Scripps

Policy: Patient Account Management, Billing and Collections

Effective: 12/10/24 **Identifier: S-FW-LD-5400**

Acute Care: ENC ☒ GR ☒ LJ ☒ MER ☒ Ambulatory ☒ SHAS ☒

PURPOSE: To provide information about the charging, billing, and collection of patient debt pursuant to the California Health and Safety Code, the Federal Patient Protection, and Affordability Care Act, and the policies and practices of Scripps Hospitals, (Scripps Memorial Hospital La Jolla, Scripps Memorial Hospital Encinitas, Scripps Green Hospital, Scripps Mercy Hospital, San Diego and Chula Vista), and Scripps Medical Foundation.

I. POLICY

A. After patient services are received, Scripps Health (Scripps) will bill guarantors and applicable payers accurately and in a timely manner. All unpaid accounts will be handled in accordance with the IRS and Treasury's 501r final rule under the authority of the Affordable Care Act.

B. Patient Insurance Billing

1. Patient Responsibility prior to services:
   a. Provide insurance benefits and coverage.
   b. Obtain all required referrals or authorizations.
   c. Contact their insurance if there are questions about financial responsibility or coverage of services.
   d. Patients are informed that they are required to pay the hospital any amounts sent directly to the patient by 3rd party payors including from legal settlements, judgements, or awards.
   e. Scripps adheres to its contractual obligations with payers. Patients are responsible for pursuing available public or private health insurance payment options.
2. Scripps Responsibility.
   a. Scripps will bill applicable third-party payers (based on information provided by or verified by the patient) in a timely manner. In circumstances where 3rd party claims are not adjudicated in a period of 6 months from the date of service, patient liability will not be pursued.
   b. After claims have been processed by insurance, Scripps will bill patients in a timely manner for their respective Hospital and Professional self-pay liability amounts as determined by their insurance benefits that were not collected at/or before the time of service.
   c. If a claim is denied (or is not processed) by a payer due to an error on our behalf, Scripps will not bill the patient for any amount in excess of what the patient would have owed had the payer paid the claim.
   d. If a claim is denied (or is not processed) by a payer due to factors outside of Scripps control, staff will follow-up with the payer and patient as appropriate to facilitate resolution of the claim. If resolution does not occur after reasonable efforts of follow-up, Scripps may bill the patient or take other actions consistent with current regulation and industry standards, i.e., Charity/Financial Assistance.

e. All attempts are made to fully collect from insurance before recognizing any patient liabilities.

C. **Patient Billing:** Patients are informed of their obligations and programs available to them through multiple methods, including:

1. When possible, and permitted by regulations, patients are advised of their expected out-of-pocket expenses prior to the delivery of services.
2. Patients are presented with an Agreement for Services, outlining their financial obligations and agreement to cooperate with Scripps in the collection of the hospital and professional debt.
3. Financial assistance program information is provided at the time of service and with the bill.
4. Billing statements will include:
   a. A prominent statement indicating the availability of financial assistance.
   b. Dates of hospital and professional service(s).
   c. If an insurance carrier has been billed.
   d. Website address where the Financial Assistance policy, plain language summary and an application can be found.
   e. Financial Assistance program information. (Plain Language Summary)
   f. Hospital Bill Complaint Program notification
   g. Language assistance notification
   h. Scripps Customer Service contact information including an address and telephone number patients may call when they have questions about their bill or to obtain help with the financial assistance application process.
5. Patient billing questions will be responded to promptly by telephone or written communication.
6. If a Guarantor disagrees with the account balance, the Guarantor may request the account balance be researched and verified prior to account assignment to a collection agency.
7. All patients may request an itemized statement of their accounts at any time.

D. **Patient Liabilities Collection**

1. All patients receive a series of 4 statements for a period of up to 135 days from the date the patient's obligation was determined.
2. All accounts are held for a minimum of 180 days before being assigned to external agency for collection. Exceptions would be:
   a. Patients who expressly refuse to pay the obligation or cannot be located.
   b. Accounts being evaluated for financial assistance.
   c. Accounts pending a resolution of a filed complaint.
3. Patients are informed that, if their account is assigned to a collection agency, all associated fees to include interest will be added to their account.
4. All collection efforts are suspended if the patient is making a good faith effort to apply for a federal or state program or the hospital's financial assistance

program. Collection efforts will resume if the patient fails to comply with requests made in connection with these programs.

5. Scripps, or a collection agency, shall not engage in Extraordinary Collection Activities.
6. All collection activity will be based upon written procedures followed by both Scripps collection staff and external collection agencies. Collections will be pursued in a consistent manner based upon those procedures and applicable law including the Federal Fair Debt and Collection Practices, State Rosenthal legislation, and state and federal financial assistance laws.
7. Extended payment plans without interest charges will be made available to patients that qualify for partial financial assistance. Payment terms will be negotiated between Scripps and the patient to allow the patient to pay the discounted amount over time. If the parties cannot agree, Scripps will implement a reasonable payment plan.
8. Accounts at a collection agency may be recalled and returned to Scripps at the discretion of Scripps and/or according to state or federal laws and regulations. Scripps may choose to work the accounts to resolution with the Guarantor or a third party as needed.
9. Accounts with a 'Returned Mail" status are eligible for collections assignment after reasonable efforts have been documented and exhausted. If the patient address is Homeless after reasonable efforts to locate the Guarantor, this account will be written off to Charity.
    a. Efforts to obtain patient contact information may include:
        i. Skip tracing to locate new Guarantor address.
        ii. Contacting the Guarantor via secure communication.

II. ATTACHMENT

Patient Financial Services Glossary of Terms

Charity Care	Considered free care, the portion of care provided by a hospital to a patient for which a third-party payer is not responsible, and the patient is unable to pay.
Discounted Financial Assistance Amount	This reduced amount represents the amount generally billed (AGB) as defined by Internal Revenue Service (IRS) requirements. Scripps uses the prospective method for determining AGB and estimates the amount it would be paid by Medicare, including amounts payable by a Medicare beneficiary. This amount represents the maximum a qualified patient will be required to pay.
Established Cash Price	Established Cash Price is the expected payment amount after applying a discount to its full charges for services. This amount is offered to patients who have no insurance and qualify under the hospital's discount payment policy but who have not been determined eligible for financial assistance. Patients determined eligible for financial assistance will not be required to pay more than the Discounted Financial Assistance Amount.
Extraordinary Collection Activities	Extraordinary collection activities are those that require legal or judicial process or involve selling an individual's debt to another party or reporting adverse information about the individual to consumer credit reporting agencies.
Family Income	Determined by recent pay stubs and tax returns.
Federal Poverty Level	The most recent poverty guidelines periodically adopted by the federal Department of Health and Human Services for determining financial eligibility for participation in various programs based upon family size as applicable to California.
Financially Qualified patient	Financially qualified patient" means a patient who is both of the following: (1) A patient who is a self-pay patient, as defined in subdivision (f), or a patient with high medical costs, as defined in subdivision (g). (2) A patient who has a family income that does not exceed 400 percent of the federal poverty level
Guarantor	The person with financial responsibility for the patients' health care services, usually the patients' parent or legal guardian.
Homelessness	A person is homeless if they live: (Source: HUD gov offices) 1. In a place not meant for human habitation such as: streets, cars, abandoned buildings, parks; 2. In an emergency shelters; 3. In transitional or supportive housing (for people coming from street or shelter) and; 4. In any of the above places, but is in a hospital/institution short-term (30 days or less) Or if they are: 5. Evicted within a week from a private dwelling. 6. Discharged within a week from an institution that does not provide housing as part of discharge planning. 7. A victim of Domestic Violence who does not have a secure living environment.

	8. Or no subsequent residence has been identified and has no resources and support networks to obtain housing.
Patients Family	(1) For persons 18 years of age and older, spouse, domestic partner, dependent children under age 21 whether living at home or not and disabled children of any age. (2) For persons under 18 years of age, parent, caretaker relatives, and other children under 21 years of age of the parent or caretaker relative. (3) For patients (1) under 18 years of age or (2) who are 18-20 years of age and are a dependent child, the patient's family also includes, other dependent children of the patient's parents or caretaker relatives if those other children are disabled.
Patient High Medical Costs	A patient with high medical costs" means a person whose family income does not exceed 400 percent of the federal poverty level, as defined in subdivision (b). 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 the lesser of 10 percent of the patient's current family income or family income in the prior 12 months. (2) Annual out-of-pocket 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.
Reasonable Efforts	A certain set of actions a healthcare organization must take to determine whether and individual is eligible for financial assistance under Scripps financial assistance policy (FAP). In general, reasonable efforts may include providing individuals with written and oral notifications about the FAP and Application process or Scripps Policies.
Reasonable Payment Plan	Means monthly payments that are not more than 10 percent of a patient's family income for a month, excluding deductions for essential living expenses. "Essential living expenses" means, for purposes of this subdivision, 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.
Self-Pay Patient	A patient who meets the following criteria: • No third-party insurance • No Medi-Cal • No compensable injury for purposes of Workers Compensation, automobile insurance, or other insurance as determined and documented by the hospital.
Total Charges	Total charges are the hospital's full established rates for patient care services