Carolinas HealthCare System
PFS Billing and Collection Policy

Created:	*08/30/2013*	*Approved Version:*	*10/19/2017*
		Revised:	*10/31/2017*

Applicability

This policy applies to the following Carolinas HealthCare System (CHS) facilities:

Carolinas HealthCare System Anson
Carolinas HealthCare System Behavioral Health – Charlotte
Carolinas HealthCare System Behavioral Health - Davidson
Carolinas HealthCare System Cleveland
Carolinas HealthCare System Kings Mountain
Carolinas HealthCare System Lincoln
Carolinas HealthCare System NorthEast
Carolinas HealthCare System Pineville
Carolinas HealthCare System Stanly
Carolinas HealthCare System Union
Carolinas HealthCare System University
Carolinas Medical Center
Carolinas Medical Center – Mercy
Carolinas Rehabilitation
Levine Children's Hospital

Objective

The Billing and Collection (B&C) policy supports the Carolinas HealthCare System's (CHS) goal of assisting patients with the complexities of billing third-party insurers, providing patient specific payment options, reviewing uninsured patient's eligibility for coverage assistance and financial assistance and taking actions concerning amounts due for services.

CHS policy is to provide care for emergency medical conditions regardless of the patient's ability to pay and without consideration of the patient's prior payment history. CHS does reserve the right to take collection actions as permitted by law concerning balances due from either the patient or third-party insurer. CHS has the following five major objectives for billing and collection:

- demonstrating CHS's core value of "Caring";
- obtaining necessary patient specific third-party insurer and personal information in advance of any scheduled services;
- complying with third-party insurer policies and State and Federal regulations related to billing and collection;
- assisting the patient to navigate the complexities of seeking reimbursement from third-party insurers; and
- establishing billing and collection processes consistent with industry standards.

CHS will achieve these objectives by implementing the following B&C strategies:

- maintaining up-to-date patient and third-party insurer information as provided by the patient or patient representative.

- assisting patients with verification of coverage and working with third-party insurers to provide patients estimates of patient cost-sharing amounts for scheduled services;
- providing various payment options for patients;
- establishing reasonable efforts to determine patient's eligibility for financial assistance programs;
- evaluating and implementing healthcare industry best practices in billing and collections; and
- maintaining a robust compliance and patient satisfaction monitoring program.

Definitions

1. Average Amount Generally Billed (AGB): The average of Medicare and all private third-party insurer allowables for all claims allowed in a 12 month period.
2. Bad Debt: Accounts that have been categorized as uncollectible because the patient has failed to pay for services rendered and are not eligible for CAFA.
3. Elective: Services that, in the opinion of a physician, are not needed or can be safely postponed.
4. Extraordinary Collection Action (ECA) – any collection activity taken against an individual that requires a legal or judicial process, involves selling an individual's debt to another party, reporting adverse information to consumer credit reporting agencies/credit bureau or denying medically necessary services due to insufficient payment.
5. Financial Assistance Score (FAS Score): A score computed by a third-party vendor to provide a proactive, consistent, and automated mechanism to substantiate a patient's financial profile. The FAS Score is not a credit score, but relies on various databases with more than 9,000 sources and 2 billion records to determine the likelihood that a patient lives in poverty. A component of the FAS Score is a Household Income Index that is calibrated to Federal Poverty Guidelines. Other components of the FAS Score include, but are not limited to, a review of census data, consumer transaction history, asset ownership files and utility files.
6. Household Financial Income: An assessment of a patient's income, as measured against annual Federal Poverty Guidelines, that includes, without limitation the following:
    - Annual household pre-tax job earnings
    - Unemployment compensation
    - Workers' compensation
    - Social Security and Supplemental Security Income
    - Veteran's payments
    - Pension or retirement income
    - Other applicable income, including for example, rents, alimony, child support and any other miscellaneous income regardless of source
7. Third-party Insurers: Any party insuring payment on behalf of a patient, including: insurance companies, workers' compensation, governmental plans such as Medicare and Medicaid, State/Federal Agency plans, Victim's Assistance, or third-party liability resulting from automobile or other accidents.
8. Uninsured: Patients who are not covered under a third-party insurer.

Policy

Pre-Service

CHS encourages each patient to pay based on their ability to pay all or a portion of the patient's estimated balance for medically necessary services prior to the scheduled service. The CHS Pre-Service team may contact the patient to obtain third-party insurer and other information needed to bill for services and may provide an estimate of the patient's out-of-pocket expenses. For insured individuals, the estimate is based on the determination of the patient specific third-party coverage for the services. The CHS Pre-Service team may request that the patient pay all or a portion of the estimated patient balance. If the patient is uninsured, the estimate of the patient's balance is based on the amount after the CHS uninsured discount is applied.

Coverage Assistance and Financial Assistance

Coverage Assistance and Financial Assistance (CAFA) is available to all uninsured North Carolina and South Carolina patients receiving medically necessary services in CHS facilities. CHS follows two different processes based on place of service when determining eligibility for financial assistance for uninsured patients.

Category I is for all patients receiving inpatient or outpatient services with a patient balance greater than or equal to $10,000 who are reviewed for CAFA by the Financial Counseling Department. A financial counselor will interview the patient and determine if the patient is eligible for other coverage opportunities. If a patient fully cooperates with this process and no coverage is available, the patient's account will be evaluated for financial assistance based on the patient's household financial income as compared to federal poverty guidelines (FPG). Any patient balance due, if any, will be less than the "average amount generally billed" as defined below. To further assist these patients, interest-free payment plan options are available for any remaining balance.

Category II is for all patients receiving any other outpatient services resulting in a patient balance less than $10,000 who are automatically reviewed for financial assistance. Each account is automatically reviewed for a financial assistance discount prior to billing. Eligibility is based on a Financial Assistance Score (FAS) from a third-party vendor that indicates the likelihood a patient lives in poverty. Patients with qualifying accounts will be extended a 100% adjustment and will not receive a bill. A patient found ineligible automatically will be extended a 50% uninsured discount. Those ineligible can also apply for a manual review by downloading an application on the CHS website.

For Emergency Department services, CHS will request a $75 copay at the time of service. CHS will review balances incurred through the Emergency Department greater than $75 for financial assistance through one of the above processes based on the patient balance.

CHS will make reasonable efforts to communicate the CHS CAFA policy to uninsured patients and determine eligibility for the CHS CAFA program prior to any extraordinary collection action.

Reasonable efforts include:

1. Wide publication of the CHS CAFA policy and plain language summary of the policy to include on the CHS website, at CHS facility admission offices and on billing statements
2. Application accessible for download on the CHS website or available by mail upon request
3. Multiple language translations of CAFA policy, plain language summary and application available on the CHS website
4. Oral notification of the CHS CAFA policy by PFS Customer Service and/or third-party collection agencies
5. A minimum of 3 billing statements. Plain language summary is included with all billing statements.

6. 30 day notice is sent to patients notifying them of their financial obligation, pending collection action and information regarding the CHS CAFA policy prior to collection agency referral or an extraordinary collection action (ECA) occurring. Notice includes the plain language summary.
7. Automated Financial Assistance Scoring (FAS) presumptive eligibility process prior to patient billing for uninsured patients. Those who are found ineligible are notified via a letter with the plain language summary detailing how to apply for CAFA should they feel their FAS based eligibility was not accurate.
8. CHS provides all patients with 240 days from the first post-discharge bill date to apply for financial assistance prior to any extraordinary collection action. All patients have 30 days to make financial arrangements regarding their bill before an ECA will occur whether within the 240 day window or outside the 240 day window.
9. All ECAs will be suspended if an application for CAFA is received during the 240 day application window or 30 day notice period. ECAs will not resume until a financial assistance determination has been made and the patient is found ineligible for financial assistance. ECAs will be reversed for any patient found eligible for financial assistance. Patients who submit incomplete applications will also have their ECA suspended and will be notified in writing of the needed information to complete their application and given 30 days to provide that information.
10. The CHS Unified Business Office has the final authority in ensuring reasonable efforts have been made to communicate the CHS CAFA policy and determine an individual's eligibility and whether an ECA can be initiated.

Average Amount Generally Billed

CHS will never bill any financial assistance eligible individual more than the "average amount generally billed" (AGB). CHS uses a look-back method to determine AGB based on all private insurer and Medicare allowables for all claims allowed within a 12 month period. All uninsured patients automatically receive a 50% uninsured discount. Patients approved for financial assistance receive at minimum a 50% financial assistance discount in addition to the 50% uninsured discount which totals a minimum of 75% off gross charges. If a patient is still responsible for any portion of the bill after all discounts, the patient's bill will indicate how the patient may obtain information on how the bill was calculated to be below AGB. Remaining balances after all discounts are eligible for the "Choice Outreach" interest free payment plan option described below.

Hardship Settlement Discount

The Hardship Settlement program is a discount program designed to assist any North Carolina or South Carolina resident who has had a catastrophic medical event that has resulted in very large hospital bills in comparison to the patient's financial resources. A patient who has incurred a balance after all third-party payments that is greater than 10% of the patient's total household financial resources may be eligible for a Hardship Settlement discount. A patient seeking a hardship settlement discount should inquire about this program by calling the customer service department after receiving the patient's first statement. Patient balances must be greater than or equal to $2,500 to qualify for a hardship settlement.

Initial Billing

As a courtesy to patients residing in the United States, CHS bills all third-party insurers on their behalf. CHS will assist the patient with all known hospital pre-authorizations and other approvals required for services as a benefit to the patient. The patient is responsible, however, for all of the insurer's prerequisites for covering services. In situations when services are denied by a third-party insurer, CHS will assist the patient in any appeal process with third-party insurers.

For insured patients, CHS submits a claim on behalf of the patient to the patient's insurance provider. If there is a patient responsibility portion after the third-party insurer pays or denies the claim, CHS will send the patient a minimum of 3 billing statements indicating the balance owed.

For uninsured patients, CHS automatically applies a 50% uninsured discount to gross charges and reviews their balance for financial assistance. Those receiving partial financial assistance or are ineligible will receive a bill in the mail.

Collection of Patient Balances

CHS reserves the right to utilize outside vendors to assist CHS and patients regarding balances due and process payment plans. When a balance is owed by the patient, CHS expects full payment and considers the account to be "Self-Pay."

- An account is determined to be Self-Pay if:
  - There is no third-party insurer on record.
  - All expected payments from the third-party insurers have been received.
  - The patient has been uncooperative with the CHS Financial Counseling Department to determine other coverage opportunities or financial assistance in accordance with the CHS CAFA Policy.
- CHS will generate at minimum three billing statements and send it to the physical address on file provided by the patient or representative. Patients who have opted for paperless billing will receive a minimum of 3 email notifications that their billing statements are available in the MyCarolinas Patient Portal on the CHS website.
- Each statement includes a plain language summary of the CHS CAFA policy regarding coverage and financial assistance.
- CHS will perform Medicaid eligibility checks on all self-pay accounts on behalf of the patient after discharge and prior to collection activity. If Medicaid coverage is identified, the account will be reclassified to Medicaid from Self-Pay and billed to Medicaid.
- The last communication will occur at least 90 days from the first post-discharge bill date and will include communication to the patient that if there is no action, the patient account will be referred for additional collection actions in 30 days. This communication also includes a plain language summary detailing the CHS CAFA policy.
- On each billing statement, it is communicated that an itemized bill can be requested by contacting the CHS Customer Service call center at 704-512-7171.
- Patients can access the MyCarolinas Patient Portal on the CHS website and request an itemized bill, ask questions, pay bills, and submit questions to the CHS Customer Service team.
- All communications 30 days prior to bad debt placement, including oral communications by third-party collectors, include communication of the CHS CAFA policy.

Patient Payment Plans

If a patient has the means to pay his or her bill but cannot pay in full, they can set up a payment plan administered by a third-party vendor, AccessOne. Patients can call the CHS Patient Financial Services Customer Service Department at 704-512-7171 or AccessOne at 1-888-458-6272 to set up a payment plan.

Three plans are available:

1. "Choice" is available to any patient with a balance less than or equal to $10,000. The program includes an interest free payment option for up to 24 months.

2. "Choice 10" is available to any patient with a balance greater than $10,000. The program expands the interest free payment for up to 100 months (based on account balance). The program also offers a fixed low interest payment option as well.

3. "Choice Outreach" is available to patients who have a high likelihood of living in poverty. For example, a patient may have already received financial assistance through the CAFA or Hardship Settlement Discount Programs, but may still have a balance for which the patient is responsible for paying. Patients who are found to be below 400% of the FPG qualify for this payment arrangement. For accounts with a balance less than $2,500, the minimum payment is set to $25 a month until the balance is paid in full. For accounts over $2,500, the minimum payment is set to a percentage of the total ranging from .50% to 1% of the balance due. All patients who were found eligible for financial assistance or a hardship discount are automatically eligible for the "Choice Outreach" payment plan program.

CHS also provides a 6 month interest free payment plan administered internally.

Refunds:

Patient refunds are processed within 45 days of the notice of overpayment. Patients who are owed a refund will receive a paper check to the address on file. Refunds may also be credited back to the credit card used at the time of payment.

Bill Inquiry:

Patients who have questions about charges on their bill can call the CHS Patient Financial Services Customer Service Department at 704-512-7171. A customer service representative will review the charges with the patient and provide them with an itemized bill upon request. If the patient still has questions regarding specific charges, the patient may request a charge audit. The Patient Financial Service Medical Audit team will validate the charges billed to the services documented in the medical record. A resolution letter will be mailed to the patient regarding the audit findings.

Collection Agency Referral:

CHS may refer certain patient accounts to contracted third-party collection agencies. All collection agencies working on behalf of CHS are expected to comply with applicable CHS Billing and Collections and CAFA policies. CHS and/or third-party collection agencies may report adverse information to a consumer credit reporting agency or credit bureau as a result of no or insufficient payment. Agency placement may occur no earlier than 120 days from the first post-discharge bill date and credit reporting may occur no earlier than 240 days from the first post-discharge bill date. CHS and external collection agencies will follow all regulations related to healthcare collections including the Fair Debt Collection Practices Act in conducting collection activities.

Collection Agency Review:

After a patient has received at least three billing statements, an account is reviewed for collection agency referral. Prior to the referral, CHS takes the following action:

- All accounts are reviewed for current Medicaid eligibility.
- Uninsured accounts reviewed for collection agency referral that were not classified as uninsured at discharge and never reviewed for financial assistance eligibility through the CAFA or FAS process will be reviewed for presumptive financial assistance through the FAS process. Those found eligible for financial assistance are extended a financial assistance discount and not referred. Those found ineligible are notified in writing with the CHS CAFA plain language summary with information on how to apply for a full CAFA review.
- Accounts are not referred if information has been obtained that would assist in resolving the account balance prior to further collection activity.

Collection Agency Placement:

- Accounts are automatically submitted to a CHS contracted primary collection agency. Accounts remain with the primary collection agency for a period of at least 270 days.
- The primary collection agency will make each patient that they contact for purposes of debt collection aware of the CHS CAFA policy.
- The primary bad debt placement agency will not credit report until 240 days from the first post-discharge bill date.

Secondary Bad Debt placement occurs 270 days after primary placement for all accounts that have had no or insufficient payment activity.

Legal Collection Actions

Legal action will be considered if an account goes unpaid and reasonable efforts have been made to determine if the account is eligible for CAFA. The CHS Unified Business Office has the final authority of determining if a legal action should be pursued and reasonable efforts, defined in this policy, have been made to communicate the CHS CAFA policy and determine if a patient is eligible for coverage or financial assistance. Legal action will not occur until 240 days from the first post-discharge bill date. Patients will be given 30 days' notice before a legal action occurs. The 30 day notice will include a plain language summary detailing the CHS CAFA policy and all subsequent communications will inform the patients of the CHS CAFA policy. Patients have 30 days from the date of the notification to apply for a CAFA review or resolve the debt before the legal action occurs. If a patient is found eligible for coverage or financial assistance after a legal action has been initiated, legal action will be temporarily ceased and coverage assistance will be initiated or financial assistance discounts will be applied. Unfortunately, legal action is required to encourage a very small minority of patients to respond and cooperate with the coverage assistance and financial assistance process. All CHS legal action is compliant with applicable state and federal legislation.

Legal actions are outlined below:

- Small Claims Collections – accounts with balances $300 - $5000 may be referred to local County small claims court.
- Lawsuits – Account balances >$5000 may be referred to an attorney for pursuit of judgments according to appropriate state laws.
- South Carolina (SC) Tax Debt Set-Off – Working through the S.C. Association of Counties, CHS files a set-off claim against any SC tax refund due the patient.

VP Approval	**Date**
SVP Approval	**Date**