Title: Credit and Collection			Policy Number: C-8212-1208
Originating Department: Revenue Cycle Management		Affected Department: Patient Accounts; All Admitting/Registration Areas; Outcomes Management; FHPG Clinics	
Original Date: 09-2004	Revised Date: 07-2017		Reviewed Date: 07-2017
Medical Director Approval (if applicable):		Vice President, Quality Approval:	
Vice President Approval:		CEO Approval:	

POLICY

Payment for services is expected at or before the time services are rendered; however, FirstHealth of the Carolinas will provide all emergency and other medically necessary medical care to all persons in need of such care, regardless of their ability to pay. Although reimbursement is critical to the operation and stability of FirstHealth, it is recognized that not all individuals possess the ability to purchase essential medical services. Therefore, in keeping with our core purpose, "To Care for People," FirstHealth will identify programs (government assistance programs and grants, as well as FirstHealth's Financial Assistance Program) that will assist our patients with their financial needs.

PURPOSE

FirstHealth has a fiscal responsibility to ensure that accounts are paid promptly and that proper business practices are followed in attempting to collect insurance and patient balances. FirstHealth also recognizes that out-of-pocket healthcare costs are rising and collecting from patients can be challenging. Many of the procedures within this policy are provided as a toolkit for staff to utilize when serving our patients, and staff is empowered to deviate from these procedures on a case-by-case basis. FirstHealth also has the responsibility to ensure that our Credit and Collection policy is available to the general public. To meet this need, plain language summaries of this policy are made available at the point of registration and are published on our FirstHealth website: firsthealth.org.

PROCEDURE

At the time of registration or pre-registration, patients will be informed of their estimated out-of-pocket based on information provided. Payment in full is requested at or before the time of service for non-emergent medical services.

- If the patient cannot pay the full amount and the amount owed is **less than $1,000,** review prior balances to determine: Is there a history of bad debt?
  - **If no**,
    - Ask the patient how much they can pay today and establish a payment arrangement for the remaining balance.
  - **If yes**,
    - Inform the patient of their prior accounts and work with the patient to establish an acceptable payment arrangement. If this cannot be achieved, review the account with management. Services may be delayed based on management review and in agreement with the patient's provider.

- If the patient cannot pay the full amount, and the amount owed is **greater than $1,000**, review prior balances to determine: Is there a history of bad debt?
    - **If no**,
        - Request a deposit of 50% of the total out-of-pocket expense and establish a payment arrangement for the remaining balance. If the patient cannot pay this amount, work with the patient to establish an acceptable deposit and payment plan.
    - **If yes**,
        - Request a deposit of 50% of the total out-of-pocket expense, inform the patient of their prior accounts and attempt to establish payment arrangements on the prior accounts. If the patient cannot pay a 50% deposit on the current account, inform the patient that this service may be delayed and review the account with management.

- If payment arrangements cannot be met, Pre-Services staff/management will communicate with the patient and physician office and will attempt to reschedule the appointment for a date that meets the medical and financial needs of all parties involved. If the patient cannot be delayed due to the urgency of the procedure, management may request review from the Chief Medical Officer or, in the case of clinic services, review from the clinic manager and the patient's provider to determine if services should be delayed until acceptable payment arrangements are made.
- Any pre-cert or authorization obtained from insurance companies will be reviewed to ensure the rescheduled appointment is still within the allowed timeframe.
- Certain payors may not allow FirstHealth to delay services for insured patients due to a lack of patient payment (due to regulation or contractual arrangement).

If an acceptable payment cannot be made as described above, other arrangements are discussed, which are described in this policy.

Monthly payments may be accepted for a period not to exceed three years (36 months), unless extended by authorized personnel. There are three payment options available to patients:

1. FirstHealth Payment Plan – FirstHealth will provide an interest-free payment plan to patients based on their total account balance. If the balance is:
    i. **less than $300**, the term will be one (1) year and the minimum payment due will be the greater of $25.00 or $1/12^{th}$ of the patient balance.
    ii. **between $301 and $2,000**, the term will be one (1) year and the minimum payment due will be the greater of $50.00 or $1/12^{th}$ of the patient balance.
    iii. **between $2,001 and $5,000**, the term may be up to two (2) years and the minimum payment due will be $1/24^{th}$ of the patient balance.
    iv. **over $5,000**, the term may be up to three (3) years and the minimum payment due will be $1/36^{th}$ of the account balance.

    In above scenarios, the initial payment should be 10% of the total account balance, or $50.00, whichever is greater.

2. FirstHealth Payroll Deduction – FirstHealth will provide its employees with the opportunity to have their medical bills deducted from their pay via payroll deduction, either by use of their badge, or by

completion of a payroll deduction letter. The payroll deduction amount is based on the total amount of all account balances owed by the employee and/or accounts for which the employee is responsible. The payment arrangements will follow the same guidelines as the FirstHealth Payment Plan as listed above, but will ***exclude*** the requirement to initially pay 10% of the total account balance. New employee payroll deduction letters will be mailed to the employee's home address for each visit, or each time they have a new patient responsibility, if they elect to continue paying all accounts through payroll deduction.

3. Mosaic Finance Solutions – Minimum payment is $25.00, or 2.5% of the patient balance. Patient is required to sign a consumer credit agreement and interest of 5.25% is assessed on the patient balance.

For patients without insurance, the first payment is requested before or at the time services are provided and within every thirty (30) days thereafter. For insured patients, the first payment is requested before or at the time services are provided and within every thirty (30) days after their insurance payment is received.

Prompt payment discounts up to 25% for hospital services and 40% for clinic services are available for patients who do not qualify for other financial arrangements, including patients without health insurance and insured patients receiving care that is not covered by their insurance plan. The discounts do not apply to patient balances after insurance. Other arrangements may be made when deemed necessary by authorized hospital and clinic personnel. FirstHealth may design self-pay programs which are not covered by insurance (e.g. CT lung screening, bariatric surgery) but are in demand in the marketplace. These services are excluded from the prompt payment discount.

If the patient is unable to pay, financial counselors are available to help identify programs they may qualify for, including Medicaid, Vocational Rehabilitation and North Carolina Purchase of Care Services. Criteria to qualify for federal or state programs are based on specific guidelines for the program. In the event a patient does not qualify for any type of government assistance program, they may qualify for aid through FirstHealth's Financial Assistance Program based on the following criteria:

A. Amount of assistance is based on a percentage of the most recent federal poverty guidelines published by the Department of Health and Human Services, available on-line at https://aspe.hhs.gov/poverty-guidelines, as well as the guidelines established by FirstHealth of the Carolinas. The financial aid percentage discount considers the "amount generally billed" by FirstHealth of the Carolinas. This amount is calculated on an annual basis by the Vice President of Finance and Support Services, and will be updated in conjunction with the federal poverty guidelines. The "amount generally billed" will be an estimate based on a historical review of FirstHealth's overall estimate of Net Revenue divided by Total Charges. This amount will also be the financial aid percentage used in the third tier (far-right column in chart below) of the poverty guidelines to ensure any patient that qualifies for financial assistance under our policy will only be responsible for the amount generally billed to our population.

2017 Poverty Guidelines for the 48 Contiguous States and the District of Columbia		FirstHealth of the Carolinas Financial Assistance Determination			
Persons in Family or Household	**Poverty Guideline**	**100% Financial Aid - Emergency Care *Only***	**90% Financial Aid**	**80% Financial Aid**	**70% Financial Aid**
		Income up to:	***Income up to:***	***Income up to:***	***Income up to:***
1	$12,060	$24,120	$24,120	$33,768	$43,416
2	$16,240	$32,480	$32,480	$45,472	$58,464
3	$20,420	$40,840	$40,840	$57,176	$73,512
4	$24,600	$49,200	$49,200	$68,880	$88,560
5	$28,780	$57,560	$57,560	$80,584	$103,608
6	$32,960	$65,920	$65,920	$92,288	$118,656
7	$37,140	$74,280	$74,280	$103,992	$133,704
8	$41,320	$82,640	$82,640	$115,696	$148,752
For families/households with more than 8 persons, add $4,180 for each additional person		*200% of Poverty Guideline*	*200% of Poverty Guideline*	*280% of Poverty Guideline*	*360% of Poverty Guideline*

B. Process for determining financial assistance:

1. Patient is interviewed by a financial counselor to evaluate all available sources of funding for the patient, including, but not limited to, Medicaid, Vocational Rehab, Crime Victims Assistance, health plans offered by the Marketplace, and other commercial insurance, etc. If the patient does not comply with the financial counselor's recommendations for other possible funding sources, access to FirstHealth's Financial Assistance Program may be denied or limited. Patients who are eligible for liability coverage are not eligible for financial assistance. Patients can access our Financial Aid Application and a plain language summary of our Credit and Collection policy (in both English and Spanish), free of charge, at the time of registration, from our patient accounting office or through our website.
2. Upon exhausting all other methods of payment, the patient completes a Financial Aid Application, which includes an analysis of income, assets, expenses and liabilities.
3. Documentation is requested to support the patient's financial position.
4. Documentation is reviewed in conjunction with the Financial Aid Application to ensure consistency and accuracy of the patient's financial position.
5. The patient's gross income will be compared to the federal poverty guidelines to determine the level of financial assistance to apply.
6. If the patient's liquid assets exceed $20,000.00 or the patient's non-liquid assets exceed $200,000.00 (excluding primary residence), the account should be referred for management review and approval.

7. Patient's liabilities and expenses are used to validate the reasonableness of the income provided.
8. If the financial counselor determines the patient has extenuating circumstances (such as significant medical expenses) to be considered in the evaluation of the patient's financial position, the account should be referred for management review and approval.

Documentation will always be requested, but may not always be made available by the patient. Under these circumstances it is left to the discretion of the financial counselor and their supervisor to review the application, approve or deny the financial aid, and to document in the account notes the rationale for their determination. Documentation of income may include utilizing a consumer credit verification tool such as Equifax, Dunn & Bradstreet, TransUnion, etc. The documentation requirement for non-liquid assets can be bypassed if the value of the assets is reasonably stated and the patient's income is validated and meets the FirstHealth poverty guidelines. The signature by the patient or family member on the application is not a requirement for determining indigence.

C. Emergency Department services – will qualify for up to 100% financial aid under FirstHealth's Financial Assistance Program. All copayments are excluded from financial assistance. Uninsured patients will have a copayment of $40.00 upon discharge from the Emergency Department.

   Collection activity is prohibited in the Emergency Department prior to service. After the patient has been seen by a physician, the procedure outlined above should be utilized when discussing payment arrangements with the patient. Collections and financial counseling activity may only occur in the Emergency Department at the time of discharge.

D. Elective services – e. g. cosmetic procedures, are not eligible for financial assistance. Elective services do not qualify for a payment plan unless approved by authorized personnel.

E. Free-standing clinic services – will qualify for up to 90% financial aid under FirstHealth's Financial Assistance Program. All copayments are excluded from financial assistance. Uninsured patients will have a copayment of $25.00 at the free-standing clinics and a copayment of $40.00 at the Convenient Care. All preventive services received in the clinic setting are not eligible for financial assistance, e.g. wellness visits and physicals. Due to NHSC (National Health Services Corp) program requirements, patients qualifying for this program will be charged a nominal flat fee in lieu of a percentage based adjustment.

F. All other services – will qualify for up to 90% financial aid under FirstHealth's Financial Assistance Program. Any services requiring implantable devices require a review of the direct cost of those implants. The estimated cost should be paid by the patient and excluded from the financial aid calculation. The remaining balance is requested from the patient prior to service, or through a monthly payment plan established within this policy. If payment arrangements cannot be met, Pre-Services staff/management will communicate with the patient and physician office and will attempt to reschedule the appointment to a date that meets the medical and financial

needs of all parties involved. If the patient cannot be delayed due to the urgency of the procedure, management may request review from the Chief Medical Officer.

G. Outpatient behavioral services and inpatient CDU 28-day treatment program are not eligible for financial assistance unless previously approved by the Behavioral Assessment Team.

H. If FirstHealth receives notification of bankruptcy from its agency, the account will be closed and returned.

I. Patients presenting from the Moore Free Care Clinic will qualify for a 100% financial aid adjustment, pending completion of Section B, step one: *Process for determining financial assistance*.

J. Any patient that provides an incomplete application will be notified within sixty (60) days that the application will not be approved until all required documentation is provided. A third-party vendor may be utilized to evaluate the patient's presumed indigence through credit scoring, if indigence cannot be determined through the application process. A patient that does not complete an application is not considered to be "financial aid eligible" and should not receive a financial aid discount.

Financial assistance can be applied to any of the patient's accounts on a retroactive basis if the date of service is less than twenty-four (24) months from the date the financial assistance was approved. Also, the financial assistance can be applied proactively to any patient's accounts if the date of service occurs within three (3) months from the date of application. Additional accounts outside of this date range can be included by authorized hospital personnel.

Healthcare providers in our community are notified of our financial aid determinations by the following methodologies:

1. On a weekly basis, Sandhills Emergency Physicians and Pinehurst Anesthesia are electronically notified of all patients that qualified under the FirstHealth Financial Assistance Program. Both providers apply the same financial aid percentage adjustment to their claim as FirstHealth.
2. Patient approval letters are sent, which contain information about their financial aid adjustment and encourages them to share this letter with any other healthcare provider they utilize. Providers use their own discretion in determining indigence.

Financial Assistance adjustments should be calculated based on the total amount of patient responsibility. Any collection actions taken against the patient for accounts approved for financial assistance and completely resolved (i.e. zero balance) should be reversed. Payments made by the patient during the financial review process, or on current accounts that have been approved for financial assistance, should be refunded to the guarantor. A current account is defined as any account discharged within two hundred forty (240) days prior to the application submission date.

Collection Criteria

A. **Patient Statement:** For hospital services, at the time of pre-registration or registration, patients are provided with an estimate of the total patient responsibility. For clinic services, the

estimation for all services may not be provided until time of check-out. A "point of service" statement with detailed charges is available for the patient at the time of outpatient services. The "point of service" bill may not be inclusive of all charges. Full charges are indicated on the patient's first statement. Itemized bills are available at the request of the patient or guarantor. A preliminary financial assistance assessment will be made at the time of pre-registration and presented to the patient, pending completion of all requirements as stated above in Section B: *Process for determining financial assistance*.

FirstHealth will mail or email statements every thirty (30) days for a total of one hundred twenty (120) days. If the account is not paid in full or acceptable payment arrangements made, FirstHealth will mail a final notice. If the balance is still not satisfied, the account will be sent to FirstHealth's collection agency. If the account balance remains unpaid or satisfactory payment arrangements are not made with the collection agency within the first thirty (30) days from placement, the balance will be listed on the guarantor's credit report. Every statement sent contains visible, easy to understand language (in both English and Spanish) encouraging patients to contact us regarding our financial aid or other assistance. Also, an automated phone call is made on the final notice, which refers to our financial aid and informs the patient that the account will be sent to an outside collection agency if financial arrangements are not made.

During the collection or billing cycle, we may be notified that the patient has deceased. FirstHealth will attempt to collect the debt for one hundred twenty (120) days and may send an inquiry to the Clerk of Court requesting information on the patient's estate. Depending on the response, authorized hospital personnel may file a claim on the estate, apply a financial aid adjustment, or cease all collection activity.

B. **Letter Follow-up:** FirstHealth may follow up by letter on third-party coverage. Self-pay accounts will be followed up for possible state or federal assistance programs. While coverage is in the process of being determined, the patient will receive a letter every thirty (30) days advising them that FirstHealth is still evaluating their account for possible assistance. When no coverage is available, the balance will be due and the above schedule for patient statements will follow.

Disputes

Patients are able to request an itemized statement by contacting the Business Office. If the patient disputes the validity of any charges, a Nurse Auditor will review the itemized statement, compare it to their medical record and provide findings to management for review. Patient Accounts staff/management will discuss the Nurse Auditor's findings with the patient and resolve the dispute.

Third-Party Coverage

FirstHealth will bill all third-party payors for the responsible party when the responsible party has furnished the necessary information in a timely manner and benefits are assigned to FirstHealth.

Liability Claims

FirstHealth will file liability claims as a courtesy to the patient. If the patient does not have other healthcare coverage, their accounts will follow the collection criteria described above. All liability insurance information necessary for filing a claim should be obtained at registration.

Bad Debts

A. **Definition**: FirstHealth will recognize accounts turned over to attorneys and collection agencies as bad debts. FirstHealth also recognizes any patient responsibility greater than a certain age as bad debt to the organization and will move these accounts to an internal agency per the Bad Debt Transfer policy. Any guarantor with a history of non-payment on accounts will be out-sourced to an outside agency.

B. **Criteria**: FirstHealth will recognize accounts as bad debts when the accounts have been through the hospital statement process without any acceptable response. Exceptions to this are as follows:

1. Account is pending Medicare or Medicaid for known reasons.
2. Authorized hospital personnel recognizes prior to seventy-five (75) days that the account should go to an attorney, collection agency or for judgment.
3. Authorized hospital personnel have other documented reasons not mentioned above.

Accounts will be deemed uncollectible and returned from collection agencies after the following criteria are met:

Moore Regional Hospital, Moore Regional Hospital - Hoke, Moore Regional Hospital - Richmond, Moore Regional Hospital - Hamlet and all FirstHealth clinics:

1. Account is placed with second placement agency for two (2) years.
2. Account balance is less than $5,000.00.
3. No active collection activity at the agency over the past six (6) months.

Montgomery Memorial Hospital:

1. Account is placed with second placement agency for one (1) year.
2. Account balance is less than $1,500.00.
3. No active collection activity over the past six (6) months.

Accounts can also be returned from agency on a case-by-case basis by authorized hospital personnel.

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