PATIENT BILLING AND COLLECTIONS POLICY

DEPARTMENT: Commonwealth Financial Resources	**POLICY DESCRIPTION: Guidelines for processing balances due from Responsible Individuals.**
Page: 1 of 10	**REVIEW DATES: December 2008, September 2009, November 2009, November 2015, September 2017**
EFFECTIVE DATE: February, 2005	**REVISION DATES: December 2006, September 2009, November 2009, July 2010, December 2010, April 2014, July 2014, November 2015, May 2016, September 2017, March 2019**
REVIEW RESPONSIBILITY: Director, CFR	**REFERENCE NUMBER: N/A**

PURPOSE

Commonwealth Financial Resources (CFR) intends to provide an efficient and effective billing and collections service that complies with all laws and regulations including those of the Fair Debt Collection Practices Act. This Patient Billing and Collection Policy provides general guidelines for patient billing and collection of payment for services and applies to each entity that is owned by Commonwealth Health Corporation (CHC) and billed by Commonwealth Financial Resources (CFR). This policy also describes the process and time frames used in taking these collection actions, including the requisite "reasonable efforts" that must be taken to determine whether an individual is eligible for financial assistance before initiating "Extraordinary Collection Actions" (ECAs).

DEFINITIONS

A. Application Period means the time period under which a Patient can apply for financial assistance. The Application Period begins on the date care is provided and ends on the 240th day after the first post discharge billing statement is provided to the Patient.
B. Extraordinary Collection Action (ECA) means any action against an individual related to obtaining payment of a self-pay balance that requires a legal or judicial process (including wage garnishment), involves reporting adverse information about the Patient to consumer credit reporting agencies or credit bureaus, sale of the Patient's debt to a third party, and/or deferring care.
C. Financial Assistance means the free or discounted services provided to Patients who have been determined to be eligible for such discounts under the Financial Assistance Policy (FAP).
D. Financial Assistance Policy (FAP) means CHC's Financial Assistance Policy which includes eligibility criteria, the basis for calculating charges, the method for applying the policy, the measures to publicize the policy, and sets forth the financial assistance program available to patients who meet certain income guidelines.
E. Patient means the person receiving medical care or the person who is financially responsible for the person receiving medical care (i.e. guarantor).
F. Plain Language Summary (PLS) means a summary that notifies an individual that CHC offers assistance under the Financial Assistance Policy in language that is clear, concise, and easy to understand. The PLS may be obtained at https://cfrbilling.patientcompass.com/RA/General/BillingPolicies.
G. Restriction Period means the timeframe during which ECAs may not be initiated. The Restriction Period begins on the date that the first post-discharge billing statement is provided and ends on the 120th day after the date of the first billing statement.

POLICY

This Patient Billing and Collection Policy is consistent with CHC's mission and in compliance with the Federal Affordable Care Act. All patients who have received emergency or medically necessary care shall be provided the opportunity to apply for free or reduced cost care in conformance with the federal Patient Protection and Affordable Care Act and its implementing regulations. CHC will not discriminate on the

basis of race, color, national origin, citizenship, alienage, religion, creed, gender, sexual preference, age, or disability in providing its services.

This policy, along with the related Financial Assistance Policy, establishes CHC's procedures regarding collection of patient accounts. The purpose of the policy is to reasonably balance the need for financial stewardship with needs of individual patients who are unable or unwilling to pay their accounts.

Note: The process below is general in nature and specific circumstances may indicate the need for customized communications with the patient or guarantor. These communications may include phone calls, forms required by an insurance carrier, requests that the patient contact their insurance carrier, etc.

I. ACQUIRED ENTITIES

CHC may at times acquire entities which are on patient accounting systems which are not compatible with the timeframes in this policy and/or have limitations that hinder the implementation of all terms of this policy. In those cases, our focus will be on ensuring that billing and collections are compliant with laws and regulations while maximizing collections and continuing to use the available systems. As these entities are converted to CHC's specified patient accounting system, we will convert these entities to this policy as soon as practical.

II. IDENTITY THEFT PREVENTION

Changes to PHI: CHC staff, including CFR personnel shall verify PHI presented by a patient or account holder with the account information in their system and will make the requested change only if the information presented is consistent with the system records.

Upon request for change of an address, insurance information or other identifiable information on a patient account, CHC personnel shall require the following information: date of birth, the last 4 digits of the patient's social security number currently stored in Meditech; and driver's license number, if available.

III. BILLING AND COLLECTION PRACTICES

A. Consistent with the terms of this policy, CHC may take legal action, including ECA's to obtain payment for medical services provided.
B. CHC will not engage in ECAs, either directly or indirectly, before "reasonable efforts" as defined in Section 501(r) of the Code and the corresponding regulations are made to determine if a Patient is eligible for financial assistance. CHC will not conduct ECAs during the Restriction Period.
C. CHC will make reasonable efforts to identify third-party payers to assist patients in resolving their bills. CHC will also take the following actions:
    1. Validate that the patient owes the unpaid bills.
    2. Collect all amounts permitted from third-party payers.
    3. Work with patients toward resolution of outstanding insurance claim payment issues.

4. Inform patients of, and provide them with reasonable assistance in applying for financial assistance offered by CHC.
5. Invoice patients for the amount of the cost of services for which they have a financial responsibility after the steps outlined above have been taken.

D. It is the patient's responsibility to provide CHC with accurate information regarding health insurance (including primary and secondary carriers), address, and applicable financial resources to determine whether the patient is eligible for coverage through private insurance or through available public assistance programs. The patient is expected to assign benefits due from any insurance carriers.

E. The patient has the responsibility to obtain proper physicians referral(s) and may be responsible for unpaid claims resulting from failure to obtain appropriate referral(s) from the insurance provider.

F. During the Notification Period, at least three separate Patient Account statements for collection of balances will be mailed to the last known address of the Patient before the end of the Notification Period. CHC will not be required to mail additional Patient Account statements after a Patient submits a complete application for financial assistance.

All Patient Account Statements will include a conspicuous written notice that informs the Patient about the availability of financial assistance, including both a telephone number of the office or department that can provide information about the Financial Assistance Policy, Financial Assistance Application process and the website where copies of the FAP, Financial Assistance Application, and Plain Language Summary may be obtained.

G. Before engaging in, or resuming, any of the ECAs described in this Policy, a written notice will be issued to the last known address of the Patient that:
   1. Describes the specific collection activities it intends to initiate (or resume)
   2. Provides a deadline after which such actions(s) will be initiated (or resumed)

H. CHC will also make a reasonable effort to orally notify the Patient about the FAP and how he or she can get help with the Financial Assistance Application process.

I. ECAs may be initiated no sooner than 30 days from the date on which an ECA notice is issued.

J. ECAs will be suspended if the Patient submits a Financial Assistance Application during the Application Period.

IV. PATIENT BILLING PROCESS

The following section describes the progression of notifications sent to patients. For payment arrangements, please see the Payment Arrangements Policy. For information about financial assistance, please see our Financial Assistance Policy.

A. Hospital Accounts With Insurance

Discounts: Patients with insurance are eligible for a 10% Quick-Pay discount if the patient out of pocket point of service estimate (excludes Co-Pays) is paid in full at the time of service. If the patient's estimated obligation (excludes Co-Pays) is met at the time of service and we subsequently determine the balance owed is greater than the initial estimate, the patient will be offered a 10% discount on any difference, provided the additional out of pocket obligation is paid within the first statement cycle. Patient Co-Pays are not eligible for the 10% Quick-Pay discount.

In circumstances where we are not able to provide a point of service estimate, patients will be offered a 10% Quick-Pay discount (excludes Co-Pays) within the first statement cycle. To receive the discount, payment must be received by the due date on the first statement.

Summary of Charges - After the account reaches final bill status, each hospital account receives a statement with a required summary of charges. For hospital accounts with insurance, we send the patient/guarantor a statement with the following wording:

> This is Not a Request for Payment
>
> Thank you for choosing {Facility Name}.
>
> We will bill the insurance listed under insurance information. You will be billed later for payments due from you under your insurance plan. These include any deductibles, co-payments and/or non-covered services as determined by your insurance company.

After an insurance payer processes the account and sends us their remittance advice, the remaining balance drops to self-pay. Patient Compass transitions the hospital account to an alpha-split cycle of 20 days based on the guarantor's last name.

Alpha-Split 20-Day Cycle: 1-A, 2-B, 3-C, 4-D, 5-E, 6-F, 7-G, 8-H, 9-I&J, 10-K, 11-L, 12-M, 13-N&O, 14-P, 15-Q&R, 16-S, 17-T, 18-U&V, 19-W, 20-X,Y&Z.

Statement 1: The first statement sent, after insurance pays, to the Patient is considered the first request for payment. The statement contains the following language:

> Your insurance plan has processed your medical expense. Your plan has informed us that you are responsible for the remaining balance.

Statement 2: The second statement sent, after insurance pays, to the Patient is considered the second request for payment. The statement contains the following language:

> Your balance is now due. Please include the payment coupon at the bottom of this statement with your payment. Please pay before the PAST DUE DATE, or call us at (270) 745-1100 or (800) 786-1581 to discuss payment options.

Statement 3: The third statement sent, after insurance pays, to the Patient is considered the third request for payment. The statement contains the following language:

> Your payment is PAST DUE. Please pay the Amount Due today to prevent further collection activity. If you have any questions, please call us at (270) 745-1100 or (800) 786-1581.

Statement 4: The fourth statement sent, after insurance pays, to the Patient is considered the fourth request for payment. The statement contains the following language:

> Your payment is SERIOUSLY PAST DUE. Please call us immediately. If we do not receive payment in full or hear from you within 10 days, your account may be sent to a collection agency.

Letter 5: The fifth request for payment sent, after insurance pays, to the Patient is considered a Letter 5 and the final request for payment. The statement contains the following language:

> PATIENT NAME
> PROVIDER: [NAME OF HOSPITAL]
> ACCOUNT #: [ACCOUNT #]
> SERVICE DATE
>
> Balance $xxx.xx
>
> The above account is now PAST DUE. Payment in full or Financial Assistance Application approval must be received within thirty (30) days from the date of this letter.
>
> Failure to pay or complete a Financial Assistance Application and receive approval for financial assistance for the services may result in the placement of the amount with a collection agency. This can result in the reporting of the debt on your credit report, placing a lien on property and/or the garnishment of wages.
>
> We would much rather resolve this account before that action is necessary.

Our goal is to give excellent medical care at the most reasonable rates.
Please contact our business office at (270)745-1100 or 800-786-1581. Our office hours are 8:00am-4:30pm Monday through Friday.

Sincerely,
Collection Department

B. Hospital Accounts Without Insurance

Discounts: Patients without insurance are eligible for a Self-Pay discount and a Quick-Pay discount. The 30% Self-Pay discount is applied to all hospital accounts without insurance and is valid until the account is deemed uncollectible. Patients may obtain an additional 10% Quick-Pay discount if the point of service estimate is paid in full at the time of service. If the patient's estimated obligation is met at the time of service and we subsequently determine the balance owed is greater than the initial estimate, the patient will be offered a 10% discount on any difference, provided the additional out of pocket obligation is paid within the first statement cycle.

In circumstances where we are not able to provide a point of service estimate, patients will be offered a 10% Quick-Pay discount within the first statement cycle. To receive the discount, payment must be received by the due date on the first statement

Statement 1: Patients without insurance will receive a first Request for Payment within 10 days after service or discharge date for hospital accounts with the wording of:

If you do not have insurance, we give you a one-time 30% discount if you pay your balance in full or call to arrange a payment plan. The discount is only available if you pay according to our payment policies. Please review our Payment Policy on the back of this statement.

Statement 2: The second statement sent to the Patient is considered the second request for payment. The statement contains the following language:

Your balance is now due. Please include the payment coupon at the bottom of this statement with your payment. Please pay before the PAST DUE DATE, or call us at (270) 745-1100 or (800) 786-1581 to discuss payment options.

Statement 3: The third statement sent to the Patient is considered the third request for payment. The statement contains the following language:

> Your payment is PAST DUE. Please pay the Amount Due today to prevent further collection activity. If you have any questions, please call us at (270) 745-1100 or (800) 786-1581.

Statement 4: The fourth statement sent to the Patient is considered the fourth request for payment. The statement contains the following language:

> Your payment is SERIOUSLY PAST DUE. Please call us immediately. If we do not receive payment in full or hear from you within 10 days, your account may be sent to a collection agency.

Letter 5: The fifth request for payment sent to the Patient is considered a Letter 5 and the final request for payment. The statement contains the following language:

> PATIENT NAME
> PROVIDER: [NAME OF HOSPITAL]
> ACCOUNT #: [ACCOUNT #]
> SERVICE DATE
>
> Balance $xxx.xx
>
> The above account is now PAST DUE. Payment in full or Financial Assistance Application approval must be received within thirty (30) days from the date of this letter.
>
> Failure to pay or complete a Financial Assistance Application and receive approval for financial assistance for the services may result in the placement of the amount with a collection agency. This can result in the reporting of the debt on your credit report, placing a lien on property and/or the garnishment of wages.
>
> We would much rather resolve this account before that action is necessary.
>
> Our goal is to give excellent medical care at the most reasonable rates.
> Please contact our business office at (270)745-1100 or 800-786-1581. Our office hours are 8:00am-4:30pm Monday through Friday.
>
> Sincerely,
> Collection Department

C. Physician and Non-Hospital Facility Accounts With Insurance

After an insurance payer processes the account and sends us their remittance advice, the remaining balance drops to self-pay. Patient Compass transitions the physician/facility account to a 30 day cycle based on the guarantor's last name separated by practice.

Statement 1: The first statement sent, after insurance pays, to the Patient is considered the first request for payment. The statement contains the following language:

> Your insurance plan has processed your medical expense. Your plan has informed us that you are responsible for the remaining balance.

Statement 2: The second statement sent, after insurance pays, to the Patient is considered the second request for payment. The statement contains the following language:

> Your balance is now due. Please include the payment coupon at the bottom of this statement with your payment. Please pay before the PAST DUE DATE, or call us at (270) 745-1100 or (800) 786-1581 to discuss payment options.

Statement 3: The third statement sent, after insurance pays, to the Patient is considered the third request for payment. The statement contains the following language:

> Your payment is PAST DUE. Please pay the Amount Due today to prevent further collection activity. If you have any questions, please call us at (270) 745-1100 or (800) 786-1581.

Statement 4: The fourth statement sent, after insurance pays, to the Patient is considered the fourth request for payment. The statement contains the following language:

> Your payment is SERIOUSLY PAST DUE. Please call us immediately. If we do not receive payment in full or hear from you within 10 days, your account may be sent to a collection agency.

D. Physician and Non-Hospital Facility Accounts Without Insurance

Discounts: Patients without insurance are eligible for a Self-Pay discount at certain practices or entities where patients often incur high charges. The entities currently meeting this profile are: Barren River Regional Cancer Center, ENT of Bowling Green, Med Center Health General Surgery, Medical Center Heart Institute, Medical Center Neuroscience Services, Medical Center Orthopaedics & Sports Medicine, Medical Center Psychiatry and The Medical Center Surgical Weight Loss Program. Other programs or entities determined by management to meet this profile may also provide the same discount for self-pay accounts. The 30% Self-Pay discount is valid until the account is deemed uncollectible.

Statement 1: Patients without insurance will receive a first Request for Payment 4 days after charges are applied to their account with the wording of:

> The amount indicated is now due on your portion of the charges. Please submit payment within 10 days.

Statement 2: The second statement sent to the Patient is considered the second request for payment. The statement contains the following language:

> Your balance is now due. Please include the payment coupon at the bottom of this statement with your payment. Please pay before the PAST DUE DATE, or call us at (270) 745-1100 or (800) 786-1581 to discuss payment options.

Statement 3: The third statement sent to the Patient is considered the third request for payment. The statement contains the following language:

> Your payment is PAST DUE. Please pay the Amount Due today to prevent further collection activity. If you have any questions, please call us at (270) 745-1100 or (800) 786-1581.

Statement 4: The fourth statement sent to the Patient is considered the fourth request for payment. The statement contains the following language:

> Your payment is SERIOUSLY PAST DUE. Please call us immediately. If we do not receive payment in full or hear from you within 10 days, your account may be sent to a collection agency.

V. COLLECTION ACTIONS

Once it has been reasonably determined that an account is not going to be paid, either by progression through the statement cycle or other means, CFR will authorize our collection agency to pursue payment in full for bad debt accounts through telephone contact and correspondence. The collection agency will abide by the Federal Debt Collection Practices Act, Federal HIPAA regulations, 501(r) as well as any other applicable laws and regulations. The collection agency is authorized to research and identify debtors who do not have the ability to pay and deem the account uncollectible. Debtors who cannot pay the balance in full may be set up on a payment plan. Accounts with individual balances over $25 will be reported on debtors' credit history.

If the above reasonable efforts to collect the balance are unsuccessful and the balance of the combined accounts warrant, Extraordinary Collection Actions (ECA), as defined in IRS Regulation 501(r), may be pursued. These ECAs include reporting of adverse information about the individual to credit agencies, as well as wage garnishment on those who are employed and /or liens on property. The collection agency will send a final notice letter to the debtor before legal action is enforced. CFR does not authorize foreclosure on property or take any steps beyond those outlined above except in extraordinary circumstances and only with the approval of Senior Management (Vice-President or higher).

Our goal is to collect payment from those who can afford to pay so that we can continue to provide care to those who cannot.