clinical decision making with patients, engage patients more actively in and improve their experience of care, and ultimately improve patient and population health outcomes.

2. Provide a realistic timeline that lists implementation steps to ensure that all supplemental funding will be expended within 12 months of award.

The following is a draft timeline of the project:

Month 1: Identify full project scope and requirements. Document current and future workflows. Determine alternatives for display of homeless/farmworker status possible in eCW.

Month 2: Modify interface between registration system and eCW and place in Test environment. Initiate request to eCW for specified custom programming for display of homeless/farmworker status.

Month 3-4: Create and place in Test environment custom eCW programming. Create educational materials for new feature. Test end to end solution with registration system and eCW.

Month 5: Education of medical staff on new feature.

Month 6: Go live with new feature.

TAB 9
Request to Approve

Draft SAC application submission

DATE: August 11, 2016

TO: Co-Applicant Board, San Mateo County Health Care for the
             Homeless/Farmworker Health (HCH/FH) Program

FROM: Jim Beaumont, Director
             HCH/FH Program

SUBJECT: REQUEST FOR THE BOARD TO TAKE ACTION TO APPROVE THE DRAFT
             APPLICATION OF THE SERVICE AREA COMPETITION (SAC) GRANT

In accordance with the Board's Bylaws, Article 3, Section L, the Board has the responsibility to approve grant applications.

As the HCH/FH program's current grant period is coming to an end and the Health Resources and Services Administration has announced the opening of the SAC for the San Mateo County service area, homeless and farmworker target populations, the Board's approval of the grant application is required. The draft SAC application is attached.

This request is for the Board to approve the draft of the SAC application reflecting the content and the concept of the final submission due August 31, 2016. A majority vote of the Board members present is required to approve the grant application.

ATTACHED: DRAFT SAC APPLICATION

San Mateo Medical Center
A County System of Healthcare

Board of Supervisors: Carole Groom • Don Horsley • Dave Pine • Warren Slocum • Adrienne Tissier
Health System Chief: Louise Rogers • **San Mateo Medical Center CEO:** Chester Kunnappilly
222 W. 39th Avenue • San Mateo, CA 94403 • **PHONE** 650.573.2222 • **CA RELAY** 711 • **FAX** 650.573.2030
www.sanmateomedicalcenter.org

Health Care for Homeless/Farmworkers Health Program 2016

Service Area Competition – Proposed Budget

Object Class Categories	Federal	
Personnel	$	490,000
Fringe Benefits	$	250,000
Travel	$	25,000
Equipment	$	-
Supplies	$	10,500
Contractual	$	1,753,004
Construction	$	-
Other	$	21,500
Total Direct Charges	$	2,550,004
Indirect Charges	$	-
Total	$	2,550,004

Clinical Performance Measures

Focus Area: Farmworker immunizations

Performance Measure Description: Percentage of farm worker patients ages 13 to 64 with one or more medical visits during the measurement year with documented, current tetanus, diphtheria, acellular pertussis (Tdap) immunizations. (Additional Measure)

Target Goal Description	By the end of the project period, 70% of farm worker patients ages 13 to 64 with one or more medical visits during the measurement year will have documented, current Tdap vaccinations.
Numerator Description	Number of farm worker patients ages 13 to 64 with one or more medical visits during the measurement year with documented, current Tdap vaccinations.
Denominator Description	Total number of farm worker patients ages 13 to 64 with one or more medical visits during the measurement year.
Baseline Data	**Baseline Year** 2015 **Measure Type** Percentage **Numerator** 0.00 **Denominator** 0.00 **Calculated Baseline** 0.00%
Progress	
Projected Data (by End of December 31st, 2018)	
Data Source & Methodology	[_] EHR [_] Chart Audit [_] Other:

Focus Area: Voluntary family planning.

Performance Measure Description: Percentage of female farm worker patients ages 13 to 50 with one or more medical visits during the measurement year with documented family planning education and counseling. (Additional Measure)

Target Goal Description	By the end of the project period, 60% of female farm worker patients ages 13 to 50 with one or more medical visits during the measurement year will have documented family planning education. and counseling.
Numerator Description	Number of female farm worker patients ages 13 to 50 with one or more medical visits during the measurement year with documented family planning education and counseling.
Denominator Description	Total number of female farm worker patients ages 13 to 50 with one or more medical visits during the measurement year.

Baseline Data	Baseline Year	2014
	Measure Type	Percentage
	Numerator	195.00
	Denominator	563.00
	Calculated Baseline	34.64%
Progress		
Projected Data (by End of December 31st, 2018)	60%	
Data Source & Methodology	[x_] EHR [_] Chart Audit [_] Other:	

Focus Area: Weight Assessment and Counseling for Children and Adolescents

Performance Measure Description: Percentage of patients aged 3 -17 years of age who had evidence of BMI percentile documentation and who had documentation of counseling for nutrition and who had documentation of counseling for physical activity during the measurement year. (Required Measure)

Target Goal Description	By the end of the project period, 85% of patients ages 3-17 will have BMI documentation and counseling for nutrition and physical activity.	
Numerator Description	Number of patients in the denominator who had their BMI percentile (not just BMI or height and weight) documented during the measurement year and who had documentation of counseling for nutrition and who had documentation of counseling for physical activity during the measurement year.	
Denominator Description	Number of patients who were 3 years of age through adolescents who were aged 17 at some point during the measurement year, who had at least one medical visit during the reporting year, and were seen by the health center for the first time prior to their 18th birthday.	
Baseline Data	Baseline Year	2015
	Measure Type	Percentage
	Numerator	52.00
	Denominator	70.00
	Calculated Baseline	74.29%
Progress	The percentage of children and adolescents in the age range with BMI documentation and counseling on nutrition and physical activity dropped slightly from 80% in 2014 to 74.29% in 2015.	
Projected Data (by End of December 31st, 2018)	85%	

Data Source & Methodology	[_] EHR **x** Chart Audit [_] Other: **Data Source and Methodology Description:** Baseline data and progress data were derived from review of representative samples charts of 70 patients in the of age range. EHR will provide progress data for all patients in the age range for future reports

Focus Area: Adult Weight Screening and Follow-Up

Performance Measure Description: Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous six months AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the current encounter. Normal parameters: Age 18 - 64 years BMI => 18.5 and < 25 kg/m², and Age 65 years and older BMI => 23 and < 30 kg/m². (Required Measure)

Target Goal Description	By the end of the project period, 75% of adult patients will have BMI calculated at last visit or within the past 6 months and, if they are over/under-weight have documented follow-up plans.
Numerator Description	Number of patients in the denominator who had their BMI (not just height and weight) documented during their most recent visit or within 6 months of the most recent visit and if the most recent BMI is outside of normal parameters, a follow-up plan is documented.
Denominator Description	Number of patients who were 18 years of age or older during the measurement year who had at least one medical visit during the reporting year.
Baseline Data	**Baseline Year** 2015 **Measure Type** Percentage **Numerator** 35 **Denominator** 70 **Calculated Baseline** 50%
Progress	The percentage of adult patients with calculated BMI and appropriate follow-up plans increased from 44.29% in 2014 to 50% in 2015.
Projected Data (by End of December 31st, 2018)	75%
Data Source & Methodology	[_] EHR [x_] Chart Audit [_] Other: **Data Source and Methodology Description:** Baseline and progress data were for derived from review of representative samples of 70 charts of patients in the age range. EHR will provide progress data on all patients in the age range for future reports.

Focus Area: Coronary Artery Disease (CAD): Lipid Therapy

Performance Measure Description: Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease (CAD) who were prescribed a lipid-lowering therapy. (Required Measure)

Target Goal Description	By the end of the project period, 96% of adult patients diagnosed with CAD will be prescribed a lipid lowering therapy.

Numerator Description	Number of patients - who received a prescription for or were provided or were taking lipid lowering medications.
Denominator Description	Number of patients who were seen during the measurement year after their 18th birthday, who had at least one medical visit during the measurement year, at least two medical visits ever, and who had an active diagnosis of coronary artery disease (CAD) including any diagnosis for myocardial infarction (MI) or who had had cardiac surgery in the past , excluding patients whose last LDL lab test during the measurement year was less than 130 mg/dL, individuals with an allergy to or a history of adverse outcomes from or intolerance to LDL lowering medications.

Baseline Data		
	Baseline Year	2015
	Measure Type	Percentage
	Numerator	242.00
	Denominator	301.00
	Calculated Baseline	80.40%

Progress	The percentage of adult patients with CAD prescribed a lipid lowering therapy decreased slightly from 90 % in 2014 to 80.4% in 2015, this reflects more accurate data with use of E.H.R. reports to show data on full population.
Projected Data (by End of December 31st, 2018)	96%
Data Source & Methodology	[x_] EHR [_] Chart Audit [_] Other: This is the first year that reports were derived from E.H.R. for data on all population to determine baseline and progress data for CAD.

Focus Area: Colorectal Cancer Screening

Performance Measure Description: Percentage of adults 50-75 years of age who had appropriate screening for colorectal cancer. (Required Measure)

Target Goal Description	By the end of the project period, 60% of patients ages 50 to 75 will have appropriate, timely colorectal cancer screening.
Numerator Description	Patients with one or more screenings for colorectal cancer. Appropriate screenings are defined by any one of the following criteria: fecal occult blood test (FOBT) during the measurement period; flexible sigmoidoscopy during the measurement period or the four years prior to the measurement period; or colonoscopy during the measurement period or the nine years prior to the measurement period.
Denominator Description	Patients 50-75 years of age with a visit during the measurement period, excluding patients with a diagnosis or past history of total colectomy or colorectal cancer.

Baseline Data		
	Baseline Year	2015
	Measure Type	Percentage
	Numerator	803
	Denominator	1652
	Calculated	48.61%

	Baseline
Progress	The percentage of patients in the age range with appropriate colorectal cancer screening increased from 34.29% in 2014 to 48.61% in 2015
Projected Data (by End of December 31st, 2018)	60%
Data Source & Methodology	**[x_]** EHR **[_]** Chart Audit **[_]** Other: This is the first year that reports were derived from E.H.R. for data on all population to determine baseline and progress data for Colorectal Cancer Screening.

Focus Area: Depression Screening and Follow Up

Performance Measure Description: Percentage of patients aged 12 years and older screened for clinical depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen. (Required Measure)

Target Goal Description	By the end of the project period, 65% of patients age 12 and over will be screened for depression AND have follow-up plans documented.
Numerator Description	Patients screened for clinical depression on the date of the encounter using an age appropriate standardized tool AND if positive, a follow-up plan is documented on the date of the positive screen.
Denominator Description	All patients aged 12 years and older before the beginning of the measurement period with at least one eligible encounter during the measurement period, excluding patients with an active diagnosis for Depression or a diagnosis of Bipolar Disorder, or patient refuses to participate, or medical reason(s), such as patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status or situations where the patient's functional capacity or motivation to improve may impact the accuracy of results of standardized depression assessment tools.

Baseline Data	**Baseline Year**	2015
	Measure Type	Percentage
	Numerator	19
	Denominator	70
	Calculated Baseline	27.14

Progress	The percentage of patients in the age range with Depression screening and follow up increased from 8.57% in 2014 to 27.14% in 2015
Projected Data (by End of December 31st, 2018)	65%
Data Source & Methodology	**[_]** EHR **x** Chart Audit **[_]** Other:

	Baseline and progress data were for derived from review of representative samples of 70 charts of patients in the age range. EHR will provide progress data on all patients in the age range for future reports.

Focus Area: HIV Linkage to Care

Performance Measure Description: Percentage of newly diagnosed HIV patients who had a medical visit for HIV care within 90 days of first-ever HIV diagnosis. (Required Measure)

Target Goal Description	By the end of the project period, 100% of newly diagnosed HIV patients will have a medical visit for HIV care within 90 days of first-ever HIV diagnosis.
Numerator Description	Patients who had a medical visit for HIV care within 90 days of first-ever HIV diagnosis.
Denominator Description	Patients first diagnosed with HIV by the health center between October 1 of the prior year through September 30 of the current measurement year.
Baseline Data	**Baseline Year** 2015 **Measure Type** Percentage **Numerator** 4.00 **Denominator** 5.00 **Calculated Baseline** 80.00%
Progress	The percentage of patients with appropriate colorectal cancer screening decreased slightly from 100% in 2014 to 80% in 2015 because of the small sample size.
Projected Data (by End of December 31st, 2018)	100%
Data Source & Methodology	**x** EHR [_] Chart Audit [_] Other: The chart for the 5 patients newly diagnosed with HIV documented linkage to primary care in less than 90 days.

Focus Area: Diabetes: Hemoglobin A1c Poor Control

Performance Measure Description: Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period. (Required Measure)

Target Goal Description	By the end of the project period, the percentage of adult patients age 18 to 75 years with a diagnosis of Type 1 or Type 2 diabetes, who have been seen in the clinic at least twice during the reporting year and who have a hemoglobin A1C level of <7% will be 50%, <8% will be 60% and <=9% will be 75%.
Numerator Description	Patients whose most recent HbA1c level (performed during the measurement period) is > 9.0%.
Denominator Description	Patients 18-75 years of age with diabetes with a visit during the measurement period.

Baseline Data	Baseline Year	2015
	Measure Type	Percentage
	Numerator	452
	Denominator	654
	Calculated Baseline	69.11%

Progress	The percentage of patients in the age range increased from 48.57% in 2014 to 69.11% in 2015

Projected Data (by End of December 31st, 2018)	75%

Data Source & Methodology	**x** EHR [_] Chart Audit [_] Other: This is the first year that reports were derived from E.H.R. for data on all population to determine baseline and progress data for Diabetic patients.

Focus Area: Hypertension: Controlling high blood pressure

Performance Measure Description: Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (less than 140/90mmHg) during the measurement period. (Required Measure)

Target Goal Description	By the end of the project period, 80% of patients 18 to 85 years of age with diagnosis of hypertension who have been seen at least twice during the reporting year will have a systolic BP <140 and at diastolic BP <90.
Numerator Description	Patients whose blood pressure at the most recent visit is adequately controlled (systolic blood pressure < 140 mmHg and diastolic blood pressure < 90 mmHg) during the measurement period.
Denominator Description	Patients 18-85 years of age who had a diagnosis of essential hypertension within the first six months of the measurement period or any time prior to the measurement period, excluding patients with evidence of end stage renal disease (ESRD), dialysis or renal transplant before or during the measurement period. Also exclude patients with a diagnosis of pregnancy during the measurement period.

Baseline Data	Baseline Year	2015
	Measure Type	Percentage
	Numerator	43
	Denominator	70
	Calculated Baseline	61.43%

Progress	The percentage of patients diagnosed with hypertension with controlled blood pressure levels decreased slightly from 64.29% in 2014 to 61.43% in 2014. This reflects more accurate sampling of patient charts from all service sites and an increase in patients newly diagnosed with hypertension

Projected Data (by End of December 31st, 2018)	80%

Data Source & Methodology	**[_] EHR** **x Chart Audit** **[_] Other:** Baseline and progress data were derived from review of representative samples of 70 charts of patients diagnosed with hypertension. Future progress data will be based on EHR for all patients with hypertension in the age range.

Focus Area: Cervical cancer screening

Performance Measure Description: Percentage of women 21-64 years of age who received one or more Pap tests to screen for cervical cancer. (Required Measure)

Target Goal Description	By the end of the project period, 75% of female patients 23-64 years of age who were seen for a medical encounter at least will have received one or more Pap tests during the two years prior to the measurement year, or for women ages 30-64 who received a Pap test accompanied with an HPV test during the four years prior to the measurement year.
Numerator Description	Women with one or more Pap tests during the measurement period or the two years prior to the measurement period.
Denominator Description	Women 23-64 years of age with a visit during the measurement period, excluding women who had a hysterectomy with no residual cervix.
Baseline Data	**Baseline Year** 2015 **Measure Type** Percentage **Numerator** 45 **Denominator** 70 **Calculated Baseline** 64.29%
Progress	The percentage of women patients in the range with timely cervical cancer screening increased from 57.14% in 2014 to 64.29% in 2015.
Projected Data (by End of December 31st, 2018)	70%
Data Source & Methodology	**[_] EHR** **[x_] Chart Audit** **[_] Other:** Baseline and progress data were derived from review of representative samples of charts of 70 women patients in the age range. Future progress data will be based on EHR for all female patients in the age range.

Focus Area: Access to prenatal care

Performance Measure Description: Percentage of prenatal care patients who entered treatment during their first trimester. (Required Measure)

Target Goal Description	By the end of the project period, at least 80% of women who receive prenatal care each year will initiate prenatal care during the first trimester of pregnancy.
Numerator Description	Women entering prenatal care at the health center or with the referred provider during their first trimester.
Denominator Description	Women seen for prenatal care during the year.

Baseline Data	Baseline Year	2015
	Measure Type	Percentage
	Numerator	110.00
	Denominator	123.00
	Calculated Baseline	89.43%
Progress	The percentage of pregnant patients who received first trimester prenatal care increased from 84.51% in 2014 to 89.43% in 2015 , exceeding our target goal	
Projected Data (by End of December 31st, 2018)	80%	
Data Source & Methodology	**[_] EHR** **x** Chart Audit **[_] Other:** **Data Source and Methodology Description:** Review of charts for all patients who received perinatal care.	

Focus Area: Low birth weight

Performance Measure Description: Percentage of patients born to health center patients whose birth weight was below normal (less than 2,500 grams). (Required Measure)

Target Goal Description	By the end of the project period, no more than 5% of women seen for prenatal care will deliver a child/children weighing under 2,500 grams.
Numerator Description	Children born with a birth weight of under 2,500 grams.
Denominator Description	Live births during the measurement year for women who received prenatal care from the health center or by a referral provider.

Baseline Data	Baseline Year	2015
	Measure Type	Percentage
	Numerator	6.00
	Denominator	75.00
	Calculated Baseline	8.00%

Progress	The percentage of women whose child weighed less than 2,500 grams decreased from 11.21% in 2014 to 8% in 2015.
Projected Data (by End of December 31st, 2018)	5%
Data Source & Methodology	**[_] EHR** **[_] Chart Audit** **[x_] Other:** **Data Source and Methodology Description:** Review of birth records for all prenatal care patients who delivered infants.

Focus Area: Childhood immunization status (CIS)

Performance Measure Description: Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV), one measles, mumps and rubella (MMR); three H influenza type B (HiB); three hepatitis B (Hep B); one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu)

vaccines by their second birthday. (Required Measure)

Target Goal Description	By the end of the project period, 90% of children with a medical encounter and their second birthday during the measurement year will have received all of the recommended vaccinations.
Numerator Description	Children who have evidence showing they received recommended vaccines, had documented history of the illness, had a seropositive test result, or had an allergic reaction to the vaccine by their second birthday.
Denominator Description	Children who turn 2 years of age during the measurement period and who have a visit during the measurement period.
Baseline Data	**Baseline Year** 2015 **Measure Type** Percentage **Numerator** 60 **Denominator** 70 **Calculated Baseline** 85.71%
Progress	The percentage of pediatric patients with their third birthdays during the measurement year with appropriate immunization decreased slightly from 88.57% in 2014 to 85.71% in 2015, which is better than the HP2020 Goal of 80%.
Projected Data (by End of December 31st, 2018)	90%
Data Source & Methodology	[_] EHR [_x] Chart Audit [_] Other: **Data Source and Methodology Description:** Baseline and progress data were derived from reviews of 70 charts. Future progress data will be based on EHR for all two-year old patients.

Focus Area: Dental sealants

Performance Measure Description: Percentage of children, age 6 through 9 years, at moderate to high risk for caries who received a sealant on a permanent first molar during the measurement period. (Required Measure)

Target Goal Description	By the end of the project period, 65% of dental patients ages 6-9 will receive sealants.
Numerator Description	Patients who received a sealant on a permanent first molar tooth in the measurement year.
Denominator Description	Dental patients aged 6- 9 who had an oral assessment or comprehensive or periodic oral evaluation visit during the measurement year and documented as having moderate to high risk for caries, excepting children for whom all first permanent molars are non-sealable.
Baseline Data	**Baseline Year** 2015 **Measure Type** Percentage **Numerator** 16 **Denominator** 70

	Calculated Baseline	22.86%
Progress	This is the first year that HCH/FH has started collecting and reporting on this measure in 2015, we do not currently have a dental E.H.R. to track progress.	
Projected Data (by End of December 31st, 2018)	<mark>65%</mark>	
Data Source & Methodology	**[_] EHR** **[x_] Chart Audit** **[_] Other:** Baseline and progress data were derived from review of representative samples of charts of 70 patients in the age range. Future progress data will be based on EHR for all patients in the age range.	

Focus Area: Tobacco use screening and cessation intervention

Performance Measure Description: Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user. (Required Measure)

Target Goal Description	By the end of the project period, 96% of adult patients will have been screened for tobacco use at least once during the measurement year or prior-year AND received cessation intervention and/or more pharmacotherapy is identified as a tobacco user.	
Numerator Description	Patients who were screened for tobacco use at least once within 24 months AND who received tobacco cessation intervention if identified as a tobacco user.	
Denominator Description	All patients aged 18 years and older seen for at least two visits or at least one preventive visit during the measurement period, excluding patients whose medical record reflects documentation of medical reason(s) for not screening for tobacco use.	
Baseline Data	**Baseline Year**	2015
	Measure Type	Percentage
	Numerator	4218
	Denominator	4584
	Calculated Baseline	92.02%
Progress	The percentage of adult patients screened for tobacco use and received cessation counseling intervention increased from 77.14% in 2014 to 92.02% in 2015.	
Projected Data (by End of December 31st, 2018)	96%	
Data Source & Methodology	**x EHR** **[_] Chart Audit** **[_] Other:** EHR was used to provide progress data on all patients in the age range, the first time year we have used all population reports.	

Focus Area: Asthma: Use of appropriate medications

Performance Measure Description: Percentage of patients 5-64 years of age who were identified as having persistent asthma and were appropriately prescribed medication during the measurement period. (Required Measure)

Target Goal Description	Percentage of patients age 5 to 46 years with a diagnosis of persistent asthma (either mild, moderate, or severe) who were prescribed either the preferred long term control medication or an acceptable alternative pharmacological therapy during the current year.
Numerator Description	Patients who were dispensed at least one prescription for a preferred therapy during the measurement period.
Denominator Description	Patients 5-64 years of age with persistent asthma and a visit during the measurement period, excluding patients with emphysema, COPD, cystic fibrosis, or acute respiratory failure during or prior to the measurement period.
Baseline Data	**Baseline Year** 2015 **Measure Type** Percentage **Numerator** 70 **Denominator** 70 **Calculated Baseline** 100%
Progress	The percentage of patients in the age range remained at 100% in 2015.
Projected Data (by End of December 31st, 2018)	100%
Data Source & Methodology	[_] EHR [x_] Chart Audit [_] Other: Baseline and progress data were derived from review of representative samples of charts of 70 patients in the age range with diagnosed persistent asthma. In future, EHR will provide progress data for all patients in the age range with diagnosed persistent asthma

Focus Area: Ischemic vascular disease (IVD): use of aspirin or another antithrombotic

Performance Measure Description: Percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) in the 12 months prior to the measurement period, or who had an active diagnosis of ischemic vascular disease (IVD) during the measurement period, and who had documentation of use of aspirin or another antithrombotic during the measurement period. (Required Measure)

Target Goal Description	By the end of the project period, 96% of adult patients discharged from hospitals after AMI,CABG, PTCA, or diagnosed with IVD will have documentation of use of aspirin or other anti-thrombotic therapy.
Numerator Description	Patients who have documentation of use of aspirin or another antithrombotic during the measurement period.
Denominator Description	Patients 18 years of age and older with a visit during the measurement period, and an active diagnosis of ischemic vascular disease (IVD) or who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) in the 12 months prior to the measurement period.

Baseline Data	**Baseline Year**	2015
	Measure Type	Percentage
	Numerator	207.00
	Denominator	233.00
	Calculated Baseline	88.84%
Progress	The percentage of adult IVD patients with documentation of aspirin or another anti-thrombotic therapy decreased from 98.57% in 2014 to 88.84% in 2015. This is the first year our program is using full population reports, this also reflects more accurate data from using reports for all of our population versus a sample.	
Projected Data (by End of December 31st, 2018)	96%	
Data Source & Methodology	**[x_]** EHR [_] Chart Audit [_] Other: Baseline and progress data were derived from E.H.R. report of all patients in the age range.	
Comments		

TAB **10**
Request to Approve

Credentialing & Privileging

DATE: August 11, 2015

TO: Co-Applicant Board, San Mateo County Health Care for the Homeless/Farmworker
               Health (HCH/FH) Program

FROM: Jim Beaumont, Director
               HCH/FH Program

SUBJECT: REQUEST TO APPROVE CREDENTIALING AND PRIVILEGING

The HCH/FH Program Credentialing and Privileging Policy was approved at the May 14, 2015 meeting.
The policy states that

> The HCH/FH Co-Applicant Board shall review the QIC's determination and take action to affirm
> SMMC compliance with HRSA requirements. As long as the SMMC Credentialing and
> Privileging policies, procedures and processes have been determined to be in compliance with
> HRSA requirements, all credentialing and privileging actions taken by the SMMC BOD shall be
> added to the HCH/FH Co-Applicant Board's next regular meeting agenda for review and
> endorsement.

The approval of Credentialing and Privileging is a required submission by August 26, 2016 on our 120-
day implementation grant condition on Program Requirement # 3 - Staffing.

This request is for the Board to approve the HCH/FH Credentialing and Privileging. Approval of this
item requires a majority vote of the Board members present.

Attachments:
SMMC Credentialing and Privileging

San Mateo Medical Center
A County System of Healthcare

Board of Supervisors: Carole Groom • Don Horsley • Dave Pine • Warren Slocum • Adrienne Tissier
Health System Chief: Jean S. Fraser • **San Mateo Medical Center CEO:** Susan Ehrlich, MD, MPP
222 W. 39th Avenue • San Mateo, CA 94403 • **PHONE** 650.573.2222 • **CA RELAY** 711 • **FAX** 650.573.2030
www.sanmateomedicalcenter.org

San Mateo Medical Center Medical Staff
CREDENTIALS UPDATE

TEMPORARY PRIVILEGES [not to exceed 120 days]

* Board Certifications - [Temporary Privileges not to exceed maximum 120 days]

NAME	Department	Specialty	Effective Dates**	Justification
ALI, Alyan	Medicine	Internal Medicine*	08/05/2016-12/03/2016	Pulmonology/ICU Coverage
BECKWITH, Stephen	Emergency Department	Emergency Department	07/26/2016-11/23/2016	Emergency Room Coverage
BIGGS, Arter	Psychiatry	Psychiatry	07/01/2016-10/29/2016	Psychiatry coverage
CALUYA-DIAZ, Lovelia	Psychiatry	Psychiatry	08/01/2016-11/29/2016	Psychiatry coverage
CHENUMALLA, Madhavi	Primary Care	Family Medicine*	06/20/2016-10/18/2016	South County Clinic Primary Care Coverage
CROZIER, Emily	Medicine	Otolaryngology*	07/26/2016-11/23/2016	Otolaryngologist coverage
JUNG, Anna	Psychiatry	Psychiatry	08/01/2016-11/29/2016	Psychiatry coverage (current Psychiatric resident)
LANGSTON, Shannon	Psychiatry	Psychiatry	07/08/2016-11/05/2016	Psychiatry coverage
RAY, Lhasa	Primary Care	Internal Medicine*	07/05/2016-11/02/2016	Primary Care Mental Health Coverage
ROHLKE, Faith	Psychiatry	Psychiatry	07/08/2016-11/05/2016	Psychiatry coverage (current Psychiatric resident
STAMM, Demetra	Psychiatry	Psychiatry	07/01/2016-10/29/2016	Psychiatry coverage
ZAIDA, Farah	Psychiatry	Psychiatry	07/08/2016-11/05/2016	Psychiatry coverage
AFFLIATE STAFF				
ROMERO, Amanda	Primary Care	Pediatric Nurse Practitioner*	04/22/2016-08/20/2016	NP coverage for Fair Oaks/South County
SAUCEDO, Bertha	Primary Care	Pediatric Nurse Practitioner*	04/22/2016-08/20/2016	NP coverage for Fair Oaks/South County
KELAVA, Luca	Primary Care	Family Nurse Practitioner*	05/02/2016-08/30/2016	NP coverage for South San Francisco
PELEJ, Joseph C.	Emergency Medicine	PA Certification*	06/01/2016-09/29/2016	Physician assistant coverage for Emergency Department
CHOPRA, Beth	Primary Care	Pediatric Nurse Practitioner*	06/13/2013-10/11/2016	NP coverage for Fair Oaks/South County
BAILEY, Sarah	Medicine	Adult-Gerontology Primary Care Nurse Practitioner	07/18/2016-11/15/2016	Edison Clinic Nurse Practitioner Coverage

NEW APPOINTMENTS (Medical Staff and Affiliate Staff)

NAME	Department	Specialty	Information	Reason
GIVEN, Jeannette	Psychiatry	Psychology	Ph.D. in Clinical Psychology University of Southern Mississippi 1988 M.S. Psychology from Mississippi State University 1983 Experience: program Director at Bethany Techniques to Wellness, San Francisco 2001-2007 Clinical Psychologist in Private Practice, San Francisco 1998-Present	Clinical Psychology services for Burlingame Long Term Care
HAQUE, Mofiz	Medicine	Internal Medicine*	Medical Doctorate degree from Brown University School of Medicine 1996 Residency in Internal Medicine at University of Hawaii 1997-1999 Residency in Internal Medicine @ The Jewish Hospital of Cincinnati 2003-2005 Master of Science from Stanford University School of Medicine 2010 Current affiliation to San Jose Regional Medical Center in the Active Medicine 2015-present	Hospitalist Medicine Coverage
SHREIBATI, Jacqueline	Medicine	Internal Medicine*	Medical Doctorate degree from Stanford University School of Medicine 2010 Residency in Internal Medicine @ Stanford from 2010-2013 Fellowship in cardiovascular medicine at Stanford Health Care from 2013-2016	Cardiology Coverage
TSUI, Jessica	Medicine	IM/Pulmonology*	Medical Doctorate degree University of Michigan School of Medicine 2012 Residency in Internal Medicine @ University of Michigan Health system from 2009-2012 Chief Medical Resident 2012-2013 Fellow in Pulmonary and Critical Care at UCSF from 2013-2016	ICU/Pulmonology Coverage
AFFILIATE STAFF				
None at this time				

Denotes ABMS or National Certification

REAPPOINTMENTS (Medical Staff and Affiliate Staff) *effective 09/01/2016 (unless otherwise noted)*

NAME	Department	Specialty	Information	Effective	Expires
BROMLEY, Jason	Psychiatry	Psychiatry	Reappoint to the Active Medical Staff	09/01/2016	08/31/2018
GESCUK, Bryan	Medicine	Rheumatology	Reappoint to the Active Medical Staff	09/01/2016	08/31/2018
HAWKINS, Rachel E.	Psychiatry	Psychology	Reappoint to the Active Medical Staff	09/01/2016	08/31/2018
HORNBERGER, John	Primary Care	Internal Medicine	Reappoint to the Courtesy Staff - Active Staff at Stanford Medical Center	09/01/2016	08/31/2018
LISSKA, Megan	Psychiatry	Psychiatry	Reappoint to the Active Medical Staff	09/01/2016	08/31/2018

AFFILIATE STAFF					
None at this time					

CHANGE IN STATUS/EXTENSION OF PROVISIONAL PERIOD (Medical Staff and Affiliate Staff)

NAME	Department	Specialty	Credential Information	Expiration
BURKE, Jasmine	Medicine	Internal Medicine	Extend Provisional Period to facilitate completion of proctoring	09/04/2016
GOWDA, Abhishek	Medicine	Physical Medicine	Extend Provisional Period to facilitate completion of proctoring	09/04/2016
GUPTA, Anamika	Medicine	Internal Medicine	Extend Provisional Period to facilitate completion of proctoring	09/04/2016
NGUYEN, Emily	Medicine	Internal Medicine	Extend Provisional Period to facilitate completion of proctoring	09/04/2016
QUANG, Angela	Medicine	Internal Medicine	Extend Provisional Period to facilitate completion of proctoring	09/04/2016

RESIGNATIONS (Medical Staff and Affiliate Staff)

NAME	Department	Specialty	Credential Information	Effective
AHMAD, Aziz	Surgery	General Surgery	Resigned from staff in good standing	01/01/2016
AILLAUD, Marissa	Primary Care	Pediatrics	Resigned from staff in good standing	08/31/2016
ALLO, Maria	Surgery	General Surgery	Did not seek reappointment; resigned from staff in good standing	08/01/2016
GOODWINE, Diane	Emergency Department	Emergency Medicine	Did not seek reappointment; resigned from staff in good standing	08/01/2016
HOLOYDA, Hang T.	Medicine	Physician's Assistant	Did not seek reappointment; resigned from staff in good standing	08/01/2016
HUNG, Michael	Surgery	Anesthesia	Did not seek reappointment; resigned from staff in good standing	08/01/2016
PATEL, Neel	Primary Care	Pediatrics	Resigned from staff in good standing	07/01/2016
PATEL, Trushnaben	Medicine	Internal Medicine	Did not seek reappointment; resigned from staff in good standing	8/01/2016
PHAN, Teresa	Primary Care	Family Medicine	Did not seek reappointment; resigned from staff in good standing	08/01/2016
SMALLWOOD, Deborah	Primary Care	Physician's Assistant	Resigned from staff in good standing	08/01/2016
YIP, Helena	Surgery	Otolaryngology	Resigned from staff in good standing	08/01/2016

MEDICAL EXECUTIVE COMMITTEE RECOMMENDATION

✓ APPROVE _____ APPROVE w/CHANGES _____ DISAPPROVE: Explain Changes/Reason for Disapproval: _____

Signed: _Janet Crews_ Date: _8/2/16_

BOARD OF DIRECTORS ACTION

✓ APPROVE _____ APPROVE w/CHANGES _____ DISAPPROVE: Explain Changes/Reason for Disapproval: _____

Signed: _____ Date: _8/4/16_

TAB 11
Quarterly Contracts Report on 2nd Quarter

DATE: August 11, 2016

TO: Co-Applicant Board, San Mateo County Health Care for the Homeless/Farmworker Health
             (HCH/FH) Program
FROM: Linda Nguyen, HCH/FH Program Coordinator and Elli Lo, Management Analyst

SUBJECT: Quarter 2 Report (April 1, 2016 through June 31, 2016)

Program Performance
The Health Care for the Homeless/Farmworker Health (HCH/FH) Program has contracts with six community-based providers, plus two County-based programs for the 2016 grant year. Contracts are for primary care services, dental care services, and enabling services such as care coordination and eligibility assistance.
The following data table includes performance for the second quarter (50%):

HCH/FH Performance 01/01/2016 – 06/30/2016	Yearly Target # Undup Pts	Actual # YTD Undup Pts	% YTD	Yearly Target # Visits	Actual YTD Visits	% YTD	HCH/FH Funding
Behavioral Health & Recovery Svs	300	126	42%	900	716	80%	$90,000
Legal Aid Society of San Mateo County *	20	0	0%	30	0	0%	$67,100
LifeMoves (care coord & eligibility)	600	322	54%	1500	694	46%	$169,000
LifeMoves (O/E)	40	16	40%				
LifeMoves (Street Medicine) *	160	11	7%	300	31	10%	$82,560
Public Health Mobile Van	1300	595	46%	2500	932	37%	$277,500
Public Health-Expanded Services	510	176	35%	782	206	26%	$178,500
Public Health- Street Medicine	125	87	70%	N/A	N/A	N/A	$218,750
Puente de la Costa Sur (CC & Intensive CC)	150	69	46%	350	322	92%	$111,300
Puente (O/E)	180	105	58%				
Ravenswood (Primary Care)	600	420	70%	1900	976	51%	$90,000
Ravenswood (Dental)	200	141	71%	600	976	163%	$50,000
Ravenswood (Care Coordination)	400	303	76%	1200	567	47%	$82,000
Samaritan House	175	100	57%	300	190	63%	$63,500
Sonrisas **	50	21	42%	150	50	33%	$31,250
Total HCH/FH Contracts	4,810	2,366	49%	10,512	5,660	54%	$1,511,460

Contract executed in June 2016
*** Two year contract, target # is for 2 years*

Health Care for the Homeless/Farmworker Health Program
Selected Outcome Measure Review (Contracts); Second Quarter (April 2016 through June 2016)

Agency	Outcome Measure	2nd Q -Progress
Behavioral Health & Recovery Services	•At least 75% (225) screened will have a behavioral health screening. •At least 55% (165) will receive case management services.	During the 2nd quarter: •126 clients (42%) had a behavioral health screening •120 (40%) received case management services
Legal Aid	•Outreach to at least 50 Farmworkers and Providers •Host eight outreach and education events targeting farmworkers	During the 2nd quarter: • Trained 15 providers • Conducted outreach to 50 farmworkers • Hosted 8 outreach events
LifeMoves	• Minimum of 50% (250) will establish a medical home. • At least 30% (150) of homeless individuals served have chronic health conditions.	During the 2nd quarter: • 54% (171) established a medical home • 2% (6) of individuals served have a chronic health condition.
LifeMoves- CHOW/Street Medicine	• 20% served will establish medical home, that don't currently have one • 80% of clients with a scheduled primary care appointment will attend at least 1 appointment	During the 2nd quarter: • 11 (100%) served established medical home • 8 (73%) attended at least 1 primary care appointment
Public Health Mobile Van	•At least 20% (250) of patient encounters will be related to a chronic disease. At least 75% of clients: • seen at foot clinic will be referred to Mobile Clinic for a medical visit • contacted at Service Connect will be seen at Mobile Clinic for medical visit	During the 2nd quarter: 18% (110) of encounters were related to chronic health. • 75% with foot patients referred to PH Mobile Clinic for medical visit •100% contacted at Service Connect will be seen at Mobile Clinic for medical visit
PH- Mobile Van- Expanded Services	• At least 75% (470) of individuals will receive comprehensive health screening. • Provide intensive primary care services to minimum of 100 residents with chronic health issues.	During the 2nd quarter: • 206 patients received a comprehensive health screening • 75 patients with chronic health issues
PH- Mobile Van- Street/Field Medicine	• At least 50% of street homeless/farmworkers seen will have a formal Depression Screen performed • At least 50% of street homeless/farmworkers seen will be referred to Primary Care	During the 2nd quarter: • 60% (47) patients received Depression screening • 55% patients referred to Primary Care

Puente de la Costa Sur	•At least 85 farmworkers served will receive case management services. •At least 25 served will be provided transportation and translation services. •At least 70% (105) will participate in at least 1 health education class/ workshop.	During the 2nd quarter: • 59 received case management services • 38 clients were provided transportation and translation services. • 15% (10) participated in Health education workshop.
RFHC – Primary Health Care	•At least 60% will receive a comprehensive health screening. •At least 250 (50%) will receive a behavioral health screening.	During the 2nd quarter: • 99% (416) received comprehensive health screening. • 65 received behavioral health screening.
RFHC – Dental Care	• At least 30% (39) will complete their treatment plans. • At least 85% will attend their scheduled treatment plan appointments. • At least 40% will complete their denture treatment plan.	During the 2nd quarter: • 13 % completed dental treatment plan. • 84 % attended their scheduled treatment plan • 40% completed denture treatment plan.
RFHC – Enabling services	• At least 95% will receive care coordination services and will create health care case plans • 80% of patients with hypertension will have blood pressure levels below 140/90	During the 2nd quarter: • 95% (42) patients receive care coordination with health care case plans • 63% (25) with hypertension have reading below 140/90
Samaritan House-Safe Harbor	•All 100% (175) will receive a healthcare assessment. •At least 95% (166) will receive ongoing case management & create health care plan. •At least 70% (122) will schedule primary care appointments and attend at least one.	During the 2nd quarter: • 105 received a healthcare assessment. • 92% 88) received case management services & created health care plan • 70% attended at least one primary care apt

[1] Medical home -defined as a minimum of (2) attended primary care appointments;
[2] Chronic health conditions- including but not limited to obesity, hypertension, and asthma.

Contractor successes & emerging trends:

- **BHRS** states that it continues to be easier and quicker to get clients into BHRS services.
  - Staff also reports that some clients are having difficulty with finding affordable housing in SMC.

- **Legal Aid** states they have been connecting to many farmworkers in Pescadero area, visiting farms and attending outreach events to foster trusting relationships.
  - Trend identified is misinformation regarding Medi-Cal share of cost, opting some to not apply for program because they think they can't afford costs.

- According to **LifeMoves** their HCH team has worked very closely with Street Medicine Team and HOT teams to coordinate care to clients.
  - Transportation continues to be a problem, more options are needed, especially out of County .

- **Public Health Mobile Clinic (Expanded Services/Street Medicine)** has found success in the coordination and referral of clients between community partners (Safe Harbor, LifeMoves, HOT teams) and Service Connect, being on-site makes access for clients easier.
  - Challenge of getting clients to go get labs done at SMMC and patient no-shows for appointments.
  - Lack of a medical nurse/case management for service coordination and tracking with clients continues to be an issue.

- **Puente** states H.S.A. Benefits Analyst ensures all who enrolled in Healthy Kids properly transferred to full scope Medi-Cal.
  - Working with Health Plan of San Mateo on ACE fee wavers for farmworker clients.

- **Ravenswood Primary Care** has been able to provide patients with same day primary care appointments. At least four appointment slots are reserved for homeless patients each week; this has been helpful in providing immediate care, mitigating the challenges of trying to track and get a hold of patients at times.
  - Patients having difficulty taking their medications in secure locations.
  - Lack of affordable housing for clients.

- **Ravenswood Dental Care** experiences success through their "Access Dentist", providing same day dental services for unscheduled homeless patients, as a designated "Access Dentist" reserves their day to provide immediate access to dental care.
  - Communication barrier to book/confirm appointments and provide reminders to patients.
  - Lack of affordable housing,

- **Ravenswood Enabling services**- great partnerships with LifeMoves, Housing Authority, Abode Services, El Concilio to assist clients and find housing.
  - Lack of affordable housing in the area.
  - Lack of lunch program during the day, would like to see food program in EPA during week

- **Samaritan House/Safe Harbor** states that Mobile Health Van is instrumental in providing comprehensive services to clients.
  - They have experienced issues with client follow-though.
  - Would like to see expanded dental services and affordable eye care for clients.