STEPHENS COUNTY HOSPITAL	
SUBJECT: Upfront Collections Policy Revised 01-26-18	**POLICY #**: PA-001
DEPARTMENT: Patient Access	**DATE:** Jan. 26, 2018
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APPROVED BY:	
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POLICY:

This policy applies to patients who have a balance under one of the circumstances (A - E below) that would create a financial responsibility for the patient. These patients do not qualify for financial assistance as designated by the hospital Financial Assistance Policy.

Generally, a patient and/or guarantor will have a self-pay liability under the following circumstances:

A. The patient has no health care coverage for facility services.

B. The patient has health care coverage for facility services; however, the service to be rendered is not covered by his or her health care coverage (example, cosmetic surgery).

C. The patient has health care coverage, however, upon verification of the health care coverage, it is determined that the patient has a cost share amount due. This amount may come in the form of an annual deductible, applicable coinsurance, or copayment for facility services rendered.

D. The patient has a penalty for out-of-network services (Stephens County Hospital is non-participating for a specified network). This penalty is imposed by payers when, a patient is treated by an out-of-network facility, and/or physician. The penalty will vary based on the patients' hospital coverage.

E. The patient has exhausted his or her health care coverage for the current benefit period (benefit year, calendar year, and/or lifetime maximums).

PROCEDURE:

If a patient/guarantor has facility health care coverage use the following guidelines for determining and/or collecting self-pay balances:

A. **Medicare Inpatient Deductible**
The Medicare Inpatient Deductible for 2018 is $1,340.00.

B. Medicare Outpatient Co-insurance
The Medicare outpatient co-insurance is 20% of the APC rate for the procedure. The Medicare rates can be found on the SCH Shared Drive/Collections. If the service rendered does not appear on the procedure listing, refer to the appropriate Medicare Fee

Schedule based on the service rendered (Rehab, MRI, CT, Mammograms, Clinical Lab, Nutritional Counseling, Diabetes Education, etc.)
Please advise beneficiary that this is an estimated out-of-pocket expense. If the liability is greater, patient will be billed for balance. If it is less than collected amount, patient will be refunded the excess amount

C. Medicaid

Generally, there are no recipient/patient out-of-pocket expenses for covered services. Based on the Medicaid level of coverage, however, there may be an out of pocket expense for **coinsurance and/or a noncovered service**.

D. Commercial and Managed Care Payers

Confirm patient's responsibility or out of pocket expense/price on the insurance card, by verifying the electronically (or Payer website) or contacting the payer. Verify if there is a patient responsibility and/or a non-covered service. Obtain the cost share amount and inform the patient. If unable to verify via the Payer website, the copayment amount can be found on the patient's insurance identification card. As a last resort, contact the corresponding payer directly.

Inpatient and Outpatient Elective Admissions, Same Day Surgery and Outpatients in a Bed (Scheduled Visits)

A Patients, with or without insurance must be **financially cleared**:

1. Prior to or on the date of pre-admission testing; or
2. No later than 12:00 Noon, two (2) business days prior to the procedure

The term **"financially cleared"** refers to insurance verification, the collection of all out-of-pocket expenses for all patients and the attainment of all required pre-certifications, authorizations, and/or referrals for those patients with insurance. For those with insurance, out-of-pocket expenses may include deductibles, coinsurance, and co-pay amounts, as well as all costs that are excluded from coverage (non-covered procedures). For those without insurance, out-of-pocket expenses are subject to the hospital collections policy unless qualified for Financial Assistance.

If a patient is not financially cleared, within the stated time frame, the Supervisor for the service area will be notified and will subsequently make a determination as to the urgency of the patient's condition regarding the procedure/test.

Pre-admissions

Stephens County Hospital will pre-register all elective services when possible. The method of payment should be identified prior to the patient being admitted, including self-pay portions and prior outstanding balances.

Financial assessments will occur prior to the patient's scheduled procedure. If necessary, the Financial Counselor will secure a financial agreement prior to the patient's scheduled procedure based on the payment alternatives outlined in this policy or in the Financial Assistance Policy.

Emergency Room

When a patient is registered for Emergency Room services, the Patient Access Representative will follow all EMTALA guidelines, making sure the patient has been

stabilized according to policy, prior to obtaining insurance information. Once EMTALA guidelines are met, the Patient Access Rep. will request and make a copy of the patient's picture I.D. and any insurance cards provided. If the patient states they do not have any insurance, the Patient Access Rep. will screen the patient for Medicaid eligibility through the Medicaid GAMMIS web portal. A copy of the GAMMIS results will be scanned into the patient's account. If no insurance is found, the patient will be registered with the financial class "Private Pay".

If the patient states that they have insurance, the Patient Access Rep will verify eligibility via tools provided and notify the patient of their financial responsibility at the time of service including any co-pays or deductibles owed. In addition, the patient's accounts should be reviewed, and the patient should be informed of any outstanding debt owed. The patient will be given the opportunity to resolve old accounts at the time of service.

Outpatient Services Not Scheduled

When a patient presents for outpatient services that have not been scheduled and pre-registered, the Patient Access Rep will request and make a copy of the patient's picture I.D. and any insurance cards provided. If the patient states that they have insurance, the Registrar will verify eligibility via tools provided, and notify the patient of their financial responsibility at the time of service including any co-pays or deductibles owed. In addition, the patient's accounts should be reviewed, and the patient should be informed of any outstanding debt owed. The patient will be given the opportunity to resolve old accounts at the time of service. If the patient states they do not have any insurance, the Registrar will screen the patient for Medicaid eligibility through the Medicaid GAMMIS web portal. A copy of the GAMMIS results will be scanned into the patient's account. If no insurance is found, the patient will be registered with the financial class "Private Pay" and will apply prompt pay discount and attempt to collect the amount due.

Managed Care Agreements:

For patients with insurance, the hospital has specific managed care agreements. The patient's responsibility will be determined by the third-party payer. The dollar amount will be calculated using the contracted rate agreed upon with the payer.

Financial Assistance Policy:

Prior to collection patients without insurance will be notified of the **Stephens County Hospital** Financial Assistance Policy (FAP) and will be screened for financial assistance eligibility and for Medicaid eligibility according to the terms of the FAP.

Payment Methods:

Stephens County Hospital will accept the following forms of payment.
Cash
Credit Card – Visa, MasterCard, American Express, Discover
Money Order
Debit Cards with Visa or Mastercard logo
Bank or Personal Check
Online Payments

Payment Agreements:

Based on **Stephens County Hospital** policy, a Financial Payment Agreement can be arranged by the Financial Counselor and approved by the Business Office Director, at the patient's request.

Documentation:

All conversations between **Stephens County Hospital** staff and patients/guarantors will be documented in the patient's record to include estimated balance owed, patient's willingness to pay, payment methods, refusal to pay, referral to financial counselor and any other pertinent collection information.

Private-Pay /Uninsured Eligibility for Financial Assistance:

In compliance with the Affordable Care Act (ACA), enacted March 23, 2010, the amount charged to a private pay patient will be the amount generally billed to individuals who have insurance coverage, or AGB and the following processes are in place to ensure compliant billing and collections processes

A. **Billing Statements**

SCH shall make reasonable efforts to provide all patients who receive care (whether emergency, inpatient or outpatient) from SCH and may be billed for that care with a conspicuous written notice on each billing statement that includes the following:

1. Information about availability of SCH's Financial Assistance Policy and other discounts available from SCH;
2. Information about eligibility for Financial Assistance and other discounts;
3. Contact information (i.e., telephone number) for a hospital employee or office from which the person may obtain further information about SCH's Financial Assistance Policy and other discounts; and
4. The direct website where copies of the Financial Assistance Policy, Financial Assistance application form, and plain language summary of the Financial Assistance Policy can be obtained.

B. Additional Notice to Patients Who Have Not Provided Proof of Health Coverage

If a patient has not provided proof of health coverage by a third party at the time care is provided or by the time the patient is discharged, SCH's first post-discharge bill will provide the patient with a bill that contains a clear and conspicuous notice including the following information:

1. A statement of charges for the services provided;
2. A request that the patient inform the hospital if the patient has coverage for the charges through health insurance, a healthcare service plan, a government-sponsored healthcare program, or other coverage;
3. A statement that, if the patient does not have health insurance coverage for the charges, the patient may be eligible for (i) a government-sponsored healthcare program, such as Medicare, Medicaid, or CHIP, (ii) coverage offered through a Health Benefits Exchange, (iii) coverage through other state- or county-funded health programs (e.g., California Children's Services program) or (iv) Financial Assistance from SCH under its Financial Assistance Policy;
4. A statement indicating how patients may obtain applications for the programs listed in (3) above and that the hospital will provide the applications;
5. A referral to a local consumer assistance center;

6. The following information about eligibility for Financial Assistance at SCH and SCH'S Financial Assistance Application:

(a) A statement if the patient lacks, or has inadequate insurance and meets SCH's eligibility requirements, including low and moderate-income requirements, the patient may qualify for Discounted Care or Charity Care; and

(b) The name and telephone number of a hospital employee or office where the patient may obtain information about SCH's Financial Assistance Policy, an application for Financial Assistance and how to apply for that assistance.

(c) A statement that if a patient applies or has a pending application for another health coverage program while he or she applies for Financial Assistance, neither application shall preclude eligibility for the other program.

(d) A notice describing SCH's Uninsured Patient discount.

C. Estimate of Charges and Financial Assistance Application

Upon the request of an Uninsured Patient, SCH will provide the patient with

(1) a written estimate of the amount the hospital will require the patient to pay, based on the sliding scale, for the health care services, procedures, and supplies that are reasonably expected to be provided to the patient by the hospital, based upon an average length of stay and services provided for the patient's diagnosis and

(2) a Financial Assistance application. This provision does not apply to a patient who receives Emergency Care.

D. Actions Taken in the Event of Non-payment and Notice Prior to Initiating Extraordinary Collection Actions (ECAs)

At least 30 days prior to initiating ECAs, SCH or its Authorized Vendor will do all the following:

1. Provide the patient with a written notice ("ECA Notice") that will:

(a) Indicate that Financial Assistance is available for eligible individuals;

(b) Identify the ECA(s) that the hospital facility or Authorized Vendor intends to initiate to obtain payment for the care;

(c) State a deadline after which such ECA(s) may be initiated that is no earlier than 30 days after the date that the written ECA notice is provided;

2. Provide the patient with SCH's plain language summary of the Financial Assistance Policy with the written ECA Notice described above.

3. Make a reasonable effort to orally notify the patient about SCH's Financial Assistance Policy and how the patient may obtain assistance submitting a Financial Assistance application.

E. Authorized Vendors

SCH may use Authorized Vendors to produce and send letters, notices, and/or bills, or other statements to patients regarding amounts owed by the patient and to contact patients regarding payment of their unpaid bills. All Authorized Vendors will comply with this Billing and Collection Policy and SCH's standard procedures relating to all such communications.

Property Liens.

(a) SCH and its Authorized Vendors that are affiliates or subsidiaries of SCH will not place liens on the primary residence or conduct a sale of the primary of a patient eligible for Financial Assistance under the Financial Assistance Policy as a means of collecting unpaid hospital bills.

Wage Garnishments.

(a) SCH or its Authorized Vendors that are affiliates or subsidiaries of SCH will not file a writ of garnishment against a patient eligible for Financial Assistance under the Financial Assistance Policy as a means of collecting unpaid hospital bills.

(b) SCH's Authorized Vendors that are not affiliates or subsidiaries of SCH will not file a writ of garnishment against a patient eligible for Financial Assistance under the Financial Assistance Policy, unless such writ is by order of the court upon noticed motion, supported by a declaration filed by the movant identifying the basis for which it believes the patient can make payments on the judgment under the wage garnishment.