VENTURA COUNTY
HEALTH CARE AGENCY

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109.200 Patient Billing and Collections

POLICY:

It is the policy of Ventura County Medical Center (VCMC) and Santa Paula Hospital (SPH) to ensure that billing and collection of patient amounts due are standardized while meeting patient care needs to ensure no patient is refused medically necessary care.

This policy applies to facility charges for Ventura County Medical Center, Santa Paula Hospital, and all charges provided by a physician or advanced practice clinician who is employed by Ventura County Health Care Agency (VCHCA), or for fees billed by the above Organizations, to the extent such care is provided within a Hospital Facility or VCHCA Ambulatory location.

Through the use of billing statements, written correspondence, and phone calls, diligent efforts will be made to inform patients/Guarantors of their financial responsibilities and available Financial Assistance options, as well as follow up with patients/Guarantors regarding outstanding accounts. These facilities (above) will not engage in Extraordinary Collections Actions before reasonable efforts to determine whether the individual is eligible for assistance under Financial Assistance policies have been made.

DEFINITIONS:

1. **Allowable Medical Expenses** - All family members' medical expenses that are eligible for federal income tax deduction, even if the expenses are more than the medical expense deduction allowed by the Internal Revenue Service (IRS). Paid and unpaid bills may be included

2. **Amount Generally Billed (AGB)** - The amounts generally billed for emergency or other medically necessary care to individuals who have insurance covering such care. This is usually described as a percent of Gross Charges. The AGB percentages are updated annually.

3. **Application Period** – The period during which Ventura County Health Care Agency must accept and process an application for financial assistance under its Financial Assistance Policy submitted by an individual in order to have made reasonable efforts to determine whether the individual is eligible for financial assistance under the policy. The Application Period begins on the date the care is provided and ends on the latter of the 240th day after the date that the first post-discharge billing statement for the care is provided or at least 30 days after Ventura County Health

Care Agency provides the individual with a written notice that sets a deadline after which Extraordinary Collection Actions (ECA)s may be initiated.

4. Billed Charges - Charges for items and services provided by Ventura County Health Care Agency as published in the Charge Description Master (CDM) and available at www.vchca.org under Price Transparency.

5. Charge Description Master - A list of items and services, along with their individual prices and codes, used to bill for services.

6. Charity Care - Full Financial Assistance (i.e., 100% discount) to qualifying patients that relieves the patient and his or her guarantor of their entire financial obligation to pay for eligible services. Charity Care does not reduce the amount, if any, that a third party may be required to pay for eligible services provided to the patient. Charity Care is differentiated from discounts or other forms of financial assistance when discussing the amount granted under a Financial Assistance program as a full waiver of the account balance (Charity Care) versus a partial waiver of the account balance (discounts or other forms of financial assistance).

7. Discounted Care - Partial Financial Assistance to qualifying patients to relieve the patient and his or her guarantor of a portion of their financial obligation to pay for eligible services. Discounted Care does not reduce the amount, if any, that a third party may be required to pay for eligible services provided to the patient. Discounts excluded from the Financial Assistance program are usual discounts whose application is not based on an ability to pay.

8. Extraordinary Collection Action (ECA) - ECAs are legal or judicial actions taken to receive payment from a patient or any other individual who has accepted or is required to accept responsibility for care covered under the Financial Assistance Policy. Examples include garnishing a patient's wages, adverse credit reporting, or deferring or denying medically necessary scheduled care. ECAs do not include any lien entitled under state law on the proceeds of a judgment, settlement, or compromise owed to an individual (or his or her representative) as a result of personal injuries for which VCHCA provided care.

a. Suspending ECAs when a Financial Assistance Application (FAA) is Submitted means VCHCA does not initiate an ECA, or take further action on any previously initiated ECAs, to obtain payment for medically necessary care until either:

1. The Facility has determined whether the individual is FAP-eligible based on a complete FAP application and met the reasonable efforts requirement, as defined herein, with respect to a completed FAA; or

2. In the case of an incomplete FAA, the individual has failed to respond to requests for additional information or documentation within a reasonable period of time (thirty (30) days) given to respond to such requests.

9. Emergency Medical Care - Refers to Emergency Services and Care, as defined in the Ventura County Health Care Agency Emergency Medical Treatment and Labor Act policy.

10. Essential Living Expenses (ELE) - The following expenses are considered Essential Living Expenses: rent or house payment and maintenance, food, household supplies, laundry and cleaning, utilities and telephone, clothing, medical and dental payments, insurance, school or child care, child or spousal support, transportation and auto expenses, including insurance, gas, repairs and installment payments, and other extraordinary expenses.

11. Family Members –

a. Family Members, of persons 18 years or older, include a spouse, domestic partner, and dependent children under 21 years, whether living at home or not.

b. Family Members of persons under 18 years include parents, caretaker relatives, and other children of the parents or caretaker relatives who are less than 21 years of age of the parent or caretaker relatives.

12. Family Income is determined consistent with the IRS definition of Modified Adjusted Gross Income for the applicant and all members of the applicant's Family. In determining eligibility, Hospital may consider the 'monetary assets' of the patient's Family. However, for purposes of this determination, monetary assets will not include retirement or deferred compensation plans qualified under the Internal Revenue Code, or nonqualified deferred compensation plans. In addition, the first ten thousand dollars ($10,000) of the monetary assets of the patient's Family shall not be counted in determining eligibility nor shall 50% of the monetary assets of the patient's Family over the first $10,000 be counted in determining eligibility. For purposes of VCHCA's Discount Payment Program, the patient's assets or the assets of the patient's family are not considered when calculating family income.

13. FAP – Ventura County Health Agency's Healthcare Financial Assistance Policies, including Charity and Discounted Payment policies.

14. Federal Income Tax Return - The IRS form/s used to report taxable income. The IRS form must be a copy of the signed and dated forms sent to the IRS.

15. Federal Poverty Level (FPL) - The poverty guidelines updated periodically in the Federal Register by the United States Department of Health and Human Services under its statutory authority.

16. Financial Assistance - The reductions in payment obligation afforded to Ventura County Health Care Agency patients if such patients qualify for assistance under these policies.

17. Good Faith Estimate - an estimate of a patient's bill for health care items and services before those items or services are provided. This is provided to self-pay patients, and those who elect not to use their health care benefits as required by the Centers for Medicare and Medicaid Services (CMS).

18. High Medical Costs - Defined as any of the following

a. Annual Out-of-Pocket expenses, incurred by an individual at Ventura County Health Care Agency facility, that exceeds the lesser of ten percent (10%) of the patient's current family income or family income in the prior 12 months.

b. Annual Out-of-Pocket expenses that are more than ten percent (10%) of the patient's family income, if the patient provides documentation of their medical expenses paid by the patient, or the patient's family, in the prior 12 months.

19. Household Income - Cumulative income of all Family Members who live in the same household as the patient, or at the home address the patient uses on income tax returns, or on other government documents. This includes the following:

a. Gross wages, salaries, tips, etc.

b. Unemployment compensation, workers' compensation, Social Security, Supplemental Social Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income.

c. Interest, dividends, royalties, income from rental properties, estates and trusts, alimony, child support, assistance from outside the household, and other miscellaneous sources

20. Limited English Proficiency (LEP) Group - A group of people who either do not speak English, or who are unable to effectively communicate in English because it is not their native language. The size of the group is the lesser of either 1,000 individuals, or five percent (5%) of the community served by the facility, or the non-English speaking populations likely to be, affected or encountered, by the facility. The facility may use any reasonable method to determine the number, or percentage, of LEP patients that may be affected, encountered, or served by the facility.

21. Medically Necessary - A service is "medically necessary" or a "medical necessity" when it is reasonable and necessary to either (a) protect life, to prevent significant illness or significant disability, (b) to alleviate severe pain, or (c) to prevent, diagnose or treat an illness, injury, condition or disease, the symptoms of an illness, injury, condition or disease, and (d) meets accepted standards of medicine.

22. No Surprises Act - The No Surprises Act is a Federal regulation that prohibits out-of-network providers from balance billing patients for services received in certain circumstances. Additionally, it requires out-of-network providers to give out-of-network patients a notification regarding their rights regarding balance billing and requires that out-of-network providers give Good Faith Estimates to out-of-network patients for services they seek.

23. Out-of-Pocket Costs - Costs which the patient pays from personal funds.

24. Patient Financial Services (PFS) - The Ventura County Health Care Agency department responsible for billing, collecting, and processing payments.

25. Payment Plan - A series of payments, made over a period of time, to pay the patient's payment obligation for items and services provided by Ventura County Health Care Agency. Monthly

payments cannot be more than ten percent (10%) of a patient's monthly family income, excluding deductions for Essential Living Expense.

26. Pending Appeal - "Pending appeal" includes any of the following:

a. A grievance against a contracting health care service plan, as described in Chapter 2.2 (commencing with Section 1340) of Division 2, or against an insurer, as described in Chapter 1 (commencing with Section 10110) of Part 2 of Division 2 of the Insurance Code.

b. An independent medical review, as described in Section 10145.3 or 10169 of the Insurance Code.

c. A fair hearing for a review of a Medi-Cal claim pursuant to Section 10950 of the Welfare and Institutions Code.

d. An appeal regarding Medicare coverage consistent with federal law and regulations.

27. Plain Language - Writing designed to ensure the reader understands quickly, easily, and completely as possible. Plain language strives to be easy to read, understand and use.

28. Presumptive Financial Assistance - When Ventura County Health Care Agency staff may assume a patient will qualify for 100% Financial Assistance based on information given to them, e.g., homelessness, etc.

29. Qualifying Patient - Patient who meets the qualifications for Financial Assistance as defined above.

30. Reasonable Payment Plan - A payment plan is a reasonable payment plan if the monthly payments are not more than 10 percent of a patient's family income for a month, excluding deductions for essential living expenses (as defined above).

31. Self-Pay Liability - Any balance due by the person who is responsible for payment. This could be a patient, or the patient's guarantor (not a third-party payer).

32. Third-Party Coverage - A policy of insurance or other prepaid coverage purchased for protection against certain events, such as health, automobile, general liability insurance, etc.

33. Uninsured Patient – Patient who does not have insurance to cover the services received.

PROCEDURE:

1. BILLING PRACTICES

VCHCA will follow standard procedures in billing and collecting on accounts related to care provided at VCHCA as follows:

A. Insurance Billing

1. For all insured patients, VCHCA will bill applicable third-party payers (based on information provided or verified by the patient/Guarantor, or appropriately verified from other sources) in a timely manner.

2. If an otherwise valid claim is denied (or not processed) by the payer due to an error by VCHCA, VCHCA will not bill the patient for any amount in excess of what the patient would have owed had the payer paid the claim.

3. If an otherwise valid claim is denied (or not processed) by a payer due to factors outside of VCHCA's control, staff will follow up with the payer and patient as appropriate to facilitate resolution of the claim. If resolution does not occur after reasonable follow-up efforts, VCHCA may bill the patient or take other actions consistent with payer contracts.

B. Patient Billing

1. All patients/Guarantors will be billed directly and timely and receive a statement as part of the Hospital Facility's normal billing process.

2. For insured patients, after claims have been processed by all available third-party payers, Hospital Facilities will bill patients/Guarantors in a timely manner for their respective liability amounts as determined by their insurance benefits.

3. All patients/Guarantors may at any time request, and the Hospital Facility will provide, an itemized statement for their accounts.

4. If a patient disputes his or her account and requests documentation regarding the bill, staff will provide the requested documentation in writing within ten (10) days (if possible) and will hold the account for at least thirty (30) days before referring the account for collection.

5. VCHCA shall approve reasonable payment plan arrangements for patients/ Guarantors who indicate they may have difficulty paying their balance in a single installment.

6. Revenue Cycle leadership has the authority to make exceptions to this provision on a case-by-case basis for special circumstances (in accordance with operating procedures).

7. VCHCA is not required to accept patient-initiated payment arrangements and may refer accounts to a third-party collection agency as outlined below if the patient defaults on an established payment plan.

C. Collection Practices

1. Any collection activities conducted by VCHCA, or its third-party collection agents will be in conformance with all federal and state laws governing debt collection practices.

2. All patients/Guarantors will have the opportunity to contact VCHCA regarding

Financial Assistance, payment plan options, and other applicable programs that may be available with respect to their accounts.

3. VCHCA's FAP's are available free of charge, and provided at vchca.org at anytime.

4. Individuals with questions regarding FAP's may contact the Patient Financial Services office by phone or in person.

5. In compliance with relevant state and federal laws, and in accordance with the provisions outlined in this Policy, VCHCA may engage in collection activities, including Permissible ECAs, to collect outstanding patient balances.

6. General collection activities may include phone calls, statements, and other reasonable efforts in accordance with standard industry practices.

7. Patient balances may be referred to a third-party for collection at the discretion of the Patient Financial Services department and in compliance with all applicable federal, state, and local non-discrimination practices. VCHCA will maintain ownership of any debt referred to debt collection agencies, and patient accounts will be referred for collection only with the following caveats:

i. There is a reasonable basis to believe the patient owes the debt.

ii. All third-party payers identified by the patient/Guarantor in a prompt and timely manner that have been properly billed, and the remaining debt is the financial responsibility of the patient.

8. VCHCA will not refer accounts for collection while a claim on the account is pending payment from a third-party payer. However, claims which remain in "pending" status with a third-party payer for an unreasonable length of time despite efforts to facilitate resolution may be re-classified as "denied."

9. VCHCA will not refer accounts for collection when the insurance claim was denied due to an error. However, the patient liability portion of such claims may still be referred for collection if unpaid.

10. VCHCA will not refer accounts for collection where the patient has initially applied for Financial Assistance, and reasonable efforts (as defined below) with respect to the account have not yet been completed.

11. Upon receipt of a notice of Bankruptcy Discharge, VCHCA will cease all collection attempts, including assignment to a collection agency. The patient/debtor will not be contacted by any method, including phone calls, letters, or statements after receipt of the notification. All communication, if necessary, must occur with the trustee or the attorney assigned to the case.

12. VCHCA shall not send any unpaid self-pay account to a third-party collection agent as long as the patient or Guarantor is engaged and cooperating with resolution efforts.

D. ECAs - Notification Requirement

1. With respect to any medically necessary care provided, a patient must be notified about the FAP as described herein, prior to initiating an ECA. The notification requirement is as follows:

i. Notification Letter- The Hospital Facility will notify a patient about the FAP by

providing the individual with a written notice (Notification Letter) at least thirty (30) days prior to initiating an ECA. The Notification Letter must:

a) Include a plain language summary of the FAP;

b) Indicate Financial Assistance is available for eligible individuals; and

c) Identify the ECA(s) that VCHCA intends to initiate to obtain payment for if the amount due is not paid or an FAA is not submitted before a specified deadline, which is no earlier than the last day of the Application Period.

E. Reasonable Efforts when a Patient Submits an Incomplete FAA

1. VCHCA will suspend any ECAs already initiated against the patient/Guarantor until Financial Assistance eligibility has been determined.

2. VCHCA will provide a written notification to the patient with a list of required documentation the patient or Guarantor must provide to consider the FAA complete and give the patient thirty (30) days to provide the necessary information. The notification will include the contact information, including telephone number and physical location of the Patient Financial Services department that can provide information about and assist with the preparation of the FAA.

F. Reasonable Efforts when a Completed FAA Is Submitted

1. If a patient submits a completed FAA during the Application Period, VCHCA will:

i. Suspend any ECAs to obtain payment for the medically necessary care.

ii. Make a determination as to whether the individual is FAP-eligible for the care and notify the individual in writing of this eligibility determination (including, if applicable, the assistance for which the individual is eligible) and the basis for this determination.

iii. If VCHCA determines the individual is FAP-eligible for the care, the following occurs:

a) Refund the individual any amount paid for the care that exceeds the amount determined to be personally responsible for paying as a FAP-eligible individual.

b) Take all reasonably available measures to reverse any ECA, including the removal of any adverse information that was reported to a consumer reporting agency or credit bureau from the individual's credit report.

iv. If VCHCA determines the individual is not FAP-eligible, VCHCA will have made reasonable efforts and may engage in the Permissible ECAs.

G. VCHCA will refrain from ECAs against a patient if he or she provides documentation that he or she has applied for health care coverage under Medicaid, or other publicly-sponsored healthcare programs, unless or until the individual's eligibility for such programs has been determined and any available coverage from third parties for the care has been billed and processed.

All revision dates: n/a

Attachments

Approval Signatures

Step Description	Approver	Date
Oversight Committee		07/01/2023
Policy Owner	Compliance Office	12/27/2023