ST. JOHN RIVERSIDE HOSPITAL
ANDRUS, DOBBS FERRY & PARK CARE PAVILIONS

CREDIT & COLLECTION POLICY

REVISED: 1/2020, 4/2020, 3/05/21,3/22, 01/23, 10/2024, 12/2025

Policy. It is the policy of St. John's Riverside Hospital to refer all self-pay accounts to external agencies for further collection efforts after following our self-pay collection process without balance resolution, financial assistance determination, or presumptive charity care determination.

Objective: This policy addresses collection activities for both uninsured and insured patients, including co-payments, co-insurance, and deductibles, for pre-service, time of service and post-service collection efforts. St. Johns Riverside Hospital is committed to informing patients regarding their financial responsibilities and available financial assistance options. All patients will be treated with dignity, respect, and compassion during our collection process.

Purpose: In our commitment to ensuring financial well-being for all patients, we prioritize the timely resolution of self-pay balances for both insured and uninsured individuals, including those underinsured. We aim to address these balances prior to their progression into delinquency or assignment to external collection agencies. To support patients facing financial hardships, we actively seek to identify their needs and provide aid through diverse options, including payment plans and charity care for those who qualify. For comprehensive details on the financial assistance available, we encourage you to review our financial assistance policy.

PROCEDURE: Steps I to III outline the statement process. Referrals will be made to an external agency once the statement criteria below have been satisfied.

I. SELF-PAY INPATIENT & OUTPATIENT ACCOUNTS: The statement cycle identified below will utilize the most up to date data derived from our EHR system, Meditech.

(A) Once an account Final bills in our EHR system, the following statement cycle will begin:

(B) 1st Statement - 5 days after final bill.

(C) 2nd Statement - 35 days after 1st Statement.

(D) 3rd Statement - 35 days after 2nd Statement.

(E) 4th Statement - 35 days after 3rd Statement

(F) 5th Statement - 35 days after the 4th Statement

(G) 35 days after the 5th Statement and the account is approximately 180 days old, the account will be referred to an external collection agency.

II. **<u>INPATIENT AND OUTPATIENT INSURED ACCOUNTS:</u> Patient Responsibility after claims processing:**

(A) **After all insurance claims have processed and patient responsibility is established, the following statement cycle will begin:**

(B) **1st Statement - 36 days after all insurance companies have successfully processed claims.**

(C) **2nd Statement -36 days after 1st Statement.**

(D) **3rd Statement - 36 days after 2nd Statement.**

(E) **4th Statement - 36 days after 3rd Statement.**

(F) **36 days after the 4th Statement and the account is approximately 180 days old, the account will be referred to an external collection agency.**

(G) **Medicare accounts will be recorded in the Bad Debt Log for reporting purposes.**

(H) **Medicare only: Accounts will be transferred to bad debt following the issuance of three or more statements, including the Pre-Collection notice identified in the 4th Statement. This process will take effect after a minimum period of 120 days from the issuance of the first statement.**

III. **<u>The following criteria are used for deductible and co-insurance amounts applicable to the Medicare Program</u>:**

(A) **<u>INPATIENT AND OUTPATIENT ACCOUNTS</u>**

1. **Medicare accounts are recorded in the Bad Debt Log.**
2. **Medicare accounts do not go through legal proceedings, agency collection only.**
3. **All Medicare Bad Debts are recorded and kept in a separate log and turned over to the Accounting Department at year end.**
4. **See section II-G-H for the Medicare Bad Debt criteria.**

After the initial 180-day period, accounts that have not been evaluated for Financial Assistance will be referred to an external agency. These accounts will then receive an additional 60 days to submit their Financial Assistance applications. It is crucial that collection agencies partnered with the hospital adhere to the established guidelines in the hospital's Financial Assistance Policy. Furthermore, these agencies are expected to provide patients with sufficient time to apply for Financial Assistance, even if their accounts have been turned over for collection. Ensuring that patients have access to needed resources during this process is a priority, thereby fostering a fair and supportive environment for those in need.

PAYMENT ARRANGEMENT PLAN CRITERIA: The following payment agreement is specifically designed for non-charity care patients. Should a patient encounter difficulty in settling their bill, they have the option to request a payment plan prior to the involvement of an external collection agency. We understand that financial situations can vary, and therefore, we encourage any patient in need of assistance to reach out to our business office. Our team is available to discuss and arrange additional payment plans to accommodate individual circumstances.

BALANCE DUE	NUMBER OF MONTHS TO PAY
LESS THAN $100	1 – 3
$100.00 TO $300.00	3 – 4
$300.00 TO $500.00	4 - 6
$500.00 TO $800.00	6 – 8
$800.00 TO $1,500.00	8 – 12
$1,500.00 TO $2,500.00	12 – 16
$2,500.00 TO $4,000.00	16 - 20
GREATER THAN $4,000.00	20 - 24

The primary collection agency operates under the following general guidelines:

1. **Telephone, written contact continues with the patient.**
2. **Accounts remain with the primary agency for six months.**
3. **All correspondence, written and verbal communications are documented in the external agencies system. All documented communications will be provided to the hospital upon request.**
4. **Upon completion of the six-month period, should payment not be received or acceptable arrangements made to address outstanding balances, the account will be returned to the hospital for appropriate adjustments or for further collection activities.**

New York State Restricts Property Liens and Money Judgments for Medical Debt

New York Governor Kathy Hochul recently signed into law A.7363-A/S.8903-A, which amends Civil Practice Law and Rules to prohibit Article 28 hospitals and health care providers authorized under Article 8 of the Education Law from placing property liens against a debtor's primary residence. It also prohibits such providers from garnishing wages in medical debt judgements.

The Governor signed the bill on November 23, 2022, with an immediate effective date. Members with questions on the implementation of these changes on their collection practices should seek the advice of legal counsel.

ADDENDUM I

1. **Inpatient and outpatient partial payment accounts are placed on the Contract Payment System.**

2. **Self-pay accounts have been outsourced to a collection agency, to make the necessary phone calls and other arrangements as required**

3. **If the patient/guarantor gives notification in writing that he/she has no intention of paying the balance of the accounts, this account will be given to an external collection agency despite the age of the account or the criteria. This will be documented in the patient's account. The only exception is Medicare accounts that will be held for 120 days.**

4. **If return mail is received or conditions present where the patient cannot be contacted, either via telephone or mail, the account will be turned over to an external collection agency despite the age of the account or the criteria. It is necessary to document the patient's account. The exception is Medicare Accounts that will be held for at least 120 days.**

5. **Behavioral Health Services patients may have their fees waived upon approval by the BHS Administrative Staff, based on their determination of medical necessity.**

6. **Ryan White Eligible Recipients - No Ryan White HIV/AIDS Program (RWHAP) patient shall be denied service due to an individual's inability to pay. HRSA RWHAP statute does not require that patients that fail to pay be turned over to debt collection agencies.**

7. **Medicaid co-pays will be written off after receiving three statements.**

8. **All eligible accounts are referred to an external collection agency after the 180-day cycle is completed with exceptions.**

9. **Agencies are given approximately six months to resolve collection efforts. If there is no resolution by the end of six months, the accounts will be returned to the hospital as closed accounts. The hospital will then determine the collectability based on the criteria stated or choose to transfer to a secondary collection agency before deeming it uncollectable.**

10. **Uninsured Patients: A discounted cash price is available for patients who are not eligible for our NYS Uniform Charity Care Program. Please refer to our Financial Assistance and Charity Care Program policy.**

In Accordance with the New York State Department of Health, Public Health Law section 2807-k the following updates were made to our Credit & Collection Policy and Charity Care Policy.

Additionally, there have been updates to consumer protections when paying for medical services in both Public Health Law (S 18C) and New York General Business Law (S 349-Gand 519-A) which apply to all patients, regardless of eligibility for financial assistance.

Effective 10/20/2024 the following summary of changes has been revised to comply with the guidance provided by the NYSDOH. All services provided on or after this date will be subject to the required changes. For Details of these changes, please refer to our Financial Assistance Policy.

a. **Patients Cannot be denied admission or treatment / services because of an unpaid medical bill.**

b. **Hospital is required to use the Uniform Financial Assistance Application.**

c. **Patients will be notified of financial assistance in writing at the intake and registration process and at discharge.**

d. **Patients can apply for financial assistance at any point, starting from the date of service and throughout the collection process.**

e. **Patients earning up to 400% of the Federal Poverty Level (FPL) are eligible for financial assistance.**

f. **Immigration status shall not be considered when determining eligibility for financial assistance.**

g. **Discount schedule based on a percentage of the Medicaid rate.**

h. **Monthly payment plans for patient medical bills may not exceed 5% of patient's income.**

i. **Hospital may not sell patient debt to a third party unless the third party will relieve the debt.**

j. **Hospital is prohibited from bringing lawsuits against patients earning up to 400% of the Federal Poverty Leve; (FPL) to collect unpaid medical bills.**

k. **To initiate legal action against a patient, the Chief Financial Officer of the hospital must provide a signed attestation that the hospital has determined the patient's income to be above the 400% of the Federal Poverty Level (FPL).**

l. **Hospital will establish sliding scale discount rates based on the patient's income level that comply with the ranges defined in the HFAL and DOH guidance on HFAL.**

m. **For patients with incomes below 200% of the Federal Poverty Level (FPL), hospitals will not charge a nominal fee for service.**

n. **Hospital will report to the Department of Health (DOH) the number of people that have applied for financial assistance annually.**

o. **No hospital or health care provider shall require credit card pre-authorization or require the patient to have a credit card on file prior to rendering emergency or medically necessary medical services.**

p. **Patients eligible for the Hospital Charity Care Program (Health Solution), established payment plan cannot exceed 10% of their gross monthly income before tax.**

q. **Patients cannot be required to pay a hospital bill while their application for financial assistance is being considered and can request to apply for financial assistance at any point, including during the collections process.**

r. **Hospital is prohibited from selling any patient debt, regardless of eligibility for financial assistance, to a third party, unless the third party intends to forgive all debt and does not intend to pursue any collections. The hospital is responsible for determining that any debt buyer is doing so for the express purpose of absolving the debt.**

s. **Each time a credit card is used to pay for services, patients will be notified of the risk of paying for medical services with a credit card, including:**
    - **i. Medical bills paid by credit card are no longer considered medical debt.**
    - **ii. By paying with a credit card, patients are forgoing federal and state protections around medical debt.**
    - **iii. Protections that patients must acknowledge forgoing:**
        1. **Prohibitions against wage garnishment and property liens**
        2. **Prohibition against reporting medical debt to credit bureaus**
        3. **Limitations on interest rates**
    - **iv: Patients must affirmatively acknowledge forgoing these protections by paying with a credit card.**

ST. JOHN'S RIVERSIDE HOSPITAL

On December 8, 2025, the Board of Trustees (the "Board") of St. John's Riverside Hospital (the "Hospital") by Board vote approved the Hospital's "Credit & Collection" policy, (as revised) (Rev. Date 12/2025).

/s/ Kevin T. Fay
Kevin T. Fay, Trustee
Assistant Secretary of the Board of Trustees
Chair, Audit & Compliance Committee