<table>
<tr><td colspan="5">Title: AD – Self-Pay and Bad Debt Collection Policy</td></tr>
<tr><td rowspan="3">Policy Level</td><td>☒</td><td colspan="3">System Level – Sets expectations for all JMH employees</td></tr>
<tr><td>☐</td><td colspan="3">Entity Level – Sets expectations for employees in <u>multiple departments</u> within one or more entities</td></tr>
<tr><td>☐</td><td colspan="3">Department Level – Sets expectations for employees in <u>only one</u> department at one or more sites</td></tr>
<tr><td>Department</td><td>☐</td><td colspan="3"></td></tr>
<tr><td rowspan="2">Entity(ies)</td><td>☐</td><td>Concord Medical Center (CMC)</td><td>☐</td><td>Walnut Creek Medical Center (WCMC)</td></tr>
<tr><td>☐</td><td>Physician Network (PN)</td><td>☐</td><td>Behavioral Health Center (BHC)</td></tr>
<tr><td>Document Type</td><td colspan="4">☐ Policy ☐ Procedure ☒ Policy and Procedure</td></tr>
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Purpose:

Set forth a fair and equitable process for collection of patient account balances, discounts, payment arrangements, financial assistance, and submission to bad debt including State and Federal regulations affecting these operations.

Definitions:

SBO – Single Billing Office that is responsible for initial and follow up billing, cash posting, credit review and refunds, reconciliation to bank lockboxes, determination of financial assistance program applications, appeal denials, manage patient concerns in regard to billing, manage all billing correspondence related to accounts receivable for all of John Muir Health entities.

JMH – an integrated system of doctors, hospitals and other services. Hospitals are John Muir Health, Walnut Creek Medical Campus; John Muir Health, Concord Medical Campus; John Muir Behavioral Health Center and are the hospital portion of John Muir Health [JMH], licensed as not for profit hospitals.

JMHPN - *John Muir Physician Network is a not-for-profit medical foundation providing primary care and specialist physicians. The network also provides hospitalists (in-patient medical services) at Walnut Creek and Concord hospitals and partner hospital San Ramon Regional Medical Center.*

Early out Vendor - *A contracted third party where self-pay accounts are assigned for collection efforts, using call campaigns, JMH statements, to collect account balances, set up time plans, etc., as an extension of the SBO. These accounts are active status*

Bad Debt Agency - *A contracted third party that assumes the responsibility for the collection efforts of a patient account once SBO writes off the balance from the Active accounts receivable to Bad Debt accounts receivable.*

Self-Pay-Balance after Insurance: Self-pay balance after insurance are accounts receivable defined by the amounts' insured patients are responsible for from their health insurance plan. For example:

- *Deductible, co-pay, and co-insurance portions.*
- *Any item the health plan deems as non-covered and assigned a patient responsibility code.*

Self-Pay-Uninsured: Patient account receivables where patients do not have health insurance, nor is the service covered by a third-party process, i.e. auto insurance.

- Remaining balance of any uninsured account after the uninsured discount is applied.

Uninsured Discount: JMH *applies an uninsured discount to all patient accounts that have no insurance to cover charges.*

- Hospital accounts currently discount 55% of total charges.
- Physician accounts currently discount 35% of total charges.

This discount is automatically calculated based on registration and coverage determination, if determined to be uninsured. It will also be applied by SBO manually if insurance provided has terminated and no other insurance is applicable and or the patient cannot meet the programs reviewed by our eligibility review, and other atypical instances of insurance denial.

Eligibility Services – JMH hospital systems uses the services of a contracted third party to determine if patients who present as uninsured can qualify and become eligible for federal, state, or local insurance programs. Attempting to assist our patients to receive benefits, if applicable for the services rendered and future needs. This service is managed by JMH Patient Access Services (PAS) department.

MyChart – JMH patient portal to schedule appointments, message care team, see lab results, check in and pay co-pay to skip the line, pay bills via e-check or credit card, and other forms of communication as technology allows.

Financial Assistance – JMH funds a patient assistance program that may cover all or part of hospital bills. Eligibility is based partly on household income. To qualify, patients or their guarantor must meet one of the following sets of criteria: A. Must have no insurance or other third party that will pay all or part of your hospital bill. And, must have a family income of no more than 400% of the Federal Poverty Guidelines, or, B. Have some form of third-party insurance, but do not receive a discounted rate from JMH because of that coverage and have an annual out of pocket cost for medical expense exceeding 10% of their family income in the past 12 months. The family income is also no more than 400% of the Federal Poverty Guidelines.

Bad Debt Agency: An agency that assumes responsibility of the collection efforts on a patient account once JMH moves the balance from the active accounts receivable to bad debt accounts receivable. These accounts are assigned to the agency for next collection activities.

Goodbye Letter: State required letter sent to the guarantor of the account detailing the accounts that will be sent to collections and their options for payment before turning over to collection agency occurs.

I. Policy:

A. JMH makes every reasonable effort to collect the patient responsibility account balance.

1. Prior to service:

   a. JMH Patient Access Services (PAS) and John Muir Physician Network staff at time of scheduling, or at time of service for Urgent/Emergent patients, review patient health insurance information. Determination of co-pay, deductible, and co-insurance amounts are verified and discussed.

      1) A request to pay known amounts (co-pays, deductibles) prior to services performed is made.

      2) If not collected, a note stating why will be made on the account.

      3) Co-insurances are calculated as a percentage of total/covered charges. A discussion of the total OOP [out of pocket] should occur so the patient is reminded of their benefit plan/patient liability amounts.

2. Time of Service:

   a. A financial liability agreement is signed by all patients at time of service, [Hospital and Physician]. The agreement identifies and assigns JMH to complete the billing of the service to the insurance, to accept assignment, to accept payment, and that patient will pay for any portion not covered by the insurance or that is denied as patient liability.

3. After Service is performed:

   a. JMH will provide a statement to the patient for each owing account as it becomes patient liability.

      1) A series of four (4) statements are produced and sent 28 days apart. The assignment to early-out vendor occurs at the first statement.

      2) Statements are generated by guarantor number and will include all owing self-pay balances from hospital and physician accounts.

   b. Each account ages on its own merit and the statement can include current, past due and final notice accounts.

   c. If a patient has MyChart electronic billing, the statement is emailed to the patient's MyChart account instead of sent to their home as a paper statement.

   d. Level four statement will also generate a Goodbye Letter packet to the patient.

      1) The packet meets State of California AB 1020 regulation enacted 1/1/2021 and includes a financial assistance application as an option.

4. The MyChart portal, the early-out vendor, the JMH SBO Customer Service team, and the JMH website are identified as ways to call, pay, or make payment plan arrangements and/or ask for financial assistance:

   a. MyChart –mobile phone application to pay, schedule, and review items in portal. Statements viewable on MyChart would include language on payment plan and financial assistance options as needed.

   b. The statement process will assign the account(s) to the early-out vendor. The Early-out vendor has a customer service telephone number on the statement. The Early-out vendor also provides a telephone Interactive Voice Response (IVR) to make payments via credit card without speaking to a person when selecting this option on the phone tree. When taking calls, the early-out vendor can help the patient set up a payment plan and can also determine the patients need for financial assistance and will mail a financial assistance application. Statements also include language on payment plans and financial assistance options as needed.

   c. SBO has a team to take calls for patients, accept payments using IVR, and answer questions. The JMH SBO Customer Service team answers question, resolves concerns, helps set up payment plans, and assists with financial assistance.

   d. Web site to pay as a guest.
      https://www.johnmuirhealth.com/content/jmh/en/home/billpay/

      The website also includes payment plans and financial assistance options.

e. SMS texting is available and will be used if an email address is provided at registration. This does not have to be part of MyChart portal to use this feature.

5. Payments can be made by using the statement and returning it with a check payment to the specific lockbox identified for patient payments.

6. Payments can be made on the next visit anywhere in the JMH organization.

B. If a patient is unable to pay their balance in full, upon request, JMH SBO and its contracted collection vendor(s) may arrange a payment plan. Patients are expected to make payments on time according to the terms of the payment plan.

C. Payment plans terms are preferred to be paid off in twelve (12) months or less; however, will be made in accordance with what the patient/guarantor shows they can afford.

II. Procedure

A. Bad Debt. Accounts will be returned weekly by the Early-Out Vendor to the SBO for review and turnover to collection agency. Accounts are ready to assign to bad debt agency/vendor that are:

1. Not paid in full.

2. Have had four (4) statements sent.

3. Have had a goodbye letter sent to the guarantor.

4. Not in a time plan, or protected status (dispute, bankruptcy or financial assistance application returned).

B. The listing of accounts for withdrawal from the Early-Out Vendor will have reasons for review and action to the Vendor Liaison team in SBO.

1. Review for retro Medi-Cal

2. Review presumptive charity

3. Review for recent payment/high balance

4. Confirm final offload to collection agency processed

C. Manual referral to Bad Debt will occur by the SBO for the following reasons:

1. The patient informs JMH or the Early-Out Vendor they will not pay their bill.

2. The patient refuses to make alternative financial arrangements or seek financial assistance when assessed as needed.

3. No contact with patient via phone, mail or other approved method after reasonable efforts have been made.

4. The patient defaults on an established payment arrangement (a.k.a. time plan) for 90 days.

5. The patient receives proceeds from a third-party liability settlement owed to the health system and does not respond to the health system's request for payment.

6. Returned mail and new address cannot be located.

7. Any call received by the Single Business Office related to payment arrangements that are identified as bad debt will be referred to the bad debt agency on file.

D. JMH excludes accounts from being automatically referred to bad debt under the following circumstances. These accounts may be manually submitted to the agency following a review and approval by an appropriate manager or supervisor.

1. Patient has established a payment plan with JMH or the early-out vendor.

2. Account is being worked by a government eligibility vendor to determine Medi-Cal eligibility.

3. Patient is undergoing the Patient Financial Assistance application process.

4. Account is associated with a patient that is currently indigent (incarcerated, homeless, etc.). Homeless are adjusted to presumptive charity after review.

5. Account is associated with a VIP patient

6. Account is associated with an outstanding patient dispute (charge, care, or safety).

7. Account is associated with a bankruptcy filing (if known prior to offload).

8. Account is filed as part of an outstanding lien.

9. Account is associated with an outstanding legal dispute between the patient and JMH and not approved for bad debt submission by the legal department.

E. Frequency – Accounts are electronically referred to the bad debt agency on a weekly basis.

F. Patient Requests while in Bad Debt

1. Payments received by JMH while in Bad Debt

   a. If a patient requests to make a payment toward an account currently with a bad debt agency or JMH receives a payment for an account currently with a bad debt agency, JMH will post the payment to the account in the patient billing system and notify the agency of the payment received.

2. Payment Arrangements while in Bad Debt

   a. If a patient requests to be put on a payment plan for an account in bad debt, the Customer Service Representative will refer the patient to the bad debt agency explaining that payment plans need to be arranged directly with them.

3. Financial Assistance while in Bad Debt

   a. If a patient requests to apply for financial assistance related to an account in bad debt, the Customer Service Representative will mail a Financial Assistance Application to the patient and explain that the account will remain with the bad debt agency until JMH receives the completed application.

   b. The bad debt agency will cease collection activities until final determination is made on the financial assistance application.

G. Recalling an Account from Bad Debt

1. The bad debt agency returns accounts to JMH under certain circumstances:

   a. Discovery of Eligible Insurance Coverage:

      If it is determined that the patient has eligible insurance coverage for account(s) in bad debt and the age of the account(s) does not conflict with established timely filing deadlines, the eligible accounts are recalled from bad debt and billed to the payer following standard billing guidelines. The account remains in-house and restarts the follow-up cycle.

      1) If the account(s) is past the timely filing deadline, the account(s) should be billed with an appeal letter documenting the reason for late submission. If the appeal is successful and payment is received from the insurance, any remaining patient portion will return to the early-out self-pay vendor and begin the normal self-pay cycle.

      2) If the account(s) is past the timely filing deadline and the appeal is unsuccessful, the bad debt will return to the Bad Debt agency to pursue.

b. Account is associated with a patient that is currently indigent (incarcerated, homeless, etc.).

c. Account is associated with a deceased patient with no estate.

d. Account is associated with a care or safety dispute.

e. Account is associated with a bankruptcy filing.

f. Account is associated with an outstanding legal dispute between the patient and JMH and not approved for bad debt submission by the Legal department.

2. Medicare patients – accounts where Medicare has deemed patient liability are provided statements as listed above in D3. A reasonable effort to collect in both active and bad debt collection efforts are made.

   a. The accounts are requested to be returned to JMH for special adjustment for cost report purposes as allowed per 42 CFR 413.89

      1) The debt must be related to covered services and derived from deductible and coinsurance amounts.

      2) The provider must be able to establish that reasonable collection efforts were made.

      3) **Non-indigent beneficiary.** A non-indigent beneficiary is a beneficiary who has not been determined to be categorically or medically needy by a State Medicaid Agency to receive medical assistance from Medicaid, nor have they been determined to be indigent by the provider for Medicare bad debt purposes. To be considered a reasonable collection effort for non-indigent beneficiaries, all the following are applicable:

         a) A provider's collection effort or the effort of a collection agency acting on the provider's behalf, or both, to collect Medicare deductible or coinsurance amounts must consist of all the following:

            (1) Be like the collection effort put forth to collect comparable amounts from non-Medicare patients.

            (2) For cost reporting periods beginning before October 1, 2020, involve the issuance of a bill to the beneficiary or the party responsible for the beneficiary's personal financial obligations on or shortly after discharge or death of the beneficiary.

            (3) For cost reporting periods beginning on or after October 1, 2020, involve the issuance of a bill to the beneficiary or the party responsible for the beneficiary's personal financial obligations on or before 120 days after the latter of one of the following:

               (a) The date of the Medicare remittance advice that results from processing the claim for services furnished to the beneficiary and generates the beneficiary's cost sharing amounts.

(b) The date of the remittance advice from the beneficiary's secondary payer, if any.

(c) The date of the notification that the beneficiary's secondary payer does not cover the service furnished to the beneficiary.

(d) The account is returned by the collection agency to JMH SBO and specific adjustment is made for cost report as Medicare Bad Debt Uncollectible.

3. Medi-Cal patients are only sent to collections for share of cost patient liability amounts, deemed by the State of California and have been provided statements.

   As per AB2297, the Medi-Cal Share of Cost may be considered for Financial Assistance.

4. Accounts will be open to the Financial Assistance program per regulation of State of California, even if assigned to collection agency.

5. Credit Bureau reporting of medical debt is no longer allowed for *Medical Provider debt* per regulation of the State of California.

H. Bad Debt agencies working for John Muir Health will follow all the guidelines identified in this Policy and as per SB1061.

III. Patient/Family Education: Provided through direct education from customer service representatives and self-pay vendor representatives in response to patient phone calls.

IV. Documentation: N/A

Reference/Regulations:
SB1061, 42 CFR413.89
Supersedes: SBO Department Bad Debt and Collection Policy; Moving to AD Policy
Primary Sponsor Name & Title:
Jeff Smith, Controller
Owner(s) Name & Title:
Jeff Smith, Controller
Record of Review Dates
List Stakeholder, Committee, Medical Staff, etc. Reviews: (with approval dates)
Tim Maurice, Interim CFO (12/10/2024)

Lisa Sander, SBO Director (12/10/2024)	
Origination Date:	12/15/2024

Record of Approval Dates – System or Entity Level Documents			
PPRC: Fast-tracked to Board			
JMPN: Fast-tracked to Board			
MEC – BHC:	**MEC – WC:**	**MEC – CC:**	
Operations Council:		**Senior Exec. / VP, or designee(s):**	
Board *(if applicable)*	1/22/25		