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Atrium Health
Billing and Collection Policy

The Billing and Collection (B&C) policy supports the Atrium Health goal of assisting patients with the complexities of billing third-party insurers, providing patient specific payment options, reviewing patient's eligibility for coverage assistance and financial assistance and taking actions concerning amounts due for services.

Atrium Health policy is to provide care for emergency medical conditions regardless of the patient's ability to pay and without consideration of the patient's prior payment history. Atrium Health does reserve the right to take collection actions as permitted by law concerning balances due from either the patient or third-party insurer.

Atrium Health has the following five objectives for billing and collection:

- **To model Atrium Health's core value of "Caring;"**
- **To obtain necessary patient specific third-party insurer and personal information in advance of any scheduled services;**
- **To comply with third-party insurer policies and State and Federal regulations related to billing and collection;**
- **To assist the patient in navigating the complexities of seeking reimbursement from third-party insurers; and**
- **To establish a billing and collection processes consistent with industry standards.**

Atrium Health will achieve these objectives by implementing the following B&C strategies:

- maintaining up-to-date patient and third-party insurer information as provided by the patient or patient representative;
- assisting patients with verification of coverage;
- providing patients with estimates of cost-sharing amounts for scheduled services;
- providing patients with various payment options;
- establishing reasonable efforts to determine patient's eligibility for financial assistance programs;
- evaluating and implementing healthcare industry best practices in billing and collections; and
- maintaining a robust compliance and patient satisfaction monitoring program.

This policy applies to the following Atrium Health facilities:

- **Atrium Health Anson**
- **Atrium Health Behavioral Health**
- **Atrium Health Cabarrus**
- **Atrium Health Cleveland**
- **Atrium Health Kings Mountain**
- **Atrium Health Lincoln**
- **Atrium Health Medical Group**
- **Atrium Health Mercy**
- **Atrium Health Navicent Baldwin**
- **Atrium Health, The Navicent Medical Center**
- **Atrium Health Navicent Peach County**
- **Atrium Health Navicent Physician Group**
- **Atrium Health Navicent Rehabilitation Hospital**
- **Atrium Health Pineville**
- **Atrium Health Stanly**
- **Atrium Health Union**
- **Atrium Health University City**
- **Carolina Medical Center**
- **Carolinas Rehabilitation**
- **Levine Children's Hospital**

Definitions

The terms used within this policy are to be interpreted as follows:

- Amounts Generally Billed (AGB): amounts generally billed for emergency or other medically necessary care to individuals who have insurance covering such care. Atrium Health calculates AGB using the look-back method by averaging Medicare and all private third-party insurer allowables for medically necessary hospital services billed in a 12-month period.
- Bad Debt: Accounts that have been categorized as uncollectible because the patient has failed to pay for services rendered and are not eligible for CAFA.
- Elective: services that, in the opinion of a physician, are not needed or can be safely postponed.
- Extraordinary Collection Action (ECA) – any collection activity taken against an individual that requires a legal or judicial process, involves selling an individual's debt to another party, reporting adverse information to consumer credit reporting agencies/credit bureau or deferring or denying medically necessary services due to insufficient payment or nonpayment of one or more bills for previously provided care.
- Financial Assistance Score (FAS Score): a score developed with the assistance of a third-party vendor to provide a proactive, consistent and automated mechanism to substantiate a patient's financial profile.
    - FAS Score is not a credit score.
    - FAS Score relies on various databases with more than 9,000 sources and 2 billion records to determine the likelihood that a patient lives in poverty.
    - A component of FAS Score is a Household Income Index that is calibrated to Federal Poverty Guidelines.
    - Other components include, but are not limited to, a review of census data, consumer transaction history, asset ownership files and utility files.
- Household: the patient and any individuals (such as a spouse, children, or other dependents) who could be included on a federal income tax return regardless of whether the patient files a tax return
- Household Financial Income: Income is monies received by the household which may require documentation and includes but is not limited to the following:
    - Annual household pre-tax job earnings
    - Unemployment compensation
    - Workers' compensation
    - Social Security and Supplemental Security Income
    - Veteran's payments
    - Pension or retirement income
    - Other applicable income, including for example, rents, alimony, child support and any other miscellaneous income regardless of source
- Household Financial Resources: Resources that are include income as well as assets such as bank account balances, investments, stock and personal property.
- Medically Necessary: healthcare services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are in accordance with the generally accepted standards of medical practice and/or clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease
- Generally Accepted Standards of Medical Practice
    - standards that are based on credible scientific evidence published in peer-reviewed, medical literature generally recognized by the relevant medical community
    - Physician Specialty Society recommendations
    - Views of Physicians practicing in the relevant clinical area
    - Any other relevant factors.

- Other Coverage Options: Options that would yield a third-party payment on account(s) under CAFA review including, but not limited to: Workers' Compensation, governmental plans such as Medicare and Medicaid, State/Federal Agency plans, Victim's Assistance, etc., or third-party liability resulting from automobile or other accidents.
- Overpayment: a payment applied to a specific account that results in a credit
- Patient: defined for purposes of this policy to be the patient or guarantor with the responsibility of paying the account balance after any third-party reimbursement has been received.
- Third-party Insurers: Any party insuring payment on behalf of a patient, including: insurance companies, workers' compensation, governmental plans such as Medicare and Medicaid, State/Federal Agency plans, Victim's Assistance, or third-party liability resulting from automobile or other accidents.
- Uninsured: Patients who are not covered under a third-party insurer.
- Under-insured: Patients who are covered under a third-party insurer but do not have adequate coverage often resulting in a large out-of-pocket expense

Pre-Service & Financial Clearance

Atrium Health encourages each patient to pay based on their ability to pay all or a portion of the patient's estimated balance for medically necessary services prior to the scheduled service. The Atrium Health Pre-Service & Financial Clearance team may contact the patient to obtain third-party insurer and other information needed to bill for services and may provide an estimate of the patient's out-of-pocket expenses. For insured individuals, the estimate is based on the determination of the patient specific third-party coverage for the services. The Atrium Health Pre-Service team may request that the patient pay all or a portion of the estimated patient balance. If the patient is uninsured, the estimate of the patient's balance is based on the amount after the Atrium Health uninsured discount is applied – 50% for hospital services and 30% for medical group services.

Initial Billing & Financial Assistance and Discount Programs:

As a courtesy to patients residing in the United States, Atrium Health strives to billall third-party insurers on their behalf. Limitations may exist when Atrium Health is not an enrolled provider or contracted with the third-party insurer. Atrium Health will assist the patient with all known hospital pre-authorizations and other approvals required for services as a benefit to the patient. The patient is responsible, however, for all of the insurer's prerequisites for covering services. In situations when services are denied by a third-party insurer, Atrium Health will assist the patient in any appeal process with third-party insurers.

For insured patients, Atrium Health submits a claim on behalf of the patient to the patient's insurance provider. If there is a patient responsibility portion after the third-party insurer pays or denies the claim, Atrium Health will send the patient a minimum of 3 billing statements indicating the balance owed.

For uninsured patients, Atrium Health automatically applies an uninsured discount to gross charges and reviews their balance for financial assistance. A 50% uninsured discount is applied for hospital services and a 30% uninsured discount is applied for medical group services.

Financial assistance programs are available through the Atrium Health Coverage Assistance and Financial Assistance (CAFA) policy for uninsured North Carolina, South Carolina and Georgia residents who are between 0% and 400% and for under-insured Georgia residents at or below 200% FPG. See the CAFA policy on the Atrium Health at,

www.atriumhealth.org/for-patients-visitors/financial-assistance for more information or contact the Patient Financial Services Customer Service department to request a copy by mail.

Any patients eligible for partial financial assistance and have a balance due will receive a bill in the mail and will never be billed more than the average amount generally billed to an insured patient. Atrium Health will never bill any financial assistance eligible individual more than the "average amount generally billed" Atrium Health uses a look-back method to determine AGB based on all private insurer and Medicare allowables for all claims allowed within a 12-month period. (AGB). All uninsured patients automatically receive a 50% uninsured discount. Patients approved for financial assistance receive at minimum 50% financial assistance in addition to the 50% uninsured discount which totals a minimum of 75% off gross charges. If a patient is still responsible for any portion of the bill after discounts and financial assistance, the patient's bill will indicate how the patient may obtain information on how the bill was calculated to be below AGB. Remaining balances after all discounts are eligible for the "Choice Outreach" interest free payment plan option described below in the patient payment plans section below.

For patients who are not eligible for financial assistance programs but have incurred excessive medical bills due to unforeseen circumstances may apply for a hardship discount. The hardship discount is a **discount program** designed to assist North Carolina, South Carolina or Georgia residents who have had a catastrophic medical event that has resulted in very large medical bill balances in comparison to the patient's financial resources. A patient who has incurred a balance after all third-party payments that is greater than 10% of the patient's total household financial resources may be eligible for a Hardship discount. A patient seeking a hardship discount should inquire about this program by calling the customer service department after receiving the patient's first statement. Patient balances must be greater than or equal to $2,500 to qualify for this program.

Collection of Patient Balances

Atrium Health reserves the right to utilize outside vendors to assist Atrium Health and patients regarding balances due and process payment plans. When a balance is owed by the patient, Atrium Health expects full payment and considers the account to be "Self-Pay."

- An account is determined to be Self-Pay if:
  - There is no third-party insurer on record.
  - All expected payments from the third-party insurers have been received.
  - The patient has been uncooperative with the Atrium Health Coverage Assistance Services department to determine other coverage opportunities or financial assistance in accordance with the Atrium Health CAFA Policy.
- Atrium Health will generate at minimum three billing statements and send it to the physical address on file provided by the patient or representative.
- Patients who have opted for paperless billing will receive a minimum of 3 email notifications that their billing statements are available in the MyAtriumHealth Patient Portal on the Atrium Health website.
- Each statement includes a plain language summary of the Atrium Health CAFA policy regarding coverage and financial assistance.
- Atrium Health will perform Medicaid eligibility checks on uninsured accounts on behalf of the patient after discharge and prior to collection activity. If Medicaid coverage is identified, the account will be reclassified to Medicaid from Self-Pay and billed to Medicaid.
- The last communication will occur at least 90 days from the first post-discharge bill date and will include communication to the patient that if there is no action, the patient account will be referred for additional

collection actions in 30 days. This communication also includes a plain language summary detailing the Atrium Health CAFA policy.

- On each billing statement, it is communicated that an itemized bill can be requested by contacting the Atrium Health Customer Service call center at 704-512-7171.
- Patients can access the MyAtriumHealth Patient Portal on the Atrium Health website and request an itemized bill, ask questions, pay bills, and submit questions to the Atrium Health Customer Service team.
- All communications 30 days prior to bad debt placement, including oral communications by third-party collectors, include communication of the Atrium Health CAFA policy.

Patient Payment Plans

If a patient has the means to pay his or her bill but cannot pay in full, they can set up a payment plan administered by a third-party vendor, AccessOne. Patients can call the Atrium Health Patient Financial Services Customer Service Department at 704-512-7171 or AccessOne at 1-888-458-6272 to set up a payment plan.

Three plans are available:

1. "Choice" is available to any patient with a balance less than or equal to $10,000. The program includes an interest free payment option for up to 24 months.

2. "Choice 10" is available to any patient with a balance greater than $10,000. The program expands the interest free payment for up to 100 months (based on account balance). The program also offers a fixed low interest payment option as well.

3. "Choice Outreach" is available to patients who have a high likelihood of living in poverty. For example, a patient may have already received financial assistance through the CAFA or Hardship Discount Programs but may still have a balance for which the patient is responsible for paying. Patients who are found to be below 400% of the FPG qualify for this payment arrangement. For accounts with a balance less than $2,500, the minimum payment is set to $25 a month until the balance is paid in full. For accounts over $2,500, the minimum payment is set to a percentage of the total ranging from .50% to 1% of the balance due. All patients who were found eligible for financial assistance or a hardship discount are automatically eligible for the "Choice Outreach" payment plan program.

Credit Balances and Refunds:

Credit balances resulting in a patient overpayment will be transferred to other Atrium Health balances owed by the same patient. If there are no other outstanding balances owed, the patient will be refunded within 45 days of the notice of overpayment.

Patients who are owed a refund will receive a paper check to the address on file. Refunds may also be credited back to the credit card used at the time of payment. Patient credits after any financial assistance adjustments will be refunded.

Bill Inquiry:

Patients who have questions about charges on their bill can call the Atrium Health Patient Financial Services Customer Service Department at 704-512-7171. A customer service representative will review the charges with the patient and provide them, free of charge, with an itemized bill upon request. If the patient still has questions regarding specific charges, the patient may request a charge audit. The Patient Financial Service Medical Audit team will validate the charges billed to the services documented in the medical record. A resolution letter will be mailed to the patient regarding the audit findings.

Collection Agency Referral:

Atrium Health may refer certain patient accounts to contracted third-party collection agencies. All collection agencies working on behalf of Atrium Health are expected to comply with applicable Atrium Health Billing and Collections and CAFA policies. Atrium Health and/or third-party collection agencies may report adverse information to a consumer credit reporting agency or credit bureau as a result of insufficient payment. Agency placement may occur no earlier than 120 days from the first post-discharge bill date and credit reporting may occur no earlier than 240 days from the first post-discharge bill date. Prior to credit reporting, patients are notified 30 days in advance via letter that includes information on the Atrium Health financial assistance policy via the plain language summary and how to apply. Atrium Health and external collection agencies will follow all applicable statutes and regulations related to healthcare collections including the Fair Debt Collection Practices Act in conducting collection activities. Although Atrium Health makes every effort to verify a patient's insurance coverage, it is ultimately the responsibility of the patient to notify and verify any coverage with Atrium Health and until Atrium Health is made aware of coverage it has no obligation to submit claims or otherwise seek payment from a third-party insurer.

Collection Agency Review:

After a patient has received at least three billing statements and a 30-day notice of potential referral for additional collection actions, an account is reviewed for collection agency referral. Prior to the referral, Atrium Health takes the following action:

- All accounts are reviewed for current Medicaid eligibility.
- Uninsured accounts reviewed for collection agency referral that were not classified as uninsured at discharge and never reviewed for financial assistance eligibility through the CAFA or FAS process will be reviewed for presumptive financial assistance through the FAS process. Those found eligible for financial assistance are extended financial assistance and not referred. Those found ineligible are notified in writing with the Atrium Health CAFA plain language summary with information on how to apply for a full CAFA review.
- Accounts are not referred if information has been obtained that would assist in resolving the account balance prior to further collection activity.

Collection Agency Placement:

- Accounts are automatically submitted to an Atrium Health contracted primary collection agency. Accounts remain with the primary collection agency for a period of at least 270 days.
- The primary collection agency will make each patient that they contact for purposes of debt collection aware of the Atrium Health CAFA policy.
- The primary bad debt placement agency will not credit report until 240 days from the first post-discharge bill date.

Secondary Bad Debt placement occurs 270 days after primary placement for all accounts that have had no or insufficient payment activity.

Legal Collection Actions

Legal action may be considered if an account goes unpaid and reasonable efforts have been made to determine if the account is eligible for financial assistance. The Atrium Health Unified Business Office has the final authority of determining if a legal action should be pursued and reasonable efforts, defined in this policy, have been made to communicate the Atrium Health CAFA policy and determine if a patient is eligible for coverage or financial assistance. Legal action will not occur until 240 days from the first post-discharge bill date. Patients will be given 30 days' notice before a legal action occurs. The 30-day notice will include a plain language summary detailing the Atrium Health CAFA policy and all subsequent communications will inform the patients of the Atrium Health CAFA policy. Patients have 30 days from the date of the notification to apply for a CAFA review or resolve the debt before the legal action occurs. If a patient is found eligible for coverage or financial assistance after a legal action has been initiated, legal action will be temporarily ceased, and coverage assistance will be initiated, or financial assistance applied if eligible. All Atrium Health legal action is compliant with applicable state and federal legislation. Atrium Health makes efforts to ensure patients who qualify for third-party insurance coverage or financial assistance are approved for such coverages, and the use of legal action is sometimes taken, among other reasons, to encourage patients to respond and cooperate with obtaining coverage for their bills or providing payment.

Legal actions are outlined below:

- Small Claims Collections – accounts with balances $300 - $5000 may be referred to local County small claims court.
- Lawsuits – Account balances >$5000 may be referred to an attorney for pursuit of judgments according to appropriate state laws.
- South Carolina (SC) Tax Debt Set-Off – Working through the S.C. Association of Counties, Atrium Health files a set-off claim against any SC tax refund due the patient.

Review of reasonable efforts made to determine financial assistance eligibility prior to extraordinary collection activity listed in this policy:

All reasonable efforts will be made to determine eligibility for financial assistance based on the Atrium Health Coverage Assistance and Financial Assistance policy prior to any extraordinary collection activity (ECA) described in this policy.

Reasonable efforts include:

- Wide publication of the Atrium Health CAFA policy and plain language summary.
    - Publication on the Atrium Health website;
    - at Atrium Health facility admission offices;
    - at Atrium Health Emergency Departments and;
    - on all Atrium Health billing statements
- Application accessible for download on the Atrium Health website and available by mail upon request
- Multiple language translations of the CAFA policy, plain language summary and application available on the Atrium Health website
- Oral notification of the Atrium Health CAFA policy by PFS Customer Service and/or third-party collection agencies
- A minimum of 3 billing statements all including the plain language summary of CAFA programs on the back of the statement
- 30-day notice sent to patients notifying them of their financial obligation and any pending ECA; notice includes information regarding the Atrium Health CAFA policy, the plain language summary and how to apply for assistance within that 30 day timeframe
- Automated Financial Assistance Scoring (FAS) presumptive eligibility process prior to patient billing for uninsured patients. Those who are found ineligible are notified via a letter with the plain language summary detailing how to apply for CAFA should they feel their FAS based eligibility was not accurate.
- 240 days from the first post-discharge bill date to apply for financial assistance. All patients have 30 days to make financial arrangements regarding their bill before an ECA will occur whether within the 240-day application window or outside the 240-day window.
- All ECAs will be suspended if an application for CAFA is received during the 240-day application window or 30-day notice period. ECAs will not resume until a financial assistance determination has been made and the patient is found ineligible for financial assistance. ECAs will be reversed for any patient found eligible for financial assistance.
- Patients who submit incomplete applications will also have their ECA suspended and will be notified in writing of the needed information to complete their application and given 30 days to provide that information.
- The Atrium Health Unified Business Office has the final authority in ensuring reasonable efforts have been made to communicate the Atrium Health CAFA policy and determine an individual's eligibility and whether an ECA can be initiated.