Amounts Generally Billed (AGB) Calculation

The Amounts General Billed (AGB) Calculation , represents what the hospital collects in payment from Insurance companies and Medicare. SRMC will collect no more from qualifying Financial Assistance patients (FAP) than from those patients that have health insurance coverage and do not qualify for Financial Assistance. FAP eligible individuals may not be charged more than AGB for emergency or medically necessary care.

The AGB amount is determined by SRMC and is periodically updated and shall be implemented with 45 days of calculation. SRMC is allowed to take up to 120 days after the end of the 12-month period used in calculating the AGB percentage(s) to begin applying the new AGB percentage(s).

AGB shall be calculated based on reimbursed claims from all payer sources, to include Medicare, Medicaid and all commercial payers or from Medicare and Commercial payers only, excluding Medicaid, whichever is higher.

The AGB calculation is found by the following calculation: Total payer allowable / Total billed charges = Reimbursement rate. Reimbursement Rate - 100% = the minimum discount rate of 37.95%.

The FAP discount is applied to gross charges due from the patient. The amount of FAP per patient shall be determined as follows:

Federal Poverty Line	**FAP**	**Amount to Collect**	**Total Bill**
100% of Poverty Level	**100%**	**0%**	**100%**
133% of Poverty Level	**79.32 %**	**20.68%**	**100%**
150% of Poverty Level	**58.63%**	**41.37%**	**100%**
200% of Poverty Level	**37.95%**	**62.05%**	**100%**
More than 200%	**0**	**100.00%**	**100%**