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Policy Area Administrative -
Fiscal

109-Xxx Bad Debt Assignment Policy

POLICY

Ventura County Health Care Agency maintains a process for resolving open balances, and at times, patients unwilling to pay or arrange payment for services rendered may be referred to an outside entity for collection of unpaid encounter (account) balances. This policy addresses expectations for Collection Agencies assigned Bad Debt, and accounting of uncollectible amounts for financial, regulatory and Cost Reporting purposes.

DEFINITIONS

1. **Bad Debt (BD)** – Amounts remaining after internal collection efforts have ceased, deemed uncollectible, and sent to a Collection Agency.
2. **Bad Debt Collection Agency (CA)** - An outside agency assigned debt collection activities for VCHCA.
3. **FAP** – Ventura County Health Agency's Healthcare Financial Assistance Policies, including Charity and Discounted Payment policies.
4. **Low-Income Uninsured Patient** - A patient eligible for assistance under one or more Financial Assistance Policies.
5. **Payment Plan** - An agreement either orally or in writing between VCHCA and the patient, whereby VCHCA 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.

PROCEDURE

BD Qualifications and Assignment

Collection efforts regardless of the payer will be the same for all patients with the exception of patients that are classified as Qualified Medicare Beneficiaries (QMB). QMB eligible patients are not sent to Bad Debt, as these patients cannot be billed for any outstanding co-payments, co- insurance, or deductibles under any circumstances.

After all internal collection efforts, including offering relevant information regarding FAP's have been exhausted, encounters with remaining balances will be assigned to an external agency specializing in healthcare collections.

1. When an encounter is assigned to a CA, the amount that will be assigned to BD will be the amount remaining after any and all prior payments, discount adjustments, and waivers have been applied to the encounter balance. At no point will Credit Agency reporting, property liens, or wage garnishments occur.
2. Encounter balances meeting certain thresholds are reviewed by Patient Financial Services leadership. Additionally, VCHCA has established minimum thresholds for assigning encounters to a CA.
3. Part of the CA process involves a determination of whether an encounter qualifies for an alternative source of payment, and a determination whether the patient has sufficient ability to pay. For encounters identified as having an alternate source of payment, or encounters identified with a guarantor that does not have sufficient ability to pay, the CA shall return the encounter to VCHCA with an explanation of the determination and the supporting data. VCHCA will attempt to collect from the alternate source and/or work to qualify the patient for financial assistance.
 - a. Note: If the patient is identified as a low-income uninsured patient, and efforts at obtaining an alternative source of payment have ceased, any encounter balance may be considered presumptive Charity Care.
4. If a patient inquires whether VCHCA offers a discount from its billed amount based on a patient's status as a cash-paying patient (no third-party coverage), the CA will promptly validate the request, and notify the patient of VCHCA's Self-Pay Discount, provide and document information regarding FAP's.
 - a. If the patient desires the Self-Pay Discount, communication is provided by the CA to VCHCA and the Self-Pay Discount is processed.
 - b. If the patient desires to negotiate an additional discount above the discount provided, then the CA will notify VCHCA for authority to adjust the encounter as appropriate.
5. Prior to filing any legal action or credit reporting against a patient, the CA shall ensure 180 days has past since the initial billing, all legal and regulatory requirements related to debt collection practices are met and have confirmed multiple attempts were made and documented to reach and negotiate with the patient.

Commented [LC1]: Changes to law will not allow medical debt to be reported to consumer credit reporting agencies.

Commented [KD2R2]: I agree with this change

Commented [LC3]: Do you want to add new requirement that 180 days must past after initial billing?

Commented [KD4R4]: I updated the paragraph to include the 180 days

6. The CA shall also

- a. Perform an analysis of the patient's income to determine whether the patient has income sufficient to justify filing any legal action; and
- b. Have VCHCA review the analysis and receive approval from the Revenue Cycle Director or their designee before the filing of any legal action against the patient.
- c. No Assignment or Subcontracting.
 - i. CA's may not assign or subcontract the work effort on any encounter without:
 1. The prior written consent of the Revenue Cycle Director or their designee; and
 2. A written agreement by the assignee or subcontractor to comply with this Policy and both Federal and California requirements.

7. General Requirements Prior to CA Action

- a. Consistency in Billing Statements. At the time of billing, VCHCA 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 VCHCA.
- b. Notice of Financial Assistance Availability. In its letters and statements to all patients, the CA 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 VCHCA. Correspondence shall also include the name/title or department and telephone number to contact for additional information.

8. Relationships with CA's

- a. Compliance with Law, Policies and Standards.
 - i. CA's contracted with VCHCA must attest to, and consistently comply with Federal and California laws applicable to the collection of consumer and patient debts.
 - ii. CA's are required to treat patients, their families, and other contacts fairly, and with dignity, compassion and respect.
 - iii. CA's must review and comply with VCHCA's policies and standards, including, without limitation, reasonable payment plan provisions, its Self-Pay Discount, and Financial Assistance Policies.

9. Standards for Contracting with CA's.

- a. VCHCA shall not engage any CA to collect on patient encounters unless:
 - i. The arrangement is set forth in a written agreement signed by the CA and the Vice President, Finance and Chief Financial Officer or their designee, and

- ii. The written agreement attaches this Policy, or includes language that matches this Policy, as an exhibit and requires the CA to comply.

10. Recordkeeping

- a. VCHCA shall maintain adequate documentation to ensure compliance with the requirements of this Policy. VCHCA shall submit this Policy to the California Department of Health Care Access and Information ("HCAI") as required by applicable law. Each CA that contracts with VCHCA 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 VCHCA's Financial Assistance and related Policies.

Bad Debt Reporting

Assignment reports are compiled based on a system-generated selection report based on age of the encounter and response to collection efforts. After the Director of Patient Financial Services or designee approves the selected assignments, the account balances will be automatically transferred from Accounts Receivable to BD via a transaction code applied in the Accounts Receivable software, which reduces the Accounts Receivable balance to zero. The accounts will then be placed on the corresponding secure portal of the CA or via automated notification to the CA.

To ensure compliance with the annual BD audit required by Medicare, a detailed accounting of encounter transactions is necessary. A report is produced annually to review encounters sent to a CA, as well as recoveries on any encounters sent at any time in the past that have payment activity within the cost reporting year under audit. Encounters will be updated with an Agency Code and updated Financial Class within the patient encounter at time of the assignment to a CA.

- 1. The following criteria must be met before including a BD encounter on the hospital's cost report:
 - a. Patients were classified as Qualified Medicare Beneficiaries at the time of service, or
 - b. Hospital business office and its CA efforts have been exhausted, or
 - c. The CA efforts have been exhausted and the CA has cancelled and returned the encounter.
 - i. The CA will update the encounter collection status, closing and returning encounters deemed uncollectible on a monthly or more frequent basis.
 - ii. The CA will provide a detailed listing of any/all cancelled and returned encounters upon request to support cost report requirements.
 - d. A minimum of 121 days has passed since the first notification to the patient

Commented [LC5]: Does this number need to be updated?

Commented [KD6R6]: No, this section in the policy addresses an internal process which is appropriate. We are unable to commence civil action against a patient for 180 days from the initial bill which is documented in the policy.

of his or her outstanding balance or last patient payment date.

Note: All returned CA balances regardless of payer are adjusted to zero in VCHCA's Accounts Receivable software, with the appropriate bad debt adjustment code present in the patient accounting system prior to inclusion in that year's Cost Report filing. If any account adjustments are required after the Cost Report period being filed, they are to be reported in a future Cost Report filing.

Attachments

[image1.jpeg](#)

Approval Signatures

Step Description

Approver

Date

DRAFT