BETHESDA HEALTH

Subject:	**Self Pay and Flat Rate Service Prices**		
Operations Regulation:	**1039**		
Department of Origin:	**Patient Access**		Effective Date: June 2013 Revised: February 14, 2014
DIVISIONS:	☐ **System**	☒ **Hospital**	☐ **Women's Health**
	☐ **Focus Fin**	☐ **BMA**	☐ **Bethesda Health City**
Approved by:	**Roger L. Kirk, President & CEO**		

I. PURPOSE:

This Policy and Procedure is established to provide transparency for Self Pay patients in regards to service rates and fees, patient's rights and collection practices. Outlined are operational guidelines for Bethesda Health Inc. (BHI) to accurately provide "Self Pay" rates for uninsured patients or insured patients seeking non-covered or elective care services and provide transparency for Patients seeking liability estimates for care provided at BHI. This policy shall also outline Self Pay Patients "rights" and identify if and when services may be constricted, if reasonable payment security for services is not identified, and how a patient's financial responsibility will be managed.

II. PRINCIPLES

BHI seeks to provide a reasonable and competitive rate for services provided to patients who do not have insurance coverage or choose not to utilize insurance for the services being provided. These rates offered will reflect a fair market price which should offset the cost for providing service and further the mission to expand and provide the best possible care to the community. BHI seeks to provide fair and consistent care and collections practices for all patients who seek care.

SELF PAY PATIENTS RIGHTS

Patients or Guarantors who are insured and do not provide adequate information required to bill Insurance Payers for services provided or knowingly receive care outside the coverage of their Insurance Payer will be directly billed utilizing the outlined rates. Uninsured emergent care patients who are Financially Indigent or Medically Indigent may qualify for charity care (free care) or financial assistance may be subject to discounts from the base Self Pay Rates.

BHI evaluates the delivery of health care services for all patients who present for services regardless of their ability to pay. However, non-emergent or non-urgent health care services (i.e., elective or primary care services) may be delayed or deferred based on the consultation with the hospital's clinical staff and, if necessary and, if available, the patient's primary care provider. The hospital may decline to provide a patient with non-emergent, non-urgent services in those cases when the Hospital is unable to identify a payment source or eligibility in a financial assistance program.

The urgency of treatment associated with each patient's presenting clinical symptoms will be determined by a medical professional as determined by local standards of practice, national and state clinical standards of care, and the hospital medical staff policies and procedures. Further, all hospitals follow the federal Emergency Medical Treatment and Active Labor Act (EMTALA) requirements by conducting a medical screening examination to determine whether an emergency medical condition exists. It is important to note that classification of patients' medical condition is for clinical management purposes only, and such classifications are intended for addressing the order in which physicians should see patients based on their presenting clinical symptoms. These classifications do not reflect evaluation of the patient's medical condition reflected in final diagnosis.

For those patients that are uninsured or underinsured, the hospital will work with patients to assist with finding a financial assistance program that may cover or finance some or all of their unpaid hospital bill(s). For those patients with private insurance, the hospital must work through the patient and the insurer to determine what may be covered under the patient's insurance policy. As the hospital is often not able to get this information from the insurer in a timely manner, it is the patient's obligation to know what services will be covered prior to seeking non-emergency level and non-urgent care services.

III. POLICY

Self-Pay Rates

Standard Self Pay rates are derived utilizing averages which reflect the previous fiscal years realized reimbursement for insured services received from Insurance Payers and the Patient residual collected on accounts. These averages utilize Medicare and Major Commercial / Managed Care Contracts rates active with BHI for the measurement period. Averages do not include Government payers (e.g. Medicaid) which reimburse below the cost to provide care. For simplification, Self Pay rates are provided in a Medicare Payer format utilizing DRG (Diagnosis Related Group) and APC (Ambulatory Payment Classification) based rates for Inpatient and Outpatient services. Rates will be evaluated each Fiscal Year and adjusted as necessary to reflect current average reimbursement levels.

INPATIENT SERVICES

Service	Rate	Rate Basis
Inpatient Services	DRG Schedule	Private pay rate is based on average total reimbursement by DRG for Medicare and Managed Care Inpatients combined. Data is collected through data warehouse reporting, based on a 12 month report selection period that is run 3 months after the final month of the selection period.

OUTPATIENT SERVICES

Service	Rate	Rate Basis
Outpatient Services	120% of APC Schedule	Private pay rate is based on average total reimbursement per case for Medicare and Managed Care Outpatients combined (Financial Classes D, H, L, N, P, Y). The aggregate per case rate calculated is compared to the per case rate for cases only reimbursed based on the latest APC schedule. The APC private pay rate schedule is adjusted up or down to achieve an aggregate per case rate equal to the Medicare and Managed care combined average per case reimbursement rate. Data is collected through data warehouse reporting, based on a 12 month report selection period that is run 3 months after the final month of the selection period.

Self-Pay Flat Rates

Rates that are not easily calculated utilizing DRG or APC tables or are typically bundled for simplicity and are provided as a "Flat Rate" which covers all Hospital based services. Flat Rates may be set in a manner to remain market competitive with Acute and Non-Acute care settings and may or may not reflect average reimbursement. Patients may receive additional billing statements from other healthcare providers related to treatment, including but not limited to Anesthesia, Radiology, other Specialty Physician services, Durable Medical Equipment or Rehabilitation services. Flat rates may or may not include follow up services related to the entire continuum of treatment which may include: rehabilitation, long

term care, infusion, pharmaceutical maintenance, implants, durable medical equipment, etc. Rates reflect normal treatment scenarios with no Complications or Comorbidities which may extend typical treatment intensity or timeframes.

Operating Room Surgical times may be estimated at the time of services but not guaranteed. Operating Room Services may include a fee of $200 for additional supplies. Inpatient overnight stays related to surgical services will include an additional $900 / day fee.

Self-Pay Flat rates must be accompanied with a signed patient / guarantor agreement to be extended. See Attachments OR1039A, OR1039B, OR1039C, OR1039D and OR1039E.

IV. PROCEDURE

Pre Service Estimation Process

Self-Pay and Flat Rate pricing can be obtained by calling or visiting BHI customer service or Outpatient Scheduling at (561) 732-2455 or 888-732-2455. Patients, Guarantors or Advocates may be required to provide detailed information in order to provide accurate Self Pay estimates which may include; Primary and Secondary Diagnosis, Procedure Name and or Code(s), primary or referring physician information, age, and relevant medical history.

BHI Customer Service and Outpatient Scheduling departments will utilize financial liability calculating software to estimate Inpatient and Outpatient pricing for non-flat rate services. A Patient estimate may be provided in written format with pricing limitation and expiration noted.

BILLING AND COLLECTION PRACTICES FOR ALL UNINSURED PATIENTS, INCLUDING THOSE WHO QUALIFY AS FINANICALLY INDIGENT OR MEDICALLY INDIGENT UNDER THIS POLICY

Fair and Respectful Treatment

Uninsured patients will be treated fairly and with respect during and after treatment, regardless of their ability to pay.

Trained Financial Counselors

All uninsured patients at BHI will be provided with financial counseling, including assistance applying for state and federal health care programs such as Medicare and Medicaid. If not eligible for governmental assistance, uninsured patients will be informed of and assisted in applying for charity care and financial assistance under the hospital's charity care and financial assistance policy. Financial counselors will attempt to meet with all uninsured patients prior to discharge from BHI.

Additional Invoice Statements or Enclosures

When sending a bill to uninsured patients, BHI should include (a) a statement on the bill or in an enclosure to the bill that indicates that if the patient meets certain income requirements, the patient may be eligible for a government-sponsored program or for financial assistance from the BHI under its charity care or financial assistance policy; and (b) a statement on the bill or in an enclosure to the bill that provides the patient a telephone number of a BHI employee or office from whom or which the patient may obtain information about such financial assistance policy for patients and how to apply for such assistance.

Hospital Billing and Collection Procedures

a. An initial bill will be sent to the responsible party for the patient's personal financial obligations.

b. The Hospital will issue subsequent billings at least every 30 days and for a minimum of 120 days after the initial bill before referring an account to an external collection agency. The patient will receive a plain language summary of the financial assistance policy with all, and at least 3, billing statements.

c. The statement or billing notices may be accompanied by telephone calls, collection letters, personal contact notices, and any other notification method that constitutes a genuine and reasonable effort to contact the party responsible for the obligation.

d. The Hospital will document alternative efforts to locate the party responsible for the obligation or the correct address on billings returned by the postal office service as "incorrect address" or "undeliverable" that is otherwise considered a "bad address." Alternative efforts may include use of skip tracing methods, use of the internet, post office records or other purchased or widely available means of tracing a patient or guarantors residence or point of contact with the intent of collecting outstanding debt or notifying them of options and other programs of public assistance that may be available to them.

e. Documentation of continuous collection action undertaken on a regular, frequent basis will be maintained by paper or electronic media.

f. The patient's file will include documentation of collection effort including bills, follow - up letters, telephone and personal contact; will be maintained until an audit is complete.

g. The Hospital will reserve the right to sell uncollected debt to a third party agency after a period of 18 months from the initial statement.

Reasonable Collection Efforts

a. The minimum requirements before writing off an account to the Bad Debt include:

1. An initial bill to the party responsible for the patient's personal financial obligations

2. Subsequent billings, telephone calls, collection letters, personal contact notices, computer notifications, and any other notification method that constitutes a genuine effort to contact the party responsible for the obligation.

3. Documentation of alternative efforts to locate the party responsible for the obligation or the correct address on billings returned by the postal office service as "incorrect address" or "undeliverable"

4. Documentation of continuous Collection Action undertaken on a regular, frequent basis.

5. Checking AHCA to ensure that the patient is not a Low Income Patient as determined by the Office of Medicaid and has not submitted an application to the AHCA system for coverage of the services under a public program.

b. The patient's file must include all documentation of the Provider's collection effort including copies of the bill(s), follow - up letters, reports of telephone and personal contact, and any other effort made.

Outside Collection Agencies

The hospital may contract with an outside collection agency to assist in the collection of certain accounts, including patient responsible amounts not resolved after issuance of hospital bills or final notices. However, as determined through this credit and collection policy, the hospital may assign such debt as bad debt or charity care (otherwise deemed as uncollectible) prior to 120 days if it is able to determine that the patient was unable to pay following the hospital's own internal financial assistance program. The hospital has a specific authorization or contract with the outside collection agency and requires such agencies to abide by the hospital's credit and collection policies for those debts that the agency is pursuing. All outside collection agencies hired by the hospital will provide the patient with an opportunity to file a grievance and will forward to the hospital the results of such patient grievances.

Reporting to Credit Bureaus

In instances where the patient or debtor has not met the criteria and standards set forth in this Policy, and all reasonable means have been exhausted, it is the practice at BHI to have collection agents report to credit bureaus regarding outstanding and unresolved debt. Any account or collective balance of several accounts with combined balances greater than $50 and no activity or arrangement in place after 45 days at a collection agency, is reported to a credit bureau. The Credit Bureaus notified include Trans Union, Equifax, and Experian. Once an account is paid in full, the collection agency will close, remove from credit report and return the account to BHI.

Interest Free, Extended Payment Plans

All uninsured patients shall be offered extended payment plans by BHI to assist the patients in settling past due outstanding BHI bills. The BHI hospitals will not charge uninsured patients any interest under such extended payment plans.

Body Attachments

BHI shall not use body attachment to require that its uninsured patients or responsible party appear in court.

Collection Agencies Follow BHI Collection Policies

BHI will define the standards and scope of practices to be used by their outside (non-hospital) collection agencies, and will obtain written agreements from such agencies that they will adhere to such standards and scope of practices. These standards and practices should not be inconsistent with BHI collection policies set forth in this Policy.

V. Responsibility and Authority

A. The President shall have overall responsibility and authority for this policy.

B. The Vice President of Finance & CFO will be responsible to assure implementation of this policy.

C. The Director of Patient Access is responsible for assuring that the Registration and Admitting Staff properly comply with these procedures for informing patients of their financial obligations at the time of service as appropriate. The Director of Patient Financial Services is responsible for ensuring proper billing and collection procedures are following in accordance with the patient's financial obligation.