FIRST AMENDMENT TO
TULARE COUNTY AGREEMENT NO. 28055

THIS [FIRST] AMENDMENT ("Amendment") to Tulare County Agreement Number 28055 (the "Agreement") is entered into by and between the **COUNTY OF TULARE** ("COUNTY") and **FINANCIAL CREDIT NETWORK, INC.** ("CONTRACTOR") as of _____, with reference to the following:

A. The COUNTY and CONTRACTOR entered into the Agreement on May 9th, 2017, for the purpose of providing account collection services;

B. COUNTY and CONTRACTOR now wish to amend the Agreement in order to replace and supersede Exhibit A and Exhibit B and add Exhibit A-1.

ACCORDINGLY, COUNTY and CONTRACTOR agree as follows:

1. Exhibits A and B are hereby replaced with the attached Exhibits A and B.

2. Exhibit A-1 is hereby added to this Agreement.

2. This First Amendment becomes effective upon signatures by the Tulare County Board of Supervisors.

3. Except as provided above, all other terms and conditions of the Agreement shall remain in full force and effect.

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FIRST AMENDMENT TO
TULARE COUNTY AGREEMENT NO. 28055

THE PARTIES, having read and considered the above provisions, indicate their agreement by their authorized signatures below.

FINANCIAL CREDIT NETWORK, INC.

Date 10/23/18

By _____

Print Name Kris Davisson

Title Vice President

Date 10/23/18

By _____

Print Name Alicia Sundstrom

Title Secretary

[Pursuant to Corporations Code section 313, County policy requires that contracts with a Corporation be signed by both (1) the chairman of the Board of Directors, the president or any vice-president (or another officer having general, operational responsibilities), and (2) the secretary, any assistant secretary, the chief financial officer, or any assistant treasurer (or another officer having recordkeeping or financial responsibilities), unless the contract is accompanied by a certified copy of a resolution of the corporation's Board of Directors authorizing the execution of the contract. Similarly, pursuant to California Corporations Code section 17703.01, County policy requires that contracts with a Limited Liability Company be signed by at least two managers, unless the contract is accompanied by a certified copy of the articles of organization stating that the LLC is managed by only one manager.]

COUNTY OF TULARE

Date _____

By _____
Chairman, Board of Supervisors

ATTEST: ~~MICHAEL C SPATA~~ JASON T. BRITT
County Administrative Officer/Clerk of the Board of Supervisors of the County of Tulare

By _____
Deputy Clerk

Approved as to Form:
County Counsel

By _____ 11/1/2018
Deputy

Matter # 20181178

EXHIBIT A

SCOPE OF SERVICES

1. **RELATIONSHIP OF PARTIES:** For the purposes of this Agreement and for no other purposes COUNTY appoints CONTRACTOR as its agent to collect such accounts it may from time to time assign to CONTRACTOR. This relationship is exclusive only as to accounts actually assigned to CONTRACTOR and only while this Agreement remains in force. COUNTY is free to designate other agents to collect other accounts of COUNTY or to collect these same accounts should they remain uncollected at the time this Agreement expires or is otherwise terminated.
2. **AUTHORITY:** COUNTY hereby grants CONTRACTOR authority to undertake the lawful and reasonable collection efforts as set forth below, which CONTRACTOR deems necessary to collect the accounts assigned by COUNTY to CONTRACTOR.
   The authority granted by COUNTY to CONTRACTOR is for CONTRACTOR to:
   a) Receive and review COUNTY accounts and undertake reasonable and lawful collection efforts on behalf of County of Tulare such as sending collection letters or contacting delinquent account holders by telephone.
   b) Receive payments from accounts in cash, check or money order and to endorse same.
   c) Forward any of COUNTY'S assigned accounts to another collection agency where the account obligor has moved out of the business area of CONTRACTOR provided however, that CONTRACTOR exercises diligence in the selection of the other collection agency and the other collection agency agrees in writing to be bound by the terms of this Agreement and CONTRACTOR notifies COUNTY of intent to forward assigned account prior to forwarding.
   d) To charge interest where the account assigned is one which entitled COUNTY to collect interest, and in such event, the interest charged shall be no more than the rate which COUNTY was entitled to collect.

COUNTY specifically does not grant authority to CONTRACTOR to undertake any unlawful or unreasonable collection efforts, or to adjust or compromise any claim without the express verbal or written consent of the Director of Tulare County Health & Human Services Agency, or designee. COUNTY shall identify the person or persons designated by the Director to adjust or compromise claims. Requests by CONTRACTOR for permission to compromise claims shall be made only by the individual officers who have signed this Agreement on behalf of CONTRACTOR, or by other persons designated by CONTRACTOR and communicated in writing to COUNTY. Notwithstanding, CONTRACTOR may adjust or compromise claims without COUNTY consent provided that any portion of the obligation forgiven is deducted from the fee owing to CONTRACTOR for the collection as provided herein, with the result that the net amount of the account which would otherwise be payable to COUNTY is not affected.

3. **ACCOUNTS:** COUNTY shall transmit from time to time a list of accounts to be assigned together with such documentation as CONTRACTOR may reasonably require in order to undertake collection efforts. Delivery of this form shall constitute assignment of the listed accounts for the purpose of this Agreement as of the date the form is signed by a COUNTY representative as indicated. In addition to delivery of the referenced assignment form, COUNTY may, at its option and for the convenience of CONTRACTOR provide a computer disk which lists the assigned accounts.

   COUNTY agrees to cooperate fully in providing all documentation required by CONTRACTOR to substantiate debts owed to COUNTY. COUNTY agrees to provide documentation within a reasonable period of time, which shall not exceed ten (10) days from the date such documentation, is requested by the CONTRACTOR. Should exigent circumstances prevent prompt provision of requested documentation, COUNTY agrees to immediately notify CONTRACTOR of that fact.

4. **WARRANTIES:** CONTRACTOR represents that:
   a. It will undertake only reasonable and lawful collection efforts.
   b. It will utilize only trained and professional staff in its collection efforts.
   c. It will comply with the Fair Debt Collection Practices Act.
   d. The individuals signing this Agreement have been fully authorized to do so.

5. **REPORTING:** CONTRACTOR agrees:
   a. In order to provide continued access to health care services without any barriers, all Health Care Center accounts managed by or sent to CONTRACTOR shall not be reported to the credit bureau for late or missed payments.
   b. If an account is inadvertently reported, CONTRACTOR shall remove any negative reporting from the client's credit report.
   c. CONTRACTOR agrees to adhere to Tulare County Health & Human Services Agency's Billing and Collection policy in its entirety.

TULARE COUNTY HEAL TH & HUMAN SERVICES AGENCY
FISCAL OPERA TIO NS BRANCH (EXHIBIT A-1)

Supersedes:	NEW	Policy Number:	10-01
Section:		Effective:	07/02/2018
Effective:	NEW	Page:	1 of 9

BILLING & COLLECTION POLICY/PROCEDURE

I. PURPOSE

The majority of Tulare County Health Care Center patients have third party insurance, and as such, the Health Care Centers rely on patient revenue as a primary revenue source. These third party payers with which the Health Care Centers contract include: Medicaid, Medicare, and many other insurance carriers such as managed care and fee-for-service plans. As Federally Qualified Health Center (FQHC) look-alikes, Tulare County Health Care Centers aim to legally and ethically maximize reimbursement from third party payers and patients to recover costs of providing health services.

This policy is designed to: 1) set out Agency standards for billing and collection of revenue for health services rendered in compliance with state and federal requirements; and, 2) define the procedural steps to be taken in billing and collection processes.

II. SCOPE

This policy applies to all Tulare County Health Care Centers.

III. AUTHORITY/REFERENCE

Section 330(k)(3)(E), (F), and (G) of the Public Health Service Act; and 42 CFR 51c.303(e), (f), and (g) and 42 CFR 56.303(e), (f), and (g); Tulare County Health and Human Services Agency (HHSA) Billing & Collection Write-Off Policy; and, HHSA Sliding Fee Scale Program Policy.

IV. POLICY

Tulare County Health Care Centers make every reasonable effort to collect reimbursement for costs of providing health services to health center patients. Payers include Medicare, Medi-Cal, marketplace qualified health plans, other public assistance programs, private health insurance, and recipients of services with a share of cost, co-payment, or Sliding Fee payment requirements.

All patients are eligible to apply for the Sliding Fee Scale program to pay for out-of-pocket expenses associated with the health services provided. (Refer to HHSA Sliding Fee Scale Program Policy.) In the event that patients are uninsured or under-insured and are not

willing to apply for discounts on services, they will be expected to pay for the full costs of services and out-of-pocket expenses. Tulare County Health Care Centers offer flexible options to assist patients with payment on their balances, including grace periods and payment plans. Tulare County Health Care Centers are committed to serving the community and treat patients regardless of their socioeconomic status or ability to pay for services.

V. PROCEDURE

1. Education of Patients on Insurance and Third Party Coverage

Staff will make every reasonable effort to obtain financial information from new and established patients to determine whether they have insurance coverage and/or whether they are eligible for other payment assistance options such as the Sliding Fee Scale Program. Established patients will be asked at each subsequent visit whether there have been any changes in financial circumstances or to their health insurance coverage since their last clinic visit. Tulare County Health Care Centers address uninsured and equal access for patients in the following manner:

a. If the patient has no medical insurance, he/she is asked to meet with the in-house Self-Sufficiency Counselor to assess the patient's eligibility status for government funded insurance programs.
b. Dependent upon the specific circumstances of each patient, other Federal and State funded programs are made available such as the following:
    i. Every Woman Counts (EWC)
    ii. Family Planning Access Care and Treatment (FPACT)
    iii. Child Health and Disability Prevention (CHDP)
    iv. Presumptive Eligibility
c. If the patient does not qualify for Federal or State funded medical insurance, Tulare County provides a Sliding Fee Scale Program based on the patient's household monthly income .
d. If the patient does not qualify for the Sliding Fee Scale Program, he/she can be placed on a monthly payment plan.

2. Patient Payments

Patients are required to make co-payments and/or any other share of cost payment at the time health services are provided. However, care is not denied for any reason including billing account status or the inability to pay a co-payment, nominal deposit or share of cost at the time of service.

a. If the patient cannot pay at the time of service, the clinic registration staff will review the patient account to determine if the patient has a payment agreement on file.
    i. If the patient has an existing payment agreement on file, clinic staff will determine, based on payment history, if the existing agreement needs modification or a new agreement should be put into place for the patient.
b. If the patient does not have an existing payment agreement on file, a payment agreement is set up with the patient.
c. Any patient with an account in "Collection Status" is referred to the Collector/Investigator, whenever possible, after checking-in, for further review of account information and financial counseling.
d. Account statements are generated and sent to the patient on a monthly basis if a balance exists on the account.

3. Billing for Health Services

1. Billing Third Party Insurance:

Third party insurances will be billed at least once a week for all patient services, although reasonable efforts will be made to bill insurances within 72 hours from the date the patient received services or within 24 hours of the Billing Unit receiving paper charge slips, whenever possible. The following steps will be taken to ensure such timelines are met:

a. Charges will be imported into the billing component of the EHR system on a regular basis.

b. Medical providers and clinic staff are flagged within the EHR system when questions arise regarding the services and/or information entered. Follow up is completed as needed until the charges are ready to be billed to the third party insurance.
c. Follow up with the third party insurances is completed as needed to ensure proper and timely payment for services is received. This may include contact via telephone calls and/or filing an appeal for payment if necessary.

All billing and claims records are maintained internally until all insurance payments, adjustments, and patient payments have posted, or the appeals process is completed. Once the account balance is settled and/or all collection attempts have been exhausted, such records are maintained pursuant to the agency records retention policy and/or state law.

II. Direct Billing to Patients:

Direct billing to patients for services provided is conducted weekly by sending an initial bill to the responsible party within 7 days of the service date. Accounts with outstanding balances will be sent additional account statements on a monthly basis.

The Health and Human Services Agency Accounts Receivable Unit will undertake the following reasonable collection efforts for patients who are uninsured, self-pay, have a share of cost, or are not covered by a payment program.

a. Patients are sent statements reflecting account balances that remain unpaid after all insurance and other third party sources have remitted payments.
b. All collection efforts adhere to the privacy and confidentiality requirements of the Health Insurance Portability and Accountability Act (HIPAA).
c. When contacted, patients with outstanding account balances will be provided with payment options such as payment plans, grace periods, etc., regardless of income level or Sliding Fee Scale pay class.
d. Patient accounts are reviewed regularly for changes in financial circumstances and patient eligibility for Medi-Cal or other coverage.

e. Incorrect address information or invalid phone information is documented in the Electronic Healthcare Records system. Efforts are made to locate the patient's correct address and/or phone number when mail is returned or phone numbers are invalid by setting up alerts in GE.

f. The Collector/Investigator will make additional attempts to contact the patient through a variety of means including subsequent billing statements, weekly telephone calls, and/or any other reasonable notification method that constitutes a genuine effort to inform the patient of outstanding account balances. If the Collector/Investigator is unable to make payment arrangements with the patient, a series of pre-collection notices will be mailed out as detailed in Section III, Follow up by Collector/Investigator.

III. Follow up by Collector/Investigator

Patients with past due balances or late payments are mailed monthly statements. Additionally, collection letters are sent and follow-up phone calls made in an effort to encourage patients to contact our office to make payment arrangements or determine eligibility for other coverage programs.

An account is considered overdue if it remains unpaid 30 days after the first statement is issued. After 60 days of nonpayment and/or issuance of two billing statements, the account automatically enters an in-house collections module. These accounts are individually reviewed by a Collector/Investigator and will flow through a series of collection statuses, defined below, with each status prompting a telephone call and/or a letter issued by the Collector/Investigator in an attempt to establish a payment plan.

a. "New Collection Status" – This status is automatically generated when a balance on an account has been in a status of "Waiting Patient Payment" for 60 days. The Collector Investigator will review and manage the account to ensure that no insurance or Sliding Fee Scale has been updated or granted. If no insurance or Sliding Fee Scale has been granted the patient is called. If the patient cannot be reached by phone, the patient's account is noted and placed in 15-day Collection status. This will trigger a system generated 15-day notice that is sent to the patient

regarding the outstanding account balance and payment options. The Collector/Investigator will set the next contact date to 30 days from that date.

b. "15-day Collection Status" – The Collector/Investigator will review and manage the account to ensure that no insurance or Sliding Fee Scale has been updated or granted. If no insurance or Sliding Fee Scale has been granted, the patient is called. If the patient cannot be reached by phone, the patient account is noted and placed in a 30-day collection status. This will trigger a system generated 30- day notice that is sent to the patient regarding the outstanding account balance and payment options. The Collector/Investigator will set the next contact date to 30 days from that date.

c. "Bankruptcy Filings" – All Accounts in "Collection Status" are reviewed for Bankruptcy (BK) filings. The Collector/Investigator investigates to verify that the patient has not filed for BK by reviewing the BK correspondence, email or Pryor website. If there is a BK notice, the Collector verifies that the information on the account matches the notice. If it matches, the account is noted and forwarded to the supervisor for adjustment under Bankruptcy. If there is no BK information or if the notice does not match the account information, the Collector/Investigator proceeds with the collection process.

d. "30-day Status" - The Collector/Investigator reviews the account to ensure that no insurance or Sliding Fee Scale has been updated or granted. If no insurance or Sliding Fee Scale has been granted, the patient is called. If the patient cannot be reached by phone, the patient account is noted and placed in Final Demand collection status. This will trigger a system-generated Final Demand Notice that is sent to the patient regarding the outstanding account balance and payment options. The Collector/Investigator will set the next contact date to 15 days from that date.

e. "Final Demand Status" - The patient is sent a final demand letter stating our intent to send the account to a collections agency. If no response or no payments are made within 10 days of receiving the Final Demand notice the account is referred for write-off. All accounts that are referred for write-off are checked one last time for eligibility status and noted in the patient's account.

f. "Bad Debt Write-Off" - Account balances over $50.00 are written off as bad debt and referred to an outside collection agency for further collections. The Collector/Investigator will change the visit owner for these tickets to "Collection Sent" and forward all paperwork to the Accounts Receivable (A/R) supervisor to perform the write-off. Once the write-off is processed, the write-off report is scanned into the patient's account for documentation. The patient profile and other supporting documents are forwarded to the collection agency for further collection. (Please see paragraph IV, Accounts Referred to Outside Collections, of this section for additional information.)

g. "Small Balance Write-Off" - Account balances under $50.00 are processed as Small Balance Write-Offs and referred to the Auditor's office for Discharge. (Please refer to Write-Off policy and Resolution Nos.79-1795 and 99-0402 for more information.) Small balance write-offs can be collected from the patient if the patient returns for services to the clinic within that same year.
Patients who are delinquent on their current payment plans are contacted by the Collector/Investigator. These accounts are individually reviewed by the Collector/Investigator and referred to an outside collection agency when two consecutive payments are missed on a payment plan and the patient cannot be reached to set up new arrangements.

Every effort is made by the Collector/Investigator to contact delinquent patients to set up a payment plan or reevaluate an existing payment plan that fits within the patient's budget with an agreed due date for the first installment. If, after all collection efforts have been exhausted, and no payments have been received, the account balance is written off and/or referred to a collections agency as appropriate.

Patients who are determined to have an ability to pay and after the collection process in Section III is followed, and are continuously referred for outside collections, and/or refuse to apply for County Programs, may be referred to Public Health Management to determine next steps, including the limitation or denial of future health services. (See section V, subsection 5 Refusal to Pay of this policy for additional information.)

IV. Accounts Referred to Outside Collections

After exhausting all in house collection efforts, accounts over $50.00 are written off by A/R as bad debt and referred to an outside collection agency for continued follow up. Collection agency services consist of reasonable efforts to contact the patient by mail and/or telephone to collect outstanding balances. Payment plans can be arranged by the collection agency upon request of the patient. Collection agency will not engage in aggressive collection tactics that could constitute a barrier to care, such as reporting delinquent accounts to credit reporting agencies.

4. Waiver of Fees

As a general rule, fees for health center services cannot be waived. However, fees for certain infectious disease (such as Tuberculosis) services for identified uninsured patients that support and extend the police powers of the Public Health Officer mandate can be waived. These services are necessary for mandated communicable disease control and surveillance activities. (Tulare County Ordinance Code section 1-15-1033.)

5. Refusal to Pay

If a patient verbally expresses an unwillingness to pay or vacates the premises without paying for services, the patient will be contacted in writing regarding their payment obligations. If the patient is not on a Sliding Fee Scale schedule, a copy of the Sliding Fee Scale program application will be sent with the notice. If the patient does not make effort to pay or fails to respond within 60 days, this constitutes a refusal to pay.

The health care clinic may explore the following options, in the following order, for those patients who have the ability to pay but refuse to pay their co-payments or share of cost payments for health services:

1. Continue attempts to establish a payment plan;
2. Refer delinquent accounts for write-off or outside collection, as appropriate;
3. Limit or deny certain health services to patient. This is an option of last resort and must be approved in writing by Public Health Management.

The patient will be notified in writing of any actions taken due to the patient's refusal to pay.

6. Billing for Supplies
   The clinic may provide related supplies or equipment such as prescriptions, braces, crutches, splints, etc., on a case by case basis. If there is an additional out-of-pocket cost to the patient for these supplies or equipment, the patient is informed of those additional costs, in writing, prior to the time of service.

VI. ENFORCEMENT

All officers, agents, and employees of HHSA **must** adhere to this policy, and all supervisors are responsible for enforcing this policy. Failure of a supervisor to take appropriate actions as required by this policy shall be considered a violation of policy which is grounds for disciplinary action, up to and including termination of employment.

Policy Author: Jessica Dunn/Laura Garay Date: 7/2/2018

The above policy is approved for immediate implementation.

Name: Robert Stewart	Director of Fiscal Operations Title	7/2/2018 Date
Name: Karen Elliott	Director of Public Health Title	7/5/18 Date

EXHIBIT B

COMPENSATION

1. **FEES:** For the accounts assigned to CONTRACTOR, CONTRACTOR shall be paid as follows:
   a. Twenty-five (25) percent of the sums collected for accounts covered by insurance.
   b. Forty (40) percent of the sums collected for accounts where no insurance pertains and the accounts are collected within twenty (20) days of assignment.
   c. Fifty (50) percent of accounts other than those identified in (a) and (b) above.
   d. Fifty (50) percent of accounts where legal action is initiated.
   e. Fifty (50) percent of accounts where it becomes necessary to forward such account to another collection agency as provided herein.

   Following assignment of an account, any sums received by COUNTY directly from the obligor shall be reported immediately in writing to the CONTRACTOR. If the individual to whom the account pertains has a current account with COUNTY in addition to the account assigned, and COUNTY receives payments from that person, COUNTY will attempt to determine whether the payments made pertain to the current account or to the assigned account. If the payments pertain to the assigned account, COUNTY will notify CONTRACTOR for appropriate credit. CONTRACTOR may, in such event, charge COUNTY the applicable percentage fee due to CONTRACTOR from such direct payments as if same had been paid to CONTRACTOR directly by the assigned debtor. The fee due to CONTRACTOR in these circumstances may be affected by offsetting same against sums due to COUNTY and shall be appropriately reflected by CONTRACTOR in an accounting sum due to COUNTY and shall be appropriately reflected by CONTRACTOR in an accounting as described in paragraph 2 below.

   The fees above are calculated on the principal and any interest which has accrued to the account prior to assignment. Following assignment, CONTRACTOR shall be entitled to the fees specified herein and shall additionally be entitled to interest, if any pertains, accruing on the accounts thereafter. Such interest shall be considered by COUNTY as part of the CONTRACTOR'S collection fee.

   It is expressly understood that there shall be no fee owing for any account which is determined at any time to be a Tulare County Medical Services (TCMS) patient account. Any fees which might otherwise pertain to such account shall be void ab initio.

2. **ACCOUNTING:** CONTRACTOR shall provide an accounting not less often than monthly on an invoice which identifies all accounts collected and reflects the amounts collected, the fees and costs pertaining, and a summary of fees owing to CONTRACTOR.