Lake Health District
Financial Services
Date Issued: 6/7/2017

Policy Number: 9-895-204
Page 1 of 7
Date Revised:

Approved by: _____ Administrator/CEO
Approved by: _____ Board of Directors
Approved by: _____ Chief Financial Officer

Lake Health District - Patient Billing and Collection Policy

PURPOSE

The purpose of this policy is to establish the guidelines and procedures for direct patient billing and collection procedures for non-payment of patient balances.

POLICY

Patients with account balances that are their responsibility for payment will be billed to the patient or their guarantor per the provisions of Lake District Hospital's financial assistance policy and the procedures listed in this collection policy. Patient balances may be the result of assigned liabilities after payment from an insurance plan or government program such as Medicare, as well as liabilities after payment from being uninsured. All billing and collection activities shall be in compliance with the Hospital Fair Pricing Policies law, Section 501(r) of the Internal Revenue Code and Fair Debt Collection Practices Act.

DEFINITIONS

I. FINANCIAL ASSISTANCE previously referred to as CHARITY CARE, is defined as follows:

Financial Assistance is financial aid to a patient or responsible party and does not include discounts normally given to insurance policy holders, contract prices that are negotiated with insurance companies or other adjustments once the final bill has been created. When the patient is able to pay part of their bill, consideration will be given to writing off a portion of that account as partial financial assistance. Financial Assistance may also include assistance to patients who have incurred high medical costs as defined as yearly healthcare costs greater than 10% of household income.

Financial Assistance is not to be considered a substitute for personal responsibility and patients are expected to cooperate with Lake District Hospital's procedure for applying for Financial Assistance, and to contribute to the cost of their care based on their individual ability to pay.

REASONABLE PAYMENT PLAN: means monthly payments that are not more than 10% of the family income for a month, excluding deductions for essential living expenses. "Essential living expenses" means expenses of any of the following: rent or mortgage payment and maintenance, food and household supplies, utilities and telephone, clothing, medical and dental payments, insurance, school or child care, child of spousal support, transportation and auto expenses,

including insurance, gas, and repairs, installment payments, laundry and cleaning, and other extraordinary expenses.

II. FINANCIAL ASSISTANCE PATIENTS ARE DEFINED AS FOLLOWS:

A. Uninsured patients (those without third party insurance, Medicare, Medicaid, or with injuries or conditions qualifying for coverage by worker's compensation or automobile insurance for injuries) who do not have the ability to pay based on criteria described in the Eligibility section below.

B. Insured patients whose insurance coverage and ability to pay are inadequate to cover their out of pocket expenses.

C. Insured patients unable to pay for their portion of the bill due to uncollected co-payments, deductibles and non-covered services.

D. An insured or uninsured patient with high medical costs, whose household income does not exceed 400% of the federal poverty level, but whose out-of-pocket medical costs or expenses exceed 10% of their income for the prior year.

E. Any patient who demonstrates an inability to pay, versus bad debt, which is the unwillingness of the patient to pay.

F. The hospital will not base its determination that the individual is not eligible for financial assistance based on information that the hospital has reason to believe is unreliable, incorrect or on information obtained under duress or coercive practices.

III. AMOUNTS GENERALLY BILLED

The Amounts Generally Billed (AGB) is defined as the maximum amount a patient who qualifies under the financial assistance policy for a charity or other discount which is equal to the average amounts historically allowed as a percentage of billed charges for all services provided under the Medicare program for a 12-month look back period calculated in accordance with IRS 501(r). Inpatient services will be priced at a certain percentage of billed charges on a sliding scale reflecting different levels of utilization of services. Outpatient services will be priced at the hospital's average Medicare allowed amounts as a percentage of billed charges during the same 12-month look back period as mentioned above for inpatient. Please see **Appendix A – Amounts Generally Billed (AGB) Calculation** for the AGB calculation.

IV. EXTRAORDINARY COLLECTIONS ACTIONS (ECAs)

As defined in Section 501(r) (6) of the Internal Revenue Code, ECAs are collection activities that may be taken against a patient or guarantor for non-payment that include but not limited to:

A. Reporting adverse information to credit agencies

B. Placing a lien on an individual property except those allowed under state law due to judgements or settlements as part of a personal injury case

C. Foreclosing on real property as permissible under state and federal regulations.

D. Attaching or seizing an individual's bank account or any other personal property

E. Commencing civil action against an individual or writ of body attachment

F. Causing an individual's arrest

G. Deferring or denying medically necessary care because of outstanding bills for previously provided care covered under the hospital's financial assistance policy

H. Requiring a payment before providing medically necessary care because of outstanding bills for previous provided care

I. Garnishing an individual's wages

J. Certain sales of the patient's debt to another party

Extraordinary collection actions does not include a lien asserted on the proceeds of a judgment, settlement or compromise owed to an individual as a result of a personal injury for which medical services were provided. Moreover, the ABG and FAP protocol does not apply to trusts, estates, partnerships, associations, corporations, LLCs, government agencies, nonprofits or businesses that assume the individuals debt. However, with regards to actions within this policy the facility will consider any individual who has accepted or is required to accept responsibility for an individual having medical treatment rendered as equivalent to the first individual receiving a hospital bill for the care.

PROCEDURES

I. INITIAL PATIENT BILLING

A. Patients without insurance or coverage by any government sponsored program will receive an initial patient billing statement within 10-30 days of the date of service.

B. All charges that are billed directly to a patient who is uninsured or covered by a government sponsored program will be billed at or discounted down from the hospital list price to the amount that is generally billed to Medicare.

C. The initial patient billing statement will include information on how to apply for financial assistance.

D. For patients with primary insurance coverage, any balances remaining after the primary insurance payment; i.e. deductibles, co-payments, co-insurances, non-covered charges will be billed to the patient within 14 days of the primary insurance payments.

E. Statements of accounts to patients with balances secondary to a primary insurance payment will include information on how to apply for financial assistance.

F. All patients may pay any amounts due over time and the hospital will negotiate a payment arrangement in good faith. If an agreement cannot be reached the hospital must accept the "reasonable payment plan" as defined by law.

G. The initial patient billing statement will include a copy of the Plain Language Summary of Hospital Financial Assistance Policy.

II. STATEMENT BILLING CYCLES

A. Balance due statements are generated every 30 days after the date of the initial statement.

B. Three statements will be generated by the hospital during the first 90 days from the initial self-pay billing.

C. After 120 days the unpaid account will be assigned to a pre-collection vendor for further follow-up activity. While the account is with the pre-collection vendor, two outgoing calls will be made to the guarantor followed by two additional statements.

D. The duration of the pre-collection activity will take 60 days and the account remains on the active accounts receivables at the hospital and is not written off to bad debt

E. Upon completion of the pre-collection cycle, the account will be automatically written off to bad debt and referred to a collection agency. No account will be assigned to collections prior to 150 days from the first patient billing, nor while a financial assistance application is in process.

F. Patients on a formal payment plan will receive a monthly statement of the current amount due until the payment plan is satisfied.

III. COLLECTION AGENCY ASSIGNMENT OF DELINQUENT ACCOUNTS

A. Patients enrolled in a formal payment plan and are making the monthly scheduled payments will not be assigned to collections unless the payment plan is delinquent.

B. If a patient is covered under the hospital's financial assistance program with an extended payment plan and the payments are not met, the hospital must take the following actions before an account can be assigned to a collection agency:

1. Attempt to contact the patient by phone.

2. Give notice in writing that the plan may become inoperative.

3. Inform the patient of the opportunity to renegotiate the payment plan and attempt to do so if requested by the patient.

4. The notice and phone call may be made to the last known phone number and address of the patient.

C. After the final statement for a delinquent account is issued the account is reviewed a final time before the assignment to a collection agency to ensure that a financial assistance application is not pending.

If the FAP application is found to be pending due to an incomplete FAP application, and the individual has submitted a FAP application during the application period, the hospital will provide the individual written notice that describes the additional information and/or documentation required under the FAP or FAP application form that must be submitted to complete the FAP application.

If the FAP application is subsequently completed during the application period, the individual will be considered to have submitted a complete FAP application during the application period.

If the account is already assigned to a collection agency, the agency will put the account on hold during the duration of the application process and the hospital will suspend any ECA actions.

Requests for financial assistance shall be processed promptly and LDH shall notify the patient in writing within 30 days of receipt of a completed application

D. Lake District Hospital contracts with external collection agencies but retains full ownership of the accounts receivables and has the final say in any account resolution.

E. Accounts will be sent to a collection agency for non-payment of the account and lack of applying for financial assistance or contacting the hospital to make payment arrangements.

F. Patients who provide inaccurate demographic data and where the hospital cannot determine a valid address may be sent to pre-collections earlier than 150 days. It is the guarantor(s) responsibility to provide a correct address at the time of service or upon moving. If the address on the account is invalid or otherwise undeliverable to the individual, the determination for "reasonable effort" will have been made.

G. The contracted collection agencies must follow the hospital's financial assistance policy in all terms related to the application for assistance procedures and time frames, negotiating payment plans and the rules for engaging ECAs.

H. ECAs will not be initiated against a patient during the first 150 days after the first billing statement was mailed; this includes negative credit reporting to credit bureaus.

I. The patient will be informed in writing no less than 30 days before any ECAs are initiated. The 30 day notice will include a copy of the Plain Language Summary of Hospital Financial Assistance Policy. A phone call attempt to contact the guarantor will be done by the pre-collection agency as part of the 30 day notification of the ECA. The pre-collection agency is responsible for making this notification before any and all ECAs are initiated. The hospital is ultimately responsible for the collection actions.

J. If a financial assistance application is made when an account is already assigned to a collection agency, the agency will put the account on hold during the duration of the application process.

K. If the hospital is made aware of any verified Medicaid or other insurance coverage, the account will be recalled from the agency and the insurance billed for the service.

L. Payments made directly to the hospital for accounts assigned to a collection agency will be reported to that agency on a daily basis.

M. Any legal actions against a patient will be limited to liens, lawsuits, and/or wage garnishments. Any legal actions must be approved by the Director of Patient Financial Services, and the proper 30 day notice in advance of such activities must be completed by the collection agencies.

N. All legal action ECAs will be conducted by the collection agency on behalf of the hospital; the hospital retains full control over any ECA legal action.

O. The fact that a patient has accounts in bad debt will not be used as a reason to deny future medical services at the hospital.

Appendix A: Amounts Generally Billed (AGB) Calculation

The method used to calculate the AGB is a historical look-back method based on actual paid claims for Medicare fee-for-service and private health insurers, including portions paid by insured individuals. A single average percentage of gross charges, or multiple percentages for separate categories of care or separate items or services. The AGB rate will be updated annually at the beginning of the fiscal year and implemented within 120 days of any AGB rate change.

After the patient's account(s) is reduced by the financial assistance adjustment based on policy, the patient is responsible for the remainder of his or her outstanding patient account which shall be no more than amounts generally billed (AGB) to individuals who have Medicare fee-for-service and private health insurers for emergency and other medically necessary care. The look-back method is used to determine AGB. Patients or members of the public may obtain this summary document at no charge by contacting the hospitals billing office.

Amounts generally billed is the sum of all amounts of claims that have been allowed by health insurers divided by the sum of the associated gross charge for those claims.

AGB % = Sum of Claims Allowed $ / Sum of Gross Charges $ for those claims

Allowed amount = Total charges less Contractual Adjustments

If no contractual adjustment is posted then total charges equals allowed amount.

Denial adjustments are excluded from the calculation as denials do not impact allowed amount.

On an annual basis the AGB is calculated for the hospital.

- Look Back Method is used. A twelve (12) month period is used.
- Includes Medicare Fee for Service and Commercial payers.
- Excludes Payers: Medicaid, Medicaid pending, uninsured, self-pay case rates, Medicare facility billing, motor vehicle and liability, and worker's compensation.

Hospital: Lake District Hospital

Amounts Generally Billed: 85%

Effective: _____