

**UNITED HOSPITAL SYSTEM, INC.
POLICY & PROCEDURE
Payment For Services & Community Care**

PROCEDURE: PAYMENT FOR SERVICES

Communication Requirements

Information about UHS's payment for services policy, including the availability of financial assistance, will be communicated to patients at the time of scheduling or registration. Printed information will be available in waiting rooms.

Authorization Coordination

Eligibility and benefits will be verified for all services that require prior-authorization. Additional eligibility and benefits will be verified based upon cost of services, incidents of denials or mutual agreement of involved leaders with consideration given to staffing and cost effectiveness. Authorization will be secured prior to the service being provided or as outlined below:

A. Inpatients

1. Authorization will be secured prior to or within one business day of admission.

B. Outpatients/Office Visits

1. Services that require authorization will not be provided until authorization is obtained.
2. Authorizations will be secured for provider-to-provider services (referrals).

This preauthorization requirement will not apply to emergency services or otherwise be used to limit access to medically necessary urgent care. Patients shall not be illegally discriminated against based on source of payment or ability to pay.

Billing and Collection Process

Third-party Payors

- A. UHS will submit bills for services actually rendered to the appropriate federal or state program, commercial insurance, self-insured funds, HMO, PPO or other third-party payor program(s) (referred to herein as payor(s)). Payment of these claims will be in accordance with the contractual agreements in place with these payors. Any patient responsibility for payment remaining after such submission or resolution of the claim with a particular payor will be handled in the manner described below or as otherwise required by existing contractual agreements with the payor and/or applicable law.

Self-pay Patients

- A. At the time of scheduling or registration, the uninsured patient will be directed to a Financial Counselor. Patients seeking scheduled or non-urgent services are required to meet with a Financial Counselor prior to receiving services. Other

patients may meet with the Financial Counselor after services are provided. The Financial Counselor will refer the patient for enrollment in State or Federal payment programs as applicable. If the patient qualifies for no governmental programs, he or she will be eligible for special payment arrangements including Uninsured Discounts, Prompt-Pay Discounts, Community Care, and payment plans. Uninsured Discounts and Prompt-Pay Discounts are available only to uninsured patients (*i.e.* they are not applied to balances owing after insurance payment, such as co-insurance and deductibles).

- B. Patients receiving uninsured services that are elective and non-urgent (*e.g.* cosmetic surgery, bariatric surgery) are required to pay the estimated charges, less the Uninsured Discount and any other special procedure discounts that may be available, prior to receiving services, unless other arrangements have been made with the Financial Counselor.
- C. For amounts that are determined to be the patients or his or her guarantor's responsibility, a cycle of statements will be initiated with reasonable intervals to allow the patient/guarantor an opportunity to contact UHS (or its billing or collection agent) if payment in full cannot be made.
- Reasonable collection efforts will be pursued prior to referring an account to a collection agency.
 - Unless specified by an applicable law or a particular payor, reasonable collection efforts are defined as at least three (3) statements including a final notice mailed to the guarantor's home address.
 - All statements contain standard language indicating that payment in full is expected. These statements are clearly written and seek to facilitate the guarantor's understanding of his or her responsibilities. They include the following:
 - Date of service
 - Payor billed, if applicable
 - Summary charge information
 - Uninsured Discount amount
 - Balance due
 - Phone number for the business office patient service contact.
 - The statement cycle is to be completed on average within 120 days from the date the account transfers to a self-pay status.
 - Small balance accounts that meet or fall below a specified threshold of \$10 for inpatient balances and \$2.50 for outpatient balances may be written off with a small balance adjustment code, and not classified as bad debt.
 - If the patient's self-pay history indicates consistent non-payment and the patient is not eligible for other payment sources in accordance with applicable law the patient may be referred to other community health care sources for non-emergent services.

Collection Agency Protocol

- A. Any collection agency used by UHS will adhere to state and federal debt collection laws as well as this policy with regard to collection parameters of practice.
- B. Collection agencies will accept placements at a minimum of once per month.

- C. Collection agencies will issue UHS at least monthly notices of collection activity and closed accounts.
- D. In accordance with applicable law, their contract, and UHS' policies and procedures, collection agencies will pursue reasonable collection efforts that include the following when appropriate:
 - Collection calls and letters
 - Credit bureau reporting
 - Property liens
 - Garnishment of wages
 - Collection based on the sale of a residence in accordance with state law.
- E. The following collection practices are unacceptable by UHS or any billing or collection agency operating on behalf of UHS:
 - Bodily harm threats
 - Body attachments
 - Initiation of foreclosure of the principal residence while owned or occupied by the guarantor or guarantor's spouse.

Internal Legal Processes

UHS staff or its agents will prepare and file the appropriate legal documentation in the following cases to attempt to secure payment for services rendered:

- A. Hospital and/or medical liens may be filed in accident related cases.
- B. Probates will be filed for deceased patients with the potential for reimbursement. Deceased patients without probate may be included as part of the Community Care Program, as applicable.
- C. Bankruptcy covered accounts will be identified and standard collection efforts will cease while payment is sought through the bankruptcy process.

COMMUNITY CARE PROGRAM

Community Care Program Requirements

UHS will provide written notice to its patients and guarantors of its Community Care Program and information as to how a patient or guarantor may apply for financial assistance under such Program.

- A. As set forth above, all uninsured patients should be evaluated for their ability to pay or otherwise receive reimbursement for their services during the scheduling, registration process, first point of access, or as soon as possible thereafter. Identification of a financial hardship, however, can take place at any time during the collection process.
- B. Patients who may qualify for financial assistance from a governmental program should be referred to the appropriate program or staff for assistance in enrollment.
- C. The Community Care Program is available to all residents of UHS' service area who have resided there for at least 90 days prior to the date of service.
- D. Ordinarily, a Community Care Program application must be completed within a year of the date of service, but preferably before being sent to a collection agency. Approved applications for Community Care will be valid for one year from approval, provided that during such time frame UHS has not received notice of any change in the guarantor's financial situation. The guarantor shall be informed as part of the application process that he or she is responsible for notifying UHS in

the event that there is a change in his or her financial situation. Patients who require unrelated treatment during that year can attest to the accuracy and completeness of their Community Care Program application as adequate verification.

- E. Patients determined to have potential eligibility in other governmental programs, but who fail to comply with requirements for completing appropriate paperwork, will not be eligible for the Community Care Program and shall be referred to other community health care sources for non-emergent services. Additionally, a patient who fails to provide requested information to potential third-party payors that results in a denial will not be eligible for the Community Care Program.
- F. Services deemed not medically necessary, as determined by a physician, are not eligible to be covered under the Community Care Program.

Presumptive Eligibility

UHS understands that certain patients may be non-responsive to United's application process. Under these circumstances, UHS may utilize other sources of information to make an individual assessment of financial need. This information will enable UHS to make an informed decision on the financial need of non-responsive patients utilizing the best estimates available in the absence of information provided directly by the patient.

UHS may utilize a third-party to conduct an electronic review of patient information to assess financial need. This review utilizes a healthcare industry-recognized model that is based on public record databases. This predictive model incorporates public record data to calculate a socio-economic and financial capacity score that includes estimates for income, assets and liquidity. The electronic technology is designed to assess each patient to the same standards and is calibrated against historical approvals for UHS financial assistance under the traditional application process.

The electronic technology will be deployed prior to bad debt assignment after all other eligibility and payment sources have been exhausted. This allows UHS to screen all patients for financial assistance prior to pursuing any extraordinary collection actions. The data returned from this electronic eligibility review will constitute adequate documentation of financial need under this policy.

When electronic enrollment is used as the basis for presumptive eligibility, the highest discount levels will be granted for eligible services for retrospective dates of service only. If a patient does not qualify under the electronic enrollment process, the patient may still be considered under the traditional financial assistance application process.

Patient accounts granted presumptive eligibility will be reclassified under the financial assistance policy. They will not be sent to collection, will not be subject to further collection actions, will not be notified of their qualification and will not be included in the hospital's bad debt expense

Determination of Patient Eligibility for Community Care Program

All patients identified as potentially eligible for community care are referred to the appropriate staff and must complete a Community Care Program application (**Appendix A**).

A. The Community Care Program application requires completion of the following information:

- Family size
- Monthly income
- Assets
- Other sources of Income (*e.g.* alimony, child support, unemployment compensation, etc.)

B. Additionally, as part of the Community Care Program application process, individuals will be asked to attest to the accuracy and completeness of the application and to submit the following materials for verification:

- Latest tax returns
- Bank statements
- Application to applicable state agencies for eligible governmental programs.

C. Upon review of the Community Care Program application, a sliding fee scale will be used based on Federal Poverty Guidelines, assets, family size and home equity (**Appendix B**).

D. The designated business office manager will be responsible for reviewing, approving or rejecting all Community Care Program applications based on the documentation provided.

Notification of Community Care Program Eligibility Determination

Notification of eligibility determination will be provided to each patient identifying the payment for services due and the amount to apply to community care, if any.

DISCOUNTING GUIDELINES

A. Risk Management

Periodic non-routine discounts off established fees may be authorized for risk management considerations after consultation with and approval of the Risk Manager and the Chief Financial Officer, and after appropriate documentation is completed.

B. Uninsured Patients

UHS will offer an Uninsured Discount that is consistent with the discounts allowed to the weighted average of the three largest managed care payors, or other similar criteria. UHS reserves the right to reverse the discounts described herein in the event that it reasonably determines that such terms violate any legal or contractual obligations.

DEFINITIONS:

Assets Anything having commercial or exchange value owned by a person.

Discount An allowance or deduction made from the providers standard charge.

Elective Patients condition permits adequate time to schedule the availability of a suitable accommodation.

Eligibility checking Verification of an active insurance policy or payor source available.

Emergent Patient requires immediate medical intervention as a result of severe, life threatening or potentially disabling conditions. Generally, the patient is admitted through the emergency room.

Family The patient, his or her spouse, including a legal common-law spouse, and his/her legal dependents according to the federal internal revenue rules.

Federal Poverty Guideline Level of income determined annually by the Department of Health and Human Services to indicate a threshold of poverty.

Income Funds generated as a result of employment or ownership of assets.

Non-emergent -- Patients condition does not require immediate medical intervention.

Payor or Third-party Payor -- Entity financially obligated for services rendered to an enrollee or assignee.

Urgent -- Patient requires immediate attention for care and treatment of a physical or mental disorder. Generally the patient is admitted to the first available and suitable accommodation.

Uninsured patients -- A patient for which there is no insurance coverage or payment from any third party payor, and patient is not aware of any other source of payment for the procedure.