

Title: Debt Collections Policy**Home Department: Patient Services****IMPORTANT NOTICE:**

The official version of this document is contained in the Policy and Procedure Manager (PPM) and may have been revised since the document was printed.

Debt Collections Policy**I. Purpose**

- a. West Covina Medical Center and its facilities, (the "Organization"), provide compassionate care to patients when they need hospital services. All patients or their guarantors have a financial responsibility related to services received at the Organization, and must make arrangements for payment, either before or after services are rendered. Such arrangements may include payment by an insurance plan, including programs offered through the Federal and California government. Payment arrangements may also be made directly with the patient, subject to the payment terms and conditions of the Organization. The Organization is committed to ensuring that conversations about financial obligations do not unreasonably impact the scheduling of care.
- b. This Policy sets out the guidelines and procedures for establishing fair, reasonable, and consistent means for collection of patient accounts owed to the Organization and ensures the Organization and any collection agency that the Organization partners with, treat all patients, their families, and other contacts with fairness, dignity, compassion, and respect. Additionally, this Policy ensures that the Organization and its assigned collection agencies comply with all applicable Federal and California law, organizational policies and procedures, and industry best practices including, without limitation, the following laws and their implementing regulations:
 - i. 26 U.S.C. Section 501 (r) et. seq. Additional Requirements for Certain Hospitals.
 - ii. 15 U.S.C. Section 1692 et seq. Debt Collection Practices.
 - iii. California Civil Code section 1788 et seq. Fair Debt Collection Practices.
 - iv. California Health & Safety Code section 1339.50 et seq. Payers' Bill of Rights.
 - v. California Health & Safety Code section 127400 et seq. Hospital Fair Pricing Policies.
 - vi. The American Hospital Association Patient Billing Guidelines Affirmation.

II. Policy**a. General Practices**

Title: Debt Collections Policy**Home Department: Patient Services****IMPORTANT NOTICE:**

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- i. If a patient account is payable by insurance, then the initial bill will be forwarded directly to the designated insurer to obtain any or all amounts owed by the insurer.
- ii. Patient balances, after insurance payments, will be billed directly to the patient.
- iii. The Organization and the patient share responsibility for timely and accurate resolution of all patient accounts. Patient cooperation and communication is essential to this process. The Organization shall make reasonable and consistent efforts to assist patients with the fulfillment of their financial responsibilities.
- iv. Payment Plans may be arranged with the Organization, on a case-by-case basis. Payment plans may be entered into in connection with the granting of assistance under the Organization's Financial Assistance Policy or as part of a debt payment arrangement between the Organization and a patient.
 1. Payment plans shall generally have a term no longer than 12-months and are free of interest charges and set-up fees.
 2. It is the patient or guarantor's responsibility to contact the Organization if circumstances change, and payment plan terms cannot be met.
 3. Once approved, any failure to pay in accordance with the payment plan terms will constitute a default, and the Organization may cancel the payment plan and begin collection activities only after the patient's failure to make payments in the amount due over any continuous 90-day period, in accordance with Federal and California law.
 - a. Prior to canceling a payment plan, the Organization shall make a reasonable attempt to notify the patient both orally and in writing that the payment plan may be cancelled, and there may be an opportunity, upon the patient's request, to renegotiate the plan terms.
 - b. The Organization shall attempt to renegotiate the terms of the defaulted payment plan, if requested by the patient.
 - c. Upon any cancellation of a payment plan, the patient's financial responsibility shall not exceed the discounted principal amount agreed under the payment plan and the patient shall receive

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credit for any payments previously made under the extended payment plan.

- v. The Organization provides the following information and special assistance to all patients:
 - 1. The Plain Language Summary of the Financial Assistance Policy.
 - 2. A Financial Assistance Application ("FAP Application") and/or an application to Medi-Cal or other appropriate government assistance program to uninsured patients, receiving non-emergency services, upon admission or prior to discharge, or in some circumstances, within 72-hours of providing services.
 - 3. Assistance in applying for its financial assistance or government assistance, at no cost to the patient.
 - 4. A written bill for services rendered by the Organization.
 - 5. A summary statement, upon request, with the expected payment by insurance, if applicable, and any or all amounts due and payable by the patient.
 - 6. A written request that the patient provide information on their health insurance coverage, if not already provided.

b. Required Approvals for Extraordinary Collection Actions

The Organization complies with Federal and California legal and regulatory requirements related to debt collection practices. The Organization shall not initiate an Extraordinary Collection Action except in accordance with this Policy, and applicable law. The Organization and any collection agency the Organization partners with:

- i. Are never permitted to engage in the following ECAs:
 - 1. Sell patient debt.
 - 2. Garnish an individual's wages.
 - 3. Foreclose on real property.
 - 4. Attach or seize an individual's bank account or other personal property.
 - 5. Cause an individual's arrest or writ of body attachment.
 - 6. Provide notice or conduct a sale of the patient's primary residence.

Title: Debt Collections Policy**Home Department: Patient Services****IMPORTANT NOTICE:**

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7. Require payment before providing medically necessary care due to outstanding bills for prior care.
8. Defer or deny medically necessary care because of non-payment of a bill for previously provided care covered under the Financial Assistance Policy.
- ii. Shall wait 180-days from the date of the first post-discharge billing statement prior to reporting any adverse information about the individual to consumer credit reporting agencies in accordance with applicable law. This action is never permitted for low-income uninsured individuals.
- iii. Shall receive approval from the Chief Financial Officer or their designee, as approved by the Chief Financial Officer and President, prior to initiating any other collection activity.
- iv. Shall not use information obtained by the Organization in connection with a patient's FAP Application for financial assistance for collection activities.

c. Suspending Collection Actions

- i. **Pending Financial Assistance FAP Application.** If a patient has properly submitted an approved FAP Application, then the Organization shall immediately suspend assignment of an account to a collection agency, or any initiated ECA until the application process is complete, or 30 days, whichever time period is longer.
- ii. **Pending government-sponsored coverage.** For patients who have an application pending for government-sponsored coverage or programs, the Organization shall not knowingly assign the account to a collection agency prior to 240 days from the date of initial billing, post-discharge.
- iii. **Cooperation to settle outstanding bill.** The Organization shall not knowingly assign an account to a collection agency for patient portions that qualify for financial assistance, or if the patient has negotiated a payment plan and is reasonably cooperating to settle an outstanding bill. Collection activities will resume in accordance with applicable laws and regulations if the patient/guarantor becomes delinquent in fulfilling the payment plan.

Title: Debt Collections Policy**Home Department: Patient Services****IMPORTANT NOTICE:**

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- iv. **Pending notice of Hospital Bill Complaint Program.** All payment collection activities by the Organization's collection agencies shall stop upon receipt of notice that a patient has submitted a complaint to the Department of Health Care Access and Information's ("HCAI") Hospital Bill Complaint Program. Collection agency activities will not resume until the complaint has been resolved, as confirmed by HCAI.
- d. **Reasonable Steps to Determine Eligibility for Financial Assistance.** Prior to assigning an account to a collection agency or initiating any ECA, the Organization shall have taken the following steps to determine a patient's financial assistance eligibility, as applicable:
 - i. **Reasonable Efforts Based on Notifications, Screenings and Amounts Not Eligible**
 - 1. The Organization shall notify patients of its financial assistance program before assigning an account to a collection agency or initiating any ECA to obtain payment for the care.
 - 2. If the patient has not submitted a FAP Application, or is determined ineligible for financial assistance, then ECAs may be initiated only as permitted by applicable law and in accordance with this Policy.
 - 3. The Organization shall not assign any patient account to a collection agency unless the Organization has first performed to the best of its ability, with reasonable effort, a patient profile/screen, and determined to its satisfaction that the patient:
 - a. Does not qualify for alternative payor sources.
 - b. Is not agreeable to applying for government insurance or programs.
 - c. Is not agreeable to payment plan/extended payment plan or is no longer cooperating with a negotiated payment plan.
 - ii. **Presumptive Eligibility.** The Organization may determine that the patient is eligible for financial assistance based on a presumptive eligibility process. Additional information regarding presumptive eligibility is found in the Financial Assistance Policy.
 - iii. **Final Notice and Notifications to Patients 30 Days Before Actions.**

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1. In compliance with Federal law, at least 30-days before assigning an account to a collection agency or initiating any ECAs, the Organization shall:
 - a. Provide the Plain Language Summary.
 - b. Identify the ECAs that the Organization intends to initiate and state a deadline after which they may be initiated, which can be no earlier than 30 days after the date that the written notice is provided.
 - c. Prior to initiating any ECAs, the Organization shall make a reasonable effort to orally notify the patient about the financial assistance program and how the patient may obtain assistance with the FAP Application.
2. In compliance with California law, before the Organization assigns a bill to collections, the Organization shall send the patient a final notice with the following information:
 - a. The name of the entity to which the bill is being assigned.
 - b. Date(s) of service of the bill that is being assigned.
 - c. Name and plan type of the health coverage for the patient.
 - d. Date(s) associated with financial assistance notices, applications, and/or decisions.
 - e. A FAP Application for financial assistance.
 - f. Information on how to obtain an itemized bill.
- iv. **Notification Before Actions in the Event of Multiple Episodes of Care.** The Organization may satisfy the notification requirements described above for multiple episodes of care in a notice that covers multiple billing statements. However, if aggregated, then the Organization must refrain from assigning debt to a collection agency or initiating an ECA until 120 days after it provided the first post-discharge billing statement for the most recent episode of care, included in the aggregation.

e. Assignment of Patient Accounts to Collection Agencies

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- i. When the Organization assigns an account to a collection agency, the amount that will be assigned for collection will be the amount remaining after any and all prior discount arrangements or waivers have been applied to the account balance.
- ii. Account balances meeting certain thresholds are reviewed by either the Associate Director or Executive Director of Patient Services. Additionally, the Organization has established minimum thresholds for assigning accounts to a collection agency.
- iii. If a collection agency determines that a patient account qualifies for an alternative source of payment or determines that the patient does not have sufficient assets, then the collection agency shall return the account to the Organization with an explanation of the determination and the supporting data. The Organization will attempt to collect from the alternate source and/or work to qualify the patient for financial assistance.
- iv. If a patient asks a collection agency whether the Organization offers a discount from its billed amount based on a patient's status as a cash-paying patient (no third-party coverage), then the collection agency will promptly validate for the patient the discount applied to all cash-paying patients and, if appropriate, notify the patient of the Organization's financial assistance program. If the patient desires to negotiate an additional discount above the discount provided, then the agency may notify the Organization for authority to adjust the account as appropriate.
- v. Prior to filing any legal action against a patient, the collection agency shall ensure all legal and regulatory requirements related to fair debt collection practices are met and have confirmed multiple attempts were made to reach and negotiate with the patient. The collection agency shall also:
 1. Perform an analysis of the patient's assets and income to determine whether the patient has assets and income sufficient to justify filing the legal action; and
 2. Have the Organization review the analysis and receive approval from the Vice President, Finance and Chief Revenue Cycle Officer or their designee before the filing of any legal action against the patient.

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- f. **No Assignment or Subcontracting.** Collection agencies may not assign or subcontract the collection of any account without:
 - i. The prior written consent of the Vice President, Finance and Chief Revenue Cycle Officer or their designee; and
 - ii. A written agreement by the assignee or subcontractor to comply with this Policy and Federal and California requirements.
- g. **General Requirements Prior to Collection Agency Action**
 - i. **Consistency in Billing Statements.** At the time of billing, the Organization shall provide to all low-income uninsured patients the same information concerning services received and amounts billed related to those services as it provides to all other patients who receive care at the Organization. The term "low-income uninsured patient" is a patient eligible for assistance under the Financial Assistance Policy.
 - ii. **Notice of Financial Assistance Availability.** In its collection letters and statements to all patients, the Organization shall include language to inform patients if they meet certain income requirements, then they may be eligible for government-sponsored payor programs or financial assistance from the Organization. Patient bills shall also include the name/title or department and telephone number to contact for additional information.
- h. **Relationships with Collection Agencies**
 - i. **Compliance with Law, Policies and Standards.**
 - 1. Collection agencies contracted with the Organization must attest to, and always comply with Federal and California laws applicable to the collection of consumer and patient debts.
 - 2. Collection agencies are required to treat patients, their families, and other contacts fairly, and with dignity, compassion and respect.
 - 3. Collection agencies must review and comply with the Organization's policies and standards, including, without limitation, the payment plan provisions of this Policy and the Financial Assistance Policy.

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- ii. **Standards for Contracting with Collection Agencies.** The Organization shall not engage any collection agency to collect patient accounts unless:
 - 1. The arrangement is set forth in a written agreement signed by the collection agency and the Vice President, Finance and Chief Revenue Cycle Officer or their designee and
 - 2. The written agreement attaches this Policy, or includes language that matches this Policy, as an exhibit and requires the collection agency to comply.

i. Recordkeeping

- i. The Organization shall maintain adequate documentation to ensure compliance with the requirements of this Policy.
- ii. The Organization shall submit this Policy to the California Department of Health Care Access and Information ("HCAI") as required by applicable law.
- iii. Each Collection Agency that contracts with the Organization is required to maintain adequate documentation to show compliance with the requirements of Federal and California consumer debt collection laws and all other requirements based on the most current version of this Policy and the Financial Assistance Policy.

III. Definitions

- a. **Collection Agency** means an outside agency assigned debt collection activities for the Organization.
- b. **Extraordinary Collection Actions ("ECAs")** means collection activities that the Organization will not undertake before making reasonable efforts to determine whether a patient is eligible for financial assistance under this Policy. Extraordinary Collection Actions are defined in the Code of Federal Regulations, 26 CFR Section 501(r)-6.

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- c. **Financial Assistance FAP Application** means the application that can be used to participate in the Organization's financial assistance program. Additional information on the application processes can be found in the Financial Assistance Policy.
- d. **Financial Assistance Program** mean's the Organization's program that utilizes a single, unified patient application for both full and partial financial assistance. Additional information on the program can be found in the Financial Assistance Policy.
- e. **Payment Plan** means an agreement between the Organization and the patient, whereby the Organization has offered, and the patient has accepted the opportunity to pay off their liability in monthly payments. Eligibility is based on certain family income thresholds, excluding deductions for Essential Living Expenses.
- f. **Plain Language Summary** means a document that notifies patients and other individuals that the Organization offers financial assistance under the Financial Assistance Policy in accordance with Federal and California law. The document is clear, concise, and easy to understand. Additional information on the Plain Language Summary can be found in the Financial Assistance Policy.

POLICY



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Statement of Certification

This Policy will be submitted to the Department of Health Care Access and Information (HCAI). Additionally, it will be made available on the Organization's website.

The Organization attests under penalty or perjury to the following:

1. The individual submitting the policy is duly authorized to submit policies on behalf of the Organization.
2. This submitted policy is a true and correct copy of the Policy for which this certification is included.