PARALLON
HCA Healthcare

DEPARTMENT: Insurance Collections	**POLICY DESCRIPTION:** General Financial Process for Patients of California Hospitals
PAGE: 1 of 4	**REPLACES POLICY DATED:** 07/01/2020, 10/1/2019, 8/11/202
APPROVED: 12/6/2024	**EFFECTIVE DATE:** 1/1/2024
ANNUAL REVIEW DATE: 06/23/2023	**REFERENCE NUMBER:** PARA.PP.COLL.001CA

SCOPE:
General financial process for HCA California hospital patient accounts serviced by the Shared Service Centers (SSC) and Customer Services Operations (CSO).

PURPOSE:
To establish a process and document authority for the financial resolution of patient and insurance receivables.

POLICY:

A. Internal Processes

During scheduling and pre-registration, patients are asked to provide proof of current insurance coverage. If insurance coverage information is provided, patients are notified about their anticipated coinsurance and deductible obligations and initial efforts are made to collect these amounts. Patients (including those who receive emergency and outpatient care) also are provided written notice containing information about availability of the hospital's discount payment and charity care policies, as well as contact information for a hospital contact from which the person may obtain further information about these policies. Also, at the time of service, the Patient Access staff calculates the patient's anticipated co-payment responsibility and requests a deposit before the services are provided. If the patient is over the age of 65 and has not provided Medicare or Managed Medicare, the Patient Access staff will verify potential Medicare or Managed Medicare coverage, update the account if the coverage is identified and/or documents the findings. If a patient is unable to pay, the Patient Access staff will propose to set up a payment schedule. Also, during this process, the staff should complete an initial assessment to identify patients who may be unable to pay and assesses whether the patient may be eligible for Medicaid or other special treatment pursuant to HCA's policies. If eligible, the Patient Access staff will follow the financial procedures in those policies for account follow-up.

If a patient does not elect the payment schedule and does not otherwise pay the applicable coinsurance or deductible amount, the SSC will initiate the billing process after the services are rendered. If insurance exists, a claim is submitted to the insurance company and when the insurance company (or companies, if the patient has multiple insurance plans) has paid or determined that it will not pay, the patient is billed for the remaining balance and for any applicable coinsurance or deductible amount, based upon payer class rules. If the patient is over the age of 65 and has not provided Medicare or

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Managed Medicare and no documentation from the Patient Access staff exists, the SSC will verify potential Medicare or Managed Medicare coverage. If coverage exists, the account will be updated and billed to Medicare or Managed Medicare. Otherwise, the findings will be documented and the account will continue through the customer service and collection cycle.

When the insurance is billed, insurance collection efforts continue until the account is resolved or qualifies for the End of Cycle process.

In the case of California hospital patients, the initial bill must include the notice advising the patient of his or her rights, in plain language, under California's Hospital Fair Pricing Policies, the Rosenthal Fair Debt Collection Practices Act, the federal Fair Debt Collection Practices Act, and a statement that nonprofit credit counseling may be available in the area. This notice shall also be included with any document indicating that collection activities may occur. If a patient is attempting to qualify for eligibility under the hospital's charity care or discount payment policy and, is attempting in good faith to settle an outstanding bill by negotiating a reasonable payment plan or by making regular partial payments of a reasonable amount, the unpaid bill will not be sent to any collection agency unless the collection agency agrees to adhere to the Hospital Fair Pricing Policies law.

If, at any point, the hospital receives proof of a patient's eligibility for Medi-Cal, the hospital must (1) notify CSO of the Medi-Cal coverage; (2) instruct any parties to cease collection efforts on the unpaid bill for the covered services; and (3) notify the patient that such steps were taken. Income or asset information obtained during the discount and charity care eligibility process shall not be used for collection purposes.

CSO will apply unique work standards based on predetermined customer service criteria. (e.g., the amount of a patient's responsibility). CSO runs all self-pay accounts through a scoring model to determine "likelihood to pay". This score will determine the work standards applied to the patient balance, but CSO shall adhere to hospital standards regardless of likelihood to pay. CSO will attempt to contact the patient via telephone or by letter within 2-28 days depending on the work standard. Letter and phone contacts will continue at specified intervals per the work standards. For uninsured patients, CSO will evaluate whether the patient account has been previously reviewed for Medi-Cal

eligibility or under HCA's charity policy. If the self-pay patient does not qualify for one of these programs, the patient account should have an uninsured patient discount.

If CSO is successful in contacting the patient, it will attempt to ascertain whether, among other things, the patient disputes the charges, any discounts or adjustments are appropriate, whether the patient qualifies for Medi-Cal, the patient received care as a result of a worker's compensation injury, the patient has declared bankruptcy or the patient is deceased.

If unable to make contact, secure payment in full or establish a payment plan and a patient does not follow through with payment, CSO sends the patient a final notice. As the last part of the verbal negotiations and prior to issuing a final notice, the patient is given the opportunity to settle the account. The balance after settlement can be paid in full or by payment arrangement. If the patient defaults on the payment arrangement, an attempt will be made to reinstate the arrangement and if unsuccessful, the settlement adjustment will be reversed and the account will be closed for next placement. If the patient does not agree to the settlement, the patient is issued a final notice including all elements required by law; the account is closed and sent to a primary bad debt collection agency under the authority of the Chief Financial Officer of the Hospital.

B. Bad Debt

1. <u>Primary Bad Debt Collection Agency</u>

On average, accounts place with the primary bad debt agency at 173 days from discharge (this will vary depending upon customer service activity). When accounts are received at the primary bad debt agency, the patient is sent a notice indicating that the account has been placed with the bad debt agency and is given 30 days to either dispute the balance or make payment. If this 30 day window passes and the patient does not dispute the balance and does not submit payment, the primary bad debt collection agency initiates a series of calls and letters to the patient at his or her home and work in accordance with contractually determined work standards.

As the last part of the verbal negotiations, the patient is given the opportunity to settle the account. The balance after settlement can be paid in full or by payment arrangement. If the patient defaults on the payment arrangement, an attempt will be made to reinstate

the arrangement and if unsuccessful, the settlement adjustment will be reversed and the account will be closed for next placement. If the patient does not agree to the settlement, the patient is issued a final notice; the account is closed and sent to a secondary bad debt collection agency.

Accounts remain with the primary bad debt collection agency for approximately 150 days, unless determined to be uncollectible prior to that time. After the expiration of 150 days, accounts that have not received a payment or a promise to pay are returned to the facility.

2. Secondary Bad Debt Collection Agency

On average, accounts place with the secondary agency at 330 days from discharge (this will vary depending upon the activity at CSO and Primary Bad Debt Agencies). The secondary agency runs all accounts through a scoring model to determine “likelihood to pay”. Accounts that score “low” will be closed and returned to the SSC within 4 - 5 business days of placement with no secondary collection activity and deemed “worthless” or “uncollectible”. Accounts that score “high” will be retained by the secondary agency for collection for up to 1 year. After placement, the secondary agency initiates a series of calls and letters to the patient at his or her home and work in accordance with contractually determined work standards and as permitted by law.

As the last part of the verbal negotiations, the patient is given the opportunity to settle the account. The balance after settlement can be paid in full or by payment arrangement. If the patient defaults on the payment arrangement, an attempt will be made to reinstate the arrangement and if unsuccessful, the settlement adjustment will be reversed and the account will be closed to bad debt. If the patient does not agree to the settlement, the patient is issued a final notice; the account is closed to bad debt.

Once the secondary agency has satisfied these minimum work standards, it typically sends out collection notices on a periodic basis. No legal action is ever initiated by the secondary agency. The SSC writes the account off of its Patient Accounting system and Hospital A/R in the general ledger once the account is returned from the secondary collection agency, regardless of age.

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If the agency has established a payment schedule that is not delinquent, the agency can retain that account in their inventory for longer than 1 year. Once the account becomes delinquent, it will be closed and returned to the SSC as "worthless" or "uncollectible".

3. Agreements with Collection Agencies

All agencies involved in patient collections will have a written agreement that it will adhere to the hospital's standards and scope of practices and comply with the hospital's definition and application of a reasonable payment plan as defined in Health and Safety Code Section 127400(i). No collection agency agreement will include purchase of the patient debt.

4. Credit Reporting and Legal Action Against Patients Prohibited

Beginning on October 1, 2019 with respect to HCA Healthcare patient accounts, no entity shall (i) report to credit bureaus; or (ii) pursue litigation activity that involves suing patients or filing liens on standard patient bad debt accounts with respect to any HCA Healthcare accounts.

REFERENCE:

- PARA.PP.OPS.016 CA Discount Charity Policy for California Patients
- PARA.PP.OPS.015 CA Uninsured Discount Policy for California Patients
- PARA.PP.PTAC.013 Procedure for Insurance Verification, Authorization, and Pre-Certification