KERN MEDICAL CENTER

Standard Structure	Department: Collections			
KERN MEDICAL CENTER	Policy No.	Effective Date:	Review Date:	Page
	COL-IM-407	March 2013	March 2016	1 of 18
Title of Procedure: Financial Screening Process				

I. PURPOSE:

To determine potential funding sources for services provided by Kern Medical Center (KMC), Patient Financial Counseling Department (PFC) staff screens unfunded qualified clients and gathers financial information to accurately complete applications for potential funding programs.

II. DEFINITION:

A. Kern Medical Center Health Plan Medically Indigent Adult Program (KMCHP MIA): A state funded program which provides assistance to individuals who may meet the guidelines for qualification related to their healthcare needs. Clients may qualify for KMCHP MIA if they are not eligible for Medi-Cal, they are under insured and/or have no means of support.
Note: The LIHP, KMCHP MCE, HCCI is included in the PFC screening process. See the D18 - Kern - LIHP Screening Policy

B. Disability Evaluation Determination (DED): Clients who are considered to have a long-term disability lasting 12 months or greater, and they are unable to be gainfully employed due to their illness. A physician's statement on the clients diagnosis must also accompany the Presumptive Eligibility Rating. DED reviews at the State level can take 4-18 months. Denials are usually made immediately (within 60 days).

C. Discount Program (AB 774): A state mandated program which provides assistance to individuals who meet the guidelines for qualification related to their healthcare needs. Clients may qualify for the discount program if they are self-pay or underinsured.

D. FPL: Federal Poverty Level

E. Restricted MIA: A covered service that occurs during a visit to KMC via the KMC Emergency Care Center as covered under Emergency Medi-Cal Treatment Act (EMTALA)

F. Qualified Clients: The client may qualify for free or reduced cost health care if certain eligibility criteria is met:
   1. General Qualifications
      a) Residency in Kern County
      b) Continuous 30 day period of residency

c) Evidence of lawful U.S. residency
d) Income at or below 300% of the Federal Poverty Level (FPL)
e) Assets must not exceed $10,000, excluding a primary residence and car

III. POLICY STATEMENT:

It is the policy of Kern Medical Center (KMC) to establish financial resources for services provided to the client by KMCHP MIA program which screens unfunded clients and gathers financial information to accurately complete applications for potential funding programs.

IV. EQUIPMENT: N/A

V. PROCEDURE:

A. KMC patients and guarantors will be notified of KMC Financial Assistance program in a number of ways:

1. Signage posted at each patient access area. (ADDENDUM G)
2. Patient friendly letters given to patient/guarantor at time of every registration. (ADDENDUM B)
3. Message on initial statement mailed to the patient/guarantor.

B. Clients are referred to the financial counselors by way of central scheduling, referral center, physician referral or self referral when an outpatient appointment is requested.

C. Inpatients and emergency department clients are pre-screened for programs at the time of service by ER Admitting/Registration Patient Financial Service Representatives. The inpatient discharge list is reviewed daily by PFC to identify patients that may need bed side screening or be discharged prior to financial screening. If a patient is not screened or advised of the programs available prior to discharge the Business office advises the patient of programs readily available on outgoing statements.

D. Screening of Clients
1. The financial counselors are notified regarding all self-pay patients.
a) Clients are referred to the financial counselors by way of central scheduling, referral center, physician referral or self referral when an outpatient appointment is requested.
b) PFC reviews daily inpatient census to identify clients that may need financial screening.

2. Pre-screening is completed by a brief telephone call, face-to-face screening, or mail-in-application. Screening is needed to determine if the client has any other funding available prior to KMCHP MIA or other Discount Program eligibility processes begin.

3. In patients (IPR) who are eligible for Medi-Cal will be referred to the PFS IPR financial counselors by phone call, page, or e-mail. If unavailable IPR patients will be referred to the Department of Human Services for completion of a Medi-Cal application (MC220).

4. Patients are eligible for Medi-Cal if they meet the following criteria:
    a) Under 21 years of age or over 65 years of age,
    b) Pregnant,
    c) Blind or disabled,
    d) Minor children in the home with deprivation of a parent

5. Patients are interviewed as outlined on the screening flowchart. (Addendum “D”.) Clients who are unable to provide the required documentation are given an additional 10 days to provide the needed documentation to make the eligibility determination.

6. MIA Eligibility determination can be based on a monthly, quarterly or yearly basis, depending on income source:
    a) Monthly: Income differs from month to month
    b) Quarterly: Homeless Client on general assistance and food stamps
    c) Yearly: Clients on a set income such as widow’s pension or Social Security Retirement

7. MIA Share of Cost: eligibility will be determined quarterly for Clients with zero Share of Cost. Clients with a Share of Cost will be determined monthly to annually depending on the type of income and the variability of the income.

8. Clients who are not eligible for Medi-Cal are screened for MIA and the Discount Program. Once it is determined that the Client does not qualify for Medi-Cal or KMCHP MCE, the Client is requested to bring in additional documentation to review asset verification for the previous month in which they applied.

9. The status of the financial screening is documented in STAR and KMCHP Portal notice of action is sent with the details of the determination and SOC.

10. MIA and Discount Program Retroactive Eligibility

11. The application for the MIA must be filed no later than 90 days from the date of services rendered. Applications for the Discount Program must be filed no later than 150 days from the date services are rendered. Applications not filed within these timeframes will not be considered valid without the Client/guarantor showing good cause as to the reason the application was not filed in a timely manner. Services incurred without a valid application are deemed payable by the Client/responsible party. Consult your supervisor when necessary.

12. Clients that qualify as indigent may be assigned a co-payment for services. Co-payments are based on income and resources and are due at the time services are provided.

13. When financial screening has been completed for the self-pay clients, the referring source is notified (i.e., central scheduling, referral center, physician referral) so the out-patient appointment may be scheduled.

E. Referral of Clients
   1. Clients without a source of funding may be referred to Case Management for a determination of medical necessity. Based on this review, payment may be requested at the time of service for non-emergency or elective services. (See P&P PFS-IM-913 CPT ESTIMATING)

F. Collections Process
   1. Payment Schedule and Financial Arrangements
      a) Internal Process
         1) Once a client is approved for Financial Assistance, it is expected that the client will continue to meet his/her required financial commitments to KMC. Interest free payment schedule will ordinarily not exceed 12 months in duration. In extraordinary circumstances, a payment schedule may extend with the approval of the Patient Financial Counseling Supervisor or Collection Supervisor.
         2) All self pay non-compliant clients are reported to an outside collection agency after 5 statements have been sent. Typically 5 to 6 months after bill discharge.

      b) External Process
         1) However, interest will accrue on the accounts of qualified clients engaged in a long term payment plan as allowed by State law, but interest will not be charged to the account so long as the qualified client follows the agreed to reasonable long term payment plan.
         2) In the event the reasonable long term payment plan is breached by a qualified Client, the full amount of the accrued but uncharged interest to date will be charged to the account.

   2. Reporting to Outside Credit Agencies
      a) KMC will not report adverse information to a consumer credit reporting agency or take civil action against the client for nonpayment at any time prior to 150 days after initial billing.
      b) KMC will not send unpaid bills to any collection agency or other assignee unless that entity has agreed to comply with AB 774 requirements while a client is attempting to qualify for eligibility or attempting in good faith to settle an outstanding bill.

G. AB 774
   1. KMC will require a signed agreement from any outside third party collection agency stating they will follow the Hospital's applicable policies

and procedures regarding the collection of outstanding accounts of qualified clients under MIA or discount programs as applicable under AB774.

2. KMC will allow any outside third party collection agency to file lawsuits, legal remedies wage garnishments after securing judgment against qualified clients so long as the provisions of AB774, including the noticed motion provisions are followed when and as required. Nothing in this policy is meant to address lawsuits or legal remedies against non-qualified Hospital clients

3. KMC will allow any outside third party collection agency to file abstracts against any property owned once judgment is rendered against a qualified client to the full extent authorized by Federal and State law, including AB 774. Neither Hospital nor it's outside third party collection agency will ever request a sale of a primary residence of a qualified client pursuant to any filed abstract in accordance with the terms of AB774, however any abstract may be paid off from any equity the qualified client has realized in the property upon a sale for refinancing of the property to the full extend allowed by AB 774.

VI. SPECIAL CONSIDERATIONS: N/A

VII. EDUCATION: N/A

VIII. DOCUMENTATION:

A. Kern Medical Center Patient Financial Counseling and the Collection Department utilize software McKesson STAR and Asset Verification Screening Tool (ADDENDUM C) to document the financial Screening Process.

IX. ADDENDUMS:

A. Financial Assistance Program Eligibility Guidelines
B. Letter: Medi-Cal, MIA and Discount Program Eligibility Determination
C. MIA Asset Verification Screening Tool
D. Flow Chart: Clients Screened for MIA, Medi-Cal or Self-Pay
E. Notice of Action Letter; MIA Share of Cost Information
F. Table for determination of financial assistance allowances
G. Posted Discount Program sign in ED Registration/Admitting Patient Access
H. Assembly Bill No. 774 Criteria
I. AB774 Program
J. AB774 Flow

X. REFERENCES: N/A

XI. KEY WORDS: MIA, financial, screening, AB774, SOC, Share of Cost, discount

OWNERSHIP (Committee/Department/Team) ..... Patient Financial Counseling ORIGINAL ..... November 1994 REVISED ..... September 2006, September 2007, September 2008, July 2012, March 2013 APPROVED BY CLIENT FINANCIAL COUNSELING ..... March 2013 DISTRIBUTION ..... Patient Financial Counseling Manual REQUIRES REVIEW ..... March 2016	
Department Manager Signature of Approval Date	Administrative Signature of Approval Date

Addendum "A"

Financial Assistance Program Eligibility Guidelines

1) Discount Programs are not applicable for non-essential services such as cosmetic surgery, convenience items, and non-medically necessary procedures as defined in policy.

2) Each person requesting financial assistance must have a completed application.

3) Proof of income must be provided. Recent pay stubs and/or income tax returns are considered acceptable proof of income.

4) An individual will be eligible for Discount Program based on the FPL. The Client/guarantor may qualify as:
   a) Self-Pay Eligible Patient: Patients/guarantors that are without third party insurance, Medicaid, and those whose injury is not a compensable injury for purposes of workers' compensation, automobile insurance, or other insurance as determined and documented by the hospital.
   b) High Medical Cost Eligible Client: Patients/guarantors who are not self-pay patients and have out-of pocket medical expenses in the prior 12 months that exceed 10% of the family's income and do not otherwise receive a discount as a consequence of third party coverage. Validation of these healthcare costs may be requested. Patients who have insurance and have a liability that is applied to discounted charges are not eligible.
      - Consider a patient with a $5,000 deductible who obtains services for which the hospital's undiscounted charge is $4,000. If the patient's coverage has negotiated an arrangement where the patient pays 60% of charges, the patient would be liable to the hospital for $2,400. Under these circumstances, AB774 would not require that patient be allowed to apply for charity or discounted care. The patient would be eligible to apply for charity or discounted care if the patient was obligated to pay the billed charges of $4,000.

5) KMC may request waivers or releases from the patients/guarantor authorizing the hospital to obtain account information from the financial or commercial institutions or other entities that may hold or maintain assets for verification; however this information may not be utilized for collection activities.
   a) Monetary assets shall not include retirement or deferred-compensation plans qualified under the Internal Revenue Code, or nonqualified deferred-compensation plans.
   b) Monetary assets of $10,000.00 or less may not be counted.
   c) Monetary assets greater than $10,000.00 may be counted at 50 percent when determining eligibility.

6) Patient liability for the self-pay eligible patient will not exceed the average rate received by a government payer.

7) Patient liability for the high medical cost eligible patient will not exceed the difference of the amount received from the third party payer and the maximum rate from a government payer.

8) Patients who qualify for MIA with a Share of Cost and Discount Program (AB774) is responsible for the lesser of the SOC or the Medicare Reimbursement Rates for Emergency Services and out-patient service or the sliding scale of the Medicare Reimbursement Rates for in-patient services.

9) Self-pay patients receiving Emergency Room or out-patient services who qualify for the Discount Program (AB774) have a monthly Share of Cost based on the FPL. The patient/guarantor are responsible for the either the monthly SOC or the monthly total of Medicare Reimbursement Rates whichever is less.

10) Self-pay clients receiving In-patient services who qualify for the Discount Program (AB774) are responsible for the sliding scale of the Medicare Reimbursement Rate not to exceed a reimbursement percentage equal to 75% of charges.

11) Restricted Medi-Cal Clients who receive non-emergent services are held liable for those services not reimbursed by Medi-Cal.

Addendum “B”

Patient Friendly Letter

Dear Patient/Guarantor:

KMC is proud of its mission to provide quality care to all who need it regardless of ability to pay.

If you need assistance paying your healthcare bills, we may be able to help. If you do not have healthcare insurance or are underinsured, you may be eligible for one of our programs:

Charity Care
Discount Programs
Medicare
Medi-Cal
KMCHP MCE (LIHP)
California Children’s Services
Healthy Families

For more information, please contact our financial counseling office at 661-326-2392. We will treat your questions with confidentiality and courtesy.

Addendum "C"

MIA Share of Cost Screening (Asset Check) — Financial Counselor

1	Do you or a family member own a vehicle? YES ( ) NO ( )		Value:					Verification:
2	Do you or any of your family own real property? (House, land, building, mobile home) YES ( ) NO ( )							
	Full Market Value ($)							Total: $
3	List all assets and the assets of family members. If none, check none.	None	Amount	Self	Spouse	Children		Verification:
	a. Money on hand							
	b. Money in checking account							
	c. Money in safe deposit							
	d. Money in savings account							
	e. Stocks or bonds							
	f. Notes, mortgages, deeds of trust							
	g. Life insurance							Total: $
4	Do you or any family member have any of the following sources of income?							Verification:
	a. Unemployment benefits							
	b. Disability benefits							
	c. Veterans benefits							
	d. Pensions							
	e. Money from someone outside the home							
	f. SSI/SSP, GR							
	g. Social Security							
	h. Workers Compensation							
	i. Military Allotment							
	j. Payment from roomers							
	k. Monetary gifts/contributions							
	l. Interest/dividends							
	m. Food Stamps							
	n. Other							Total: $
5	Name of Employer		Applicant		Spouse			Verification:
	How often Paid Net Earnings per pay period $							Total: $

GUIDELINE		
Family Member	Minimum Income	Assets not to exceed:
1	$ 840.00	$ 2,000.00
2	$ 840.00	$ 3,000.00
3	$ 840.00	$ 3,150.00
4	$ 990.00	$ 3,300.00
5	$ 1,130.00	$ 3,450.00
6	$ 1,275.00	$ 3,600.00
7	$ 1,445.00	$ 3,750.00
8	$ 1,595.00	$ 3,900.00
9	$ 1,745.00	$ 4,050.00
10 or more	$ 1,765.00	$ 4,200.00

Items 1-3 Total $

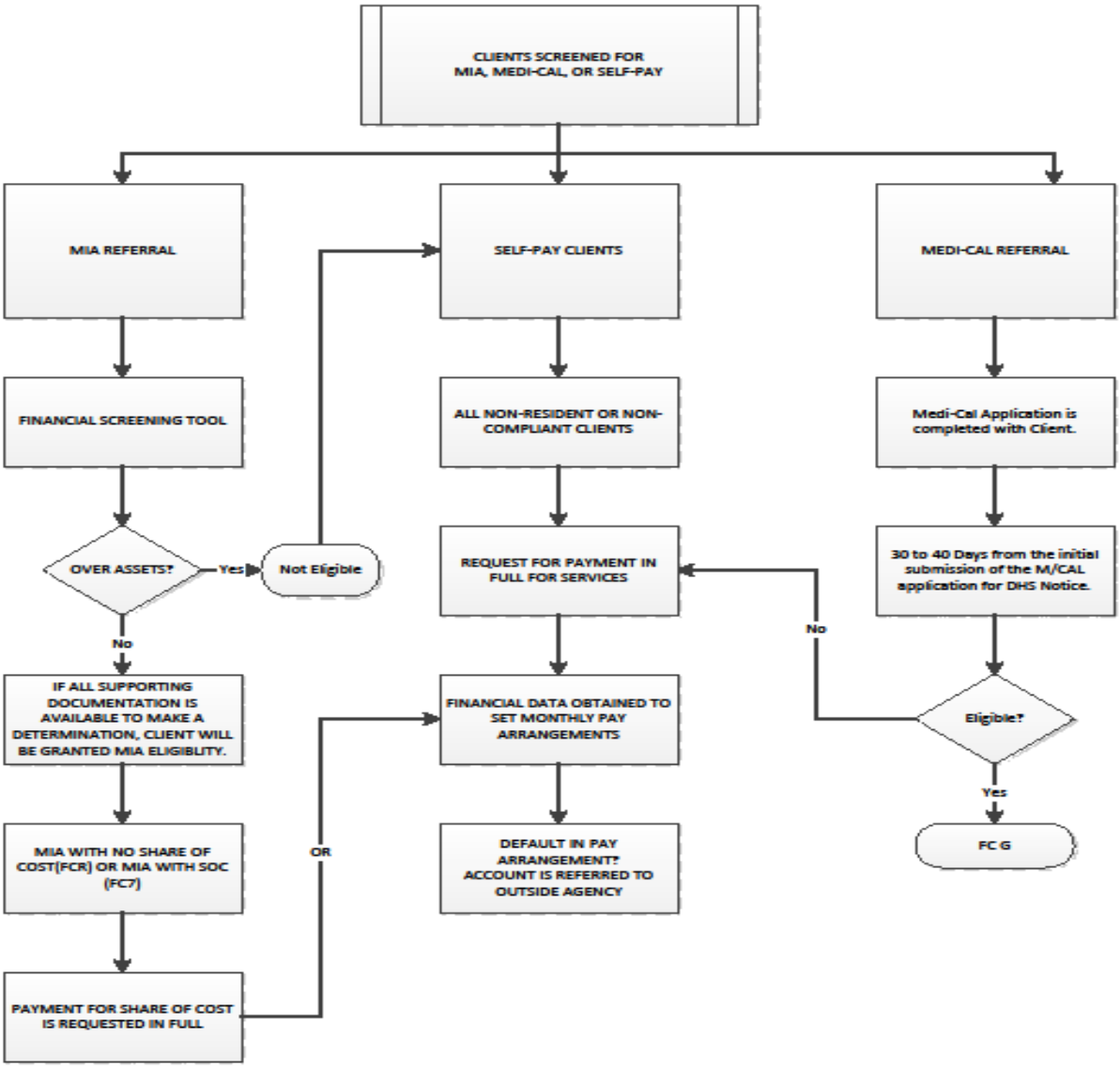
Items 4 & 5 Total: $

Minimum Income $

Patient's SOC $

Note: MIA SOC members are only responsible for their share of cost for ER and Inpatient services.

ADDENDUM "D"



Patient Financial
Counseling Department
Rev. March 2013

"E"

Medically Indigent Adult (MIA) Share of Cost Information

Member's Name: [INSERT NAME]
Member's KMCHP ID #: [INSERT KMCHP ID from Portal]
Member's KMC Medical Record # (if applicable): [KXXXXXXXXXX]

For those patients who do not quality for Medi-Cal, they may be eligible for alternate assistance from the County of Kern through the Kern Medical Center Health Plan (KMCHP) - Medically Indigent Adult (MIA) program administered by Kern Medical Center.

All services provided through Kern Medical Center Health Plan are dependent on your eligibility and financial status. Your eligibility and share of cost is determined by reviewing your financial records and is available from the Patient Financial Services Department.

According to our records, your monthly Share of Cost is: $XXX.XX
Monthly Share of Cost is only collected for Emergency Department and Inpatient Services

This share of cost was based on the following information:
Monthly Income: $XXX.XX
Personal Property: $XXX.XX
Number in Household: X

Your financial classification is KMCHP MIA SOC
Eligible Start Date: XX/XX/XXXX
Eligible End Date: XX/XX/XXXX

If your eligibility information changes, including but not limited to income, county of residency, age (over 64 years of age), or MediCal status, please notify KMCHP within 10 business days of the change. It is the patient's responsibility to provide the Patient Financial Services Department and KMCHP with proper information to determine eligibility for the program. KMCHP can review your eligibility at any time during your enrollment year and are required to redetermine eligibility every 12 months.

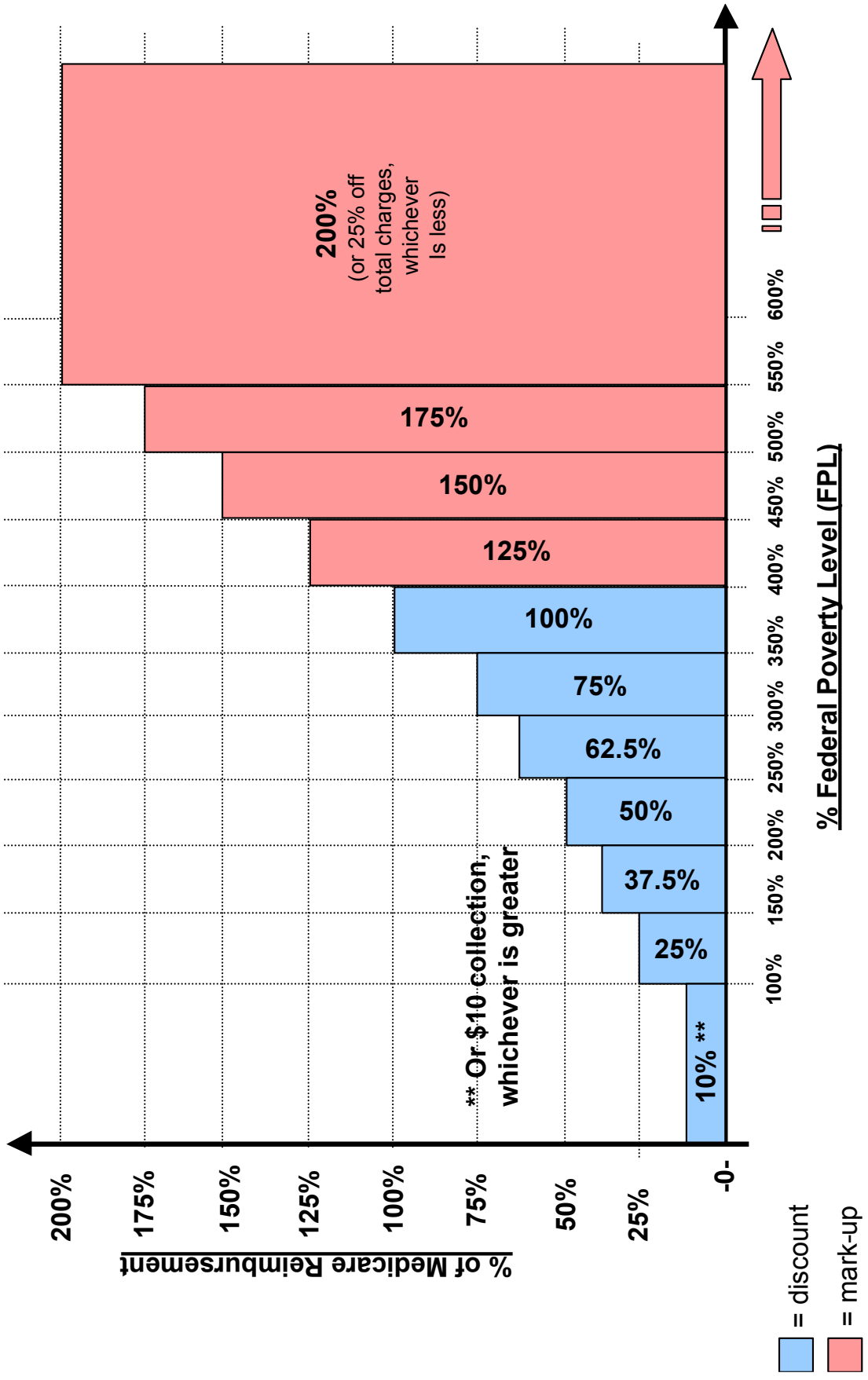
Once enrolled, KMCHP – MIA SOC will pay for covered primary and specialty medical services. All health care charges obtained prior to the issuing of this letter are the patient's responsibility. KMCHP – MIA SOC patients will only be charge a Share of Cost for Emergency Room and Inpatient services. Additionally, services that are not a benefit of the KMCHP Health Care Coverage Initiative (HCCI) program are excluded from the KMCMHP – MIA SOC program and require full payment by the patient.

In the event that KMC cannot provide the care, and the health care required is a covered benefit of the program, KMCHP will make arrangements to provide the necessary care; however, prior authorization is required from the KMCHP Utilization Management (UM) Department. All health care charges incurred outside KMC without prior authorization by the KMCHP UM Department and/or KMC are the patient's responsibility. Once Medi-Cal or your Disability claim has been granted, you will no longer be eligible for the benefits detailed above.

IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call Kern Medical Center Health Plan's Member Services Department at 1-888-498-1942 right away.

IMPORTANTE: ¿Puede leer esta carta? Si no, nosotros le podemos ayudar a leerla. Además, usted puede recibir esta carta escrita en su propio idioma. Para obtener ayuda gratuita, llame ahora mismo al Departamento de Servicios para Miembros al 1-888-498-1942.

ADDENDUM "F"


200%
(or 25% off total charges, whichever Is less)
175%
150%
125%
100%
75%
62.5%
50%
37.5%
25%
10% **
** Or $10 collection, whichever is greater
% of Medicare Reimbursement
200%
175%
150%
125%
100%
75%
50%
25%
-0-
% Federal Poverty Level (FPL)
100%
150%
200%
250%
300%
350%
400%
450%
500%
550%
600%
= discount
= mark-up

ADDENDUM "G"

KERN MEDICAL CENTER

AFFILIATED WITH UNIVERSITYOF CALIFORNIA SCHOOLS OF MEDICINE AT LOS ANGELES AND IRVINE

Attention Patients

If you need assistance and need help paying your health care bills you may qualify for financial assistance.

Kern Medical Center has a program to assist you with payment of your health care bills.

For more information please contact
Patient Financial Services
at
(661) 326-2392

Atencion a los Pacientes

Si usted nececita asistencia y nececita ayuda para pagar sus cuentas para el cuidado de su salud, usted podria calificar para asistencia financeria.

El Centro Medico Kern cuenta con un programa para asistirle con el pago de sus cuentas para el cuidado de su salud.

Para mas informacion, por favor llame a la oficina de Servicios Financieros para Pacientes al
(661) 326-2392

ADDENDUM "H"

AB 774

Who is Financially Eligible?

California Residents and/or Undocumented (able to prove California Residency)

1. **Self-Pay patients (Uninsured)**

- No 3rd Party Coverage
- No Medicaid
- No Workers Comp,
- No Automobile Insurance
- No other insurance
- Income at or below 350% FPL

2. **High Medical Cost Patients (Under-Insured)**

- Cannot be Self-Pay
- Income at or below 350% FPL
- Out-of-Pocket medical expense in prior 12 Months exceeds 10% of family income, and
- Patient does not otherwise receive discount as a result of 3rd party coverage. (Insurance company has negotiated reduced rates with hospital.)

Proof of Income:

- Pay stubs and/or Income Tax returns. If not available, bank statements, public assistance.

Monetary (Of or relating to Money) Assets:

- Waive the 1st $10,000. Note: Patient does not have to divulge info on monetary assets.
- Consider 50% over $10,000. Note: Does not include property or patients' homes

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DISCOUNT; In Patient Services - DRG Rate

- If DRG is lower than the Patient charges listed, the DRG rate is considered the amount owed.

DISCOUNT; Out Patient Services - FPL Guideline

- Discount using the FPL Guideline they fall under. Use this total to make payment arrangements.

COLLECTION

- Cannot send to collection agency prior to 150 days after the initial bill.
- Cannot send to collection if making regularly and/or partial payments.
- Cannot send to collections if patient is attempting to negotiate payment arrangement.

ADDENDUM "I"

AB774 Financial Counselor

After a thorough financial screening, those patients not qualified for any assisted program are responsible for services.

1. Patient must apply for AB774 program. If eligible, the patient may be responsible for a portion of their bill according to where they fall within the FPL Scale. (see scale attached)
2. Patient is given an option to set monthly payment arrangements if financially unable to resolve their liability in full.
3. Patients not eligible for any program including AB774 are offered a reasonable discount of 10% if paid within 15 to 30 day so of the final bill.
4. Payment in full is required on any pending services. A 70% deposit of approximate charges will be made on those not able to meet the payment in full requirement. These are reviewed on a case-by-case basis. Payment arrangements will be made on the remaining balance.
5. Complete Term Agreement Form.
6. Add to your tickler file for follow-up.
7. Once time has come to follow-up, Check to see if patient has made agreed payments. If not, Reverse the discount and call them up to make new payment arrangements. Note account thoroughly.

Prior to determination

1. Collect all information from the patient/patient family to assist in calculation.
2. Make sure the Federal poverty guideline is for the current year.
3. Supervisor/Manger review of screen cases should be part of the process.
4. Make sure we state eligibility criteria based on the income consistent with the application of the Federal poverty level.

Prerequisites for assignment of AB774

Hospital Fair Pricing policy requires the following:

- Allowance for financially qualified patients' "means, with respect to services rendered to a financially qualified patient, an allowance that is applied after the hospital's charge are imposed on the patient, due to the patients determined financial inability to pay the charges.
- "Federal Poverty Level" means the poverty guideline updated periodically in the Federal Register by the United States Department of Health and Human Services under authority of subsection (2) of Section 9902 of Title 42 of the United States Code.

Financially qualified patient" means a patient who is both of the following:

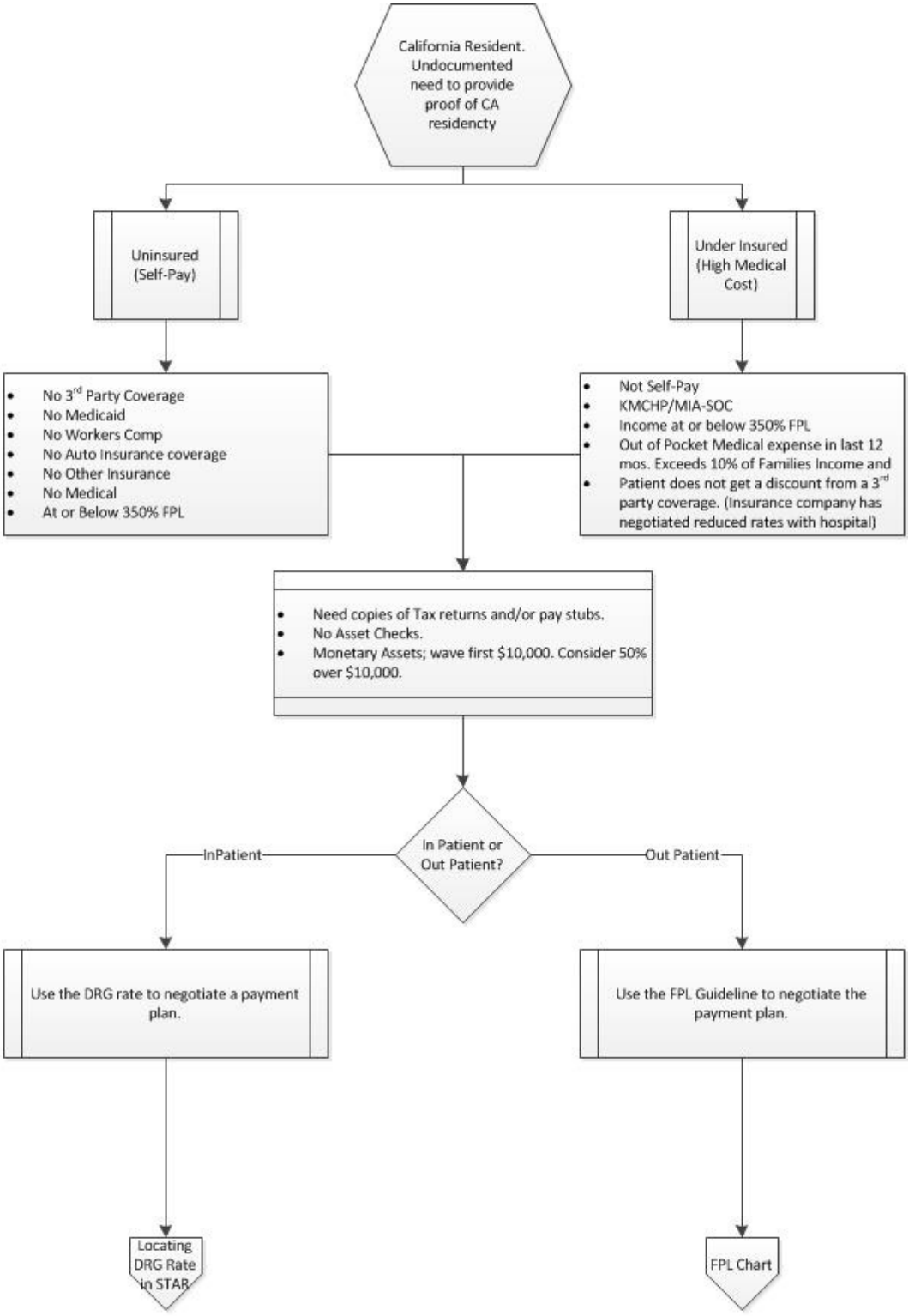
- A patient who is a self-pay patient as defined in subdivision (f) ("Self-pay patient" means a patient who does not have third-party coverage from health insurer, health care service plan, Medicare, or Medi-Cal and whose injury in not a compensable injury for purposes of workers' compensation, automobile insurance, or other insurance as determined and documented by the hospital. Self-pay patient may include charity care patients). Or a patient with high medical cost as defined in subdivision (g) ("A patient with high medical costs" means a person whose family income does not exceed 350% of the federal poverty level, if

that individual dos not receive a discount rate from the hospital as a result of his or her third-party coverage. For this purpose, "high medical costs" means any of the following items:

- Annual out-of-pocket cost incurred by the individual at the hospital exceed 10 percent of the patient's family income and the prior 12 months, or
- Annual out-of-pocket expenses that exceed 10% of the patients family income, if the patient provides documentation of the patient's medical expenses paid by the patient or the patient's family in the prior 12 months).

- A patient who has a family income that does not exceed 350% of the federal poverty guidelines.

ADDENDUM "J"



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