



Origination Date: 12/01/1998

Effective Date: 06/28/2022

Next Review Date: 06/27/2025

Owner: Scott Abram: SH VP Revenue Cycle

Policy Area: Revenue Cycle

Billing and Collections for Sutter Health Network Hospitals Policy

PURPOSE

The purpose of this policy is to establish procedures for hospital billing and collection processes.

POLICY

It is policy to bill patients and applicable Third-Party Payers accurately, timely, and consistent with applicable laws and regulations, including without limitation California Health and Safety Code section 127400 et seq. and regulations issued by the United States Department of the Treasury under section 501(r) of the Internal Revenue Code.

SCOPE

This policy applies to Sutter Health and any legal entity for which Sutter Health or its affiliate is the sole member or directly or indirectly controls greater than 50% of the voting power or equity interest (herein referred to as Sutter). This policy applies to any billing or Collection Agency working on behalf of a hospital.

DEFINITIONS

Billed Charges means the undiscounted amounts that a hospital customarily bills for items and services.

Collection Agency means any entity engaged by a hospital to pursue or collect payment from Patients.

Extraordinary Collection Action means any of the following:

- Any action to obtain payment from a Patient that requires a legal or judicial process, including without limitation, the filing of a lawsuit;
- Selling a Patient's debt to the hospital to another party, including without limitation, to a Collection Agency;
- Reporting adverse information about a Patient to a consumer credit reporting agency or credit bureau;
- Seizing a bank account;
- Causing an arrest in connection with collection of a debt;
- Wage garnishment;
- Lien on a residence or other personal or real property;
- Foreclosure on real or personal property;
- Delay or denial of medically necessary care based on the existence of an outstanding balance for prior service(s); or
- Obtaining an order for examination.

Extraordinary Collection Actions do not include the assertion of, or collection under, a lien asserted under Civil Code sections 3040 or 3045. Further, filing a claim in a bankruptcy proceeding is not an Extraordinary Collection Action.

Federal Health Care Program means any plan or program providing health care benefits, whether directly through insurance or otherwise, that is funded directly, in whole or in part by the U.S. government or any state health care program. Federal Health Care Programs include, but are not limited to, traditional fee-for-service Medicare and Medi-Cal, Medicare Advantage plans, TRICARE, Veterans' Administration and Indian Health Service programs.

Financial Assistance refers to Full Charity Care and High Medical Cost Charity Care, as those terms are defined in the Sutter Policy on Financial Assistance for Sutter Hospitals (Charity Care).

Insured Patient means a patient who has a third-party source of payment for a portion of their medical expenses.

Patient means an individual who received services at a hospital and for purposes of this policy, includes any person financially responsible for their care.

Patient Responsibility means the amount that an Insured Patient is responsible to pay out-of-pocket after the Patient's third-party coverage has determined the amount of the Patient's benefits.

Payer is a commercial or government sponsored third party that is financially responsible to pay for some portion of a Patient's medical care services.

Self-Pay Patient means a Patient who has benefits for such items/services under a group health plan, group or individual health insurance coverage offered by a health insurance issuer, or a health benefits plan, but does not seek to have a claim submitted to their plan, issuer, or carrier for the item or service.

Third-Party Payer means a non-government third-party payer that provides coverage for health care services to a Patient.

Uninsured Patient means a Patient who has no third-party source of payment for any portion of their medical expenses, including without limitation, commercial or other insurance, government sponsored health care benefit programs, or third party liability, and includes a Patient whose benefits under all potential sources of payment have been exhausted prior to an admission.

PROCEDURE

A. Billing Third-Party Payers

1. Obtaining Coverage Information

Hospitals shall make reasonable efforts to obtain information from Patients about whether private or public health insurance or sponsorship may fully or partially cover the services rendered by the hospital to the Patient.

2. Billing Third-Party Payers

Hospitals shall diligently pursue all amounts due from Third-Party Payers, including but not limited to, contracted and non-contracted Payers, indemnity Payers, liability and auto insurers, and government program Payers that may be financially responsible for a Patient's care. Sutter will bill all applicable Third-Party Payers based on information provided by or verified by the Patient or their representative in a timely manner.

3. Dispute Resolution with Third Party Payers

Before initiating litigation or arbitration against a Third-Party Payer, hospitals should consult and comply with the Policy on Initiating Litigation or Arbitration Involving Third Party Payers.

B. Billing Patients

Each hospital's individual responsible for finance, or designee, shall grant to Sutter Shared Services (S3) the authority to pursue collections from Patients.

1. Billing Insured Patients

Hospitals shall promptly bill Insured Patients for the Patient Responsibility amount as computed by the explanation of benefits and

directed by the Third-Party Payer.

2. Billing Uninsured Patients

When an Uninsured Patient has not been approved to receive Financial Assistance, hospitals shall promptly bill Uninsured Patients for items and services provided by the hospital, using hospital's Billed Charges less the standard uninsured discount or rural uninsured discount, as follows:

- a. Standard Uninsured Discount is a 40% reduction of Billed Charges for inpatient services and 20% reduction of Billed Charges for outpatient services.
- b. Rural Uninsured Discount is a 20% reduction of Billed Charges for inpatient and outpatient Services at rural hospitals (e.g., Sutter Lakeside Hospital and Center for Health, Sutter Coast Hospital, and Sutter Amador Hospital).
- c. The Uninsured Patient discount does not apply to patients who qualify for Financial Assistance or receive services that are already discounted (i.e., package discounts for 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 bills to Patients shall include the Notice of Rights (see Attachment A), which includes a summary of Financial Assistance that is available to eligible Patients.

4. Itemized Statement

All patients may request an itemized statement for their account at any time.

5. Prompt Payment Discount

All bills to Patients shall include information about the prompt payment discount. The prompt payment discount is an additional write-off of the hospital's bill available to Uninsured Patients who pay promptly. The prompt payment discount is a discount of 10% of the amount owed by an Uninsured Patient after all other discounts have been applied. An Uninsured Patient is eligible for this discount if payment is made at time of service or within thirty (30) calendar days of the date of first billing to the Patient.

6. Disputes

Any Patient may dispute an item or charge on their bill. Patients may initiate a dispute in writing or over the phone with a customer service representative. If a Patient requests documentation regarding the bill, staff members will use reasonable efforts to provide the requested documentation within ten (10) calendar days. Hospitals will hold the account for at least thirty (30) calendar days after the Patient initiates the dispute before engaging in further collection activities.

C. Good Faith Estimates (GFE)

1. Uninsured and Self-Pay Patients must be advised both orally and in writing that they have the right to request a GFE before they schedule an item or service, and if not requested, a GFE of expected charges must be provided upon scheduling.
2. The GFE must reflect the expected charges, including any expected discounts or other relevant adjustments that the provider or facility expects to apply to an Uninsured or Self-Pay Patient's actual Billed Charges.
3. Pursuant to the Uninsured or Self-Pay Patient's requested method of delivery, the GFE must be provided either on paper or electronically (for example, electronic transmission of the GFE through provider's patient portal or electronic mail). If provided electronically it must be in a manner that allows the GFE to be saved and printed.
4. Timing of Delivery of GFE
 - a. If an Uninsured or Self-Pay Patient requests the GFE is prior to them scheduling a service, the GFE must be provided no later than three (3) business days after the request.
 - b. If a service is scheduled at least three (3) days, but less than ten (10) days in advance, the GFE must be provided no later than one (1) business day after the date of scheduling.
 - c. If a service is scheduled at least ten (10) days in advance, the GFE must be provided no later than three (3) business days after the date of scheduling.

D. Uninsured/Self-Pay Dispute Resolution Process

1. An Uninsured or Self-Pay Patient has the right to initiate the patient-provider dispute resolution process if the actual Billed Charges are at least \$400 more than the total amount of expected charges listed in the GFE.
2. Within one hundred twenty (120) days of receiving the bill containing charges at least \$400 more than the GFE an Uninsured or Self-Pay Patient may initiate

the patient-provider dispute resolution process by submitting a notification on the [Federal IDR portal](#) or on paper to the Secretary of HHS.

E. Collection Practices

1. General Collection Practices

Hospitals may employ reasonable collection efforts to obtain payment from Patients. General collection activities may include issuing Patient statements, phone calls, and referral of statements that have been sent to the Patient or guarantor. Hospitals must develop procedures to confirm that Patient questions and complaints about bills are researched and corrected where appropriate, with timely follow up with the Patient.

2. Prohibition on Extraordinary Collection Action

Hospitals and Collection Agencies shall not employ Extraordinary Collection Action to attempt to collect from a Patient.

3. No Collection during Financial Assistance Application Process

Hospital and Collection Agencies shall not pursue collection from a Patient who has submitted an application for Financial Assistance and shall return any amount received from the Patient before or during the time the Patient's application is pending.

4. Prohibition on Use of Information from Financial Assistance Application

Hospitals and Collection Agencies may not use in collection activities any information obtained from a Patient during the application process for Financial Assistance. Nothing in this section prohibits the use of information obtained by hospital or Collection Agency independently of the eligibility process for Financial Assistance.

5. Copayment Waivers

a. Federal and State Health Care Program

A federal or state health care program patient's co-pay, coinsurance or deductible amounts may be discounted or waived only if all three (3) of the following requirements are met:

i. The waiver / discount was not advertised or otherwise solicited;

ii. The waiver / discount is not routinely offered; and,

iii. The waiver / discount is made after determining, in good faith, that the individual is in financial need.

b. Facilities shall evaluate each patient's financial need based on the guidelines found in the applicable Sutter policies on financial assistance and charity care (see Medical Foundation Charity Care and Low Income Uninsured Policy and the Policy on Financial Assistance for Sutter Hospitals (Charity Care). Any waiver or reduction of a federal or state health care program beneficiary's co-

pay, coinsurance or deductible obligation that does not comply with the above standards is prohibited.

6. Payment Plans:

a. Eligible Patients

Hospitals and any Collection Agency acting on their behalf shall offer Uninsured Patients and any Patient who qualifies for Financial Assistance the option to enter into an agreement to pay their Patient Responsibility (for Insured Patients) and any other amounts due over time. Hospitals may also enter into payment plans for Insured Patients who indicate an inability to pay a Patient Responsibility amount in a single installment.

b. Terms of Payment Plans

All payment plans shall be interest-free. Patients shall have the opportunity to negotiate the terms of the payment plan. If a hospital and Patient are unable to agree on the terms of the payment plan, the hospital shall extend a payment plan option under which the Patient may make a monthly payment of not more than ten percent (10%) of the Patient's monthly family income after excluding essential living expenses. "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 child care, child or spousal support, transportation and auto expenses, including insurance, gas, and repairs, installment payments, laundry and cleaning, and other extraordinary expenses.

c. Declaring Payment Plan Inoperative

An extended payment plan may be declared no longer operative after the Patient's failure to make all consecutive payments due during a ninety (90) calendar day period. Before declaring the extended payment plan no longer operative, the hospital or Collection Agency shall make a reasonable attempt to contact the Patient by phone and to give notice in writing that the extended payment plan may become inoperative and that the Patient has the opportunity to renegotiate the extended payment plan. Prior to the extended payment plan being declared inoperative, the hospital or Collection Agency shall attempt to renegotiate the terms of the defaulted extended payment plan, if requested by the Patient. For purposes of this section, the notice and phone call to the Patient may be made to the last known phone number and address of the Patient. After a payment plan is declared inoperative, the hospital or Collection Agency may commence collection activities in a manner consistent with this policy.

F. Collection Agencies

Hospitals may refer Patient accounts to a Collection Agency, subject to the following conditions:

1. The Collection Agency must have a written agreement with the hospital.
2. Hospital's written agreement with the Collection Agency must provide that the Collection Agency's performance of its functions shall adhere to Sutter's mission, vision, core values, the terms of the Policy on Financial Assistance for Sutter Hospitals (Charity Care), this policy, and the Hospital Fair Pricing Act, Health and Safety Code section 127400 through 127446.
3. The Collection Agency must agree that it will not engage in any Extraordinary Collection Actions to collect a Patient debt.
4. Hospital must maintain ownership of the debt (i.e., the debt is not "sold" to the Collection Agency).
5. The Collection Agency must have processes in place to identify Patients who may qualify for Financial Assistance, communicate the availability and details of the Policy on Financial Assistance for Sutter Hospitals (Charity Care) to these patients, and refer patients who are seeking Financial Assistance back to the hospital's patient financial services at 855-398-1633 or at sutterhealth.org. The Collection Agency shall not seek any payment from a Patient who has submitted an application for Financial Assistance and shall return any amount received from the Patient before or during the time the patient's application is pending.
6. All Third-Party Payers must have been properly billed, payment from a Third-Party Payer must no longer be pending, and the remaining debt must be the financial responsibility of the Patient. A Collection Agency shall not bill a Patient for any amount that a Third-Party Payer is obligated to pay.
7. The Collection Agency must send every Patient a copy of the Notice of Rights (see Attachment A).
8. At least one hundred-twenty (120) calendar days must have passed since the hospital sent the initial bill to the Patient on the account.
9. The Patient is not negotiating a payment plan or making regular partial payments of a reasonable amount.

G. Third-Party Liability

Nothing in this policy precludes hospital affiliates or outside collection agencies from pursuing third-party liability in a manner consistent with the Hospital Third Party Lien Policy.

REFERENCES

26 Code of Federal Regulations 1.501(r)-1 through 1.501(r)-7
California Health and Safety Code section 124700 through 127446
Federal IDR Portal
Hospital Third Party Lien Policy

Internal Revenue Code section 501(r)
Medical Foundation Charity Care and Low Income Uninsured Policy
Policy on Financial Assistance for Sutter Hospitals (Charity Care)
Policy for Initiation of Litigation or Arbitration Involving Third Party Payers

ATTACHMENTS

Attachment A: Notice of Rights

COPY

Attachment A -- Notice of Rights

Thank you for selecting Sutter Health for your recent services. Enclosed please find a statement of the charges for your hospital visit. **Payment is due immediately.** You may be entitled to discounts if you meet certain financial qualifications, discussed below, or if you submit payment promptly.

If you are having difficulty understanding your bill or the payment process, there are organizations that will help patients understand the billing and payment process. For helpful information regarding the billing and payment process, please visit **Health Consumer Alliance** at <https://healthconsumer.org/>.

Please be aware that this is the bill for hospital services only. There may be additional charges for services that will be provided by physicians during your stay in the hospital, such as bills from physicians, and any anesthesiologists, pathologists, radiologists, ambulance services, or other medical professionals who are not employees of the hospital. You may receive a separate bill for their services.

Summary of Your Rights: State and federal law require debt collectors to treat you fairly and prohibit debt collectors from making false statements or threats of violence, using obscene or profane language, or making improper communications with third parties, including your employer. Except under unusual circumstances, debt collectors may not contact you before 8:00 a.m. or after 9:00 p.m. In general, a debt collector may not give information about your debt to another person, other than your attorney or spouse. A debt collector may contact another person to confirm your location or to enforce a judgment. For more information about debt collection activities, you may contact the Federal Trade Commission by telephone at 1-877-FTC-HELP (328-4357) or online at www.ftc.gov.

Nonprofit credit counseling services, as well as consumer assistance from local legal services offices, may be available in your area. Please contact Patient Financial Services office at 855-398-1633 for a referral

Sutter Health has agreements with external collection agencies to collect payments from patients. Collection Agencies are required to comply with the hospital's policies. Collection Agencies are also required to recognize and adhere to any payments plans agreed upon by the hospital and the patient.

Financial Assistance (Charity Care): Sutter Health is committed to providing financial assistance to qualified low-income patients and patients who have insurance that requires the patient to pay significant portion of their care. The following is a summary of the eligibility requirements for Financial Assistance and the application process for patient who wish to seek Financial Assistance. The following categories of patients who are eligible for Financial Assistance:

- Patients who have no third-party source of payment, such as an insurance company or government program, for any portion of their medical expenses **and** have a family income at or below 400% of the federal poverty level.
- Patients who are covered by insurance but have (i) family income at or below 400%

of the federal poverty level; **and** (ii) medical expenses for themselves or their family (incurred at the hospital affiliate or paid to other providers in the past 12 months) that exceed 10% of the patient's family income.

- Patients who are covered by insurance but exhaust their benefits either before or during their stay at the hospital, and have a family income at or below 400% of the federal poverty level.

You may apply for Financial Assistance using the application form that is available from Patient Financial Services, which is located within the Patient Access / Registration Departments at the Hospital, by calling Patient Financial Services at 855-398-1633 or on the Sutter Health or Hospital website (www.sutterhealth.org). You may also submit an application by speaking with a representative from Patient Financial Services, who will assist you with completing the application. During the application process you will be asked to provide information regarding the number of people in your family, your monthly income, and other information that will assist the hospital with determining your eligibility for Financial Assistance. You may be asked to provide a pay stub or tax records to assist Sutter with verifying your income.

After you submit the application, the hospital will review the information and notify you in writing regarding your eligibility. If you have any questions during the application process, you may contact the Patient Financial Services office at (855) 398-1633.

If you disagree with the hospital's decision, you may submit a dispute to the Patient Financial Services office.

Copies of this Hospital's Financial Assistance Policy, the Plain Language Summary and Application, as well as government program applications are available in multiple languages in multiple languages in person at our Patient Registration or Patient Financial Services offices, as well as at www.sutterhealth.org and available by mail. We can also send you a copy of the Financial Assistance Policy free of charge if you contact our Patient Financial Services office at 855-398-1633.

In accordance with Internal Revenue Code Section 1.501(r)-5, Sutter Health adopts the prospective Medicare method for amounts generally billed; however, patients who are eligible for financial assistance are not financially responsible for more than the amounts generally billed because eligible patients do not pay any amount.

Pending applications: If an application has been submitted for another health coverage program at the same time that you submit an application for charity care, neither application shall preclude eligibility for the other program.

Health Insurance/Government Program Coverage/Financial Assistance: If you have health insurance coverage, Medicare, Medi-Cal, California Children's Services, or any other source of payment for this bill, please contact Patient Financial Services at 855-398-1633. If appropriate, Patient Financial Services will bill those entities for your care.

If you do not have health insurance or coverage through a government program like Medi-Cal or Medicare, you may be eligible for government program assistance. Patient Financial Services

can provide you with application forms, and assist you with the application process.

You may qualify for immediate temporary Medi-Cal coverage while you apply for permanent Medi-Cal or other health coverage under the Hospital's Presumptive Eligibility Program. To learn more, contact Patient Financial Services at 855-398-1633.

If you have received an award of Financial Assistance from the Hospital that you believe covers the services that are the subject of this bill, please contact Patient Financial Services at 855-398-1633.

California Health Benefit Exchange: You may be eligible for health care coverage under Covered California. Contact the hospital business office or the Cover California website (<https://www.healthforcalifornia.com/>).

Healthcare Cost Transparency: Sutter Health supports healthcare cost transparency, in order to help you make informed decisions a list of the Hospital's shoppable services, pursuant to Section 180.60 of Title 45 of the Code of Federal Regulations can be found at <https://www.sutterhealth.org/for-patients/healthcare-cost-transparency>.

Contact Information: Patient Financial Services is available to answer questions you may have about your hospital bill, or would like to apply for Financial Assistance or government program. The telephone number is 855-398-1633. Our telephone hours are 8:00 A.M. to 5:00 P.M., Monday through Friday.