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Patient Billing and Collection Policy

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Scope:

This policy applies to all Lake Health District employees, board members, trustees, business associates, administrative staff, workforce, students, volunteers, contractors, vendors, and other third parties/persons performing work for or at Lake Health District;

This policy is applied to all those seeking services within any Lake Health District or affiliated facility.

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 under ORS 646.639, ORS 646.641, and the Fair Debt Collection Practices Act

This policy includes sections related to patient billing for all acknowledged insurance types as well as patients who are employees of the Lake Health District or any of its affiliated facilities.

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 follow the Hospital Fair Pricing Policies law, Section 50l(r) of the Internal Revenue Code and Fair Debt Collection Practices Act.

Employees of Lake Health District:

All Employees of Lake Health District and its affiliated facilities may receive a 20% discount on any unpaid insurance balance for services received within Lake District Hospital. This benefit is for employees only (not for spouses or dependents), including Lake Health and Alturas Health Clinics.

If the employee does not qualify for Lake Health District's health plan benefit, the discount would still be

allowed, even if there is no insurance coverage or the insurance coverage is from an outside plan, i.e., a spouse's plan. Due to the number of employees on staff at Lake Health District, it will be the employee's responsibility to bring the discount to the attention of the business office on outside insurance plans.

Employees may also use vacation hours to pay hospital bills or may set up a payroll deduction plan through the credit department for District services / bills. Other than the above-described discount, all Employees of Lake Health District and its affiliated facilities will be held to the same standards as any other patient when they receive and are billed for services rendered.

Definitions:

Centers for Medicare and Medicaid Services (CMS)	The Centers for Medicare & Medicaid Services (CMS), is a federal agency within the United States Department of Health and Human Services (HHS) that administers the Medicare program and works in partnership with state governments to administer Medicaid, the Children's Health Insurance Program (CHIP), and health insurance portability standards.
Coinsurance:	A form of medical cost sharing in a health insurance plan that requires an insured person to pay a stated percentage of medical expenses after the deductible amount, if any, was paid. ¨ Once any deductible amount and coinsurance are paid, the insurer is responsible for the rest of the reimbursement for covered benefits up to allowed charges: the individual could also be responsible for any charges more than what the insurer determines to be “usual, customary and reasonable”. ¨ Coinsurance rates may differ if services are received from an approved provider (i.e., a provider with whom the insurer has a contract or an agreement specifying payment levels and other contract requirements) or if received by providers not on the approved list. ¨ In addition to overall coinsurance rates, rates may also differ for different types of services.
Copayment:	A form of medical cost sharing in a health insurance plan that requires an insured person to pay a fixed dollar amount when a medical service is received. The insurer is responsible for the rest of the reimbursement. ¨ There may be separate copayments for different services. ¨ Some plans require that a deductible first be met for some specific services before a copayment applies. Deductible - A fixed dollar amount during the benefit period - usually a year - that an insured person pays before the insurer starts to make payments for covered medical services. Plans may have both per individual and family deductibles. ¨ Some plans may have separate deductibles for specific services. For example, a plan may have a hospitalization deductible per admission. ¨ Deductibles may differ if services are received from an approved provider or if received from providers not on the approved list.
Emergency medical conditions:	Defined within the meaning of section 1867 of the Social Security Act (42 U.S.C. 1395dd).
Extraordinary Collection Actions	actions taken by a hospital facility against an individual related to obtaining payment of a bill for care covered under the hospital facility’s FAP that • involve selling an individual’s debt to another party, • involve reporting adverse information about an individual to

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	consumer credit reporting agencies or credit bureaus (collectively, "credit agencies"), • involve deferring or denying, or requiring a payment before providing, medically necessary care (***Does not apply to Emergency Services / ER EMS***) because of an individual's non-payment of one or more bills for previously provided care covered under the hospital facility's FAP, or • require a legal or judicial process.
Flexible spending accounts or arrangements (FSA)	Accounts offered and administered by employers that provide a way for employees to set aside, out of their paycheck, pretax dollars to pay for the employee's share of insurance premiums or medical expenses not covered by the employer's health plan. The employer may also make contributions to an FSA. Typically, benefits or cash must be used within the given benefit year, or the employee loses the money. Flexible spending accounts can also be provided to cover childcare expenses, but those accounts must be established separately from medical FSAs.
Flexible benefits plan (Cafeteria plan) (IRS 125 Plan):	A benefit program under Section 125 of the Internal Revenue Code that offers employees a choice between permissible taxable benefits, including cash, and nontaxable benefits such as life and health insurance, vacations, retirement plans and childcare. Although a common core of benefits may be required, the employee can determine how his or her remaining benefit dollars are to be allocated for each type of benefit from the total amount promised by the employer. Sometimes employee contributions may be made for additional coverage. Fully insured plan - A plan where the employer contracts with another organization to assume financial responsibility for the enrollees' medical claims and for all incurred administrative costs.
Financial Assistance:	Healthcare services that have been or will be provided for free or at a discount to individuals who meet established criteria.
Gatekeeper:	Under some health insurance arrangements, a gatekeeper is responsible for the administration of the patient's treatment; the gatekeeper coordinates and authorizes all medical services, laboratory studies, specialty referrals and hospitalizations. Group purchasing arrangement – Any of a wide array of arrangements in which two or more small employers purchase health insurance collectively, often through a common intermediary who acts on their collective behalf. Such arrangements may go by many different names, including cooperatives, alliances, or business groups on health. They differ from one another along several dimensions, including governance, functions, and status under federal and State laws. Some are set up or chartered by States while others are entirely private enterprises. Some centralize more of the purchasing functions than others, including functions such as risk pooling, price negotiation, choice of health plans offered to employees, and various administrative tasks. Depending on their functions, they may be subject to different State and/or federal rules. For example, they may be regulated as Multiple Employer Welfare Arrangements (MEWAs).
Gross Charges:	The total charges at the organization's full established rates for the provision of patient care services before deductions from revenue are applied.

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Health Care Plans and Systems:	Association Health Plans:	This term is sometimes used loosely to refer to any health plan sponsored by an association. It also has a precise definition under the Health Insurance Portability and Accountability Act of 1996 that exempts from certain requirements insurers that sell insurance to small employers only through association health plans that meet the definition.
	Indemnity plan:	A type of medical plan that reimburses the patient and/or provider as expenses are incurred.
	Conventional indemnity plan:	An indemnity that allows the participant the choice of any provider without effect on reimbursement. These plans reimburse the patient and/or provider as expenses are incurred.
	Preferred provider organization (PPO) plan:	An indemnity plan where coverage is provided to participants through a network of selected health care providers (such as hospitals and physicians). The enrollees may go outside the network but would incur larger costs in the form of higher deductibles, higher coinsurance rates, or non-discounted charges from the providers.
	Exclusive provider organization (EPO) plan:	A more restrictive type of preferred provider organization plan under which employees must use providers from the specified network of physicians and hospitals to receive coverage; there is no coverage for care received from a non-network provider except in an emergency.
	Health maintenance organization (HMO):	A health care system that assumes both the financial risks associated with providing comprehensive medical services (insurance and service risk) and the responsibility for health care delivery in a particular geographic area to HMO members, usually in return for a fixed, prepaid fee. Financial risk may be shared with the providers participating in the HMO.
	Group Model HMO:	An HMO that contracts with a single multi-specialty medical group to provide care to the HMO's membership. The group practice may work exclusively with the HMO, or it may provide services to non-HMO patients as well. The HMO pays the medical group a negotiated, per capita rate, which the group distributes among its physicians, usually on a salaried basis.
	Staff Model HMO:	A type of closed-panel HMO (where patients can receive services only through a limited number of providers) in which physicians are employees of the HMO. The physicians see patients in the HMO's own

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		facilities.
	Network Model HMO:	An HMO model that contracts with multiple physician groups to provide services to HMO members; may involve large single and multispecialty groups. The physician groups may provide services to both HMO and non-HMO plan participants.
	Individual Practice Association (IPA) HMO:	A type of health care provider organization composed of a group of independent practicing physicians who maintain their own offices and band together for the purpose of contracting their services to HMOs. An IPA may contract with and provide services to both HMO and non-HMO plan participants.
	Point-of-service (POS) plan:	A POS plan is an "HMO/PPO" hybrid; sometimes referred to as an "open-ended" HMO when offered by an HMO. POS plans resemble HMOs for in-network services. Services received outside of the network are usually reimbursed in a manner like conventional indemnity plans (e.g., provider reimbursement based on a fee schedule or usual, customary and reasonable charges).
	Physician-hospital organization (PHO):	Alliances between physicians and hospitals to help providers attain market share, improve bargaining power and reduce administrative costs. These entities sell their services to managed care organizations or directly to employers.
Household:	A single individual; or Spouses, domestic partners, or a parent and child under 18 years of age, living together; and Other individuals for whom a single individual, spouse, domestic partner, or parent is financially responsible.	
Household Income:	Household income is determined using the 2020, Centers for Medicare and Medicaid Services (CMS) Modified Adjust Gross Income (MAGI) guidelines.	
Managed care plans:	Managed care plans generally provide comprehensive health services to their members and offer financial incentives for patients to use the providers who belong to the plan. Examples of managed care plans include:	
	Health maintenance organizations (HMOs),	
	Preferred provider organizations (PPOs),	
	Exclusive provider organizations (EPOs), and	
	Point of service plans (POSs).	
Managed care provisions:	Features within health plans that provide insurers with a way to manage the cost, use and quality of health care services received by group members. Examples of managed care provisions include:	

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	Preadmission certification:	An authorization for hospital admission given by a health care provider to a group member prior to their hospitalization. Failure to obtain a preadmission certification in non-emergency situations reduces or eliminates the health care provider's obligation to pay for services rendered.
	Utilization review:	The process of reviewing the appropriateness and quality of care provided to patients. Utilization review may take place before, during, or after the services are rendered.
	Preadmission testing:	A requirement designed to encourage patients to obtain necessary diagnostic services on an outpatient basis prior to non-emergency hospital admission. The testing is designed to reduce the length of a hospital stay.
	Non-emergency weekend admission restriction:	A requirement that imposes limits on reimbursement to patients for non-emergency weekend hospital admissions. ¨ Second surgical opinion - A cost-management strategy that encourages or requires patients to obtain the opinion of another doctor after a physician has recommended that a non-emergency or elective surgery be performed. Programs may be voluntary or mandatory in that reimbursement is reduced or denied if the participant does not obtain the second opinion. Plans usually require that such opinions be obtained from board-certified specialists with no personal or financial interest in the outcome. Maximum plan dollar limit - The maximum amount payable by the insurer for covered expenses for the insured and each covered dependent while covered under the health plan. ¨ Plans can have a yearly and/or a lifetime maximum dollar limit. ¨ The most typical of maximums is a lifetime amount of $1 million per individual.
Maximum out-of-pocket expense:	The maximum dollar amount a group member is required to pay out of pocket during a year. Until this maximum is met, the plan and group member shares in the cost of covered expenses. After the maximum is reached, the insurance carrier pays all covered expenses, often up to a lifetime maximum. (See previous definition.)	
Medical savings accounts (MSA):	Savings accounts designated for out-of-pocket medical expenses. In an MSA, employers and individuals are allowed to contribute to a savings account on a pre-tax basis and carry over the unused funds at the end of the year. One major difference between a Flexible Spending Account (FSA) and a Medical Savings Account (MSA) is the ability under an MSA to carry over the unused funds for use in a future year, instead of losing unused funds at the end of the year. Most MSAs allow unused balances and earnings to	

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	accumulate. Unlike FSAs, most MSAs are combined with a high deductible or catastrophic health insurance plan.	
Medically necessary:	Services necessary to prevent, diagnose or treat an illness, injury, condition or disease, or the symptoms of an illness, injury, condition, or disease; and meeting accepted standards of medicine.	
Minimum premium plan (MPP):	A plan where the employer and the insurer agree that the employer will be responsible for paying all claims up to an agreed-upon aggregate level, with the insurer responsible for the excess. The insurer usually is also responsible for processing claims and administrative services.	
Modified Adjust Gross Income (MAGI)	Adjusted gross income (AGI) after considering certain allowable deductions	
Multiple Employer Welfare Arrangement (MEWA):	MEWA is a technical term under federal law that encompasses essentially any arrangement not maintained pursuant to a collective bargaining agreement (other than a State-licensed insurance company or HMO) that provides health insurance benefits to the employees of two or more private employers. Some MEWAs are sponsored by associations that are local, specific to a trade or industry, and exist for business purposes other than providing health insurance. Such MEWAs most often are regulated as employee health benefit plans under the Employee Retirement Income Security Act of 1974 (ERISA), although States generally also retain the right to regulate them, much the way States regulate insurance companies. They can be funded through tax-exempt trusts known as Voluntary Employees Beneficiary Associations (VEBAs) and they can and often do use these trusts to self-insure rather than to purchase insurance policies. Other MEWAs are sponsored by Chambers of Commerce or similar organizations of relatively unrelated employers. These MEWAs are not considered to be health plans under ERISA. Instead, each participating employer's plan is regulated separately under ERISA. States are free to regulate the MEWAs themselves. These MEWAs tend to serve as vehicles for participating employers to buy insurance policies from State licensed insurance companies or HMOs. They do not tend to self-insure.	
Multi-employer health plan:	Generally, an employee health benefit plan maintained pursuant to a collective bargaining agreement that includes employees of two or more employers. These plans are also known as Taft-Hartley plans or jointly administered plans. They are subject to federal but not State law (although States may regulate any insurance policies that they buy). They often self-insure.	
Patient Classification	Upon admission a patient is classified into one of the following categories (If an Out of State patient present to the hospital, they will follow the same process as the patient that is local.):	
Patient's Cost:	means the portion of charges billed to a patient for care received at a hospital or a hospital- affiliated clinic that are not reimbursed by insurance or a publicly funded health care program	
	1. Private Pay	Patients are expected to pay at the time of service but if this is not possible, a Patient Service

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		Representative will meet with the patient to discuss the payment arrangements and will offer Financial Assistance Application if needed. Methods of payments accepted are cash, check, Visa, MasterCard and American Express.
	2. Insurance	Insurance coverage will be verified at each visit. If the insurance can -not be verified, the account is setup as a Private Pay patient. Co-pays, deductibles, and co-insurances will be attempted to be collected at the time of the visit, if applicable. The only exception will be for the ER. The difference in the number of charges, reimbursement from insurance company and contractual adjustments, will be billed to the patient.
	3. Medicare / Medicaid	Medicare and Medicaid will be billed number of services and the difference between amount billed and reimbursement from fiscal intermediaries except for deductible and co-insurance must be written off to respective contractual adjustments.
	4. Workman's Compensation	It is the responsibility of the patient to provide all the necessary information to bill the Workman's Compensation company for the services rendered. The difference between what the hospital bills and what the Workman's compensation pays must be written off to respective contractual adjustments.
Premium:	Agreed upon fees paid for coverage of medical benefits for a defined benefit period. Premiums can be paid by employers, unions, employees, or shared by both the insured individual and the plan sponsor.	
Premium equivalent:	For self-insured plans, the cost per covered employee, or the amount the firm would expect to reflect the cost of claims paid, administrative costs, and stop-loss premiums.	
Primary care physician (PCP):	A physician who serves as a group member's primary contact within the health plan. In a managed care plan, the primary care physician provides basic medical services, coordinates and, if required by the plan, authorizes referrals to specialists and hospitals.	
Reinsurance:	The acceptance by one or more insurers, called reinsurers or assuming companies, of a portion of the risk underwritten by another insurer that has contracted with an employer for the entire coverage.	
Self-insured plan:	A plan offered by employers who directly assume the major cost of health insurance for their employees. Some self-insured plans bear the entire risk. Other self-insured employers insure against large claims by purchasing stop-loss coverage. Some self-insured employers' contract with insurance carriers or third party administrators for claims processing and other administrative services; other self-insured plans are self-administered. Minimum Premium Plans (MPP) are included in the self-insured health plan category. All types	

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	of plans (Conventional Indemnity, PPO, EPO, HMO, POS, and PHOs) can be financed on a self-insured basis. Employers may offer both self-insured and fully insured plans to their employees.
Stop-loss coverage:	A form of reinsurance for self-insured employers that limits the amount the employers will have to pay for each person's health care (individual limit) or for the total expenses of the employer (group limit).
Third party administrator (TPA):	An individual or firm hired by an employer to handle claims processing, pay providers, and manage other functions related to the operation of health insurance. The TPA is not the policyholder or the insurer.
Under-insured:	The patient has some level of insurance or third-party assistance, but still has out-of-pocket expenses that exceed his/her financial abilities.
Uninsured:	The patient has no level of insurance or third-party assistance to assist with meeting his/her payment obligations.

Procedure:

Employee Access to billing accounts.

"Protected Health Information" or "PHI" is any individually identifiable health information, in any form or media, whether electronic, paper or oral. "Individually identifiable" means that the health or medical information includes or contains any element of personal identifying information sufficient to allow identification of the individual, such as the patient's name, address, electronic mail address, telephone number, or social security number, genetic or other information that, alone or in combination with other publicly available information, reveals the individual's identity. PHI includes: medical information; patient billing and health insurance information; and applies to a patient's past, current or future physical or mental health or treatment.

Individuals should only have access to Lake Health District Restricted Information and Electronic Information Resources as necessary for their job functions. Lake Health District shall determine which individuals are authorized to access Restricted Information and Electronic Information Resources in accordance with their job responsibilities. Lake Health District shall establish unique user identification for each individual who is authorized to access Restricted Information.

Permitted Access to PHI:

Access to patient records is limited to authorized business purposes only. This means that access must be work-related and limited to the following purposes:

A. Billing
B. Collections assignment

Prohibited Access to PHI:

Accessing patient records outside of the above reasons is not permitted and will be considered a violation of patient privacy and of Lake Health District privacy policies. Typical examples of accessing patient records for non-business reasons or personal reasons includes accessing records of:

A. Family members and friends
B. Co-workers

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C. Celebrities, athletes, public figures, or other VIPs

Restriction of Access

Employees conducting billing and collection operations are expected to hold themselves to the highest standards of professionalism. At no time shall any employee, regardless of job position discuss or divulge information relevant to a client/patients bill with anyone outside of their direct scope of duties. Lake Health District systems monitor entries made to billing accounts to ensure appropriate access and confidentiality is maintained. This means that remarks and adjustments to billing documents are recorded and digitally stamped with the name of the billing personnel who made such adjustments or remarks, as well as the time and date of access and changes made. At no time shall an employee be responsible for or allowed to handle the billing account of a family member or themselves.

Lake Health DIstrict reserves the right to conduct both periodic and random audits of billing accounts for accuracy, appropriateness, and signs of potential fraud waste or abuse. For more information, See "Lake Health District HIPAA Compliance Program" and "Lake Health District Fraud, Waste, and Abuse Prevention and Detection Policy

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 can 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.

Financial Assistance has no bearing on the District's Fee schedule as required by law. Financial assistance shall be provided based upon a graduated discount scale dictated by the U.S. Department of health and Human Services Poverty Guide:

Federal Income Poverty Level (Updated Annually)					
Federal Income Poverty Level 2023	Base Line	< 200%	200% - 300%	300% - 350%	350%
Discount %	100%	100%	75%	50%	2
Persons in family / household	Annual Income				
1	$15,960	$31,920	$31,921 - $47,880	$47,881 - $55,860	$ 55,861
2	$21,640	$43,280	$43,281 - $64,920	$64,921 - $75,740	$ 75,741
3	$27,320	$54,640	$54,641 - $81,960	$81,961 - $95,620	$ 95,621
4	$33,000	$66,000	$66,001 - $99,000	$99,001 - $115,500	$115,501
5	$38,680	$77,360	$77,361 - $116,040	$116,041 - $135,380	$135,380
6	$44,360	$88,720	$88,721 - $133,080	$133,080 - $155,260	$155,260

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7	$50,040	$100,080	$100,081 - $150,120	$150,121 - $175,140	$175,141
8	$55,720	$111,440	$111,441 - $167,160	$167,161 - $195,020	$195,021
For families/households with more than 8 persons, add $5,680 for each additional person.					

Information retrieved from: https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines

See: https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines

See: Financial Assistance Policy

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 childcare, child of spousal support, transportation, and auto expenses, including insurance, gas, and repairs, installment payments, laundry and cleaning, and other extraordinary expenses.

Financial Assistance Patients are Defined as Follows:

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.

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

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

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.

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

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.

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 50l(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.

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Patient Classification:

Upon admission a patient is classified into one of the following categories:

1. Private Pay
2. Insurance
3. Medicare
4. Medicaid
5. Workman's Compensation

(See: Patient Classification Policy)

Extraordinary Collections Actions (ECAs)

As defined in Section 501(r) (6) of the Internal Revenue Code, ECAs are defined as actions taken by a hospital facility against an individual related to obtaining payment of a bill for care covered under the hospital facility's FAP that;

- involve selling an individual's debt to another party,
- involve reporting adverse information about an individual to consumer credit reporting agencies or credit bureaus (collectively, "credit agencies"),
- require a legal or judicial process.

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Examples of actions that may require a legal or judicial process include, but are not limited to:

- Placing a lien on an individual's property
- Foreclosing on an individual's real property
- Attaching or seizing an individual's bank account or any other personal property
- Commencing a civil action against an individual
- Causing an individual's arrest
- Causing an individual to be subject to a writ of body attachment
- Garnishing an individual's wages

A claim filed by a hospital facility in any bankruptcy proceeding is not an ECA. Also, a lien placed on the proceeds of a judgment, settlement, or compromise owed to an individual (or his or her representative) as a result of personal injuries caused by a third party for which the hospital facility provided care is not an ECA.

The Following federal benefits are exempt from Garnishment by a creditor

- Public Assistance
- Supplemental Security Income (SSI)
- Social Security
- Social Security Disability (SSD)
- Veterans Benefits (VA)
- Child Support
- Spousal Support
- Workers Compensation
- Unemployment Insurance

- Railroad Retirement Benefits
- Public and private pensions
- Retirement savings account (401(k)), 403(b), and IRAs)
- All the principal and 90% of payments from a private trust

Credit and Refund Policy:

Credit

To serve the community, the hospital must collect funds form those who are able to pay. Charges to patients reflect the services rendered. No patient will be discriminated against because of race, color, religion, creed, national origin, personal relations, or handicap.

It is the policy of Lake District Hospital to adhere to all regulations and guidelines that are set by the Federal Government and the State of Oregon. Policies can be reviewed for discounts and charity assistance at the hospital reception desk and the hospital website. If requested, paper copies are also available.

Refunds:

Under Oregon law, Lake Health District shall submit refunds for overpayment of accounts within thirty (30) days of the overpayment discovery. Lake Health District will not refund amounts of $5.00 US Dollars and will likewise not send statements for payment balances of less than $5.00 US Dollars

Procedures:

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A. **Initial Patient Billing:**

1. 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.
2. 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.
3. The initial patient billing statement will include information on how to apply for financial assistance.
4. 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.
5. Statements of accounts to patients with balances secondary to a primary insurance payment will include information on how to apply for financial assistance.
6. 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. (***If the minimum payment exceeds 10% of the family income for a month, excluding deductions for essential living expenses creates a financial hardship for the patient or their family***).
7. The initial patient billing statement will include a copy of the Plain Language Summary of Hospital Financial Assistance Policy.

B. **Statement Billing Cycles:**

1. Balance due statements are generated every 30 days after the date of the initial statement.
2. Three statements will be generated by the hospital during the first 90 days from the initial self-pay billing.

3. After 150 days the unpaid account will be assigned to a collection vendor for further follow-up activity. A final phone call will be placed to the guarantor before the bill is sent to the third party collections agency.
4. 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.
5. Patients on a formal payment plan will receive a monthly statement of the current amount due until the payment plan is satisfied. Patient who have two missed payments on a payment plan will be contacted 1x and held for 30 days. If no response, the patient will be sent to a third party collection agency.
6. Financial aid agreements require that the agreed upon amount must be paid within 1 calendar year (365 days) of the signed agreement

C. **Collection Agency Assignment of Delinquent Accounts:** Under Oregon Law, the statute of limitations for an attempt to sue for settlement of a Debt is six (6) years. Should Lake Health District fail to collect the remaining balance of the debt, fail to remit the remaining balance of the debt to an appropriate collection agency, or fail to file claim against a patients estate within that time frame, Lake Health District shall right off the remaining balance as a loss.

1. 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. Under Oregon law, If the agreement requires the consumer/patient to pay a specified amount per payment, Lake Health is not required to consider a lesser amount as a good payment.
2. 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:
    a. Attempt to contact the patient by phone.
    b. Give notice in writing that the plan may become inoperative.
    c. Inform the patient of the opportunity to renegotiate the payment plan and attempt to do so if requested by the patient.
    d. The notice and phone call may be made to the last known phone number and address of the patient. (Negative contact with the patient or failure to return correspondence in any manner available by the patient after 120 days, shall be treated as a refusal to pay)
3. 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 FAP is not pending.
    a. 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.
    b. 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.
    c. 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.
    d. 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

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4. 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.
5. 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 after 150 days and a final notification call.
6. Patients who provide inaccurate demographic data and where the hospital cannot determine a valid mailing address or telephone number may be sent to collections earlier than 150 days. It is the guarantor(s) responsibility to provide a correct contact information at the time of service or upon moving. If the contact information on the account is invalid or otherwise undeliverable to the individual, the determination for "reasonable effort" will have been made.
7. 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.
8. The patient will be informed in writing at 120 days delinquency before any ECAs are initiated. This 30-day notice will be sent prior to the 150day delinquency of payment and include a copy of the Plain Language Summary of Hospital Financial Assistance Policy.
9. 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.
10. 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.
11. Payments made directly to the hospital for accounts assigned to a collection agency will be reported to that agency daily.
12. 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.
13. 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.
14. 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.

D. **Debt Claim against a Decedents Estate:**

1. As a rule, an individual/patient's debts do not go away when they die. Those debts are owed by and paid from the deceased person's estate, not individual surviving family members with the following exceptions.
    - co-signed the obligation (Bill for services, Loan, etc.
    - were legally responsible for resolving the estate and didn't follow certain state probate laws.

In such cases, as a patient is deceased, thus no longer able to fulfill their financial obligation, Lake Health District will work with its legal council to file claim for the balance due on the decedent's estate.

References:

- Lake Health District Employee Handbook
- The Fair Credit Reporting Act, 15 U.S.C. § 1681 et seq
- The Consumer Credit Protection Act Of 1968 (CCPA)
- The Fair Debt Collection Practices Act, Pub. L. 95-109; 91 Stat. 874, codified as 15 U.S.C. § 1692 –1692p

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- Oregon Fair Debt Collection Practices Act ORS 646.639
- ORS 646.641 Civil action for unlawful collection practice
- ORS 697 Debt Collection and Management
- ORS 725 Consumer Finance

Responsible POC:

- Blanca Hudson Ext. 244 — Business Office Manager
- Edward Keough Ext. 220 — Chief Financial Officer

Previous Versions.:

- Pre PolicyStat 9-895-204
- Pre PolicyStat Number: 9-895-204
- PolicyStat “Refund and Billing Policy” (enveloped in this policy)
- PolicyStat “Credit Policies” (enveloped in this policy)

All Revision Dates

1/19/2026, 1/30/2024, 12/27/2023

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Attachments

Appendix A: Amounts Generally Billed (AGB) Calculation

Approval Signatures

Step Description	Approver	Date
Chief Executive Officer	Landon Dybdal: Chief Executive Officer	1/19/2026
Chief Financial Officer	Kelly Johnston: CFO	1/16/2026