Jackson County Memorial Hospital Collection Policy

Purpose

Recognizing that the primary objective of Jackson County Memorial Hospital is to provide excellent care to the residents of Southwest Oklahoma and North Texas in a fiscally responsible manner, the Board of Trustees of Jackson County Memorial does hereby adopt the following policies concerning collection for services rendered to patients.

Policy

The Revenue Cycle Department is committed to the financial well being of Jackson County Memorial Hospital and to ensuring that all accounts are processed and paid in a timely manner. Revenue Cycle staff will work with hospital staff, patients, medical staff, third party payers, governmental agencies and others involved in the payment process in an ethical and professional manner. Financial assistance for some patients must be balanced with broader fiscal responsibilities in order to keep the hospital's doors open for all who need care.

PATIENTS SEEKING EMERGENT CARE AND URGENT PATIENTS:

JCMH will provide emergency services regardless of the patient's ability to pay for those services consistent with our organizational mission and in compliance with applicable Federal and State regulations. When a patient presents for treatment at the JCMH Emergency Room, the patient's presenting complaint, demographic, and insurance information will be collected in order to create a medical record for the ER staff's use. The treatment of an emergent patient will never be delayed in order to obtain or verify financial information or to collect payment for services. Only after the medical screening examination has been completed and the patient has been stabilized, will JCMH Revenue Cycle staff notify and work with patients to resolve their insurance and financial requirements.

NON-EMERGENT UNSCHEDULED PATIENTS:

Patients are expected to resolve their financial obligations, as identified in the collections guidelines section of this policy, 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 reviewed for delay, rescheduling or cancellation as appropriate.

NON-EMERGENT SCHEDULED PATIENTS:

Patients are expected to resolve their identified financial obligations to JCMH at or before time of service. Upon receipt of a request for scheduling of non-emergency services, the method of payment will be established by the Admissions/ Scheduling/ Financial Counseling staff. Elective inpatient surgery, same day surgery and outpatient procedure patients must be pre-admitted by 6:00 p.m. two business days prior to the scheduled procedure. If the patient does not resolve the account(s) as defined within the financial policy guidelines, the service request may be reviewed for delay, rescheduling or cancellation as appropriate.

I. Collection Guidelines

A. Patients are responsible for providing accurate third-party coverage information to hospital admission personnel. Coverage will be verified and pre-certification requested as necessary by the Admission, Scheduling or Financial Counseling staff. Prior to (or at) the time of service, deductibles and estimated co-pays will be collected. If a patient is unable to pay the estimated amount due, satisfactory payment arrangements must be made. Deposits are not required for patients with Medicare, Medicaid or Tri-care coverage.

B. JCMH Physician Clinics may either decline to see or schedule as "cash only" patients with bad debts. If an existing clinic patient is turned to bad debt, they will receive written notice that services may be suspended or discontinued. Those patients who meet EMTALA criteria will be treated regardless of their financial status.

C. Permission for assignment of third-party coverage of benefits will be obtained on the admission face sheet or JCMH clinic demographic and consent form. All claims filed will indicate that JCMH has an assignment of benefits, which will notify the payer to make all payments to JCMH.

D. Although the hospital bills third party payers on the patient's behalf, the responsibility for payment is ultimately the patient's (or responsible party's). The admissions form includes an agreement to pay for services that all patients (or responsible party) must sign. In general, the assignment of benefits is considered acceptable for 60 days before the outstanding balance is determined to be the patient's responsibility. Other methods of payment are cash, check, and credit card (Visa, Mastercard, Discover).

E. Work related injuries will be treated as third-party insurance claims. It is the patient's responsibility to provide JCMH with all appropriate information. Benefits should be confirmed within 48 hours of admission to the hospital. If worker's compensation is denied and alternative insurance information is provided, the JCMH Revenue Cycle staff will bill the alternate insurance. Otherwise, the patient will be responsible for all outstanding balances.

F. In the case of services provided to treat injuries due to a vehicle accident or injury with a third party liability, JCMH will hold patients responsible for their bill. Liens may be filed against insurances or with attorneys. Since such cases may require many months to resolve, JCMH will not wait for final legal decisions. Payment arrangements should be made on such accounts to prevent them from becoming past due.

G. Patients with no third party coverage are generally expected to pay in full at time of service or at the time of billing. If a patient is unable to pay the estimated amount due, a 45% deposit and satisfactory payment arrangements must be made or the patient may complete a Financial Assistance Application to be evaluated.

H. Account balances outstanding beyond 60 days from the date of billing may be assessed an interest rate of 10% per annum. If interest is charged, full disclosure under the Consumer Credit Code will be satisfied. All collection activities at JCMH will comply with the Fair Debt Collection Practices Act of 1978.

I. The following payment schedule is acceptable for self pay balances:

Balance	Maximum Months to Repay	Minimum Payments
Up to $600	6	equal monthly installments but not less than $10.00
$600 to $1200	12	equal monthly installments
$1201 +	18	equal monthly installments

J. Financial counseling/admissions staff will evaluate all patients presenting as self pay for potential Medicaid coverage. Applications for coverage are available in the admissions area and all staff are trained to assist patients with completing and submitting Medicaid applications.

k. Any patient (or the patient's legal representative) seeking financial assistance from the hospital shall provide the hospital with accurate and complete information concerning health benefits coverage, financial status and any other information that is necessary for the hospital to make a determination regarding the patient's status relative to the hospital's charity care policy or eligibility for government-sponsored programs.

l. Patients with insurance who have estimated co-pay and deductible amounts greater than $50.00 may be eligible for a 15% discount if paid at time of service and a 10% discount if paid within 30 days of first statement mailing as an incentive to pay the entire amount due in full. Patients without insurance (self-pay patients) who have an estimated self-pay balance greater than $50.00 may be eligible for a 25% discount if paid at time of service and a 10% discount if paid within 30 days of first statement mailing as an incentive to pay the entire amount due in full. There must be a clear understanding that the offer is for a specific time frame and payment in full must be received before the discount will be given.

m. Account balances or $10 or less may be considered immaterial and written off as a "small balance write-off".

n. When it is in the best interest of the hospital, account balances may be discounted/adjusted as an "administrative adjustment" by the Director of Revenue Cycle, with the approval of the Chief Financial Officer.

o. In addition to the financial arrangements and payment expectations extended to all other patients, JCMH employees are also eligible for payment through payroll deduction. Payroll deduction is offered on an interest-free basis to all current employees. Arrangements for this benefit may be made in the Revenue Cycle department.

p. At the discretion of Senior Management, non-emergent services may be provided to patients who do not (or cannot) make satisfactory financial arrangements. Services will not be withheld, for financial reasons, from any patient 16 years of age or younger.

q. At the discretion of the Director of Revenue Cycle, JCMH may accept reduced payments and/or waive interest on a patient's account. Adequate documentation must be obtained to demonstrate that the patient cannot make regular payments, and the Director must conclude that such action would be in the best interest of the hospital.

r. Patients struggling to pay delinquent accounts may be referred to Consumer Credit Counseling Service. JCMH will accept payments from patients actively participating in this program without further collection efforts.

s. Accounts in self pay status with balances over 60 days old that are not meeting minimum payment requirements may be classified as bad debt and turned to a collection agency or referred to the hospital attorney for collection purposes.

t. Legal action, including the garnishment of wages, may be taken to enforce the terms of the payment plan when there is evidence that the patient or responsible party has sufficient income and/or assets to meet his or her obligation. The hospital will not place a lien on a patient's primary residence if this is the patient's sole real asset, unless the value of the property indicates the ability to assume the financial obligation.

II. OK Self-pay Discount/Charity Care Programs

A. OK Self-pay Discount -In 2006, Oklahoma House Bill 2842 established a discount program for qualified self-pay patients. Patients that complete the financial assistance application process may be approved for a discount based on the estimated Medicare cost of the treatment provided through this program as long as the following criteria is met:
   1. Patient or responsible party must request a discount on the balance owed.
   2. Patient or responsible party's income must fall below 300% of poverty guidelines. Documentation must be submitted with the financial assistance application to show proof of this income.
   3. Patient does not have third-party insurance coverage or access to a third party insurance plan.
   4. The Director of Revenue Cycle, CFO or another member of Executive Management has approved the financial assistance application.

B. Charity care is that portion of services provided by the hospital for which a third-party payer is not responsible and a patient has the inability to pay. Charity care will be granted on a per admission basis and is not necessarily granted for subsequent hospital visits. The follow types of patients may be eligible for charity care:
   1. Patients with a yearly income that falls below current federal poverty guidelines
   2. Patients who qualify for Medicaid but for whom the hospital does not receive compensation for all charges.
   3. Patients who are not insured or are under-insured, do not qualify for state or federal programs, and based on analysis of their financial situation, it is determined that full payment of the hospital bill would cause excessive financial hardship.
   4. Patients who are assigned to the hospital contracted collection agency. The agency may also screen for charity care and refer them back to the hospital.
   5. Patients may be screened for and/or identified for charity by Revenue Cycle staff or other hospital staff members.
   6. Other circumstances at the discretion of the Director of Revenue Cycle and CFO.

   A completed application for financial assistance is required for charity care, with the following exceptions:
   1. Patients already qualified for Medicaid
   2. Incarcerated patients whose care is not eligible for payment through the corrections department.
   3. Patients in nursing homes with minimal available funds.
   4. Deceased patients with no estate.
   5. Patients referred for testing through the Jackson County Free Care Clinic

C. Patients applying for financial assistance or charity care will be notified of their eligibility within 14 working days of receipt of a completed financial assistance application.

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