Regulatory Tools and Policies for Transparency Compliance with ACA, and 501(r) Requirements Related to Billing and Collection and Financial Assistance

WHA Transparency Task Force

2015

Background
Wisconsin has been ahead of the curve on hospital price transparency through the development and advancement of the PricePoint website, but regulatory changes and healthcare market changes mean we must continue to lead and play a proactive role in advancing policy in this area. WHA convened the Transparency Task Force (TTF) to focus on developing best practices in the provision of price and quality information to consumers. As patients face increased exposure to healthcare costs, they have a need for meaningful and transparent price and quality information.

The Healthcare Financial Management Association (HFMA) released a Price Transparency Task Force Report in 2014 (https://www.hfma.org/transparency/) which included key recommendations for improving price transparency in health care. The HFMA Task Force included representatives from health plans, providers, consumers, employer groups, physician groups and others. They identified that health plans were in the best position to help their members find out the total estimated price of health care services. They identified Hospitals as the best source of price information for the uninsured. The WHA TTF endorsed the HFMA report and as part of their mission, explored ways to help hospitals improve pricing information, financial assistance, and billing and collection policy communications with their patients.

Deliverables
This document includes information regarding two separate regulatory transparency issues, the ACA hospital charges requirement, and the IRS 501(r) rule as it relates to financial assistance and billing & collections.

The ACA section contains rationale and a sample policy for one way to approach complying with the ACA hospital charge posting requirement and making it easier for patients to find charge information. The 501(r) section contains several checklists to help improve the financial assistance and billing & collection processes and communication with patients as outlined as part of the 501(r) regulations. There is also a sample billing and collection policy.

All of these resources are meant to help providers meet the obligations as outlined in the HFMA report and also to help meet the regulatory requirements of the ACA and some components of 501(r).

A special thank you goes out to the WHA Transparency Task Force for their work on this document and on other ongoing policy work to help improve health care transparency for the people of Wisconsin.

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The information contained in this material is for advisory and educational purposes only and is not intended as legal advice. Americollect has graciously provided a sample of a portion of its checklists and billing and collection policies which are included with these materials – these checklists and policies are only provided as an example of what one organization has implemented. WHA and the Taskforce encourages hospitals to review this information in conjunction with its own policies and procedures, to review the materials with its consultants and advisors, and implement changes, if necessary, including when additional guidance and/or regulations become available. Always cconsult your legal counsel with specific legal matters.

ACA Hospital Charges Transparency Requirement

Hospital Charges Transparency Requirement Under the Affordable Care Act

Background

As a result of the Affordable Care Act (ACA), under section 2718(e) of the Public Health Service Act, there is a requirement that:

> *''[e]ach hospital operating within the United States shall for each year establish (and update) and make public (in accordance with guidelines developed by the Secretary) a list of the hospital's standard charges for items and services provided by the hospital, including for diagnosis-related groups established under section 1886(d)(4) of the Social Security Act.''*

In the FY 2015 IPPS/LTCH PPS final rule (79 FR 50146), CMS reminded hospitals of their obligation to comply with the provisions of section 2718(e) of the Public Health Service Act. CMS reiterated that their guidelines for implementing section 2718(e) of the Public Health Service Act are that hospitals either make public a list of their standard charges (whether that be the charge master itself or in another form of their choice), or their policies for allowing the public to view a list of those charges in response to an inquiry.

MedPAC suggested that hospitals be required to post the list of charges on the Internet, and while CMS agreed that this would be one approach that would satisfy the guidelines, CMS believes hospitals are in the best position to determine the exact manner and method by which to make the list public in accordance with the guidelines. CMS encourages hospitals to undertake efforts to engage in consumer friendly communication of their charges to help patients understand what their potential financial liability might be for services they obtain at the hospital, and to enable patients to compare charges for similar services across hospitals. CMS expects that hospitals will update the information at least annually, or more often as appropriate, to reflect current charges.

Summary of PricePoint

The WHA Transparency Taskforce reviewed the ACA requirement to assess whether and how WHA's PricePoint information, which provides public access to hospital charge information, could be used by hospitals to meet the ACA requirement.

Key properties of a transparency compliance solution mentioned by CMS included:

1. Making charge information public
2. Making charge information consumer friendly
3. Making charge information comparable across hospitals
4. Updating charge information at least annually

These properties are all key components of the PricePoint website.

The PricePoint website provides health care consumers with facility-specific information about healthcare services and charges. Consumers can query information for inpatient services, outpatient surgeries, emergency department and urgent care visits, observation services, and ancillary services, such as radiology and therapy services.

PricePoint was designed for consumers. For example, it contains many consumer resources in addition to information on hospital charges, including average hospital discounts. The website also contains information on health insurance plans in Wisconsin and their role in providing out of pocket cost information.

PricePoint also allows users to easily compare charge information for multiple hospitals, and the data used to populate the site is updated quarterly using the most current four quarters of data available from the WHA Information Center.

PricePoint is becoming an established model for displaying hospital charge information as this platform is being used in eleven states in addition to Wisconsin. PricePoint has been highlighted in various national reports on price transparency and is included in the American Hospital Association toolkit for hospitals: http://www.ahacommunityconnections.org/tools-resources/transparency.shtml.

While the ACA requirement focuses on hospital charges, quality data is also essential for consumers. Quality measures, in conjunction with price information, allows users to better define health care "value". PricePoint's sister website, CheckPoint, provides consumer-focused initiatives that include reported measures of health care in Wisconsin to aid the selection of quality health care and assessment of quality improvement activities within the hospital field. PricePoint and CheckPoint are linked together to allow the user to easily compare Wisconsin hospitals on both charges and quality measure scores.

WHA Transparency Taskforce Recommendation

After reviewing the ACA provision regarding hospital charge transparency and CMS' limited guidance provided in various payment rules, the Taskforce feels that a prominent link to PricePoint on a hospital's website would be part of a reasonable approach by a Wisconsin hospital to comply with the ACA requirement.

However, because PricePoint provides select and summary charge information, a hospital should also include a name/position and contact number at the hospital as an additional resource for providing hospital charge information to the public.

Attached is a sample policy and procedure template to illustrate how a hospital might incorporate PricePoint into their ACA compliance policy.

The Taskforce also encourages hospitals to implement changes, if necessary, when, and if, additional guidance and/or regulations become available.

SAMPLE POLICY AND PROCEDURE

POLICY #

SUBJECT: PUBLIC AVAILABILITY OF HOSPITAL CHARGE INFORMATION

POLICY:

It is a policy of XX Hospital to make available the Hospital's charge information in compliance with the Affordable Care Act (ACA), Section 2718(e) of the Public Health Service Act.

PURPOSE:

This policy is designed to promote transparency for patients and to comply with the ACA.

PROCEDURE:

AVAILABILITY OF STANDARD CHARGES

A. The Hospital will make available its standard charges.

1. The public may view hospital charges via a link on the Hospital website to the Wisconsin PricePoint website at www.wipricepoint.org.
2. Patients may contact the Patient Financial Services Department at (xxx) xxx-xxxx for additional information and inquiries regarding charge information or questions related to PricePoint.

B. Any charge information that is provided will generally be gross charges (prior to any applicable insurance being applied) for the service without complications.

C. The information provided will not be, and is not intended to be, a quote or guarantee of what the charges will be for a specific patient's care, nor does it include the cost of professional services (for example, services provided by physicians, anesthesiologists, radiologists, advance practice nurses, physician assistants or other independent practitioners). The Hospital's website and responses to any inquiries will include the disclaimer/limitation.

RESPONSIBILITY: Vice President, Finance/CFO

EFFECTIVE: xx/xx/xxxx

Reference: Affordable Care Act (ACA), Section 2718(e)

Financial Assistance and Billing & Collection Policy

Tools and Resources

Financial Assistance Policy Checklist

Eligibility Criteria that Can Be Used

Attestation: Will you allow your financial counselors to use attestation?

The final regulations allow a hospital facility the ability to grant financial assistance based on evidence other than that described in a Financial Assistance Policy (FAP) or Financial Assistance (FA) application based on an attestation by the applicant, even if the FAP or FA application does not describe such evidence or attestations.

Oral Application: Will you allow your financial counselors to use oral communications to complete an application?

Will language be included on the financial assistance application, policy, and plain language summary to encourage oral applications?

The final regulations amend the definition of "FAP application" to clarify that the term is not intended to refer only to written submissions and that a hospital facility may obtain written or oral information from an individual (or a combination of both).

FAP – Possible Additions

Prior Applications: How long will your hospital allow an eligibility determination to be used?

Have you included language in your financial assistance policy for the length of time prior applications will be used?

A prior FAP application can be used if your FAP describes whether and under what circumstances prior FAP-eligibility determinations will be used. This criteria needs to be described in your FAP.

Presumptive Determinations: Will your hospital facility use presumptive determinations?

The final regulations require that a hospital facility include in its FAP any information obtained from sources the hospital facility uses (other than individuals seeking assistance).

Most Generous Discount: Have you included language in your financial assistance policy for presumptive determinations? FAP Wording Example: Hospital recognizes that some patients will be unable to comply with or be unresponsive to traditional FAP processes; and in an effort to remove barriers for these patients and improve community benefits, the hospital will utilize an electronic screening process prior to bad debt assignment after all other funding sources have been exhausted; and that the information returned via this electronic screening will constitute adequate documentation under the Hospital's policy; and the patient's eligibility through this process will receive the most generous financial assistance discount and will not be assigned to bad debt. (must include criteria of the score being used to make the determination).

Financial Assistance Policy Checklist

Presumptive Financial Assistance Less Than Most Generous Discount Items to Include:

1. Is the hospital notifying those presumed FAP-eligible individuals about how they can apply for more generous assistance under the FAP?

2. Is the hospital still giving patients a reasonable amount of time to apply before initiating ECAs to obtain any outstanding balances?

3. Has the hospital complied with the "reasonable efforts" requirements if a presumed FAP-eligible individual requests more generous assistance by completing a FAP application?

WARNING: Cannot use presumptive determinations for ineligibility.

Patient to Cooperate: Do you want a statement in your FAP requiring a patient to cooperate?

While the final rule does not mandate cooperation it does note that hospitals have the flexibility to include any additional information in the FAP that the hospital chooses to convey or that may be helpful to the community, including a cooperation statement.

Discounts: Are there other discounts you would like to claim on your 990?

The final regulations only require the FAP to describe discounts "available under the FAP" rather than all discounts offered by the hospital facility. However, only discounts specified in a hospital facility's FAP (therefore subject to the Amounts Generally Billed (AGB) limitation) may be reported as "financial assistance" on Schedule H of Form 990. Discounts provided by a hospital facility that are not specified in a hospital facility's FAP will not be considered community benefit activities for purposes of section 9007(e)(1)(B) of the Affordable Care Act nor for purposes of circumstances that are considered in determining whether a hospital organization is described in section 501(c)(3).

Suggestion: Hospitals should attempt to shoehorn as many discounts as possible under the FAP, unless such expansion is impractical or unworkable. Example: Patient qualifies for financial assistance and receives a discount at least at the AGB level. If patient decides to pay in full to take advantage of the prompt pay discount, hospital could count the prompt pay discount on 990 if the FAP discusses a prompt pay discount.

Separate Billing and Collection Policy - Will your organization create a separate billing and collection policy?

If yes, does the FAP point to the billing and collection policy and how the public can obtain one?

Financial Assistance Policy Checklist

FAP – Required Additions

Specify Eligibility: Did you specify the eligibility criteria (free or discounted care) for receiving financial assistance under the FAP? (No requirements on how to check eligibility, but do need to describe how your hospital will determine eligibility in your FAP)

Documentation: Does your Financial Assistance Application and Policy request any financial documentation?

If you do not request any documentation you cannot deny based upon lack of documentation.

"Reliable evidence" What do you consider "reliable evidence" under your for FAP? Examples:

a) Federal Tax Return
b) Paystubs
c) Documents establishing qualification for certain specified state means-tested programs
d) If these are not available, the patient may call the hospital's financial assistance office to discuss other evidence they may provide.

Time Frame: Will your facility narrow or broaden the time frame to assess?

Will you use the service date, application date, or other date to determine eligibility?

Hospitals may use the service date, the application date, or some other date to assess eligibility. Whatever period the hospital chooses should inform how the hospital designs its FAP application. For example, will the hospital accept as evidence of household income last month's paystub? If so, this suggests a narrower period for assessing eligibility. Will the hospital accept last year's tax return? This suggests a broader period for assessing FAP-eligibility.

Amount Generally Billed: Does your organization's FAP disclose your AGB?

Does your organization's FAP state that: FAP-eligible individuals will not be charged more than the AGB for emergency or other medically necessary care?

Specify the Amount(s): Did you specify the amount(s) (example - gross charges) to which any discount percentages will be applied.

Suggestion: Create an appendix for the AGB to make it easy to change each year.

Physicians on FAP: Did you create a list of all physicians (separate practices) ***who provide emergency or other medically necessary care*** in the hospital facility and specify which providers are covered by the hospital facility's FAP and which are not? Update – IRS clarified that the names of practices are acceptable.

Financial Assistance Policy Checklist

Suggestion: Create the provider list in an appendix to the FAP so that it could be revised easily without having to redraft the entire FAP every time a provider is added or deleted.

What isn't Covered by Financial Assistance: Does your FAP clearly state that non-emergency and non-medically necessary care will not be covered under your FAP? If not, then 501(r)(5) applies and the use of gross charges cannot be used for elective procedures.

Will you use the Medicaid definition used in the hospital facility state, other definition provided by state law, or a definition that refers to the generally accepted standards of medicine in the community or an examining physician's determination to define "medically necessary care"?

Suggestion: FAPs may—but often do not—cover elective or non-medically necessary care. Hospitals should review their FAPs to determine whether they should explicitly exclude care that is neither emergency nor medically necessary. Further, the FAP should define what constitutes "medically necessary care." The Final Regulations allow hospitals to import definitions based on state law, including a Medicaid definition, about generally accepted standards of medicine in the community or about an examining physician's determination.

Evidence of Eligibility

Other Evidence: What other financial items will you request be documented?

Many hospitals do request additional information to determine FAP eligibility. Below is a short list of items:

a) Retirement/Pension Accounts Balance
b) Investment Accounts Balance
c) Annuities
d) Bank statements
e) Property Ownership (Home, Second Home, Rental, or Land)
f) Type of Vehicle
g) Recreational Vehicles
h) Copy of Denial of Eligibility from Medicaid
i) Child Support Payments (12 months)
j) Social Security
k) Alimony Payments
l) Unemployment Payments
m) Work Compensation Payments
n) Trust Income
o) Veterans' Benefits
p) Health Savings Account/Flex Balance

Expenses: Will you request a patient's expenses?

Many hospitals do request additional information to determine FAP eligibility. Below is a short list of items:

Financial Assistance Policy Checklist

a) Mortgage/ Rent
b) Automobile
c) Utilities
d) Gas
e) Electricity
f) Water
g) Telephone (include cell phone)
h) Cable
i) Prescriptions
j) Food/ Groceries
k) Other Medical Bills
l) Credit Cards (list each by name and account number)

Other Coverage: Will you ask about other coverage such as worker's comp, auto insurance, etc.?

a) Are you seeking Financial Assistance because of a work-related accident or injury?
b) Are you seeking Financial Assistance because of a motor vehicle accident?
c) Do you have a lawsuit or other insurance claim pending for coverage of this illness or injury?
d) Obtain written verification from each employer whether or not health insurance is offered to employees?
e) Eligible for Federally Facilitated Exchange Plan through the Marketplace Exchange and did not enroll?

Reasonable Efforts Checklist

5 Steps for Reasonable Efforts

1. **Plain Language Summary**: The requirement to "*offer*" a plain language summary as part of the discharge or intake process is actually found under § 1.501(r)-4 of "*widely publicizing.*" This should be considered the starting point to make a "reasonable effort."

Did you train the access and discharge teams to understand that hospital facilities only have to "offer" a plain language summary?

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2. **Three Bills/Statements** - Based on typical billing cycles reported by commenter's, the IRS suggests that the patient receive at least three bills before facing any Extraordinary Collection Actions. The IRS referenced HFMA's Medical Debt Flow Chart in this section - http://www.hfma.org/WorkArea/DownloadAsset.aspx?id=21228

Conspicuous Written Notice (Statements): Does your billing statement include a **conspicuous written notice** that informs the recipient about the availability of FA under the hospital FAP that includes the telephone number of the hospital, department, or facility and direct web site address where copies of documents may be obtained? Also is it of sufficient size and clearly readable?

Mail Returns: "Provided" is the date it was mailed, emailed, or delivered by hand. Does your Billing and Collection Policy contain language similar to: "It is the Responsible Individual(s) obligation to provide a correct mailing address at the time of service or upon moving. If an account does not have a valid address, the determination for "Reasonable Effort" will have been made."

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3. **Plain Language Summary:** Final regulations require a plain language summary to be included with only one post-discharge communication (mail or email) and give hospitals the flexibility to send this one plain language summary to the subset of patients against whom the hospitals actually intend to use extraordinary collection actions.

Will the mailed Plain Language Summary be included in 1) one of the three statements, 2) by itself, 3) backer of statement (back side) or 4) with the final notice?

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4. **Final Notice-** The regulation requires that the final notice include the "intended" Extraordinary Collection Actions along with a deadline date before Extraordinary Collection Actions can occur. The deadline date is required to be at least 30 days before Extraordinary Collection Actions can occur. The deadline date can be no earlier than 120 days from the first post discharge statement. Suggestion: Small Balance Accounts - Combine the third statement and the Final Notice to save postage charges.

Did you update your final notice with the "intended" Extraordinary Collection Actions also mentioning that financial assistance is available? Suggestion for final notice language: *"Your account is past due and about to be listed with our collection agency partner. Financial Assistance is available to those who qualify. Please call 800-xxx-xxxx for assistance or visit www.xxxx.com for copies of our financial assistance information. We will allow and/or intend for our collection agency partner to place this account on your credit bureaus and/or take legal or judicial action at the discretion of our collection agency. The Deadline date for this account to be turned over to our collection agency is xx/xx/xxxx"*

Documents created and shared with WHA by AMERICOLLECT

Reasonable Efforts Checklist

DEADLINE - Did you inform the patient of the deadline date and is it no earlier than 30 days after the "intended" Extraordinary Collection Action final notice was sent by mail or electronic mail?

Does the DEADLINE date occur 120 days or more after the first post-discharge statement?

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5. **Oral Communication**: Did the hospital facility make a reasonable effort to verbally notify those patients against whom the hospital facility intends to engage in ECAs at least 30 days before they intend to initiate the ECA?

Scripting Suggestion: *"financial assistance is available for those who qualify* "

Remember that the hospital does not have to actually speak with the individual; it must only make a "reasonable effort" to communicate.

Widely Publicized Checklist

1. **Paper Copies Available at "Public Locations"**: Do you have paper copies of the Financial Assistance Policy (FAP) and application available to the public for free at:

the emergency department

admissions areas

as part of the intake (outpatient) and/or

discharge (inpatient) process, are you offering patients a FAP?

Suggestion: Train Access Staff to understand that the hospital only has to **offer** a plain language summary.

What do you need to have at these locations?

1. Financial Assistance Application
2. Plain Language Summary
3. FAP
4. Billing and Collection Policy

Are they translated (if applicable) and also available?

Translation of Plain Language Summary and Financial Assistance Application based on lesser of 5% of the population or 1,000 individuals encountered by the hospital. May use "any reasonable method to determine such populations" and can use either U.S. Census Bureau or American Community Survey data. If there are fewer than 50 persons in a language group that reaches the 5-percent trigger, the recipient of federal financial assistance does not have to translate vital written materials to satisfy the safe harbor but may provide written notice in the primary language of the limited English proficiency (LEP) language group of the right to receive competent oral interpretation of those written materials, free of cost.

2**. Are the following Documents Available on Website**:

1. Financial Assistance Application
2. Plain Language Summary
3. FAP
4. Billing and Collection Policy

Widely Publicized Checklist

Suggestion: 1. Each hospital should consider embedding a link on its home page leading viewers to a dedicated FAP webpage. This was one of the examples the Treasury provided.

Don't HIDE it in the Patients Section!

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3. **Conspicuous Written Notice** (Statements): Does your billing statement include a conspicuous written notice that notifies and informs the recipient about the availability of financial assistance under the hospital FAP including the telephone number of the hospital department or facility and direct web site address where copies of documents may be obtained?

This is also required to be of sufficient size and clearly readable.

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4. Conspicuous Public Display: Do you have Conspicuous Public Displays (signs) that attract visitors' attention (in the emergency room and admissions area?) The final regulations require these to be in "noticeable size" and in minimum "public locations" meaning emergency rooms and admissions areas.

Suggestion: The Treasury provided the following example for verbiage: "Uninsured? Having trouble paying your hospital bill? You may be eligible for financial assistance." Also include the website and telephone number for assistance. Finally, it is suggested that the signs have brochures that are basically the plain language summary.

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5. **Notify and Inform the Community:** How are you notifying and informing members of the community about the FAP?

Churches
Homeless Shelters
Food Pantry
Library
Post Office
Government Offices
Power company low income program (LIHEAP)

Billing and Collection Policy Checklist

There are six steps to complete a billing and collection policy:

Step 1. Describe the actions the hospital will take. A starting place for this requirement is the "reasonable efforts" that are required:

Reasonable Effort 1: Three separate statements during the 120 day period - Each statement is required to have a conspicuous written notice that includes: 1) statement that financial assistance is available, 2) telephone number to call for help 3) direct website address. This is required to be of sufficient size and clearly readable.

Reasonable Effort 2: Plain Language Summary to be included with one post-discharge communication. Some facilities have used the back of the notice (back page) to include the plain language summary in each notice.

Reasonable Effort 3: Final Notice- The regulation requires that the final notice include the intended Extraordinary Collection Actions (ECA) along with a deadline date before ECAs can occur. The deadline date must be at least 30 days before Extraordinary Collection Actions begin, as well as no earlier than 120 days from the first post-discharge statement. The final notice is only required to be sent to the subset of patients that the ECA are intended to be performed upon.

Reasonable Effort 4: Oral Communication "Attempt": Prior to initiation of any ECAs, an oral attempt will be made to contact the responsible individual(s) by telephone at the last known telephone number, if any, at least once during the series of mailed or emailed statements as long as the account remains unpaid. The oral attempt is only required to the subset of patients that the ECA are intended to be performed upon. Many facilities are training all those that communicate with patients with regards to a patient's financial obligations to orally offer financial assistance in all conversations. This is similar to "our calls may be recorded" but with "financial assistance is available to those that qualify".

Other possible additions of the actions the hospital will take:

Application Submissions - What will happen if an application is denied or incomplete? What actions will your hospital take?

General statement to protect the Hospital: Hospital may take any and all legal actions, including Extraordinary Collection Actions, to obtain payment for medical services provided.

Scoring: Responsible individual(s) propensity to pay will be scored based on an assessment of the responsible individual(s) likelihood to pay and dollar amount.

Step 2. Describe the Actions a collection partner may take

Extraordinary Collection Actions (ECA): Did you describe the ECA that the collection agency will take?

Additional requirement is to describe actions a collection partner may take "not limited to just the ECAs": Did you describe, in a general manner, the other items the collection agency may take such as: "Hospital and external collection agencies may also take any and all legal actions including but not

limited to telephone calls, emails, texts, mailing notices, and skip tracing to obtain payment for medical services provided."

Step 3. Describe the process and timeframes the Hospital (or other authorized party) will use in taking these actions.

The regulation spells out these timeframes clearly. 1) 120 days from the post-discharge statement for ECAs. 2) required to give a Deadline date no earlier than the 120 day past the post discharge statement or 30 days after mailing; whichever is greater.
If an application is denied or incomplete you will be required to notify the patient of denial or requirements to complete the application within a reasonable time (ex: deadline date of 30 days) before ECAs will resume or begin.

Step 4. Describe any reasonable efforts to determine whether an individual is FAP-eligible as described in section 501(r)(6). See Step 1 above.

Step 5. The FAP or billing and collections policy must describe the office, department, committee, or other body with the final authority or responsibility for determining that the hospital facility has made reasonable efforts to determine whether an individual is FAP-eligible and may therefore engage in Extraordinary Collection Actions against the individual.

Step 6. How can individuals obtain a free copy?

Billing and Collection Policy Sample

Community Hospital	
Policy Title:	Collection Policy
Policy #	12345
Effective Date:	01/01/2014
Revision Date:	
Review Responsibility and Final Authority to Determine Reasonable Effort has been made:	Director of Patient Financial Services

I. PURPOSE:

This policy applies to Community Hospital and its employed medical partners (collectively "CH") , together with Financial Assistance Policy, is intended to meet the requirements of applicable federal, state, and local laws, including, without limitation, section 501(r) of the Internal Revenue Code of 1986, as amended, and the regulations there under. This policy establishes the actions that may be taken in the event of nonpayment for medical care provided by CH, including but not limited to extraordinary collection actions. The guiding principles behind this policy are to treat all patients and Individual(s)'s Responsible equally with dignity and respect and to ensure appropriate billing and collection procedures are uniformly followed and to ensure that reasonable efforts are made to determine whether the Individual(s) Responsible for payment of all or a portion of a patient account is eligible for assistance under the Financial Assistance Policy.

II. DEFINITION:

Plain Language Summary means a written statement that notifies an Individual(s) that CH offers financial assistance under the FAP for inpatient and outpatient hospital services and contains the information required to be included in such statement under the FAP.
Application Period means the period during which CH must accept and process an application for financial assistance under the FAP. The Application Period begins on the date the care is provided and ends on the 240th day after the CH provides the first post discharge billing statement.
Billing Deadline means the date after which CH or collection agency may initiate an ECA against a Responsible Individual(s) who has failed to submit an application for financial assistance under the FAP. The Billing Deadline must be specified in a written notice to the Responsible Individual(s) provided at least 30 days prior to such deadline, but no earlier than 120 days after the first post discharge statement.
Completion Deadline means the date after which CH or collection agency may initiate or resume an ECA against an Individual(s) who has submitted an incomplete FAP if that Individual(s) has not provided the missing information and/or documentation necessary to complete the application or denied application. The Completion Deadline must be specified in a written notice and must be no earlier than the later of (1) 30 days after CH provides the Individual(s) with this notice; or (2) the last day of the Application Period.
Extraordinary Collection Action (ECA) means any action against an Individual(s) responsible for a bill related to obtaining payment of a Self-Pay Account that requires a legal or judicial process or reporting adverse information about the Responsible Individual(s) to consumer credit reporting agencies/credit bureaus. ECAs do not include transferring of a Self-Pay Account to another party for purposes of collection without the use of any ECAs.
FAP-Eligible Individual(s) means a Responsible Individual(s) eligible for financial assistance under the FAP without regard to whether the Individual(s) has applied for assistance.
Financial Assistance Policy (FAP) means CH's Financial Assistance Program for Uninsured Patients Policy, which includes eligibility criteria, the basis for calculating charges, the method for applying the policy, and the measures to publicize the policy, and sets forth the financial assistance program.
PFS means Patient Financial Services, the operating unit of CH responsible for billing and collecting Self-Pay Accounts.

Responsible Individual(s) means the patient and any other Individual(s) having financial responsibility for a Self-Pay Account. There may be more than one Responsible Individual(s).
Self-Pay Account means that portion of a patient account that is the Individual(s) responsibility of the patient or other Responsible Individual(s), net of the application of payments made by any available healthcare insurance or other third-party payer (including co-payments, co-insurance and deductibles), and net of any reduction or write off made with respect to such patient account after application of an Assistance Program, as applicable.

III. POLICY

A. Subject to compliance with the provisions of this policy, CH may take any and all legal actions, including Extraordinary Collection Actions, to obtain payment for medical services provided.

B. CH will not engage in ECAs, either directly or by any debt collection agency or other party to which the hospital has referred the patient's debt, before reasonable efforts are made to determine whether a Responsible Individual(s) is eligible for assistance under the FAP.

C. All patients will be offered a Plain Language Summary and an application form for financial assistance under the FAP as part of the discharge or intake process from a hospital.

D. At least three separate statements for collection of Self-Pay Accounts shall be mailed or emailed to the last known address of each Responsible Individual(s); provided, however, that no additional statements need be sent after a Responsible Individual(s) submits a complete application for financial assistance under the FAP or has paid-in-full. At least 60 days shall have elapsed between the first and last of the required three mailings. It is the Responsible Individual(s) obligation to provide a correct mailing address at the time of service or upon moving. If an account does not have a valid address, the determination for "Reasonable Effort" will have been made. All Single Patient Account statements of Self-Pay Accounts will include but not limited to:

1. An accurate summary of the hospital services covered by the statement;
2. The charges for such services;
3. The amount required to be paid by the Responsible Individual(s) (or, if such amount is not known, a good faith estimate of such amount as of the date of the initial statement); and
4. A conspicuous written notice that notifies and informs the Responsible Individual(s) about the availability of Financial Assistance under the hospital FAP including the telephone number of the department and direct website address where copies of documents may be obtained.

E. At least one of the statements mailed or emailed will include written notice that informs the Responsible Individual(s) about the ECAs that are intended to be taken if the Responsible Individual(s) does not apply for financial assistance under the FAP or pay the amount due by the Billing Deadline. Such statement must be provided to the Responsible Individual(s) at least 30 days before the deadline specified in the statement. A Plain Language Summary will accompany this statement. It is the Responsible Individual(s) obligation to provide a correct mailing address at the time of service or upon moving. If an account does not have a valid address, the determination for "Reasonable Effort" will have been made.

F. Responsible Individual(s) propensity to pay will be scored based on that assessment of the Responsible Individual(s) likelihood to pay and dollar amount of the Self-Pay account.

G. Prior to initiation of any ECAs, an oral attempt will be made to contact Responsible Individual(s) by telephone at the last known telephone number, if any, at least once during the series of mailed or emailed statements if the account remains unpaid. During all conversations, the patient or Responsible Individual(s) will be informed about the financial assistance that may be available under the FAP.

H. ECAs may be commenced as follows:

1. If any Responsible Individual(s) fail to apply for financial assistance under the FAP by 120 days after the first post discharge statement, and the Responsible Parties have received a statement with a Billing Deadline described in Section III.E above, then CH or collection agency may initiate ECAs.

2. If any Responsible Individual(s) submits an incomplete application for financial assistance under the FAP prior to the Application Deadline, then ECAs may not be initiated until after each of the following steps has been completed:

a. PFS provides the Responsible Individual(s) with a written notice that describes the additional information or documentation required under the FAP in order to complete the application for financial assistance, which notice will include a copy of the Plain Language Summary.

b. PFS provides the Responsible Individual(s) with at least 30 days' prior written notice of the ECAs that CH or collection agency may initiate against the Responsible Individual(s) if the FAP application is not completed or payment is not made; provided, however, that the Completion Deadline for payment may not be set prior to 120 days after the first post discharge statement.

c. If the Responsible Individual(s) who has submitted the incomplete application completes the application for financial assistance, and PFS determines definitively that the Responsible Individual(s) is ineligible for any financial assistance under the FAP, CH will inform the Responsible Individual(s) in writing the denial and include a 30 days' prior written notice of the ECAs that CH or collection agency may initiate against the Responsible Individual(s); provided, however, that the Billing Deadline may not be set prior to 120 days after the first post discharge statement.

d. If the Responsible Individual(s) who has submitted the incomplete application fails to complete the application by the Completion Deadline set in the notice provided pursuant to Section III.G.3.b above, then ECAs may be initiated.

e. If an application, complete or incomplete, for financial assistance under the FAP is submitted by a Responsible Individual(s), at any time prior to the Application Deadline, CH will suspend ECAs while such financial assistance application is pending.

I. After the commencement of ECAs is permitted under Section III.G above, collection agencies shall be authorized to report unpaid accounts to credit agencies, and to file judicial or legal action, garnishment, obtain judgment liens and execute upon such judgment liens using lawful means of collection; provided, however, that prior approval of PFS shall be required before initial lawsuits may be initiated. CH and external collection agencies may also take any and all legal other actions including but not limited to telephone calls, emails, texts, mailing notices, and skip tracing to obtain payment for medical services provided.

IV. POLICY AVAILABILITY

Contact our Business Office at 111-111-1111 for information regarding eligibility or the programs that may be available to you, to request a copy of the FAP, FAP application form, or Collection Policy to be mailed to you, or if you need a copy of the FAP, FAP application form, or Collection Policy translated to Spanish. Full disclosure of the FAP, FAP application form, or Collection Policy may be found at www.abcmemorialhosp.org. A paper copy of our FAP, FAP application form, or Collection Policy can be obtained at our facility located at 111. S. Main St., Anywhere, WI 5XXXX at the patient accounting office, admissions and registration areas, emergency department or the local community library located at 222 S. Main St., Anywhere, WI 5XXXX.