


KERN MEDICAL CENTER

Standard Structure 	Department: Collections			
	Policy No. COL-IM-407	Effective Date: September 2008	Review Date: September 2011	Page 1 of 5 (plus addendums)
Title of Procedure: Financial Screening Process				

I. PURPOSE:

To determine potential funding sources for services provided by Kern Medical Center (KMC), Medically Indigent Adult (MIA) staff screens unfunded qualified patients and gathers financial information to accurately complete applications for potential funding programs.

II. DEFINITION:

A. Medically Indigent Adult Program (MIA): A state funded program which provides assistance to individuals who may meet the guidelines for qualification related to their healthcare needs. Patients may qualify for MIA if they are not eligible for Medi-Cal, and they have no insurance and no means of support.

Note: The Coverage Initiative (CI) is included in the MIA screening.

B. Disability Evaluation Determination (DED): Patients 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 patient 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. Patients may qualify for the discount program if they are self-pay or underinsured. Patients may also qualify for MIA in addition to the AB 774.

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 Patients: The patient 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 residence
- d) Income at or below 300% of the Federal Poverty Level (FPL)
- e) Assets must not exceed \$10,000, excluding a primary residence and a car

III. POLICY STATEMENT:

It is the policy of Kern Medical Center to establish financial resources for services provided to the patient at Kern Medical Center (KMC) Medically Indigent Adult (MIA) program which screens unfunded patients 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.
 - 2. Patient friendly letters given to patient/guarantor at time of every registration.
 - 3. Message on each statement mailed to the patient/guarantor.
- B. Patients 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 patients are referred to the financial counselors for screening at the time of service. The inpatient discharge list is reviewed daily to identify patients that may be discharged prior to financial screening. If a self-pay patient was not financially screened during their visit, a letter is sent offering assistance with a Medi-Cal, MIA and Discount Program application. (Refer to Addendum "B".)
- D. Screening of Patients
 - 1. The financial counselors are notified regarding all self-pay patients.
 - a) Patients are referred to the financial counselors by way of central scheduling, referral center, physician referral or self referral when an outpatient appointment is requested.
- E. A brief telephone or face-to-face screening is completed before a scheduled appointment is given to the patient. Screening is done to determine if the patient has any other funding available prior to MIA or other Discount Program eligibility processes begin.
- F. Patients who are eligible for Medi-Cal will be referred to the Department of Human Services for completion of a Medi-Cal application. Patients are eligible for Medi-Cal if they meet the following criteria:
 - 1. Under 21 years of age or over 65 years of age
 - 2. Pregnant
 - 3. Blind or disabled

4. Minor children in the home with deprivation of a parent
- G. Patients are interviewed as outlined on the screening flowchart. Refer to Addendum "D".) An MIA Linkage Evaluation form is completed. (Refer to Addendum "C"). Patients who do not bring required documentation are rescheduled for their screening interview.
1. 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 patient on general assistance and food stamps
 - c) Yearly: Patients on a set income such as widow's pension or Social Security Retirement
 2. Share of Cost: MIA eligibility will be determined quarterly for patients with zero Share of Cost. Patients with a Share of Cost will be determined monthly. Patients on a fixed income (i.e., widow's pension, retirement) will be determined for 6 months with zero Share of Cost.
- H. Patients who are not eligible for Medi-Cal are screened for MIA and the Discount Program. An appointment is scheduled for a face-to-face interview, and the patient is requested to bring proof of Kern County residency and documents relating to income and asset verification for the past 30 days.
- I. The status of the financial screening is documented in HBOC and MICRS (Medically Indigent Care Reporting System).
- J. MIA and Discount Program Retroactive Eligibility
1. 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 patient/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 patient/responsible party. Consult your supervisor when necessary.
 2. Patients 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.
- K. When financial screening has been completed for the self-pay patients, the referring source is notified (i.e., central scheduling, referral center, physician referral) so the outpatient appointment may be scheduled.
- L. Referral of Patients
1. Patients 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.
- M. Collections Process
1. Payment Schedule and Financial Arrangements
 - a) Internal Process
 - 1) Once a patient is approved for Financial Assistance, it is expected that the patient 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 collection department supervisor.

- 2) All self pay non-compliant accounts are reported to an outside collection agency within 30-45 days of bill discharge.

b) External Process

- 1) However, interest will accrue on the accounts of qualified patients 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 patient follows the agreed to reasonable long term payment plan. In the event the reasonable long term payment plan is breached by a qualified patient, the full amount of the accrued but uncharged interest to date will be charged to the account.

2. Reporting to Outside Credit Agency

- a) KMC will not report adverse information to a consumer credit reporting agency or take civil action against the patient for nonpayment at any time prior to 150 days after initial billing. 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 patient is attempting to qualify for eligibility or attempting in good faith to settle an outstanding bill.

N. 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 patients 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 patients 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 Patients.
3. KMC will allow any outside third party collection agency to file abstracts against any property owned once judgment is rendered against a qualified patient 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 patient pursuant to any filed abstract in accordance with the terms of AB774, however any abstract may be paid off from any equity the qualified patient 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 Collection Department utilizes financial screening software (HBOC and MICRS) 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 Linkage Evaluation
- D. Flow Chart: Patients Screened for MIA, Medi-Cal or Self-Pay
- E. Share of Cost Information
- F. Table for determination of financial assistance allowances

X. REFERENCES: N/A

XI. KEY WORDS: MIA, financial, screening

OWNERSHIP (Committee/Department/Team) Collections	
ORIGINAL November 1994	
REVIEWED, NO REVISIONS	
REVISED September 2006, September 2007, September 2008	
APPROVED BY COLLECTIONS DEPARTMENT September 2007	
APPROVED BY COMPLIANCE COMMITTEE September 30, 2008	
DISTRIBUTION Collections Manual	
REQUIRES REVIEW September 2011	
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Administrative 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 patient/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 Patient: 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. Patient's 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 patient/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 Outpatient Service or the sliding scale of the Medicare Reimbursement Rates for Inpatient Services.
- 9) Self-pay patients receiving Emergency room or outpatient 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 patients receiving Inpatient 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 patients who receive non-emergent services are held liable for those services not reimbursed by Medi-Cal.

Addendum “B”

Patient Friendly Letter

Dear Patient/Guarantor:

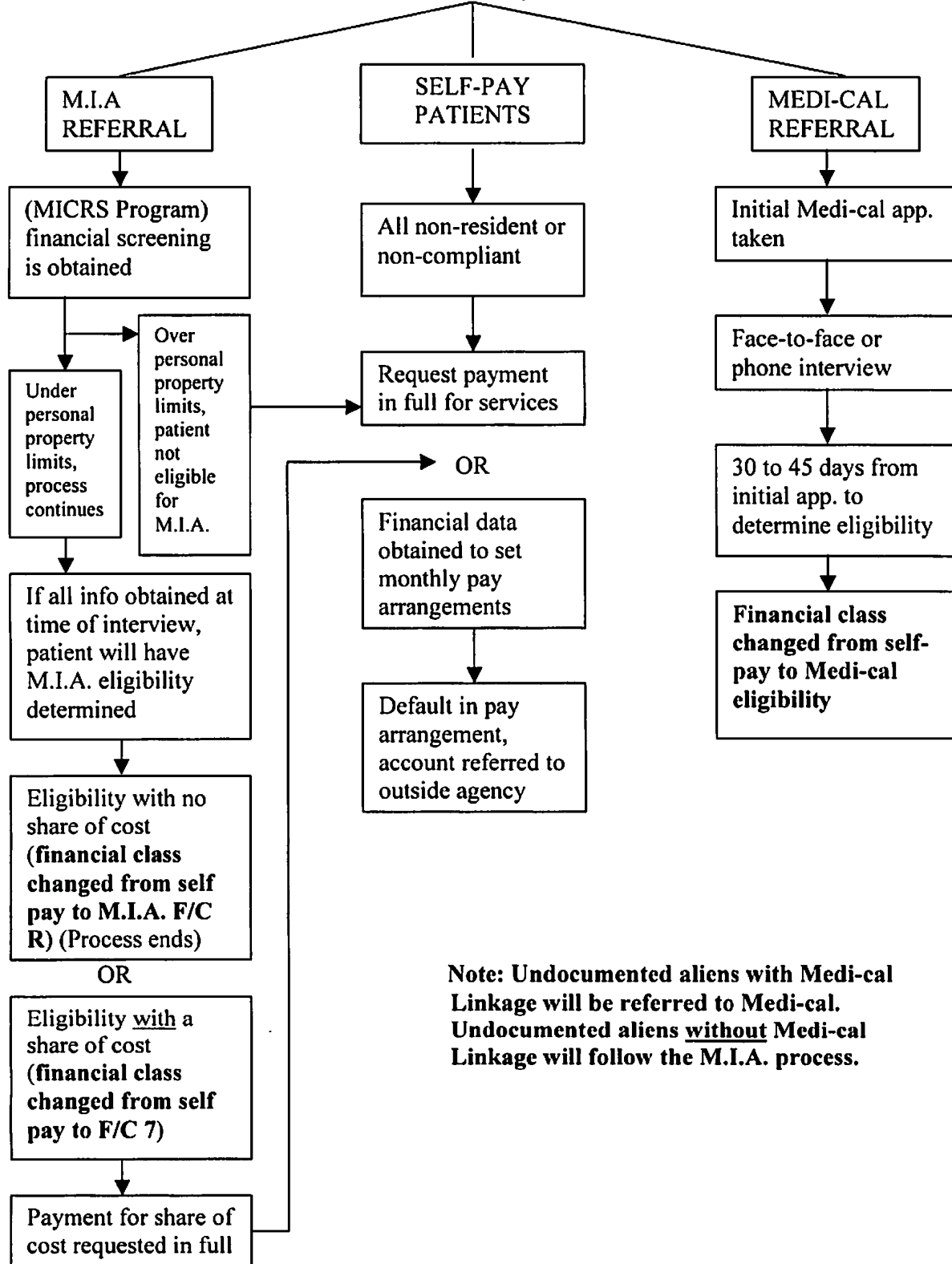
KMC is proud of its mission to provide quality care to all who need it regardless of ability to pay.

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
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.

Patients Screened for M.I.A., MEDI-CAL, or Self-Pay



Note: Undocumented aliens with Medi-cal Linkage will be referred to Medi-cal. Undocumented aliens without Medi-cal Linkage will follow the M.I.A. process.



AFFILIATED WITH UNIVERSITY OF CALIFORNIA SCHOOLS OF MEDICINE AT LOS ANGELES, SAN DIEGO AND IRVINE

SHARE OF COST INFORMATION

Patient's Name:

Patient's Medical Record Number:

For those patients who do not qualify for Medi-Cal they may be eligible for alternative assistance from the County of Kern through the Medically Indigent Program(MIA) administered at Kern Medical Center.

The charges to you for services provided at Kern Medical Center are dependent on your eligibility and financial status. Your eligibility and/or Share of Cost is determined by reviewing your financial records and is available from the Accounts Receivables Department.

A preliminary indication of your Share of Cost is based on the following information:

MONTHLY INCOME:

PERSONAL PROPERTY:

NUMBER IN HOUSEHOLD:

Based on this information, your total **Share of Cost** is
Financial Classification is _____ and Insurance Plan # _____
This letter is effective _____ **and expires** _____

Your eligibility and Share of Cost may be redetermined based on additional information. It is the patient's responsibility to provide the MIA program with necessary information to determine eligibility for the MIA program. Services that are not a benefit of the Medi-Cal Program are excluded from this special assistance program and require full payment by the patient.

The MIA program will pay for covered medical services only if received at KMC after issuance of this letter. **All health care charges obtained prior to the issuing of this letter are the patient's responsibility.** In the event that Kern Medical Center cannot provide the care, and the health care required is a covered benefit of the program, KMC will make arrangements to provide the necessary care. Prior authorization is required from the Case Management Department at Kern Medical Center. **All health care charges incurred outside KMC without prior authorization by the Case Management Department are the patient's responsibility.**

Once Medi-Cal or your Disability Claim has been granted, you will no longer be eligible for the MIA benefits as outlined above.

I acknowledge that the above information provided by me is true and that it is a preliminary indication of my MIA and/or Share of Cost status.

Patient or Responsible Party: _____

By:

Issue Date:

Addendum "F"

