hfma
healthcare financial management association

Patient Financial Communications Training Program

Financial Policy Examples

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Introduction

This document contains examples of financial policies that most hospitals have or would like to develop. The policies present organizational guidelines for estimating prices for patients, communicating that information to patients, and determining when and how to extend financial assistance to patients. Every organization will have its own policies and its own way of stating those policies. These examples may be helpful in developing or modifying your organization's policies.

Note: These policies were gathered from a variety of third-party sources and are intended for illustrative purposes only without any warranty or endorsement by HFMA. Use of these policies should be independently verified for suitability and compliance with applicable laws and regulations.

Policy: Estimation of the Price of Service

Policy Number: _____

Responsible Party: Patient Access Representative, Financial Counselor

Effective Date: _____

Policy:
ABC Healthcare provides price estimates to all patients prior to or at the time of service. The price estimate consists of the following information:

- Patient's name
- Address, City, State, Zip
- Telephone number
- Date of service
- Attending/ordering physician
- Diagnosis/procedure
- Primary Insurance eligibility and benefits
- Secondary insurance eligibility and benefits
- Service(s) or test(s) ordered
- Charge(s)
- Adjudicated amount based on benefits, provider's contract with the payer(s)
- Status of deductible/co-insurance requirements
- Estimated patient liability

This estimate will be produced using ABC's Patient Insurance Price Estimator Tool. The estimated patient liability will be communicated to the patient following the patient financial communications communication policy. A written copy of the estimate will be provided upon request.

Patient Access representatives and financial counselors interacting with patients are expected to complete these estimates according to the Patient Financial Communications Best Practices.™ The performance standard for completing these estimates and the corresponding patient financial conversation is 100% of all patients where price estimates have been provided.

Approved by: _____ Date: _____

Financial Assistance Policy

POLICY: Hospital affiliates shall fulfill their charitable missions by providing health care services to all individuals without regard to their ability to pay. The hospital and its affiliates shall provide fair discounts and financial protection to low income underinsured or uninsured patients. The hospital and its affiliates shall use consistent and fair collection practices for all patients.

SCOPE: Systemwide. All hospital and wholly owned affiliate facilities including, but not limited to, hospitals and ambulatory surgery centers.

PROCEDURE: The hospital and affiliates are committed to meeting the needs of everyone in their communities, including those who cannot pay for their care. Similarly, patients who are able to pay have an obligation to pay and providers have a duty to seek payment from these individuals.

Financial Assistance Guidelines**.** Financial assistance will be available for only medically necessary healthcare services provided to persons who meet the financial and documentation criteria defined in this policy. Certain substance abuse and mental health programs reserve the right to offer different discounts as determined appropriate by the facility. Discounts shall be based on the following guidelines:

Hospital Patients, Physician Clinic Patients and Home Health Patients

- Full charity care shall be provided to underinsured and uninsured patients earning 200 percent or less of the federal poverty income guideline (FPIG).

- For financially needy underinsured or uninsured patients earning between 201 percent and 400 percent of the FPIG, discounts shall be provided to limit such patient's payment obligation to the amount of the patient account balance after subtracting the percentage discount applicable to the patient's FPIG household income provided in the following table.

Discount	Current Year's Federal Poverty Income Guidelines for Family Size
100%	Family income is less than or equal to **200%** of FPIG
80%	Family income is **201%** to **225%** of FPIG
60%	Family income is **226%** to **250%** of FPIG
40%	Family income is **251%** to **300%** of FPIG
20%	Family income is **301%** to **400%** of FPIG
0%	Family income is greater than **400%** of FPIG

An individual who is presumed eligible under these criteria will continue to remain eligible for six months following the date of the initial approval, unless facility personnel have reason to believe the patient no longer meets the criteria.

- The health system reserves the right to limit eligibility to a shorter period and/or may require periodic reviews to confirm continuing eligibility.

- The health system reserves the right, on a case-by-case basis and at the discretion of the affiliate CFO or CFO designee, to extend eligibility for financial assistance to patients who have household incomes that exceed 400 percent of the FPIG.

- Presumptive eligibility. Patients who qualify and are receiving benefits from the following programs may be presumed eligible for 100 percent financial assistance:
    - **Food stamps.** The U.S. Department of Agriculture Food and Nutrition Service Food Stamp Program.
    - **Family Investment Program, under [state code]**
    - **Limited eligibility - Illegal undocumented persons' three-day emergency window**. The [state] Department of Human Services allows for up to three days of Medicaid benefits to pay for the cost of emergency services for undocumented persons who do not meet citizenship, alien status, or social security number requirements. The emergency services must be provided in a facility such as a hospital, clinic, or office that can provide the required care after the emergency medical condition has occurred. Presumptive eligibility for this category will be considered valid six months from the date of the emergent event.
    - **County and state relief programs.** Some [state] counties offer a financial assistance program designed to provide emergency short-term assistance to persons lacking the resources to meet their basic needs for food, shelter, fuel, utilities, clothing, medical, dental, hospital care and burial. The state also offers programs providing energy assistance to applicants who qualify. Accepted programs also include WIC nutrition assistance.
    - **Other programs.** These programs may be added at the discretion of the facility.

  Patients who meet presumptive eligibility criteria may be granted financial assistance without completing the financial assistance application. Documentation supporting the patient's qualification for or participation in a program must be obtained and kept on file. Documentation may include a copy of a government issued card or other documentation listing eligibility or qualification, or print screen of web page listing the patient's eligibility. Unless otherwise noted, an individual who is presumed eligible under these presumptive criteria will continue to remain eligible for six months following the date of the initial approval, unless facility personnel have reason to believe the patient no longer meets the presumptive criteria.

- The federal poverty income guidelines will be updated annually from updates published by the United States Department of Health and Human Services.

- This policy can be applicable to patient deductibles. It is not applicable to discounts provided under the Discounts for Uninsured Patients Policy.

- In determining whether a patient meets the eligibility criteria for financial assistance, the affiliate will consider the extent to which the patient's household has assets other than income that could be used to meet his or her financial obligation. The affiliate will also take into account any liabilities that are the responsibility of the patient's household.

- Unlike income, assets and liabilities have a lot of variability. Assets will include such things as cash, savings and checking accounts, certificates of deposit, stocks and bonds, individual retirement accounts, trust funds, real estate, and motor vehicles. This list is not intended to be inclusive.

- Household income will be considered in determining whether a patient is eligible for assistance. Household income includes but is not limited to the following: traditional married couples, children (biological, step, or adoption), and couples living together. (Married or couples living together requires that the parties present as a couple and share expenses, whether same sex or male/female.)

- Waivers or discounts of Medicare or Medicaid copayments or deductibles may be granted based on financial need as provided below under "Discounts for Government Sponsored Program Patients (Medicare or Medicaid)."

- Medical indigency. Financial assistance may be provided to patients who are determined to be medically indigent. "Medically indigent" means patients who are unable to pay some or all of their medical bills because their medical bills exceed a certain percentage of their family or household income or assets (for example, due to catastrophic costs or conditions), even though they have income or assets that otherwise exceed the generally applicable eligibility requirements for free or discounted care under the health system guidelines.
    - The patient shall apply for financial assistance in accordance with this policy. The patient shall supply documentation to support his/her medically indigent status. Examples of documentation that may be used include but are not limited to, copies of patient medical bills, information related to patient's drug costs, or other evidence of healthcare costs for which the patient is responsible.
    - In most cases, the patient shall be expected to pay a portion of the medical bill.

Hospital Patient Financial Assistance Calculation.

- Amounts charged for hospital emergency or other medically necessary hospital care that is provided to individuals eligible for assistance under this policy may not be more than the amounts generally billed to individuals who have insurance covering such care. Amounts billed to those who qualify for financial assistance may be based on either the best, or an average of the three best, negotiated commercial rates, or Medicare rates. Hospitals may not use gross charges to calculate such amounts.
    - The following method should be used to calculate amounts generally billed to individuals who have insurance. A hospital must first establish a collection rate per contract based on historical negotiated commercial rates (for example, 70 percent of billed charges) based upon the past three years (for example, 69 percent, 70 percent, 71 percent = 70 percent).
    - For underinsured patients, the total billed charges will be reduced by the applicable rate (for example, under the scenario above, an underinsured patient's responsibility should be equal to or less than 70 percent of total billed charges).
    - For uninsured patients who qualify for financial assistance, the total billed charges will be reduced by the applicable discount (30 percent in the example above) prior to application of any financial assistance to such bill.

Discounts for Government Sponsored Program Patients (Medicare or Medicaid).

- Health system affiliates may waive or reduce Medicare or Medicaid coinsurance or deductibles only based on financial need if the following requirements are met:
    - The waiver or discount is not advertised. (It is proper to advise patients on an individual basis that waivers of copayments or deductibles in the event of financial need are possible and the patient may apply for such benefits at the time or immediately before treatment is provided.)
    - The discount is not routinely offered, but only to those patients in financial need who wish to apply.
    - The waiver or discount satisfies one of the following:
        - The waiver or discount is made following an individualized good faith assessment of financial need.
        - The waiver or discount is made after reasonable efforts have failed to collect the copayment, deductibles, or full payment directly from the patient.
        - The waiver or discount is in settlement of a disputed claim resulting from services provided to the beneficiary.

- Written records documenting the reasons for each waiver or discount shall be considered cost report supporting documents and therefore shall be retained as such in accordance with the Record Retention Policy.

Communicating Availability of Charity Care and Financial Assistance.

- Affiliate Responsibilities. Each affiliate will have a means of widely communicating the availability of charity care and financial assistance to all patients and within the community served by the affiliate. Examples of mechanisms that the provider may use to do this include:

    - Placing signage, information, or brochures in appropriate areas of the provider (e.g., the emergency department, and registration and check-out/cashier areas) stating that the provider/physician practice offers charity care and describing how to obtain more information about financial assistance
    - Placing a note on the healthcare bill and statements regarding how to request information about financial assistance
    - Placing a notice on the opening page of the website of hospital providers
    - Placing a notice that summarizes the hospital's policy concerning charity care and financial assistance in a media outlet of general circulation in the community at least two times/year
    - Designating departments or individuals who can explain the provider's charity care policy
    - Instructing staff who interact with patients to direct questions regarding the charity care policy to the proper provider representative

- After receiving the patient's request for financial assistance and any financial information or other documentation needed to determine eligibility for financial assistance, the patient will be notified of the patient's eligibility determination within a reasonable period of time.

Patient Responsibilities Regarding Financial Assistance. If applicable, prior to being considered for financial assistance, the patient/family must cooperate with the provider to furnish information and documentation to apply for other existing financial resources that may be available to pay for the patient's health care, such as Medicaid, Medicare, third-party liability, etc. Patients with valid healthcare coverage through out-of-network providers may be required to access their primary network before being considered for financial assistance.

- To be considered for charity care or financial assistance the patient/family must furnish the provider with a completed application provided by the provider or, if requested, documentation to support the presumptive eligibility criteria described in the "Financial Assistance Guidelines" above.

- In the event the patient does not initially qualify for charity care or financial assistance after providing the requested information and documentation, the patient may re-apply if there is a change in their income, assets, or family responsibilities.

- A patient who qualifies for partial discounts must cooperate with the provider to establish a reasonable payment plan that takes into account available income and assets, the amount of the discounted bill(s), and any prior payments.

- Patients who qualify for partial discounts must make a good faith effort to honor the payment plans for their discounted healthcare bills. They are responsible for communicating to the provider any change in their financial situation that may impact their ability to pay their discounted healthcare bills or to honor the provisions of their payment plans.

Collection Guidelines. Hospital affiliates' collection efforts shall not include wage garnishments or other legal process seizures without the prior approval of the central billing office, the affiliate CFO or compliance officer. Personal property (other than cash or cash equivalents) attachment or seizure will not occur. The entry of a judgment automatically attaches to real estate; however, no seizure of the patient's primary residence will occur.

Organizational Financial Policy

PURPOSE

ABC Hospital is a not-for profit healthcare provider committed to providing quality health care services. In order to provide necessary medical services to the community, the Hospital must maintain a strong financial foundation that includes the timely collection of its accounts receivable. This policy establishes the Hospital's financial requirements for account resolution based on consistent criteria that incorporates individual patient financial circumstances. This policy will ensure the appropriate patient financial resolution to ABC Hospital while maintaining optimal customer satisfaction. As a non-profit hospital, ABC Hospital is committed to providing medically necessary services to all patients regardless of their ability to pay.

POLICY

COMPREHENSIVE PROCESSING: All patients meeting comprehensive processing criteria, as defined in Appendix A, will undergo access processing which includes scheduling, pre-registration/registration, medical necessity review, insurance verification, pre-authorization review, estimation of patient and third party liabilities, financial education and financial resolution, as applicable. Comprehensive processing will be completed for all scheduled patients prior to their scheduled date and time of service. For non-scheduled patients including emergency patients, comprehensive access processing will be completed at the earliest opportunity at the time of service but no later than the time of discharge.

LIMITED PROCESSING: Patients not meeting comprehensive processing criteria, as defined in Appendix A, will undergo limited processing which includes pre-registration/registration, LCD/NCD (Local Coverage Determination/National Coverage Determination) review when required to determine medical necessity, electronic insurance verification, and financial resolution of identified patient co-payment and deductible amounts. Limited processing will be completed for all scheduled patients prior to the scheduled date and time of service. For non-scheduled patients, limited processing will be completed at the earliest opportunity at the time of service but no later than the time of discharge.

SCHEDULED PATIENTS: Patients are expected to resolve their identified financial obligations to ABC Hospital prior to their scheduled date and time of service. If the patient does not resolve

the account(s) as defined within the financial policy guidelines, the service request may be clinically reviewed for delay, rescheduling or cancellation as appropriate.

NON-EMERGENCY UNSCHEDULED PATIENTS: Patients are expected to resolve their identified financial obligations to ABC Hospital at the earliest appropriate opportunity at the time of service but no later than the time of discharge. If the patient does not resolve the account(s) as defined within the financial policy guidelines, the service request may be clinically reviewed for delay, rescheduling or cancellation as appropriate.

PATIENTS SEEKING EMERGENCY CARE: ABC Hospital will provide emergency services regardless of the patient's ability to pay, in compliance with applicable Federal and State regulations. Only after the medical screening has been completed and the patient is stabilized, will ABC Hospital initiate calls to third party payers to verify insurance coverage. Treated and released emergency patients will be requested, prior to discharge, to comply with the same financial requirements as non-emergency unscheduled patients. Patients admitted to ABC Hospital will be identified and monitored for financial resolution prior to discharge.

Processing Guidelines:

A. PATIENTS WITH VALID INSURANCE COVERAGE: ABC Hospital will complete and process all valid insurance claim activities for billing and payment according to the following guidelines:

1. Insurance claims will be filed without an assignment of benefits only when all identified unassigned insurance accounts have been paid in full.

2. Insurance will be accepted as satisfying a patient's requirement for financial resolution as part of comprehensive processing when all required insurance data set information has been collected/validated/updated and coverage is verified. Insurance accounts with anticipated deductibles, co-payments and non-covered charges will be screened and processed as follows:

    a. Insurance accounts with deductibles, co-payments, and non-covered charges identified during pre-service or time of service will be flagged for financial resolution of these balances no later than the time of discharge. Based on clinical review, services may be delayed or canceled, as appropriate, pending pre-service or time of service payment. For

emergency patients, identified co-payments and co-insurance will be requested only after treatment has been completed.

b. Insurance accounts where patient liabilities cannot be identified until after insurance processing will become a patient liability and will be processed according to patient liability billing and follow-up guidelines.

c. Insurance accounts with identified patient liabilities will be required to financially resolve identified amounts using the payment options listed in Appendix C – payment options no later than discharge. Based on clinical review, services may be delayed or canceled, as appropriate, pending pre-service or time of service financial resolution.

3. All open insurance liabilities remaining unresolved 60 days after the date of clean claim submission will become due and payable from the patient unless prohibited by managed care contract or applicable state and/or federal regulations. The account financial liability will be shifted to the patient and processing will be continued according to patient liability billing and follow-up guidelines. Disputes between the patient and responsible insurance carrier resulting in undue or unreasonable delays or refusal of payment will become the responsibility of the patient for full and prompt payment according to patient liability billing and follow-up guidelines.

a. Where contracts prohibit ABC Hospital from pursuing open insurance liabilities from the patient, Patient Accounting associates will continue to pursue payment with the third party payer until payment is received according to established follow-up policy and procedure.

b. For contracted payers where a pattern of payment delays has been determined by the Patient Accounting associates, the issue will be referred to the Patient Accounting manager. The Patient Accounting manager will work with the third party payer to resolve the issue.

B. NON-MEDICALLY NECESSARY CARE: ABC Hospital will complete Medical Necessity reviews on patients as follows:

1. Non-surgical Medicare outpatients - LMRP review: Medicare will only pay for services that it determines to be "reasonable and necessary" under section 1862(a)(1) of the Medicare law. Based on LMRP criteria, ABC Hospital will screen Medicare patients requesting outpatient services to determine if the requested procedures/tests are medically necessary. For services that are determined "not medically necessary" according to LMRP criteria, an Advanced Beneficiary Notice (ABN) will be generated and the patient will be asked to sign

the form agreeing to be personally and fully responsible for the payment. Claims will be completed and submitted according to CMS billing guidelines. Patient liability balances where an ABN is on file will be processed according to self pay guidelines.

2. Inpatients, observation patients & skilled patients - ABC Hospital clinical staff will utilize Interqual criteria to validate that the requested level of service is clinically supported by the diagnosis. When a medical necessity issue is identified, clinical staff will coordinate resolution, as appropriate, with the physician.

C. PATIENTS IDENTIFIED AS SELF PAY: When the patient has no insurance coverage, the account will be documented as the responsibility of the patient/guarantor and processed according to the following guidelines:

1. All patients identified as self pay and above established thresholds will have screening for Medicaid eligibility and Financial Assistance eligibility initiated.

   a. Accounts will be evaluated for Medicaid coverage using established Medicaid screening criteria as identified in Appendix B and will also be evaluated for possible Financial Assistance qualification according to established eligibility rules as defined in the Financial Assistance Policy and Procedure.

   b. Accounts meeting initial Medicaid eligibility screening criteria will be processed according to the established Medicaid Eligibility program processing.

   c. Accounts exceeding Medicaid eligibility criteria but meeting Financial Assistance screening criteria will be processed according to the established Financial Assistance Policy and Procedure. Processing these accounts occurs in accordance with IRS 501(r) regulations.

   d. Accounts exceeding Financial Assistance eligibility requirements will continue to be processed according to self pay party underinsured processing as outlined in step 2 below.

2. Remaining self pay accounts will be flagged for financial education according to established financial education procedures to ensure that the patient is given a full understanding of their financial liability for their requested service. Financial education will be completed at the earliest opportunity prior to service for scheduled patients and at the time of service or no later than discharge for non-scheduled patients including emergency patients.

3. Upon completion of patient financial education, patients are required to finalize a mutually acceptable financial agreement with ABC Hospital. Self pay patients will be required to financially resolve their estimated charges using the payment options listed in Appendix C prior to or at the time of service. Based on clinical review, services may be delayed or canceled, as appropriate, pending pre-service or time of service financial resolution.

D. PATIENT LIABILITY BILLING AND FOLLOW-UP: Patient liability billing and follow-up will be completed on all accounts in the self pay category, insurance accounts closed for non-payment and balances after insurance. Patient liability billing and follow-up processing will be completed according to the following guidelines:

1. An initial billing will be generated and mailed to the patient/guarantor for all accounts meeting criteria for self-pay processing with a due date of 30 days for the total balance. A second notice will be sent at 30 days for non-payment on accounts remaining unresolved at 30 days. Telephone contact will be made at 30 days for all accounts remaining unresolved at this time. A 3rd notice will be sent at 60 days on all remaining unresolved accounts. Telephone contacts continue from 30 through 90 days for remaining unresolved accounts based on established dollar criteria. Continued unresolved accounts will receive a final collection notice at 90 days and the account will be flagged for bad debt placement or legal collection placement at 120 days and will be processed for write off according to the established collection program policy and procedures. Approval levels for bad debt write offs are included in Appendix D.

2. Self pay accounts included in a declared bankruptcy will have all collection activities terminated. Bankruptcies will be referred for processing according the established bankruptcy policy and procedure.

3. Self pay accounts may be written off in part or in their entirety for administrative reasons related to risk management or public relations according to the Administrative Adjustment policy and procedure. Approval levels for these write-offs are included in Appendix D.

4. Medicare covered patients who do not pay identified deductibles and/or co-payments will be treated in accordance to applicable regulations as defined by Center for Medicare and Medicaid Services (CMS) in the Hospital Insurance Manual (HIM 10) to ensure that appropriate reimbursement is received from Medicare for unpaid bad debts.

5. Credit balances on patient accounts will be processed according to established credit balancing procedures. Patient refunds will not be made if outstanding patient balances exist on active or bad debt accounts.

APPENDIX A: Threshold Determination

Threshold processing is determined according to the type of service, anticipated charge and/or if the service is known to have restricted coverage based on completing comprehensive processing activities.

1. The following service classifications meet threshold criteria for comprehensive processing:

   All inpatients

   All surgical patients

   All emergency patients

   All observation patients

   All extended recovery patients

   All series patients

2. Remaining patients are determined to meet threshold criteria for comprehensive processing if at least one of the following is present:

   a. Outpatient services where charges are anticipated to exceed $500.00, or

   b. Outpatient services where reimbursement would be impacted without comprehensive processing.

   c. Current and previously unresolved self-pay balances are anticipated to exceed $500.00

3. Threshold patients with identified personal liabilities over $500.00 will be flagged for contact to complete financial education and resolution.

4. Threshold levels will be re-accessed, at a minimum, once annually.

APPENDIX B: Medicaid Screening Criteria

Accounts will be referred for Medicaid application processing as follows:

Assigned staff will complete financial education with self pay patients with an actual or anticipated balance at or above established threshold amounts and determine potential eligibility for Medicaid.

Newborns

Assigned ABC Hospital staff complete the Medicaid form with the patient and forward the original form to the County. The account is placed on hold until the baby is added to Medicaid.

APPENDIX C: Financial Matrix for Payment Alternatives

Payment Options:

1. CASH PAYMENTS: Accept cash and money orders.

2. CHECKS: Accepts checks for payment

3. CREDIT CARDS: Accept MasterCard or VISA for payment

4. SHORT-TERM PAYMENT PLANS: ABC Hospital offers internal payment plans for patients who agree to resolve the balance based on the payment plan guidelines policy included as APPENDIX E. If the original balance is >$1,000, ABC Hospital reserves the right to require an initial payment equal to 10% of the total balance due. ABC Hospital reserves the right to require Electronic Funds Transfer from the patient's bank account in order to qualify for this option.

5. BANKING: ABC Hospital may offer an alternative financing program through bank financing for patients wishing to make long term monthly payments for longer than 24 months. Bank financing is based on a revolving charge with interest charges.

6. FINANCIAL ASSISTANCE: ABC Hospital encourages patients to apply for financial assistance; Patients will be screened sequentially for the following programs, as applicable:
    a. Victims of Crime
    b. Medicaid/other healthcare assistance programs
    c. Traditional Charity Care Program

APPENDIX D: Approval levels for discounts, settlements and bed debt write-offs

Bad Debt

A. Self pay processing agency identifies potential bad debt accounts weekly and forwards a list identifying the accounts to the designated Credit and Collections Associate.

B. Assigned Associate Administrator reviews and approves.

C. Required bad debt approvals are as follows:

< $10,000	Patient Accounting Manager
>=$10,000	CEO or CFO

Discounts

A. Contractual Arrangements - Based on Decision Support/Contracting documentation according to "Discounts policy and procedure".

B. Administrative Adjustments - Required approvals are as follows:

< $1,000	Risk Manager, Customer Service Coordinator
>= $1,000	CEO, COO, CFO

C. Waiver of penalty for using non-preferred provider - determined using established financial assistance criteria for Financial Assistance

D. Third Party Payer Discount Requests - Required approvals are as follows:

Billed accounts - not authorized

Unbilled accounts - 5% prompt pay within 21 days as approved by – Patient Accounting Manager.

Settlements - Processed according to "Discounts policy and procedure." Required approvals are as follows:

< $ 1,000	Patient Accounting Manager
>= $ 1,000	CEO, CFO

APPENDIX E

Payment Plan Guidelines

Payment plans are extended to patients without interest for the following terms based on total balance(s) due:

Balance up to $300.00	Maximum of 6 monthly payments
Balance $301.00 to $2,500.00	Maximum of 24 monthly payments; minimum monthly payment requirement is $50.00
Balance > $2,500.00	Maximum of 36 monthly payments; minimum monthly payment requirement is $75.00

Patients who cannot meet the payment guidelines will be referred to any bank loan/medical credit card service in effect at the time through [organization's] self pay program.

Financial Assistance Policy Statement (for Patients)

ABC hospitals want to help patients who do not have health insurance or who need help paying their hospital bills. As a nonprofit health care organization, ABC and our member hospitals and health service organizations care about the patients and communities we serve through better health and better health care.

Our staff can help you:

• Apply for health insurance through the new Marketplace
• Apply for Medicaid assistance
• Determine if you qualify for financial assistance from ABC

ABC Financial Assistance
First and foremost, your financial circumstances will not affect your care. All patients are treated with respect and fairness. Patients who meet certain income guidelines may qualify for ABC Financial Assistance, including reduced hospital charges and long-term, interest-free payment plans.

Patients without insurance will automatically receive a 25 percent discount on the billed charges and will be considered for additional reductions and assistance. All patients will need to pay a minimum amount for medical services, depending on their family income, family size and financial need. The amount charged may not exceed the amount generally billed for a financial assistance-eligible patient.

Applying for Financial Assistance
You may apply for Financial Assistance at any time – before, during or after your care, up to 240 days after your initial bill. We will send information with your bill about how to apply for assistance. Applications are also available upon request at any ABC facility, on our websites and at **www.ABC.org**. The application requires proof of income such as a W-2 statement or paycheck stub.

Patients who have been enrolled in Medicaid in the last six months automatically qualify for Financial Assistance for medical services that are not covered by Medicaid. (The only exception is if the previous Medicaid enrollment was due to pregnancy. In that case, you can still apply for Financial Assistance.)

Medical Qualifications for Financial Assistance
ABC hospitals will provide, without exception, care for emergency medical conditions to all patients seeking such care, regardless of ability to pay or to qualify for financial assistance, in accordance with the requirements of the Emergency Medical Treatment and Active Labor Act (EMTALA).

Financial assistance is available only for emergency and medically necessary services. It does not apply to elective procedures such as cosmetic surgery. It also does not apply to the portion of your services that have been paid for by a third party such as an insurance company or government program.

Financial Assistance is available to patients who live in [state or states]. Because XYZ Hospital and XXX Hospital serve patients from across the region, patients who live outside [state or states] will be considered for assistance at these two hospitals on an individual basis.

Income Guidelines for Financial Assistance

The amount of financial assistance you receive is based on Federal Poverty Level information set by the U.S. government each year. To be eligible for a discount, your family income must not be more than three times the Federal Poverty Level (300 percent). We can give you a Financial Assistance Policy Income and Discount chart that shows these income levels upon request. In addition to your income, the discount will also take into account the size of your family. Patients with family income over $100,000 a year are not eligible for ABC Financial Assistance, regardless of family size. Uninsured [adjoining state] residents receiving services at ZZZ Memorial Hospital may be eligible for additional discounts under the [state uninsured discount or assistance law].

In the case of a catastrophic medical event, patients who may not ordinarily qualify for Financial Assistance will be granted aid. Under these special circumstances, patient payment responsibilities will not be more than 30 percent of annual family income.

Learn more

You can get more information about the ABC Financial Assistance Policy and an application by speaking with a Patient Services representative at your hospital or by calling **866-xxx-xxxx.** Information also is available on our websites and at **www.ABC.org**.

Please feel free to ask about Financial Assistance. We are here to help.

Policy on Patient Payment, Credit, and Access

PURPOSE:

• ABC Healthcare desires to clarify requirements related to patient payment and credit as they relate to a patient's access to medical services.

• ABC Healthcare entities are committed to providing medical services to patients regardless of their ability to pay. However, in those instances where services provided may be reimbursable, if the patient complies with the requirements of a third party or governmental payer, ABC Healthcare requests those patients to assist ABC Healthcare in securing reimbursement for those services. Failure to do so will result in the patient assuming responsibility for payment of the services rendered.

I. Patient Credit Policy

A. Urgent and Emergent Services

Urgent and emergent services are defined as services required when a physician determines that immediate care is required to avoid the loss of life, limb or disability. Urgent and emergent services will be provided to patients regardless of their ability to pay. Each clinical department will determine when urgent and emergent services are needed, consistent with the above stated definition.

In the event that a patient has an "emergency medical condition" as defined under the ABC Healthcare Patient Transfer Policy and EMTALA, a medical screening examination and appropriate treatment shall not be delayed to permit an inquiry regarding the patient's method of payment or insurance status, as further described in Section IV, Subsection C of this policy.

If it is determined that urgent and emergent services are needed, and the patient is not covered by insurance, ABC Healthcare, with the cooperation of the patient, will apply for Medical Assistance on behalf of the patient in an attempt to secure reimbursement for the services provided. Such patients who are admitted will be asked to sign a statement that he or she will fully cooperate with ABC Healthcare with respect to obtaining Medical Assistance coverage and he or she will be liable for payment of services rendered in the event that the Medical Assistance coverage is denied. A patient who has previously been determined ineligible for Medical Assistance will be asked to comply with this process if urgent and emergent services are needed.

B. Non-Urgent/Emergent services and Elective Services

Patients presenting for elective or non-urgent/emergent services who are uninsured or who have insurance coverage that does not cover the elective or non-urgent/emergent services requested will be asked to apply for Medical Assistance and obtain approval for such elective or non-urgent/emergent services in advance of services being rendered. If approval for services cannot be obtained, the patient will need to provide a deposit to ABC Healthcare equal to the following:

a) Admissions – one hundred (100%) of the total room and board charges (based on a standard medical, semi-private accommodation rate) dependent upon the patient's anticipated length of stay and any associated charges.
b) Outpatient Services – one hundred percent (100%) of the total visit charge or of the procedure charge if the patient is not admitted or is ambulatory.

A patient who has been denied coverage for Medical Assistance will be asked to comply with this deposit requirement. The deposit will be refunded if the patient secures alternative reimbursement for ABC Healthcare.

C. Emergency Department

ABC Healthcare complies with the requirement of the Emergency Medical Treatment and Active Labor Act (EMTALA) and there is nothing contained in this policy, which will preclude such compliance. Pursuant to the EMTALA Policy, no medical screening exam or treatment shall be delayed to permit an inquiry regarding the patient's method of payment or insurance status.

Subject to EMTALA requirements in the Emergency Department, all patients receiving Emergency Services will be triaged and registered. If it is determined that the patient is presenting with an urgent or emergent condition, ABC HEALTHCARE shall comply with the procedures identified in Section IV, Subsection A for urgent and emergent services and treatment will be provided regardless of insurance status. If it is determined that a patient is presenting with a non-urgent/non-emergent condition, and the patient does not have insurance coverage, the patient will be directed to follow-up in a non-urgent/emergent setting and ABC Healthcare shall comply with the procedures identified in Section IV, Subsection B for non-urgent/non-emergent services and elective services.

D. Point Of Service Collections

All co-payments, deductibles and outstanding self-pay balances will be collected prior to the service being rendered for all non-urgent/non-emergent services. The patient will be informed at the time of scheduling and/or at the “point-of-service” as to any amounts owed. Those amounts will be collected at the “point-of-service” prior to the services being provided to the patient. If the patient refuses to pay or cannot establish an agreed upon payment plan with a BSC, services will not be provided until such arrangements are agreed upon.

E. Financial Need

When a patient presents for non-urgent/non-emergent medically necessary services and does not possess insurance or the services in question are non-covered, a discount, based on gross charges, may be offered to the patient. The discount in question is determined based upon family size and household income. The determination and the appropriateness of the discounted amount are based upon utilizing the “Income Guideline Matrix.” Refer to the ABC Healthcare Uncompensated Care Policy for additional guidance.

Patients deemed not eligible for uncompensated care may be eligible for a discount on gross charges. Refer to ABC Healthcare Uninsured Patient Discount Policy for additional guidance.

F. Collection Policy

This policy will also establish the collection process on patient balances due after all available insurance coverages are exhausted or due from patient if uninsured. The following outlines the collection process:

a) A four (4) month pre-collection process consisting of a minimum of four (4) patient statements from ABC Healthcare from the “date of service” or from the time that the balance becomes the guarantor’s responsibility.

b) After three (3) months, a bad debt pre-list will be supplied to management and the physician of record of all patients who may be eligible for transfer to bad debt within thirty (30) days.

c) After the first four months, unpaid balances will be screened for presumptive charity; balances owed by patients with ability to pay will be considered immediately payable, classified as bad debt and assigned to a first placement collection agency for a period not to exceed six (6) months.

d) If primary agency fails to resolve after this initial six (6) month first placement collection effort, the patient will be reported to

the various “credit reporting” agencies establishing the account on the individual patient’s credit history.

e) Furthermore, if the balance remains unpaid after this timeframe, the balance will be assigned to a second placement agency for a period not to exceed six (6) months.

f) Legal action will be considered on a case-by-case basis in order to establish a lien on assets or proceeds from future legal claims. ABC Healthcare will not pursue the enforcement of any liens nor garnish wages.

g) Upon return from secondary collection agency, outstanding delinquent balances will be again screened for presumptive charity; balances owed by patients with ability to pay will remain in active status and are due and payable at the next scheduled medical visit.

h) Patients may request to be evaluated for uncompensated care at any time during the collection cycle. Collection agencies will return accounts to ABC Healthcare on those patients that are subsequently approved for uncompensated care.

i) In extreme circumstances where patients have ability to pay, and refuse to cooperate with ABC Healthcare in securing payment, ABC Healthcare may seek to discharge a patient from elective care. Such recommendations will be made to the ABC Healthcare entity and/or attending physician after securing approval from ABC Healthcare Legal Counsel.

Policy: Prior Balance Resolution – Patient Financial Communications

Policy Number: _____

Responsible Party: Patient Access Representative, Financial Counselor

Effective Date: _____

Policy:

ABC Healthcare organization recognizes the importance of conducting financial conversations with all patients or their designated representative at the appropriate point in the scheduling or encounter with the healthcare organization. For scheduled encounters, the discussion will occur during the scheduling or pre-registration contact. For services outside the emergency department, the discussion will occur during the arrival process, during treatment only if not disruptive to the treatment or service being provided, or at the time of discharge. In the emergency department, the discussion will occur after the patient has been triaged and clinically stabilized, either bedside or at time of discharge.

Patient financial communications shall include a discussion to make the patient aware of any prior visit account balances for which the patient is responsible. If requested, a detailed list of the accounts with a patient balance will be provided; this list will include date(s) of service, total charges, insurance payments and adjustments, if any, and the patient's balance.

The result of the conversation about the prior balance(s) will be appropriately documented in the patient's record.

It is the policy of ABC Healthcare to attempt to resolve both the current and any prior balances at the appropriate point in the encounter. Resolution options include insurance billing, full or partial payment, agreement to a payment plan contract, referral for Medicaid eligibility, or assistance with the current Financial Assistance Application.

Patient Access representatives and financial counselors interacting with patients to discuss prior balances are expected to complete these conversations according to the Patient Financial Communications Best Practices.™ The performance standard for completing these conversations is to complete the conversations for 95% of all patients where a prior balance exists.

Approved by: _____ Date: _____

Policy: Discounts for Uninsured Patients

Policy: Discounts will be provided to uninsured patients (defined below), as provided in this policy.

Scope: Systemwide. Wholly owned affiliate facilities including hospitals and ambulatory surgery centers, home care programs (excluding, however, provide duty nursing services, and home medical equipment services), physician practices owned by an affiliate, and physicians employed by a hospital or health system affiliate. [This provider is a 501(c) 3 tax-exempt entity.]

Procedures: Affiliates may grant discounts under this policy as follows:

1. Procedures Applicable to All Patients:

- Registration personnel will attempt to identify uninsured patients (defined below) at the time of registration and will advise patients of the availability of the discount provided in this policy. If other healthcare personnel learn that a patient is uninsured or learn of a patient's need for financial assistance, they are required to: (a) refer the patient to a financial counselor or registration personnel and confirm that the financial counselor or registration personnel know of the patient's needs; or (b) tell the patient of the availability of the discounts provided in this policy and Hospital's policy for individuals eligible for financial assistance under IRS 501(r) regulations. Under no circumstances will an appropriate medical screening examination be delayed for patients appearing at a hospital or an emergency department and requesting, or on whose behalf a request is made for, medical care. Affiliate hospital personnel should follow Affiliate Emergency Medical Treatment and Labor Act (EMTALA) policies for instruction on proper registration procedures and medical screening examination requirements.

- Uninsured patients will be screened for financial assistance under the Financial Assistance Policy. Uninsured patients who qualify for both Discounts for Uninsured Patients, and Financial Assistance, may receive the benefits of the policy that benefits the patient the most.

- Documentation of each discount applied pursuant to this policy will be retained in accordance with our Record Retention Policy. The documentation may be in the form of an adjustment code, etc.

- This policy is not applicable to co-payment or deductible amounts of a patient's health benefit plan. Nor is this policy applicable to healthcare services whose charges are identified, known and agreed upon prior to the service, such as cosmetic surgery procedures whose charges are combined and offered for a package price to patients.

- Questions concerning this policy should be taken to the person in charge of patient accounts for the affiliate, the central billing office, the affiliate CFO or the affiliate compliance officer.

2. Procedures Applicable to Physician Services:

- Uninsured patients (defined below) receiving physician services may receive a 20-percent discount on the physician professional and ancillary services charges billed by the physician's clinic and performed at the time if the charges for the services provided are paid at the time of service. (See related hospital services.)

- Uninsured patients, for purposes of this Section 2 physician services portion of this policy, are patients to whom any of the following criteria apply:

    - Are not insured by a health insurance policy or health benefits plan (health savings accounts are considered insurance)
    - Are not beneficiaries of a government sponsored healthcare program such as Medicare or Medicaid
    - Are patients for which there is no insurance company to file a claim or no insurance claim to be filed
    - Are insured by payers who do not provide discounts for care provided at our facilities or who exclude our facilities/physicians from exclusive provider panels and for which we does not file a claim

- The term uninsured patients does not include patients in health savings accounts; or whose care is excluded or not covered by the patient's health insurance or health benefits plan because the charges exceed the limits of the plan; or are excluded from the plan's coverage.

- Physician professional services, for purposes of this policy, include physicians employed by one of our affiliates, whether they provide services in an emergency department, a hospital-based department or clinic, or another facility or clinic.

3. Procedures Applicable to Hospital Services:

- Uninsured patients (defined below) will receive a 20-percent discount if an account is paid in full within 60 days from the last date of service, or a 10-percent discount if an account has timely payments and is paid in full within 6 months from the last date of service.

- Upon approval of the affiliate CFO, a hospital may grant to uninsured patients the same discount (as given to related physician services referred to above) for physician services provided by physicians employed by the hospital.

- Uninsured patients for purposes of this Section 3 hospital services portion of this policy are patients to whom any of the following criteria apply:

    - Are not insured by a health insurance policy or health benefits plan (health savings accounts are considered insurance)
    - Are not beneficiaries of a government-sponsored healthcare program such as Medicare or Medicaid
    - Are insured by a health insurance policy or health benefits plan, but (a) who are not eligible for benefits applicable to the services provided from their health insurance or other health benefits plan; or (b) whose medically necessary care is excluded or not covered by their plan.

Policy: Deferral of Service

Policy Number: _____

Responsible Party: Patient Access Representative, Financial Counselor, Attending Physician

Effective Date: _____

Policy:
ABC Healthcare requires the completion of financial clearance for all scheduled patients no later than the date of service. If financial clearance cannot be accomplished, the financial counselor will promptly notify that attending physician verbally or by secured electronic communication that the patient has declined to complete the provider's financial clearance process and request that if clinically appropriate, the physician approve deferring the service until financial clearance has been completed.

If financial clearance cannot be completed due to a failure on the part of the provider (physician) to comply with the current pre-authorization requirements, the patient will be notified that the patient may be responsible for the entire cost of the service/test because the patient's insurance plan rules have not been followed. The service will be cancelled or rescheduled as requested by the patient. If the patient opts to cancel or reschedule the service the provider (physician) of record will be notified immediately. The patient may opt to accept financial responsibility for the service; in this case, the required payment resolution options will be used to resolve the estimated cost for the service.

In no case will treatment be deferred in emergency cases.

Patient Access representatives and financial counselors interacting with patients are expected to complete these conversations according to the Patient Financial Communications Best Practices.™ The performance standard for completing these conversations is to complete the conversations for 100% of all patients where financial clearance has not been achieved.

Approved by: _____ Date: _____

Policy: Credit Balances

POLICY: It is the policy of ABC Healthcare to handle all credit balances in a timely, appropriate, and consistent manner.

Credit balances are part of the patient account representative's (PAR's) responsibility, and should be handled regularly. They should be reviewed to determine if there is an overpayment or if it results from a posting error. If it is a posting error, the PAR should restore the account to the correct balance.

REFUND REQUESTS:

1. Before requesting a patient refund of a credit balance, the PAR should check account access by medical record number. If the patient has any other accounts with a self-pay balance, the credit balance should be used to reduce or eliminate the balances on those accounts. Requests for transferring payment from one account to another must be given to a supervisor or a hospital cashier for handling.

2. Once a refund is determined to be necessary, the refund request should be written up, using the automated form available in account access. The form should be completed fully with the payee name and address, as well as the amount. The requestor should sign and date the form, and note the account with the details of the request.

3. If the refund is based on a patient request, "RUSH PATIENT REQUEST" should be written across the top of the refund request.

4. In addition to the procedure described above, if the payee is an insurance company, the PAR should notify the company of the overpayment, either by telephone or letter.

5. The account should always show the current financial class/insurance the same as the payee on the refund request (for example, a patient refund should show the current financial class to be self-pay).

6. The completed refund request form will be given to the PAR's supervisor, who will approve or refer to the next level of management, depending on the dollar amount of the refund request.

7. Once the refund has been approved, the form is given to accounts payable (AP). The person approving the refund should indicate the referral to AP in notes.

8. Once AP gets the refund request, the AP clerk will post a transaction on the account, reversing the credit balance. While the credit balance will no longer appear on the account in affinity, it will now reside in the AP system as a payable item, awaiting issue of a check.

9. If the insurance company recoups their payment prior to issuance of a refund check, then the AP transaction on the account will be reversed. This should be done by AP staff only.

I am signing below to indicate that I have received a copy of this policy and that I understand its contents.

Signature Date