

ST. VINCENT'S MEDICAL CENTER

BILLING AND COLLECTION POLICY

Effective as of July 1, 2018

POLICY/PRINCIPLES

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

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

This Billing and Collection Policy applies to all emergency and other medically necessary services provided in the Organization, including employed physician services and behavioral health. This Billing and Collection Policy does not apply to payment arrangements for elective procedures.

DEFINITIONS

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

2. "**Application Period**" means the period during which a FAP Application may be submitted to the Organization. The Application Period begins on the earlier of the date the FAP Application is submitted or the date care is provided and ends on the date specified in an Application Period Termination Notice.

3. "**Application Period Termination Notice**" means a written notice stating the deadline after which the Organization will no longer accept and process a FAP Application submitted (or, if applicable, completed) by the Patient for the previously provided care at issue, with the deadline specified in the written notice being no earlier than the later of (a) thirty (30) days after the date that the written notice is provided, (b) 240 days after the date that the first post-discharge billing statement was provided for the previously provided care, or (c) in the case of a Patient who has been deemed presumptively eligible for Financial Assistance less than 100%, then end of a reasonable time to apply for Financial Assistance as described herein. The Application Period Termination Notice may be a separate written document or may be language included within another written notice sent to Patient.

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

- a. Selling a Patient’s debt to another party, unless the purchaser is subjected to certain restrictions as described below.
- b. Reporting adverse information about the Patient to consumer credit reporting agencies or credit bureaus.
- c. Deferring or denying, or requiring a payment before providing, medically necessary care because of a Patient’s nonpayment of one or more bills for previously provided care covered under the FAP.
- d. Actions that require legal or judicial process, except for claims filed in a bankruptcy or personal injury proceeding. These actions include, but are not limited to,
 - i. placing a lien on the Patient’s property,
 - ii. foreclosing on a Patient’s property,
 - iii. placing a levy against or otherwise attaching or seizing a Patient’s bank account or other personal property,
 - iv. commencing a civil action against a Patient, and
 - v. garnishing a Patient’s wages.

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

- a. the sale of a Patient’s debt if, prior to the sale, a legally binding written agreement exists with the purchaser of the debt pursuant to which
 - i. the purchaser is prohibited from engaging in any ECAs to obtain payment for the care;
 - ii. the purchaser is prohibited from charging interest on the debt in excess of the rate in effect under section 6621(a)(2) of the Internal Revenue Code at the time the debt is sold (or such other interest rate set by notice or other guidance published in the Internal Revenue Bulletin);
 - iii. the debt is returnable to or recallable by the Organization upon a determination by the Organization or the purchaser that the Patient is eligible for Financial Assistance; and
 - iv. the purchaser is required to adhere to procedures specified in the agreement that ensure that the Patient does not pay, and has no obligation to pay, the purchaser and the Organization together more than he or she is personally responsible for paying pursuant to the FAP if the Patient is determined to be eligible for Financial Assistance and the debt is not returned to or recalled by the Organization;
- b. any lien that the Organization is entitled to assert under state law on the proceeds of a judgment, settlement, or compromise owed to a Patient as a result of personal injuries for which the Organization provided care; or
- c. the filing of a claim in any bankruptcy proceeding.

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

6. “**FAP Application**” means the application for Financial Assistance.

7. “**Financial Assistance**” means the assistance the Organization may provide to a Patient pursuant to the Organization’s FAP.

8. “**Organization**” means St. Vincent’s Medical Center, which is part of Ascension Health. To request additional information, submit questions or comments, or submit an appeal, you may contact the office listed below or as listed in any applicable notice or communication you receive from the Organization:

Patient Financial Services
Customer Service Call Center Manager
203-576-5374
2720 Main Street, Bridgeport CT, 06606
Attention: Customer Service

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

BILLING AND COLLECTION PRACTICES

The Organization maintains an orderly process for regularly issuing billing statements to Patients for services rendered and for communicating with Patients. In the event of nonpayment by a Patient for services provided by the Organization, the Organization may engage in actions to obtain payment, including, but not limited to, attempts to communicate by telephone, email, and in-person, and one (1) or more ECAs, subject to the provisions and restrictions contained in this Billing and Collection Policy.

Pursuant to 501(r), this Billing and Collection Policy identifies the reasonable efforts the Organization must undertake to determine whether a Patient is eligible under its FAP for Financial Assistance before it engages in an extraordinary collection action, or ECA. Once a determination is made, the Organization may proceed with one or more ECAs, as described herein.

1. **FAP Application Processing**. Except as provided below, a Patient may submit a FAP Application at any time during the Application Period. The Organization will not be obligated to accept a FAP Application after the Application Period unless otherwise specifically required by 501(r). Determinations of eligibility for Financial Assistance will be processed based on the following general categories.

- a. Complete FAP Applications. In the case of a Patient who submits a complete FAP Application during the Application Period, the Organization shall, in a timely manner, suspend any ECAs to obtain payment for the care, make an eligibility determination, and provide written notification, as provided below.
- b. Presumptive Eligibility Determinations. If a Patient is presumptively determined to be eligible for less than the most generous assistance available under the FAP (for example, the determination of eligibility is based on an application submitted with respect to prior care), the Organization will notify the Patient of the basis for the determination and give the Patient a reasonable period of time to apply for more generous assistance before initiating an ECA.
- c. Notice and Process Where No Application Submitted. Unless a complete FAP Application is submitted or eligibility is determined under the presumptive eligibility criteria of the FAP, the Organization will refrain from initiating ECAs for at least 120 days from the date the first post-discharge billing statement for the care is sent to the Patient. In the case of multiple episodes of care, these notification provisions may be aggregated, in which case the timeframes would be based on the most recent episode of care included in the aggregation. Before initiating one (1) or more ECA(s) to obtain payment for care from a Patient who has not submitted a FAP Application, the Organization shall take the following actions:
 - i. Provide the Patient with a written notice that indicates Financial Assistance is available for eligible Patients, identifies the ECA(s) that are intended to be taken to obtain payment for the care, and states a deadline after which such ECA(s) may be initiated that is no earlier than 30 days after the date the written notice is provided;
 - ii. Provide the Patient with the plain language summary of the FAP; and
 - iii. Make a reasonable effort to orally notify the Patient about the FAP and the FAP Application process.
- d. Incomplete FAP Applications. In the case of a Patient who submits an incomplete FAP Application during the Application Period, the Organization shall notify the Patient in writing about how to complete the FAP Application and give the Patient thirty (30) calendar days to do so. Any pending ECAs shall be suspended during this time, and the written notice shall (i) describe the additional information and/or documentation required under the FAP or the FAP Application that is needed to complete the application, and (ii) include appropriate contact information.
- e. Termination of the FAP Application Period. The Application Period may be terminated by the Organization by delivering a written Application Period Termination Notice to the Patient.

2. Restrictions on Deferring or Denying Care. In a situation where the Organization intends to defer or deny, or require a payment before providing, medically necessary care, as defined in the FAP, because of a Patient's nonpayment of one or more bills for previously provided care

covered under the FAP, the Patient will be provided a FAP Application and a written notice indicating that Financial Assistance is available for eligible Patients. Patient may also be given an Application Period Termination Notice.

3. Determination Notification.

- a. Determinations. Once a completed FAP Application is received on a Patient's account, the Organization will evaluate the FAP Application to determine eligibility and notify the Patient in writing of the final determination within forty-five (45) calendar days. The notification will include a determination of the amount for which the Patient will be financially responsible to pay. If the application for the FAP is denied, a notice will be sent explaining the reason for the denial and instructions for appeal or reconsideration.
- b. Refunds. The Organization will provide a refund for the amount a Patient has paid for care that exceeds the amount the Patient is determined to be personally responsible for paying under the FAP, unless such excess amount is less than \$5.00.
- c. Reversal of ECA(s). To the extent a Patient is determined to be eligible for Financial Assistance under the FAP, the Organization will take all reasonably available measures to reverse any ECA taken against the Patient to obtain payment for the care. Such reasonably available measures generally include, but are not limited to, measures to vacate any judgment against the Patient, lift any levy or lien on the Patient's property, and remove from the Patient's credit report any adverse information that was reported to a consumer reporting agency or credit bureau.

4. Appeals. The Patient may appeal a denial of eligibility for Financial Assistance by providing additional information to the Organization within fourteen (14) calendar days of receipt of notification of denial. All appeals will be reviewed by the Organization for a final determination. If the final determination affirms the previous denial of Financial Assistance, written notification will be sent to Patient. An appeal does not otherwise extend or reset the application process provided in this Billing and Collection Policy.

5. Notification Prior to Collections. Prior to referring any debt to an external debt collection agency or initiating an action against a Patient or a Patient's estate to collect fees arising from care provided at the Organization, the Organization must make a determination as to whether the Patient is uninsured and whether the Patient is eligible for the hospital bed fund as described in the FAP. An uninsured patient means any person who is liable for one or more hospital charges whose income is at or below two hundred fifty per cent (250%) of the poverty income guidelines who (A) has applied and has been denied eligibility for any medical or health care coverage provided under the Medicaid program due to failure to satisfy income or other eligibility requirements and (B) is not eligible for coverage for hospital services under the Medicare of CHAMPUS programs, or under any Medicaid or health insurance program of another state, nation or commonwealth or, or under any other governmental or privately sponsored health or accident insurance or benefit program including, but not limited to, workers' compensation and

awards, settlements or judgments arising from claims, suits or proceedings involving motor vehicle accidents or alleged negligence.

6. Collections. Upon conclusion of the above procedures, the Organization may proceed with ECAs against uninsured and underinsured Patients with delinquent accounts, as determined in the Organization's procedures for establishing, processing, and monitoring Patient bills and payment plans.

- a. Under no circumstances may the Organization or a third party operating on behalf of the Organization collect from an uninsured Patient more than the Organization's cost of providing services. The "cost of providing services" means the Organization's published charges at the time of billing, multiplied by the Organization's most recent relationships of costs to charges as taken from the Organization's most recently available annual financial filing with the Department of Public Health Office of Health Care Access.
- b. Subject to the restrictions identified herein, the Organization may utilize a reputable external bad debt collection agency or other service provider for processing bad debt accounts, and such agencies or service providers shall comply with the provisions of 501(r) applicable to third parties and the provisions of Connecticut General Statutes Sections 19a-673 and 19a-673b.

7. Cessation of Collection Efforts Upon Debtor's Eligibility for Bed Funds or Other Services. If, at any point in the debt collection process, the Organization or any party acting on behalf of the Organization, including a debt collector or a consumer debt collection agency, becomes aware that a Patient from whom the Organization is seeking payment for services is eligible for hospital bed funds, free or reduced price hospital services, or any other program which would result in the elimination of liability for the debt or reduction in the amount of such liability, the Organization or relevant third party acting on behalf of the Organization must promptly discontinue collection efforts and refer the collection file to the Organization for determination of such eligibility. No collection efforts may resume until such determination is made.