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Owner	Amanda Escobedo: Training Coord-Revenue Cycle
Area	Patient Financial Services/Patient Access Services
Applicability	SCOR SCV SGH SMB SMC SMH SMV
References	Policy & Procedure, Self Pay Visits/ Accounts

Discounts, 15603.99

I. PURPOSE

To define the extent to which employees, volunteers, physicians (community and staff), and patients are entitled to discounts on their self-pay portion/responsibility received within the Sharp HealthCare system.

II. DEFINITIONS

A. CHARITY CARE – Free care.

B. CO-INSURANCE – The percentage of the contracted rate the patient is responsible for according to their insurance benefits.

C. CO-PAYMENT – The amount set by the HMO insurance that the patient must pay when accessing the Primary Medical Group (PMG), Emergency Room, and other services. HMOs are designed to contain cost and the providers are bound to control costs.

D. DEDUCTIBLE – An annual amount set by the insurance that the patient must pay out of pocket prior to benefits coverage.
DISCOUNTED PAYMENT or DISCOUNT PAYMENT – Any charge for care that is reduced but not free.

E. EMPLOYEES – Persons on the payroll of Sharp HealthCare and affiliates.

F. MEDICAL DEBT – a debt owed by a consumer to a person whose primary business is providing "medical services, products, or devices," or to that person's agent or assignee, for the provision of medical services, products, or devices. Medical debt includes, but is not limited to, medical bills that are not past due or that have been paid.

- A holder of this medical debt contract is prohibited by Section 1785.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable.

G. MEDICAL SERVICE, PRODUCT, OR DEVICE – does not include cosmetic surgery, but does include, without limitation, all of the following:

- Any service, drug, medication, product, or device sold, offered, or provided to a patient by licensed health care facilities or providers.
- Initial or subsequent reconstructive surgeries, and follow-up care deemed necessary by the attending physician and surgeon.
- Initial or subsequent prosthetic devices, and follow-up care deemed necessary by the attending physician and surgeon.
- A mastectomy.

H. OUT OF POCKET COSTS AND EXPENSES – Any expenses for medical care that are not reimbursed by insurance or a health coverage program, such as Medicare copays or Medi-Cal cost sharing.

- HEALTH & SAFETY CODE 127400(g) – Defines a "patient with high medical costs" as follows: (g) "A patient with high medical costs" means a person whose family income does not exceed 350 percent of the federal poverty level, as defined in subdivision (b), if that individual does not receive a discounted rate from the hospital as a result of his or her third-party coverage. For these purposes, "high medical costs" means any of the following:
    1. Annual out-of-pocket costs incurred by the individual at the hospital that exceed 10 percent of the patient's family income in the prior 12 months.
    2. Annual out-of-pocket expenses (including Essential Living Expenses) that exceed 10 percent of the patient's family income, if the patient provides documentation of the patient's medical expenses paid by the patient or the patient's family in the prior 12 months.
    3. A lower level determined by the hospital in accordance with the hospital's charity care policy.

I. PATIENTS – Persons obtaining health care services from Sharp HealthCare hospital associated entity.

J. PATIENT'S FAMILY –

- For patients 18 years of age or older, patient's family includes dependent children of any age if those children are disabled.

- For patients (1) under 18 years of age or (2) who are 18 to 20 years of age and are a dependent child, the patient's family includes other dependent children of the patient's parents or caretake relatives if those other children are disabled.

K. PHYSICIANS – Medical practitioners, active or retired, with doctorate degrees in medicine or osteopathy that are staff, community, or hospital based.

L. SELF-PAY – Is a courtesy 25% discount rate granted to uninsured patients within our community.

M. SHARE OF COST – Refers to Medi-Cal patients that have an amount that must be contributed towards the cost of their care before they receive coverage through Medi-Cal.

III. TEXT

Discount pricing is available on most self-pay portions/responsibilities, including patients who are at or below 350 percent of the federal poverty level, and who are also either uninsured or who have "high medical costs." An emergency room physician who provides emergency medical services in a hospital that provides emergency care is also required by law to provide discounts to uninsured patients or patients with high medical costs who are at or below 350 percent of the federal poverty level (emergency room physician's bill and review for discounts/financial assistance separately from the hospital). The following reductions/discounts may be offered during discount negotiations with the patient or patient representative:

A. **DISCOUNTS**

1. Self-Pay Discounts – Following department guidelines, discount of the self-pay portion/responsibility (either after insurance or straight self-pay plan codes and excludes co-payments and/or deductible amounts). As part of the Self-Pay Discount process, the patient/guarantor is offered a 25% discount on total charges as a courtesy to the community. Self-Pay discounts are automatically adjudicated with the 25% discount upon billing.
2. Additional Discounts – At Sharp's discretion, we may further discount service and/or procedures based on courtesy, administrative, patient relations, risk management or other reasons as identified.

B. **PAYMENT PLANS**

Patients can be offered interest-free payment plans:

1. Standard payment plans length will not exceed 12 months or less, depending on the balance. Longer payment plans are provided on an exception basis, with sufficient management approval. Patient may have the option to outsource longer payment plans with a third-party vendor. Using the vendor means the loan becomes recourse to Sharp HealthCare in the event of a default.
2. A payment plan may be declared inoperative after the patient's failure to make all consecutive payments due during two billing cycles. Before declaring a payment plan no longer operative, the hospital, shall make reasonable attempt to contact the patient via there communication preference to resolve the delinquency and or

renegotiate the extended payment plan. Payment plans in good standing will be allowed to increase new balances as long as the total amount allows for repayment within the 12-month repayment term.

C. **ELIGIBILITY**

The eligibility criteria for a discount price, any charge for care that is reduced but not free, on a patient portion/responsibility include:

- Any patient portion/responsibility based on the patient's Explanation of Benefits (EOB)
- Straight self-pay visit
- Extreme financial hardship – the patient is to complete a patient financial statement along with the eligibility criteria (refer to Financial Assistance Policy # 15602.99), which based upon income consistent with the application of the federal poverty level and if needed, includes an extended hospital/patient negotiated payment plan:

1. The hospital shall limit expected payment to the amount the hospital would expect, in good faith, to receive from Medicare, Medi-Cal, Healthy Families, or another government-sponsored health program of health benefits in which the hospital participates, whichever is greater. If the hospital provides a service for which there is no established payment by Medicare or other government sponsored program of health benefits in which the hospital participates, the hospital shall establish an appropriate discounted payment.
2. For purposes of determining eligibility for discounted payment, documentation of income shall be limited to most recent 2 months of pay stubs or the most recent income tax returns.
3. If the patient fails to provide information that is reasonable and necessary for the hospital to make a discount determination, the hospital may deny the application and inform the patient/patient representative via correspondence.
4. Information about a patient's assets may not be used for collections activities; it does not prohibit the use of information obtained by the hospital, collection agency, or assignee independently of the eligibility process for charity care or discounted payment.
5. No Consideration of Assets – Hospitals can no longer consider a patient's monetary assets when determining that patient's eligibility for discount payment or charity care.
    a. Exception for Health Savings Accounts and Extended Payment Plans: As a narrow exception to the general prohibition against considering monetary assets, hospitals may consider HSAs when negotiating the terms of an extended payment plan to allow a patient to pay the discounted price over time.
    b. Note Regarding Waiver or Reduction of Medi-Cal and Medicare Cost-Sharing Amounts: Hospitals may waive or reduce Medi-Cal

and Medicare cost-sharing amounts as part of their charity care or discount payment program. In doing so, a hospital may consider some of the patient's monetary assets to the extent required for the hospital to be reimbursed under the Medicare program for Medicare bad debt without seeking to collect cost-sharing amounts from the patient as required by federal law. (See law for details on which assets may be considered.)

6. Other Forms of Income Documentation:
    a. Hospitals may accept other forms of documentation of income but shall not require those other forms.
    b. If a patient does not submit an application or documentation of income, a hospital may presumptively determine that a patient is eligible for charity care or discounted payment based on information other than that provided by the patient or based on a prior eligibility determination.
7. Cannot Require Discount Payment Patients to Apply for Health Coverage: Hospitals cannot require a patient to apply for Medicare, Medi-Cal, or other coverage before the patient is screened for, or provided, discount payment.
    a. However, hospital can require a patient to apply for Medicare, Medi-Cal, or other coverage before screening for, or providing, charity care.
    b. When screening for discount payment, can require patient to participate in screening for Medi-Cal eligibility.
8. No Application Deadlines: Hospitals cannot impose time limits for charity care or discount payment applications. Hospitals also cannot deny eligibility based on the timing of a patient's application. May need to pull accounts back from collections.

D. For Flat Rates, Package Price Rates, refer to Policy # 15612.99 Flat Rate, Self Pay Quotes, & Discounted Pricing.

E. Multiple discount combinations should not be offered (i.e., Flat Rate and Prompt Pay, Administrative and Prompt Pay, or Volunteer Discount and Prompt Pay Discount), without Upper Managements approval.

F. **DEBT COLLECTION**

1. No Consideration of Patient Assets for Debt Recovery Determinations: In determining the amount of a debt it may seek to recover from patients who are eligible under its charity care or discount payment policy, a hospital may only consider income and not monetary assets.
2. No Liens on Any Real Property for Collections: Wage garnishments and liens on any real property owned by the patient cannot be used as a means of collecting unpaid hospital bills by (i) the hospital, (ii) assignees that are affiliates or subsidiaries of the hospital, (iii) collection agencies, (iv) debt buyers, and (v) other assignees that are not subsidiaries or affiliates of the hospital.

G. **MISCELLANEOUS**

1. Two types of permissible reimbursements from the patient or guarantor:
    - A hospital may require a patient or guarantor to pay the hospital the entire amount of any reimbursement sent directly to the patient or guarantor by a third-party payer for that hospital's services.
    - If a patient receives a legal settlement, judgment, or award under a liable third-party action that includes payment for health care services or medical care related to the injury, a hospital may require the patient or guarantor to reimburse the hospital for the related health care services rendered up to the amount reasonably awarded for that purpose.
2. 5-Year Record Retention for Money Owed to the Hospital: A hospital must maintain all records relating to money owed to the hospital by a patient or a patient's guarantor for 5 years, including, but not limited to, all of the following: (a) documents related to litigation filed by the hospital, (b) a contract and significant related records by which a hospital assigns or sells medical debt to a third party, (c) a list, updated at least annually, of every person, including the person's name and contact information, that is either: (i) a debt collector to whom the hospital sold or assigned medical debt or (ii) retained by the hospital to pursue litigation for debts owed by patients on behalf of the hospital.
3. Contracts With Assignees and Debt Buyers Must Require 5-Year Record Retention: Any contract entered into by a hospital related to the assignment or sale of medical debt must require the assignee or buyer (and any subsequent assignee or buyer) to maintain records related to litigation for five years.
4. Changed Relevant Lookback Date for Policy's Application to the Time the Patient Was First Billed: A hospital must not deny a patient financial assistance that would be available under the hospital's policy published on HCAI's website at the time the patient was first billed by the hospital.

H. **SPECIAL CIRCUMSTANCES**

1. Discounts can be combined in special circumstances to achieve appropriate customer service outcome as documented in patient visit notes. Discount combination cannot exceed authorization level by user. Use appropriate transaction codes to reflect actual agreement and discounts given.
2. Surrogacy services and International patients will be reviewed on a case by case basis by PAS Management.
3. Medical Debt Must Be Excluded from Consumer Credit Reports: No consumer credit reporting agency shall make any consumer credit report containing medical debt.
4. Hospitals Cannot Provide Information Regarding Medical Debt to Consumer Credit Reporting Agencies: Hospitals must not furnish information regarding a medical debt to a consumer credit reporting agency.
5. 180 Day Grace Period: Hospitals cannot commence civil action against a patient for nonpayment of medical debt before 180 days after initial billing.

I. **DOCUMENTATION**

1. Once discount is extended to patient/guarantor, document in patient visit notes the agreement and any conditions (i.e., payment timelines).
2. All Administrative Discounts and Patient Relations Discounts need approval of a TL and/or Manager.
3. Appropriate documentation is required.

J. **AUTHORIZATION**

1. Prompt Payment and Courtesy Discounts within department guidelines require staff level documentation.
2. Prompt Payment and Courtesy Discounts over the department guidelines require documented approval from the TL, Supervisor and/or Manager.
3. Administrative Discounts and Patient Relations Discounts require documented approval from the TL, Supervisor, Manager or Upper Management.

IV. REFERENCES:

V. ORIGINATOR:

Patient Financial Services

VI. LEGAL REFERENCES:

AB 774 (1/1/2007) & AB 1503 (1/1/2011), Health & Safety Code 127400(g) & 127405

VII. CROSS REFERENCES

A. Policy #15602.99, Financial Assistance for Uninsured or Low Income Patients
B. Policy # 15612.99, Flat Rates, Self Pay Quotes, & Package Price Rates
C. Policy 15801 Billing, Collections and Bad Debt Review

VIII. APPROVAL

A. PFS Policy and Procedure Committee - 8/96, 7/98, 05/02; 04/03; 10/04; 01/06; 12/09; 12/10; 12/13; 03/15; 7/23; 12/24
B. PFS - Team Leader - 04/03; 02/16
C. Policy & Procedure Steering Cmte - 09/98

IX. HISTORY

System #15603.99; orig. dtd. 7/96
Reviewed\Revised: 12/98; 05/02; 04/03; 10/04; 01/06; 12/09; 12/10; 12/13; 03/15; 03/16; 02/19; 07/23; 12/24

Approval Signatures

Step Description	Approver	Date
Administrator	Tamara Westgate: Prgm Mgr-Policies and Procedures	12/2024
	Amanda Escobedo: Training Coord-Revenue Cycle	12/2024

Applicability

Chula Vista, Coronado, Grossmont, Mary Birch, McDonald Center, Memorial, Mesa Vista, Sharp HealthCare