San Joaquin General Hospital	Department Patient Financial Services		Page: 1
	Policy/Procedure No.	Effective Date: 01/01/2025	Date Replaces:
Title of Policy/Procedure San Joaquin General Hospital, Billing and Collection Policy			

POLICY:

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To provide clear and consistent guidelines for conducting billing, collections, and recovery functions in a manner that promotes compliance with applicable collection laws and regulations, patient satisfaction, and efficiency.

PURPOSE:

This Policy outlines the circumstances under which San Joaquin General Hospital (the Hospital) will undertake collections actions on delinquent patient accounts related to the provision of Emergency Medical Care and Medically Necessary Care (herein referred to as EMCare) and identifies Permissible Collections Activities. This Policy describes the actions that San Joaquin General Hospital may take to obtain payment of a bill for EMCare in the event of non-payment, including, but not limited to, any permissible collection actions.

PROCEDURE:

After patients have received services, the Hospital will bill patients/Guarantors and applicable payers accurately and in a timely manner. During this billing and collections process, staff will provide quality customer service and timely follow-up, and all outstanding accounts will be handled in accordance with all applicable laws and regulations. In addition, San Joaquin General Hospital values require that all individuals be treated with reverence and compassion.

APPLICATION

A. This Policy applies to:

- All charges for EMCare provided by the Hospital.

- All charges for EMCare provided by a physician or advanced practice clinician who is employed by the Hospital, to the extent such care is provided within the hospital or clinic.

- Non-covered Medically Necessary Care provided to patients where the patient would bear responsibility for the charges, such as charges for days beyond a length of stay limit or in circumstances where the patient's benefits have been exhausted.

- Any collection and recovery activities conducted by the Hospital or a designated supplier of billing and collections services (Designated Supplier), or its third-party collection agents of the Hospital to collect amounts owed for EMCare described above. All third-party

agreements governing such collection and recovery activities must include a provision requiring compliance with this Policy and indemnification for failures as a result of its noncompliance. This includes, but is not limited to, agreements between third-parties who subsequently sell or refer debt of the Hospital.

B. Coordination with other laws

The provision of Financial Assistance and billing and collection of patient accounts may now or in the future be subject to additional regulation pursuant to federal, state, or local laws. Such law governs to the extent it imposes more stringent requirements than this Policy. In the event that a subsequently adopted state or local law directly conflicts with this Policy, the Hospital shall, after consultation with legal counsel, the Hospital Revenue Cycle leadership, and the Hospital Tax leadership, be permitted to adopt an addendum to this Policy before the next policy review cycle, with such minimal changes to this Policy as are necessary to achieve compliance with any applicable laws.

PRINCIPLES

Through the use of billing statements, written correspondence, and phone calls, the Hospital will make diligent efforts to inform patients/Guarantors of their financial responsibilities and available Financial Assistance options, as well as follow up with patients/Guarantors regarding outstanding accounts. San Joaquin General Hospital serves to meet the needs of patients and others who seek care, regardless of their financial abilities to pay for the services provided.

DEFINITIONS

Amounts Generally Billed (AGB) means the maximum charge a patient who is eligible for Financial Assistance under this Financial Assistance Policy is personally responsible for paying, after all deductions and discounts (including discounts available under this Policy) have been applied and less any amounts reimbursed by insurers. No patient eligible for Financial Assistance will be charged more than the AGB for EMCare provided to the patient. San Joaquin General Hospital calculates the AGB using the “lookback” method by multiplying the “Gross Charges” for any EMCare that it provides by AGB percentages, which are based upon past claims allowed under Medicare and private insurance as set forth in federal law. “Gross Charges” for these purposes means the amount listed on the Hospital’s chargemaster for each EMCare service.

Emergency Medical Care, EMTALA - Any patient seeking care for an emergency medical condition within the meaning of Section 1867 of the Social Security Act (42 U.S.C. 1395dd) at San Joaquin General Hospital shall be treated without discrimination and without regard

to a patient's ability to pay for care. Furthermore, any action that discourages patients from seeking EMCare, including, but not limited to, demanding payment before treatment or permitting debt collection and recovery activities that interfere with the provision of EMCare, is prohibited. San Joaquin General Hospital shall also operate in accordance with all federal and state requirements for the provision of care relating to emergency medical conditions, including screening, treatment and transfer requirements under the federal Emergency Medical Treatment and Labor Act (EMTALA) and in accordance with 42 CFR 482.55 (or any successor regulation). The Hospital should consult and be guided by any San Joaquin General Hospital EMTALA Policy, EMTALA regulations, and applicable Medicare/Medicaid Conditions of Participation in determining what constitutes an emergency medical condition and the processes to be followed with respect to each.

Extraordinary Collection Actions (ECAs) - The Hospital will not engage in ECAs against an individual prior to making a reasonable effort to determine eligibility under the Hospital's FAP. An ECA may include selling an individual's debt to another party except as expressly provided by federal law

ECAs do not include any lien that the Hospital is entitled to assert 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 the Hospital provided care. The Hospital will not seek any lien against the patient's real property and will not seek any wage garnishment as a means of collecting any unpaid debt.

Financial Assistance means assistance provided to patients for whom it would be a financial hardship to fully pay the expected out-of-pocket expenses for EMCare provided at the Hospital and who meet the eligibility criteria for such assistance. Financial Assistance is offered to insured patients to the extent allowed under the patient's insurance carrier contract.

Financial Assistance Policy (FAP) means San Joaquin General Hospital's, *Financial Assistance Policy*, which describes the Hospital's Financial Assistance program, including the criteria patients/Guarantors must meet in order to be eligible for Financial Assistance as well as the process by which individuals may apply for Financial Assistance.

Guarantor means an individual who is legally responsible for payment of the patient's bill.

Medically Necessary Care means any procedure reasonably determined (by a provider) to be necessary to prevent, diagnose, correct, cure, alleviate, or avert the worsening of any condition, illness, injury or disease that endangers life, cause suffering or pain, results in illness or infirmity, threatens to cause or aggravate a handicap, or cause physical deformity or malfunction, or to improve the functioning of a malformed body member, if there is no

other equally effective, more conservative or less costly course of treatment available. Medically Necessary Care does not include elective or cosmetic procedures only to improve aesthetic appeal of a normal, or normally functioning, body part.
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Notification Period means the 180-day period beginning on the date the Hospital provides the first post-discharge billing statement for the EMCare. The Hospital will refrain from engaging in an ECA during the Notification Period, unless reasonable efforts have been made to determine a patient is eligible for Financial Assistance.

Presumptive Financial Assistance means the determination of eligibility for Financial Assistance that may rely on information provided by third-party vendors and other publicly available information. A determination that a patient is presumptively eligible for Financial Assistance will result in free or discounted EMCare for the period during which the individual is presumptively eligible. See also Presumptive Eligibility in San Joaquin General Hospital's *Financial Assistance Policy.*

Suspending ECAs when a Financial Assistance Application (FAA) is Submitted means the Hospital (or other authorized party) does not initiate an ECA, or take further action on any previously initiated ECAs, to obtain payment for the EMCare until either:
- The Hospital 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
- 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.

Uninsured means an individual having no third-party coverage by a commercial third-party insurer, an ERISA plan, a Federal Health Care Program (including without limitation Medicare, Medicaid, SCHIP, and TRICARE), Worker's Compensation, or other third-party assistance to assist with meeting his or her payment obligations.

Underinsured means an individual with private or public insurance coverage, for whom it would be a financial hardship to fully pay the expected out-of-pocket expenses for EMCare covered by this Policy.

BILLING PRACTICES

San Joaquin General Hospital will follow standard procedures in collecting on accounts related to EMCare provided at the Hospital as follows:

A. Insurance Billing

- For all insured patients, the Hospital 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.

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

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

B. Patient Billing

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

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

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

- 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.

- The Hospital shall approve payment plan arrangements for patients/Guarantors who indicate they may have difficulty paying their balance in a single installment.

- 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).

- The Hospital 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

- Any collection activities conducted by the Hospital, a Designated Supplier, or its third-party collection agents will be in conformance with all federal and state laws governing debt collection practices.

- All patients/Guarantors will have the opportunity to contact the Hospital regarding Financial Assistance, payment plan options, and other applicable programs that may be available with respect to their accounts.

o The Hospital's FAP is available free of charge.

o Individuals with questions regarding the Hospital's FAP may contact the financial counseling office by phone or in person.

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

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

o The Patient Financial Services Director shall have authority to advance any patient debt for collection activities in accordance with this policy. Patient balances may be referred to a third-party for collection at the discretion of the Patient Financial Services Director and in compliance with all applicable federal, state, and local non-discrimination practices. The Hospital will maintain ownership of any debt referred to debt collection agencies, and patient accounts will be referred for collection only with the following caveats:

- There is a reasonable basis to believe the patient owes the debt. In determining the amount of debt the Hospital seeks to recover from any patient who is eligible under the Hospital's Charity Care Policy or other discount payments policy, the Hospital shall consider only income and monetary assets as limited by California Health and Safety Code section 127405.

- 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. The Hospital shall not bill a patient for any amount the insurance company or a third-party is obligated to pay.

- The Hospital 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."

- The Hospital will not refer accounts for collection when the insurance claim was denied due to a Hospital error. However, the Hospital may still refer the patient liability portion of such claims for collection if unpaid.

- The Hospital will not refer accounts for collection where the patient has initially applied for Financial Assistance, and the Hospital has not yet made reasonable efforts (as defined below) with respect to the account.

- Upon receipt of a notice of Bankruptcy Discharge, San Joaquin General Hospital 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.

The Hospital will not use any information from tax returns, paystubs, or the monetary asset documentation collected to determine eligibility for the Charity Care Policy or other discount payment programs for any collections activities.

REASONABLE EFFORTS AND EXTRAORDINARY COLLECTION ACTIONS

Before engaging in ECAs to obtain payment for EMCare, the Hospital must make reasonable efforts to determine whether an individual is eligible for Financial Assistance. In no event will an ECA be initiated prior to 180 days (or longer, if required by applicable law) from the date the Hospital provides the first post-discharge billing statement (i.e., during the Notification Period) unless all reasonable efforts have been made. The following scenarios describe the reasonable efforts that the Hospital must take before engaging in ECAs.

A. Engaging in ECAs – Notification Requirement

▪ With respect to any EMCare provided in the Hospital, a patient must be notified about the FAP as described herein, prior to initiating an ECA. The notification requirement is as follows:

o **Notification Letter -** The Hospital 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:

- ▪ Include a plain language summary of the FAP;
- ▪ Indicate Financial Assistance is available for eligible individuals; and
- ▪ Identify the ECA(s) that the Hospital (or other authorized party) intends to initiate to obtain payment for the EMCare if the amount due is not paid or an FAA is not submitted before a specified deadline.

o **Oral Notification -** In conjunction with the provision of the Notification Letter, the Hospital will attempt to orally notify the patient about how to obtain assistance under the FAP during the registration process, using the most current telephone number provided by the patient. This attempt will be documented contemporaneously.

o **Notification in the Event of Multiple Episodes of Care** - The Hospital may satisfy this notification requirement simultaneously for multiple episodes of EMCare and notify the individual about the ECAs the Hospital intends to initiate to obtain payment for multiple outstanding bills for EMCare. However, if the Hospital aggregates an individual's outstanding bills for multiple episodes of EMCare before initiating one or more ECAs to obtain payment for those bills, it will have not have made reasonable efforts to determine whether the individual is FAP-eligible unless it refrains from initiating the ECA(s) until 180 days after the first post-discharge billing statement for the most recent episode of EMCare included in the aggregation.

B. Reasonable Efforts when a Patient Submits an Incomplete FAA

▪ The Hospital will suspend any ECAs already initiated against the patient/Guarantor until Financial Assistance eligibility has been determined.

▪ The Hospital 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 Hospital or department within the Hospital that can provide information about and assist with the preparation of the FAA.

C. Reasonable Efforts when a Completed FAA Is Submitted

- If a patient submits a completed FAA, the Hospital must:

  o Suspend any ECAs to obtain payment for the EMCare.

  o Make a determination as to whether the individual is FAP-eligible for the EMCare 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.

  o If the Hospital determines the individual is FAP-eligible for the EMCare, the Hospital must do the following:

    - Refund the individual any amount he or she has paid for the EMCare (whether to the Hospital or any other party to whom the Hospital has referred or sold the individual's debt for the EMCare) that exceeds the amount he or she is determined to be personally responsible for paying as a FAP-eligible individual.

    - 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.

  o If the Hospital determines the individual is not FAP-eligible for the EMCare, the Hospital will have made reasonable efforts and may engage in the Permissible ECAs.

D. Reasonable Efforts when No FAA Is Submitted within ninety (90) days after the First Post-Discharge Billing Statement for the Most Recent Episode of EMCare

- The Hospital will issue the Notification Letter as described under Reasonable Efforts – Engaging in ECAs – Notification Requirement. If no FAA is received within thirty (30) days after the Notification Letter has been sent, the requirement to engage in reasonable efforts to determine FAP-eligibility will have been satisfied. Thus, the Hospital may engage in ECAs that are permitted under this Policy beginning 180 days after the first post-discharge billing statement.

- **Waiver** - Under no circumstances will the Hospital accept from any individual a waiver, whether oral or written, that an individual does not wish to apply for Financial Assistance, for the purpose of satisfying the requirements to engage in reasonable efforts described in this Policy.

E. Permissible Extraordinary Collections Actions

- After making reasonable efforts, which includes the notification requirement, to determine Financial Assistance eligibility as outlined above, the Hospital (or other authorized party) may engage in the following ECAs to obtain payment for EMCare:

  o Selling an individual's debt to another party except as expressly provided by federal law; and

  o Reporting adverse information about the individual to consumer credit bureaus.

The Hospital 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 EMCare has been billed and processed.

F. Reasonable Efforts - Third-Party Agreements

- With respect to any sale or referral of an individual's debt related to EMCare to another party (except for those debt sales not considered an ECA as described in the Internal Revenue Service Treasury Regulations) the Hospital will enter into and, to the extent applicable, enforce a legally binding written agreement with the party. To meet the requirement to engage in reasonable efforts to determine an individual's FAP-eligibility, these agreements must, at a minimum, include the following provisions:

  o If the individual submits an FAA (whether complete or incomplete) after the referral or sale of the debt, the party will Suspend ECAs to obtain payment for the EMCare.

  o If the individual submits an FAA (whether complete or incomplete) after the referral or sale of the debt and is determined to be FAP-eligible for the EMCare, the party will do the following in a timely manner:

    - Adhere to procedures specified in the agreement and this Policy so that the individual does not pay, and has no obligation to pay, the party and the Hospital together more than he or she is required to pay for the EMCare as a FAP-eligible individual.

- If applicable, and if the party (rather than the Hospital) has the authority to do so, take all reasonably available measures to reverse any ECA (other than the sale of a debt) taken against the individual.

o If the third-party contractor refers or sells the debt to a subsequent party (the fourth party,) the third-party will obtain a written agreement from that subsequent party including all the elements described under this section.

o The third-party contractor must make reasonable attempts to work with a patient with unpaid bills to resolve his/her account. Aggressive or unethical collection practices are not tolerated.

G. Reasonable Efforts – Providing Documents Electronically

- The Hospital may provide any written notice or communication described herein electronically (for example, by email) to any individual who indicates he or she prefers to receive the written notice or communication electronically.

FINANCIAL ASSISTANCE DOCUMENTATION

A. Processing Requests

- Requests for Financial Assistance shall be processed promptly, and Hospital shall notify the patient or applicant in writing within thirty (30) to sixty (60) days of receipt of a completed application.

- The Hospital will not make a determination of eligibility on information it has reason to believe is false or unreliable or obtained through the use of coercive practices.

- If eligibility is approved based on the completion of an FAA, the patient will be granted Financial Assistance for all eligible accounts incurred for services received.

- If eligibility is approved based on Presumptive Eligibility criteria, Financial Assistance will also be applied to all eligible accounts incurred for services.

- If denied eligibility for Financial Assistance offered by the Hospital, a patient or Guarantor may re-apply whenever there has been a material change of income or status.

- Patients/Guarantors may seek a review from the Hospital in the event of a dispute over the application of this Policy or the FAP. Patients/Guarantors denied Financial Assistance may also appeal their eligibility determination.

- The basis for the dispute or appeal should be in writing and submitted within three (3) months of the decision on Financial Assistance eligibility.

- The Hospital will postpone any determination of FAP eligibility because the Hospital is awaiting the results of a Medicaid application.

B. Presumptive Financial Assistance

- Reasonable efforts to determine FAP-eligibility are not required when an individual is determined eligible for Presumptive Financial Assistance.

- **Medicaid** - Medicaid patients who receive non-covered medically necessary services will be considered for Presumptive Financial Assistance. Financial assistance may be approved in instances prior to the Medicaid effective date.

RESPONSIBILITY

San Joaquin General Hospital Revenue Cycle leadership is ultimately responsible for determining whether the Hospital has made reasonable efforts to determine whether an individual is eligible for Financial Assistance. This body also has final authority in deciding whether the Hospital may proceed with any of the ECAs outlined in this Policy.

REFERENCES

San Joaquin General Hospital, *Financial Assistance Policy*

ANNUAL APPROVAL

APPROVED BY THE SAN JOAQUIN COUNTY BOARD OF SUPERVISORS: [DATE]

Revised:							
Reviewed							