Community Hospitals and Wellness Centers
CHWC Montpelier Hospital (CAH)
CHWC Bryan Hospital
CHWC Archbold Medical Center

PATIENT ACCOUNTS POLICY AND PROCEDURE MANUAL

DATE INITIATED: 12/01

REVISED: 01/05, 06/08, 06/11, 04/12, 7/12, 12/12, 6/13, 10/14, 8/16

REVIEWED: 01/05, 06/08, 06/11, 04/12, 7/12, 12/12, 6/13, 10/14, 9/15, 8/16

SUBJECT: SELF PAY BILLING AND COLLECTIONS POLICY

PA0003

OBJECTIVE/PURPOSE:
In accordance with Community Hospitals and Wellness Centers core values of compassion, integrity, honesty, respect and accountability, CHWC has established a billing and collections policy that allows every guarantor reasonable time to receive bills for their services, ask questions on any charge or billing issues, apply for financial assistance and make arrangements for payment of any balance due by the guarantor.

POLICY:
It is the policy of Community Hospitals and Wellness Centers to provide emergency and medically necessary care to all patients, without discrimination or regard to ability to pay (reference hospital EMTALA policy ER000099). Patients will be given the opportunity to apply for financial assistance, and will be offered the option to set up monthly payment plans for any balance that is not covered by health insurance or eligible for adjustment under one of the financial assistance programs. This policy is applicable to all 3 locations of Community Hospitals and Wellness Centers including Bryan, Archbold and Montpelier.

PROCEDURE:
At the time of registration, uninsured patients receive a financial application and summary of the hospital financial program (Plain Language Summary). Patients will also receive information on enrolling for Medicaid or the Health Insurance Marketplace. The Social Services Department at CHWC is available to assist patients with enrollment for the Medicaid program. The Financial Application and Plain Language Summary is also available on the hospital website or can be requested by any uninsured or insured patient from the admissions or billing office at CHWC. Financial discounts will be applied to the patient balance, after appropriate insurance payments and contractual adjustments have been posted to the account.

Emergency / Medically necessary Care:

CHWC follows Ohio Medicaid policy in determining services that meet medical necessity (reference Ohio Administrative Code 5160-1-01). Most cosmetic surgery is not considered to be medically necessary medical care and payment will be the responsibility of the patient.

Statement Cycle:
The first statement mailed to the Patient/Guarantor is a statement summarizing the charges and insurance payments, if applicable. This statement is mailed to the guarantor the day after the account is final billed in the hospital system, or the day following receipt and settlement of insurance payment, if applicable. If insurance has pended processing of a claim, holding for requested information from the policy holder, a letter is sent to the Patient/Guarantor asking them to provide the insurance with the requested information and notify the Patient Accounts office when it is completed. If the patient does not respond to the letter by the due date, the account will be changed to self pay prior to insurance payment, and the patient will begin receiving statements. Following the initial summary statement, a guarantor statement is mailed to the guarantor the first week of each month, until the account is settled in full, or referred to an outside agency for collections. The guarantor statement lists all accounts with an outstanding patient balance, excluding bad debt accounts that are processing with a collection agency. Accounts processing with insurance will not be included on Patient/Guarantor statements, until there is a patient balance due on the account.

Phone Calls:
CHWC will attempt to make a phone call to all patients with no insurance approximately 2 weeks after the date of service, to discuss potential enrollment in an insurance plan through the Health Insurance Marketplace, offer assistance with Medicaid enrollment, financial assistance or setting up payment arrangements. This phone call will be documented on the account notes.

Payment Arrangement Guidelines:
The patient statement includes contact information for the Patient Accounts billing office. Patient Representatives are available to set up payment arrangements with the guarantor. When a guarantor calls to set up payment arrangements, the guarantor is asked to pay in full, and offered the option of a 15% prompt pay discount if paid in full within 30 days of the first statement date. Requests for discounts exceeding 15% are to be approved by the President/CEO or EVP of Finance.

If payment in full is not possible, the guarantor is asked to make monthly payments to pay the account in full within 18 months, and with a minimum payment of $50.00 per month. Exceptions can be made to these payment guidelines to allow a smaller payment or extended time to pay off the bill, if determination is made that the guarantor is making every effort to pay and agrees to increase payments in the future, if the financial circumstances change. The guarantor may be asked to complete a financial application to determine eligibility for financial assistance, if he/she is not able to make acceptable payment arrangements. (See Financial Assistance Policy).

Final Notice:
If no payment is received or payment arrangement established by day 63 from the initial statement date, a “Past Due Letter” is sent to the guarantor with a request to pay in full or contact

Patient Accounts within 30 days. The past due letter will include the 'Plain Language summary". The past due letter will inform the patient that the account will be considered for collections if there is no response within 30 days, and will also list the ECA's (see ECA below) that may be initiated if the guarantor does not respond. If there is no response by the 38th day following the date of the 'Past Due Letter" or acceptable payments have not been established, the account is reviewed by the Patient Representative to determine eligibility for bad debt and collection agency processing. If the patient had previously established a payment arrangement but did not follow through with timely payments, a phone call to the patient will be made in an attempt to re-establish the payment arrangement. If the patient is not able to be reached after a minimum of 2 attempts, or is not cooperative, the account will be considered for bad debt/collections during the next transfer of accounts.

Invalid Address or Contact Information:
If a patient statement is returned for an invalid address, the patient will be contacted by phone to obtain correct billing information. If there is no valid phone contact, or the patient doesn't respond to a phone call, the account may be sent to the collection agency prior to sending a final "past due letter". The agency will attempt to locate a valid address for the guarantor. The agency will notify the hospital if a valid address is obtained. If the patient does not cooperate with the collection agency regarding payment or completion of a financial application, the agency will contact the hospital so that a final 'past due letter' can be sent. If there is no response to the past due letter, the collection agency may continue with appropriate ECA's 240 days from the original statement date. The hospital and agency will work together to assure the agency has the appropriate 1st statement date since the accounts may be initially sent to the agency prior to the normal minimum of day 100.

Presumptive Eligibility:
Prior to sending an account to collections, the account is sent to "I-Solutions" to review and determine charity eligibility and propensity to pay. Any accounts that list on the I-Solutions report as "yes" under the charity column will receive a charity discount equal to 75% of the "w/o amount" listed on the report. Any account that lists a positive "w/o amount" and falls in the "BD" or "Low" propensity to pay category will receive a charity discount equal to 75% of the "w/o amount" listed on the report. Accounts with no listed propensity to pay and a positive "w/o amount" will also receive a charity discount equal to 75% of the "w/o amount" listed on the report. The minimum discount applied to any charity eligible account through I-Solutions will be no less than the minimum charity level applied from a financial application, which is based on the AGB for the applicable fiscal year. Visits with a propensity to pay "NMD" (need more data) do not receive a charity discount. The balance after all charity discounts are applied, is moved to bad debt in the hospital system and sent to the appropriate collection agency.

The admission authorization form includes a statement authorizing the hospital to review the guarantor's credit information. If this is not signed by the patient or his/her representative, the visit will <u>not</u> be sent to I-Solutions for review. It will be forwarded directly to the collection agency. The admissions office will send a tickler note to Patient Accounts stating that the patient refused to sign the authorization.

Accounts receiving a discount based on presumptive eligibility are eligible to apply for an

additional discount, if a financial application is completed within 240 days from the 1st statement date.

Incomplete Financial Applications:
If CHWC receives an incomplete financial application, the patient will be contacted by phone to get the additional information. If the patient is not able to be reached by phone, a copy of the financial application is sent back to the patient along with a note explaining the additional information that is needed. If a guarantor has not returned the requested information to complete the financial application, a denial letter is sent to the guarantor. If the guarantor provides the information at a later date, the application will be reconsidered, if it is received within 240 days from the 1st patient statement, or within 3 year from the date of service, if the patient is eligible for HCAP.

Collection Agency account follow up:
The collection agency will send a written notice of outstanding account balance to the guarantor, and will make multiple attempts to reach the patient by phone. The collection agency will make the patient aware of financial assistance opportunities, if the patient has not already competed the financial application. Accounts at the collection agency will be eligible for legal action following day 140 from the date the account is opened with the agency. This will allow the patient a minimum of 240 days to respond to the patient bill before the first ECA may be initiated. Accounts will not be reported to a guarantor's credit report by the primary agency until legal action has been approved by the Patient Accounts Director and initiated by the agency.

Accounts without legal action and no active payment arrangement may be placed with a secondary agency 15 months after initial collection agency placement. The primary agency will close the account prior to placement with the 2nd agency. The 2nd agency may report to the guarantor's credit report 30 days after placement.

Financial assistance prior to and after reported to collections:
CHWC will make every attempt to inform each guarantor of the financial assistance program, prior to sending accounts to a collection agency. The collection agency will also make patients aware of the financial assistance program before an ECA is completed. A guarantor is eligible to apply for financial assistance for up to 240 days following the 1st statement date, or up to 3 years from the date of service, for the HCAP program. Following is the process CHWC will follow when a financial application is received after an account is at collections.

1. If a financial application is received after an eligible account is at collections but prior to day 240 from the 1st statement date, the account will be placed on hold at the agency while a review is completed. After financial assistance is determined, and if there is a patient balance remaining, the account will be released, and the collection agency may continue with the collection process.
2. If a financial application is received after an eligible account is at collections and an ECA has been filed, the account is no longer eligible for financial assistance, but may be eligible for HCAP if within the HCAP timeliness requirements. The application may also be used for other accounts with open balances, that are within 240 days of the initial statement date.

Refund of patient payments following charity determination:
If an account is eligible for HCAP adjustment, all patient payments on the account will be refunded to the guarantor/patient within 2 weeks of HCAP determination. If an account is eligible for a full charity discount, patient payments on accounts with a '1st statement date' within 240 days of the charity application receipt date, will be refunded to the Patient/Guarantor. If an account is eligible for a partial charity discount, patient payments on accounts with a '1st statement date' within 240 days of the charity application receipt date, and exceeding the percentage due by the patient, will be refunded to the Patient/Guarantor following the posting of the charity discount.

Accounts with a '1st statement date' greater than 240 days from the charity application date, and still active with CHWC (not at a collection agency) will be considered for a charitable discount, but previous patient payments will not be refunded.

Bad Debt Accounts at a Collection Agency:
Accounts listed in bad debt are not considered to be active on the hospital system. The collection agency makes arrangements for payments and monitors the payments. The hospital can accept direct payments on accounts with a collection agency, but the guarantor is encouraged to make payments direct to the agency. A daily report of payments received at the hospital is sent in a secure email to the appropriate collection agency.

Extraordinary Collection Actions (ECA):
It is the policy of Community Hospitals and Wellness Centers to make every reasonable effort to obtain payment or to determine eligibility for financial assistance on an account before any ECA is initiated. CHWC will not initiate one of the following ECA's prior to 240 days after the first patient statement date, and after multiple statements and phone call attempts have been unsuccessful in settling the account.

1. Report the delinquent account to a consumer credit reporting agency/credit bureau.
2. File legal action to obtain payment of an account through a garnishment.

Other ECA's as noted in 501r policy are never implemented by CHWC, or their Collection agencies.

Legal action initiated by the collection agency requires a signature of approval by the Director of Patient Accounts.

Closing of accounts at Collection:
Collection agencies are asked to review all accounts yearly to determine accounts that are not collectible. The uncollectible accounts will be closed by the agency and returned to CHWC. Accounts on the closed report that have Medicare are included with the Medicare bad debt totals for the cost report. (See Medicare bad debt policy #PA0006).

DOCUMENTATION:
Not applicable

REFERENCES:
Not applicable

APPROVALS:
Board of Directors 07/11, 04/12, 08/12, 12/12, 6/13, 10/14, 9/15, 8/16