| **Ascension Saint Agnes**<br>System Policy and Procedure Manual | **Page 1 of 7** | **SYS FI 51** |
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| **Subject:**<br><br>Ascension Saint Agnes Billing and Collection Policy | **Effective Date:** 7/16 | |
| | **Reviewed:**<br>**Revised:** 7/17, 6/20, 10/20, 12/21, 12/23 | |
| Approvals:<br>Final - President/CEO: _____ Date: _____<br><br>Concurrence: _____ Date: _____<br>*(Policies become effective 30 days after CEO signs.)* | | |

## POLICY/PRINCIPLES

It is the policy of Ascension Saint Agnes to ensure a socially just practice for providing emergency and other medically necessary care at the Organization pursuant to its Financial Assistance Policy (or "FAP"). This Billing and Collection Policy is specifically designed to address the billing and collection practices for Patients who are in need of financial assistance and receive care at the Organization.

All billing and collection practices will reflect our commitment to and reverence for individual human dignity and the common good, our special concern for and solidarity with persons living in poverty and other vulnerable persons, and our commitment to distributive justice and stewardship. The Organization's employees and agents shall behave in a manner that reflects the policies and values of a Catholic-sponsored facility, including treating Patients and their families with dignity, respect and compassion.

This Billing and Collection Policy applies to all emergency and other medically necessary care provided by the Organization, including employed physician services and behavioral health. This Billing and Collection Policy does not apply to payment arrangements for care that is not "emergency" and other "medically necessary care" (as those terms are defined in the Organization's FAP).

## DEFINITIONS

1. "**501(r)**" means Section 501(r) of the Internal Revenue Code and the regulations promulgated thereunder.

2. "**Extraordinary Collections Actions**" **or** "**ECAs**" means any of the following collection activities that are subject to restrictions under 501(r):

   a. Selling a Patient's debt to another party.[1]

   b. Reporting adverse information about the Patient to consumer credit reporting agencies or credit bureaus.[2]

[1] Pursuant to Maryland Code, Health – General, Section 19-214.2(b)(2), Organization shall not sell any debt.

[2] Pursuant to Maryland Code, Health – General, Section 19-214.2(b)(5), Organization shall not report to a consumer reporting agency within 180 days after the initial bill is provided to Patient.

c. Deferring or denying, or requiring a payment before providing, medically necessary care because of a Patient's nonpayment of one or more bills for previously provided care covered under the FAP.

d. Actions that require legal or judicial process, except for claims filed in a bankruptcy or personal injury proceeding. These actions include, but are not limited to,
   i. placing a lien on the Patient's property[3],
   ii. foreclosing on a Patient's property[4],
   iii. placing a levy against or otherwise attaching or seizing a Patient's bank account or other personal property,
   iv. commencing a civil action against a Patient[5], and
   v. garnishing a Patient's wages.

An ECA does not include any of the following (even if the criteria for an ECA as set forth above are otherwise generally met):

a. any lien that the Organization is entitled to assert under state law on the proceeds of a judgment, settlement, or compromise owed to a Patient as a result of personal injuries for which the Organization provided care; or

b. the filing of a claim in any bankruptcy proceeding.

3. "**FAP**" means the Organization's Financial Assistance Policy, which is a policy to provide Financial Assistance to eligible Patients in furtherance of the Organization's and Ascension Health's mission and in compliance with 501(r).

4. "**FAP Application**" means the application for Financial Assistance.

5. "**Financial Assistance**" means the assistance the Organization may provide to a Patient pursuant to the Organization's FAP.

6. "**Organization**" means Ascension St Agnes. To request additional information, submit questions or comments, or submit an appeal, you may contact the office listed below or as listed in any applicable notice or communication you receive from the Organization:

   Patient Financial Services @ 1-667-234-2140

7. "**Patient**" means an individual receiving care (or who has received care) from the Organization and any other person financially responsible for such care (including family members and guardians).

## BILLING AND COLLECTION PRACTICES

The Organization maintains an orderly process for regularly issuing billing statements to Patients for services rendered and for communicating with Patients. In the event of nonpayment by a Patient for services provided by the Organization, the Organization may engage in actions to obtain payment, including, but not limited to, attempts to communicate by telephone, mail, email, and in-person. The Organization rarely

[3] Pursuant to Maryland Code, Health – General, Section 19-214.2(g)(2), Organization shall not request a lien against a Patient's primary residence to collect a debt owed on a hospital bill.
[4] Pursuant to Maryland Code, Health – General, Section 19-214.2(g)(1), Organization shall not foreclose on a Patient's primary residence to collect debt owed on a hospital bill.
[5] Pursuant to Maryland Code, Health – General, Section 19-214.2(b)(5), Organization shall not file a civil action to collect debt within 180 days after the initial bill is provided to Patient.

utilizes extraordinary collection actions, or "ECAs," to obtain payment. However, in order to ensure the Organization's resources remain available for and directed to those Patients in need under our financial assistance policy ("FAP"), the Organization may use ECAs in extreme circumstances, which include with respect to accounts with unpaid balances that relate to elective services that are not emergency or other medically necessary care, situations where a Patient has substantial resources (e.g., high net worth) and is refusing to pay the amount due, or where the Organization believes the nonpayment constitutes an intentional abuse of the terms of its FAP or this policy. Under those extreme circumstances, the Organization may utilize one or more ECAs, subject to the provisions and restrictions contained in this Billing and Collection Policy. The Organization does not use ECAs for accounts that have a remaining balance due to qualifying for only partial financial assistance under the Organization's FAP or with respect to co-pays on accounts that have qualified for full financial assistance under the FAP. The Ascension Senior Vice President / Chief Revenue Officer has final authority to determine that the Organization has made reasonable efforts to determine financial assistance eligibility and that extreme circumstances exist such that the Organization may engage in ECAs on a case-by-case basis.

Pursuant to 501(r), this Billing and Collection Policy identifies the reasonable efforts the Organization must undertake to determine whether a Patient is eligible under its FAP for Financial Assistance or that an extreme circumstance exists justifying engaging in an ECA.

Once a determination is made that an extreme circumstance exists and that the Patient does not qualify for financial assistance under the FAP, the Organization may proceed with one or more ECAs, as described herein.

1. FAP Application Processing. Except as provided below, a Patient may submit a FAP Application at any time with respect to emergency and other medically necessary care received from the Organization. Determinations of eligibility for Financial Assistance will be processed based on the following general categories.

    a. Complete FAP Applications. In the case of a Patient who submits a complete FAP Application, the Organization shall, in a timely manner, suspend any ECAs to obtain payment for the care, make an eligibility determination, and provide written notification, as provided below.

    b. Presumptive Eligibility Determinations. If a Patient is presumptively determined to be eligible for less than the most generous assistance available under the FAP, the Organization will notify the Patient of the basis for the determination and give the Patient a reasonable period of time to apply for more generous assistance.

    c. Notice and Process Where No Application Submitted. Unless a complete FAP Application is submitted or eligibility is determined under the presumptive eligibility criteria of the FAP, the Organization will refrain from initiating ECAs for at least 120 days (or such longer period required by law, as set forth in this Policy) from the date the first post-discharge billing statement for the care is sent to the Patient. In the case of multiple episodes of care, these notification provisions may be aggregated, in which case the timeframes would be based on the most recent episode of care included in the aggregation. Before initiating one (1) or more ECA(s) to obtain payment for care from a Patient who has not submitted a FAP Application and before a determination is made whether extreme circumstances justify the use of ECAs, the Organization shall take the following actions:
        i. Provide the Patient with a written notice that indicates Financial Assistance is available for eligible Patients, identifies the ECA(s) that are intended to be taken to obtain payment for the care, and states a deadline after which such ECA(s) may be initiated that is no earlier than 30 days after the date the written notice is provided;
        ii. Provide the Patient with the plain language summary of the FAP; and

iii. Make a reasonable effort to orally notify the Patient about the FAP and the FAP Application process.

d. Incomplete FAP Applications. In the case of a Patient who submits an incomplete FAP Application, the Organization shall notify the Patient in writing about how to complete the FAP Application and give the Patient thirty (30) calendar days to do so. Any pending ECAs shall be suspended during this time, and the written notice shall (i) describe the additional information and/or documentation required under the FAP or the FAP Application that is needed to complete the Application, and (ii) include appropriate contact information.

2. Restrictions on Deferring or Denying Care. In a situation where the Organization intends to defer or deny, or require a payment before providing, medically necessary care, as defined in the FAP, because of a Patient's nonpayment of one or more bills for previously provided care covered under the FAP, the Patient will be provided a FAP Application and a written notice indicating that Financial Assistance is available for eligible Patients.

3. Determination Notification; Payment Plan Option.

a. Determinations. Once a completed FAP Application is received on a Patient's account, the Organization will evaluate the FAP Application to determine eligibility and notify the Patient in writing of the final determination, including whether Patient is eligible for a payment plan, within fourteen (14) calendar days. The notification will include a determination of the amount for which the Patient will be financially responsible to pay. If the Application for the FAP is denied, a notice will be sent explaining the reason for the denial and instructions for appeal or reconsideration.

b. Payment Plans. If Patient meets the eligibility requirements, if any, for a payment plan, any such payment plans will be subject to the terms set forth in the Organization's Financial Assistance Policy, which may be amended from time to time. If at any point a Patient wishes to modify the terms of a payment plan, the Patient may contact the Customer Service department.[6]

c. Compliance with Payment Plans. There will be no penalty or fee for prepayment or early payment of a payment plan. Patient will be deemed compliant with a payment plan if Patient makes at least eleven (11) scheduled payments within a twelve (12) month period. If Patient misses a scheduled monthly payment, then Patient may make up this payment within one (1) year after the date of missed payment with no penalty to Patient. Organization may waive any additional missed payments that occur within a twelve (12) month period and allow Patient to continue to participate in the payment plan without referring outstanding debts to a collection agency or taking further legal action.[7]

d. Refunds. The Organization will provide a refund for the amount a Patient has paid for care that exceeds the amount the Patient is determined to be personally responsible for paying under the FAP, unless such excess amount is less than $5.00.

i. Pursuant to Maryland Code, Health – General, Section 19-214.2(b)(8), Organization shall provide for a refund of amounts collected from Patient or the guarantor of Patient who was later found to be eligible for free care within 240 days after the initial bill was provided. Subject to Section 9, Organization shall

[6] Pursuant to Maryland Code, Health – General, Section 19-214.2(b)(10)(iii), Patient and Organization may mutually agree to modify the terms of a payment plan offered or entered into with Patient.
[7] See Maryland Code, Health – General, Section 19-214.2(e).

also vacate any judgment obtained against a Patient or retract any adverse credit report in this situation.

ii. Pursuant to Maryland Code, Health – General, Section 19-214.2(c)(1), Organization shall provide for a refund of amounts exceeding $25 collected from a Patient or the guarantor of a Patient who, within a two-year period after the date of service, was found to be eligible for free care on the date of service.

iii. Organization may reduce the two-year period under paragraph (b)(ii) of this section to no less than 30 days after the date the Organization requests information from a Patient, or the guarantor of a Patient, to determine the Patient's eligibility for free care at the time of service, if Organization documents the lack of cooperation of Patient or the guarantor of Patient in providing the required information.

iv. If a Patient is enrolled in a means-tested government health care plan that requires the Patient to pay out-of-pocket for hospital services, Organization shall provide for a refund that complies with the terms of the Patient's plan.

e. Reversal of ECA(s). To the extent a Patient is determined to be eligible for Financial Assistance under the FAP within 240 days after the initial bill was provided for which the ECA was reported[8], the Organization will take all reasonably available measures to reverse any ECA taken against the Patient to obtain payment for the care. Such reasonably available measures generally include, but are not limited to, measures to vacate any judgment against the Patient, lift any levy or lien on the Patient's property, and remove from the Patient's credit report any adverse information that was reported to a consumer reporting agency or credit bureau. Pursuant to Maryland Code, Health – General, Section 19-214.2(f)(2), Organization shall report the fulfillment of Patient's payment obligation within sixty (60) days after the obligation is fulfilled to any consumer reporting agency to which the Organization had reported adverse information about the Patient. Organization shall also retract the adverse information about Patient if Organization is informed that an appeal or review of a health insurance decision is pending, and until sixty (60) days after the appeal is complete; or until sixty (60) days after Organization has completed a requested reconsideration of the denial of Financial Assistance.[9]

4. Appeals and Grievances. The Patient may appeal a denial of eligibility for Financial Assistance by providing additional information to the Organization within fourteen (14) calendar days of receipt of notification of denial. All appeals will be reviewed by the Organization for a final determination. If the final determination affirms the previous denial of Financial Assistance, written notification will be sent to Patient. If Patient wishes to file a complaint with Organization regarding the collection of a medical debt by Organization or a debt collector, Patient may contact the Customer Service Department.[10]

5. Collections. Subject to Section 9, upon conclusion of the above procedures (including reasonable efforts to determine whether a Patient is eligible under its FAP for Financial Assistance) and upon a determination that extreme circumstances exist that justify the use of ECAs, the Organization may proceed with ECAs against uninsured and underinsured Patients with delinquent accounts, as determined in the Organization's procedures for establishing, processing, and monitoring Patient bills and payment plans. Subject to the restrictions identified herein and pursuant to Maryland law, the Organization may utilize a reputable external bad debt collection agency or other service provider for processing bad debt accounts, and such agencies or service providers shall comply with the provisions

[8] See Maryland Code, Health – General, Section 19-214.2(b)(9).
[9] See Maryland Code, Health – General, Section 19-214.2(f)(5).
[10] Pursuant to Maryland Code, Health – General, Section 19-214.2(b)(10), Organization must provide a mechanism for a Patient to file a complaint regarding the handling of the Patient's bill.

of 501(r) applicable to third parties and with state law and this Policy.[11] Organization shall have active oversight of any contract for the collection of debts pursuant to this policy. Organization **shall not** do any of the following in an attempt to collect a Patient debt in relation to a hospital bill[12]:

a. Request a sale, foreclosure or lien against a Patient's primary residence;
b. Cause a court to issue a body attachment or arrest warrant against Patient;
c. Request garnishment of wages if Patient is eligible for Financial Assistance;
d. File a claim against the estate of deceased Patient if Organization knows that Patient was eligible for free care, or if the value of the estate after tax obligations are fulfilled is less than half of the debt owed;
e. File an action against Patient, or provide required written notice of intent to file an action against Patient, until 180 days after the initial bill was provided;
f. File an action against Patient before the hospital determines whether Patient is eligible for Financial Assistance.
g. File an action against Patient without first providing forty-five (45) days written notice of intent to file an action, which notice complies with the requirements of Maryland Code, Health-General, Section 19-214.2(i) and COMAR 10.37.10.26.
h. Report adverse information about Patient to a consumer reporting agency within 180 days after issuing the initial patient bill.
i. Report adverse information about Patient to a consumer reporting agency, commence a civil action, or delegate collection activity to a debt collector if the Organization was notified in accordance with federal law that an appeal or review of a health insurance decision is pending within the immediately preceding 60 days. If an adverse report was made to a consumer reporting agency prior to Organization learning of the appeal, Organization will instruct the agency to delete the adverse report in accordance with Section 3(e).
j. Report adverse information about Patient to a consumer reporting agency, commence a civil action, or delegate collection activity to a debt collector if Organization has completed a requested reconsideration of the denial of free or reduced-cost care that was appropriately completed by the Patient within the immediately preceding 60 days. If an adverse report was made to a consumer reporting agency prior to Organization learning of the appeal, Organization will instruct the agency to delete the adverse report.
k. Report adverse information about a Patient to a consumer reporting agency for a Patient who, at the time of service, was uninsured or eligible for Financial Assistance.

6. Assumption of Liability. No individual may be held liable for medical debt of another who is at least 18 years of age unless the individual voluntarily consents to be held liable. This consent must be in writing on a separate document, may not be solicited in an emergency room or other emergency situation, and may not be required as a condition of providing emergency services.

7. Interest. Organization shall not charge interest on bills incurred by self-pay patients before a court judgment is obtained. Organization may not charge interest or fees on any debt incurred on or after the date of service by a Patient who is eligible for Financial Assistance.[13]

8. Fees. Organization shall not collect additional fees in an amount that exceeds the approved charge for the hospital service as established by Maryland law from a Patient who is eligible for Financial Assistance.[14]

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[11] Pursuant to Maryland Code, Health – General, Section 19-214.2(k)(4)(iii), the Organization and the debt collector are jointly and severally responsible for meeting the requirements of Section 19-214.2. See also COMAR 10.37.10.26.
[12] See Maryland Code, Health – General, Section 19-214.2.
[13] See Maryland Code, Health – General, Section 19-214.2(b)(3) and Section 19-214.2(d).
[14] See Maryland Code, Health – General, Section 19-214.2(b)(11).

9. Current Practices. Notwithstanding any provision of this Billing and Collection Policy to the contrary, the Organization does not currently seek judgments against Patients, report adverse information against Patients to credit agencies, or charge interest on late payments of medical debt. Any change to current practices will be implemented in accordance with Maryland Code, Health – General, Section 19-214.1 *et seq.*, following consultation with the Organization's Chief Financial Officer and Legal Department. At a minimum, the Organization will not seek legal action against a Patient until the Organization has established and implemented a payment plan policy that complies with guidelines issued by the State of Maryland.

10. Reporting Requirements. Organization shall collect the following information as necessary to comply with state reporting requirements:
    a. The total number of Patients by race/ethnicity, gender, and zip code against whom the Organization or its contracted debt collector filed an action to collect medical debt;
    b. The total number of Patients by race/ethnicity, gender, and zip code for whom the Organization has and has not reported or classified a bad debt; and
    c. The total dollar amount of charges not collected from Patients with insurance, including out-of-pocket costs, and from Patients without insurance.[15]

[15] See Maryland Code, Health – General, Section 19-214.2(a).