Title: Billing and Debt Collection Policy

SARATOGA HOSPITAL

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Area Manual: Administrative Policy I **Page:** 1

Reference Number: I-017a

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Scope:

Saratoga Hospital (Hospital) will follow billing and debt collection practices that:

(i) comply with all requirements of federal and state law, including the Fair Debt Collection Practice Acts and IRS §501r standards for tax-exempt hospitals;

(ii) balance the need to diligently pursue funds owed to the organization for services provided, with the need to provide financial assistance to eligible patients and to treat all patients with respect and compassion; and

(iii) reflect the mission and values of this organization.

Policy:

I. Billing

A. *Insured Patients* (e.g., Medicare, Medicaid or commercial payor)

1. Where the patient is insured (and has assigned to the Hospital his or her right to payment), the Hospital will submit its claim for payment to the insurer and not bill the patient directly, except as set forth in paragraph 2.
2. The Hospital may still bill an insured patient who has assigned claims:
   (a) For patient cost-sharing amounts (e.g., co-pays, coinsurance or deductibles); and
   (b) For services not covered by the patient's health plan, or services covered by the plan but for which payment is denied in whole or part by the plan, or balances due after insurance payment, to the extent billing for such amounts are permitted by law and by the Hospital's contract with the insurer. When billing for such amounts, the Hospital will follow the practices set forth in section I.B below, to the extent such practices are permitted by law and by the Hospital's contract with the insurer.

B. *Uninsured Patients* (i.e., self-pay patients).

1. Billing amount. Where the patient is uninsured (or has not assigned to the Hospital his or her right to payment), the Hospital will determine the billing amount as follows:

   (a) The Hospital will inform the patient of its Financial Assistance Policy in accordance with Hospital Policy #I-17. If the patient applies for and is eligible for financial assistance, the bill will be discounted in accordance with such policy.

   (b)The Hospital does not charge uninsured patients more for emergency or other medically necessary services more than amounts generally billed to insured individuals receiving the same care. The Hospital determines amounts generally billed [(1)] for services by determining the discount from standard Hospital charges that payment from Medicare for the related services would represent. Any uninsured patients are provided an automatic payment discount off of standard charges which is intended to bring the net charges billed down to the level of payment the Hospital would expect to receive from Medicare for the same services.

   (c) Patients who do not qualify for financial assistance, and who do not pay within 30 days of the date appearing on their first statement, will thereafter be billed at the discounted amount generally billed to Medicare for the same services.

   (d) Dental services are excluded from the standard discount policy. Preventative services will be discounted by 50% and non-preventative services will be discounted by 15% if paid at the time of service.

   (e) Exceptions to the standard discount policy described above are for services provided to uninsured patients in the Hospital Emergency Department and the Hospital's Urgent Care site at Wilton Medical Arts. Special tiered discount programs are in place for services provided at those locations, and are described below:

Emergency Department Services:

Tier 1-available for patients receiving any services during an outpatient emergency department visit, unless the services include a CT and/or MRI scan. The discounted patient payment for this level of Emergency Department services is $300 which includes New York State DOH surcharge.

Tier 2-available for outpatient Emergency Department visits when the visit includes a CT and/or MRI scan. The discounted patient payment for this level of Emergency Department services is $700 which includes New York State DOH surcharge.

Urgent Care Services (Wilton Medical Arts):

Tier 1- available for patient receiving any services during an Urgent care visit if those services include a lab test and/or any imaging test, unless the imaging test is a Ct and/or MRI scan. The discounted patient payment for this level of Urgent Care services is $180 which includes New York State DOH surcharge.

Tier 2- available for patient receiving any services during an Urgent care visit if those services include a Ct and/or MRI scan. The discounted patient payment for this level of Urgent Care services is $500 which includes New York State DOH surcharge.

The special tiered discounts available to Emergency Room department and Urgent Care services are intended to provide uninsured patients with an automatic discount for those services that exceeds the standard discount for all other services to uninsured patients.

Patients are not required to take any action in order to receive the standard discount and the Emergency department and Urgent Care discounts. These adjustments are automatically made to patient's bills before the statements are sent out. These discounts apply to all uninsured patients whether or not a patient lives within the Hospital's geographic service area. A prompt pay discount is available to uninsured patients at the time of service.

2. Billing procedure.

   (a) The Hospital will send such patient a minimum of three statements over a 120 day period. Each such statement will provide information about the Financial Assistance Policy (or a reference to a web address with such information). During such period, the Hospital shall not engage in any Extraordinary Collection Actions. Exceptions are made in cases where the Hospital is unable to establish an address or phone contact for the patient or the patient has been verbally contacted but refuse to engage in a dialogue with the Hospital.

   (b) After 120 days, a final notice letter will be sent to the patient describing collection actions that may be taken by the Hospital should the patient fail to respond within 30 days of the date of the letter.(c)At 150 days after the initial statement, if full payment or an application for the Hospital's Financial Assistance Program has not been received, or other payment arrangements negotiated, the account may be referred to the Hospital's collection agency, which may commence Extraordinary Collection Actions (defined below).

3. Payment Plans

Payment plans are available in certain circumstances. Once established, payment plans will be reviewed periodically to ensure the account remains in good standing. If you feel at any time that your payment arrangement has become a burden due to a change in financial situation a meeting can be scheduled with a financial counselor.

II. Extraordinary Collection Actions.

A. Basic Limitation on Extraordinary Collection Actions.

   1. The Hospital shall not engage in Extraordinary Collection Actions as defined in paragraph B below, against an individual until the Hospital has made *reasonable efforts*, as described in paragraph C below, to determine whether the individual is eligible for assistance under the Hospital financial assistance policy (FAP).

B. *Extraordinary collection actions* defined

   1. *Extraordinary collection actions* are actions taken related to obtaining payment of a bill for Hospital services that either:

      (a) require a legal or judicial process,
      (b) involve selling an individuals' debt to another party, or
      (c) involve reporting adverse information about the individual to consumer credit reporting agencies or credit bureaus.

2. Actions that require legal or judicial process include, but are not limited to, actions to-

(a) Place a lien on an individual's property;
(b) Foreclose on an individual's real property (other than a primary residence);
(c) Attach or seize an individual's bank account or any other personal property;
(d) Commence a civil action against an individual;
(e) Cause an individual's arrest;
(f) Cause an individual to be subject to a writ of body attachment; and
(g) Garnish an individual's wages.

C. *Reasonable efforts.*

1. Reasonable efforts mean that the Hospital:

(a) Gave a plain language summary of its Financial Assistance Plan (FAP) and offer an application form, to the patient before discharge from the Hospital;

(b) Included information about the availability of Financial Assistance and about how to access the FAP Summary with all (and at least three) billing statements for the care and all other written communications regarding the bill provided to the individual during the period of date of Hospitalization until 150 days after the first billings statement (the "notification period.") Exceptions to this rule include refusal by patient/guarantor to discuss a bill and/or return address with no means to locate patient/guarantor.

(c) Informs the individual about the FAP in all oral communications with the individual regarding the amount due for the care that occur during the notification period; and

(d) Provides the individual with at least one written notice that (i) informs the individual about the Extraordinary Collection Efforts the Hospital or other authorized party may take if the individual does not submit a FAP application or pay the amount due by a deadline (specified in the notice); and (ii) is provided to the individual at least 30 days before the deadline specified in the written notice. This notice will not be sent any earlier than 120 days after the date of the first billing statement sent to the patient.

2. With respect to a patient who submitted an incomplete FAP application, reasonable efforts means that the Hospital:

(a) suspends extraordinary collection efforts against the patient;

(b) provides the patient with a written notice that describes the additional information and/or documentation required, and includes a copy of the FAP;

(c) complies with C.1.(d) above.

3. Hospital will not permit a third party collection agent to commence an extraordinary collection effort against a person for an unpaid Hospital services bill unless and until a Hospital official has authorized the specific action(s) against the specific person.

III. Fair Debt Collection Practices.

A. The Hospital, directly or through billing or collection agents, shall comply with the requirements of the federal Fair Debt Collection Practices Act. Specifically, the Hospital

shall not engage in any of the following abusive and deceptive practices when attempting to collect debts:

1. **Hours for phone contact**: contacting consumers by telephone outside of the hours of 8:00 a.m. to 9:00 p.m. local time;
2. **Failure to cease communication upon request**: communicating with consumers in any way (other than litigation) after receiving *written* notice that said consumer wishes no further communication or refuses to pay the alleged debt, with certain exceptions, including advising that collection efforts are being terminated or that the collector intends to file a lawsuit or pursue other remedies where permitted;
3. **Causing a telephone to ring or engaging any person in telephone conversation repeatedly or continuously**: with intent to annoy, abuse, or harass any person at the called number;
4. **Communicating with consumers at their place of employment** after having been advised that this is unacceptable or prohibited by the employer;
5. **Contacting consumer known to be represented by an attorney;**
6. **Communicating with consumer after request for validation has been made**: communicating with the consumer or the pursuing collection efforts by the debt collector *after* receipt of a consumer's written request for verification of a debt made within the 30 day validation period (or for the name and address of the original creditor on a debt) and *before* the debt collector mails the consumer the requested verification or original creditor's name and address
7. **Misrepresentation or deceit**: misrepresenting the debt or using deception to collect the debt, including a debt collector's misrepresentation that he or she is an attorney or law enforcement officer;
8. **Publishing the consumer's name or address** on a "bad debt" list;
9. **Seeking unjustified amounts**, which would include demanding any amounts not permitted under an applicable contract or as provided under applicable law;
10. **Threatening arrest or legal action** that is either not permitted or not actually contemplated;
11. **Abusive or profane language** used in the course of communication related to the debt;
12. **Communication with third parties**: revealing or discussing the nature of debts with third parties *(other than the consumer's spouse or attorney, or others to the extent permitted by the FDPA.*
13. **Contact by embarrassing media**, such as communicating with a consumer regarding a debt by post card, or using any language or symbol, other than the debt collector's address, on any envelope when communicating with a consumer by use of the mails or by telegram, except that a debt collector may use his business name if such name does not indicate that he is in the debt collection business;
14. **Reporting false information on a consumer's credit report** or threatening to do so in the process of collection

[1]The Hospital uses the look-back method prescribed by IRS Section 501(r) in order to determine Medicare amounts generally billed. Information regarding the Hospital's calculation of amounts generally billed to Medicare may be obtained free of charge may be obtained by contacting the Hospital Fiscal Services Department at 518/583-8497.

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Signature, Title: VP + CFO

Print Name: **Gary Foster, Vice President and CFO**

References: Statutory or regulatory citations, best practice publication, existing SARATOGA HOSPITAL policies.