

# The MetroHealth System

Policy: V-9

**Subject: Billing, Credit, Collection, and The MetroHealth Plan**

## I. POLICY

- A. The MetroHealth System (System) Board of Trustees has a statutory duty to set fees for services rendered to patients. The System has responsibility to collect fees for services rendered patients in a fair and equitable manner using competent business practices.
- B. The System has pledged to render health care services to residents of Cuyahoga County regardless of their ability to pay and to provide a plan for charity services to such residents.
- C. Patients who are not legal residents of Cuyahoga County may be admitted or registered if full payment of System costs is assured. Those persons requiring emergency medical care will be served regardless of residency and regardless of their ability to pay. However, upon stabilization of the clinical conditions, arrangements are to be made for care at person's County of residence or arrangements made for full payment of System costs.
- D. The System reserves the right to deny non-emergency services to individuals who have not cooperated in meeting appropriate financial obligations to the System as described in this Policy.

II. PURPOSE: To establish policy for internal collection efforts including criteria for The MetroHealth Plan (formerly called charity care), account write-off and utilization of external collection services, consistent with System policies. The topics contained in this policy are:

- A. Operating Procedures
- B. Extended Payment Terms
- C. The MetroHealth Plan
- D. Routine Collection Process
- E. Exceptions to Routine Collection
- F. Property Liens
- G. Refunds

III. SCOPE: This policy applies to all units of the System and for all fees charged by the System.

## IV. OPERATING PROCEDURES

- A. General

1. The System will follow the procedure below in billing and collecting for services provided to patients:
    - a) Render a prompt and accurate bill.
    - b) Provide for collection at the time of service (including payment incentives) and/or require payment at time of service for appropriate charges (co-payments, etc.).
    - c) Assist patients in applying for programs that may provide coverage for services rendered.
    - d) Bill a patient's insurer as a courtesy to our patients if an assignment of benefits has been received by the System. The System will assist in the filing of insurance claims for patients who do not provide an assignment of benefits after all accounts are paid in full.
    - e) Supply reasonable additional information to expedite payments when requested (see [Policy I-44 Medical Record Access](#) and [Policy V-22 Third Party Audits of Patient Accounts/Medical Records](#)).
    - f) Advise patients of the availability of free care through the Ohio Hospital Care Assurance Program or Charity Allowances for those patients unable to pay and without insurance or government entitlement programs (Medicare, Medicaid, General Relief, Disability Assistance, etc.) via a written summary for inpatients, posted notices for outpatients (in enrollment areas) and in response to any patient inquiry (see section IV.C. below). This does not apply to individuals seeking Long Term Care or Home Health Services.
    - g) Utilize collection services after the above steps have failed to result in settlement of the account due.
  2. Whenever possible, determinations regarding payment for inpatient services (i.e. insurance status, lump sum payment or payment terms) should be made prior to admission. Advance payment will be required for certain procedures which are not medically necessary (abortion, cosmetic surgery, sterilization, etc.) if insurance coverage cannot be assured.
- B. Extended Payment Terms: When payment of the remaining balance on an account cannot be made, and the patient/guarantor is making a good faith effort to clear the account, an extended payment plan may be arranged in lieu of sending an account to a collection agency. The following criteria for such plans must be met:

1. Appropriate documentation is supplied supporting the application for an extended payment arrangement.
2. Payment receipts must be of sufficient size to justify the cost of maintaining the account (statement mailers, review, etc.) Payments of less than \$20.00 per month do not meet these criteria.
3. The payments must be of sufficient size in relationship to the patient's means to assure that the debt is being discharged in the most timely fashion that is reasonable.
4. Any account whose payment plan extends beyond six months is to be approved by the Manager in charge of collections , and be reviewed (with a new application required of the patient) every six months to assure that the payment amount is discharging the patient's debt at the most timely pace sustainable.
5. If scheduled payments are not met, the extended payment plan may be revoked and the account placed with a collection agency.

C. The MetroHealth Plan

1. If, after cooperating fully with any program that might make payment for the services rendered, any Cuyahoga County resident is unable to pay for their services; they may apply for The MetroHealth Plan. Cuyahoga County residents whose income is within the guidelines of the annually published Charity Allowance Schedule are eligible for The MetroHealth Plan allowance of 20-80 percent for medically necessary services if they complete an application for such allowance and supply appropriate documentation to verify their status. The System retains the option to include assets in this allowance determination at its discretion and to reduce the allowance based on the availability of such assets.
2. Out-of-county residents are not eligible for The MetroHealth Plan. Eligibility for the Ohio Hospital Care Assurance program must be established before any non-emergency services can be scheduled. Abortions, cosmetic surgery, and other non-medically necessary services will not be eligible for charity care in any instance.
3. **Patients who are new to the MetroHealth System** seeking to schedule non emergency (non EMTALA) care, may not be scheduled for any outpatient clinic or ancillary services until determinations regarding payment for outpatient services (i.e. insurance status, eligibility for entitlement programs, The MetroHealth Plan) have been completed. **Patients who have an established relationship with a MetroHealth provider** (a provider by whom Evaluation and Management services have been

provided to the patient) may be scheduled for one visit with that provider before determinations regarding payment have been completed. They may not receive ancillary services or be scheduled with or referred to any other MetroHealth provider with whom they do not have an established relationship until determinations regarding payment have been completed.

**Inpatients requiring post discharge services and all patients requiring TB services** are excluded from this requirement.

**Patients who do not reside in Cuyahoga County** must establish eligibility for the Ohio Care Assurance Program or establish their ability to pay for services before any non-emergency (non-EMTALA) services can be provided. **Patients who are unwilling to cooperate in the financial counseling process** will be asked to seek care elsewhere except in emergent and EMTALA situations.

4. Discounts beyond the scheduled allowance may be granted in cases where even a 20 percent payment is not feasible economically, if the patient requests such, on an account specific basis only. The authority for approvals for such discounts are to be identical to the adjustment authority outlined in "E" below. Documentation to justify either a discount allowance or further reductions beyond that allowance must include a completed MetroHealth Plan Application, documentation of current income, and authorization for the System to independently verify the information presented.
5. The MetroHealth System will follow the criteria set periodically by the Ohio Hospital Care Assurance program.

D. Routine Collection Process

1. If a patient does not make payment for services received, once any charity allowance (if applicable) has been made, or if the patient refuses to cooperate with any program which would provide payment, it is the policy of the System to pursue collection through collection agencies.
2. Collection agencies may be used in a case where the patient has been notified of his debt and asked for payment at least three times, and the account is aged at least 120 days from the date the services were received. At any time before 120 days, a direct statement from the patient or guarantor that the individual refuses to pay the account, combined with the patient either not qualifying for The MetroHealth Plan or refusing to apply for The MetroHealth Plan shall be cause to immediately refer the account to an outside collection agency. In addition, any patient with a history of bad debt, or a combination of other circumstances which the Director

believes will compromise collection (bad address, moved no forwarding address, etc.) may be referred to collection immediately.

E. Exceptions to Routine Collection

1. In certain circumstances, it may be in the best interest of the System accept a payment of less than the full amount of an account in full settlement of an outstanding obligation. In other circumstances, administrative adjustments may be warranted. Authority for approval of all such adjustments when they are necessary is as follows:

| <u>Position</u>  | <u>Adjustment Approval Authority</u>             |
|--|--|
| Manager,<br>In Charge of Collection                          | Up to \$500                                      |
| General Manager,<br>In Charge of Collection                  | \$0 - \$5,000 or less than<br>20% of any account |
| Controller/Executive Director,<br>Patient Financial Services | \$5,000 - \$10,000                               |
| Chief Financial Officer                                      | \$10,000 - \$20,000                              |
| Board of Trustees  | Any adjustment over \$20,000                     |

2. While approval for a settlement adjustment can be granted per the above schedule, such adjustments are not final until the remaining balance is paid.

F. Liens: The System will protect the general public whose interest it serves by filing liens against real property, when appropriate, so that ultimate collection of accounts can be realized at the time such property is sold, however the System will not commence proceedings to foreclose on a lien which would result in a patient (or patient's spouse) being removed from their primary residence.

G. Refunds: Refunds of overpayments will be made when all accounts of the patient/guarantor are paid in full. Insurance proceeds will not be refunded to the patient/guarantor without the approval of the insurer.

V. DATES

A. Initiated: March 1997

B. Reviewed/Revised:

1. February 2002
2. October 2002

VI. APPROVED

Terry R. White  
President and Chief Executive Officer