CALAIS COMMUNITY HOSPITAL
POLICIES & PROCEDURES

Policy #5965292

TITLE: Billing and Collections

SECTION: Patient Financial Services	**APPROVED BY:**	**DATE:**
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Purpose: The purpose of this Policy is to establish a procedure for collecting patient accounts including those that have become delinquent due to lack of payment from the patient or responsible party.

Policy: Calais Community Hospital (CCH) strives to collect all self-pay patient accounts in a timely manner in order to maximize cash flow. CCH utilizes a series of billing statements, through the hospital billing system, as well as the services of collection agencies to accomplish this. It is the policy of CCH to comply with Section 501(r) of the Internal Revenue Code and implementing regulations with respect to CCH's billing and collection activities.

Definitions:

Financial Assistance Policy ("FAP"): CCH's Financial Assistance Policy (Policy # 1016), as amended from time to time.

Extraordinary Collection Actions ("ECAs"):

The following actions taken by CCH, or an authorized contractor or agent of CCH, against an individual related to obtaining payment for a bill for care covered under the FAP:

- Selling an individual's debt to another party.
- Reporting adverse information to a consumer credit reporting agency or credit bureau.
- Deferring or denying, or requiring payment before providing, medically necessary care because of nonpayment of one or more bills for previously provided care under CCH's FAP;
- Actions that require legal or judicial process, including but not limited to:
    - Placing a lien on property.
    - Foreclosing on real estate.
    - Attaching or seizing a bank account or other property.
    - Commencing a civil action.
    - Causing an arrest.
    - Causing the issuance of a writ of body attachment.

    - Garnishment of wages; and
- Other actions that are ECAs under 26 C.F.R. § 1.501(r)-6(b).

The following activities are **not** ECAs:

- Liens CCH would be allowed to assert under state law on the proceeds of a judgment, settlement, or compromise as a result of personal injuries for which CCH provided care; and
- The filing of any claim in a bankruptcy proceeding.

Amounts Generally Billed ("AGB"): As used in this Policy, AGB shall have the same meaning given this term in the FAP.

Procedure:

I. Collection Activities, Generally: In both the hospital and physician practices, accounts are written off and placed with collection agencies at the end of each month according to billing frequency guidelines and this Policy.

II. Initiating ECAs:

Prior to engaging in any ECA against a patient (or any individual who has accepted or is required to accept responsibility for the patient's bill) to obtain payment for care, CCH shall take steps to determine whether the individual is FAP-eligible for the care as provided under subsections A or B below.

A. Presumptive FAP-Eligibility Determinations Based on Third-Party Information or Prior FAP-Eligibility Determinations

With respect to any care provided by CCH to an individual, CCH may determine that an individual is FAP-eligible based on information other than that provided by the individual or based on a prior FAP-eligibility determination. If the individual is presumptively determined to be eligible for assistance less than free care under the FAP, CCH shall:

1. Notify the individual regarding the basis for the presumptive FAP-eligibility determination and the way to apply for more generous assistance under the FAP;

2. Give the individual a reasonable period of time to apply for more generous assistance before initiating ECAs to obtain the discounted amount owed for the care; and

3. If the individual submits a complete FAP application seeking more generous assistance during the reasonable period of time,

determine whether the individual is eligible for a more generous discount and take the steps under Subsection II.B.4.

If the individual fails to apply for more generous assistance within the reasonable period of time, CCH may engage in ECAs.

B. Notification and Processing of a FAP Application

CCH shall make reasonable efforts to notify patients of CCH's FAP and process FAP applications under this Subsection as follows:

1. CCH shall refrain from engaging in any ECA until at least 120 days after CCH provides the first post-discharge billing statement for the care (or multiple episodes of care); and

2. At least 30 days before initiating an ECA to obtain payment for the care, CCH shall:

(i) Provide the individual, in a clear and conspicuous manner, with a plain language summary of the FAP and a written notice that (a) indicates financial assistance is available for eligible individuals, (b) identifies the ECAs that CCH (or CCH's representative) intends to initiate to obtain payment for the care, and (c) states a deadline after which such ECAs may be initiated that is no earlier than 30 days after the date that the written notice is provided; and

(ii) Make a reasonable effort to orally notify the individual about CCH's FAP and about how the individual can obtain assistance with the FAP application process; and

3. In the case that an individual submits an incomplete FAP application by the application deadline, CCH shall:

(i) Notify the individual in writing about how to complete the FAP application and provide a phone number and location of Patient Financial Services; and

(ii) Not initiate, or take further action on previously initiated, ECAs until the individual has failed to respond to requests for additional information and/or documentation within a reasonable period of time, or if the individual completes the FAP application, CCH has determined whether the individual is FAP-eligible; and

4. In the case that an individual submits a complete FAP application by the application deadline, CCH shall:

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(i) Not initiate, or take further action on previously initiated, ECAs;

(ii) Make a determination as to whether the individual is FAP-eligible for the care and notifies the individual in writing of this eligibility determination and the basis for this determination; and

(iii) If it is determined that the individual is FAP-eligible:

(a) If the individual is eligible for assistance other than free care, provide the individual with a billing statement that indicates the amount the individual owes.

(b) Refund to the individual any amount paid for the care that exceeds the amount the individual is determined to owe as a FAP-eligible individual, unless such excess amount is less than $5 (or such other amount set by notice or other guidance by the IRS); and

(c) Take all reasonably available measures to reverse any ECA taken against the individual to obtain payment for the care. Such measures may include, but are not limited to, vacating any judgment against the individual, releasing a lien, and removing adverse information reported to a credit bureau.

5. In the case that an individual in already know to be FAP eligible for a 100% discount on charges, the individual will not receive a bill and not be eligible for ECAs. Individuals qualified for a 75% discount on charges will receive a bill for their portion owed and will be subject to ECAs on only to balance due from the patient.

If after receiving a FAP application CCH believes that the individual may qualify for Medicaid, CCH may postpone determining whether the individual is FAP-eligible until after the individual's Medicaid application has been completed and submitted and a Medicaid determination has been made.

III. ECAs that May Be Used

ECAs that may be initiated in accordance with this Policy are as follows:

- Accounts are reported to credit agencies such as Experian, TransUnion, and Equifax after 90 days of non-payment to the collection agencies assigned to the account.

- Liens on residences and lawsuits may be considered depending on the circumstances surrounding non-payment. All lawsuits must be approved by the CEO before implementation.

The Patient Financial Services Director in coordination with the CFO will ensure that the patient financial services department and processes have executed reasonable efforts to determine if an individual is FAP-eligible in accordance with this Policy before CCH engages in the above approved ECAs. Refer to the Financial Assistance Policy for further details.

Hospital accounts are assigned to a collection agency:

The Thomas Agency, PO Box 6759, Portland, ME 04103

All physician practice accounts are sent to The Thomas Agency, PO Box 6759, Portland, ME 04103.

Hospital Accounts:
The hospital utilizes eManagement Associates (EMA) to manage its claim statement process. Patient bills are sent according to the frequency set by EMA as instructed by the hospital, beginning the day of discharge for self-pay patients, and following payment from insurance for patients with insurance. For hospital bills this frequency is as follows:

- If the patient balance is $3.00 to $5.00 one statement is sent. At day 30 the account is marked by EMA for write off (not placed with a collection agency).
- If the patient balance is $5.01 and over, four statements are sent, with the final statement going out at day 90. At day 90 the statement informs the patient that the account will be sent to collection in 30 days if payment or arrangements are not made and that the collection agency may report the outstanding balance to the appropriate credit agencies. At day 120 the account is marked by EMA for collection. However, no accounts may be marked by EMA for collection, or a report be made to a credit reporting agency unless all requirements under this Policy are met.

Physician Office Accounts:
The physician practices use Athena to manage its claims statement process. Patient bills are sent on 30-day cycles for a total of three statements over 90 days. Patient bills are remitted to collection agencies 120 days after non-payment beginning the date that CCH provides the first post-discharge billing statement for care for self-pay patients and following payment from insurance for patients with insurance. All other self-pay billing and collection procedures are the same as the hospital.

Payment arrangements may be made for accounts. Accounts that are under payment arrangements are sent monthly statements. If payments are made on a monthly basis as agreed, the account remains current. Upon 120 days without a payment, the accounts are

marked for collection and go through the collection process; provided, however, that no accounts may be marked for collection unless all requirements under this Policy are met.

IV. Payment Arrangements and Prompt-Pay Discounts

Guidelines for payment arrangements:

Accounts are to be paid in full unless payment arrangements are made for the account.

Payment arrangements are as follows:

Term length	Account Balance	Monthly Payment
• 6 months	$100.00-$600.00	$25.00-$100.00
• 12 months	$600.01-$1200.00	$50.00-$100.00
• 24 months	$1200.01-$5000.00	$50.00-$209.00
• 36 months	$5000.01 +	$139.00 +

- Employees of CCH may make payment arrangements on hospital accounts through the payroll deduction process. This can be initiated through the PFS Director.
- Alternative payment arrangements may be made at the discretion of the PFS Director or Physician Billing Supervisor upon request of the patient.

Prompt pay discounts of 3% are offered for payment in full within 30 days of the patient being mailed a statement. This is for balances over $100.00. Guidelines are as follows:

- Discounts will not be given on accounts that have been placed with collection agencies except in the case of settlements and will only be granted by the PFS Director or CFO.
- Discounts may be considered on a case-by-case basis by the PFS Director with non-contracted insurance providers and payment must be made within 30 business days.

Prompt pay discounts of 5% will be given if the full estimated payment is made at the time of service. This does not apply to office copay amounts.

A discount of 15% will be assessed automatically on all private pay accounts at the time of billing.