Garnet Health	POLICY LEVEL ☑ Garnet Health ☐ Garnet Health Medical Center ☐ Garnet Health Medical Center - Catskills ☐ Garnet Health Doctors ☐ Garnet Health Urgent Care CATEGORY: Credit & Collections	Page 1 of 5
APPLIES TO: ☑ System ☐ Organization ☐ Department (specify)		DOCUMENT CONTROL NUMBER: 300003

Title:
BILLING AND COLLECTION POLICY

Attachments: A.		

Purpose:

This policy addresses collection activities for both uninsured patients and insured patients, including copayments, co-insurance, and deductibles, for pre-service, time of service and post service collection efforts. Garnet Health is committed to informing patients regarding their financial responsibilities and available financial assistance options, and communicating with patients regarding outstanding accounts in a manner that treats patients with dignity and respect.

As described herein, Garnet Health will not engage in any extraordinary collection actions (see Section III) against an individual to obtain payment for care before reasonable efforts have been made to determine whether the individual is eligible for assistance under the Financial Assistance Policy (FAP).

Definitions:
AGB means "Amounts Generally Billed" for emergency or other medically necessary care to individuals who have insurance coverage. "Application Period" means the period during which Garnet Health must accept and process an application for financial assistance under its FAP submitted by an individual in order to have made reasonable efforts to determine whether the individual is eligible for financial assistance under the policy. The Application Period begins on the date the care is provided and ends on the latter of the 240th day after the date that the first post-discharge billing statement for the care is provided or at least 30 days after Garnet Health provides the individual with a written notice that sets a deadline after which extraordinary collection actions ("ECAs") may be initiated.

A/R means "accounts receivable"

ECA means "Extraordinary Collection Actions" – a list of collection activities as defined by the Internal Revenue Service and the U.S. Treasury Department that healthcare organizations may only take against an individual to obtain payment for care *after* reasonable efforts have been made to determine whether the individual is eligible for financial assistance.

FAP means the "Financial Assistance Policy"

FAP-Eligible Individual means an individual eligible for financial assistance under the Financial Assistance Policy.

Patient means the individual receiving medical treatment and/or, in the case of an emancipated minor or other dependent, the parent, legal guardian or other person (guarantor) who is financially responsible for the patient.

Policy:

Securing Payment / Establishing Payment Arrangements or Financial Assistance:

Garnet Health shall maximize collections by securing payment or arranging for payment terms for individual patient balances owed. Garnet Health will assist in identifying payment sources, including establishing payment arrangements or financial assistance for those who qualify. The following options are available to patients:

a. Cash, debit card, check, or credit card, health spending card with credit card logo (there will be a returned check fee of $20 for returned checks). Payment plans are also available to patients.
b. Patients with existing accounts with balances will be offered discounts to make payment in full.

Garnet Health Collection Process:

The Credit & Collection Department will attempt to collect all debts by way of monthly statements, telephone contacts, and/or collection letters for up to 120 days from the first post-discharge billing statement. Credit Representatives will:

a. Request payment in full.
b. If full payment is not possible, a payment arrangement option will be offered.
c. If patient is not able to pay, the Financial Assistance Program will be offered.
    i. When a patient does not qualify for Financial Assistance, Patient Financial Services may in its discretion apply other discounts, including for example discounts to encourage prompt payment or to recognize unique cases of financial hardship.

Accounts that remain unpaid and not in the organization's financial assistance application process, after a collection effort of up to 120 days or more and/or have not remitted a payment within 45 days, will be referred to an outside collection agency and are subject to ECAs. The unresolved accounts will be assigned to the agencies, by an alpha split, established within the EPIC system routing rules. Returned mail deemed as a bad address will be referred to outside collection agency at any point in the collection cycle. Contact the Credit and Collections Department for an accurate Agency Listing.

Bankruptcy:

Garnet Health will identify those accounts where the guarantors have filed for bankruptcy. The purpose for identifying accounts for those guarantors that have filed for bankruptcy is to cease all guarantor's billing and collection efforts both internally and externally to all early out and bad debt vendors. This will eliminate any communication from the hospital or its third party vendors until notice is received from the courts stating the status of bankruptcy.

1) As a representative of Credit & Collections, it will be the responsibility for an investigation by the department to identify those patients that are the sole responsibility of the guarantor at time of service or discharge in cases of shielding related patients from the collection pursuit of

the department.

2) Credit representative is notified of bankruptcy/discharge via mail, patient correspondence and vendors.

3) Credit representative posts results in each account. This includes Bankruptcy file date and Bankruptcy case #.
    a) Bankruptcy adjustment code 5003 will be used for Active AR balances in Garnet Health. Transaction code 5042 will be used for Bad Debt balances that are currently not listed in the active A/R.

4) Notification of bankruptcy adjustments for collection balances are reported to the appropriate Collection Agency. Garnet Health adjustments are reported electronically via a weekly file.

5) The bankruptcy filing notice/discharge notice is scanned to each account via On Base **for retrieval and auditing purposes.**

6) If insurance or guarantor reimbursement is obtained on a claim that was adjusted as bankruptcy, Credit Representative Staff will reverse the bankruptcy adjustment for the total amount of the payment and/or adjustment. Upon posting the payment transactions, the date of service will revert back to a zero balance.

Pre-Bad Debt:

a. A weekly EPIC data extract is generated to identify patients with balances due. This dataset is forwarded to the EPIC IT Analyst who electronically conducts a search, using the Garnet Health insurance eligibility vendor, for active Medicaid coverage. The output is reviewed by the credit and collection representatives prior to agency referral to identify patients that may have active and valid Medicaid coverage, which is not listed on their account(s) for the date of service in review. In the event that active coverage is identified it will be billed accordingly and removed from the pre-bad debt workflow. After the primary bad debt agency has worked the account for 180 days with no success, accounts are to be returned as uncollectible. The primary bad debt agency will flag Medicare uncollectible accounts for review for Medicare bad debt reporting on the cost report. Excluding Physician Billing (PB) and Urgent Care balances, any Hospital Billing (HB) account with a balance above $1,400 will be referred to a secondary collection agency after return from the primary agency. All PB and Urgent Care balances, greater than the small balance write-off amount, will go to the secondary collection agency after the primary collection agency returns the account as uncollectible.

b. The secondary bad agency will work accounts up to 180 days or more and return accounts according to the placement date that do not have a payment plan or hold status.

c. The annual Medicare cost report will be updated to reflect any payment received after an uncollectable balance write-off was noted.

d. All agency recommendations for litigation are reviewed for accuracy. No litigation is pursued on any account prior to agency referral. Once an account is approved for legal action, all information provided to Garnet Health will be reported to the appropriate collection agency.

e. Agencies will report Garnet Health balances $250 and over to the credit bureaus after 90 days from placement. At such time when the account is returned as uncollectable to Garnet Health, the account will be removed from reporting to the credit bureaus.

f. A reconciliation will be performed monthly between the agency and Garnet Health of the open hospital A/R to the open A/R accounts of the collection agencies to be completed by the end of the following month.

g. Each month the collection agencies will remit detailed lists of paid accounts and uncollectible accounts to the Credit & Collection Department.

I. Extraordinary Collection Actions (ECAs)

Garnet Health (or other authorized party) will not engage in ECAs before making reasonable efforts to determine whether a patient is eligible for assistance under the Garnet Health FAP. ECAs in which Garnet Health (or other authorized party) may engage include:

a. Garnishing Wages
b. Placing Liens on Property
c. Pursuing Legal Action
d. Credit reporting to the major credit bureaus

II. Determining Financial Assistance Eligibility Prior to ECA

Garnet Health will make reasonable efforts to determine whether individuals are eligible for financial assistance. To that end, Garnet Health (or other authorized party) will notify individuals about the FAP before initiating any ECAs to obtain payment for the care and refrain from initiating such ECAs for up to 120 days from the date Garnet Health provides the first post-discharge billing statement.

Garnet Health (or other authorized party) will take the following actions at least 30 days before first initiating one or more of the above ECAs to obtain payment for care:

1. Documentation required under the FAP or FA application form that the individual must submit to Garnet Health to complete his/her FAP application.

a. If an individual who has submitted an incomplete FA application during the Application Period subsequently completes the FA application during the Application Period (or, if later, within a reasonable timeframe given to respond to requests for additional information and/or documentation), the individual will be considered to have submitted a complete FA application during the Application Period. For the application review and approval process, please refer to Financial Assistance Policy.

VI. Miscellaneous Provisions

Anti-Abuse Rule – Garnet Health will not base its determination that an individual is not FA-eligible on information that Garnet Health has reason to believe is unreliable or incorrect or on information obtained from the individual under duress or through the use of coercive practices.

No Waiver of FA Application – Garnet Health will not seek to obtain a signed waiver from any individual stating that the individual does not wish to apply for assistance under the FAP, or receive the information described above, in order to determine that the individual is not FA-eligible.

Final Authority for Determining FAP Eligibility – Final authority for determining that Garnet Health has made reasonable efforts to determine whether an individual is FA-eligible and may therefore engage in ECAs against the individual rests with the Director of Credit & Collections.

Agreements with Other Parties – If Garnet Health sells or refers an individual's debt related to care to another party, Garnet Health will enter into a legally binding written agreement with the party that is reasonably designed to ensure that no ECAs are taken to obtain payment for the care until reasonable efforts have been made to determine whether the individual is FA-eligible for the care.

Providing Documents Electronically – Garnet Health may provide any written notice or communication described in this policy electronically (for example, by email) to any individual who indicates he or she prefers to receive the written notice or communication electronically

VII. Garnet Health Contact Information

Garnet Health Medical Center/ Garnet Health Doctors/ Urgent Care
707 East Main Street
Middletown, NY 10940
Telephone-845-333-1000
Website-www.garnethealth.org

Garnet Health Medical Center - Catskills
68 Harris-Bushville Road
Harris, NY 12742
Telephone-845-794-3300
Website-www.garnethealth.org

Garnet Health Doctors/Urgent Care
38 Concord Road,
Monticello, NY 12701
Telephone-845-333-6500
Website-www.garnethealth.org

Garnet Health Medical Center - Catskills
8881 Route 97
Callicoon, NY 12723
Telephone-845-887-5530
Website-www.garnethealth.org

Standard(s):
501R Final Regulations

Reference(s):
Garnet Health Financial Policy

Author/Title:
William Scheuermann, Vice President, Revenue Strategy & Managed Care

Approver/Title:
James Grigg/ Garnet Health CFO

Concurrences

Patient Access Management	Compliance Office
Patient Financial Services	
Credit & Collections	

Document Control

Status Key:		**A** = New	**B** = Reviewed **+ #**	**C** = Revised **+ #**	**D** = Archived
Status	**#**	**Description of Change**		**Date**	**Author/Title**
C	0	Created in new format and updated 501r requirements. Changed policy name from Self Pay Collection to Billing & Collection Policy		7/6/2020	W. Scheuermann, Vice President, Revenue Strategy & Managed Care