



Policy Name: Patient Financial Obligations	Originator: Chip Giffin	Origination Date: 07/12/13
Policy Section: Revenue Cycle Pod	Approved By: Chip Giffin, VP Revenue Cycle	Approved Date:
		Revised Date: 08/25/14, 7/27/15, 03/28/17, 04/16/17, 9/15/17, 1/22/18, 2/15/18, 2/12/19, 05/29/20, 06/25/20, 02/25/21

Policy: As a benefit and obligation to the community, the hospital recognizes its responsibility to provide medically necessary services and to provide financial assistance to patients paying for those services. As important, is the hospital's financial ability to provide future community benefits which necessitates that those with the ability to pay are required to do so and may be pursued to the fullest extent available within the laws of the Commonwealth of Pennsylvania governing debt collection. This policy will comply with all requirements of the IRS of a non-profit organization, and all other regulations, such as EMTALA, that relate to the provision of service.

Purpose: To provide a continuum of financial assistance/requirements across the entire patient experience at all service entry/delivery points that define the patient's financial obligations, provides the methodology for assistance, the available forms of assistance, and the processes to assist in the communication and understanding of the same by all involved.

Definitions:

Financial Assistance – Includes all forms of financial help for payment/resolution of patient liable balances including full or graduated reductions in liable balance or all payment arrangements.

Financial Liability - the amount calculated to reflect liability assigned to the patient. This may include full charges, discounted services after appropriate approved self pay discount is applied, or balance after patient's insurance has processed a claim. This may include unmet deductible, coinsurance, and copay assigned by the insurance carrier and is the patient's or guarantor's responsibility.

Pre-collect Amount – the amount of the patient liability that a hospital may require a patient to pay in advance of elective, non-emergent services. This will be determined by each individual POD hospital. (state here for each facility what their precollection percentage is)

Medically Necessary Services – Services provided that are supported by patient diagnoses that meet the current definitions as defined by Medicare and other accepted criteria used by the hospital. Services not meeting this definition include personal cosmetic and other services not required to treat a medical condition.

Emergency Care – Care provided in the section of the hospital designated as Emergency Room and/or those areas subject to EMTALA.

Guarantor – The person who is financially obligated to pay for out of pocket expense for services to the patient.

Financial Assistance Policy (FAP) – Term used by the IRS for the policy of providing assistance for those in need.

AGB – Amounts Generally Billed to those covered by insurance.

ECA – Extraordinary Collection Actions that cannot be taken before expiration of 240 days or when there is an open/unprocessed FAP application.

Presumptive Score – A numerical value of the guarantor's ability to meet financial obligations based on income and family size information adjusted for statistical validity for the community served by the hospital.

Surgical Services - All services that are defined in the HCPCS code range of 10000 – 69999 with the exclusion of venipuncture.

Writ of Body Attachment -It is the civil equivalent of a bench warrant issued by a court. Typically, it is used where someone has failed to obey a civil court order, such as not paying child support, refusing to turn over property or ignoring a subpoena. The Sheriff will arrest the miscreant and bring him before the judge to explain why he shouldn't be committed to jail for civil contempt.

I Requirements – General:

- 1) Patient obligations and related financial assistance levels is a continuum that is segmented enough to provide consistency as a guarantor's financial position moves from 100% debt forgiveness through relaxed payment arrangements to requiring the guarantor to seek alternative external financing.
- 2) The framework for the determination of 1) above is found in Appendix A. Each hospital and other covered entities will independently determine the percentages of the poverty used for the graduated benefit/requirements as needed to meet their FAP and financial goals of their respective organizations.
- 3) Each hospital will also identify the calculations used for determining the AGB, identify an effective date, record this information on Appendix A, and distribute the information each time there is a change. This calculation can be adjusted as needed but should be reviewed at least annually. The person assigned this duty will be responsible for providing written notification to the POD Director of Access along with an explanation of the calculation that will be posted on the hospital's web site. The POD Director of Access will provide this information to the hospital's web site maintenance owner.
- 4) The providers included in the hospital FAP will be identified in Appendix A . The complete listing of providers, whether or not covered by this policy that perform services within the entities included in this policy will be maintained by the medical staff office or as assigned by the CFO. This listing will be posted on the hospital's web site and printed listings will be available by request from the office of the CFO. Reference copies of the policy will also be maintained by each financial counselor.
- 5) Medical savings, reimbursement and all other similar accounts must be depleted prior to providing any type of financial assistance. The exception to this rule is the utilization of a presumptive score for active lower balance accounts or for all accounts upon return from the primary bad debt agency.

- 6) All Charges will be posted in a consistent manner regardless of the available insurance, available coverage and/or the patient's ability to pay.
- 7) Patient with no insurance coverage will have an adjustment applied to the gross charges as determined by the individual hospital. The amount billed to a patient with no insurance represents each hospital's respective AGB – Amounts Generally Billed to those covered by insurance. See Appendix A for calculation method, amount for current fiscal year, and effective date. AGB discounts may be separate amounts for inpatient and outpatient services. A separate adjustment code will be used for the reduction of the balance to the AGB. AGB amounts are not to be classified as bad debt or charity (PFA) but is classified as uncompensated care.
- 8) Pennsylvania Medicaid Fee Schedules may not include items and services which are then considered grouped into the payment received for other services paid under the fee schedule. Services not included on the MA Fee Schedule are required to be adjusted and those amounts are to be classified as uncompensated care. A separate adjustment code having a description of "Not On MA Fee Schedule" will be used to adjust the impacted charges.
- 9) For patients that have insurance coverage, the financial assistance is limited to defined patient liabilities (deductible, coinsurance, co-pay) and non-covered services. Patient liabilities, including deductible and coinsurance required by both public and private insurance payers in which the hospital has a contractual relationship. An approved FAP may also include non-covered charges for days exceeding the length-of-stay limit for patients covered by Medicaid or other indigent care programs, if known. For those with an approved PFA application at the time of the insurance payment, the amount of patient liability will be compared to the AGB as if the patient did not have any insurance. The patient liability will be reduced to the AGB when it exceeds the AGB. The same process will be followed for subsequent PFA approved applications as they are determined. A spreadsheet with the calculations will be made available to the financial counselors to assist with this review process. Spreadsheet layout can be reviewed in Appendix D.
- 10) Valid health insurance coverage will be accepted in lieu of immediate payment and a claim will be sent on behalf of the patient provided that the patient fully cooperates with any and all requirements needed to process the claim including but not limited to:
 - a. Steps necessary to obtain required notifications, authorizations, or approvals.
 - b. Provide accurate and comprehensive demographic and insurance information.
 - c. Assignment of insurance benefits.
 - d. All necessary information releases.
 - e. Prompt responses to insurance and/or hospital correspondence or communication necessary to adjudicate the claim such as COB questionnaires, etc.

Failure to adequately or promptly respond to these requirements may require a demand of immediate and full payment of the account balance. No self-pay discounts would apply as the insurance should remain on the account and the balance moved to the patient responsibility. In addition, acceptance of the insurance does not lessen the financial obligation of the debtor.

- 11) Patients have the right to refuse insurance coverage for specific services. Due to the various legal requirements of this option, adherence to the following is required:



- a. This is only an option for elective services. No emergency related services may use this option
- b. This option is not available when a government insurance is on the account regardless of payer priority,
- c. This option must be elected individually for each account.
- d. An insurance named “Self Pay by Request” (do not update Demo recall) will be added to the account so that:
 - i. An insurance is never added to the affected account after this option is elected.
 - ii. All other parties that process the account can easily identify that this option was elected.
- e. Medical records for these services cannot be sent to the patient’s insurance carrier. Releasing medical records to their insurance for a patient selecting this option may create a HIPAA disclosure violation.
- f. The option must be elected prior to the service and prior to providing insurance information that has been eligibility verified and/or used to obtain authorization.
- g. Payment in the amount of 100% of the AGB calculated amount must be provided at the time of election as a deposit toward the financial settlement of the account. Any difference in actual AGB amount post service will be due and payable.
- h.

12) Balances after an insurance claim has processed will be billed to the patient based on the type of coverage or denial classification as determined in Appendix C. Additional explanations to Appendix C are as follows

- a. **NON-COVERED** Services denied as non-covered (No benefit type denial) will be considered as no benefit coverage was available for that type of service. Non-covered denials will not be considered provider liable regardless of contractual language or misclassification of the denial by the insurance coverage entity.
- b. **EXPERIMENTAL** Services classified by an insurance company as experimental will be patient liable provided that the service is a medically acceptable practice. However, the insurance coverage entity should use a denial that is classified as Medically Appropriate. All other cases will be the considered a non-covered service and therefore a patient liability as the insurance has deemed the service to be non-covered based on their benefit determination.

13) An AGB adjustment is applied regardless of the guarantor’s ability to pay and will be reversed when insurance coverage payment becomes available on the account. This adjustment does not apply to patient liabilities identified through a claim adjudication process or for when the patient elects not to use insurance coverage that is valid at the time of service.

- 14) The amount of approved financial assistance (debt forgiveness) will be classified/adjusted as charity but referred to in all communications as patient financial assistance.
- 15) Financial assistance applicants that make any material misrepresentations will result in the reversal of approval and denial of open applications. Any related reductions will be reversed and the applicant will be barred from participation for a period of 3 years.
- 16) There are two independent approval processes to identify financial assistance: 1) an approved Financial Assistance Application, and 2), a Presumptive Charity Score. For each process, a unique transaction code will be used to relieve the financial obligation on the account
 - a. The Financial Assistance Application process is available from the inception of the account to the 120th day from placement of any open balances with the Primary Bad Debt Collection Agency. Full and partial PFA benefits are available using this process.
 - b. The Presumptive Charity Score process occurs upon the return of uncollectable accounts from the Primary Bad Debt Collection agency. No reference is made to any Patient Financial Application processes or decisions as the score is a stand-alone independent identifier and approval of charity. Only full PFA benefit is available using this process. The utilization of the score is as follows:
 - i. Accounts with Medicare - all valid amounts are to be posted using the Medicare Bad Debt–score transaction code as indigent cases. Remaining account balances not eligible for Medicare bad debt are to be posted to the charity –score transaction.
 - ii. Accounts with dual eligibility - all valid amounts are to be posted using the Medicare Bad Debt–score transaction code as dual eligible cases. Remaining account balances not eligible for Medicare bad debt are to be posted to the charity–score transaction.
 - c. Under no circumstances are the same balances to be considered for both charity and Medicare bad debt (mutually exclusive).
 - d. Transaction codes will be established to differentiate/classify and support the varying definitions of charity and bad debt only when other information on the account cannot be used for such differentiation/classification. This position is necessary to keep the number and adjustment definitions at levels that promote accuracy and minimize confusion.
- 17) Patients may request the plain language summary and/or the entire PFO policy. Both will also be posted on the hospital's web site. Although historically hospitals have provided non-interest-bearing loan arrangements in the form of accepting monthly payments (with or without approval), the patient liability shift necessitates the reinforcement of the following payment arrangement requirements:
 - a. The monthly payment amount requirements are indexed using the poverty levels and family size to determine the minimum amount. This provides a method of automatically adjusting the required minimum monthly payment for new payment arrangements. This indexing only applies to current debt being considered for payment arrangements and is not retroactively

applied to previously accepted existing payment arrangements without a discussion with the debtor to consolidate the payment arrangement

- b. Payment arrangements must be approved by the hospital and are not automatically accepted based on consecutively received monthly payments. Statement messaging will be configured to communicate this requirement. Monthly payment minimums identified in Appendix A are considered extended payment arrangements. All other cases must be paid within 90 days or the guarantor must seek alternative financing through a bank or like financial entity that provides loan services. Only if a guarantor receives and produces a copy of a loan denial will hospital extended payment arrangements be considered. Need to resolve this with b above
- c. Each hospital may participate in debt financing of the patient liabilities however all returned debt may immediately be placed with a collection agency as bad debt regardless of the time period (subject to governmental reimbursement requirements).
- d. Agreed upon payment arrangements only include the debt at the time of the payment arrangement. The guarantor will need to discuss any new debt and seek a new payment arrangement.

18) Prompt pay discounts are not available and are not to be offered. However, a settlement (accepting less than full payment of balance as payment in full) may be considered on individual cases provided that the following conditions are met:

- a. The patient balance on the account(s) represents a minimum of 150% of the current year's part A deductible. Settlements are not available for smaller balances.
- b. Settlements that are less than 90% of the open balance require the approval of the CFO.
- c. Settlements cannot be combined with any type of extended payment arrangements.
- d. The payment must be received within 10 days of the settlement agreement.
- e. The discount is not taken until the settlement amount is received.

19) Settlement campaigns of payment arrangement accounts exceeding 6 months in duration may be occasionally offered. However, this approach should not be routine or be on a fixed schedule to avoid payment delays (awaiting a scheduled campaign).

20) Catastrophic circumstances may justify financial assistance to an individual that falls outside the score and/or income levels established in this policy. For these extenuating situations, patient financial assistance adjustments may be given upon documented recommendation of revenue cycle leadership and approval by the CEO or CFO. Criteria for determining such catastrophic circumstances is based on the judgement of the executive for the situation but should be a rare occurrence.

21) Agreements with the Amish or other groups that self-fund their health insurance expense are processed like other contracts and are excluded from this process when a financial agreement exists with the family clan or governing body.

- 22) Patients who choose to restrict the reporting/sharing of all medical information will:
- Be advised that such a restriction will not be in effect until total payment is received for all restricted services
 - Service that requires prepayment will require 100% payment of the estimated amount prior to performing the service or the service will be re-scheduled. Patients who drop the privacy restriction will only be required to pay the amounts designated in section VI using the hospital specific matrix.
- 23) No information obtained from this process may be disclosed to any party that is not a part of their position responsibilities. Inappropriate disclosure will result in disciplinary action and/or dismissal.

II Patient Financial Assistance Application Approval Process:

- Financial Assistance provided to the patient in the form of balance forgiveness (charity) may be determined by application that indicates the patient's ability to pay.
- The Financial Assistance application process includes the following:
 - A completed application is presented to a Financial Counselor. The application form must be completed in its entirety. (See Appendix B)
 - All supporting documentation is required with the application form, including proof of income and proof of assets
 - Financial Counselor will review and verify the completed application and supporting documentation, using the Financial Assistance application checklist and guidelines. (See Appendix B)
 - Determination will be made as to the patient's eligibility and level of balance forgiveness for which the patient qualifies.
 - Copies of application and supporting documentation will be retained by the facility for as long as record retention policies dictate.
 - Open balance accounts will be reviewed for qualification of balance forgiveness and appropriate adjustments will be made.
 - Patient will be notified in writing of the determination whether approved or denied for Financial Assistance.
 - Patient will be instructed to present the letter of notification of eligibility or issued Financial Assistance card, when registering for services at the respective facility. The letter is valid for Medicare patients for a period of 1 year and non-Medicare for a period of 6 months. All letters presented with an expired date will be removed from the account and the patient advised to re-apply.
- Automatic approval for financial assistance may occur using a charity scoring system under the following circumstances:

Reclassification of Bad Debt to Charity using Presumptive Charity:

- a. Guarantors may be scored to determine a presumptive approval for charity at the time the account is returned from the primary bad debt agency.
- b. The referral for review of the scoring process will occur after the first placement collection agency has completed their attempts to collect and before placing the account with the second collection agency.
- c. A presumptive score will work independent of the application process for only this population of patients to avoid excessive administrative expense of reviewing each account for application history.
- d. A presumptive charity score may be used as an indicator to pursue/encourage the completion of an application for financial assistance.

This process should not be used to determine assistance eligibility for current or future services.

III Requirements – Communication:

- 1) The hospital will widely publicize the Patient Financial Assistance policy by completing the following:
 - a. Make available paper copies of the application when requested and provide the Patient Financial Obligation Policy without charge to distribute by mail, in person and at locations in the hospital.
 - b. Notification by way of postings.
 - c. Document the activities used to inform the community served about the program on a minimum of an annual basis. Information provided on the hospital web site and other electronic media on the policy and how to obtain additional information.

IV Requirements – Emergency Care:

- 1) No financial interactions will occur before patient is medically screened and stabilized. Once a patient has been stabilized, in accordance with EMTALA, conversations regarding patient liability payments will only occur during the discharge process.
- 2) Patients will be registered as soon as possible without interfering with the provision of care.
- 3) *Financial counseling:* Patient is offered information regarding the provider's financial counseling services and assistance policies upon request
- 4) *Prior balance and patient share discussions:* These discussions will occur upon discharge. All hospital employees will provide the support necessary to ensure that the patient returns to the discharge area. This stipulation will be implemented based on the schedule for each hospital as it is dependent upon the transition of the community toward increased payment obligations and the skills of the employees necessary to administer this provision. The provider representative will:
 - a. Provide as much information as possible about patient's likely financial obligations, including a list of the types of service providers that typically participate in the service both verbally and if the patient requests, in writing.
 - b. Inform patient that actual charges may vary from estimates depending on actual services performed or timing issues with other payments affecting the patient's deductible.

- c. *Balance resolution:* Once the provider organization has fulfilled the best practice steps as outlined above, it is appropriate to inquire about how the patient would like to resolve the balance for the current service and any prior balance the patient may have.

V Payment Requirements – Advance of Care (Large Dollar Cases):

- 1) The scope of services for this section of the process includes scheduled high dollar services including but not limited to:
 - a. Inpatient elective
 - b. Outpatient Surgery included under the definition of surgery
 - c. MRI/CT/PET and any other hospital defined procedures
 - d. Nuclear stress testing
 - e. Chemotherapy
 - f. Radiation therapy
 - g. Infusions involving high dollar drug therapies.
 - h. Any other hospital specific identified tests.
- 2) Services considered to be personal cosmetic and personal services require 100% of the estimated charges be paid prior to receiving the service.
- 3) Non Emergency Room services will be considered elective and are subject to the requirements contained in this Advance of Care section.
- 4) Services are to be scheduled in advance as much as possible but a minimum of 7 days is preferred in order to ensure ample time to provide the patient with complete financial counseling and assistance.
- 5) Prior to service payment requirements are identified in Appendix A by hospital. This includes the minimum payment amounts when either time or information is unavailable to determine the patient's ability to pay. The following process will be used when advance payment requirements are not met;
 - a. Advise the ordering/scheduling physician that the service may be re-scheduled due to advance payment requirements.
 - b. If the ordering/scheduling physician is in disagreement with re-scheduling the patient, they will contact the hospital's chief clinical representative which would include the Medical Director, or clinical coverage person (VP Nursing or similar position) and discuss the medical needs of the patient. Should the re-scheduling delay be unacceptable, the clinical justification should be communicated to the Patient Financial Counseling representative to approve the elective service without meeting the minimum pre-service payment requirement. All referred cases that are approved in this manner will be tracked and submitted at least on a monthly basis to the hospital CFO. Review of these cases by the hospital's executive team is recommended to ensure an acceptable level of application of the intent and requirements of this process.
- 6) Patient Financial Interactions in Advance of Service

- a. Appropriately trained provider representatives will have these discussions with the guarantor. Guarantor should be given the opportunity to request a patient advocate or family member to assist them in these conversations.
 - b. Discussions will occur using the most appropriate means of communication for the patient. These conversations may take place via:
 - i. Outbound contact to patient in advance of a scheduled service.
 - ii. Inbound contact from patient inquiring about their upcoming service.
 - iii. Scheduling / Contact center when appointment is made.
- 7) All discussions with patients will occur as early as possible, taking place before a financial obligation is incurred up to the point at which care is provided. Timely discussions will ensure patients understand their financial obligation and providers are aware of the patient's ability to pay.
- 8) All representatives will maintain a record of conversations that occurred with the patient so that these conversations will not occur again.
- 9) The representative will first gather basic registration information including, insurance coverage, as well as determining the potential need for financial assistance.
- 10) The representative will review insurance benefit details with the patient to ensure information accuracy. Uninsured patients will be informed the goal of collecting information is to identify paying solutions or financial assistance options that may assist them with their obligations for this visit.
- 11) Guarantor is offered information regarding the provider's financial counseling services and assistance policies.
- 12) *Financial counseling:* Patient is offered information regarding the provider's financial counseling services and assistance policies.
- 13) *Prior balance and patient share discussions:* These discussions will occur once the provider organization has fulfilled the previous best practice requirements. Interactions will not interfere with patient care and will focus on patient education. During patient share and prior balance interactions, the provider representative will:
- a. Provide as much information as possible about patient's likely financial obligations, including a list of the types of service providers that typically participate in the service both verbally and if the patient requests, in writing.
 - b. Inform patient that actual costs may vary from estimates depending on actual services performed or timing issues with other payments affecting the patient's deductible.
 - c. Ask the patient if they are interested in receiving information regarding payment options.
 - d. Ask the patient if they are interested in receiving information regarding the provider's financial assistance programs.
- 14) *Balance resolution:* Once the provider organization has fulfilled the best practice steps as outlined above, it is appropriate to inquire about how the patient would like to resolve the balance for the current service and any prior balance the patient may have.

- 15) Upon request, the patient will receive in writing, information regarding the provider's supportive financial assistance programs, and a summary of the financial implications for the services rendered, including a phone number to call with questions.

VI Requirements – At Time of Service (Non-Emergency Care):

- 1) All co-pays are due at the time of service and are to be requested prior to completing the service.
- 2) Patient will be expected to provide any and all information required for a complete and accurate claim, including active insurance information, to Patient Access staff during the registration process.
- 3) Refusal to provide insurance information or to allow billing to available active insurance will result in implementation of the Self Pay By Request process. (APPENDIX E)

VII Requirements – Collection Process:

- 1) Patients will receive a minimum of 4 statements over a period of 120 days prior to consideration for placement as bad debt with a third-party agency.
- 2) Accounts associated with the same guarantor may be tied or grouped for the purpose of consolidated statement processing and for attempting to contact the guarantor. Other than the first notice of payment from the patient, new accounts entering the self-pay collection cycle will be moved to the progressive step of existing accounts in the active collection flow. The hospital reserves the right to move active self-pay account balances directly to bad debt when repetitive and current account history indicates defiant and consistent avoidance in the resolution of account balances.
- 3) Guarantors who explicitly state that they will not pay the account and will not make any arrangements to pay the account may be placed directly to a final notice status without completion of the normal collection flow.
- 4) Returned mail for which a correct address cannot be obtained will also be sent directly to a bad debt agency for skip trace processing.
- 5) Patients who are insulting and/or abusive may be disconnected after professional attempts have been made to advise the patient to refrain from such activities. The account may be placed directly to a final notice status without completion of the normal collection flow.
- 6) The hospital reserves the right to record telephone conversations provided the notice requirements have been fulfilled.
- 7) Partial payments on an account that are not part of an existing approved payment arrangement will be considered as payment on account and are not to be construed as an acceptance to a payment arrangement or the prepayment of future payment arrangement requirements. Subsequent statements will so advise the guarantor to avoid any misunderstanding of an offer and acceptance.
- 8) Partial payments will be applied to the oldest account in the self-pay flow so to ensure appropriate statement messaging and support character recognition and payment allocation technology. Exceptions to this requirement would be web and IVR payments that are account specific. However, the statement messages are not to be reset unless the minimum payment requirements of an agreed upon payment arrangement are satisfied.

- 9) ECAs or extra collection actions are not permitted when a PFO application has been received during the first 240 days of a collection cycle. The collection cycle includes both active and bad debt periods. ECAs include, but may not be limited to:
- a. Place a lien on an individual's property
 - b. Foreclose on an individual's real property
 - c. Attach or seize an individual's bank account or other personal property
 - d. Commence a civil action against an individual,
 - e. Cause an individual's arrest,
 - f. Cause an individual to be subject to a writ of body attachment
 - g. Garnish an individual's wages
 - h. Reporting to credit agencies.
- 10) The self-pay collection flow will be as follows to ensure compliance to Medicare and 990 requirements:
- a. Medicare patients should receive a patient balance statement within 90 days of Medicare payment or 60 days of a secondary/tertiary claim payment when such insurance exists.
 - b. Active self-pay collection flow will be a minimum of 120 days. A minimum of 4 statements will be sent with the third as a Final Notice and the fourth as a Third Party Collection attempt. Outbound phone attempts may occur at any time after 10 days from the initial statement. PFA applications will be accepted during this entire period.
 - c. Accounts not paid or in an acceptable payment arrangement will be referred to a primary collection agency (bad debt) for a period of 6 months. No ECAs are permitted during this period. PFA applications not completed during an above period will be continued through this period. New PFA applications will be accepted during this period through the first 120 days of placement. All incomplete and open PFA applications at 150 days old will be sent a letter to request the application be finished or it will automatically be denied at the end of the 6 month placement cycle.
 - d. All balances returned in step c above will be placed with a second agency (bad debt). No PFA applications will be accepted or processed during this period. All ECAs that are approved by the hospital will be utilized during this period. All secondary placements will be immediately reported to the credit reporting agencies.

Requirements – Responsible Parties:

PFO Process Updating	PMHA VP Finance/Revenue Cycle
PFA Application and Procedure	RC Pod Director Access
Emergency Care Policy	Hospital Assignee: Director Emergency Services
Community Needs Assessment	Hospital Assignee: Hospital Executive Team
AGB Discount:	
Percent Calculation	Hospital Assignee: Controller/Director Reimbursement
System Updating	Hospital Assignee: Onsite Rev Cycle Supervisor
Outreach:	
Publications	Hospital Assignee: Public Relations
Website	Hospital Assignee: CIO Assignee
Handouts	Hospital Assignee: Onsite Access Supervisor
Signs	Hospital Assignee: Public Relations



Appendix A

Punxsutawney Matrix									
Part A Deductable	1,556								
Score									
Poverty Level Percent	100%	150%	200%	250%	300%	350%	400%	450%	500%
Family Size									
1	12,880	19,320	25,760	32,200	38,640	45,080	51,520	57,960	64,400
2	17,420	26,130	34,840	43,550	52,260	60,970	69,680	78,390	87,100
3	21,960	32,940	43,920	54,900	65,880	76,860	87,840	98,820	109,800
4	26,500	39,750	53,000	66,250	79,500	92,750	106,000	119,250	132,500
5	31,040	46,560	62,080	77,600	93,120	108,640	124,160	139,680	155,200
6	35,580	53,370	71,160	88,950	106,740	124,530	142,320	160,110	177,900
7	40,120	60,180	80,240	100,300	120,360	140,420	160,480	180,540	200,600
8	44,660	66,990	89,320	111,650	133,980	156,310	178,640	200,970	223,300
Financial Assistance									
Reduction Percent	100%	100%	90%	80%	0%	0%	0%	0%	0%
Minimum Monthly Payment									
Monthly Pmt Min %	0.0%	0.0%	0.5%	1.0%	2.0%	2.5%	3.0%	3.5%	4.0%
Monthly Payment Min Amt									
Family Size									
1	-	-	37	93	223	326	447	586	744
2	-	-	33	84	201	293	401	527	669
3	-	-	30	74	178	259	356	467	593
4	-	-	26	65	155	226	310	407	517
5	-	-	26	65	155	226	310	407	517
6	-	-	26	65	155	226	310	407	517
7	-	-	26	65	155	226	310	407	517
8	-	-	26	65	155	226	310	407	517
Pre-Service Payment Requirements									
Min % of Est Liability	0%	0%	25%	25%	25%	30%	35%	40%	45%
Min % of Prior Bad Debt	0%	0%	25%	25%	25%	30%	35%	40%	45%
Percent and maximum amount when ability to pay is unknown:					45%	to max of	\$ 1,184		

Appendix A Continued

Presumptive Charity Information

Fiscal Year	Vendor Used	Process/Population Used	Effective Date	Cut Off Score Value

AGB Calculation:

Fiscal Year	Calculation Method	Effective Date Claim Date	AGB Percent
	EXAMPLE: Annually updated based on data from cost accounting module of Meditech from the previously completed fiscal year. All accts are included except Medicaid, Medicare, Medicaid Managed Care, and Self-pay. Total payments collected are divided by the total charges and that reciprocal is used as the respective 501R discount percentage.		
2022	Inpatient		36%
	Outpatient		68%
	Home Health		4%



Appendix B

FINANCIAL ASSISTANCE APPLICATION

APPLICANT INFORMATION

Name:		
Date of birth:	SSN:	Phone:
Current address:		
City:	State:	ZIP Code:
Cell Phone:	E-mail Address:	

EMPLOYMENT INFORMATION

Please indicate if you are Employed/Retired/Disabled:		
Current employer (I/A):		
Employer address:		How long?
City:	State:	ZIP Code:
Position:	Annual income:	

HOUSEHOLD CO-APPLICANT INFORMATION

Name:		
Date of birth:	SSN:	Phone:
Current address:		
City:	State:	ZIP Code:

EMPLOYMENT INFORMATION

Please indicate if the co-applicant is Employed/Retired/Disabled:		
Current employer (I/A):		
Employer address:		How long?
City:	State:	ZIP Code:
Position:	Annual income:	

ADDITIONAL HOUSEHOLD MEMBERS AND INCOME, IF ANY

Name	Relationship to Applicant and Age	Annual Income

OTHER ASSETS OR SOURCES OF INCOME - **(SEE "PROOF OF ASSETS" ON CHECKLIST)**

Description	Amount per month or value



FINANCIAL ASSISTANCE APPLICATION

ACCOUNTS RELATED TO APPLICATION REQUEST **(FOR OFFICE USE ONLY)**

Patient Name:	Account no.	Date of Service:	Amount:

I certify that the above information is true and accurate to the best of my knowledge. I will exhaust all other sources of assistance such as Medicaid, Medicare and/or the Exchanges which may be available for payment of my hospital related services.

I understand that this application is completed so that the hospital can determine my eligibility for uncompensated health services under the hospital's established Financial Assistance guidelines. If any of the information I have given proves to be untrue, I understand that the hospital can re-evaluate my financial status and take whatever action becomes appropriate.

Signature of applicant

Date

Signature of co-applicant, I/A

Date

ELIGIBILITY DETERMINATION (FOR OFFICE USE ONLY)

Date Received: _____

Verification Completed: Yes ____ No ____

The applicant was approved for a reduction of _____% of allowable charges. Date approved: _____

The applicant was denied for the following reason(s)

Date of Denial _____

Date Applicant Notified of Determination _____

Individual Completing Review: _____

Appendix B Continued

Financial Assistance Application Check List

Verification of the following information is needed to complete your application for Financial Assistance:

- Proof of Medical Assistance application may be required if applicable
 - Proof of Income:
 - Household income household income is defined as all income for individuals in the household who have a tax/taxable relationship to the patient. (File joint return or is a dependent on another individual's return) This follows the same definition guidelines as PA Medicaid.
 - Income Tax Return, most recent. (if applying in first three months of calendar year)
 - Pay Stubs and/or Unemployment Compensation Income statements for the past three months (for applications April through December)
 - Unemployment Compensation
 - Social Security verification
 - Pension
 - Workers Compensation
 - Sick Benefits
 - Self-Employment
 - Rental Income
 - Child Support
 - Interest or Dividends
 - Any other income into the household
 - MA162 with income information
 - Payments from personal insurance policies that provide additional income or payment to defray medical related incident costs.
 - Proof of Asset (Balance of \$10,000/individual or \$15,000/couple not eligible for Assistance)*
 - Checking Account – most recent statement
 - Savings Account – most recent statement
 - Certificate of Deposit (CD)
 - US Savings Bond
 - Stocks or Bonds
 - HRA, HAS, FSA, or any medical savings account

Disclaimer Points:

1. You must apply within 240 days from date of self-pay balance or application will be denied.
2. Any material misrepresentations will result in the reversal of approved applications, and denial of open applications. Any related reductions will be reversed and the applicant will be barred from participation for a period of 3 years.
3. Services considered to be personal and/or cosmetic will not qualify for Financial Assistance.
4. Medical savings, reimbursement and all other similar accounts must be depleted prior to providing any type of financial assistance

Appendix B Continued

Financial Assistance Guidelines:

Household size includes:

- Guarantor that is not claimed on another individual's income tax
- Child over 18
- Disabled over 18
- Emancipated Minor

Dependents defined as:

- Applicant/Co-applicant – significant other at the time of the application
- Child- income tax or proof of child support

Automatic Eligibility:

- Scoring Results

Not Qualified:

- Cosmetic Surgery
- Pre-Collection Amounts
- Amish and/or like contract
- If any data is misrepresented
- If Medical Savings Account Exists with Balance
- Medicaid denial not related to low income, i.e. incomplete application

Medicaid Application

Medicaid Applications are required for high dollar encounters, i.e. Inpatients, Observation, SDC's (Same Day Outpatient Surgeries)

Accounts with no insurance until presumptive scoring is used for automated approvals of financial assistance for active accounts (non-bad debt).

MA application is required if patient's anticipated liability for ordered future elective service is \$2000 or more. If patient refuses to apply for PA Medicaid, patient is not permitted to apply for Financial Assistance.

If household income is equal to or less than 140% of the FPG and patient has accounts less than 90 days old, MA application is required prior to FAP.

If household income is equal to or less than 140% of the FPG and patient has no accounts less than 90 days old, MA application is not required prior to FAP

Approval Period:

Medicare eligible individual – 1 year (Recommend anniversary month of patient's birthday)

Non-Medicare individual - 6 months

Insurance will be deleted from demo recall based on the expiration dates.

Appendix C

Denial Categories

Classification	Denial Type	Patient Liable		Comments
		Non-regulatory Ins	Regulatory Ins	
Authorization	Clinical	No - unless ABN	No - unless ABN	Billable to patient if no contract exists or is out of network and is considered medically acceptable practice
Billing	Administrative	No	No	
COB	Administrative	No	No	Possibly billable to patient if non-cooperative with providing necessary information
Coding	Clinical	No	No	
Documentation	Clinical	No -unless ABN	No - unless ABN	
Duplicate Claims	Administrative	No	No	
Eligibility	Coverage	Yes	Yes	
Exhaust Benefits	Coverage	Yes	Yes	
Experimental	Coverage	Yes	No - unless ABN	Cannot bill Medicare or Medicaid without advanced notice
Info Request NP	Administrative	No	No	Possibly billable to patient if non-cooperative with providing necessary information
Medical Necessity	Clinical	No - unless ABN	No - unless ABN	Billable to patient if no contract exists and is considered medically acceptable practice
Non-covered	Coverage	Yes	No - unless ABN	Patient does not have benefit coverage for this service. Cannot bill Medicare or Medicaid without advanced notice or the items are considered exclusions
No Pay Claim	Administrative	No	No	
Other Adjustment	Administrative	No	No	
Pending	Administrative	No	No	
Payer Initiated	Administrative	Yes	No	Patient is liable if initial payment is reversed for coverage reasons
Reductions				
PMT Reduced	Administrative	No	No	Possibly billable only if no contract exists
Registration	Administrative	No	No	
Review Required	Administrative	No	No	
Untimely Filing	Administrative	No	No	Billable if no contract provision to the contrary exists or the patient is not cooperative
PR	Coverage	Yes	Yes	



Appendix D

501r AGB Discount Calculation For Balances after Insurance.

	Calculation	
a Total Account Charges		
b AGB Payment Rate		
c AGB Discount Amount	$= (1-b)*a$	-
d Maximum Amount Billed to Patient (AGB)	$= a-c$	-
e Account Balance Due From Patient		
f Percent Charity Discount		
g Charity Discount Amount	$= e*f$	-
h Balance of Patient Liability	$= e-g$	-
i Amount of AGB Discount (calculate difference only when line 22 exceeds line 12)	$= h-d$	
j Max Billable to Patient	$= h-i$	-

Appendix E

Process Name: Registration for patients refusing assignment of available insurance or presenting with non-par or out of network insurance; use of insurance titled Self-pay By Request

Origination Date: 4/7/17

Revision Date: 9/13/17

Process: Insurance titled Self-pay By Request will be used for registration of patients under the following circumstances:

1. Patient refuses to allow use of existing and active medical insurance
2. Patient has insurance the hospital is not contracted with, and for which the hospital is deemed to be out of network by the payer.

Scope: Patient Access, Financial Counseling, Patient Accounting

Owner: Deb Mumper, Director POD Patient Access

Process Steps – Patient Access:

1. If patient presents for elective services and refuses to provide insurance information and states or requests that available active insurance not be billed for this service, patient must be informed that he/she must see Financial Counseling for an estimate of charges for service ordered, and arrange for prepayment of 100% of estimated charges before service will be provided.
2. Patient Access Rep may create a Pre-registered or Pended account and use insurance “Self-pay by Request”. This insurance will prevent a self-pay discount from posting (uses separate billing rules from routine self-pay) and make the patient responsible for full charges.
3. If patient presents with acknowledgement of responsibility signed with and witnessed by a financial counselor, patient will be registered with insurance Self Pay By Request, using the pre-registered account number written on the form.
4. If patient is registered in error using an out of network insurance, and claim is denied, Patient Access will receive a task from Patient Accounting to add Self Pay By Request to the insurance. Task will be completed and Patient Accounting will rebill the account accordingly.

Appendix E Continued

Process Steps – Financial Counseling:

1. If patient requests to be registered without using available insurance, patient may present to Financial Counseling for an estimate of charges for ordered services.
2. Financial Counselor will determine approximate charges for services ordered and inform the patient.
3. Financial Counselor will advise patient that payment must be made in full prior to service being rendered. Patient will also be advised that the quote is for an estimate and that actual charges may not be exactly as quoted. Any balance will be billed to the patient and any credit will be refunded if the patient has no other outstanding balances with the hospital.
4. Patient will be advised that insurance will not be billed by request after the date of service.
5. Patient will be asked to sign an acknowledgement of responsibility separate from the registration consent form. This acknowledgement should be signed and witnessed by the financial counselor, and patient should present this form with physician order, to register for elective service.
6. Financial Counselor will create a preregistered outpatient account. Prepayment will be posted to that account. Account number will be written on the signed acknowledgement of patient responsibility form and a copy provided to the patient. The acknowledgement will be scanned to the account.

Process Steps – Patient Accounting

1. Patient Accounting will recognize that use of the insurance “Self Pay by Request” indicates that the patient has requested that available insurance not be billed for this service. It will also insure that no discounts are applied to the account balance.
2. Upon any inquiry, patient will be reminded that insurance was not billed per the patient’s request and confirm that balances are patient responsibility.
3. Credit balances will be submitted per protocol for refund to the patient or applied to other outstanding self-pay balances.



Appendix E Continued

HOSPITAL LOGO HERE

ELECTION TO SELF-PAY FOR ELECTIVE SERVICES (Non-Medicare Patient With Insurance)

Patient Name _____ Date of Birth _____

Hospital Account Number _____ Date of Service _____

Elective Service Requested _____

1. I am requesting elective services at _____ [hospital name].
2. I understand that my insurance will **not** be billed for the charges associated with the requested services for the following reason (choose one):
 - 2.1 _____ I am choosing to receive elective services at this hospital knowing that the hospital is out of my insurance plan network, causing services to be noncovered.
 - 2.2 _____ I am electing this option due to having a High Deductible Health Plan and I waive the use of that insurance for the account at any time, understand that a claim will not be submitted, and the related services will not be applied to my deductible.
 - 2.3 _____ I do not wish to have my insurance plan billed and elect to assume full responsibility for the charges associated with this service.
 - 2.4 _____ The service is not covered by my insurance.
3. I will be solely responsible for payment of the AGB amount and agree to meet the hospital's terms for prepayment of the estimate of charges. I understand that the charges quoted to me are an estimate. I will receive a bill for any balance remaining for this encounter.
4. I understand that my insurance will not be billed or added at a later date, medical records will not be sent to my insurance, and I am not covered by any government funded insurance programs.
5. This form does not apply to emergency services. If I go to the hospital seeking treatment for a possible emergency medical condition, the hospital will provide an appropriate medical screening exam regardless of my ability to pay.

Patient Signature _____ Date _____

Witness _____ Date _____