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Financial Assistance, Self Pay Collections, and Payment Plan Policy, FN 100

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This policy is intended as a guideline to assist in the delivery of patient care or management of hospital services. It is not intended to replace professional judgment in patient care or administrative matters.

PURPOSE:

Frederick Health is committed to providing quality medically necessary health care for all patients regardless of their ability to pay and without discrimination on the grounds of race, sex, age, color, national origin or creed, marital status, sexual orientation, gender identity, or disability. The purpose of this document is to present a formal set of policies and procedures designed to assist Patient Financial Services personnel in the day-to-day application of this commitment. The procedures describe how applications for Financial Assistance should be made, the criteria for eligibility, and the steps for processing applications. The procedures also describe the manner in which Frederick Health will initiate collection actions and the write-off of accounts receivable as well as the subsequent placement of the receivables with outside agencies or attorneys for collection. This policy documents a consistent practice for collecting amounts due from patients, regardless of insurance coverage, and the procedures necessary to record write-offs taken.

This policy is intended to comply with all applicable law, including Section 501(r) of the Internal Revenue Code and Section 19-214.1 and Section 19-214.2 of the Health General Article of the Maryland Code and any implementing regulations. It has been adopted by the Board of Directors of Frederick Health Hospital, Inc. and Frederick Health, Inc. and shall be reviewed and approved by such Boards at least every two years unless more frequent approvals are required by law.

POLICY:

This policy applies to (1) patients seeking emergency or other medically necessary care at Frederick Health Hospital ("FHH" or the "Hospital"), (2) patients seeking medically necessary professional medical services from Frederick Health Medical Group ("FHMG"), (3) patient accounts identified as self-pay or with a remaining patient responsibility after insurance and/or financial assistance for services provided by FHH or FHMG, and (4) any employee of FHH or FHMG who performs collection activity in the Patient Financial Services ("PFS") Department and any vendor that assists FHH or FHMG with its debt collection activities. For purposes of this policy only, FHH and FHMG are collectively referred to herein as "FHH/FHMG."

The Financial Assistance procedures described in this Policy are designed to assist individuals who qualify for less than full coverage under available federal, state and local Medical Assistance programs, but whose outstanding "self-pay" balances exceed their own ability to pay. The underlying principle is that a person, over a reasonable period of time, can be expected to pay only a maximum percentage of their disposable income towards charges incurred while in the hospital. Any "self-pay" amount in excess of this percentage would place an undue financial hardship on the patient or their family and may be adjusted off as Financial Assistance. In addition, the credit and collections procedures described in this Policy are designed to ensure that FHH/FHMG performs its credit and collection functions in a dignified and respectful manner and in compliance with all applicable law.

PROCEDURE:

I. ***Financial Assistance***

A. **OVERVIEW**

1. Financial Assistance can be offered before, during, or after services are rendered. After submission of an application, FHH/FHMG will send an acknowledgment letter to the patient within two (2) business days and an eligibility determination will be made within fourteen (14) days of a completed application.
    i. For purposes of this policy, "Financial Assistance" refers to healthcare services provided without charge or at a reduced charge to qualifying patients.
    ii. FHH/FHMG maintains a list of all providers who may care for patients while at FHH/FHMG available at https://www.frederickhealth.org/find-a-provider/. Only providers employed by FHH/FHMG are covered under this policy and are indicated on the provider list. Non-FHH/ FHMG providers bill separately for their services and not all participate in the FHH/FHMG Financial Assistance Program. If a provider is not covered under this policy, patients should contact the provider's office to determine if Financial Assistance is available.
    iii. Should a patient need assistance applying for Financial Assistance, help is available at our physical location at 400 West Seventh St. Frederick, MD 21701. Patients can also call 240-566-4214 with any inquiries regarding the Financial Assistance application process.
2. Notice of the Availability of Financial Assistance:
    a. FHH/FHMG will make available brochures informing the public of its Financial Assistance Policy. Such brochures will be available throughout the community and within FHH/FHMG locations.
    b. Notices of the availability of Financial Assistance will be posted at appropriate admission areas, the Patient Financial Services department, and other key patient access areas.
    c. Notice of the Financial Assistance Policy will be provided to the patient, the patient's family, or the patient's authorized representative before discharging the patient and in each communication to the patient regarding collection of the bill.
    d. A statement on the availability of Financial Assistance will be included on patient billing statements.
    e. A Plain Language Summary of the Financial Assistance Policy will be

provided to patients receiving inpatient services with their Summary Bill and will be made available to all patients upon request.

f. This Policy, a Plain Language Summary of the Financial Assistance policy, and the Financial Assistance Application are available to patients upon request at FHH/FHMG, through mail (postal service), and on the FHH/FHMG website at https://www.frederickhealth.org/about/billing-financial-assistance/.

g. This Policy, the Plain Language Summary, and the Financial Assistance Application are available in Spanish.

i. On an annual basis, FHH/FHMG shall assess the needs of our limited English proficiency community and determine whether additional translations are needed.

3. Availability of Financial Assistance: FHH/FHMG retains the right, in its sole discretion, to determine a patient's ability to pay, in accordance with Maryland and Federal law.

a. Financial Assistance may be extended when a review of a patient's individual financial circumstances has been conducted and documented. This may include the patient's existing medical expenses, including any accounts having gone to bad debt, as well as projected medical expenses.

b. All patients presenting for emergency services will be treated regardless of their ability to pay.

i. For emergent services, applications for Financial Assistance will be completed, received, and evaluated retrospectively and will not delay patients from receiving care.

4. Limitation of Charges: Individuals receiving Hospital services who are eligible for reduced-cost care under this policy will not be charged more than the Hospital's standard charges, as set by Maryland's Health Services Cost Review Commission (HSCRC).

a. The Hospital's rate structure is governed by the HSCRC's rate setting authority. As an "all- payer system", all patient care in the regulated hospital setting is charged according to the resources consumed in treating them regardless of the patient's ability to pay.

b. Regulated hospital charges are developed based on a relative predetermined value set by the HSCRC at the approved unit rate developed by the HSCRC.

B. **PROGRAM ELIGIBILITY**

1. FHH/FHMG strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care. FHH/FHMG reserves the right to grant Financial Assistance without formal application being made by patients. These patients may include the homeless or those with returned mail with no forwarding address.

2. Patients who are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay for medically necessary care may be eligible for the FHH/FHMG Financial Assistance Program.

3. Healthcare services that are eligible for Financial Assistance are emergency medical care and other medically necessary services delivered by FHH and FHMG.

a. For these purposes, emergency medical care means care provided by FHH for emergency medical conditions, which means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in: (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part. With respect to a pregnant woman who is having contractions, emergency medical conditions means that: (i) there is inadequate time to effect a safe transfer to another hospital before delivery, or (ii) transfer may pose a threat to the health or safety of the woman or the unborn child.

b. For these purposes, medically necessary services means services that are reasonably determined to prevent, diagnose, correct, cure, alleviate, or prevent the worsening of conditions in a patient that (i) endanger life; (ii) cause suffering or pain; (iii) result in illness or infirmity; (iv) threaten to cause or aggravate a handicap; or (v) cause physical deformity or malfunction.

4. Exclusions from Financial Assistance: Specific exclusions to coverage under the Financial Assistance program include the following:

    a. Patients whose insurance program or policy denies coverage for the services received (e.g., HMO, PPO, Workers Compensation, or Medicaid);

        i. Exceptions to this exclusion may be made, in FHH/FHMG's sole discretion, considering medical and programmatic implications.

    b. Unpaid balances resulting from cosmetic or other non-medically necessary services;

    c. Patient convenience items.

5. Ineligibility: Patients may become ineligible for Financial Assistance, for a specific date of service, for the following reasons:

    a. After being notified by FHH/FHMG, refusal to apply for or provide requested documentation or information required to complete a Financial Assistance Application within the 240 days after the patient receives the first post-discharge billing statement (approximately 8 months). (If an individual submits an incomplete Financial Assistance Application within 240 days after the patient receives the first post-discharge billing statement, FHH/FHMG shall give the individual a reasonable period of time to complete the application.)

    b. Unless seeking emergency medical services, having insurance coverage through an HMO, PPO, Workers Compensation, Medicaid, or other insurance programs that deny access to FHH/ FHMG due to insurance plan restrictions/limits.

    c. Failure to pay co-payments as required by the Financial Assistance Program.

    d. Failure to keep current on existing payment arrangements with FHH/ FHMG, as further detailed in this policy.

    e. Failure to make appropriate arrangements on past payment obligations owed to FHH/FHMG (including those patients who were referred to an

outside collection agency for a previous debt).

f. Refusal to be screened or apply for other assistance programs prior to submitting an application to the Financial Assistance Program, unless FHH/FHMG can readily determine that the patient would fail to meet the eligibility requirements.

6. Patients who become ineligible for the program will be required to pay any open balances and may be submitted to a collection agency if the balance remains unpaid in the agreed upon time periods.
7. Patients who indicate they are unemployed and have no insurance coverage shall be required to submit a Financial Assistance Application unless they meet Presumptive Financial Assistance eligibility criteria (See Section I.D.2 below).
    a. If a patient qualifies for COBRA coverage, the patient's financial ability to pay COBRA insurance premiums shall be reviewed by appropriate personnel and recommendations shall be made to Senior Leadership for approval.
    b. Individuals with the financial capacity to purchase health insurance shall be encouraged to do so as a means of assuring access to health care services.
8. Coverage amounts will be calculated using a sliding fee scale based on federal poverty guidelines.

C. **PATIENT FINANCIAL ASSISTANCE GUIDELINES**

1. Services eligible under this Policy will be made available to the patient on a sliding fee scale as described in this section and in ***Appendix A***.
2. A patient's eligibility for Financial Assistance shall be calculated at the time of service or updated, as appropriate, to account for any change in financial circumstances of the patient that occurs within 240 days after the initial medical bill is provided.
3. US Federal Poverty guidelines are updated annually by the Department of Health and Human Services and are available at https://www.healthcare.gov/glossary/federal-poverty-level-fpl/.

D. **PRESUMPTIVE FINANCIAL ASSISTANCE**

1. Patients may be eligible for Financial Assistance on a presumptive basis. There are instances when a patient may appear eligible for Financial Assistance, but there is no Financial Assistance application and/or supporting documentation on file. Often there is adequate information provided by the patient or other sources that is sufficient for determining Financial Assistance eligibility.
    a. In the event there is no evidence to support a patient's eligibility for Financial Assistance, FHH/FHMG reserves the right to use outside agencies, or propensity to pay modeling in determining Financial Assistance eligibility.
    b. Patients who are determined to satisfy presumptive eligibility will receive free care on that date of service. Presumptive Financial Assistance eligibility shall only cover the patient's specific date of service.
2. Presumptive eligibility may be determined on the basis of individual life circumstances that may include:

a. Active Medical Assistance pharmacy coverage;
b. Qualified Medicare Beneficiary ("QMB") coverage (covers Medicare deductibles) and Special Low Income Medicare Beneficiary ("SLMB") coverage (covers Medicare Part B premiums);
c. Homelessness;
d. Maryland Public Health System Emergency Petition patients;
e. Being a beneficiary/recipient of the following means-tested social service programs: Women, Infants and Children Programs ("WIC"); Food Stamp/ Supplemental Nutritional Assistance Program; households with children in the free or reduced lunch program; low-income-household energy assistance program; Primary Adult Care Program ("PAC"), until such time as inpatient benefits are added to the PAC benefit package; or other means-tested social services programs deemed eligible for hospital free care policies by the Maryland Department of Health and the HSCRC, consistent with HSCRC regulations;
f. Eligibility for other state or local assistance programs;
g. Deceased with no known estate; and
h. Patients that are determined to meet eligibility criteria established under former State Only Medical Assistance Program.

3. Patients deemed to be presumptively eligible for Financial Assistance based on participation in a social service program identified above must submit proof of enrollment within 30 days of such eligibility determination. A patient, or a patient's representative, may request an additional 30 days to submit required proof.
4. Exclusions from consideration for presumptive eligibility include purely elective, non-medically necessary procedures (*e.g.,* cosmetic procedures).

E. **MEDICAL HARDSHIP PROGRAM**

1. In addition to, but separate from, Patient Financial Assistance described elsewhere in this policy, eligible patients may qualify for the Medical Hardship Program.
    a. Patients may qualify for this program if they have incurred collective family medical debt at FHH/ FHMG, exceeding 25% of the combined household income, during a 12-month period, regardless of income.
        i. Medical debt for this purpose is defined as out-of-pocket expenses for medically necessary care received at FHH/FHMG, including co-payments, co-insurance, and deductibles.
2. FHH/FHMG applies the medical debt criteria set forth above to a patient's balance after any insurance payments have been received.
3. If determined eligible, patients and their immediate family qualify for a 20% reduction in the cost of medically necessary care, for a 12-month period effective on the date the medically necessary care was initially received.
4. In situations where a patient is separately eligible for both the Medical Hardship Program and the standard Financial Assistance Program, FHH/FHMG will apply the reduction in charges that is most favorable to the patient.
5. Patients are required to notify FHH/FHMG of their potential eligibility for the Medical Hardship Program.

F. **ASSISTANCE BASED ON INDIVIDUAL CIRCUMSTANCES**: FHH/FHMG reserves the right to consider individual patient and family financial circumstances to grant reduced-cost care in excess of criteria required by law or established by this policy.

1. The eligibility, duration, and discount shall be patient-situation specific.
2. Patient balance after insurance accounts may be eligible for consideration.
3. Cases falling into this category require management review and approval.
4. On a case-by-case basis and with the input of FHH/FHMG's legal counsel, management can develop a special financial assistance program for particular categories of patients under this section. The financial assistance provided under any such special program shall be at least consistent with but may exceed the assistance that would otherwise apply under this Policy.

G. **ASSET CONSIDERATION**

1. Household monetary assets are generally not considered as part of a patient's Financial Assistance eligibility determination unless they are deemed substantial enough to cover all or part of the patient's responsibility without causing undue hardship. When household monetary assets are reviewed, individual patient financial circumstances, such as the ability to replenish the asset and future income potential, are taken into consideration.
2. FHH/FHMG may consider only household monetary assets in excess of $100,000 when determining eligibility for Financial Assistance under this policy; provided, however, that retirement assets, regardless of balance, to which the IRS has granted preferential tax treatment as a retirement account (including deferred-compensation plans qualified under the Internal Revenue Code or nonqualified deferred compensation plans), shall be excluded. (Generally, this consists of plans that are tax exempt and/or have penalties for early withdrawal.)

H. **APPEALS**

1. Patients whose Financial Assistance applications are denied have the option to appeal the decision. Appeals should be made in writing and mailed to: Frederick Health 400 West Seventh Street Frederick, MD 21701 Attn: Financial Counseling Team.
2. Patients are encouraged to submit additional supporting documentation justifying why the denial should be overturned.
3. Appeals are documented and reviewed by the next level of management for additional reconsideration.
4. If the first level appeal does not result in the denial being overturned, patients have the option of escalating to the next level of management for additional reconsideration.
5. Appeals can be escalated up to the Chief Financial Officer who will render the final decision.
6. Patients who have formally submitted an appeal will receive a letter of the final determination.
7. Patients have thirty (30) days after denial to submit their appeal.
8. The Health Education and Advocacy Unit ("HEAU") is available to assist patients and their authorized representatives in filing and mediating reconsideration requests/ appeals. The HEAU can be contacted using the following information:

Office of the Attorney General Consumer Protection Division Health Education and Advocacy Unit 200 Saint Paul Place
Baltimore, Maryland 21202-2021
Phone number: 410-528-1840 or 1-877-261-8807 Email address: heau@oag.state.md.us
Fax number: 410-576-6571
Website: https://www.marylandattorneygeneral.gov/pages/cpd/heau/default.aspx

9. Patients may file a complaint against a hospital for an alleged violation of its Financial Assistance Policy by sending the complaint to the Maryland Health Services Cost Review Commission at hscrc.patient-complaints@maryland.gov. Complaints may also be filed jointly with the HEAU using the information provided above.

I. PATIENT REFUND/CORRECTIVE ACTION

1. If, within a two (2) year period after the date of service, a patient is found to be eligible for free or reduced-cost care under FHH/FHMG's Financial Assistance Program, for that date of service, the patient shall be refunded payments in excess of their financial obligation where such refund is greater than $5.
    a. The two (2) year period may be reduced to 240 days (approximately 8 months) after receipt of the first post-discharge billing statement where FHH/FHMG's documentation demonstrates a lack of cooperation by the patient, or guarantor, in providing documentation or information necessary for determining patient's eligibility.
2. If a patient is found to be eligible for Financial Assistance after FHH/FHMG has initiated extraordinary collection actions (ECA) as described in this Policy, FHH/FHMG will not take any further ECA and will take all reasonable steps available to reverse any ECA already taken (*i.e.*, to vacate the judgment or strike the adverse information).
3. For purposes of clarification and avoidance of doubt, the patient's eligibility for Financial Assistance for purposes of this Section I.I shall be calculated consistent with Section I.C(2).

J. OPERATIONS

1. FHH/FHMG will designate a trained person or persons who will be responsible for taking Financial Assistance Applications. These staff can be Financial Counselors, Self-Pay Collection Specialists, or other designated trained staff.
2. Every effort will be made to determine eligibility prior to date of service. Where possible, designated staff will consult via phone or meet with patients who request Financial Assistance to determine if they meet preliminary criteria for assistance.
    a. Staff will complete an eligibility check with the applicable state Medicaid program to determine whether patients have current coverage or may be eligible for coverage.
        i. To facilitate this process, each applicant must provide information about family size and income (as defined by Medicaid regulations).
    b. FHH/FHMG will provide patients with the Maryland State Uniform Financial Assistance Application and a checklist of what paperwork is required for a final determination of eligibility.

i. In addition to a completed Maryland State Uniform Financial Assistance Application, patients may be required to submit:
    a. A copy of their most recent Federal Income Tax Return (if married and filing separately, then also a copy of spouse's tax return and a copy of any other person's tax return whose income is considered part of the family income);
    b. Proof of disability income (if applicable);
    c. A copy of their most recent pay stubs (if employed), other evidence of income of any other person whose income is considered part of the family income or documentation of how they are paying for living expenses;
    d. Proof of social security income (if applicable);
    e. A Medical Assistance Notice of Determination (if applicable);
    f. Reasonable proof of other declared expenses; and
    g. If unemployed, reasonable proof of unemployment such as statement from the Office of Unemployment Insurance, a statement from current source of financial support, etc.

3. If a patient has not submitted a completed Financial Assistance application or any required supporting documentation within 30 days after a formal request, a letter will be sent reminding the patient that Financial Assistance is available and informing the patient of the collection actions that will be taken if no documentation is received.
    a. A deadline for submission, prior to initiation of collection actions, will be included in the letter. Such deadline will be no earlier than 30 days after the date the reminder letter is provided.
    b. No extraordinary collection actions (as described in this Policy) will be taken prior to 180 days after the first post-discharge billing statement (approximately 6 months).
    c. If documentation is received after collection actions have been initiated, but within 240 days after the patient's receipt of the first post discharge billing statement, FHH/FHMG shall cease all collection actions and determine whether the patient is eligible for Financial Assistance.
4. A Plain Language Summary of this policy shall be included with the letter and FHH/FHMG staff must make a reasonable effort to orally notify the individual of FHH/FHMG's Financial Assistance program.
5. Once a patient has submitted all the required information, appropriate personnel will review and analyze the application and forward it to the Patient Financial Services Department for determination of eligibility based on FHH/FHMG guidelines.
    a. If the patient's application for Financial Assistance is determined to be complete and appropriate, appropriate personnel will recommend the patient's level of eligibility.
    b. For complete applications, the patient will receive a letter notifying them

of approval/denial within 14 days of submitting the completed applications. FHH/FHMG shall suspend any billing or collections actions while eligibility is being determined.

c. If an application is determined to be incomplete, the patient will be contacted regarding any additional required documentation or information.

a. If a patient is determined to be ineligible prior to receiving services, all efforts to collect co- pays, deductibles or a percentage of the expected balance for the service will be made prior to the date of service or may be scheduled for collection on the date of service.

b. If a patient is determined to be ineligible after receiving services, a payment arrangement will be offered on any balance due by the patient.

6. Except as noted below, once a patient is approved for Financial Assistance, such Financial Assistance shall be effective as of the date treatment is received and the following twelve (12) calendar months.

a. Presumptive Financial Assistance cases will apply to the date of service only.

b. Financial Assistance for patients who reside outside of the United States will apply to the date(s) of service only, unless otherwise determined by management in its sole discretion.

c. If additional healthcare services are provided beyond the approval period, patients must reapply to continue to receive Financial Assistance.

7. The following may result in the reconsideration of Financial Assistance approval:

a. Post approval discovery of an ability to pay; and

b. Changes to the patient's income, assets, expenses or family status which are expected to be communicated to FHH/FHMG.

8. FHH/FHMG will track patients' qualification for Financial Assistance or Medical Hardship. However, it is ultimately the responsibility of the patient to accurately inform FHH/FHMG of their eligibility status (and any updates to such eligibility) at the time of registration, upon receiving a statement, or at any other time.

9. FHH/FHMG will not use a patient's citizenship or immigration status as an eligibility requirement for Financial Assistance or withhold Financial Assistance or deny a patient's application for Financial Assistance on the basis of race, color, religion, ancestry or national origin, sex, age, marital status, sexual orientation, gender identity, genetic information, or on the basis of disability.

II. ***CREDIT & COLLECTIONS***

A. **OVERVIEW**

1. FHH/FHMG expects patients to pay for services at the time service is provided or within thirty (30) days of the first billing statement for services not covered by insurance or Financial Assistance, unless the patient and FHH/FHMG have entered into an approved payment plan in accordance with this policy.

2. FHH/FHMG must take effective action to maintain timely accounts receivable turnover and ensure that the value of accounts receivable is accurately stated. To do

this, patient accounts will be aged and written off as bad debts or charity and may be outsourced to collection agencies for further follow-up.

3. Emergency services will be provided to all patients regardless of ability to pay. Scheduled services will be provided after appropriate financial arrangements are confirmed by FHH/FHMG. Deposits may be required prior to scheduling services. Failure to pay required deposits may result in the rescheduling of non-emergent services.
4. FHH/FHMG may use external collection agencies for extended business office, legal and/or collection activity to assist with collecting on patient accounts. FHH/FHMG will provide active oversight of any collection agency that collects debts on their behalf, and such agencies shall be required to abide by this policy.

B. **Cash Collections**

1. Payment for identified co-payments and deductibles will be requested prior to or at the time of service. In the case of emergency services, no payment shall be requested until after a patient has received a medical screening exam and any necessary stabilizing treatment.
    a. FHH/FHMG accepts cash, checks and credit cards to settle outstanding accounts.
    b. Medically necessary care will not be deferred or denied due to an outstanding balance for previously provided care.
2. There may be scenarios that occur during the collection process outlined in this policy that may result in placing a hold on collection efforts (called an "administrative hold") until additional information is provided. All accounts on administrative hold will be compiled into a report by threshold levels for review by management on a monthly basis, with certain levels being reviewed on a weekly basis.
3. An account balance is delinquent when a payment in full has not been received within forty-five (45) days after receipt of first bill, unless the patient has entered into a payment plan.

C. **Payment Plans**

1. FHH/FHMG may make payment arrangements for patients to resolve open balances within a reasonable timeframe.
2. FHH/FHMG shall make income-based payment plans available to help all patients, regardless of income, pay for medically necessary hospital services at FHH, as well as most services provided by FHMG (to be determined by management in its discretion), after care has been provided.
    a. The criteria set forth in this section do not apply to arrangements to make payments prior to the provision of a FHH/FHMG service (a "prepayment plan"). FHH/FHMG may offer patients a prepayment plan provided that it follows all applicable law in doing so.
    b. Notwithstanding anything to the contrary provided herein, FHH/FHMG is not obligated to make income-based payment plans available to patients who reside outside of the United States, and, further, to the extent FHH/FHMG does make an income-based payment plan available to a patient who resides outside of the United States, FHH/FHMG is not required to comply with the requirements of this Section II.C. For purposes of

example only, this means that FHH/FHMG may require a patient who resides outside of the United States to make monthly payments on an income-based payment plan that exceed 5% of the individual patient's adjusted gross monthly income.

3. FHH/FHMG shall provide information about the availability of income-based payment plans in writing to each patient who incurs medical debt and to the patient's family, authorized representative, or legal guardian before the patient is discharged, with the medical bill, on request, and in each written communication to the patient regarding collection of medical debt.
4. Before entering into any payment plan with a patient, FHH/FHMG shall evaluate if the patient is eligible for Financial Assistance (including free care, reduced-cost care, and reduced-cost care due to medical hardship) in accordance with this Policy and apply any Financial Assistance reduction for which patient is eligible prior to entering into a payment plan.
5. When considering whether to approve any payment plan arrangement, FHH/FHMG shall consider all applicable criteria in accordance with Maryland law, including the following (which shall be modified to ensure compliance with any changes to such law):
    a. Ensure that FHH/FHMG does not require a patient to make total payments in a month under all income-based payment plans provided to the patient by FHH/FHMG that exceeds 5% of the lessor of the individual patient's federal or state adjusted gross monthly income, calculated and determined in accordance with applicable HSCRC guidance.
    b. Ensure that FHH/FHMG considers medical hardship as defined in this Policy.
    c. Prohibit interest payments for patients who qualify for free or reduced cost care under this Policy and for self-pay patients and consider whether it would be appropriate to impose interest payments for all other patients, which may not begin before 180 days after the due date of the first payment.
    d. Prohibit penalties or fees for prepayment or early payment or late payments.
6. FHH/FHMG shall only modify a payment plan in a manner that complies with this Policy and applicable law. Requests for modification shall be made by contacting the FHH/FHMG Business Office at 240-566-3055. If a patient requests a modification, FHH/FHMG must consider patient's eligibility for Financial Assistance and apply any Financial Assistance reduction in its modification. Patient and FHH/FHMG must mutually agree to any modified payment plan, unless otherwise permitted by law.
7. Patients shall be deemed compliant with a payment plan if the patient makes at least eleven (11) scheduled monthly payments within a twelve (12) month period. FHH/FHMG shall comply with applicable law with respect to the treatment of missed payments.
8. Payment arrangements that remain current as set forth herein will not be forwarded to bad debt collections. If a patient defaults on a payment plan and the parties are not able to agree to a modification, then FHH/FHMG shall forward the account to bad debt collections in compliance with this Policy and applicable law.

D. **Credit Balance Accounts**

1. FHH/FHMG will not refund insurance over-payments to the guarantor (patient or guardian) until all accounts for which the guarantor is responsible are paid in full. "Paid in full" means that the total account balance(s) owed are zero and not waiting for an insurance payment.
2. Approved refunds will be issued on a reasonable and regular basis.

E. **Accounts Receivable**

1. Patient statements, letters, or data mailers will be sent to patients on a 30-day cycle. Patients/ guarantors will receive four (4) or more statements in approximately 120 days of the date on which the patient's financial responsibility has been determined. This time period can be extended in certain circumstances, including, for example, if a patient applies for Financial Assistance.
2. Depending on the patient's balance, age of account, and other variables, phone calls may be placed with patients/guarantors to collect on outstanding balances.
3. If the patient/guarantor has not made a payment within 120 days of the first billing date, or if the terms of an approved payment plan are not being met, the account shall be eligible for placement with a collection agency.
4. If a statement is returned to FHH/FHMG from the U.S. Post Office with an incorrect address, the account will be researched to find a correct address. If a correct address is not found, the account shall be placed with a collection agency prior to 120 days of the first billing date to assist in further collection efforts.
5. FHH/FHMG contact information and a notice of availability of Financial Assistance and payment plans shall be included on all statements or other communications regarding collection that are sent to the guarantor/patient.

F. **Write-Off Review**

1. If a patient account reaches a pre-determined aging with no account payment activity, or where the terms of an approved payment plan are not being met, the account will be assessed for possible small balance, bad debt or charity write off as follows:
    a. **Small Balance Write-Offs**: An automated process will be used to identify accounts with a debit balance. The accounts are processed with adjustment transactions and do not pass to bad debt, but rather to established "small balance write-off" codes for balances outlined in the Responsibility section of this policy.
    b. **Bad Debt Write-Offs**: A periodic report will be generated to "pre-list" self-pay and self-pay after insurance accounts that may meet bad debt criteria outlined in the Responsibility section. Those accounts will be subject to review by management, including based upon dollar balance, prior to submitting into bad debt status.
        i. Only specific employees in the PFS Department will be given access to the bad debt functions in the patient accounting system.
        ii. Unless an administrative hold is placed on an account that has qualified for the bad debt pre-list, all accounts will be moved into a bad debt status during the overnight batch processing within the patient accounting system.

iii. Consistent with Maryland law regarding balance billing, accounts with a third-party insurance balance that have no insurance payment from the insurer for sixty (60) days may have that balance deemed to be self-pay. At that time, the patient may begin to receive statements in the same manner as a self-pay patient.

iv. Wherever appropriate, write-offs shall be identified as charity care in accordance with this Policy. Any write-offs so identified will not be referred to any outside collection agencies.

v. Patients may request, or may be requested by FHH/FHMG, to apply for Medical Assistance (*i.e.,* Medicaid) prior to being awarded Financial Assistance. This request may be made prior to service, at the time of service, or during the billing and collection cycle. The account in question will not be forwarded to a collection agency during the Medical Assistance application process.

G. **Debt Collections**

1. Where appropriate, FHH/FHMG may use a bad debt collection agency to continue to try to collect on greater than 120 day after first bill aged accounts (*i.e.,* FHH/FHMG will not refer accounts to a collection agency prior to 120 days after the first post-discharge billing statement). Patients with balances that have been referred to a collection agency must resolve unpaid balances, request a payment plan, dispute amounts owed, or request Financial Assistance. Collection agencies may assess finance charges and fees on the unpaid principal account balance to the extent permitted by applicable law and this policy.
    a. Notwithstanding anything to the contrary provided in this Policy, FHH/FHMG (and any collection agencies acting on their behalf) cannot charge interest or fees on any debt incurred on or after the date of service by a patient who is eligible for Financial Assistance. To the extent not covered by the immediately preceding sentence, FHH (and any collection agencies acting on its behalf) may not collect additional fees in an amount that exceeds the approved charge for the hospital service as established by the HSCRC for which the medical debt is owed on a bill for a patient who is eligible for Financial Assistance.

2. For self-pay accounts that have not been assessed for Financial Assistance eligibility, FHH/FHMG shall provide written notice to the patient or responsible party at least thirty (30) days prior to referring an account to a bad debt collection agency. Such written notice shall:
    a. Inform the patient of the availability of financial assistance and payment plans;
    b. Identify the collection actions that FHH/FHMG plans to initiate to obtain payment.
    c. State a deadline after which such collection actions may be initiated that is no earlier than 30 days after the date that the written notice is provided; and
    d. Include a plain language summary of FHH/FHMG's Financial Assistance Policy.

3. FHH/FHMG shall make a reasonable effort to orally notify the individual about FHH/FHMG's Financial Assistance Policy and the process for applying.
4. Balances that remain open due to insurance denials will not be placed with a collection agency. However, a collection agency may perform payer collections on insurance denials acting as an extension of the business office.
5. Circumstances, such as pending eligibility for Financial Assistance or insurance coverage with Medicaid, may delay an account from being referred to a collection agency.
6. Patients may file a grievance with FHH/FHMG regarding the treatment or undesirable activities performed by FHH/FHMG or contracted collection agencies regarding the handling of a patient's bill by contacting the PFS Department. Contracted collection agencies shall be instructed to forward to FHH/FHMG any patient grievance filed with such collection agency.
7. FHH/FHMG shall not charge interest on bills incurred by self-pay patients before a court judgement is obtained and shall not engage in the following extraordinary collection actions ("ECAs") against an individual to obtain payment for care: (i) selling an individual's debt to another party; (ii) deferring or denying or requiring a payment before providing medically necessary care because of nonpayment of one or more bills for previously provided care covered under the Financial Assistance Policy; (iii) requesting a lien against or forcing the sale or foreclosure of an individual's primary residence to collect a debt owed on a medical bill; (iv) garnishing an individual's wages; (v) attaching or seizing an individual's bank account or any other personal property; (vi) causing an individual's arrest; or (vii) causing an individual to be subject to a writ of body attachment.
8. Although FHH/FHMG does not typically take such actions in the normal course of collection, it reserves the right to pursue collections through the following ECAs (the "Permitted ECAs") at the direction of senior management after verification of the individual's ability to pay and a determination of the individual's eligibility for financial assistance: (i) reporting adverse information about an individual to consumer credit reporting agencies or credit bureaus; (ii) commencing a civil action against an individual; and (iii) requesting a lien against or forcing the sale or foreclosure of an individual's real property other than a primary residence to collect a debt owed on a medical bill.
9. FHH/FHMG shall not take the Permitted ECAs and cannot give written notice to a patient of the intent to file an action as set forth below in Section II.G(11) until 180 days after the initial bill was provided.
10. FHH/FHMG cannot make a claim against the estate of a deceased patient to collect a debt owed on a medical bill if the deceased patient was known by FHH/FHMG to be eligible for free care under the Financial Assistance Policy or if the value of the estate after tax obligations are fulfilled is less than half of the debt owed. FHH/FHMG may offer the family of the deceased patient the ability to apply for Financial Assistance.
11. At least 45 days before filing an action against a patient to collect on the debt owed on a medical bill, FHH/FHMG must send written notice of the intent to file an action to the patient in a form and manner that complies with Section 19-214.2 of the Health General Article of the Maryland Code.
12. If FHH/FHMG files an action to collect a debt owed on a medical bill by a patient, the complaint shall comply with all applicable requirements of Section 19-214.2 of the

Health General Article of the Maryland Code, including, without limitation, with respect to the documents and information that must be included with or in such complaint.

13. FHH/FHMG shall report the fulfillment of an individual's payment obligation within sixty (60) days after the obligation is fulfilled to any consumer reporting agency to which it had reported adverse information about the individual.
14. FHH/FHMG shall not delegate collection activity to a debt collector or take the Permitted ECAs if FHH/FHMG either (i) was notified in accordance with federal law by the patient or the insurance carrier that an appeal or a review of a health insurance decision is pending within the immediately preceding 60 days; or (ii) has completed a requested reconsideration of the denial of free or reduced cost care under the Financial Assistance Policy that was appropriately completed by the patient within the immediately preceding 60 days. If FHH/FHMG reported adverse information about a patient to a consumer reporting agency, it shall instruct the consumer reporting agency to delete the adverse information about the patient (A) if FHH/FHMG was informed by the patient or the insurance carrier that an appeal or a review of a health insurance decision is pending, and until 60 days after the appeal is complete; or (B) until 60 days after FHH/FHMG has completed a requested reconsideration of the denial of free or reduced-cost care under the Financial Assistance Policy.
15. A spouse or another individual may not be held liable for the debt owed on a medical bill of an individual who is at least 18 years old unless that person has voluntarily consented to assume liability for the debt owed and the consent is (i) made on a separate document signed by the individual; (ii) not solicited in an emergency room or during an emergency situation; and (iii) not required as a condition of providing any emergency or nonemergency health care services.

H. **Responsibility**

Bad debt "pre-list" criteria used prior to bad debt placement:

	Criteria	Other Criteria
Hospital	>$10	Greater than 120 days from first post-discharge statement or 30 days after written notice of intent to initiate collection actions, whichever is later. Action must be reviewed by management prior to sending.
FHMG/ Professional Service	>$5	Greater than 120 days from first post-discharge statement or 30 days after written notice of intent to initiate collection actions, whichever is later. Action must be reviewed by management prior to sending.

Small Balance Criteria:

	Criteria
Hospital	$9.99
FHMG/Professional Service	$4.99

Attachments

Appendix A - Federal Government Poverty Guidelines

Attachments

2024 Appendix A FA FPL Matrix Guidelines.pdf

Approval Signatures

Step Description	Approver	Date
Senior Leader Approval	Hannah Jacobs: Senior Vice President CFO	09/2024
Owner Approval	Shawn McCardell: AVP Revenue Cycle	07/2024

Standards

No standards are associated with this document