HealthPAC

Health Program of Alameda County

ALAMEDA COUNTY HEALTH CARE SERVICES AGENCY

HealthPAC PLAN:

Eligibility, Applications, Enrollment, and Services

Effective: July 1, 2015

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ALAMEDA COUNTY
HEALTH PROGRAM OF ALAMEDA COUNTY (HealthPAC) PLAN

A. POLICY STATEMENT AND PROGRAM OBJECTIVES:

It is the policy of the County of Alameda to provide comprehensive health care services through a contracted network of health care providers to its medically indigent population. This program is referred to as the Health Program of Alameda County (HealthPAC). Health care services are provided through the HealthPAC Provider Network, which includes Alameda Health System (AHS), Alameda County Behavioral Health Care Services, and community-based organizations.

HealthPAC is not health insurance. HealthPAC does not meet the federal mandate under the Patient Protection and Affordable Care Act ("Act") that requires individuals to have health insurance or pay a penalty.

The Program objectives are to (1) optimize patient health and well-being by focusing on prevention and proactive health management, (2) control health care costs through a variety of means including reductions in the inappropriate utilization of crisis and emergency services, (3) provide an equitable and uniform method of payment for health services, (4) provide consistency in application of eligibility standards, (5) develop a standardized and coordinated demographic and service database, and (6) more fully empower patients to take a more active role in their own care.

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B. PROGRAM MANAGEMENT:

The HealthPAC Plan, under the direction of the Board of Supervisors, is **administered by the Alameda County Health Care Services Agency (HCSA).**

C. SCOPE OF SERVICES:

The **HealthPAC** services are modeled on the Medi-Cal Scope of Services as defined in Section 14132 of the California Welfare and Institutions Code.

See Appendix A, the HealthPAC Division of Financial Responsibility (DOFR) for more information. HealthPAC is always the payor of last resort. HealthPAC has an approved formulary (which is hereby incorporated and made part of this Plan by this reference) that is available at http://acgov.org/health/indigent/pac-prov.htm.

D. ELIGIBILITY:

1. TO BE ELIGIBLE FOR HEALTHPAC COVERAGE, AN INDIVIDUAL MUST:

a. Be a current County of Alameda resident, with proof of residency.
i. persons with a valid Visa are not eligible, **and**

b. Have a gross monthly household income level at or below 200% of the Federal Poverty Level (FPL) (refer to Appendix B, Federal Poverty Level Schedule, Appendix C, Guidelines for Determining Family Size, and Appendix D, Using Federal Tax Forms to Document Income), **and**

b. Not be enrolled in or eligible for full-scope Medi-Cal, **and**

c. Not be enrolled in or eligible for Covered California[1] (whether the enrollment period is open or not) **and**

d. Not be enrolled in private insurance.

e. Enrollment is voluntary.

f. Enrollment Discrimination is prohibited.

[1] Individuals who did not sign up for Covered California during open enrollment and do not have a change of circumstance must wait until the next open enrollment period and are not eligible for HealthPAC.

E. APPLICATION:

1. SCREENING FOR THE HEALTHPAC APPLICATION:

The HealthPAC Provider Network and enrollment sites determine HealthPAC eligibility using One-e-App, the web-based eligibility and enrollment system of record for HealthPAC. All applicants shall be pre-screened through the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS) prior to enrollment into HealthPAC.

a. All reasonable efforts should be made to initiate HealthPAC applications prior to the clinical appointment in order to ensure HealthPAC coverage.
   i. Eligibility for ***unscheduled*** services, i.e., ER/UC should be determined at time of service unless previously enrolled.

   ii. Assistors are prohibited from handling any applications for themselves, their relatives, friends, fellow employees, or acquaintances.

b. During the application process, the applicant is required to choose a medical home. Participants can change their medical home at renewal time or by calling HealthPAC customer service.

c. As part of the application process the application assistor will inform applicants of how to report a complaint or problem.

d. Applications are audited and approved or denied by County staff. If an application is missing verification documentation, it may be returned to the application assistor. The application assistor has 45 calendar days to complete and return the application to the auditor. If the application is not completed, it will be denied and a notification letter will be sent to the applicant stating the specific denial reason.

2. DISENROLLMENT NOTIFICATION:

a. Disenrolled participants will receive a letter via mail within approximately two weeks after their disenrollment date confirming that they are no longer in HealthPAC. The letter will clearly state the reason(s) for the disenrollment.
b. HealthPAC provider sites can use One-E-App (OEA) to verify a participant's HealthPAC program status at the time of service or for billing purposes. OEA will indicate if a participant has been disenrolled and display the disenrollment effective date.

F. ENROLLMENT:

1. ENROLLMENT PERIOD:

The enrollment period for HealthPAC will be for a one-year period.

The enrollment period starts on, and dates back to, the first day of the month in which the application was started.

2. DOCUMENTATION REQUIREMENTS:

a. Enrollment in **HealthPAC** requires documentation to prove identity, income, and Alameda County residency (see Appendix E, HealthPAC Verification Documents, and Appendix F, HealthPAC Statement of Income and Residency).

3. RETROACTIVE ENROLLMENT:

a. There is **no** retroactive eligibility for **HealthPAC**. In other words, the enrollment begins no sooner than the first of the month of the application as described above in F.1.

4. SERVING PARTICIPANTS:

a. HealthPAC eligibility determined **for any participant** by **any** provider within the HealthPAC **outpatient** provider network shall be honored by all providers within the HealthPAC **outpatient** provider network for the duration of the eligibility determination period provided that there has been no change of circumstance impacting eligibility.

b. All new HealthPAC participants will receive an identification card indicating membership and a designated medical home chosen by the participant. Primary care services will be provided by the medical home provider. Specialty, emergency room, and inpatient services will be provided by Alameda Health System and St. Rose Hospital (emergency room care and inpatient services only).

c. A medical home provides:

i. Enrollment (renewal) assistance in HealthPAC.
ii. A primary health care contact who facilitates the participant's access to preventive, primary, specialty, behavioral health, or chronic illness treatment, as appropriate.
iii. An intake assessment of each new participant's general health status.
iv. Referrals to qualified professionals, community resources, or other agencies as needed.
v. Care coordination for the beneficiary across the service delivery system, as agreed to between the medical home and the County. This may include

facilitating communication among participant's health care providers, including appropriate outreach to mental health providers.

vi. Care management, case management, and transitions among levels of care, if needed and as agreed to between the medical home and the County. This includes arranging the Participants' follow-up appointment and short-term refill of medications associated with an inpatient stay.

vii. Use of clinical guidelines and other evidence-based medicine when applicable for treatment of the participant's health care issues and timing of clinical preventive services.

viii. Focus on continuous improvement in quality of care.

ix. Timely access to qualified health care interpretation as needed and as appropriate for participants with limited English proficiency, as determined by applicable federal guidelines.

x. Health information, education, and support to beneficiaries and, where appropriate, their families, if and when needed, in a culturally competent manner.

d. Primary Care and related pharmacy, radiology and laboratory services are provided by the patient's medical home. Specialty, inpatient, and emergency services (and related pharmacy, radiology, and laboratory) are provided by the Alameda Health System and St. Rose Hospital (emergency room care and inpatient services only). If Alameda Health System hospitals do not provide a covered specialty or inpatient service, AHS will contract out to another provider.

e. Specialty behavioral health services are provided through Alameda County Behavioral Health Care Services (BHCS) or a contractor of BHCS and include, but are not limited to outpatient mental health visits, group therapy, crisis intervention and psychiatric medications. Once a patient is stabilized (either by County specialty mental health or AHS), and sent back to primary care, the care and related pharmacy services are the responsibility of the medical home.

5. DISENROLLMENT:

a. HealthPAC participants can voluntarily disenroll anytime during their enrollment period by contacting their medical home or HealthPAC Customer Service.

b. A participant can be disenrolled from **HealthPAC at any time** for the following reasons:

i. He/she no longer meets the Federal Poverty Level requirement (disenrolled back to date of circumstance change).

ii. He/she no longer meets the Alameda County residency requirement (disenrolled back to date of circumstance change).

iii. He/she provided false information at the time of enrollment (disenrolled back to the first day of the enrollment period).

iv. He/she is deceased.
v. He/she is enrolled in private insurance (disenrolled back to date of circumstance change).
vi. He/she is enrolled in or becomes eligible for Medi-Cal (disenrolled back to date of circumstance change).
vii. He/she is enrolled in or becomes eligible for Covered California (disenrolled back to date of circumstance change).
viii. He/she is incarcerated (disenrolled back to first day of enrollment period).
ix. He/she is institutionalized in IMD (disenrolled back to day institutionalized).
x. He/she requests disenrollment (disenrolled back to the requested date).
xi. His/her application is audited and determined to be incomplete (disenrolled back to first day of enrollment period).

c. Disenrollment discrimination is prohibited.

G. FINANCIAL LIABILITY:

1. HealthPAC eligible participants with incomes between 138% FPL – 200% FPL may be responsible for a co-payment at the time of service (refer to Appendix G, HealthPAC Liability Schedule). Providers will be responsible for collection of a co-payment and for determining the rules governing collection of these fees.

2. HealthPAC participants eligible for specialty mental health services may be responsible for an UMDAP (Uniform Method of Determining Ability to Pay) amount that may or may not exceed the HealthPAC co-payment amount *(refer to Appendix G, HealthPAC Liability Schedule)*. UMDAP is mandated by Sections 5709 and 5710 of the California Welfare and Institutions Code. The UMDAP amount is based on a sliding fee schedule that determines an annual fee for a family, regardless of the type of mental health service or the number of visits, and is based on family size, assets and income. All HealthPAC participants receiving mental health services are liable for this annual amount.

3. HealthPAC participants who receive bills for services rendered outside of the HealthPAC provider network for services other than the co-payment or UMDAP liability are financially responsible for these bills. Per program rule, HealthPAC does not cover services rendered outside of the HealthPAC provider network (refer to Appendix A, HealthPAC DOFR).

4. HealthPAC participants that receive bills for covered services rendered in the HealthPAC provider network should contact their medical home or HealthPAC customer service.

5. HealthPAC eligible persons who have a referral from the Public Health Department that requires a mandated Public Health Service shall have their HealthPAC co-payment waived. This includes assessment, evaluation, and treatment for: outpatient Tuberculosis (TB), sexually transmitted diseases (STDs), immunizations, vaccine preventable diseases, enteric infections

and other acute communicable disease related medical services for cases and suspected cases and contacts.

H. AUDIT PROTOCOL:

HealthPAC application audits will be randomly conducted remotely via the ACHCSA centralized eligibility and enrollment database (One-e-App). Audits will be comprehensive and will include, but not be limited to the following:

1. Review of verifications of Identifications.
2. Review of verifications of income.
3. Review of verifications of Alameda County residency.
4. Review of current Medi-Cal and/or Covered California eligibility or coverage or non-compliance with enrollment.
5. Review of consent signatures and dates.

Based on audit results, HealthPAC administration will develop a report with key findings that will be used to improve Assistor training and provide technical assistance.

I. QUALITY MEASUREMENT AND IMPROVEMENT:

Health Care Services Agency will objectively monitor and evaluate the quality, appropriateness, and outcome of care and services delivered to participants of HealthPAC (see Appendix H, HealthPAC Quality Measurement and Improvement Plan).

HealthPAC
Health Program of Alameda County

Division of Financial Responsibility – DOFR

Effective July 1, 2015

Key:
CBO = Community Based Organization
AHS = Alameda Health System
SRH = St. Rose Hospital
PCP = Primary Care Provider
County = HCSA and/or one of its departments
"x"= indicates this group is financially responsible for the provision of the designated service
NA = Non-Covered Service
N = No
Y = Yes

HEALTH CARE SERVICE	CBO + AHS PCP Clinics	AHS Hospitals/ Specialty	SRH Hospital	County	Referral to AHS	Authorization Required	COMMENTS
ABORTION / PREGNANCY SERVICES / FAMILY PLANNING	NA	NA			N	N	• Limited to Family PACT (California Family Planning, Access, Care, and Treatment).
ACUPUNCTURE	x				N	N	• Limited to under 19 year of age
ALLERGY IMMUNOTHERAPY		x			Y	N	
ALLERGY TESTING,TREATMENT AND SERUM		x			Y	N	
AMBULANCE - EMERGENCY • In Area • Out of Area				x NA	N	N	

HEALTH CARE SERVICE	CBO + AHS PCP Clinics	AHS Hospitals/ Specialty	SRH Hospital	County	Referral to AHS	Authorization Required	COMMENTS
ANESTHESIOLOGY (related to surgery)		x			N	N	
AUDIOLOGY SERVICES (including Hearing Aids, repairs, maintenance, and surgically implanted)		x			Y	N	• Limited to under 19 years of age
BLOOD/BLOOD PRODUCTS • Blood Bank • Autologous/Homologous • Storage and Collection of Blood		 x x x			Y	N	
CARDIAC REHABILITATION -When associated with Inpatient, • Technical Component • Professional Component		 x x			Y	N	
CARDIAC REHABILITATION – If in MD office or referred by MD office, except when associated with IP stay • Technical Component • Professional Component		 x x			Y	N	
CCS					N/A	N/A	• Carve out to CCS
CHEMICAL DEPENDENCY / SUBSTANCE ABUSE	x			x	N	Y	• Limited to authorized services for individuals with co-occurring mental health conditions. BHCS needs to authorize that client meets specialty mental health eligibility criteria.
CHEMOTHERAPY • Drugs, including Epogen, Neupogen and adjunctive therapies • Facility Component • Professional Component		x x x			N	N	

HEALTH CARE SERVICE	CBO + AHS PCP Clinics	AHS Hospitals/ Specialty	SRH Hospital	County	Referral to AHS	Authorization Required	COMMENTS
CHIROPRACTIC	x				N	N	• Limited to under 19 years of age
COSMETIC SURGERY (Medically Necessary) • Facility Component • Professional Component		x x			Y	N	
CRITICAL CARE VISITS • Facility • Professional		x x			N/A	N/A	
DENTAL SERVICES • Facility Component • Professional Component	x x	x x			N	N	
DIAGNOSTIC TESTING IN OFFICE (EKG, X-RAY)	x				N	N	
DIAGNOSTIC TESTING (Including but not limited to sleep studies, CT Scans, PET Scans, MRIs, hearing tests, diagnostic colonoscopies, EEG etc.) • Facility Component • Professional Component		x x			Y	N	• When associated with IP stay, Ambulatory or OP Surgery and ER; includes outside facility during an IP stay.
DURABLE MEDICAL EQUIPMENT • Outpatient • Surgically Implanted		x x			Y	Y	• Authorized by AHS, PCP clinic provides MD contact, documentation of medical necessity • Process does not require that member register or visit AHS site

HEALTH CARE SERVICE	CBO + AHS PCP Clinics	AHS Hospitals/ Specialty	SRH Hospital	County	Referral to AHS	Authorization Required	COMMENTS
EMERGENCY ADMISSIONS – • Facility Component • Professional Component		 x x	 x x		N	N	• HealthPAC patients should not be billed beyond the co-pay schedule for facility and professional services.
EMERGENCY ROOM VISITS – • Facility Component • Professional Component		 x x	 x x		N	N	• HealthPAC patients should not be billed beyond the co-pay schedule for facility and professional services.
EXTENDED CARE/SKILLED NURSING FACILITY • Facility Component • Professional Component		 x x			Y	Y	• AHS authorization
HEMODIALYSIS • Facility Component • Dialysis Drugs • Professional Component		 x x x			Y	N	
IMMUNIZATIONS – Standard Adult and Pediatric—NOT TRAVEL related and NOT work related.	x				N	N	
INCONTINENCE CREAMS / WASHES	x	x			Y	N	• Limited to Age < 19
INJECTIBLES		x			Y	N	
LABORATORY SERVICES • Office Reference lab (per defined CPT code)	X	X x			Y	 Y	• Authorization for reference lab done by AHS
LITHOTRIPSY • Facility Component Professional Component		 x x			Y	N	
MEDICAL SUPPLIES	x	x			Y	N	

HEALTH CARE SERVICE	CBO + AHS PCP Clinics	AHS Hospitals/ Specialty	SRH Hospital	County	Referral to AHS	Authorization Required	COMMENTS
BEHAVIORAL HEALTH – John George/Inpatient and ER • Facility Component • Professional Component		 x x				Y	• No authorization required for ER. Services covered under separate contract b/w BHCS and AHS.
BEHAVIORAL HEALTH – Specialty Outpatient • Facility Component • Professional Component	 x x			 x x	N	Y	• Auth Completed by BHCS (for specialty behavioral health only) • Specialty mental health services for HealthPAC patients that meet diagnostic criteria.
OFFICE VISITS • Primary Care • Mental Health	 x x				N	N	
PATHOLOGY- When associated with IP, Ambulatory Surgery or Emergency Room • Professional Component • Technical Component		 x x			N	N	• Except PAP smears
PATHOLOGY – In MD office or when referred by MD office, except when associated with, IP stay, OP/Ambulatory Surgery or ER, as noted above) • Technical Component • Professional Component		 x x			N	N	
PHARMACY SERVICES	x	x			N/A	N	• HealthPAC has an approved formulary available at http://www.acgov.org/health/indigent/pac-prov.htm. Clinics are responsible for filling prescriptions for patients assigned to medical home after being

HEALTH CARE SERVICE	CBO + AHS PCP Clinics	AHS Hospitals/ Specialty	SRH Hospital	County	Referral to AHS	Authorization Required	COMMENTS
							released from an inpatient stay. Hospitals generally provide a 3 day fill.
PODIATRY	x	x			Y	N	• Referral required for hospital based service only.
PROSTHETIC/ORTHOTIC DEVICES • Outpatient • Surgically Implanted		 x x			Y	N	
PSYCHOLOGY SERVICES	x	x		x		Y (for County provided services)	• Medi-Cal exclusion allows services at FQHC. County provides services for SMI population.
RADIATION THERAPY		x			Y	N	
Specialty Care Office Procedures		x			Y	N	
Specialty Care Office Visits		x			Y	N	
Specialty Procedures • Diagnostic • Therapeutic		 x x			Y	N	
SURGERY - Inpatient • Facility Component • Professional Component		 x x			Y	N	
SURGERY – Outpatient • Facility Component • Professional Component		 x x			Y	N	
THERAPY: Physical • Inpatient • Outpatient/Office		 x x			Y	N	

HEALTH CARE SERVICE	CBO + AHS PCP Clinics	AHS Hospitals/ Specialty	SRH Hospital	County	Referral to AHS	Authorization Required	COMMENTS
TRANSPLANTS • Facility Component • Organ Procurement • Covered Immunosuppressive • Professional Component	NA	NA			N/A	N	• Not a covered benefit
TRANSPORTATION, NON EMERGENCY MEDICAL	x	x				Y	• Authorization done by CBO and AHS.

HealthPAC NON-COVERED SERVICES	COMMENTS
• Acupuncture Age ≥ 19 • Adult Day Health Care • Alopecia treatment • Artificial Insemination, Infertility Services and Conception by artificial means • Audiology Age ≥ 19 • Bariatric Surgery • Biofeedback • Chemical dependency services (without co-occurring mental health condition) • Chiropractic Age ≥ 19 • Custodial Care • Cosmetic Services - to change the way you look, not medically necessary • Exercise and hygiene equipment • Home health • Hospice Care • Incontinence Supplies Age ≥ 19 • Infertility Testing and Treatment... Refer to Family PACT • Inpatient Convenience items • Maternity - deliveries • Organ Transplants and Post-Transplant Services • Private Rooms • Reversal of Sterilization • Services provided as a requirement of employment, licensing or court order • Speech and hearing exams • Travel & lodging expenses • Therapy- occupational, respiratory and speech. Speech is covered for age < 19 years. • Vision care - for Adults ≥ 19 services only include procedures for evaluation of visual system. Does NOT include eyeglasses or other eye appliances. • Services provided outside of the HealthPAC provider network	**NON-COVERED MEDICAL SERVICES**

APPENDIX B: HEALTH PROGRAM OF ALAMEDA COUNTY FEDERAL POVERTY LEVEL SCHEDULE

ALAMEDA COUNTY HEALTH CARE SERVICES AGENCY

ALAMEDA HEALTH SYSTEM / COMMUNITY BASED ORGANIZATION

HEALTH PROGRAM OF ALAMEDA COUNTY (HealthPAC) FEDERAL POVERTY LEVEL SCHEDULE

4/1/2015 - 3/31/2016

% OF POVERTY LEVEL	***MAXIMUM GROSS MONTHLY INCOME (IN US DOLLARS) PER FAMILY SIZE***										
	1	2	3	4	5	6	7	8	9	10	FOR EACH ADD'L MEMBER ADD:
0-138%	1,354	1,832	2,311	2,789	3,268	3,746	4,224	4,703	5,181	5,660	479
138.01 - 150%	1,472	1,992	2,512	3,032	3,552	4,072	4,592	5,112	5,632	6,152	521
150.01 - 200%	1,962	2,655	3,349	4,042	4,735	5,429	6,122	6,815	7,509	8,202	694
Over 200%	PATIENTS WHOSE GROSS MONTHLY INCOME IS OVER 200% OF THE FEDERAL POVERTY INCOME GUIDELINES ARE NOT ELIGIBLE FOR HEALTHPAC AND SHALL BE CONSIDERED PRIVATE PAY.										

APPENDIX C: GUIDELINES FOR DETERMINING FAMILY SIZE
July 1, 2015

FAMILY UNIT:

A family unit is comprised of:

1) any child under age 21 living at home or away at a school and claimed as a tax dependent
2) a single adult with or without birth or adoptive children,
3) a married couple with or without birth, adoptive, or step children, or
4) an unmarried couple with common birth children.

Note: If there is more than one family unit living in the household—parents of adults, grandparents, uncles/aunts/cousins, etc.--each family will be ***considered a separate Family Unit.***

FAMILY INCOME:

Family income includes income from all family members including public funds (i.e., SSI, Cal-Works, etc.) and cash income.

- **Student loans, grants and scholarships are exempt from income but should be declared.**
- **Care expenses are not deducted from gross income. This includes, but is not limited to: alimony, child support, child care or elderly support.**

Table 1 provides scenarios for determining family unit and family income in order to help determine HealthPAC eligibility.

IN DETERMINING HealthPAC ELIGIBILITY, ELIGIBILITY OF ANY MEMBER IN THE FAMILY INTO OTHER HEALTH COVERAGE PROGRAMS, I.E., MEDI-CAL, COVERED CALIFORNIA, ETC. NEEDS TO BE PURSUED PRIOR TO ENROLLMENT INTO THE HealthPAC PROGRAM.

Table 1

SCENARIO	FAMILY UNIT	INCOME CONSIDERED (Refer to HealthPAC Liability Schedule to determine HealthPAC eligibility)
1. *Single working male/female*	*One*	*Total gross income*
2. *Married working couple w/no children*	*Two*	*Total gross income*
3. *Married working couple with four children under age 21 living in household.*	*Six*	*Total gross income*
4. *Married couple whose elderly parents live with them but parents have no income*	*Two separate family units* • *Married couple = 2* • *Elderly parents = 2*	• *Married couple's gross income.* • *Elderly parents, aid in kind from adult children*
5. *Married couple receiving income for a foster child*	*Two (foster parents only)*	*Income of foster parents only.* *(Foster care allocation is not considered when determining gross monthly income.)*
6. *Grandparents taking care of grandchildren who are on CalWorks.*	*Two (grandparents only)*	*Income of grandparents only.* *(CalWorks income for grandchildren is not considered when determining gross monthly income.)*
7. *Married couple, husband receives SSI; wife needs health care and only income is husband's SSI.*	*Two*	*Husband's income from SSI.*
8. *Unmarried couple with no children; Male is working, female is not working and needs health care*	*One* • *Female=1*	*Female needs to complete the HealthPAC Statement of Income and Residency*
9. *Unmarried couple with two (2)* ***common children*** *and two (2) children from other marriages/relationships.* • *Male works, female does not work.* • *Male or female or* ***common child*** *presents for health care*	*Six*	*Income from male*

Using Federal Income Tax Forms to Document Income for the HealthPAC Program

Using federal income tax forms documents the income only for those family members in the household who are self-employed and whose income is reported on that form. Other family members whose incomes are counted and not listed (e.g., spouses filing separately, spouses who are employed, children who receive child support, Social Security, etc.) must provide separate proof of income.

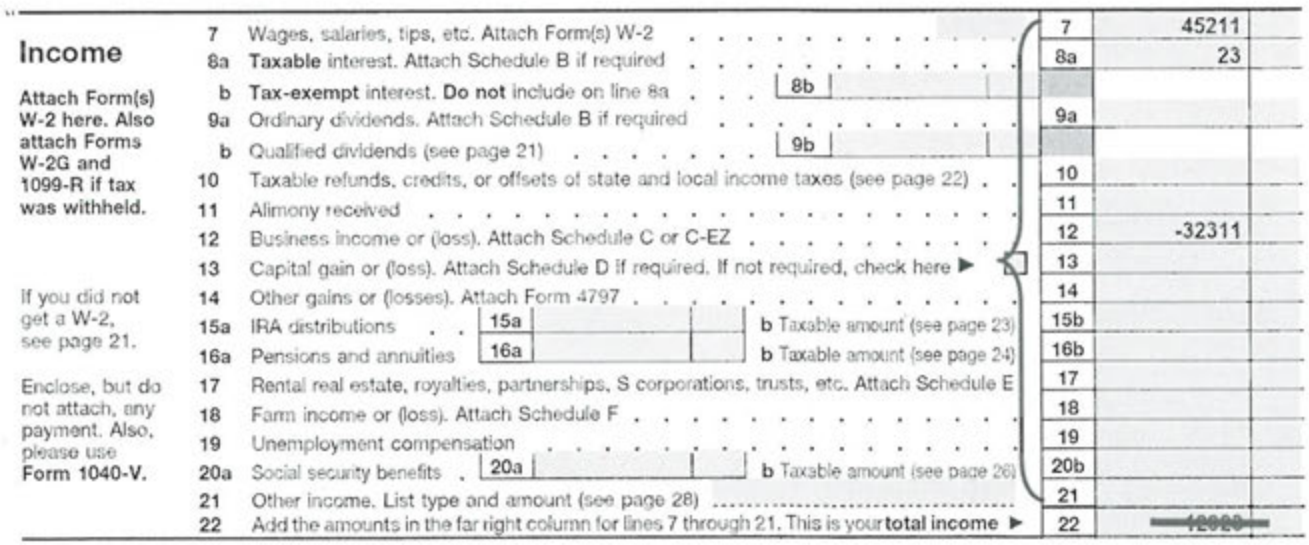
Using the federal income tax form for the year prior to the previous year will only be accepted until the April 15th tax filing deadline. For example, if a family applied in February 2009, the 2007 federal tax forms could have been used to verify the family's income. After April 15th of each year, applicants can only use their federal tax forms for the previous year. If applicants submit federal tax forms from a period other than the previous year, the tax forms will be considered too old and will not be accepted as proof of income. Applicants will be required to submit their previous year's federal tax forms or some other form of documentation to prove their income. Instructions for using specific federal tax forms are listed below.

Form 1040 U.S. Individual Income Tax Form

Add together all of the positive amounts listed in the "Income Section" (Lines 7 through 21). If applicants have reported losses (negative amounts) on any of the lines of this section, these amounts are counted as zero (see example #1 below – line 12 should be counted as zero.)

So in the example below, the total income should be 45211 + 23 +0 = 45,234.

Remember: DO NOT subtract any losses from the positive gross income amount. This amount may be different. DO NOT use the amount on Line 22.



Income				
Attach Form(s) W-2 here. Also attach Forms W-2G and 1099-R if tax was withheld.	7	Wages, salaries, tips, etc. Attach Form(s) W-2	7	45211
	8a	**Taxable** interest. Attach Schedule B if required	8a	23
	b	**Tax-exempt** interest. **Do not** include on line 8a [8b]		
	9a	Ordinary dividends. Attach Schedule B if required	9a	
	b	Qualified dividends (see page 21) [9b]		
	10	Taxable refunds, credits, or offsets of state and local income taxes (see page 22)	10	
	11	Alimony received	11	
	12	Business income or (loss). Attach Schedule C or C-EZ	12	-32311
	13	Capital gain or (loss). Attach Schedule D if required. If not required, check here ▶ ☐	13	
If you did not get a W-2, see page 21.	14	Other gains or (losses). Attach Form 4797	14	
	15a	IRA distributions [15a] b Taxable amount (see page 23)	15b	
	16a	Pensions and annuities [16a] b Taxable amount (see page 24)	16b	
Enclose, but do not attach, any payment. Also, please use Form 1040-V.	17	Rental real estate, royalties, partnerships, S corporations, trusts, etc. Attach Schedule E	17	
	18	Farm income or (loss). Attach Schedule F	18	
	19	Unemployment compensation	19	
	20a	Social security benefits [20a] b Taxable amount (see page 26)	20b	
	21	Other income. List type and amount (see page 28)	21	
	22	Add the amounts in the far right column for lines 7 through 21. This is your **total income** ▶	22	45234

Form 1040A U.S. Individual Income Tax Form

Add together all the positive amounts listed in the "Income Section" (Lines 7 through 14b). This may be different than the amount listed on line 15.

So in the example below, the total income should be 45211 + 23 + 1900 = 47,134.

Income

Attach Form(s) W-2 here. Also attach Form(s) 1099-R if tax was withheld.

If you did not get a W-2, see page 23.

Enclose, but do not attach, any payment.

7	Wages, salaries, tips, etc. Attach Form(s) W-2.			7	45211
8a	**Taxable** interest. Attach Schedule 1 if required.			8a	23
b	**Tax-exempt** interest. **Do not** include on line 8a.	8b			
9a	Ordinary dividends. Attach Schedule 1 if required.			9a	
b	Qualified dividends (see page 24).	9b			
10	Capital gain distributions (see page 24).			10	
11a	IRA distributions.	11a	**11b** Taxable amount (see page 24).	11b	1900
12a	Pensions and annuities.	12a	**12b** Taxable amount (see page 25).	12b	
13	Unemployment compensation and Alaska Permanent Fund dividends.			13	
14a	Social security benefits.	14a	**14b** Taxable amount (see page 27).	14b	
15	Add lines 7 through 14b (far right column). This is your **total income.** ▶			15	47134

Form 1040EZ U.S. Individual Income Tax Form

Use Line 4 (Lines 1 through 3) as gross income.

So in the example below, the total income should be 45,234

Income

Attach Form(s) W-2 here.

Enclose, but do not attach, any payment.

1	Wages, salaries, and tips. This should be shown in box 1 of your Form(s) W-2. Attach your Form(s) W-2.	1	45211
2	Taxable interest. If the total is over $1,500, you cannot use Form 1040EZ.	2	23
3	Unemployment compensation and Alaska Permanent Fund dividends (see page 11).	3	
4	Add lines 1, 2, and 3. This is your **adjusted gross income.**	4	45234

APPENDIX E: HEALTHPAC VERIFICATION DOCUMENTS (July 2015)
ALAMEDA COUNTY HEALTH CARE SERVICES AGENCY

IDENTIFICATION *(Column 1)*	**ALAMEDA COUNTY RESIDENCY** *(Column 2)*	**INCOME** *(Column 3)*
	❖ **RECENT VERIFICATION AS AN ALAMEDA COUNTY RESIDENT**	❖ **MOST RECENT INCOME, PREFERRABLY ONE MONTH WORTH FROM LESS THAN 45 DAYS AGO,**
1. A recent and valid California or out-of- state motor vehicle Driver's License	1. Current utility bill in applicant's/family name	1. Paycheck stubs (gross earnings including tips, commission, meal-in/dine-in. In certain circumstances HealthPAC may request additional pay stubs).
2. Identification card issued by the Department of Motor Vehicles	2. A current and valid California motor vehicle registration in applicant's/family's name	2. Social Security, RSDI, SSI/SSP, or VA: award letters, checks, or bank statement showing direct deposit
3. Voter's Registration Card from other country which has picture, name and birth date	3. A recent Alameda County rent or mortgage receipt	3. Statement from providers of other income (contributions, gifts, loans, refunds, child support, etc.)
4. Check cashing card with photo	4. Evidence that applicant is receiving General Assistance in Alameda County	4. State Disability: check stubs or award letter
5. School Identification card with a photo	5. Paycheck stub w/home address	5. Self-employment information: Last year's 1040 tax return (add positive amounts in Lines 7 through 21. Negative amounts are counted as zero).
6. A U.S Passport *(issued with limitation)*	Other written documentation : *(Includes but not limited to the following)*	6. State Unemployment: check stubs or award letter
7. Work badge, building pass	6. Voter Registration Card (Current)	7. Worker's Compensation: check stubs
8. Consulate identification *(Matricula Consular)*	7. Bank account statement w/home address	8. Retirement/pension benefits: check stubs or award letter
9. Tribal Enrollment Card w/photo	8. School Registration printout	9. Income tax documentation from prior calendar year (1040 only). If submitting a hand written tax return, must also provide the signature page.
10. Border Crossing Card w/photo	9. Sworn statement from relative/friend with whom they are living, along with a utility bill in their name	10. Other Income – *Interest from* Savings account, annuity, etc: bank statement (For persons with no income other than from savings accounts, annuities, etc., complete a HealthPAC Statement of Income and Residency form)
11. Work Permit w/photo	10. CalWIN printout showing Alameda County residency	11. Personal checks count as cash income. Have applicant also complete the HealthPAC Statement of Income and Residency form
12. U.S. Military I.D. card or draft record	11. Student loan/grant award letter or loan grant papers with home address	Other written documentation: 12. CalWIN printout for GA and CalWORKS recipients only 13. Letter from Employer 14. Aid In-Kind
13. Federal, state, or local government I.D. card with same identifying information as a driver's license	*If a P.O. Box is used for Mailing address, must provide verification of Residential address*	***HealthPAC Statement of Income and Residency form only for declaring no income, cash income, or other unverifiable income.***
14. U.S Military dependent identification card	***HealthPAC Statement of Income and Residency form only when no other verification exists***	
15. Certificate of Degree of Indian Blood or other U.S American Indian/Alaska Native Tribal	**ALAMEDA COUNTY RESIDENCY *AND* INCOME**	
16. U.S Coast Guard Merchant Mariner Card	1. Award letter, check, or bank statement with home address showing amount of Social Security, RSDI, SSI/SSP or VA payment	
	2. CalWIN printout for GA and CalWORKS recipients only	
	3. State Unemployment check stubs with home address or award letter	
	4. State Disability check stubs or award letter with home address	
	5. Worker's Compensation check stubs with home address	
	6. Retirement/pension benefits check stubs or award letter with home address	
	7. Income tax documentation from prior calendar year (1040 only) with current home address	
	8. Notice of Action with home address	

APPENDIX E: HEALTHPAC VERIFICATION DOCUMENTS (July 2015)
ALAMEDA COUNTY HEALTH CARE SERVICES AGENCY

INSTRUCTIONS FOR NEEDED DOCUMENTATION

Enrollment in **HealthPAC requires** documentation to prove:

1. Identity
2. Alameda County residency
3. Income

- HealthPAC Applicants do NOT need to prove Citizenship.

- Applicants DO need to provide one identity document from the first column and either one Alameda County Residency document from the second column and one income document from the third column, or one document from the Alameda County Residency and Income section.

- The HealthPAC Statement of Income and Residency can be used to establish residency and income if all attempts have been made to get other documentation.

- *In rare cases, the HealthPAC Statement of Income and Residency can also be used to establish identity*.

Appendix F

ALAMEDA COUNTY HEALTH CARE SERVICES AGENCY

Health Program of Alameda County (HealthPAC)

HealthPAC Statement of Income and Residency

I, (1) _____, and (2) _____,
(Print Full Name) *(Print Full Name)*

residing at _____,
(Street address-Do not use a P.O. Box) *(City)* *(State)* *(Zip code)*

declare under the penalty of perjury that the following information is true and correct to the best of my/our knowledge and belief: *(Check all that apply)*

_____ I am/We are currently unemployed and have no source of income.

_____ I am/We are currently residing with a relative/friend who is providing free room and board.

_____ I am/We are currently living off my/our savings account *(please provide most recent bank statement).*

_____ I am/We are currently a student receiving a student grant/loan/scholarship.

_____ I /We receive free room and board in lieu of managing an apartment.

_____ I /We receive rental income. I receive $_____ monthly.

_____ I am /We are currently homeless in Alameda County (currently residing in a shelter or lacking adequate night time residence).

_____ Other (Specify) _____.

_____ I am/We are currently receiving cash payment for work performed as follows:

CASH INCOME

NOTE: DO NOT USE THIS FORM IF YOU RECEIVE: Check stubs; Social Security; Unemployment; Disability; Pensions or are Self-Employed. Refer to Appendix E for acceptable verifications.

TYPE OF WORK:	*PAYMENT FREQUENCY:*	
_____ Day Care Provider	_____ $ _____	Daily
_____ Beauty Salon	_____ $ _____	Weekly
_____ General Labor	_____ $ _____	Bi-Weekly *(every other week)*
_____ House Cleaning	_____ $ _____	Semi-Monthly *(twice a month)*
_____ Waiter/Waitress	_____ $ _____	Monthly
_____ Other *(Specify)* _____	_____ $ _____	Other *(Specify)*

_____ _____
SIGNATURE *DATE*

APPENDIX G: HEALTH PROGRAM OF ALAMEDA COUNTY LIABILITY SCHEDULE

ALAMEDA COUNTY HEALTH CARE SERVICES AGENCY

ALAMEDA HEALTH SYSTEM / COMMUNITY BASED ORGANIZATION

HEALTH PROGRAM OF ALAMEDA COUNTY (HealthPAC) LIABILITY SCHEDULE

4/1/2015 - 3/31/2016

	HealthPAC CO-PAYMENT					***MAXIMUM GROSS MONTHLY INCOME (IN US DOLLARS) PER FAMILY SIZE***										
% OF POVERTY LEVEL	Emergency Co-Pay	Inpatient Co-Pay	Outpatient Co-Pay	Pharmacy Co-Pay[1]	Special Procedure[2] Co-Pay	1	2	3	4	5	6	7	8	9	10	FOR EACH ADD'L MEMBER ADD:
0-138%	0	0	0	0	0	1,354	1,832	2,311	2,789	3,268	3,746	4,224	4,703	5,181	5,660	479
138.01 - 150%	35	100	10	5	100	1,472	1,992	2,512	3,032	3,552	4,072	4,592	5,112	5,632	6,152	521
150.01 - 200%	50	100	15	5	100	1,962	2,655	3,349	4,042	4,735	5,429	6,122	6,815	7,509	8,202	694
Over 200%	PATIENTS WHOSE GROSS MONTHLY INCOME IS OVER 200% OF THE FEDERAL POVERTY INCOME GUIDELINES ARE NOT ELIGIBLE FOR HEALTHPAC AND SHALL BE CONSIDERED SELF PAY.															

[1] Pharmacy charge $5 per prescription drug with $50 per visit maximum.

[2] Examples of special procedures include:

bronchoscopy
cat scans
cholecystectomy
colonoscopy
EMG (electromyography)
endoscopy
holter monitor
hysteroscopy
implantation of pumps
pacemakers
stimulators or other devices
IV infusion/chemotherapy (co-pay to cover duration of treatment plan)
laparoscopy
MRI (Magnetic Resonance Imaging)
myelography
nuclear med
thoracscopy
venous/arterial catheter placement

HealthPAC
Health Program of Alameda County

Quality Measurement and Improvement Plan

QUALITY IMPROVEMENT PROGRAM GOALS AND SCOPE

The purpose of the HealthPAC Quality Improvement (QI) Program, overseen by the Alameda County Health Care Services Agency (HCSA), is to objectively monitor and evaluate the quality, appropriateness, and outcome of care and services delivered to members of HealthPAC. The QI Program is structured to continuously pursue opportunities for improvement and problem resolution. Settings and types of care to examine are selected based on volume, opportunities for improvement, risk, and evidence of disparities.

The QI program is designed to ensure that:

- High quality, safe, and appropriate care that meets professionally recognized standards of practice is delivered to all enrollees.
- The plan promotes objective and systematic measurement, monitoring, and evaluation of services and implements quality improvement activities based upon the findings.
- Activities to improve processes by which care and services are delivered are developed, implemented, evaluated and reassessed.
- Quality of care problems are identified and corrected for all provider entities.
- Physicians and other appropriate licensed professionals are an integral part of the QI program.
- Appropriate care consistent with professionally recognized standards of practice is not withheld or delayed for any reason, such as potential financial gain or incentive to plan providers.
- The plan does not pressure institutions to grant privileges to health care providers that would not otherwise be granted.
- The plan does not pressure health care providers or institutions to render care beyond the scope of their training or experience.

The scope of the QI Program is comprehensive and encompasses major aspects of care and service in the HeathPAC delivery system, and the clinical/non-clinical issues that affect its membership. These include:

- Availability and access to care, clinical services, and care management.
- Cultural and linguistic issues
- Special needs populations such as persons with chronic conditions, homeless individuals, individuals with serious mental illness, the re-entry population, and others.
- Patient safety

- Member and Provider satisfaction
- Member and Provider education
- Continuity and coordination of care
- Utilization trends including over- and under-utilization
- Clinical practice guideline development, compliance, and revision
- Acute, chronic, and preventive care services for adults
- Primary, specialty, emergency, inpatient, and ancillary care services
- Case review of suspected instances of poor quality

ORGANIZATIONAL STRUCTURE AND RESPONSIBILITY

Overview

HCSA is responsible for oversight of the QI program. The program will utilize and build upon existing quality assurance and improvement structures and activities already taking place among members of the Alameda County Safety Net Council.

Alameda County Health Care Services Safety Net Council

The Safety Net Council is comprised of Health Care Services Agency leadership (director, finance director, HealthPAC administrator, Public Health Director, Medical Director, Behavioral Health Care Services Director and Medical Director); Alameda County Board of Supervisors Health Committee, Alameda County Social Services Agency leadership, the Alameda Alliance for Health leadership (Chief Executive Officer, Medical Officer); Alameda Health System leadership (Chief Executive Officer, Chief Strategy & Integration Officer, Chief Financial Officer); all HealthPAC clinic Chief Executive Officers; the Alameda Health Consortium leadership (Executive Director and Policy Director), Children's Hospital Oakland leadership, and Roots Community Health Center Chief Executive Officer.

The Safety Net Council and its members provide advisory level input into the HealthPAC Quality Improvement (QI) Program; however, the HCSA director is ultimately responsible for making decisions about the program. The Safety Net Council duties include:

- Annually review, update and approve the Quality Improvement Program description, defining the scope, objectives, activities, and structure of the program.
- Review annual QI report and evaluation of QI studies, activities, and data on utilization and quality of services.
- Assess QI program's effectiveness and direct modification of operations as indicated.
- Provide oversight and guidance of the work of the Clinical Implementation Work Group.
- Designate a member of senior management within their organizations that has the authority and responsibility for the overall operation of the quality improvement program within their organization.

HealthPAC Clinical Implementation Workgroup (CIWG)

The Clinical Implementation Workgroup is responsible for the development, implementation, oversight, and monitoring of quality improvement activities within HealthPAC with a focus on priority areas as identified by the Safety Net Council. This workgroup meets at least quarterly, and as often as needed, to follow-up on findings and required actions. This group includes key administrative and clinical staff members that represent the range of providers.

CIWG responsibilities include:

- Approving the selection, design, and schedule for studies and improvement activities.
- Designing standards of care such as panel management standards, care management standards, and other best practice models.
- Review of results of established quality measures, annual site visit assessments, and improvement and intervention activities.
- Providing on-going reporting to the Safety Net Council.
- Meeting at least quarterly and maintaining minutes of all committee meetings.
- Review of member grievance.
- Review of utilization management results.
- Providing guidance to staff on quality management priorities and projects.
- Monitoring progress in meeting quality improvement goals.
- Annual evaluation of the effectiveness of the Quality Improvement Program.
- Review and approval of QI policy and procedure revisions, and annual QI Program description, work plan, and evaluation.

Alameda County Behavioral Health Care Services

The Behavioral Health Care Services (BHCS) department of HCSA participates in the aforementioned groups with designated staff members and provides additional quality improvement data and support to the HealthPAC QI effort. BHCS performs the following functions:

- Ensure appropriate credentialing of specialty mental health participating providers;
- Quarterly reports on mutually identified measures;
- Provide ad-hoc quality reports as requested by HCSA and/or the QI,
- Provide reports on utilization trends, and
- Report on the number of grievances related to access to care and quality of care issues and the resolution applied.

HSCA Medical Director

The HCSA Medical Director is a physician who is responsible for, and oversees the Quality Improvement Program. The Medical Director provides leadership to the Quality Improvement Program through oversight of QI study design, development, and implementation. The Medical Director periodically reports on committee activities, QI study and activity results, and the annual program evaluation to the Safety Net Council.

HealthPAC Quality Improvement Program Manager

The HealthPAC Quality Improvement Program Manager coordinates the HealthPAC Quality Improvement Program including planning, development, and evaluation. The Program Manager conducts site visits, does assessments, collects and analyzes data, and presents information to the Clinical Implementation Work Group.

CONFIDENTIALITY AND CONFLICT OF INTEREST

All employees, contracted providers, and sub-contractors of the HealthPAC maintain the confidentiality of personally identifiable health information, medical records, peer review, internal and external, and internal electronic transmissions and quality improvement records. They will ensure that these records and information are not improperly disclosed, lost, altered, tampered with, destroyed, or misused in any manner. All information used in QI activities is maintained as confidential in compliance with applicable federal and state laws and regulations.

Access to member or provider-specific peer review and other QI information is restricted to individuals and/or committees responsible for these activities. Outside parties asking for information about QI activities must submit a written request to the Medical Officer. Release of all information will be in accordance with state and federal laws.

Committee members may not participate in the review of any case in which they have a direct professional, financial, or personal interest. It is each committee member's obligation to declare actual or potential conflicts of interest.

All QI meeting material and minutes are marked with the statement "Confidential". Copies of QI meeting documents and other QI data are maintained separately and secured to ensure strict confidentiality.

METHODS AND PROCESSES FOR QUALITY IMPROVEMENT

The Quality Improvement Program employs a systematic method for identifying opportunities for improvement and evaluating the results of interventions. All program activities are documented in writing and all quality studies are performed on any service or product for which it seems relevant.

Data Sources

Data sources include, but are not limited, to the following:

- Claim and encounter submissions.
- Disease registry information.
- Credentialing, medical record review, and audit findings.
- Member complaint data.
- Potential Quality Issue tracking/trending data.
- Other clinical or administrative data.

- Public health department population data.

Data Collection, Analysis, and Reporting

HealthPAC has the capability to design sound studies of clinical and service quality that produce meaningful data. Data collection and coordination activities are performed primarily through the Clinical Implementation Workgroup.

COMMUNICATION

The County's contracts with its providers foster open communication and cooperation with QI activities. Contract language specifically addresses:

- Provider cooperation with QI activities.
- Plan access to provider medical records to the extent permitted by state and federal law.
- Provider maintenance of medical record confidentiality.
- Open provider-patient communication about treatment alternatives for medically necessary or appropriate care.

Provider involvement in the QI program occurs through membership in standing and ad-hoc committees, and attendance at CIWG and Safety Net Council meetings. Providers and members may request copies of the QI program description, work plan, and annual evaluation. Provider participation is essential to the success of QI studies and those that focus on improving aspects of member care. Additionally, provider feedback on surveys and questionnaires is encouraged as a means of continuously improving the QI Program.

EVALUATION OF QUALITY IMPROVEMENT PROGRAM

The CIWG reviews a written evaluation of the overall effectiveness of the Quality Improvement program on an annual basis. The evaluation includes, at a minimum:

- Changes in staffing, reorganization, structure, or scope of the program during the year.
- Resources allocated to support the program.
- Comparison of results with goals and targets.
- Tracking and trending of key indicators.
- Description of completed and on-going QI activities.
- Analysis of the overall effectiveness of the program, including assessment of barriers or limitations.
- Recommendations for goals, targets, activities, or priorities in subsequent Quality Improvement Work Plan

The review and revision of the program may be conducted more frequently as deemed appropriate by the CIWG, Medical Officer, Director of Health Care Services Agency, or Safety Net Council. The CIWG's recommendations for revision are incorporated into the Quality Improvement Program description, as appropriate, which is reviewed by the Safety Net Council and submitted to DHCS on an annual basis.

ANNUAL WORK PLAN

A Quality Improvement Work Plan is received and approved annually by the Safety Net Council. The work plan describes the quality management goals and objectives, planned projects, and activities for the year, including continued follow-up on previously identified quality issues, and a mechanism for adding new activities to the plan as the need is identified. The work plan delineates the responsible party and the time frame in which planned activities will be implemented.