

COMMUNITY HOSPITAL OF THE MONTEREY PENINSULA	DP-5.6678
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PURPOSE

To describe the hospital's collection policy that is consistent with best practices in the industry and in compliance with regulatory requirements. This policy will include policies relevant to collections, such as negotiated discounts, credit check, uncollectible accounts, write-offs and collection agency transfers.

POLICY STATEMENT

Community Hospital of the Monterey Peninsula pursues a collection policy in keeping with best practices in the industry, California Hospital Association (CHA) recommendations, the Hospital Fair Pricing Policies Act, and all federal, state and local laws governing the collection of a patient debt, including Section 501(r) of the Internal Revenue Code. The hospital will clearly and conspicuously post and maintain signs notifying patients of the hospital's Sponsored Care and Discount Payment Programs, and the availability of funds from other programs to assist with payment of bills. The signs are placed in every registration site, the patient business office, the emergency department, the billing office, the admissions office, other outpatient settings, and the hospital website.

COLLECTION POLICY

General Practice

- A. Patient Business Services (PBS) shall adhere to the following guidelines in the collection of any patient debt to the hospital stemming from medical services rendered at any site or in any department. Every patient will be accorded respect and treated with dignity at all times. These collection guidelines are established under the authority of the Patient Business Services Department, and debts will not be advanced for collection without review based on the Authorization process by dollar threshold. The decision to advance a debt for collection will be made on a case-by-case basis, following the policy and processes set forth below. The collection process may be automated if certain criteria are met. The decision to advance a debt for collection will be based on such factors as lack of payment, failure to apply for available programs, failure to respond to hospital requests, or failure to contact the hospital in response to a bill. At the discretion of the Patient Business Services and in compliance with relevant legal requirements, a bill may be advanced for collection after due notifications. Regardless of the age of a bill, the hospital will always be open to compromise regarding a debt.
- B. Collection is initially conducted by the hospital but may be advanced for collection by an external collection agency or legal action as set forth below. This collection policy governs all communications between the hospital and a patient concerning collection of amounts owed to the hospital.

Types of Balances

- A. Patient balances stem from four sets of circumstances:
 1. The patient has qualified for or may be eligible for the Sponsored Care or Discount Payment Programs. This category may include:

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- a. A self-pay patient who meets the income and/or monetary asset requirements of the Sponsored Care or Discount Payment Programs and who does not have third-party health insurance coverage, a health care service plan, Medicare or Medicaid, and whose injury is not a compensable injury for purposes of workers' compensation, automobile insurance, or any other insurance that may cover the hospital services provided to the patient.
 - b. An insured patient who meets the Discount Payment Program eligibility standards concerning income (at or below 350% of the Federal Poverty Level) and who has high medical costs (out-of-pocket medical expenses in the 12 months before services were rendered exceed 10% of the patient's family income during the same 12-month period).
2. The patient has no third-party coverage (self-pay) and is not eligible for the hospital's Sponsored Care or Discount Payment Programs.
 3. The patient has third-party coverage but has deductibles, co-pays or non-covered services, and is not eligible for the hospital's Sponsored Care or Discount Payment Programs.
 4. The patient has insurance that does not pay the hospital despite consistent follow-up by staff and no contractual or legal exclusions limit the hospital's ability to pursue the patient for payment.

Processes

- A. Whenever possible, all patients will be pre-registered for services. Patients with no insurance will be encouraged to work with the hospital enrollment counselors to locate government programs and or the California Health Benefit Exchange for which they may qualify. Patients will be given information about the hospital Sponsored Care Program and will help them apply.
- B. Collection procedures vary depending on the type of visit, as follows:
 - 1. Patient who may be eligible for the hospital's Sponsored Care or Discount Payment Program.**
 - a. Patients who meet income and/or asset requirements may qualify for the hospital's Sponsored Care or Discount Payment Program. All efforts should be made to determine eligibility for these programs pre-service if possible or as soon as practicable after services are provided. The hospital's Social Services Department or the Patient Business Services Department will review applications for Sponsored Care or Discount Payment Program eligibility in accordance with hospital policy. All patients shall be provided at least 240 days to submit a complete application for the hospital's Sponsored Care or Discount Payment Program ("Application Period"). While the patient's application is pending, the hospital may send billing statements, but will not commence any collection activity within 120 days of the hospital's first post-discharge billing statement. The billing statement will include a plain language summary of the hospital's Sponsored Care & Discount Payment Program Policy. Prior to

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commencing any collection activity, the hospital shall provide patients with a written notice describing the potential collection activities that may be initiated in the event of nonpayment. The notice will include a deadline after which collection activities may be initiated that is no earlier than thirty days after the date of the notice.

- b. In the event that a patient submits an application for the hospital's Sponsored Care or Discount Payment Program during the Application Period, the hospital will immediately suspend any collection actions pending against the patient until a final determination has been made regarding the patient's eligibility for financial assistance or the patient has failed to respond to requests for additional information necessary for the hospital to make a final determination regarding eligibility.
- c. In the event that a patient submits an incomplete application for the hospital's Sponsored Care or Discount Payment Program during the Application Period, the hospital will provide the patient with a written notice that describes the additional documentation required to complete the application. Patients will be provided at least 30 days to respond to follow-up requests for additional information related to incomplete applications.

2. Patients who successfully qualify for the hospital's Sponsored Care or Discount Payment Program.

- a. Upon reaching a determination that the patient is eligible for the Sponsored Care or Discount Payment Program, the hospital will determine the amount owed by the patient in accordance with the hospital's Sponsored Care & Discount Payment Program Policy. If the patient is not able to pay the amount due in a lump sum, the patient will be offered the opportunity to negotiate and agree to a payment plan.
- b. If the patient has signed a Sponsored Care & Discount Payment Program Payment Plan, and the patient fails to timely make all scheduled payments during any 90-day period, the hospital may terminate the Payment Plan. Before terminating the Payment Plan, the hospital will contact the patient by telephone and in writing and inform the patient that the Payment Plan may be terminated due to default in scheduled payments. If the patient requests, the hospital will renegotiate the Payment Plan.
- c. The hospital will not report adverse information to a consumer credit reporting agency or begin a civil action against the patient for nonpayment before the Payment Plan is terminated.
- d. The hospital will not use the monetary asset information it obtained in determining eligibility for the Sponsored Care Program for collection activities. Information concerning income and monetary assets that are obtained as part of the eligibility determination is not to be shared with collection agencies.

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- e. For a period of 150 days after the initial billing to the patient, the hospital will not report adverse information to a consumer credit reporting agency concerning, or commence a civil action against, a patient who lacks coverage or provides information that he or she may be eligible for the Sponsored Care or Discount Payment Program.
- f. If a patient is attempting to qualify for the Discount Payment or Sponsored Care Program and is attempting in good faith to settle an outstanding bill by negotiating a payment plan or making reasonable, regular payments on his/her bill, the hospital will not send the patient's visit to a collection agency unless the agency agrees to comply with the hospital's collection policy, California Health & Safety Code § 127400 et seq. (Hospital Fair Pricing Policies Act) and the provisions of 26 C.F.R. 1.501(r)-6(b)(2) governing extraordinary collection actions.
- g. The hospital will not use wage garnishments or liens on primary residences as a means of collecting unpaid hospital bills from patients who are eligible for the Discount Payment or Sponsored Care Program.
- h. If a patient appeals, the hospital's decision concerning eligibility or level of benefits of the patient for either the Sponsored Care or Discount Payment Program, or appeals a coverage of determination of a third party, the hospital will not report adverse information to a consumer credit reporting agency concerning, or commence a civil action against, the patient provided the patient has filed an appeal in compliance with the hospital's Sponsored Care & Discount Payment Program Policy, or makes a reasonable effort to communicate with the hospital about the progress of any coverage appeal pending with a third party. The hospital will not begin the 150-day period referenced above until after the resolution of the patient's appeal is completed to afford the patient the full 150 days to make payment.
- i. Before beginning any collection activity against any patient, including those who are not eligible for the Sponsored Care or Discount Payment Programs, the hospital will provide the patient with a plain language summary of the hospital's Sponsored Care or Discount Payment Policy and a clear and conspicuous notice of the patient's rights under the Fair Pricing Policies Act, the Rosenthal Fair Debt Collection Practices Act, and the federal Fair Debt Collection Practices Act. The notice will state:

"State and federal law require debt collectors to treat you fairly and prohibit debt collectors from making false statements or threats of violence, using obscene or profane language, and making improper communications with third parties, including your employer. Except under unusual circumstances, debt collectors may not contact you before 8:00 a.m. or after 9:00 p.m. In general, a debt collector may not give information about your debt to another person, other than your attorney or spouse. A debt collector may contact another person to confirm your location or enforce a judgment. For more information about debt collection activities, you may contact the Federal

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Trade Commission by telephone at 877-FTC-HELP (382-4357) or online at www.ftc.gov. Nonprofit credit counseling services may be available in the area.

If you are uninsured or have high medical costs, please contact Community Hospital's Patient Business Services Department at (831) 625-4922 or (888) 625-4922 for information on discounts and programs for which you may be eligible, including the Medi-Cal program. If you have coverage, please tell us so that we may bill your plan."

- j. This notice will also be given in any document indicating that the commencement of collection activities may occur and will include a deadline after which collection activities may be initiated that is no earlier than thirty days after the date of the notice.
- k. In the event the hospital collects payments from a patient who subsequently qualifies for the Sponsored Care or Discount Payment Policy, the hospital will refund any excess previously paid by the patient, together with interest thereon at the current rate (refer to refund procedure) per annum from the date the hospital received the overpayment, or the date the patient qualifies for the Sponsored Care or Discount Payment Policy, whichever date is later.

3. Self-Pay Patients Pre-Service

Patients who access the hospital without third-party coverage shall be processed as follows:

- a. Efforts will be made to advise scheduled self-pay patients that payment or payment arrangements are expected at the time of service and shall be given an estimated amount for the service if requested. Upon request, an estimate will be provided in writing on a document that clearly specifies the service to be rendered, the estimated cost, and a clear disclaimer that the estimate may prove to be higher or lower than the actual services received and that the difference will be either refunded or payable at the time of final billing. All patients will be given the opportunity to work with the hospital enrollment counselors to locate government programs and/or the California Benefit Exchange for which they may qualify and will be provided with a notice advising them of the hospital's Sponsored Care and Discount Payment programs.
- b. If a patient indicates that s/he cannot pay the bill or s/he may require help in paying the bill, the hospital representative will first determine if the service is urgent. If the service is not urgent, it may be postponed, with the concurrence of the physician, until the patient can make arrangements to pay for the services. If the services are deemed to be urgent, the following actions(s) will be taken:
 - i. Refer the patient to the hospital enrollment counselors to be screened for eligibility for any state, or federal program and/or the California Benefit Exchange for which s/he may qualify. Refer to the Government Programs

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Reference Guide located in the Patient Business Office and Patient Access.

- ii. Provide the patient with a list of other possible sources of assistance including information about the hospital's Sponsored Care and Discount Payment programs. Provide patient with a copy of the plain language summary of the Sponsored Care & Discount Payment Program Policy and corresponding application forms.
- iii. Advise the patient that an application for the Sponsored Care or Discount Payment Program may be submitted pre-service, or it must be submitted within 240 days following receipt of the first post-charge billing statement for hospital services.

4. Self-Pay Patients During Hospital Stay or Post-Service

All self-pay patients who have not been screened prior to coming in for inpatient services or for outpatient surgery or other major procedures will be screened by the Financial Counselor whenever possible. Screening is mandatory for inpatients. The Financial Counselor will discuss payment options with the patient or his/her legal representative and will request payment as appropriate. If the patient states that s/he is unable to pay for services, the Financial Counselor shall take the following action:

- a. Provide the patient with information of other possible sources of assistance, including information about the hospital's Sponsored Care and Discount Payment programs. Provide application forms to the patient.
- b. Refer the patient to hospital enrollment counselors to be screened for eligibility for any state or federal program and/or the California Benefit Exchange for which s/he may qualify. Refer to the Government Programs Reference Guide located in the Patient Business Office and Patient Access.
- c. For patients interested in Sponsored Care, advise the patient that an application for the Sponsored Care or Discount Payment Program must be submitted within 240 days following receipt of the first post-charge billing statement for hospital services. Provide the patient with a copy of the plain language summary of the Sponsored Care & Discount Payment Program Policy and corresponding application forms. Encourage the patient to work with the hospital enrollment counselors to be screened for eligibility for state or federal programs and/or the California Benefit Exchange for which they may qualify. All uninsured patients will be awarded a standard discount at the time of billing.

5. Deductibles, Co-Pays and Non-Covered Services

- a. Whenever or wherever a patient calls or presents for services, third-party coverage information must be gathered. Verify coverage whenever possible prior to services being rendered. If the patient has deductibles due, and it can be established that the deductibles have not been met, always ask for the

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deductible amount to be paid prior to services. Any service not covered by the patient's insurance must be considered self-pay and the self-pay process above must be followed. Non-urgent services may be postponed if not covered by insurance, in consultation with the patient's physician.

- b. In the case of Government Insurance such as Medi-Cal, Tri-West, etc., current rules for collection of co-pays, deductibles and cost shares must be followed. If the co-pay or deductible amounts cannot be determined, do not attempt to collect the co-pay or deductible prior to the claim being billed and adjudicated.
- c. Medicare requires that Medical Necessity be checked for all outpatient services. If the process shows that the services may not be covered, the patient must be advised and given an Advanced Beneficiary Notice (ABN) form to sign. The patient may choose to postpone the service, sign the ABN with the understanding s/he may be billed for the service should Medicare deny payment, or refuse to sign and elect to have service anyway, in which case the patient is responsible for the payment and may be asked to pay for the service in advance.
- d. If the patient states s/he cannot pay the amount owed, provide information and an application for the hospital's Sponsored Care and Discount Payment Programs (including a plain language summary), and information about other possible sources of assistance. Follow the self-pay processes for referring the patient for assistance.

6. Third Party Default on Payment

- a. Completed claims with third-party insurers are filed 5 days after discharged. Claims containing errors as detected by the billing system will be reviewed and repaired as appropriate.
- b. The follow-up team will track each claim in an attempt to receive timely payment from the payer. PBS will provide additional information required to have the claim paid, including Medical Records (by following the procedures for providing Medical Records) and Explanation of Benefits (EOB's) from prior payers etc. The insurer will be given appropriate time permitted by law to pay an uncontested claim. Should the payer fail to pay in that timeframe without a legitimate and expressed reason, appropriate follow-up and appeals will be made based on the procedures located in Patient Business Services.
- c. Patients are only billed for unpaid balances as allowed by law.
- d. Once the bill becomes the patient's responsibility, the financial class is changed to self-pay and the patient will be contacted for payment. The self-pay patient process set forth above shall then be followed in processing and collecting the visit.

7. Collecting on a Visit That Is Not Eligible for Third-Party Coverage, the Sponsored Care Program, or the Discount Payment Program

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- a. Unless prohibited by law, every patient who has a balance after insurance or is not eligible for third-party coverage or the hospital's Sponsored Care or Discount Payment Program will receive billing statements. If the patient has not been screened, or has not responded to the hospital's offer of screening for assistance, the patient will be billed as soon as the bill is produced. A summary of the patient's rights under the Fair Pricing Policies Act, the Rosenthal Fair Debt Collection Practices Act, and the federal Fair Debt Collection Practices will be sent to the patient before beginning any collection activity. In addition, the hospital will provide a summary of the Sponsored Care and Discount Payment Programs with every billing statement. The notice will include a deadline after which collection activities may be initiated that is no earlier than thirty days after the date of the notice.
- b. Statement process is designed to provide the patient ample opportunity to contact the hospital to make payment arrangements, request assistance, or apply for the Sponsored Care or Discount Payment program.
- c. Patients who are not eligible for financial assistance or the hospital's Sponsored Care or Discount Payment Program may be assisted in several other ways as follows:
 - i. All Self-Pay Patients receive a 15% discount automatically off the bill. The first statement sent to the patient will show the discount given.
 - ii. An additional prompt pay discount may be offered to encourage the patient/guarantor to make payment full, at a rate not to exceed 10% if paid within 30 days of the initial billing statement.
 - iii. Patients may make interest free monthly payments for a maximum of 25 months.
 - iv. Patients may choose other financing options available to them.
- d. Failure on the part of the patient to contact the hospital for payment arrangements and collection notices, or patients who fail to follow through on promises to pay may be referred to a collection agency or an attorney. Referral of a visit to a collection agency will be determined on aging or on a case-by-case basis. A visit may be referred directly for patients who have consistently refused to pay on prior visits. PBS will follow state and federal laws pertaining to referring patient visits for collections.
- e. Medicare patients, patients who are ineligible for financial assistance, and patients who do not make arrangements for payment may also be referred to collections after 120 days provided they have received the same notifications and opportunities to pay as any other patient, unless there is a pending appeal for coverage of the services. A visit may be referred directly for patients who have consistently refused to pay on prior visits. Medicare patients may be referred for collections in these cases but may not be sued for payment.

- f. Transient and incarcerated patients may be eligible for Sponsored Care or Uncompensated Care.
- g. If a debt is reduced to judgment, wage garnishment may be imposed in accordance with state and federal law. Liens may be filed but no foreclosures may be initiated except in very rare circumstances and must be approved by administration and on the advice of legal counsel. Foreclosure may never be considered on the primary residence of a patient or the patient's spouse.

8. Referral to Collection Agencies

- a. The hospital will obtain a written agreement from any agency that collects hospital receivables to ensure the agency complies with the hospital's standards and practices for debt collection. All agencies employed by the hospital must adhere to all of the Federal, State and local laws and regulations regarding collection practices. Violations reported by patients or witnessed by employees must be reported to management and investigated at once. Any agency found to practice unethical or unlawful collection tactics will be subject to immediate cancellation of contract.

- b. Manual Staff Authorization Process to Advance Visits to Collections

Up to \$2,500.00	Patient Business Services Representatives
\$2,500.01 - \$10,000.00	Patient Business Services Lead
\$10,000.01-\$15,000.00	Patient Business Services Supervisor
\$15,000.01-\$25,000.00	Patient Business Services Asst. Director
\$25,000.01-\$50,000.00	Director of Patient Business Services
\$50,000.01+	Hospital Chief Financial Officer

- c. System Automated Process to Advance Visits to Collections

Up to \$5,000.00 upon aging

NEGOTIATED DISCOUNT

- A. There are occasions when the hospital (and/or its hospital-based physicians) will enter into an agreement with the patient and/or an insurance company regarding the payment for hospital services. This includes arrangements between hospital based physicians to accept the allowed amounts by the patients' insurance for the professional component of specific services.
- B. In order to assure the proper billing to patients, the following procedure will be followed:
 - 1. When a Physician, Patient Access or PBS enters into an agreement with the patient or insurance company, a letter is provided regarding the negotiated discount and/or a comment is placed in AMPFM regarding the negotiation.
 - 2. If a letter is provided, it is scanned into Electronic Patient Folder (EPF).

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- a. The user adds the appropriate insurance to the hospital account record. If they are Self Pay, this becomes the primary payer; if they have insurance, this becomes the secondary or tertiary payer
3. The agreement is reviewed by the Customer Service Representative to determine the appropriate action.
4. The customer service representative will use choose the appropriate charity program in the financial assistance module.

MH MedData-Other

MH Pending Medi-Cal/SOC Clearance

MH Pre-Spon Care

MH Rotocare

MH Ryan White (OPIS)

MH SART Program

MH Sherry Cockle

MH Sponsored Care - Coburn Fund

MH Sponsored Care - Post Adj

MH Sponsored Care Discount

MH Transient

MH Women in Need

CREDIT CHECK

Policy

- A. Credit checks may be run after admission if it is determined that collectability of a significant amount is questionable, or if the patient applies for financial assistance or a payment plan. .
- B. Customer Service Representatives have the authority to run a credit bureau check to ascertain the ability of the guarantor to meet his/her responsibility.
- C. When used to determine the patient's ability to pay, the credit record is scanned and become part of the electronic patient folder. Credit checks are limited to registered patients of the hospital but will not be run on the following:
 - Employees
 - Employee Dependents
 - Medical Staff
 - Physician Dependents, and
 - Other entities of Montage Health, identified as such.

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- D. Knowledge and the use of the access codes required to perform a credit check are limited to the Customer Service Unit staff, Director and Assistant Director of Patient Business Services, Financial Counselor and the VP of Finance.

UNCOLLECTIBLE ACCOUNTS, WRITE-OFFS AND COLLECTION AGENCY TRANSFERS

Uncollectible accounts with a balance over \$100.00 will be assigned to a collection agency upon approval.

Policy

- A. No referrals to a Collection Agency will be made until:
- a. It has been determined that we cannot locate the responsible party, OR
 - b. Appropriate notification has been given the responsible party, up to and including the final notice, and the account has proved uncollectible.
- B. Community Hospital of the Monterey Peninsula reserves the rights to refer to collection based on a patient's payment history. At the discretion of the Patient Business Services and in compliance with relevant legal requirements, a bill may be advanced for collection after due notifications.
- C. PBS Customer Service Representatives have the authority to write off accounts with balances up to \$2,500 to a collection agency.
- D. PBS Customer Service Lead has the authority to write off accounts with balances up to \$10,000 to a collection agency.
- E. The PBS Customer Service Supervisor has the authority to write off accounts with balances up to \$15,000 to a collection agency.
- F. The Assistant Director of PBS may approve balances up to \$25,000 for assignment to a collection agency.
- G. The Director of PBS may approve balances up to \$50,000 for assignment to a collection agency.
- H. Collection agency referral of balances over \$50,000 must be approved by the Vice President/Chief Financial Officer or the equivalent or a higher level from the Hospital Administration.
- I. If the collection agency has taken certain action on an account, it may not be possible to retract an account. Any account must be thoroughly reviewed before retraction. Retraction of an account from the collection agency requires the approval of the Customer Service Supervisor.

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ONTENTS	DESCRIPTION
Submitted by:	Daisy Noguera, Director, Patient Business Services
Next review date:	2020
Effective date:	April 2019
Applicable to:	Patient Business Services Staff
Approved by:	Director, Patient Business Services
Reviewed by:	Management Team and Procedure Committee, Patient Business Services
Replaces:	Patient Business Services Policy: PBS Collection Effort Policy, version 2015.
References:	
Key Words:	Financial assistance, Sponsored Care, Discount Payment Program, self-pay, third-party coverage, government-sponsored programs, Medi-Cal, California Benefit Exchange, application period, collection authorization level, negotiated discount, credit record, write-off, collection agency, collection retraction.
Distribution:	CHOMP Intranet Policies and Procedures, Patient Business Services Staff. Patient Access, Financial Services, Legal Services, PAC.
Additional information:	
Related policies or programs:	DP-5.6630 Patient Business Services Policy: Financial Assistance Programs - Sponsored Care and Discount Payment