Owner: Wendy Dumais	Level 1 - CH Health System
Approver(s): Scott Sloane	
Effective: 10/25/2022	Last Reviewed: 10/25/2022

Applicable to: Concord Hospital - ALL

Title: Credit and Collections - Policy

1. Obtaining a Copy of this Policy

Copies of this policy are available on the Concord Hospital website, www.concordhospital.org, or by calling Customer Service, toll free, at (855) 705-4971

2. Scope

This Credit and Collection policy covers services provided by Concord Hospital, Concord Hospital – Laconia, Concord Hospital – Franklin and Concord Hospital Medical Group (CHMG). This includes all physicians who are employed directly by the hospital.

Any Concord Hospital (CH) reference contained in this policy includes all entities listed above.

3. Policy

Concord Hospital is a charitable organization which exists to meet the health needs of individuals within the community it serves. It is the established policy of Concord Hospital to provide services on the sole basis of the medical necessity of such services as determined by the medical staff without reference to race, color, ethnicity, national origin, sexual orientation, marital status, religion, age, gender, disability, or inability to pay for such services.

As such, patients requiring urgent or emergent services shall not be denied those services based on ability to pay. However, to ensure the financial viability and ongoing operation of the organization, Concord Hospital (CH) will take all appropriate business measures to ensure that prompt payment is collected for services provided. This policy outlines those measures. It extends to third party payers, individuals with balances after insurance, and uninsured individuals.

It is the policy of Concord Hospital to ensure individuals eligible for assistance under the Financial Assistance Policy (FAP) are not billed more for medically necessary care than the amounts generally billed (ABG) to individuals who have insurance as required by law.

4. Purpose

To outline the billing and collection efforts that CH will take to obtain payment from responsible individuals; to ensure that reasonable efforts are made to determine whether the individual responsible for payment of an account is eligible for assistance; and to maximize collections from individuals who have the ability to pay. This policy is designed to ensure compliance with state and federal law and regulations.

5. Abbreviations

AGB – Amounts Generally Billed

CH – Concord Hospital

CHMG – Concord Hospital Medical Group

ECA – Extraordinary Collection Actions

FA – Financial Assistance

FAP – Financial Assistance Policy

IRS – Internal Revenue Service

LOP – Letter of Protection

PLS – Plain Language Summary

6. Definitions

Encounter: Each visit is associated with one encounter. One patient may have multiple encounters.

Encounter Number: A ten digit number associated with each account.

AGB Percentage: A percentage calculated annually by dividing the allowed amount by the total gross charges for the same set of claims.

Allowable Rates: The "allowable rate" is used in the AGB calculation. It refers to the reimbursement amounts for all claims adjudicated by Medicare and private insurance companies, plus the amounts paid or expected to be paid by the responsible party in the form of co-insurance, copayment, or deductibles.

Award Letter: Letter provided to an individual who has been awarded Financial Assistance. This letter contains the details of the award.

Claim: A form submitted either electronically or on paper to a third party insurance company for the purposes of receiving payment for medical care.

Contracted Payer: A third-party insurance company that has a contracted agreement with CH.

Co-Insurance: A percentage of the allowed amount the responsible party is required to pay for covered health care services after the deductible is met.

Co-Payment: A fixed amount the responsible party is required to pay for covered health care services after the deductible is met.

Credit Balance: When payments are received in excess of the amount owed, this is called a credit balance.

Days: In this policy, references to days mean calendar days (as opposed to business days) unless otherwise specified.

Deductible: The amount the responsible party is required to pay for covered health care services before insurance starts to pay. Once the deductible is met, typically the responsible party will only pay for co-payments or coinsurance.

Dunning Levels: A dunning level is an indicator of the current age of a patient balance. Each dunning level corresponds with a system activity, specifically statement messages or agency referrals.

Extraordinary Collection Actions (ECAs): As defined by Section 501(r) of the Internal Revenue Code, ECAs are specific collection actions taken by the hospital against a patient related to obtaining payment for medically necessary care.

Financial Assistance Policy (FAP): CH provides charitable care to insured and uninsured individuals who qualify. The eligibility criteria and application process are described in the Financial Assistance Policy, which is available on the concordhospital.org website and by calling (800) 562-1542.

Financial Assistance Plain Language Summary (PLS): A brief, easy-to-read summary of the CH Financial Assistance Policy including eligibility requirements; program offerings; and instructions explaining how to obtain the full policy, apply, and who to contact for help completing the application.

First Statement Date: The date that the first post-discharge billing statement was sent to the responsible party on an individual account. For multiple accounts placed with a collection attorney, the first statement on the most recent episode of care will be used. The first statement date is used to calculate the deadline after which Extraordinary Collection Action(s) (ECAs) may begin.

Gross Charges: Gross charges are used in the AGB calculation. Gross charges refer to the full, established price for medical care before any contractual allowances, negotiated discounts, or patient discounts are applied.

Guarantor: See definition for Responsible Party.

Initiation Notice: The initiation notice informs the responsible party that CH is prepared to initiate Extraordinary Collection Actions (ECAs).

Insurance Filing Limit: An insurance filing limit is a date on which claims may no longer be submitted to insurance, because too much time has passed between the date of service and the claim submission date. Most insurance plans allow between 90 days and a year for claim filing.

Lien: A lien is a legal claim placed against an individual’s assets, typically real estate property or a pending settlement, in order to protect the hospital’s interest for

obtaining payment against the services provided. The responsible party may be held liable for interest, attorney fees, and court costs.

Medically Necessary Care: Health care services or supplies needed to diagnose or treat an illness, injury, condition, disease, or its symptoms that meet accepted standards of medicine. The following are examples of services that are not considered medically necessary and do not quality for financial assistance: prescription drugs, cosmetic procedures, complementary medical services, outpatient preventive dental services, investigational services, or elective non-covered services as specified by Medicare and other third-party coverage guidelines.

Missing Document Letter: Letter that informs a financial assistance applicant that the application is incomplete. The letter includes a checklist of the documents or items that must be provided in order to process the application.

Non-Contracted Payer: A third party insurance company that does not have a contracted agreement with CH.

Out of Network Costs – Surcharge amount an insurance may charge as a penalty for obtaining services out of the payer's network.

Pre-Payment Deposit: A payment amount due prior to the provision of services.

Responsible Party (Guarantor): The person who will assume financial responsibility for any and all self-pay balances associated with the patient's care. The responsible party is typically assigned at the time of registration. For more information about assignment of the responsible party, see the Guarantor Assignment policy.

Third-Party Payer: An organization other than the patient that may pay all or part of a patient's medical bill. Third-party payers include health insurance, auto insurance, and workers compensation insurance companies.

Uninsured: Uninsured patients are patients that do not have third-party coverage from a health insurer, Medicare, Medicaid or other Federal health care program. Additionally, in order to qualify as an uninsured patient, the patient's injury cannot be a compensable injury for the purposes of workers' compensation, automobile insurance, or other insurance as determined and documented by CH. If the patient has either a Health Savings Accounts or a health Reimbursement Account they will not quality as uninsured. Uninsured patients will not be charged more for emergency or other medically necessary care than the amounts generally billed to patients with insurance.

Uninsured Discount: The uninsured discount is a percentage adjustment to gross charges for uninsured individuals. It's calculated by subtracting the AGB percent from 100 percent.

7. No Surprises Act

Concord Hospital will follow all guidelines and regulations to be in compliance with the CMS No Surprises rule which addresses requirements for self-pay patients. This rule gives protection from surprise patient billing for self-pay patients. It requires providers to notify patients of estimated costs via a Good Faith Estimate (GFE).

7.1 Identifying Patients

On a daily basis, all patients that are scheduled for any service in the hospital or a provider office will populate a worklist in revenue cycle. That list will be filtered for those patients that have an appointment and are true self-pay,

7.2 Determining Cost

To the best of our ability based on scheduling reason and historical data for the office/facility, a cost of care estimate will be determined.

7.3 Notifications- GFE's

Once the amount has been determined a GFE letter will be generated that provides all of the data outlined by the federal government including the estimated cost of the scheduled visit. This will be mailed to the patient within the federal guidelines outlined in the No Surprises Rule.

7.4 Disputes

Patients have the right to dispute the GFE and the amount billed. To dispute either, the responsible party should contact Concord Hospital Customer Service. They can be reached by calling (603)228-7145 or by email at PFSCustomerSVC@crhc.org. The account will be reviewed by the Manager of Credit and Collections taking into account: the information provided for the GFE, actual service rendered and any additional services. The patient will receive a written response. If we agree the account will be adjusted. If we disagree, we will provide the patient with the reason why and substantiating documentation.

7.5 Out of network costs

Concord Hospital will not bill or hold the patient (or guarantor) responsible for these costs. When identified by the payer, CH will adjust the charges off prior to billing. Should CH not be notified but the patient is, they should contact Customer Service. Once provided with the corrected information, CH will adjust the balance accordingly.

8. Point of Service Collections

CH may attempt to collect a co-payment, deductible, and/or pre-payment deposit prior to the provision of non-emergent services. Pursuant to the Emergency Medical Treatment and Labor Act (EMTALA), CH will stabilize and treat an individual coming to the emergency department regardless of their insurance status or ability to pay.

9. Financial Assistance

Concord Hospital has a generous Financial Assistance program. Individuals who cannot afford to pay for their medical care are encouraged to apply for Financial Assistance. Financial Assistance is available to individuals who are uninsured and for those individuals who have insurance, but cannot afford their out-of-pocket costs such as co-payments, co-insurance, and deductibles. It's important to note that individuals will only be considered for Financial Assistance if they complete the application and provide all required supporting documentation as outlined in the Financial Assistance Policy. Per IRS code 501r, individuals have up to 240 days from date of service to apply for Financial Assistance.

While CH does provide Financial Assistance for those who qualify, all patients, regardless of income, may be asked to participate in paying a portion of their health care costs.

For more information about Financial Assistance, see the Financial Assistance Policy on the concordhospital.org or concordhospital-laconia websites.

10. Billing Insurance

If insurance information is provided to CH at the time of registration, or following registration but before the insurance filing limit expires, CH will submit all covered charges to insurance in order to collect all available patient insurance benefits prior to attempting to collect from the responsible party.

Billing statements are mailed to the responsible party only after all claims have been settled with third-party payers, unless one or more of the following conditions are met:

- CH has made repeated attempts to seek payment with a non-contracted payer, who has not paid the claim
- The responsible party has not responded to payer requests for additional information required, and the plan denies payment of the claim
- The responsible party has not provided correct or complete billing information within the health plan filing limit
- If insurance information is provided beyond the time the plan allows CH to bill, the guarantor will be responsible for the entire balance.
- No patient will be billed out of network costs. Any difference will be written off as contractual allowance.

11. Uninsured Discount Program and the AGB Percentage

11.1. Eligibility for the Uninsured Discount: Pursuant to IRS Code 501(r), CH must ensure that individuals eligible under the Financial Assistance Policy

are not billed more for their care than individuals who have insurance. CH complies with this law by applying an uninsured discount to all uninsured individuals, regardless of whether or not that individual applies for Financial Assistance. Individuals who do not have medical or other third party liability insurance coverage will qualify for CH's Uninsured Discount program for all medically necessary care. Responsible parties who refuse to provide insurance information or make assignment to CH, or those who choose to bill their own insurance will not be considered uninsured and are not entitled to the uninsured discount. Self-pay balances for insured individuals, such as co-payments, deductibles, and co-insurance, are not eligible for the Uninsured Discount.

11.2. Calculating AGB Percentage: CH calculates its AGB amount annually using the look-back method. CH uses the allowable rates set by private health insurers and Medicare on claims adjudicated over the prior twelve month fiscal year, which is October 1 through September 30. The total allowed for these claims divided by the total gross charges for the same claims results in the AGB percentage.

11.3. Calculating the Uninsured Discount Percentage: The AGB percentage is subtracted from 100 percent to determine the Uninsured Discount percentage. CH updates the Uninsured Discount Amount each January 1 based on the prior fiscal years' AGB percentage.

12. Billing Statements

Billing statements are sent to the responsible party indicated on the encounter. All statements are generated at the visit level, meaning responsible parties will receive a separate statement for each visit. CH does not support family billing at this time.

Each statement includes the following:

- A summary of services provided
- The charges for such services
- A summary of payments and adjustments
- The balance due on the account
- Pursuant to NH RSA 151:12-b, statements will inform the patient that uninsured patients receive a discount consistent with the amounts generally billed/received from insurance for the same services
- CH's payment plan guidelines and a plain language summary (PLS) of the Financial Assistance Policy
- A statement that itemized bills are available upon request

13. Payments

13.1. Payment Due Dates: Payment is requested upon receipt of the first statement; however, payment plans and other programs are available to assist individuals who cannot pay in full within thirty days.

13.2. Payment Posting: Payments will be posted to the encounter associated with the statement. If the corresponding payment stub is not returned with the payment, the payment will be posted to the oldest active encounter.

13.3. Credit Balances: Credit balances will be transferred to any outstanding balance(s) for the patient or any other balances for which the patient is the guarantor prior to issuing a refund check. If the patient does not have any encounters with outstanding balances, Concord Hospital is responsible to return over-payments to their rightful owners as quickly as is possible and within the confines of applicable laws and regulations.

14. Encounter Adjustments

Concord Hospital (CH) adjusts balances on accounts for appropriate processing of encounters. These are the standard CH encounter adjustments.

14.1. Employer/Agency

Unless otherwise negotiated or contracted with Concord Hospital, there shall be no employer/agency balance adjustments.

For contracted discounts the appropriate adjustment will be taken when payment is received by Cash Applications.

14.2. Charity/ Financial Assistance

Once an application is approved by Financial Assistance, the entire patient balance shall be adjusted off.

14.3 Small Balance

Small balances shall be defined as any balance between -9.99 and 9.99 for both self-pay and insurance (with the exception of all government programs).

15. Statement Schedule/ Dunning Levels

Dunning levels are assigned prior to producing the statement, based on payments posted. If a payment is not made on a timely basis, the dunning level will escalate.

15.1. First Statement (Dunning Level 1): The initial or first statement will be mailed once an encounter is considered “self-pay.” If the individual has insurance, we will wait for insurance to process the claim, as outlined in Section 9. Small balances, defined as $9.99 or less, will be adjusted off and not billed.

15.2. Overdue Statement (Dunning Level 2): If payment is not received within 30 days of the initial statement, an overdue statement is mailed.

15.3. Final Notice (Dunning Level 3): If payment is not received within 30 days of the overdue statement, a final notice is mailed. Typically, CH will also attempt to reach the responsible party by phone. If payment is not received within 30 days of the final notice, the encounter will be pre-listed for Bad Debt – see section 15.1.

16. Payment Options

16.1. Standard Payment Plans: CH offers interest free payment plans upon request. The minimum payment plan amount is either 10% of the total balance or $40.00 per month; whichever is greater. Exceptions will be considered. Extended payment may be allowed if an individual is requesting a payment schedule that would exceed twelve months, but not exceed twenty four months.

16.2. Budget Payment Plans: CH offers interest free extended payment plans for individuals who are committed to meeting their financial obligation, but are not able to meet the minimum payment requirements for a standard payment plan. The maximum repayment schedule for a budget payment plan is 60 months. CH reserves the right to make exceptions to this.

17. Bad Debt and Collection Agency Referral

17.1. Bad Debt Pre-List (Dunning Level 4): If payment is not received within 30 days of the Final Notice, and the Responsible Party has not contacted us to make other arrangements, the encounter will be pre-listed for Bad Debt.

17.2. Collection Agency Referral (Dunning Level 5): The encounter will be placed with a collection agency the first day of the month following the pre-list date. At this point, the balance on the encounter is written off to bad debt. CH reserves the right to transfer encounters to collection agencies as soon as it is established that the encounters do not have a valid mailing address. CH works with a few different Collection Agencies. They are business partners of CH and are not authorized to charge interest on any encounters they are assigned. At this time, they are also not permitted to report balances to credit reporting agencies.

17.3. Collection Agency Referral Exceptions:

17.3.1. No Estates or known deceased patients' encounters will be sent to a collection agency if CH or our collection attorney have determined there are no assets in the estate. However, filing may be made with the Probate Court to protect the hospital's interests.

17.3.2. When we are notified of bankruptcy filing, balances associated with the bankruptcy will not be assigned to a collection agency. A proof of claim filing may be made at the time we are notified of the filing.

18. Extraordinary Collection Actions

18.1. Extraordinary Collection Actions (ECAs): As a result of non-payment, Concord Hospital may engage in the following ECAs: Engaging in a legal or judicial process, including, but not limited to placing a lien on an individual's property; attaching or seizing a bank account or other personal property; wage garnishments; commencing civil action; and arrest. See Section 17.

18.2. Timing of ECAs: CH may initiate ECAs as soon as 120 days following the initial billing statement or within 30 days of an ECA Initiation Notice, whichever is later.

19. Collection Attorney Referrals and Legal Action

19.1. Referral to Collection Attorney: Each month, CH reviews encounters pre-listed for bad debt (Dunning Level 4) for potential referral to the collection attorney. Encounters that are already placed with a Collection Agency may also be referred to a collection attorney. Referral to a collection attorney may, but does not always, result in legal action against the responsible party.

19.1.1. Referral Criteria: Encounters may be referred in the following situations:

- The individual encounter balance, or combined responsible party encounter balances total $10,000.00 or more
- OR the responsible parties have a high volume of encounters and refuse to pay or demonstrate a pattern of non-payment
- OR the responsible party is otherwise noncompliant (e.g. has not contacted the insurance company to resolve an outstanding issue preventing payment to CH)
- AND CH has no reason to believe the responsible party is unable to pay.

19.1.2. Oral Notification: Concurrent to referring the encounter(s) to the Collection Attorney, the Manager of Customer Service or designee will provide the Financial Assistance Supervisor a copy of the list of individuals and encounters to be referred. The Financial Assistance Supervisor or designee will attempt to orally notify each responsible party of the availability of financial assistance and the application process. The Financial Assistance Supervisor or designee will record in the Timeline the date and outcome of the call.

19.1.2.1. If an incomplete app is already on file, we will still attempt to orally notify the responsible party.

19.1.2.2. If responsible party has already applied and been denied, we will not attempt to notify. These encounters will be omitted from the list sent to the Supervisor of Financial Assistance.

19.1.3. Initiation Notice: Concurrent to referring the encounter(s) to the Collection Attorney, the Manager of Customer Service or designee will send a written notice to the responsible party. This notice will include the following information:

- Statement of encounter(s) that are being placed with Collection Attorney
- Statement of the ECA(s) that may be initiated
- Deadline that the ECA(s) may be initiated, which will be no sooner than 120 days passed the mailing date of the first statement or 30 days passed the mailing date of the initiation notice, whichever is later
- Financial Assistance Plain Language Summary

The Manger of Customer Service or designee will record on the encounters timeline the date the notice was mailed. He or she will also send a copy of the notice to be scanned to the patient's encounter(s).

19.2. Authorization of Legal Action: The collection attorney may recommend legal action when the responsible party has sufficient assets to pay all or a portion of the debt. Prior to engaging in legal action, the collection attorney must receive written approval from the Manager of Customer Service, or Director of Patient Financial Services. These individuals may only authorize legal action if all of the following conditions are met:

- The collection attorney has no reason to believe the responsible party is unable to pay the debt.
- AND at least 120 days have passed since the mailing date of the first statement
- AND at least 30 days have passed since the mailing date of the initiation notice
- AND the encounter timeline indicate that CH has made at least one attempt to orally notify the individual about the financial assistance policy.

19.3. Financial Assistance Application Received during the Legal Process: Pursuant to IRS Code 501(r), CH must process Financial Assistance Applications received within 240 days of the first statement date or within 30 days of the initiation notice, whichever comes later. CH may, but is not required to, process applications received after this date. It is the responsibility of the Manager of Customer Service or designee to work with the Financial Assistance department and the Collection Attorney to ensure the below requirements are met.

19.3.1. Incomplete Application Received: When an incomplete Financial Assistance Application is received, the Financial Counselor will notify the Manager of Customer Service or designee and send a Missing Document Letter to the responsible party indicating the application is incomplete. The letter will include all of the following information:

- A statement listing the potential ECAs that may be initiated
- A plain language summary of the Financial Assistance Policy
- A checklist of documents or items that must be provided in order to process the application
- Contact information for the department or person that can help the patient complete the application

The Financial Counselor will notify the Manager of Customer Service or designee that an incomplete application was received and provide the date the Missing Document Letter was mailed. The Manager of Customer Service or designee will notify the Collection Attorney to suspend all ECAs until either the application is completed or 30 days have passed from the mailing date on the Missing Document Letter, whichever comes first.

19.3.2. Complete Application Received: When a complete Financial Assistance Application is received, the Financial Counselor will notify the Manager of Customer Service or designee. The Manager of Customer Service or designee will notify the Collection Attorney to suspend all ECAs until CH has determined whether the patient meets Financial Assistance eligibility criteria.

19.3.3. Financial Assistance Denied: If the responsible party does not meet the eligibility requirements of the Financial Assistance Policy, the Financial Counselor will mail a letter to the responsible party explaining the decision and the basis of the decision. The Financial Counselor will notify the Manager of Customer Service or designee

of the outcome. The Manager of Customer Service or designee will send the patient an updated Initiation Notice and work with the Collection Attorney to resume ECAs.

19.3.4. **Financial Assistance Approved**: If the responsible party is awarded Financial Assistance, the Financial Assistance Counselor will mail an award letter to the responsible party. The Financial Counselor will notify the Manager of Customer Service or designee of the outcome.

19.3.4.1. **Approved for Free Care:** The Manager of Customer Service or designee will work with the Collection Attorney to reverse any ECAs that may have been initiated. If patient payments are made after approved for free care, payments will be refunded.

19.3.4.2. **Approved for Partial Catastrophic Assistance:** The Manager or designee of Customer Service will send the responsible party an updated Initiation Notice, a copy of the award letter, and itemized bills for any encounters with a remaining balance.

20. Bankruptcy

There are two types of bankruptcy notices sent by the Bankruptcy Court: (1) Notice of commencement of filing and (2) Discharge/Disallowance of Debtor. When a notice of commencement is received by CH the filing can either be individual or joint. All family members must be identified and each encounter provided with notification of bankruptcy proceedings having commenced, and the date of filing. If any encounter has been placed with an outside collection agency, it must be noted and a copy of the filing sent to the agency for their records. All charges previous to the filing of bankruptcy should be included in a proof of claim filing. All billing activity will be curtailed at this time until a final notice of discharge or disallowance is issued.

21. Litigation of Third party Liability Claims

CH will curtail its credit and collections efforts for encounter(s) over $2,500.00 in litigation if an enforceable Letter of Protection is sent by the attorney representing the responsible party stating the litigant will protect CH's interest in any subsequent settlement or judgment. The Letter of Protection will be forwarded to our collection agency attorney to determine if the LOP adequately protects the hospital's rights and the encounter(s) will be assigned to the collection attorney to protect the interests of the hospital. If the personal injury case fails, the balances revert back to the responsible party and arrangements for payment must be made. Any encounters less than $2,500.00 will not be subject to protection.

22. Contract Billing, Credit, and Collections

22.1. **Outside Contracts Credit Policy:** CH provides contracted healthcare and general services to area businesses. These services fall into two categories:

22.1.1. **Occupational Health Accounts:** Services required by an employer, such as pre-employment screening and physicals, return to work clearance, drug testing, ergonomic assessments, DOT screenings, etc. These services are paid by the employer.

22.1.2. **Nursing Home/Skilled Nursing Facility:** Services include primarily laboratory services, but also include radiology and pharmacy. Services are paid by the facility.

22.2. **Contract Billing and Collections:** Statements are generated monthly. Payment in full is expected within 30 days of the statement date. No payment arrangements will be made on these accounts. Accounts over 30 days old will be sent a series of three letters indicating the amount due. The first is a reminder, the second is an overdue notice, and the third is a final notice. The author of the contract will be notified when collection efforts have failed, and the author will curtail services or collect fees at the time services are rendered. At this time, the account will be written off to bad debt. Higher dollar balances may be referred to the Manager of Customer Service or designee for referral to a collection agency or attorney.

23. Related Documents

EMTALA Policy

Financial Assistance Policy

Guarantor Assignment Policy

Initiation Letter

24. Authorizing Body

Approved by the CH Board of Trustees on XX/XX/XXXX

25. Associated Committees

N/A