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PURPOSE

To describe Community Hospital of the Monterey Peninsula's collection policy that is consistent with best practices in the industry and in compliance with regulatory requirements. This document includes policies relevant to collections, credit check, uncollectible accounts, write-offs, and collection agency transfers.

POLICY STATEMENT

Community Hospital of the Monterey Peninsula (hospital) 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.

In addition to the information set forth in this policy, patients should be aware that there are organizations that will help the patient understand the billing and payment process, as well as information regarding Covered California and Medi-Cal presumptive eligibility. Patients may visit the Health Consumer Alliance website for more information, <https://healthconsumer.org>.

COLLECTION POLICY

General Practice

- A. Patient Business Services (PBS) adheres 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 refer a debt to 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 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.

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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 Program. This category may include:
 - a. A self-pay patient who meets the income requirements of the Sponsored Care or Discount Payment Program and does not have third-party health insurance coverage, a health care service plan, 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 400% of the Federal Poverty Level
 - 2. The patient has no third-party coverage (self-pay) and is not eligible for the hospital's Sponsored Care or Discount Payment Program.
 - 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 Program.
 - 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 or the California Health Benefit Exchange for which they may qualify. Patients will be given information about the hospital's Sponsored Care Program and assisted with Sponsored Care Program applications.
- 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 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 Care Coordination Services Department, Hospital departments, or the Patient Business Services Department will review applications for Sponsored Care or Discount Payment Program eligibility in accordance with hospital policy.

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While the patient's application is pending, the hospital may send billing statements, but will not commence any collection activity within at least 180 days of the hospital's first post-discharge billing statement. The first billing statement will include a plain language summary of the hospital's Sponsored Care & Discount Payment Program Policy.

- b. Prior to commencing any collection activity, the hospital shall provide patients with a written notice containing all of the following information:
 - The date or dates of service of the bill that is being assigned to collections or sold;
 - The name of the entity the bill is being assigned or sold to;
 - A statement informing the patient how to obtain an itemized hospital bill from the hospital;
 - The name and plan type of the health coverage for the patient on record with the hospital at the time of services or a statement that the hospital does not have that information;
 - An application for the hospital's charity care and financial assistance; and
 - The date or dates the patient was originally sent a notice about applying for financial assistance, the date or dates the patient was sent a financial assistance application, and, if applicable, the date a decision on the application was made.
 - c. 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.
 - d. 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 and

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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 up for a Sponsored Care and Discount Payment Program Payment Plan, and the patient fails to 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 begin a civil action against the patient for nonpayment before the Payment Plan is terminated.
- d. Information concerning income obtained as part of the eligibility determination is not to be shared with collection agencies.
- e. For a period of 180 days after the initial billing to the patient, the hospital will not 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 (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 commence a civil action against, the patient provided the patient has filed an appeal in compliance with the hospital's Sponsored Care and 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 180-day period referenced above until after the resolution of the patient's appeal is completed to afford the patient the full 180 days to make payment.

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- i. Before beginning any collection activity against any patient, including those who are not eligible for the Sponsored Care or Discount Payment Program, the hospital will provide the patient with a plain language summary of the hospital's Sponsored Care and 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 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 date the patient qualifies for the Sponsored Care or Discount Payment Policy, whichever date is later. The hospital will refund the patient within 30 days.

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

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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 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 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 and Discount Payment Program Policy and corresponding application forms.

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 actions:

- 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

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Reference Guide located in the Patient Business Services and Patient Access departments.

- c. For patients interested in Sponsored Care,, provide the patient with a copy of the plain language summary of the Sponsored Care and 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 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 that 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

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- a. Completed claims with third-party insurers are filed five days on average after the patients are discharged. Claims containing errors as detected by the billing system will be reviewed and repaired as appropriate.
- b. The Patient Business Services team will track each claim in an attempt to receive timely payment from the payer. Patient Business Services 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. 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

- 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:
 - All self-pay patients receive a 30 percent discount automatically off the bill. The first statement sent to the patient will show the discount given.
 - Patients may make interest free monthly payments for a maximum of 25 months.

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- Patients may choose other financing options available to them.
- d. Patients who fail to contact the hospital for payment arrangements or in response to collection notices, or 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. Patient Business Services 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 180 days provided they have received the same notifications and opportunities to pay as any other patients, 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 Presumptive Sponsored 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 not sell patient debt to a debt buyer unless all of the following apply:
 - The hospital has found the patient ineligible for financial assistance or the patient has not responded to any attempts to bill or offer financial assistance for 180 days;
 - The hospital includes contractual language in the sales agreement in which the debt buyer agrees to return, and the hospital agrees to accept, any account in which the balance has been determined to be incorrect due to the availability of a third-party payer, including a health plan or government health coverage program, or the patient is eligible for charity care or financial assistance;
 - The debt buyer agrees to not resell or otherwise transfer the patient debt, except to the originating hospital or a tax-exempt organization described in Section 127444, or if the debt buyer is sold or merged with another entity;
 - The debt buyer agrees not to charge interest or fees on the patient debt; and

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- The debt buyer is licensed as a debt collector by the Department of Financial Protection and Innovation.
- b. 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.
- c. 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/VP

- d. 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 by hospital-based physicians to accept the allowed amounts by the patients' insurance for the professional component of specific services.
- B. In order to assure proper billing to patients, the following procedure will be followed:
 1. When a physician, Patient Access or Patient Business Services enters into an agreement with the patient or insurance company, following an approval process, a letter is provided by the requesting party regarding the negotiated discount. The account is documented regarding the negotiation.
 2. The letter is scanned into Epic.
 3. Place patient in proper financial class. Put account back to self-pay if a statement needs to be generated.
 4. Negotiated discounts for accounts in bad debt, will be approved through the appropriate levels using e-mail. Approval e-mail will be copied in system notes. Once the negotiated payment is made, adjustment will be added using the appropriate administrative write off code below:
 - Insurance- 3006 Administrative Insurance Write Off

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- Patient – 5001 Administrative Guarantor Write-Off

CREDIT CHECK

Policy

- Credit checks may be run before or after admission if it is determined that collectability of a significant amount is questionable, or if the patient applies for financial assistance.
- Customer Service Representatives have the authority to run a patient financial tool to ascertain the ability of the guarantor to meet his/her responsibility.

When used to determine the patient's ability to pay, the the patient financial tool that determines the ability to pay and all results is stored in Epic. UNCOLLECTIBLE ACCOUNTS, WRITE-OFFS AND COLLECTION AGENCY TRANSFERS

Uncollectible accounts with a balance over \$25 may be assigned to a collection agency, following the approval process.

Policy

- No referrals to a collection agency will be made until:
 - It has been determined that we cannot locate the responsible party, or
 - Appropriate notification has been given to the responsible party, up to and including the final notice, and the account has proved uncollectible.
- 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 referred for collection after due notifications.
- Patient Business Services Customer Service Representatives have the authority to refer accounts with balances up to \$2,500 to a collection agency.
- Patient Business Services Customer Service Lead has the authority to refer accounts with balances up to \$10,000 to a collection agency.
- The Patient Business Services Customer Service Supervisor has the authority to refer accounts with balances up to \$15,000 to a collection agency.
- The assistant director of Patient Business Services may approve balances up to \$25,000 for assignment to a collection agency.

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- G. The director of Patient Business Services may approve balances up to \$50,000 for assignment to a collection agency.
- H. Patients that qualify for state programs or qualify for Sponsored Care based on their FPL reported score may be written off to Presumptive Sponsored Care instead of being sent to a collection agency, even if they do not complete their Sponsored Care application.
- I. 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.
- J. 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.

ONTENTS	DESCRIPTION
Submitted by:	Director, Revenue Cycle
Next review date:	January 2028
Effective date:	January 2022
Applicable to:	CHOMP
Approved by:	Director, Revenue Cycle
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:	AD-1029 General Administrative Procedure - Sponsored Care and Discount Payment Program