Billing, Collections and Bad Debt Review, 15801

I. PURPOSE

To give clear instructions for Sharp HealthCare hospitals to handle billing and collections in a way that follows the law. Set the rules for collecting money owed for visits and for identifying bad debt referrals.

II. SCOPE:

This policy applies to all Sharp HealthCare Hospitals and Hospital Services. This policy also applies to any collection agency working for a Hospital. Unless otherwise specified, this policy does not apply to doctors or other health professionals, including emergency room doctors, anesthesiologists, radiologists, pathologists, etc., whose services are not part of the Hospital bill. This policy does not require the Hospital to pay for these doctors' or health professionals' services.

III. DEFINITIONS

A. **Financial Assistance Policy (FAP):** The written policy of Sharp HealthCare hospitals that explains who qualifies and the steps for Charity Care and discount programs.

B. **Financial Assistance or Charity Care:** Free care or full financial help provided to patients who qualify, which removes the entire patient bill. Charity Care does not reduce what a third party may need to pay for services.

C. **Discounted Payment Amount following Amount Generally Billed (AGB):** Care that costs less but is not free. This amount is based on IRS rules. Sharp HealthCare uses a standard method to calculate AGB based on estimated Medicare payment amounts.

D. **Hospital or Sharp HealthCare Hospitals:** Means (a) all licensed hospital buildings run by Sharp HealthCare; (b) any hospital where Sharp HealthCare or an Affiliated Entity owns more than 50%; and (c) all closely related entities, as defined in 26 C.F.R. § 1.501(r)-1(b)(28), if they give emergency care.

E. **Hospital Services:** All medically needed care provided by Sharp HealthCare hospitals.

F. **Guarantor:** If not the patient, a guarantor is the person responsible for the patient's healthcare costs, usually a parent or legal guardian.

G. **Patient Family:** To decide eligibility for Charity Care or Discounted Payment

under California's Hospital Fair Billing laws, "patient's family" means the patient and the people whose income is counted when deciding family income and size under the Federal Poverty Level (FPL) rules, as required by state law.

The patient's family may include, but is not limited to:

Persons 18 years of age and older, spouse, domestic partner, and dependent children under 21 years of age, or any age if disabled, whether living at home or not. However, for persons 18 to 20 years of age, family members also include parent, caretaker relatives, and parents or caretaker relatives' other dependent children under 21 years of age or any age if disabled. For persons under 18 years of age, parent, caretaker relatives, and other children under 21 years of age or any age if disabled.

Eligibility for Charity Care or Discounted Payment is based on family income and family size, as defined above, and not solely on the patient's individual income. Eligibility decisions must follow California Health and Safety Code §§127400 through 127446, including AB 2297, and HCAI guidance.

H. **Billed Charges:** The full amount a hospital usually bills for services.

I. **Patient Responsibility:** The part of the bill the patient must pay after insurance, adjustments or discounts have been applied.

J. **Third Party Payor:** A non-government payer that covers healthcare costs for a patient.

K. **Collection Agency:** A company hired by a hospital to collect payment from patients.

L. **Uninsured Patient:** A patient with no insurance or other way to pay for care. This includes:

- Job-based plans
- Medicare
- Medi-Cal
- Car insurance
- Other insurance

M. **Self-pay patient:** A patient with insurance who does not submit a claim for covered or non-covered services.

N. **Insured Patient:** A patient with insurance to help pay for care. This can be private insurance, Medicare, Medi-Cal, or another program.

O. **Extraordinary Collection Action (ECA):**

1. Includes:

a. Assigning hospital debt to a third party like a collection agency.
b. Denying or delaying needed care, or asking for payment before care, because of unpaid bills.
c. Legal actions not taken by Sharp HealthCare may include:
    - Placing a lien on property
    - Obtaining an order for examination
    - Seizing bank accounts
    - Filing a civil lawsuit
    - Causing an individual to be subject to arrest
    - Garnishing wages

2. ECA Restrictions: The hospital or any affiliate or subsidiary cannot use wage garnishments or property liens to collect unpaid hospital bills from patients who qualify for charity care or discount payment programs.
3. ECA does not include:
    a. If a hospital assigns a patient's debt to another party and there is a legal agreement that stops the assignee from using extraordinary collection actions (ECAs), the assignment must be limited. Sharp HealthCare does not sell accounts to bad debt agencies. Sharp HealthCare may assign accounts to a bad debt agency. The debt can be returned to the Hospital if the patient is found eligible for Financial Assistance. Delay or denial of needed care because of an unpaid balance for prior services is not allowed.
    b. Any lien the Hospital can legally claim under state law on money from a judgment, settlement, or compromise for personal injuries where the Hospital provided care. This includes liens under Civil Code sections 3040 or 3045.

P. **Statement Levels:** This means the number of statements sent to a patient.
1. The first statement is mailed after the visit is billed and the patient's responsibility is set.
2. More statements are mailed approximately every 28 days for a total of four billing cycles.
3. A **Goodbye Letter** is mailed to any guarantor who still owes charges after the fourth statement and 10 days before the account is sent to bad debt.

Q. **Contact:** Hospital may call patients using direct or automated systems to offer

payment plans, help with government funding, or financial assistance.

Hospitals must follow the following laws:

1. Rosenthal Act
2. Fair Debt Collection Practices Act (FDCPA)
3. Health Insurance Portability and Accountability Act (HIPAA)
4. Telephone Consumer Practices Act (TCPA)

R. **Bad Debt:** Bad debt means money owed to a hospital for services when:

1. The patient or guarantor refuses to pay or does not agree to a payment plan.
2. The Hospital cannot reach the patient or guarantor because of missing information, returned mail, or no response.
3. The collection agency cannot use ECAs or report negative information to credit bureaus.

S. **Patient Provider Dispute Resolution (PPDR):** Uninsured or Self-pay Patient can dispute their bill if it is $400 or more above the estimate. An independent third party will decide the correct amount the patient should pay.

T. **Medical Debt:** Medical debt means money owed for medical services, products, or devices. It includes current or paid bills.

1. "Medical service, product, or device" does not include cosmetic surgery, but does include:
    - Any service, drug, medication, product, or device sold, offered, or provided to a patient by licensed health care facilities or providers.
    - Reconstructive surgeries and follow-up care needed by the doctor.
    - Prosthetic devices and follow-up care needed by the doctor.
    - A mastectomy.

U. **Good Faith Estimate (GFE):** A document that gives an estimated cost for medical services to patients before care.

V. **Authority:** Collection actions and assignments may be authorized and performed under the direction of the Chief Revenue Cycle Officer (CRCO), Single Billing Office (SBO) Manager, or Revenue Cycle Call Center (RCCC) Supervisor, as required by the Hospital's written debt collection policy and all applicable Hospital Fair Billing laws, including Health and Safety Code § 127425 and related statutory and regulatory requirements.

IV. POLICY

Sharp HealthCare will bill patients and third-party payers accurately, on time, and in compliance with the law, including California Health and Safety Code section 127400 and IRS rules under section 501(r) of the Internal Revenue Code.

V. PROCEDURE

Hospitals will make reasonable efforts to contact the patient or guarantor to resolve unpaid bills. The goal of these efforts is to explain the bill and work toward payment or another resolution.

The Hospital may send accounts to bad debt only after multiple contact attempts. This may also occur if no contact information is available or if no payment agreement is made. If the patient or guarantor refuses to pay or cannot be reached, the account may be placed for bad debt.

A. **Billing Third-Party Payers**

1. **Getting Coverage Information:** Hospitals will try to find out if the patient has private or public insurance that may cover all or part of the care.
2. **Billing Third-Party Payers:** Hospitals will work to collect money from all payers, including:
    - Contracted and non-contracted payers
    - Indemnity payers
    - Liability and auto insurers
    - Government programs

Sharp HealthCare will bill all payers based on information provided or confirmed by the patient or their representative and will do so promptly.

B. **Billing Patients:** Sharp HealthCare will bill the patient for services rendered or shall grant authority to the collection agency to pursue collections on behalf of Sharp Hospitals.

1. Billing Insured Patients: Hospitals must bill insured patients or other insurance listed for the patient responsibility amount as computed by the Explanation of Benefits (EOB).
2. Billing Uninsured Patients: Hospitals will bill uninsured patients for services using the hospital's billed charges, minus the standard uninsured discount.

a. For scheduled services, payment is due before services.
    i. Good Faith Estimates for expected services are provided as follows:
        - Within 3 business days if scheduled more than 10 days in advance.
        - Within 1 business day if scheduled within 3 days of service.
    ii. If the actual bill is $400 or more above the estimate, the patient can start the PPDR process.

b. Standard Uninsured Discount: 25% off billed charges for inpatient and outpatient services. The Uninsured Patient Discount does not apply to patients who receive services that are already discounted (i.e. package discounts or cosmetic services). Case rate and package rate pricing should not result in an expected payment that is less than what the Hospital would expect had the uninsured patient discount been applied to billed charges for the services.

3. Financial Assistance Information

   All patient bills must include the Notice of Rights. This notice is on the back of the billing statement (Attachment A). It tells patients that Financial Assistance is available if they qualify. Each hospital must take reasonable steps to find out if a patient qualifies for Financial Assistance.

   A hospital has taken reasonable steps when at least one of the following occurs:

   a. The patient was screened for presumptive eligibility.
   b. The patient turned in a complete Financial Assistance application.
   c. The hospital sent the patient a Goodbye Letter before taking any collection actions.
   d. The patient turned in an incomplete application and the hospital did all of the following:
       - Told the patient what was missing.
       - Gave the patient time to complete it.
       - Stopped all collection actions.

- Sent the patient a written notice with a phone number and office address for help.

4. Detail Bill

   Patients can ask for an itemized statement (IZ) for their account anytime. Flat rate itemized statements will not include charges.

5. Disputes

   Patients can dispute a charge on their bill by phone or in writing. If a patient asks for documentation, staff will try to provide it within 10 days. During a dispute, all collection activity will stop until the dispute is resolved. Hospitals will also review timing rules under PPDR.

C. **Good Faith Estimates (GFE)**

1. **Notice of Right to Request GFE:** Uninsured and Self-pay Patient must be told, both verbally and in writing, that they have the right to ask for a GFE before scheduling a service. If they do not ask, a GFE of expected charges must be given when the service is scheduled.
2. **Content of the GFE:** The GFE must show expected charges, including any discounts or adjustments the provider expects to apply to the patient's billed charges.
3. **Delivery of GFE:** The GFE must be sent by the patient's chosen method, paper or electronic such as email or patient portal. If sent electronically, it must be easy to save and print.
4. **Timing of GFE Delivery:**
   - If requested before scheduling, the GFE must be provided within 3 business days.
   - If scheduled 3 to 10 days in advance, the GFE must be provided within 1 business day.
   - If scheduled 10 or more days in advance, the GFE must be provided within 3 business days.

D. **Uninsured/Self-pay Dispute Resolution**

1. Patients can start a dispute (PPDR) process if the actual bill is $400 or more above the GFE.
2. They must start the process within 120 days of getting the first bill by submitting a notice through the Federal IDR (Federal Independent Dispute Resolution) portal or by mail to the U.S. Department of Health and Human Services.

E. **Collection Practices:** Hospitals may use reasonable efforts to collect payment.

1. The hospital may send statements or make phone calls.
2. No collections during Financial Assistance review: Hospitals and collection agencies cannot pursue payment or start ECAs while a Financial Assistance application is being reviewed.
3. No Use of Financial Assistance Info: Information from a Financial Assistance application cannot be used for collections.
4. Payment Plans
    a. Hospitals may offer payment plans for patients who cannot pay in full.
    b. Plans must be interest-free, and patients may negotiate reasonable terms.
    c. Before ending a payment plan, hospitals must try to renegotiate if the patient asks.
        i. Rules for Ending a Payment Plan:
            - The 90-day period starts after the first missed payment.
            - Notices must be sent at least 60 days after the missed payment, giving 30 more days to pay.
            - If the plan ends, the patient's responsibility cannot exceed the discounted amount, and any payments made will count.
5. Collection Agencies

    Hospitals may only refer accounts to a collection agency under the following conditions:

    a. There is a written agreement with the agency.
    b. The agency follows Sharp HealthCare's mission, values, and policies.
    c. The agency agrees not to use ECAs.
    d. The hospital keeps ownership of the debt (it is not sold).
    e. All third-party payers have been billed first.
        i. The agency must:
            - Identify patients who may qualify for Financial Assistance and refer them back to the hospital.
            - Stop ECAs until Financial Assistance eligibility is

resolved.

- Ensure patients do not pay more than they owe under the policy.
- Reverse any ECAs if the patient qualifies for assistance.
- If the debt is transferred to another party, the new party must agree to these same rules.

f. Billing Third-Party Payers:

All third-party payers must be billed correctly. A collection agency cannot bill a patient for any amount that a third-party payer is responsible for.

g. Notice to Patients:

When notified, the collection agency must send every patient a copy of the Notice of Rights and a Goodbye Letter.

F. **Third-Party Liability:** This policy does not prevent hospital affiliates or outside collection agencies from pursuing third-party liability if they follow the Third-Party Lien Billing Practices.

G. **Credit Reporting Restrictions:** For any contract creating medical debt, the holder of the debt may not share information about the debt with a credit reporting agency under Civil Code §1785.27. A violation makes the debt void and unenforceable and may result in legal penalties.