Billing and Collection Policy

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Approved by:	Ted Sirotta, Sr. VP, Chief Financial Officer		

PURPOSE This policy establishes Henry Mayo Newhall Hospital's principles and guidelines for patient billing and collection practices.

SCOPE Related policies include: Bad Debt Assignment, Financial Assistance Program (FAP), Patient Payment Plans

DEFINITIONS

Follow-up and Collection – Defined as account processing after billing has occurred, that is proactive, timely and efficient in moving an account toward resolution.

An account process is considered "proactive" when an active intervention occurs to move the account further along toward a more timely resolution and/or favorable outcome. It is important that the intervention takes place before a potential processing breakdown that will require additional time spent reacting to problems, such as denials.

To be considered "timely", a certain population of accounts – those with unpaid gross charges of $10,000 ($5,000 for professional fee billing accounts) or more shall receive staff intervention no less frequently than every 15 days. All other accounts shall receive staff intervention at least once every 30 days.

Account processing is "effective" when each intervention clearly moves the account toward a more timely and/or favorable outcome. Moreover, no actions on one specific account (or group of accounts for the same patient) should be repeated. For example, after ongoing follow-up with a payer regarding a delinquent payment, it is never appropriate to accept the same answer, such as, "we don't have the claim yet" or "the claim is in processing and should pay in the next couple of weeks." Effective account processing can only result when each incidence of contact escalates progress toward resolution. Responses with the health plans need to be in accordance with AB1455, California Health and Safety Code, California Department of Insurance.

PROCEDURE

GENERAL PRINCIPLES

1. All patients will be treated fairly, with dignity, compassion and respect.

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2. Henry Mayo Newhall Hospital (the "Hospital") has developed a Financial Assistance Policy (FAP) that is consistent with its purpose statement, vision and values and government regulations. The policy is broadly communicated to reflect a commitment to provide financial assistance to patients who cannot pay for part or all of the care they receive.

3. The Hospital's FAP balances a patient's need for financial assistance with the Hospital's broader financial responsibilities.

4. Debt collection practices , both for the Hospital and its external collection agencies, reflect the Hospital's purpose statement, vision and values.

5. Financial assistance provided by the Hospital is not a substitute for personal responsibility. All patients are expected to contribute to the cost of their care, based upon their individual ability to pay, and applicable laws and regulations.

6. Financial assistance will be available for both uninsured and underinsured patients, including patients that do not have the financial ability to pay for their coinsurance and deductible portions after their insurance has paid.

7. The Hospital will endeavor to provide patients with "user friendly" billing statements and use best practices in patient financial communications.

POINT OF SERVICE COLLECTIONS

Medical services will be provided to patients regardless of ability to pay, except for elective services, i.e., teeth extractions, voluntary sterilizations, and cosmetic surgery.

The Hospital's goal is to pre-register as many patients as possible. This affords the Hospital time in advance of providing the service, to verify insurance coverage, including patient deductible and copay amounts, and to discuss payment arrangements in advance with the patient, including patient financial assistance programs available by the Hospital and other agencies. In circumstances where it is possible to estimate the charges for services during the pre-registration process, the Hospital communicates this information to the patient and requests advance payment of any deductible or copay amounts. Elective services require payment in full, in advance of the scheduled service, including any outstanding balances related to prior services, unless approved by the Director of Patient Financial Services or CFO.

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Patients receiving services in the ED shall be requested by PAS to pay their estimated patient liability after the physician assessment. Inpatients and observation patients may be visited by a PAS representative to discuss and collect on self-pay accounts, deductibles and copays while the patient is on the nursing unit, if not arranged prior to admission. HMNH's financial assistance program and payment plans will also be discussed with the patient at that time, as appropriate.

For all other patients that receive other outpatient services that are not pre-registered, PAS and registration staff will attempt to collect in advance any patient liability due for services to be rendered, if indicated and determined by information contained on the patient's insurance card or insurance company's website. Any patients that do not have insurance coverage that cannot pay for their services shall be directed to a PAS Financial Counselor for further assistance.

BILLING FOLLOW-UP AND COLLECTION PRACTICES

Billing follow-up and collection responsibilities are generally allocated amongst Patient Financial Services staff by payer. The Director and Managers of Patient Financial Services will provide assistance on collecting larger balance accounts that we experience payment delays on.

The follow-up and collection activities shall be performed as defined herein and in accordance with applicable laws and regulations. It is expected that account worklists and/or accounts receivable aging reports will be used by staff to assist them in their follow-up and collection activities. Work queues/reports are periodically reviewed by the Director and Managers of Patient Financial Services to ensure timely follow-up and collection. All follow-up and collection activities shall be documented in the on-line notes section of the patient billing software.

The CFO reviews aging reports by financial classification monthly to identify trends.

FOLLOW-UP AND COLLECTION ON SELF-PAY BALANCES

The Hospital bills and collects on self-pay balances. Each bill will include a statement that indicates that the Hospital offers financial assistance to its patients that meet established criteria, and certain additional information regarding the financial assistance program as required by laws and regulations.

Patient balance statements will be sent out every thirty days. The statements will include all accounts and service dates having a self-pay balance for each patient. The fourth statement and final notice to patient shall include the following:

1. The date or dates of service of the bill that will be assigned to a collection agency if the bill is not resolved.
2. The name of the entity the bill is being assigned to if the bill is not resolved.

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3. A statement informing the patient how to obtain an itemized bill form the Hospital.
4. 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.
5. An application for the Hospital's financial assistance.
6. 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.

All accounts unresolved that are at least 180 days old (measured from the date the first bill was sent to the patient) will be moved from "pre-collections" to "collections". This will also include assigning the individual to the credit reporting agencies for outstanding balances in excess of $50. There are exceptions for patients who have an application pending for either government-sponsored coverage (e.g., Medicaid) or for the Hospital's financial assistance program, and/or they are reasonably cooperating with the Hospital in an effort to settle an outstanding bill. Under these exceptions, the Hospital may not send their bill to a collection agency.

The Hospital, or assignee of the Hospital, including a collection agency, shall not report adverse information to a consumer credit reporting agency or commence civil action against the patient for nonpayment before 180 days after initial billing.

If a patient is attempting to qualify for eligibility under the Hospital's financial assistance program and is attempting in good faith to settle an outstanding bill with the Hospital by negotiating a reasonable payment plan offered by the Hospital, the Hospital shall not send the unpaid bill to any collection agency.

For any patient that has not provided proof of coverage by a third party at the time the care is provided or upon discharge, as part of that billing, the patient shall be provided with a clear and conspicuous notice that includes all of the following:

1. A statement of charges for services rendered by the Hospital.
2. A request that the patient inform the Hospital if the patient has health insurance coverage, Medicare, Medi-Cal, or other coverage.
3. A statement that, if the patient does not have health insurance coverage, the patient may be eligible for Medicare, Medi-Cal, coverage offered through California Health Benefit Exchange, California's Children's Services, other state or county funded health coverage, or charity care.
4. A statement indicating how patients may obtain applications for the Medi-Cal program, coverage offered through the California Health Benefit Exchange, or other state or county funded health coverage programs and that the Hospital will provide these applications. The Hospital shall also provide patients with a referral to a local consumer

assistance center housed at legal services offices. If the patient does not indicate coverage by a third party payer or requests a discounted price or charity care, then the patient shall be provided an application for the Medi-Cal program or other state or county funded health coverage programs. This application shall be provided prior to discharge if the patient has been admitted or to patients receiving emergency or outpatient care.

5. Information regarding the Hospital's financial assistance application, including the following:
    a. A statement that indicates that if the patient lacks, or has inadequate insurance, and meets certain low and moderate income requirements, the patient may qualify for financial assistance.
    b. The name and phone number of a Hospital employee or office from whom or which the patient may obtain information about the Hospital's financial assistance program, and how to apply for that program.
    c. If a patient applies, or has a pending application, for another health coverage program at the same time that the patient applies for the Hospital's financial assistance program, neither application shall preclude eligibility for the other program.

Any legal actions to be taken against the patient for outstanding amounts owed to the Hospital, including such actions that may be taken by the Hospital's collection agencies, must be approved by the CFO (unless otherwise noted below), and are subject to the following guidelines:

- Liens may be placed on assets, including primary residences for outstanding balances in excess of $5,000; however, foreclosures on primary residences are prohibited. Liens on primary residences are not permitted for patients that qualify for financial assistance.
- Liens may be placed on a patient's third-party claims, i.e., automobile accidents, with the exception of verified workers' compensation claims. No CFO approval is required.
- Wage garnishments are not permitted.
- Liens against judgments are permitted.

Legal action shall be considered a last resort after all reasonable collection efforts have been exhausted. Charges incurred related to any legal fees and court costs may be charged to the patient.

If there is no means to contact the patient or patient's family, i.e., phone number is disconnected, return mail, Hospital staff or Hospital's early out contracted billing services may utilize skip tracing, access to databases, or other reasonable and lawful means to locate and communicate with the patient or their legal representative to attempt collection. As soon as it is determined that the patient or their legal representative cannot be located or contacted, but in

no event earlier than 180 days after initial billing to patient, the balance will be referred to a collection agency if the account does not qualify for charity per our financial assistance policy guidelines.

Upon a Hospital contracted collection agency's first attempt to collect a debt from a Hospital patient, the collection agency shall, among other regulatory requirements, include in the first written communication to the patient a copy of the final notice provided by Hospital prior to referring the account to a collection agency, along with information about the Hospital's financial assistance program and a financial assistance application.

OTHER

The Hospital shall obtain a written agreement from any service it contracts with to collect Hospital receivables that such service will adhere to all applicable Hospital policies and procedures with respect to financial assistance, billing and collection practices, and payment plans as well as all applicable federal, state, and local regulations.

References:

Patient Protection and Affordable Care Act
IRS Notice 2014-2 issued on December 30, 2013
Healthcare Financial Management Association Patient Financial Communications Best Practices (2014)
Healthcare Financial management Association Patient Friendly Billing Guidelines
California AB 1020