Patient Financial Services

Policy Title: Upfront Collections Policy
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Updated by: Luke Kelland, Director of Revenue Cycle

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 co-payment for facility services rendered.

D. The patient has a penalty for out-of-network services (if Elbert Memorial 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 2023 is $1600.00.

B. Medicare Outpatient Co-insurance
The Medicare outpatient co-insurance is 20% of the charge for the procedure. Please refer to the either the EZ Cost Estimator or the machine readable chargemaster, both available on the EMH website,
Please advise the beneficiary that this is an estimated out-of-pocket expense. If the liability is greater, the patient will be billed for the balance. If it is less than the collected amount, the patient will be refunded the excess amount or applied to other accounts owed by the patient, if any.

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. Please refer to the patient eligibility screen on the Georgia MMIS (GAMMIS)

D. Commercial and Managed Care Payers
Confirm patient's responsibility or out of pocket expense/price on the insurance card, by verifying this electronically via eligibility reports or on payer website or contacting the payer. Verify if there is 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 advisory of, and attempt to collect, all out-of-pocket expenses for all patient 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 self-pay rates. (SEE FINANCIAL CLEARANCE POLICY)

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

Pre-admissions

Elbert Memorial Hospital will pre-register all elective services when possible. The method of payment should be identified prior to the patient being admitted wherever possible, 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 Registration clerk 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 Registrar 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 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".

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.

Outpatient Services Not Scheduled

When a patient presents for outpatient services that have not been scheduled and pre-registered, the Registrar 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 have the private pay discount applied and attempt to collect the amount due.

Managed Care Agreements/Commercial Insurance:

For patients with insurance, the hospital has specific managed care agreements. The patient's responsibility will be determined by the third-party insurance 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 Elbert Memorial 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:

Elbert Memorial 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 the Elbert Memorial Hospital policy, a Financial Payment Agreement can be arranged by the Financial Counselor and approved by the Director of Revenue Cycle or Designee, at the patient's request.

Documentation:

All conversations between Elbert Memorial 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 Discounts:

When a private-pay patient is notified of their financial responsibility for the current visit the following steps should be taken:

1. Elbert Memorial Hospital will never bill any uninsured or financial-assistance-eligible individual more than the average amount generally billed (AGB) to someone who is insured.
2. AGB is determined using a 'look back' method, where past claims for all commercial and governmental payors are reviewed to compute the average discount. For the 12-month period ended April 30, 2022 the average discount was 60%, which is what will be applied to uninsured and financial-assistance-eligible accounts.
3. If the private pay patient is unable to pay at the time of service, they will be referred to the Financial Counselor and according to the Financial Assistance Policy (FAP) will be screened for financial assistance eligibility and for Medicaid eligibility according to the terms of the FAP. 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 below.

FINANCIAL ASSISTANCE PROGRAMS AND ELIGIBILITY CRITERIA

This Policy identifies those circumstances when EMH may provide care without charge or at a discount based on a patient's financial need. Proof of residency is required for qualification into any of the following programs:

- Presumptive Charity Care- Hospital bill is reduced by 100% on an episode basis for uninsured patients only, who are presumed eligible and not required to complete an application because the patient is receiving benefits from one of the following programs or is in the following situation:
  - Homelessness
  - Deceased patients with no estate
  - Mentally incapacitated with no one to act on the patient's behalf
  - Confirmation of income below 138% of poverty level
  - Other circumstances may qualify on a case-by-case basis

EMH will apply the stated presumptive eligibility criteria to uninsured patients as soon as possible after they receive health care services from EMH.

- Financial Assistance - Hospital bills are reduced on a sliding scale from 138%-250% based on the Federal Poverty Guidelines, subject to submission of all required documentation (see below section on required documentation). Financial Assistance may be applied after primary insurance payment to cover deductibles, coinsurances, and copays.
  - Family income is equal to or less than 138% of the Federal Poverty Guidelines

- Procedure/Requirements: The hospital Patient Registration personnel should attempt to identify potential uncompensated care upon admission or outpatient registration. The Patient or Patient Representative can complete the application and return it within 30 days of the first post-discharge bill, or the application may be done in writing or orally by the Financial Counselor.
- With the patient's permission, the Financial Counselor may ask for submission of the most recent Federal Income Tax Return in determining income or may assist the patient in filing for Medicaid. After determination of classification of eligibility, the patient should be notified with the appropriate form. (Attached are forms for each specific eligibility or ineligibility).
- A patient's medical needs will receive first priority in all cases, and only after needs have been determined will the patient's ability to pay be determined.
- Out of County residents will not be considered for Financial Assistance/Charity Care, only Elbert County residents are eligible. Exceptions for out-of-county residents must be approved by the Director of Revenue Cycle on a case-by-case basis.
- Applications can be accessed on the hospital website, by email request, at each Registration area and by mail at no charge.
- Each Registration area must have a notice posted regarding the offering of Charity and Financial Assistance. Statements also must offer the availability of both.
- Doctors, Lab, and Radiology Facilities that are used within the hospital are notified of our charity approval for each patient. Each contracted Facility/Doctor uses their own guidelines for approving charity and will bill separately for the services provided.
- Approval is good for 1 year from the date of the approval.

❖ Accepted Documents
- Pay Stubs
- Employee W-2 Forms
- Federal income tax return
- Statements from employer
- Social Security Award Letter, benefit payment check
- Unemployment compensation letter
- Bank Statements

SERVICES ELIGIBLE UNDER THIS POLICY

For purposes of this policy, "financial assistance" or "charity" refers to healthcare services provided by EMH without charge or at a discount to qualifying patients. The following healthcare services are eligible for charity:

- Emergency medical services provided in an emergency room setting.
- Services for a condition which, if not promptly treated, would lead to an adverse change in the health status of an individual.
- Non-elective services provided in response to life-threatening circumstances in a non-emergency room setting; and medically necessary services, evaluated on a case-by-case at EMH's discretion.

COLLECTIONS AND OTHER ACTIONS TAKEN IN THE EVENT OF NON-PAYMENT

EMH has the right to pursue collections directly or through a third-party collection agency. If the Financial Assistance Application Form is not completed by the specified deadline, EMH will pursue collections from the patient. EMH may list a patient's account with a credit agency or credit bureau. EMH reserves the right to attach liens to insurance (auto, liability, life, and health) in connection with its collections process to the extent a third-party liability insurance exists. No other personal judgements or liens will be filed against FAP-eligible individuals. No collection action will be initiated until at least 120 days after EMH provides its first post-discharge billing statement. No collection action will be initiated against accounts that are statue barred.

AVERAGE AMOUNT GENERALLY BILLED (AGB)

Elbert Memorial Hospital will never bill any financial-assistance-eligible individual more than the average amount generally billed to someone who is insured. AGB is determined using a 'look back' method, where past claims for all commercial and governmental payors are reviewed to compute the average discount. For the 12-month period ended April 30, 2022 the average discount was 60%, which is what is applied to those financial-assistance-eligible accounts.

CONFIDENTIALITY

EMH respects the confidentiality and dignity of its patients and understands that the need to apply for financial assistance may be a sensitive issue. EMH staff will provide access to financial assistance related information only to those directly involved with the determination process and will comply with all HIPAA requirements for handling personal health information.

CONTACT US

To obtain a copy of the financial assistance application, please visit www.emhcare.net. Paper copies of the application are also available in the following locations:

Emergency Department
Outpatient Registration
Patient Financial Services

Completed Applications should be returned or mailed to:

Elbert Memorial Hospital
4 Medical Drive
Elberton, Ga. 30635

ATTN: Aimee Kennedy
Certified Financial Counselor
Direct line: 706-213-2599
Fax: 706-283-8609

For billing or applications questions contact the Certified Financial Counselor.