KernMedical	Department: Patient Access			
	Policy No. PAC-IM-960	Effective Date: January 2022	Review Date: January 2025	Page 1 of 12 (with addendums)
Title: Charity Care and Discount Program				

I. PURPOSE:

To define and describe the criteria for qualifying individuals for Kern Medical Center's (KMC) charity care requirements of the California Hospital Fair Pricing Policies Act, defined by State Assembly Bill AB 532, AB 774 and AB 1020. These bills stipulate uninsured patients are protected from gross hospital charges, which are determined by the hospital's charge master. Hospitals must have a written charity care and discount policy. The Fair Pricing Act prohibits hospitals from charging eligible patients more for care than they could charge Medicare. For discounting, KMC will utilize the Medicare DRG for inpatient services and not to exceed 125% of Medicare rates for outpatient services.

II. DEFINITIONS:

A. **AB 532** – Requires the hospital to provide the written forms related to the hospital's financial assistance and charity care policies to uninsured and self-pay patients at the time of service, if the patient is able to receive them. If the patient is unable to receive the form(s), the hospital must provide them at the time the patient leaves the facility or within 72-hours by mail.

B. **AB 774** – A state bill adding language to the California Health and Safety Code. It applies to general acute care hospitals and mandates hospitals to financially qualify patients for charity care

C. **AB 1020** – Updates financial aid, disclosure and debt collection requirements for general acute care hospitals (GACH), updates the meaning of a patient with high medical costs to a person whose family income is less than or equal to 400% of the federal poverty level (FPL) and the patient can document that the patient or patient's family has paid more than 10% of the patient's current income or family income in the prior twelve (12) months.

D. **Charity Care** – Defined as any medically necessary inpatient or outpatient hospital service provided to a patient, who has income below 400% of the current FPL and who has been deemed ineligible for other government assistance programs, including the Kern Medical Wellness Program (KMWP).

E. **Essential Living Expenses** – Any of the following: rent or house payment and maintenance, food and household supplies, utilities and telephone, clothing, medical and dental payments, insurance, school or child care, child or spousal support, transportation and auto expenses (including insurance, gas and repairs), installment payments, laundry and cleaning expenses, and other extraordinary expenses

F. **Federal Poverty Levels (FPL)** – Used by man assistance programs, including some states' Medicaid programs, as a way to set financial eligibility criteria. Often programs limit participant's income to 100% of the FPL or some percentage of the FPL, such as 138% or 400%.

G. **Medically Necessary Services** – Financial assistance will apply to medically necessary services, using InterQual criteria, excluding services that are primarily for patient comfort and/or patient convenience

III. POLICY STATEMENT:

It is the policy of KMC to establish financial resources for services provided to all clients, who have health care needs and are uninsured, or have high medical costs, who are at or below 400% of the FPL. Determination is made available to clients by means of a designated hospital revenue cycle employee or preferred vendor representative that assists to screen uninsured and under-insured clients by gathering financial information to accurately complete applications for potential funding programs, including possible charity care.

IV. EQUIPMENT: N/A

V. PROCEDURE:

A. Eligibility Criteria for Patient Payment Assistance

1. Eligibility is provided for any patient whose family income is below 400% of the current FPL, if covered by third-party insurance, which does not otherwise afford the patient a discount from standard hospital rates, as provided in the KMC charge description master (CDM).
2. The KMC Patient Accounting Department can, at the request of the patient, review the KMWP application to check to see if the patient is eligible for additional assistance beyond Medi-Cal eligibility and the KMWP. The information provided is placed in a tool where the patient's household size and income are reviewed for possible discounts to the patient's bill. These discounts are assessed based on income level. Below 200% of FPL would be eligible for full discount to charity care, above 200%, but not more than 400% of the FPL, would be eligible to receive services at the rates of payment received from Medicare. Patient would be notified in writing of the results.
3. Eligibility requires cooperation of individual patients, who may be eligible for assistance. To facilitate receipt of accurate and timely information, KMC uses the information provided by the patient. KMC will request a minimum deposit of $100.00 and/or establish initial short-term interest free payment arrangements (NTE 12 months) for uninsured patients, until such time as the necessary and required documents have been secured to process a determination (within 150 days from the last date of service or NTE 2 years for Medi-Cal fair hearings cases) and link the patient to a government health care program or other coverage. KMC may choose to waive a minimum deposit (non-emergent) for patients seeking medically necessary services, when the patient has already been identified as having restricted Medi-Cal (ER/pregnancy and long-term care only).
4. The granting of payment assistance will be based on an individualized determination of financial need and will not take into account age, gender, race, immigration status, sexual orientation or religion. Initial payment arrangements may be reevaluated, if it is determined that the patient's financial circumstances have changed significantly at any point during the lifecycle of the patient account. Said changes should be communicated to the hospital's Patient Accounting representative.

5. If private or public health insurance is available to partially or fully cover a patient's charges, KMC will consider coverage offered through the California Health Benefit Exchange, as well as government-sponsored health programs, such as, but not limited to, Medicare, Medi-Cal, Healthy Families Program, California Children's Services (CCS) or other state or county-funded health coverage. Inpatient admissions with private health insurance will be monitored weekly by the hospital's Health Benefits Advisors using the weekly high dollar report. The Financial Disclosure Form (HMO/PPO) may be secured in applicable cases for out of network health plans. The hospital's Health Benefits Advisors will communicate via estimate letter to the patient/guarantor during the inpatient confinement or outpatient encounter to circumvent "surprise billing" after discharge. The estimate letter is an approximation based on similar cases and is no way a guarantee of bill amount of services.
6. KMC will inform patients that have not provided proof of third-party coverage that they may be eligible for coverage offered through the California Health Benefit Exchange and other state or county-funded health coverage, as well as Medicare (SSI/SSDI), Medi-Cal, Health Families and CCS. Each patient should be issued a Patient Financial Assistance brochure (English/Spanish).

B. Determination of Financial Need
   1. Financial need may be determined through a screening process with the hospital's Health Benefits Advisors or designated Patient Accounting staff that may include the following:
      a) Application process in which the client is required to supply documentation necessary to make the determination of financial need
      b) The use of available public sources that can provide information on the patient's ability to pay
      c) A reasonable effort by KMC or its contracted vendors and agencies must be made to assist patients in applying for appropriate alternative sources of payment and coverage from public programs, taking into consideration the patient's financial resources and assets

C. Payment Assistance Guidelines
   1. Services eligible under the policy will be determined on a sliding fee, in accordance with the FPL in effect at the time of the determination, as follows:
      a) Clients that are at or below 400% of the FPL may be eligible to be financially screened to determine if they meet charity care criteria.
      b) Clients that may be currently eligible for Med-Cal restricted services (ER/pregnancy related) will be screened to determine if they meet eligibility for full scope Medi-Cal and/or KMWP before consideration for charity care.
      c) Clients whose income is between 138-400% of the FPL and do not qualify for any other health coverage will be financially screened and be encouraged to apply for KMWP. Refer to policy, POL-KMWP-100.

d) Clients whose income is above 200% but not more than 400% of the FPL would be eligible to receive services at the rates of payment received from Medicare (DRG for inpatient admissions and NTE 125% Medicare rates for elective outpatient services prepaid prior to time of service).

D. Vendor Relations
   1. The hospital Health Benefit Advisors will notify the vendor relations unit of the hospital's business office upon notification that the patient may be eligible for charity review and consideration. Such notification may result from receipt of the Notice of Action from Medi-Cal that a patient has been deemed ineligible for coverage, notification that a patient has been determined ineligible for KMWP, notification that the patient has expressed a hardship in being able to meet their high out of pocket deductible and/or co-insurance, or that the patient has had a change in their income status.
   2. For the accounts in accounts receivable status, the vendor/agency will refer all patient queries for charity assistance to the Director of Patient Financial Services. Refer to Section V, Subsection A, 2.

VI. SPECIAL CONSIDERATIONS:

A. All requests for charity care adjustments will be reviewed by the Director of Patient Financial Services, who will recommend that the Chief Financial Officer (CFO) or designated approver via signature approve such charity care adjustment accordingly. The patient/guarantor will be notified of their charity care determination by designed Patient Financial Services staff and the hospital's vendor relations unit will be responsible for communicating that these accounts be cancelled/closed from the vendor/agency in applicable cases. **Under no circumstances, except for those outlined in this policy, will any account be requested to be adjusted to charity.**

VII. EDUCATION:

A. Kern Medical Center Staff: Annual education of this policy will be required for all Patient Access and Patient Financial staff assigned to assist patients with charity care applications or as regulatory changes require.

VIII. DOCUMENTATION:

A. KMC Revenue Cycle staff will document relevant information into the hospital's information system and/or document imaging application, in accordance with record retention requirements.
B. Neither Patient Access staff nor scheduling appointment staff will assign the charity care plan code to any booked appointment or registration. The assignment of the charity care plan code is reserved for Patient Financial Services use only.

IX. ADDENDUMS:

A. KMWP Application
B. Notice of Financial Disclosure (HMO/PPO)

X. REFERENCES:

A. KMC Policy, POL-KMWP-100

B. KMC Policy, PAC-IM-403, Referral of Self Pay Patients for Medi-Cal Application IP/ER
C. KMC Policy, COL-IM-409, Charges, Payments and Collections
D. The Affordable Care Act (ACA), IRS §501(r)
E. ASC 606
F. State Assembly Bills, AB 532, AB 774 and AB 1020

XI. KEY WORDS: Charity Care, Screening, Discount

OWNERSHIP (Committee/Department/Team) ..... Patient Access ORIGINAL.....November 1994 REVIEWED, NO REVISIONS..... January 2022 REVISED .....September 2006, September 2007, September 2008, July 2012, March 2013, March 2019 APPROVED BY DIRECTOR OF PATIENT FINANCIAL SERVICES.....January 2016, March 2019, January 2022 DISTRIBUTION..... Patient Access Services Policy Manual REQUIRES REVIEW ..... January 2025	
Administrative Signature of Approval Date	Signature of Approval Date

KernMedical
WELLNESS PROGRAM

What is Kern Medical Wellness Program (KMWP)?
Kern Medical Wellness Program (KMWP) is a hospital managed wellness program designed to provide access to care for low-income, uninsured Kern County residents. Members will have access to Kern Medical facilities and treatment by some of the best medical professionals within our community. For those eligible, Kern Medical's health care services will be provided at discounted rates or little cost.

KMWP is not a health insurance plan. KMWP is designed to promote overall wellness for its member and provide access to limited wellness care primarily at Kern Medical facilities. KMWP does not cover the cost associated with care provided by Non-Kern Medical (out-of-network) providers or facilities. Members will be financially responsible for medical services, supplies and medications not offered as part of KMWP.

Kern Medical Wellness Program not intended to replace or provide medical insurance coverage. KMWP members are strongly encouraged to obtain health insurance coverage. KMWP members will periodically be scheduled to meet with Kern Medical Health Benefit Advisors to determine eligibility for state funded health insurance programs, such as Medi-Cal or Covered California.

Don't Wait until you're Sick to Seek Medical Care
KMWP Enrollees are assigned to a Kern Medical Clinic and have access to comprehensive primary and specialty care from doctors who are familiar with their medical histories and special medical needs.

Do you qualify?
If you are all of the following you may qualify for Kern Medical Wellness Program (KMWP):

- A Kern County resident (must be a Kern resident for the past 30 days)
- Not eligible for any other public insurance programs such as Medi-Cal or CHIP
- Between the ages of 19 and 64
- Living within program income guidelines

Enrollee Benefits
In addition to our program services, all KMWP enrollees receive a patient ID card, health education materials, a free newsletter subscription, and access to our Member Services toll free phone line.

How to Apply
To complete your application, here's what you need to do:

1. **Complete the application form and sign it.**
   Complete all items on the application and sign on page 3.

2. **Collect your documents.**
   On page 4 of the application, we have listed all applicable documents that must be submitted with your application. Please review this carefully.

3. **Mail your completed form and supportive documentation to:**
   Kern Medical Wellness Program
   1700 Mount Vernon Ave.
   Bakersfield, CA 93306

Applications may take up to 45 business days to process. Additional items may also be needed in some cases in order to determine eligibility. If needed, the Health Benefit Advisor will request additional items. If you have any questions, please call KMWP Financial Services at (661) 326-2392.

Kern Medical Wellness Program
1700 Mount Vernon Ave. Bakersfield, CA 93306 ~ Phone: (661)326-2392

Application

Please fill out all information on this form. Print clearly.
Use black or blue ink only.

Questions? Please call: 661-326-2392

Mail your completed form to:
Kern Medical Wellness Program
1700 Mount Vernon Ave.
Bakersfield, CA 93306

Tell us about the applicant filling out this form.

1. _____
Last Name First Name Middle Initial

2. _____
Home Address *(Number and Street)* Do NOT use a P.O. Box – unless homeless Apt. #

3. _____
City State Zip Code

4. _____
Mailing Address *(if different from above)* or P.O. Box Apt. #

5. _____
City State Zip Email Address (optional)

6. _____
Home Phone Work Phone Cell Phone

7. What Language do you want us to speak to you in? ☐ English ☐ Spanish ☐ Other: _____

8. What Language should we write to you in? ☐ English ☐ Spanish ☐ Other: _____

Tell us about those applying for KMWP and those living in the household.

List all family members who live in the home. Include spouse, children and/or stepparents living in the home. Do not list aunts, uncles, nieces, nephews, or grandparents.

		Applicant	Spouse	Child	Child
9			Is this person also applying for KMWP? ☐ Yes ☐ No	Is this person also applying for KMWP? ☐ Yes ☐ No	Is this person also applying for KMWP? ☐ Yes ☐ No
10	Name Last, First, MI				
11	Name on birth certificate (if different from name above)				
12	Home Address (if different from address in 2)				
13	Mailing Address (if different from address in 4)				
14	County of Residence	☐ Kern ☐ Other If other:	☐ Kern ☐ Other If other:	☐ Kern ☐ Other If other:	☐ Kern ☐ Other If other:
15	Date of Birth (mo/day/yr)	___/___/___	___/___/___	___/___/___	___/___/___

KMWP Application Last Revised 8/22/16

Application

Please fill out all information on this form. Print clearly.
Use black or blue ink only.

KMWP

Questions? Please call: 661-326-2392

16	Gender	☐ Male ☐ Female ☐ Other	☐ Male ☐ Female ☐ Other	☐ Male ☐ Female ☐ Other	☐ Male ☐ Female ☐ Other
17	Marital Status	☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated	☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated	☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated	☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated
18	Ethnicity – *Optional*	☐ Hispanic ☐ Latino ☐ Non-Hispanic	☐ Hispanic ☐ Latino ☐ Non-Hispanic	☐ Hispanic ☐ Latino ☐ Non-Hispanic	☐ Hispanic ☐ Latino ☐ Non-Hispanic
19	Race – *Optional*	☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other:	☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other:	☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other:	☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other:
20	Or foreign country				
21	Social Security No.				
22	U.S. Citizen or National? If *No*, date arrived in the U.S.	☐ Yes ☐ No ___/___/___	☐ Yes ☐ No ___/___/___	☐ Yes ☐ No ___/___/___	☐ Yes ☐ No ___/___/___
23	Primary Language				
24	Preferred Language				
25	KERN MEDICAL Medical Record # (if applicable)				
Other Insurance Information					
26	Does this person have other health insurance?	☐ Yes ☐ No If yes, complete next section	☐ Yes ☐ No If yes, complete next section	☐ Yes ☐ No If yes, complete next section	☐ Yes ☐ No If yes, complete next section
27	Insurance Name				
28	Group Number				
29	Insurance Phone Number				
30	Coverage type				
31	Effective Date				
32	Expiration Date (if applicable)				

KMWP Application Last Revised 8/22/16

Application

Please fill out all information on this form. Print clearly.
Use black or blue ink only.

Questions? Please call: 661-326-2392

Family Income Information

Do you or any family member have any of the following sources of income? List all family income for the prior month, including child support and spousal support **received.**

Number of adults in household:_____ Number of children in household: _____

Source of Income	**Applicant** List the amount and how often the income is received (weekly, biweekly, monthly)	**Spouse** List the amount and how often the income is received (weekly, biweekly, monthly)	**Child** List the amount and how often the income is received (weekly, biweekly, monthly)
Employment status	☐ Full-Time ☐ Part-Time ☐ Unemployed ☐ Retired ☐ Self-Employed ☐ Volunteer ☐ Student ☐ Temporary	☐ Full-Time ☐ Part-Time ☐ Unemployed ☐ Retired ☐ Self-Employed ☐ Volunteer ☐ Student ☐ Temporary	☐ Full-Time ☐ Part-Time ☐ Unemployed ☐ Retired ☐ Self-Employed ☐ Volunteer ☐ Student ☐ Temporary
Job	$ *How often:*	$ *How often:*	$ *How often:*
Unemployment benefits If unemployed, what is the last date worked?	$ *How often:* _____/_____/_____	$ *How often:* _____/_____/_____	$ *How often:* _____/_____/_____
Social Security Disability benefits	$ *How often:*	$ *How often:*	$ *How often:*
Veterans Benefits	$ *How often:*	$ *How often:*	$ *How often:*
Social Security Retirement			
Social Security Survivors	$ *How often:*	$ *How often:*	$ *How often:*
Military Allotment	$ *How often:*	$ *How often:*	$ *How often:*
Payment form roomers	$ *How often:*	$ *How often:*	$ *How often:*
Interest/ dividends	$ *How often:*	$ *How often:*	$ *How often:*
Other:_____	$ *How often:*	$ *How often:*	$ *How often:*

Member Responsibilities:

I have read the KMWP Enrollment Form, and understand that by enrolling in the program:

- I agree to participate in KMWP and comply with the program requirements;
- I agree to attend all medical appointments made on my behalf;
- I agree to provide my care manager, physicians, nurses, and other health care and social service professionals with all appropriate information regarding my health;
- Upon signing this form, I will receive a copy.

I declare under penalty of perjury under California state law that I have read this application, the answers provided, and the documents enclosed and, to the best of my knowledge, they are correct and true.

_____ _____
Participant Signature Date

_____ _____
Witness (Kern Medical Staff) Signature Date

KMWP Application Last Revised 8/22/16

Application

Please fill out all information on this form. Print clearly.
Use black or blue ink only.

KMWP

Questions? Please call: 661-326-2392

Fill out below ONLY if a Certified Application Assistant (CAA) helped you fill out this form.

☐ Check this box and sign below to allow Healthy Families and Medi-Cal to speak to a representative of the Enrollment Entity (EE) listed below about the status of this Application. This permission ends when the program mails you its decision on this Application.

I certify the CAA listed below helped me complete this application. This CAA helped me for free.

Applicant Signature:_____ Date: _____

CAA#_____ EE# _____

CAA Signature:_____ Date: _____

Supportive Documentation for KMWP Application

Listed below are the majority of items needed for most persons to determine eligibility. Mail items with your completed application that you think may be of assistance in determining eligibility. Additional items may be needed in some cases in order to determine eligibility. If needed, the financial counselor will request additional items.

1. Proof of Kern County Residency (e.g. utility bill)
2. Valid Picture Identification
3. Proof of U.S. Citizenship or Legal Residency **(Required from KMWP Select)**
    a. Birth Certificate
    b. U.S. Passport
    c. Adoption Papers
    d. Military Record showing birth in the U.S.
    e. Report or Certification of Birth Abroad of a U.S. citizen (form FS-240 or FS-545)
    f. U.S. Citizenship I.D. Card (DHS I-197)
    g. Permanent Resident Card ("Green Card") (Client Alien Registration Number)
4. Social Security card for all applicants
5. Verification of *all* income in household
    a. Earnings
    b. Unemployment Income (UIB)
        i. Unemployment print-out 1-800-300-5616
    c. State Disability Income (SDI)
    d. Social Security Income (SSI)/Social Security Disability (SSD)
    e. Other (Profit & Loss Statement)
6. Record of application/ denial for Social Security Disability (SSD), Social Security Income (SSI), Medi-Cal, Unemployment Income (UIB), State Disability Income (SDI), Workman's Comp Income (WCI)

KMWP Application Last Revised 8/22/16

KERN MEDICAL
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HMO/PPO WAIVER

Due to the wide variation of health insurance benefits, your HMO/PPO insurance carrier may not authorize reimbursement to Kern Medical for services rendered to you and/or your dependent(s).

In the event that your HMO/PPO Insurance carrier does not cover services at Kern Medical, you will become financially responsible for all charges incurred. Determination of insurance plan coverage will be made by your HMO/PPO Insurance carrier. You will be notified by your health insurance carrier if the services provided were not covered under your benefit plan upon receipt of the Explanation of Benefits (EOB).

STATEMENT OF UNDERSTANDING

I have read the above information and my signature below acknowledges my understanding of my financial responsibility in the event my HMO/PPO/Insurance carrier does not cover the services incurred at the Kern Medical.

_____ _____

(PATIENT OR GUARDIAN'S SIGNATURE) (DATE)

Form 3441 (6/16) Owner: Patient Access Approved by Forms Committee 3/27/15

Owned and Operated by the Kern County Hospital Authority
A Designated Public Hospital
1700 Mount Vernon Avenue | Bakersfield, CA 93306 | (661) 326-2000 | KernMedical.com

FormFast

KERN MEDICAL
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RENUNCIA DE HMO/PPO

Debido a la gran variedad de beneficios de seguro de salud, su compañía de seguros HMO / PPO no puede autorizar el reembolso a Kern Medical por los servicios prestados a usted y / o su (s) dependiente (s).

En caso de que su compañía de seguros HMO / PPO no cubra los servicios en Kern Medical, usted será financieramente responsable por todos los cargos incurridos. La determinación de la cobertura del plan de seguro será realizada por su compañía de seguros HMO / PPO. Su proveedor de seguros de salud le notificará si los servicios proporcionados no estaban cubiertos por su plan de beneficios una vez que recibió la Explicación de beneficios (EOB).

DECLARACIÓN DE ENTENDIMIENTO

He leído la información anterior y mi firma a continuación reconoce mi comprensión de mi responsabilidad financiera en caso de que mi HMO / PPO / compañía de seguros no cubra los servicios incurridos en Kern Medical.

_____ _____

(FIRMA DEL PACIENTE O GUARDIÁN) (Fecha)

Form 3441 (6/16) SPANISH Owner: Patient Access Approved by Forms Committee 3/27/15

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