

# **Debt Collection Policy**

## **Effective Date: January 1, 2025**

### **I. Purpose**

- a. Cedars-Sinai Medical Center, Cedars-Sinai Marina Hospital, Cedars-Sinai Medical Care Foundation ("CSMCF"), Huntington Hospital and Huntington Health Physicians (each separately, the "Organization") provide compassionate care to patients when they need medical services. All patients or their guarantors have a financial responsibility related to services received at the Organization, and must make arrangements for payment, either before or after services are rendered. Such arrangements may include payment by an insurance plan, including programs offered through the federal and California government. Payment arrangements may also be made directly with the patient, subject to the payment terms and conditions of the Organization. The Organization is committed to ensuring that conversations about financial obligations do not unreasonably impact the scheduling of care.
- b. This Policy sets out the guidelines and procedures for establishing fair, reasonable, and consistent means for collection of patient accounts owed to the Organization and ensures that the Organization and any Collection Agency that the Organization partners with treat all patients, their families, and other contacts with fairness, dignity, compassion, and respect. Additionally, this Policy ensures that the Organization and its assigned Collection Agencies comply with all applicable federal and California law, organizational policies and procedures, and industry best practices including, without limitation, the following laws and their implementing regulations:
  - i. 26 U.S.C. Section 501(r) et seq. Additional Requirements for Certain Hospitals.
  - ii. 15 U.S.C. Section 1692 et seq. Debt Collection Practices.
  - iii. California Civil Code section 1788 et seq. Fair Debt Collection Practices.
  - iv. California Health & Safety Code section 1339.50 et seq. Payers' Bill of Rights.
  - v. California Health & Safety Code section 127400 et seq. Hospital Fair Pricing Policies.
  - vi. The American Hospital Association Patient Billing Guidelines Affirmation.

### **II. Policy**

#### **a. General Practices**

- i. If a patient account is payable by insurance, then the initial bill will be forwarded directly to the designated insurer to obtain any or all amounts owed by the insurer.

- ii. Patient balances, after insurance payments, will be billed directly to the patient.
- iii. The Organization and the patient share responsibility for timely and accurate resolution of all patient accounts. Patient cooperation and communication are essential to this process. The Organization shall make reasonable and consistent efforts to assist patients with the fulfillment of their financial responsibilities.
- iv. Payment Plans may be arranged with the Organization on a case-by-case basis. Payment Plans may be established in connection with the granting of assistance under the Organization's Financial Assistance Policy or as part of a debt payment arrangement between the Organization and a patient.
  - 1. Payment Plans are free of interest charges and set-up fees.
  - 2. The Organization may consider Health Savings Accounts when establishing the terms of a Payment Plan.
  - 3. It is the patient or guarantor's responsibility to contact the Organization if circumstances change and Payment Plan terms cannot be met.
  - 4. Once approved, any failure to pay in accordance with the Payment Plan terms will constitute a default, and the Organization may cancel the Payment Plan and begin collection activities only after the patient's failure to make payments in the amount due over any continuous 90-day period, in accordance with federal and California law.
    - a. Prior to canceling a Payment Plan, the Organization shall make a reasonable attempt to notify the patient both orally and in writing that the Payment Plan may be canceled, allowing the patient another opportunity to respond and renegotiate the Payment Plan terms.
    - b. Upon any cancellation of a Payment Plan, the patient's financial responsibility shall not exceed the principal amount agreed under the Payment Plan and the patient shall receive credit for any payments previously made under the extended Payment Plan.
- v. The Organization requires a patient or guarantor to pay the Organization the entire amount of any reimbursement sent directly to the patient or guarantor by a third-party payer for the Organization'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, the

Organization requires the patient or guarantor to reimburse the Organization for the related health care services rendered up to the amount reasonably awarded for that purpose.

vi. The Organization makes available the following information and special assistance to all patients:

1. The Plain Language Summary.
2. A Financial Assistance Application ("Application") and/or an application to Medi-Cal or other appropriate government assistance program to uninsured patients and to patients with high medical costs receiving non-emergency services, upon admission or prior to discharge, or in some circumstances, within 72 hours of providing services.
3. Assistance in applying for its financial assistance or government assistance at no cost to the patient.
4. Contact information.
5. A written bill for services rendered by the Organization.
6. A summary statement, upon request, with the expected payment by insurance, if applicable, and any or all amounts due and payable by the patient.
7. A written request that the patient provide information on their health insurance coverage, if not already provided.

b. **Required Approvals for Extraordinary Collection Actions.** The Organization complies with federal and California legal and regulatory requirements related to debt collection practices. The Organization shall not initiate an ECA except in accordance with this Policy and applicable law. The Organization and any Collection Agency:

- i. Are never permitted to engage in the following ECAs or collection practices:
  1. Sell patient debt.
  2. Garnish an individual's wages.
  3. Foreclose on real property.

4. Place a lien on any real property owned, in part or completely, by the patient.
  5. Attach or seize an individual's bank account or other personal property.
  6. Cause an individual's arrest or writ of body attachment.
  7. Provide notice or conduct a sale of any real property owned, in part or completely, by the patient.
  8. Require payment before providing medically necessary care due to outstanding bills for prior care.
  9. Defer or deny medically necessary care because of non-payment of a bill for previously provided care covered under the Financial Assistance Policy.
  10. Report adverse information to a consumer credit reporting agency.
  11. Commence civil action against the patient for nonpayment before 180 days after initial billing.
- ii. Shall receive approval from the Vice President, Finance and Chief Revenue Cycle Officer or their designee, as approved by the Chief Financial Officer and President, prior to initiating any other collection activity.
  - iii. Shall not use information obtained by the Organization in connection with a patient's Application for financial assistance for collection activities.

#### c. **Suspending Collection Actions**

- i. **Pending Application.** If a patient has properly submitted an approved Application, then the Organization shall immediately suspend assignment of an account to a Collection Agency or any initiated ECA until the Application process is complete, or 30 days, whichever time period is longer.
- ii. **Pending government-sponsored coverage.** For patients who have an application pending for government-sponsored coverage or programs, the Organization shall not knowingly assign the account to a Collection Agency prior to 240 days from the date of initial billing, post-discharge.
- iii. **Cooperation to settle outstanding bill.** The Organization shall not knowingly assign an account to a Collection Agency for patient portions that qualify for

financial assistance or if the patient has negotiated a Payment Plan and is reasonably cooperating to settle an outstanding bill. Collection activities will resume in accordance with applicable laws and regulations if the patient/guarantor becomes delinquent in fulfilling the Payment Plan.

- iv. **Pending notice of Hospital Bill Complaint Program.** All payment collection activities by the Collection Agency shall stop upon receipt of notice that a patient has submitted a complaint to the Department of Health Care Access and Information's ("HCAI") Hospital Bill Complaint Program. Collection Agency activities will not resume until the complaint has been resolved, as confirmed by HCAI.
- d. **Reasonable Steps to Determine Eligibility for Financial Assistance.** Prior to assigning an account to a Collection Agency or initiating any ECA, the Organization shall have taken the following steps to determine a patient's financial assistance eligibility, as applicable.
  - i. **Reasonable Efforts Based on Notifications, Screenings and Amounts Not Eligible**
    - 1. The Organization shall notify patients of its financial assistance program before assigning an account to a Collection Agency or initiating any ECA to obtain payment for the care.
    - 2. If the patient has not submitted an Application, or is determined ineligible for financial assistance, then ECAs may be initiated only as permitted by applicable law and in accordance with this Policy.
    - 3. The Organization shall not assign any patient account to a Collection Agency unless the Organization has first performed to the best of its ability, with reasonable effort, a patient profile/screen, and determined to its satisfaction that the patient:
      - a. Does not qualify for alternative payor sources.
      - b. Is not agreeable to applying for government insurance or programs.
      - c. Is not agreeable to a Payment Plan/extended Payment Plan or is no longer cooperating with a negotiated Payment Plan.
  - ii. **Presumptive Eligibility.** The Organization may determine that the patient is eligible for financial assistance based on a presumptive eligibility process.

Additional information regarding presumptive eligibility is found in the Financial Assistance Policy.

iii. **Final Notice and Notifications to Patients 30 Days Before Actions**

1. In compliance with federal law, at least 30 days before assigning an account to a Collection Agency or initiating any ECAs, the Organization shall:
  - a. Provide the Plain Language Summary.
  - b. Identify the ECAs that the Organization intends to initiate and state a deadline after which they may be initiated, which can be no earlier than 30 days after the date that the written notice is provided.
  - c. Prior to initiating any ECAs, the Organization shall make a reasonable effort to orally notify the patient about the financial assistance program and how the patient may obtain assistance with the Application.
2. In compliance with California law, before the Organization assigns a bill to collections, the Organization shall send the patient a final notice with the following information:
  - a. The name of the entity to which the bill is being assigned.
  - b. Date(s) of service of the bill that is being assigned.
  - c. Name and plan type of the health coverage for the patient.
  - d. Date(s) associated with financial assistance notices, applications, and/or decisions.
  - e. An Application for financial assistance.
  - f. Information on how to obtain an itemized bill.

- iv. **Notification Before Actions in the Event of Multiple Episodes of Care.** The Organization may satisfy the notification requirements described above for multiple episodes of care in a notice that covers multiple billing statements. The Organization will refrain from assigning debt to a Collection Agency or initiating

an ECA until 120 days after it provided the first post-discharge billing statement for each episode of care.

**e. Assignment of Patient Accounts to Collection Agencies**

- i. When the Organization assigns an account to a Collection Agency, the amount that will be assigned for collection will be the amount remaining after any and all prior discount arrangements or waivers have been applied to the account balance.
- ii. Account balances meeting certain thresholds are reviewed by the Associate Director of Patient Services or their designee before being sent to a Collection Agency. Additionally, the Organization has established minimum thresholds for assigning accounts to a Collection Agency.
- iii. If a Collection Agency determines that a patient account qualifies for an alternative source of payment or is uncollectible, then the Collection Agency shall return the account to the Organization with an explanation of the determination and the supporting data. The Organization will attempt to collect from the alternate source and/or work to qualify the patient for financial assistance.
- iv. If a patient asks a Collection Agency whether the Organization offers a discount from its billed amount based on a patient's status as a self-pay patient (no third-party coverage), then the Collection Agency will promptly validate for the patient the discount applied to all self-pay patients and, if appropriate, notify the patient of the Organization's financial assistance program. If the patient desires to negotiate an additional discount above the discount provided, then the Collection Agency may notify the Organization for authority to adjust the account as appropriate. Prior to filing any legal action against a patient, the Collection Agency shall ensure all legal and regulatory requirements related to fair debt collection practices are met and have confirmed multiple attempts were made to reach and negotiate with the patient. Any such action shall receive the prior written approval from the Vice President, Finance and Chief Revenue Cycle Officer or their designee.

**f. No Assignment or Subcontracting.** Collection Agencies may not assign or subcontract the collection of any account without:

- i. The prior written consent of the Vice President, Finance and Chief Revenue Cycle Officer or their designee; and

- ii. A written agreement by the assignee or subcontractor to comply with this Policy and federal and California requirements.

g. **General Requirements Prior to Collection Agency Action**

- i. **Consistency in Billing Statements.** At the time of billing, the Organization shall provide to all low-income uninsured patients the same information concerning services received and amounts billed related to those services as it provides to all other patients who receive care at the Organization. The term "low-income uninsured patient" is a patient eligible for assistance under the Financial Assistance Policy.
- ii. **Notice of Financial Assistance Availability.** In its collection letters and statements to all patients, the Organization shall include language to inform patients if they meet certain income requirements, then they may be eligible for government-sponsored payor programs or financial assistance from the Organization. Patient bills shall also include the name/title or department and telephone number to contact for additional information.

h. **Relationships with Collection Agencies**

- i. **Compliance with Law, Policies and Standards.**
  - 1. Collection Agencies contracted with the Organization must attest to and always comply with federal and California laws applicable to the collection of consumer and patient debts.
  - 2. Collection Agencies are required to treat patients, their families, and other contacts fairly, and with dignity, compassion and respect.
  - 3. Collection Agencies must review and comply with the Organization's policies and standards, including, without limitation, the Payment Plan provisions of this Policy and the Financial Assistance Policy.
- ii. **Standards for Contracting with Collection Agencies.** The Organization shall not engage any Collection Agency to collect patient accounts unless:
  - 1. The arrangement is set forth in a written agreement signed by the Collection Agency and the Vice President, Finance and Chief Revenue Cycle Officer or their designee.



2. The written agreement attaches this Policy, or includes language that matches this Policy, as an exhibit and requires the Collection Agency to comply.

i. **Recordkeeping**

- i. The Organization shall maintain adequate documentation to ensure compliance with the requirements of this Policy.
- ii. The Organization shall submit this Policy to HCAI as required by applicable law.
- iii. Each Collection Agency that contracts with the Organization is required to maintain adequate documentation to show compliance with the requirements of federal and California consumer debt collection laws and all other requirements based on the most current version of this Policy and the Financial Assistance Policy.
- iv. The Organization will maintain all records relating to money owed by a patient or guarantor for 5 years, including, but not limited to: (a) documents related to litigation filed by the Organization, (b) a contract and significant related records by which the Organization assigns 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 Organization assigned Medical Debt or (ii) retained by the Organization to pursue litigation for debts owed by patients on behalf of the Organization.

III. **Definitions**

- a. **Collection Agency** means an outside agency assigned debt collection activities for the Organization.
- b. **Extraordinary Collection Actions ("ECAs")** means collection activities that the Organization will not undertake before making reasonable efforts to determine whether a patient is eligible for financial assistance under this Policy. Extraordinary Collection Actions are defined in the Code of Federal Regulations, 26 CFR Section 501(r)-6.
- c. **Essential Living Expenses** means expenses for any of the following: rent or house payment and maintenance, food and household supplies, utilities and telephone, clothing, medical and dental payments, insurance, school or childcare, child or spousal support, transportation and auto expenses, including insurance, gas, and repairs, installment payments, laundry and cleaning, and other extraordinary expenses.

- d. **Financial Assistance Application** means the application that can be used to participate in the Organization's financial assistance program. Additional information on the application processes can be found in the Financial Assistance Policy.
- e. **Financial Assistance Program** means the Organization's program that utilizes a single, unified patient application for financial assistance. Additional information on the program can be found in the Financial Assistance Policy.
- f. **Medical Debt** means 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.
- g. **Medical services, products, or devices** does not include cosmetic surgery, but does include, without limitation, all of the following: (a) Any service, drug, medication, product, or device sold, offered, or provided to a patient by licensed health care facilities or providers, (b) Initial or subsequent reconstructive surgeries, and follow-up care deemed necessary by the attending physician and surgeon, (c) Initial or subsequent prosthetic devices, and follow-up care deemed necessary by the attending physician and surgeon, or (d) A mastectomy.
- h. **Payment Plan** means an agreement between the Organization and the patient, whereby the Organization has offered, and the patient has accepted the opportunity to pay off their liability in monthly installments. For patients approved for a Discount Payment through the financial assistance program, Essential Living Expenses will be taken into account when determining the terms of a Payment Plan, to ensure that it is reasonable for the patient.
- i. **Plain Language Summary** means a document that notifies patients and other individuals that the Organization offers financial assistance under the Financial Assistance Policy in accordance with federal and California law. The document is clear, concise, and easy to understand. Additional information on the Plain Language Summary can be found in the Financial Assistance Policy.

## HISTORY:

POLICY VERSION EFFECTIVE DATE: 01/01/25  
REVISION DATE: 09/01/25

## Statement of Certification

This policy and its attachments will be submitted to the Department of Health Care Access and Information (HCAI). Additionally, it will be made available on the Organization's website.

The Organization attests under penalty of perjury to the following:

1. The individual submitting the policy is duly authorized to submit policies on behalf of the Organization.
2. The submitted policy is a true and correct copy for which this certification is attached.

DocuSigned by:  
*Lisa Maqueira*  
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9/4/2025 | 5:59 PM PDT

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Lisa Maqueira  
Vice President, Finance and Chief Revenue Cycle Officer

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Date