File ID 14-1347 No. 23

Monterey County

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Board Order

Upon motion of Supervisor Salinas, seconded by Supervisor Armenta and carried by those members present, the Board of Supervisors hereby:

Approved the Health Department's Clinic Services Bureau, Billing and Collection of Self-Pay Account Policy and Procedure, which, among other things, would authorize either the Clinic Services Bureau Chief ("Bureau Chief") or the Monterey County Health Department Clinic Services Bureau Finance Manager II with the written concurrence of the Assistant Director of Health/Administration Bureau, to compromise patient debts and write off outstanding, self-pay guarantor accounts receivable in the amount up to two-thousand dollars ($2,000).

PASSED AND ADOPTED on this 16th day of December 2014, by the following vote, to wit:

AYES: Supervisors Armenta, Calcagno, Salinas, Parker and Potter
NOES: None
ABSENT: None

I, Gail T. Borkowski, Clerk of the Board of Supervisors of the County of Monterey, State of California, hereby certify that the foregoing is a true copy of an original order of said Board of Supervisors duly made and entered in the minutes thereof of Minute Book 77 for the meeting on December 16, 2014.

Dated: December 23, 2014
File Number: 14-1347

Gail T. Borkowski, Clerk of the Board of Supervisors
County of Monterey, State of California

By Denise Hancock
Deputy

Clinic Services Bureau	POLICIES AND PROCEDURES
Policy #: FP001	**Department: Clinic Services Bureau**
Policy Title: Billing and Collection of Self-Pay Account	
Original Date:	**Last Revision Date:**
Approved By:	
Effective Date:	**Version**: V1

Purpose

The purpose of this Billing and Collection of Self Pay Account Policy ("Policy") is to address billing and collection of guarantor accounts receivables due and owing to the Monterey County Health Department, Clinic Services Bureau ("MCHD-CSB") in accordance with requirements listed in Section 330(k)(3)(F) and (G) of the Public Health Service Act and other applicable laws regarding the adjustment of guarantor accounts. This policy describes how the guarantor accounts, and remaining self-pay balances, will be managed after the services provided to the patient have been billed to third party payors.

Policy

MCHD-CSB is a safety net provider and the only source of health care for many Monterey County residents. MCHD-CSB will provide services to patients regardless of their ability to pay. Eligible patients of MCHD-CSB, who are uninsured or underinsured and are at or below 200% of the Federal Poverty Level (FPL), are offered Sliding Scale Discount Fees (see SSF policy) to assist with the costs of their health care. In order to determine eligibility, a patient must apply for the Sliding Scale Discount Program.

The registration/intake staff will collect and verify patient's medical insurance coverage and will evaluate their ability to pay for services. MCHD-CSB will bill Medicare, Medi-Cal, Commercial Health Insurance Plan ("CHIP"), or other public assistance programs and private third party payors, as applicable, within approximately 30 days after services are rendered in accordance with the patient's insurance coverage. MCHD-CSB will attempt to collect full reimbursements from applicable third party payors.

Any amounts for which a patient is responsible (co-pay, deductible and/or co-insurance), as indicated by third party payors, will be transferred to guarantor accounts and patients will be billed for the remaining account balances. Where MCHD-CSB is an out-of-network provider of the third party payor, the patient shall be liable for all charges not reimbursed by the third party payor. If a patient is at or below 200% FPL and is approved for eligibility, a sliding scale discount will be applied to service charges and the patient will be billed the discounted amount if it is lower than the amount indicated by the third party.

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Amounts chargeable to Self-Pay account:	1) Insurance Co-Payments: co-payments required by a patient's insurance will be applied to services being provided on the day of the visit and will be shown as a co-payment. 2) Insurance/Medi-Cal denials: If the insurance denial is due to patient's oversight, patient may be billed for the balance due to "not meeting primary insurance carrier's obligations". 3) Medi-Cal Share of Cost: Share of Cost is a monthly deductible a patient is required to pay per Medi-Cal. If a payment was made, it shall be applied to the earliest date of service for the month the patient owes a Share of Cost for. "Applied to Share of Cost" payment code is to use to post the payment in the Electronic Medical Record system and the amount cleared from the Share of Cost will be posted in the Automated Eligibility Verification System. 4) Self pay service fee charges: Patients without any insurance coverage will be charged according to an approved fee schedule. Patients without any insurance coverage and who are at or below 200% FPL can apply for the sliding-scale discount and will receive the discount if approved for eligibility. All self-pay patient related payments will be applied to the oldest invoice outstanding on the guarantor account in the clinics' Electronic Medical Record (EMR) system unless the patient specifies a date of services for the payments.
Charges patients are not responsible for:	Medi-Cal denials due to a non-payment by the primary insurance, the account balance cannot be transferred to patients. MCHD-CSB is legally unable to bill a Medi-Cal patient unless the patient has an unmet Share of Cost, or has requested services that are not covered by Medi-Cal.
Patient Billing Cycle:	All accounts with outstanding self-pay guarantor balances shall be mailed statements for three consecutive months. The statements include a warning notice that the account will be transferred to a collections agency if payment in full is not received within 120 days. MCHD-CSB offers an option for patients to set-up a payment plan within the 120 days; however, if the patient is non-compliant with the payment plan, the account will be sent to a collections agency.
Collections Agency Accounts:	All guarantor accounts of $5.00 and over will be assigned to a collections agency, after billing statements have been issued for three consecutive months without collection of the full debt within 120 days of date of service. The

	collections agency will report monthly payments by the agency. Such payment will be recorded in the EMR for each transaction. *See Attachment A for the collection procedures to be followed by the commercial collections agency with which the Monterey County Health Department has contracted for the provision of collection services.*
Minimum Balance Write-off	Guarantor account balances of $4.99 or less, and at least six-months old and without payment activity, shall be submitted to the MCHD-CSB Finance Manager II for review and approval for write off as uncollectable. Approved balances will be written off using a minimum balance write off code to allow for accurate accounting and reporting. The MCHD-CSB Finance Manager II shall prepare bi-annual reports regarding patient accounts receivables as well as those minimum balances written off.
Mandatory Account Write Off	Some categories of debt shall be deemed uncollectible and will fall into a mandatory write off category. Those categories include, but are not limited to: a. Bills generated for necessary public health surveillance and testing where patient has no insurance; b. The debtor is deceased; however, if the debtor has an account balance of $2,000.00 and above, the account will be sent to a collections agency for attempt to collect from estate; c. Debtor has declared bankruptcy and no further prospects for worthwhile recovery are available.
Write-Off Limitations	The MCHD-CSB Bureau Chief or the MCHD-CSB Finance Manager II, with the written concurrence of the Assistant Director of Health/Administration Bureau, has authority pursuant to this Policy to compromise patient debts and to write-off guarantor accounts receivables in the amount up to $2,000.00 per guarantor account. Note: the average guarantor account size of MCHD-CSB is under $300.00. All amounts written off will be included in the bi-annual report.
Glossary of Terms	**Commercial Health Insurance Plan, or CHIP:** A type of health insurance that covers medical expenses and disability income for the insured. Commercial health insurance can be categorized according to its renewal provisions and type of medical benefits provided. Commercial policies can be sold individually or as part of a group plan. **Co-Payment:** Amount patient is required to pay for their medical care, based on their insurance contract.

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FQHC-LA: Federally Qualified Health Center Look Alike clinic charged by HRSA to provide services to Medi-Cal, Medicare and Medically Indigent patients regardless of their ability to pay.

Governmental Insurance: Medicare and Medi-Cal are governmental insurance types.

Guarantor account: A guarantor financial account holds invoices for all family members that have been associated with the guarantor. A guarantor account may be one person, or it can be an entire family. The association is determined by who is responsible for payment of the account.

HRSA: Health Resources and Services Administration. HRSA is the division of the Federal government responsible for licensure and oversight of Federally Qualified Health Centers and Look-Alikes.

Medicare Bad Debt: Co-payments, deductibles, shares of cost owed by a Medicare patient as a self- pay balance that the patient is not willing or able to pay.

Minimum Balance: A dollar amount ranging between a negative balances of four dollars and ninety- nine cents to a positive balance of four dollars and ninety nine cents. (-$4.99 to $4.99)

Presumptive Eligibility: Granting of insurance eligibility on the basis of a patient completed form, commonly used for Medi-Cal to grant two months of full scope Medi-Cal for children and pregnant women.

Private Pay: Account or balance on an account that is the sole responsibility of the patient.

Share of Cost: Amount that a patient is required to pay, per Medi-Cal or their private insurance. This amount is solely the patient's responsibility.

Sliding Scale Fee: Federally Mandated policy for FQHC-LA clinics that allows patients with incomes at or below 200% of the Federal Poverty Level to receive discounts for services on a sliding scale based on income level and number of family members.

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Write Off: Adjusting a guarantor account to zero balance by applying a negative or positive amount to reach a zero balance.

Revision History

Date Revised	Reason	Approved By	Date Approved

MONTEREY COUNTY HEALTH DEPARTMENT Clinic Services Bureau	POLICIES AND PROCEDURES
Policy #: SSDF-01 Attachment A	**Department: Clinic Services Bureau**
Policy Title: SSFD Procedures	
Original Date:	**Last Revision Date:**
Approved By:	
Effective Date:	**Version**: V1 Page **1** of **2**

PURPOSE: Procedures for submitting outstanding guarantor accounts to a collection agency- outlined in Policy FP001.

PROCEDURES:

1. All uncollected debt on guarantor accounts of $5, after issuing billing statements for three consecutive months, are indicated as a bad debt in Practice Management, Electronic Medical Record System (EMR), unless the individual has worked out a payment plan with Clinic Services staff.
2. The qualifying bad debt is assigned to a collections agency. The Billing Supervisor will upload bad-debt file for all qualifying uncollected guarantor accounts to the collection agency once per month.
3. The Billing Supervisor provides all necessary information, data and documents to the collection agency within ten (10) days of assigning an uncollected guarantor account.
4. The collection agency uses reasonable efforts, consistent with all applicable laws, to respond to inquiries on the assigned bad debt.
5. Should a patient attempt to pay Clinic Services on an account already assigned to the collection agency, Clinic Services shall accept (cash only), deposit and report the payment to the agency.
6. All payments collected by the agency are reported to Clinic Services and documented in the Electronic Medical Record (EMR) to represent the corresponding services. The payments are further distributed as thirty-five percent (35%) fee designated for the collection agency and sixty-five percent (65%) patient revenue.
7. The agency will follow the remit schedule and protocol in accordance with its contract with clinic services.

**The collection agency uses appropriate safeguards to prevent use or disclosure of Patient Health Information (PHI) as well as never using or disclosing PHI other than permitted by the agreement.*

REVISION HISTORY

Date Revised	Reason	Approved By	Date Approved
<insert date>	<State reason for revision here>	Ex: CHCB	<insert date)