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Mat Su Regional Medical Center Collection Cycle Policy

The following is a brief summary of Mat Su Regional Medical Center's standard collection cycle.

Scheduled services are pre-registered in advance of the service date. Insurance is verified, an estimate is created and a search for other open-balance accounts is conducted. Patients are called in advance of their service date and given the estimated amount they will owe when they present for service. The hospital provides Online Pre-Registration services.

During the registration process, the registrar will gather employer information for both the patient and guarantor. Copies of the insurance card and a driver's license or picture ID will be taken. Payer plans are established based on the insurance/employer and are tied to a 'contract' in the contract management system, if the payer is a contracted payer. As the registration proceeds past the screen where the insurance information is input, if the payer is set up to send an eligibility transaction this will be done automatically as the registrar proceeds in the registration. A response is brought back to the registrar usually before the registration is completed, listing coverage and benefits. The registration clerk can use this information to complete an estimate for the patient. Medical Necessity checking is conducted in advance for Medicare outpatient services.

AR is stated at gross and contractual discounts are not posted until the payment is received. Payers who are set up to provide electronic remittance advices (ERAs) provide payment and contractual discount information on their remittances and both are posted by the ERA software. Uninsured patients receive an 'uninsured discount' which is posted at time of final bill.

Charges are generated through 'order processing', keyed through 'data entry' from charge tickets, or automated through the system, such as room and board charges.

The bill hold period after discharge is 2 days for non-Medicare patients and Medicare Inpatients; 5 days for Medicare Rehab and PSY patients and 3 days for outpatient Medicare patients. The 3 day hold for outpatient Medicare patients allows us to comply with the Medicare 3-day payment window rule.

Staff are to make consistent effort to collect estimated patient amounts due in advance of service or at discharge. Tools have been provided that allows the staff to provide 'estimates' based on services as well as integrated insurance coverage and benefits to allow for a more precise estimate of the patient's responsibility.

Patients who cannot pay are referred to a financial counselor and/or ESS, our self-pay screening vendor, to determine if the patient may qualify for Medicare, Medicaid, Undocumented Alien

1011 program, or any other Federal, State or Local program coverage. During the screening process, staff will determine if the patient qualifies for the hospital's financial assistance/charity care program or hospital discount program (if applicable). Patients who do not qualify for any form of assistance and have no resources available to pay are offered payment arrangements.

Online Payment services are available to our patients.

At the end of the collection letter cycle, accounts are referred to our internal collection agency, PASI, for processing. The collection letter cycle is defined as 120 days minimum from the first statement mailed to the patient, to the date the account is placed for collection and written off to bad debt.

All self-pay balances receive a minimum of 5 statements. The letters are spaced 28 days apart. Medicare patients, who owe balances after Medicare payment, receive only 4 statements. All letters contain information on how to contact the hospital if they are unable to pay and information regarding the availability of financial assistance. Once the final letter is mailed notifying the patient that their account will be turned over for collection if not paid, the account is held a minimum of 14 days to allow time for payment. During this 14 day period, the Business Office Manager, or designee, will review accounts and have the ability to place accounts on hold. Otherwise, if not paid, and not placed on hold, the account is then moved to the internal collection agency, Professional Account Services, Inc (PASI).

Patient accounts with no insurance, are placed with ESS, our self-pay screening vendor, for follow-up when staff was not available at time of service, or when the patient leaves without seeing the screening vendor. The screening vendor, ESS, continues to attempt to contact the patient to determine if they may qualify for third party coverage, financial assistance, etc. ESS may refer accounts to a secondary eligibility vendor from time to time to see if they are successful in contacting patient and obtaining third party coverage or financial assistance applications. This contact is occurring simultaneous with the letter cycle. If contact has not been successful by the end of the letter cycle, ESS, or secondary eligibility screening vendor, closes and returns the account when it prelists for placement with the internal collection agency. If contact has been made and the patient appears to qualify for coverage in one or more program, ESS staff will change the financial class from self-pay to 'pending Medicaid' or 'pending financial assistance/charity', for example, and will continue following the account until all required information is received to make a final determination.

After insurance pays, account balances are reviewed to determine if the remaining balance is the patient's responsibility. If so, the financial class is changed to self-pay after insurance, or self pay after Medicare.

Bankruptcy accounts as well as 'deceased, no estate' accounts are immediately moved to a protected bad debt financial class where statements and letters cease.

All governmental insurance accounts as well as financial assistance/charity accounts are protected from receiving any collection letters, as long as they remain in a governmental insurance financial class or financial assistance financial class.

At any point in the active receivables collection cycle or within 240 days from the first statement date, if the patient indicates an inability to pay, the patient is screened for the financial assistance program.

During the registration process, all self-pay accounts and Medicare, MVA, and Liability accounts with no secondary insurance are automatically checked for Medicaid coverage. In addition, the screening vendor and hospital staff can check for Medicaid or other insurance coverage at any time after registration. Periodically 'batch' status reports are ran against the Medicaid eligibility system since patients often become eligible for Medicaid after the service is delivered but coverage is retroactive to cover the hospital service date.

Within the collection cycle, various 'hold' options have been developed to allow staff to interrupt the automated collection cycle. For example, staff can stop an account from receiving letters, or stop all activity on an account, including placement of an account with our internal collection agency. Accounts on 'hold' are monitored on a monthly basis to determine if the 'hold' needs to be removed.

Accounts that are placed with the internal collection agency will remain a minimum of 6 months (with some exceptions). If PASI has not been able to establish suitable payment arrangements within the 6 month period, the account will be screened for potential litigation. Accounts that meet the criteria for suit will be forwarded to the facility representative for approval. If no payments or suit has been initiated within the 6 months, PASI will close the account and place with the secondary collection agency. The secondary agency has 18 months to attempt to collect the bill or secure payment arrangements. If payment arrangement is not initiated by the end of the 18 months, or if litigation has not been approved, the account is closed as 'uncollectible'.

Once accounts are returned as 'closed/uncollectible', all collection efforts cease.