



Patient Financial Services – Hospital Financial Assistance, Charity Care, Billing & Collection Policy

Dates Previously Reviewed/Revised:
Newly Reviewed By:
Effective Date: December 1, 1997
Review Date: August 15, 2012
F&A Committee Approval: September 21, 2012
Board of Trustees Approval: September 27, 2012

Owner: Director of Patient Financial Services

Approver Title: Chief Financial Officer

Approval Signature

Scope: Anne Arundel Medical Center

Policy Statement:

To promote access to all for medically necessary services regardless of an individual's ability to pay, to provide a method of documenting uncompensated care and to ensure fair treatment of all applicants and applications

Purpose:

- To assure the hospital communicates patient responsibility amounts in a fair and consistent manner.
- To provide opportunity to resolve questions regarding charges or insurance benefits paid.
- To assure the hospital meets the requirements of Maryland standards for hospital billing and collection practices
- To provide opportunity to resolve questions regarding charges or insurance benefits paid.
- To define the hospital's decision making process for referral for collection or legal action.
- To assure the hospital meets the requirements of Maryland standards for hospital billing and collection practices

Hospital Financial Assistance Communications

- The Financial Assistance Signage is conspicuously displayed in English & Spanish in the Emergency Department, Cashiering & Financial Counseling.
- Financial Assistance Policy as well as a printable Uniform Financial Assistance application is posted on the AAMC website.
- English/Spanish table top tents display this information at every patient entry point and it is included in each patient guide located in the inpatient rooms.
- Registration staff and Financial Coordinators are trained on how to refer patients for financial assistance.
- The financial assistance application is available at all registration points – but in particular the Emergency Department.

- A brochure “What you need to know About Paying for Your Health Services” is available at every patient access point. The brochure was developed by Patient Financial Services with guidance from Public Relations. This brochure includes information regarding financial assistance/contact points and is available in English/Spanish. Also, it is posted on AAMC’s website.
- It is mandatory that all inpatients receive the “What you need to know about paying for your health services” brochure as part of the admission packet.
- Informational “business cards” are available through the patient access/registration staff to provide to the uninsured or any individual concerned about paying their hospital bill directing them to the hospital Financial Counseling office for assistance.
- Hospital Patient Financial Service staff receive extensive training on the revenue cycle and are incentivized to obtain AAHAM Technical (CPAT) certifications to demonstrate their expertise in billing and revenue cycle requirements.

Charity Care

- **Determination of Probable Eligibility:** Within two business days following a patient’s request for charity care services, application for medical assistance, or both, the hospital must make a determination of probable eligibility.
- AAMC provides 100% charity to individuals with household income at or below 200% of the US Poverty guideline but deemed ineligible for any County, State or Federal Medicaid or other funding program.
- AAMC provides 100% charity to individuals enrolled in the Medicaid Primary Adult Care program and other means tested State & Local programs.
- AAMC provides a sliding fee scale for individuals with household income at or below 330% of the US poverty guideline but deemed ineligible for any County, State or Federal Medicaid or other funding program.
- AAMC provides financial assistance not only to the uninsured but to patients with a demonstrated inability to pay their deductibles, copayments and balance after insurance.
- The hospital excludes assets such as the patient’s primary home, method of transportation and cash assets less than \$15,000.
- For all income levels, AAMC will take into account special circumstances such as the amount of the bill compared to income and cumulative impact of all medical bills.
- AAMC developed an initiative with the A.A. County Department of Health to help provide free prenatal diagnostic testing for uninsured unregistered immigrants. These individuals are not eligible for any Medicaid program.
- AAMC participates with an Anne Arundel County specific program (REACH) administered through the AA County Department of Health to provide free care to low income uninsured or under-insured individuals (below 200% of the US Poverty Guideline). These individuals come to AAMC on an elective basis and are prescreened by the local Department of Social Services.
- Diagnostic and Treatment services are provide free of charge to referrals from the AAMC Outreach Free Clinic initiative located in downtown Annapolis.
- Payment plans, Interest Free

Billing

Patient Statement of Charges:

- A Summary Bill of charges, formally referred to as the Uniform Summary Bill is mailed to every inpatient within 15 days of discharge from the hospital. This contains information on the insurance company billed as well as how to contact the Patient Financial Services office for questions or assistance.
- Uninsured patients receive this Summary as well
- Each bill for outpatient services includes detail charge information on the first request for payment.
- At any time, the patient may request a copy of their detailed itemized bill.
- The HSCRC required Patient Billing Information sheet data is printed on the Uniform Summary Bill and the back of all patient billing statements.
- A representative list of services and charges is available to the public on the hospital's website and in written form. The website will be updated quarterly with the most recent average charge per case for each of the services.
- Requests and inquires for current charges for specific procedures/services will be directed to the ACP Financial Coordinator or if applicable the specific department Financial Coordinator. The Coordinator will communicate with the patient and the patient's provider of care to provide the best possible estimate of charges. Using the CPT code, service description and/or other supply/hospitalization time charge estimates are based on, a) review of the charge master for the CPT code/service description, and/or b) review of cost of similar surgical procedures/treatments/hospital stays. The patient will be informed cost quotes are estimates and could vary based on the actual procedure(s) performed, supplies used, hospital stay/OR time & changes in HSCRC rates. If the Coordinator requires guidance or additional information to provide the estimate he/she will contact the Reimbursement Department. Every effort will be made to respond to the request for charges within 2 business days depending on information needed to fulfill the patient's request.

Patient Balance Billing:

- From the point in which it is known that the patient has a balance for which they are responsible the hospital begins billing the patient to request payment.
- Each patient receives a minimum of 3 requests for payment over a 90 day period.
- Each patient bill includes contact information for financial assistance and states where to call to request a payment plan.
- Each bill informs the patient they may receive bills from physicians or other professionals.
- Short and Long term interest free payment plans are available. The hospital takes into account the balance of the bill and the patient's financial circumstances in determining the appropriate agreement.
- Should the patient contact Patient Financial Services Customer Service unit regarding inability to pay – financial assistance is offered and the financial assistance screening process begins.

Collection Agency process:

- If there is no indication from the patient or a representative that they cannot pay and no attempt at payment or reasonable payment arrangements is made, the account is referred to a collection agency.

- The collection agency referral would typically occur between 90 – 110 days from the first request to the patient to pay assuming the patient made no attempt to work out payment arrangements or indicated financial need.
- The final statement to the patient communicates the account will be referred to an external agency if the balance is not satisfied.

Collections

- The Director of Patient Financial Services oversees the hospital's business relationship with the Collection Agency.
- AAMC does not utilize a credit reporting bureau.
- AAMC does not charge interest to patients
- The collection agency performs a financial checkpoint before taking the next step to legal action.
- AAMC staff reviews each case before being referred for legal action
- The collection agency is educated on how to make referrals to AAMC's financial counseling department for individuals indicating they have an inability to pay.
- The collection agency will establish payment arrangements in compliance with AAMC's interest free commitment.
- As a last resort, AAMC will file suit for collection of debts.
- If the court makes judgment in the hospitals favor – a formal legal credit mark referred to as a “judgment” is placed on an individual's credit and remains intact for 10 years. Once the full payment is made the patient may request that the judgment reflects as satisfied on the credit rating.
- AAMC will file suit against estates and in some cases, when appropriate, trust funds.
- AAMC does actively enforce a lien against an individual's primary home.