BAPTIST HEALTH Revenue Cycle Services
Hospital Collection Policy

This policy is to be consistently followed for all patients regardless of financial class, unless otherwise noted. Consistent with the principles of a faith-based healthcare ministry, any patient seeking medically necessary care at Baptist Health shall be treated without regard to a patient's ability to pay for care. Baptist Health shall operate in accordance with all federal and state requirements for the provision of health care services, including screening and transfer requirements under the Federal Emergency Medical Treatment and Active Labor Act (EMTALA). Baptist Health will also not engage in actions that would discourage individuals from seeking emergency medical care.

Financial Assistance: BAPTIST HEALTH has a financial assistance program. Applications are available to every patient. An application for assistance may be obtained from a team member of Admissions, Social Work, Patient Financial Services or our external patient balance vendor at any time during the collection process. The application is also available on our website at Baptist-Health.com https:// www.baptist-health.com/patients-visitors/insurance-financial-assistance/.

Hospital Collection Policy: BAPTIST HEALTH strives for timely resolution of patient financial obligations related to services rendered at one of its hospital facilities. Our goal is to bill any and all insurance companies as quickly as possible for the collection of the money due from the insurance company or other third party payer. Amounts due from the patient are considered due at the time the service is rendered.

Upon Admission: A financial counselor will notify our patients of this Hospital Collection Policy upon admission and may ask the patient to pay their deductible, co-insurance or non-covered services at the time of service. Deductibles or co-pay amounts are calculated based on information from the payer through the insurance verification process. Deposit may be requested from those patients who are uninsured or under insured. Payment arrangements may be made in advance of the service.

Patients may arrange for a payment plan on their balance due via the BAPTIST HEALTH website or by speaking with a team member from Admissions, Patient Financial Services, or our external patient balance vendor.

After Discharge: Collection of any remaining balance is made through a patient statement mailing process as well as telephone calls. Self-pay accounts are sent to an early out vendor on day five after discharge, or when the account has been coded. Insured account are sent to this vendor on day five after the final insurance payment has been made. The collection schedule is as follows:

- Financial Assistance information will be placed on every billing and collections statement. A copy of the Financial Assistance Application will be included on the first three billing statements.
- The first billing statement is mailed within 2 days of receipt by vendor.
- A 30 day statement is sent with a late message.
- 15 days later, a personal letter is sent. Phone calls also begin this day, which average 2.5 calls a month per account.
- A 60 day statement is sent.
- 15 days later another letter is sent.
- A 90 day statement is sent.
- Patients are given 120 days to apply for financial assistance.
- If no payment plan is made, the account is charged off and sent back to Baptist Health on day 120.
- Extraordinary Collections Actions (ECA's) will not be allowed during this stage of collection activity. ECA's are defined as:
    - Credit bureau reporting
    - Selling an individual's debt to another party
    - Placing a lien on or foreclosing on property, except liens on responsible third party payments pursuant to Ark. Code Ann. & 18-46-101, et seq.
    - Attaching bank accounts
    - Causing an arrest
    - Garnishing wages
    - Issuance of a write of body attachment
    - Commencing a civil action

After the accounts are returned by the early out vendor, a final charity qualification is performed to ensure that all accounts that qualify for charity are given this status. This final charity identification process is outlined below:

BAPTIST HEALTH recognizes that, as a benefit to the Communities that we serve, some patients are unable to or unwilling to ask for financial assistance due to barriers to applying for assistance such as educational level and literacy, documentation limitations, etc. BAPTIST HEALTH is willing to extend benefit to those patients that

face these barriers based on the best information that can be gathered about the patient. BAPTIST HEALTH intends to use a PARO model to process patient accounts for eligible charity scoring at the completion of the revenue cycle and after eligibility efforts for alternative funding or public assistance have been exhausted.

The PARO model is software that allows Baptist Health to determine if patients qualify for financial assistance even if the patient does not respond to offers for financial assistance. This software utilizes public record data and returns information that is utilized to determine characteristics for the consumer. PARO is designed to identify patients likely to qualify for financial assistance based on a predictive model and other financial and asset estimates for the patient derived from public record sources. In the absence of additional information from the patient, this rule set is applied to all patients exiting the revenue cycle to determine which patients would have likely qualified for financial assistance.

Once all accounts that are determined to qualify for charity are moved to that classification, the remaining accounts are then sent to a collection agency for further collection efforts in compliance with the Fair Debt Collection Practices Act (FDCPA). The collection agency process is outlined below:

- Accounts are referred for collections one week after being returned from the early out vendor
- A FDCPA compliant validation letter allowing the patient to dispute the debt is sent within five (5) days of the initial communication with the patient, if not contained in the original communication.
- The patient is given 30 days to dispute the debt before additional collection activity begins. The FDCPA will be complied with during any dispute process.
- The first collection letter is sent on day 31 if the debt is not disputed.
- Telephone calls begin on day 45.
- Patients are given 120 days to apply for financial assistance, pay their debt or arrange a payment plan.
- If there is no response, legal action will begin.
- The law office will send written communication and make phone calls to the patient to notify them of pending legal action.
- BAPTIST HEALTH will approve all accounts selected for legal action by verifying balances and signing the affidavit.
- No liens will be executed to force the sale of the primary residences of patients.
- Accounts will stay at the primary collection agency for 180 days and then will be returned if no payment plan is in place.

- Extraordinary Collection Actions listed below will not be allowed in any instance:

    - Credit bureau reporting
    - Selling an individual's debt to another party
    - Attaching bank accounts
    - Causing an arrest
    - Issuing a writ of body attachment
    - Commencing civil action

Accounts that are considered uncollectible at the collection agency are returned and then transferred to a secondary collection agency, which will then follow the same collections steps are outlined above.

All billing and collection vendors will be required to sign a copy of this policy to attest to their adherence to the above collection practices.

Patients may request clarification of charges or an audit of charges from any BAPTIST HEALTH team member. Should a review of the account find an error, billing will be corrected with the payer and will be reflected on the account. Funds due to the payer of the patient will be refunded promptly.

As a business partner of Baptist Health, I agree to abide by the above policy in all business actions and transactions.

Name: Date:

Business Name: