Billing and Collections

Policy & Procedure Number	24828
Policy Manual	Administrative
Type	Policy & Procedure
Document Owner	Silva, Natalie
Effective Date	12/16/2024
Next Review Date	12/16/2027
Application Scope (Applies to)	All Community Medical Centers (CMC) Entities
Approved By / Approved Date	Christopher Neuman, SVP Chief Financial Officer: 12/05/2024 01:45PM PST Craig Wagoner, EVP Chief Operating Officer: 12/06/2024 06:54AM PST Craig S. Castro, President and Chief Executive Officer: 12/16/2024 02:33PM PST Finance and Planning (A): 12/16/2024 02:56PM PST
Status / Rev #	Official (Rev 6)
Submitted by	Burnett, Brandon M

I. PURPOSE

To ensure Community Medical Centers (CMC) billing and collections activities are conducted in a manner that complies will all applicable laws.

II. DEFINITIONS

A. Extraordinary Collection Action(s) (ECA(s)): Any of the following actions to collect a debt:
   1. Deferring or denying, or requiring a payment before providing medically necessary care because of an individual's nonpayment of one or more bills for previously provided care covered under CMC's Financial Assistance Policy.
   2. Actions that require a legal or judicial process, including but not limited to:
      a. Attaching or seizing an individual's bank account or any other personal property;
      b. Commencing a civil action against an individual (except as noted in Section IV.M.1-7, herein);
      c. Causing an individual's arrest;
      d. Causing an individual to be subject to a writ of body attachment; and
      e. Garnishing an individual's wages.
   3. Selling an individual's debt to another party.

B. Patient: An individual who received services at CMC.

C. Community Medical Centers Licensed Hospital Facilities: Community Regional Medical Center, including its remote location of Fresno Heart & Surgical Hospital, and Clovis Community Medical Center.

D. Financial Assistance Policy: The Financial Assistance Policy is the CMC policy on Financial Assistance, which describes the types of Financial Assistance available as well as the process by which Patients must apply for Financial Assistance.

E. Financial Assistance: Full Charity Care, Partial Charity Care, High Medical Costs Charity Care, Bankruptcy Charity Care, and Uninsured Discounts, as defined herein and in the Financial Assistance Policy.

F. Primary Language of CMC's Service Area: A language used by the lesser of 1,000 people or 5% of the community served by CMC or the population likely to be affected or encountered

by CMC. Community Medical Centers may determine the percentage or number of limited English proficiency individuals in CMC's community or likely to be affected or encountered by CMC using any reasonable method.

G. Uninsured Patient: 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 healthcare benefit programs or third-party liability. Patients whose benefits under insurance have been exhausted prior to the admission will also be considered uninsured for purposes of this policy.

H. Insured Patient: A Patient who has a third-party source of payment which has paid for a portion of their medical expenses.

I. Patient Responsibility Amount: 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.

J. Financially Qualified Patient (also known as a FAP-Eligible Patient in IRS rules and regulations): A Patient who, according to CMC's Financial Assistance Policy, is a Patient for whom both of the following are true:
    1. The Patient is an Uninsured Patient or a Patient with High Medical Costs; and
    2. The Patient has a family income that does not exceed 400 % of the FPL.

K. High Medical Costs Charity Care: A complete write-off of the Patient Responsibility Amount for Covered Services. This discount is available to Insured Patients who meet the following criteria:
    1. The Patient's family income is less than 400% of the FPL; and
    2. The Patient's, or the Patient's family's, out of pocket expenses for Covered Services (incurred at CMC or other providers in the past twelve (12) months) exceed the lesser of 10% of the Patient's family income or the Patient's family income in the last twelve (12) months ("High Medical Costs"). Out of pocket expenses include 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.

L. Collection Agency: Any entity engaged by CMC to pursue or collect payment from Patients.

M. Billed Charges: The undiscounted amounts that CMC customarily bills for items and services.

N. Reasonable Payment Plan: 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 all of the following, as applicable to the Patient's individual circumstances: 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, the availability of a health savings account held by the Patient or Patient's Family, and other extraordinary expenses.

O. Plain Language Summary of the Financial Assistance Policy: A written statement that notifies a Patient that CMC offers financial assistance, and that provides the following additional information in language that is clear, concise and easy to understand, including but not limited to:
    1. A brief description of the eligibility requirements, which advises the Patient of the maximum gross monthly household income per family size to qualify for Financial Assistance, as well as the assistance offered;
    2. A brief summary of how to apply for assistance; and
    3. Contact information, including telephone number, website and physical location of the CMC department that can provide information about CMC's policy and assistance with the application process.
    4. The internet address for the Health Consumer Alliance (https://healthconsumer.org);
    5. An explanation that there are organizations that can help the Patient understand the billing and payment process;
    6. Information regarding Covered California and Medi-Cal presumptive eligibility; and

7. The internet address for CMC's list of shoppable services, under 45 CFR § 180.60.

P. Notice of Rights: A clear and conspicuous notice drafted by CMC that includes all of the items required by California Health & Safety Code 127420(b)(1) -(5).
Q. Notice of Legal Rights: A clear and conspicuous notice drafted by CMC that includes all of the items required by California Health & Safety Code 127430.
R. Notice of Collections Activity: A notice required before assigning a bill to a Collection Agency that includes all of the items required by California Health & Safety Code 127425(e).

III. POLICY

A. Community Medical Centers will bill Patients and third-party payers accurately, timely, and in accordance with all 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 Treasury under section 501(r) of the Internal Revenue Code.
B. This policy applies to all CMC facilities, and all Collection Agencies working on behalf of CMC, as applicable.
C. Unless otherwise specified, this policy does not apply to physicians or other medical providers, including emergency room physicians, anesthesiologists, radiologists, hospitalists, pathologists, etc., whose services are not included in CMC's bill. This policy does not create an obligation for CMC to pay for such physicians' or other medical providers' services. In California, an emergency physician who provides emergency medical services in a hospital is required to provide discounts to Uninsured Patients or Patients with high medical costs who are at or below 400% of the Federal Poverty Level ("FPL").
D. Financially Qualified Patients who are able to establish eligibility for Financial Assistance in accordance with this policy and the Financial Assistance Policy by providing insurance status and income information to CMC shall receive Financial Assistance. Financially Qualified Patients who do not apply for Financial Assistance but are uninsured may qualify for Full Charity Care based on demographic analysis performed by CMC.
E. Community Medical Centers and any Collection Agency acting on its behalf shall provide information to low-income Patients and Patients with High Medical Costs about the availability of Financial Assistance, consistent with CMC's Financial Assistance Policy.
F. Community Medical Centers and any Collection Agency acting on its behalf shall provide Patients with an application enabling them to apply for Financial Assistance if they indicate at any time they are financially unable to pay a bill for hospital services or their household income is less than 400% FPL.
G. Community Medical Centers and any Collection Agency acting on its behalf shall comply with all requirements of the Federal Fair Debt Collection Practices Act (FDCPA), 15 USC §§ 1692 et seq., and the Rosenthal Fair Debt Collection Practices Act, Civil Code §§ 1788 et seq.

IV. PROCEDURE

A. Obtaining Coverage Information
    1. Community Medical Centers shall make all reasonable efforts to obtain information from Patients about whether private or government sponsored insurance may fully or partially cover the services rendered by CMC to the Patient.
B. Billing Third Parties
    1. Community Medical Centers 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. Community Medical Centers will bill all applicable third-party payers based on information provided by or verified by the Patient or their representative in a timely manner.

2. Community Medical Centers will make reasonable efforts to assist Patients in obtaining payment from third-party payers, including but not limited to verifying that coverage with a third-party payer was active at the time care was provided when possible, timely making Patients aware of problems obtaining payment and, where feasible, helping Patients understand how to resolve the problem.

C. Billing Insured Patients
    1. Community Medical Centers shall promptly bill Insured Patients for the Patient Responsibility Amount as computed by the Explanation of Benefits ("EOB") and directed by the third-party payer.
        a. If CMC or any Collection Agency acting on its behalf obtains notification from Medi-Cal that the Patient is eligible for Medi-Cal for relevant dates of service, CMC and Collection Agency shall not seek to obtain payment for the cost of those covered health care services from the eligible Patient (other than applicable Share of Cost or copays), and CMC shall promptly instruct Collection Agency to cease collection efforts on the unpaid bill for covered services.
        b. Community Medical Centers shall not seek to obtain payment for the cost of covered services from Patients who are Qualified Medicare Beneficiaries (QMBs).

D. Billing Uninsured Patients.
    1. Community Medical Centers shall promptly bill Uninsured Patients for items and services provided by CMC using CMC's Billed Charges. As part of this billing, CMC shall provide Uninsured Patients with a Notice of Rights, as defined in Section II.P. of this Policy.

E. Financial Assistance Information
    1. Billing Statement Notice: All bills to Patients shall include a Notice of Rights, which also informs Patients of CMC's Financial Assistance Policy. The Notice of Rights will be conspicuously placed and of sufficient size to be clearly readable.
    2. Widely Publicize: CMC and any Collection Agency acting on its behalf shall widely publicize the Financial Assistance Policy in a manner that is reasonably calculated to reach, notify and inform those Patients in our communities who are most likely to require Financial Assistance.
    3. Community Medical Centers and any Collection Agency acting on its behalf will encourage Patients to complete the Application for Financial Assistance as soon as possible. Patients will be advised they may request assistance with completing the Application from CMC, or CMC will refer them to a local consumer assistance center housed at legal services offices.
    4. If a Patient indicates at any time, through and including referral for Extraordinary Collection Action(s), that they are financially unable to pay a bill for hospital services or their household income is less than 400% of FPL, CMC and Collection Agency shall promptly give such Patient the opportunity to have their eligibility for Financial Assistance evaluated by CMC's Patient Financial Services Department.

F. Itemized Statement
    1. All Patients may request an itemized statement for their account at any time at no charge to the Patient.

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

2. Community Medical Centers shall ensure that Patient questions and complaints about bills are researched and corrected where appropriate, with timely follow up with the Patient.

H. Collection Practices

1. General Collection Practices: Subject to this Policy and CMC's Financial Assistance Policy, CMC or any Collection Agency acting on its behalf may employ reasonable collection efforts to obtain payment from Patients, in a manner consistent with the Federal Fair Debt Collection Practices Act (FDCPA), 15 USC §§ 1692 et seq., and the Rosenthal Fair Debt Collection Practices Act, Civil Code §§ 1788 et seq., as applicable. General collection activities may include issuing Patient statements, past due statements, final statements, making phone calls and sending letters. At no less than 180 days after providing the Patient with a post-discharge billing statement accounts may be placed with third party billing agencies or collection agencies.
2. Languages: When CMC and Collection Agency has reason to know that a Patient's primary language is not English, all notices/communications provided the Patient and written correspondence to the Patient shall be in the language spoken by the Patient, provided it is one of the Primary Language(s) of CMC's Service Area.
3. Prohibition on Extraordinary Collection Action: Community Medical Centers and Collection Agencies shall not employ Extraordinary Collection Action to attempt to collect from a Patient except as described in Section IV.M., below.
4. No Collection During Financial Assistance Application Process: Community Medical Centers 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.
5. Prohibition on use of Information from Financial Assistance Application: Community Medical Centers and any Collection Agency acting on its behalf shall not use for collection activities any information concerning income obtained from a Patient during the application process for Financial Assistance. Nothing in this section prohibits the use of information obtained by CMC or Collection Agency independently from the eligibility process for Financial Assistance.
6. Community Medical Centers and any Collection Agency acting on its behalf shall not use information that it has reason to believe is unreliable, incorrect or obtained from the Patient under duress or through the use of coercive practices in order to obtain payment from Patients.

I. Payment Plans

1. Terms of Payment Plans: All Patients who indicate an inability to pay a bill for hospital services in a single installment shall have the opportunity to negotiate the terms of a payment plan. All payment plans shall be interest-free.
2. If a Financially Qualified Patient and CMC or any Collection Agency acting on its behalf are unable to agree on the terms of the payment plan, CMC or Collection Agency shall offer any Financially Qualified Patient a Reasonable Payment Plan, using the formula described in Section II.N. of this policy.
3. Declaring Payment Plan Inoperative: An extended payment plan may be declared no longer operative after the Patient's failure to make timely all payments due during a 90-day period. Before declaring the extended payment plan no longer operative, CMC or Collection Agency shall make a reasonable attempt to contact the Patient by phone, and will 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, CMC 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,

CMC or Collection Agency may commence collection activities in a manner consistent with this policy.

J. Collection Agencies
    1. Community Medical Centers may refer Patient accounts to a Collection Agency subject to the following conditions:
        a. The Collection Agency must have a written agreement with CMC;
        b. Community Medical Center's written agreement with the Collection Agency must provide that the Collection Agency's performance of its functions shall adhere to the terms of CMC's Financial Assistance Policy, this Billing and Collections Policy, and all relevant statutes and regulations. Community Medical Center's written agreement with the Collection Agency must also provide that the Collection Agency will comply with CMC's definition and application of a Reasonable Payment Plan.
        c. The Collection Agency must agree that it will not engage in any Extraordinary Collection Actions to collect a Patient debt except as noted in Section IV.M. below;
        d. Community Medical Centers must maintain ownership of the debt and the debt may not be sold to the Collection Agency;
        e. The Collection Agency must have processes in place to: identify Patients who may qualify for Financial Assistance; communicate the availability and details of the Financial Assistance Policy to these Patients; and refer Patients who are seeking Financial Assistance back to CMC's Patient Financial Services Department. The Collection Agency shall not seek any payment from a Patient whose application for Financial Assistance is pending. Upon approval of a Patient's application for Financial Assistance, the Collection Agency shall return any amount received from the Patient before or during the time the Patient's application is pending. Collections may resume if a Patient's application for Financial Assistance is denied.

K. Presumptive Eligibility
    1. In the event that an Uninsured Patient does not return a completed Financial Assistance application, at no less than 150 days after providing the Patient with a post-discharge billing statement, CMC will screen the Patient for presumptive eligibility for Financial Assistance using demographic software. If the demographic software indicates the Patient likely qualifies for Full Charity Care, CMC will provide the Patient with a complete write-off of CMC's undiscounted charges for Covered Services. Such Patient bills shall not be advanced to collections.

L. Advancing Accounts for Collection: Accounts may be advanced for collections under the following circumstances:
    1. A bill may be advanced for collection if not paid within 180 days of the date the initial invoice is sent, at the discretion of the Director of Patient Financial Services, subject to the following conditions:
        a. 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.
        b. The Patient is not attempting in good faith to settle an outstanding bill with CMC by negotiating a payment plan.
        c. The Patient is not making regular partial payments of a reasonable amount.
        d. A final determination has been made with respect to any pending appeal for coverage of the services, which includes any of the following: a grievance; an independent medical review; or a fair hearing.
    2. On the Patient's final billing statement and with any document indicating that the commencement of collection activities may occur, CMC or a Collection Agency acting on CMC's behalf, shall provide the Patient with a clear and conspicuous

written Notice of Legal Rights, as defined in Section II.Q of this Policy, as well as a Plain Language Summary of CMC's Financial Assistance Policy.

3. Community Medical Centers must have sent a Notice of Collections Activity, as defined in Section II.R of this Policy.
4. A lack of payment, failure to apply for Financial Assistance programs and failure to contact CMC will be factors considered in advancing an account to collections.
5. Third Party Liability: Nothing in this policy precludes CMC or its affiliates or outside collection agencies from pursuing third party liability.

M. Extraordinary Collection Actions

1. Prior to engaging in any Extraordinary Collection Actions and after normal collection efforts have not produced regular payments of a reasonable amount and the Patient has not completed a Financial Assistance application, complied with requests for documentation, or is otherwise non-responsive to the application process, Patient Financial Services on behalf of CMC, shall make reasonable efforts to presumptively determine whether a Patient is eligible for Financial Assistance based on prior eligibility for Financial Assistance or the use of demographic software of an external service provider.
2. A Collection Agency shall assess a Patient or guarantor's ability to pay by reviewing, at a minimum, a current credit report for the Patient, if available, and reliable sources of publicly available information for Patients with little or no credit history, or a third party electronic review of Patient information.
3. In those cases where the Collection Agency has indicated that the Patient or guarantor is not a Financially Qualified Patient, as defined in Section II.J. and is refusing to pay for the medical services received, the Collection Agency may be permitted to take action to collect the unpaid balance. If the Collection Agency has determined that legal or judicial action is appropriate and criteria for Extraordinary Collection Actions have been met, the agency must forward a written request to the facility's Vice President of Revenue Cycle, or a Director or above in Patient Financial Services, for approval prior to taking any legal or judicial action. The request must include relevant particulars of the account, including a copy of the agency's documentation that led it to believe that the Patient or guarantor has the ability to pay for the services, and that it has otherwise complied with all applicable provisions of this policy and all applicable laws and regulations.
4. Before legal or judicial action is initiated, one additional phone call will be placed by Patient Financial Services to inform the Patient or guarantor of CMC's Financial Assistance program and their ability to apply to same. If Patient or guarantor asks to apply for assistance, an application will be sent and no ECAs will be initiated until the application is received and processed, or an additional 30 days have passed without an application being received.
5. The Vice President of Revenue Cycle or a Director or above in Patient Financial Services must approve each individual legal or judicial action in writing, after determining that CMC and/or Collection Agency has made reasonable efforts to determine the individual is a Financially Qualified Patient, and CMC must maintain a copy of the signed authorization for legal or judicial action. In no case will the Collection Agency be allowed to file a legal or judicial action as a last resort to motivate a Patient to pay when the Collection Agency has no information as to the Patient's or guarantor's ability to pay.
6. Limitations on Use of Extraordinary Collection Actions: In dealing with Financially Qualified Patients, CMC shall not use wage garnishments as a means of collecting unpaid hospital bills. Any Collection Agency acting on CMC's behalf shall not use wage garnishments a means of collecting the unpaid hospital bills of Financially Qualified Patients, except in the limited circumstances permitted under Health and Safety Code 127425(f)(2)(A)-(B).
7. If a Patient is approved for Financial Assistance under this policy or the Patient Responsibility Amount has been satisfied and/or paid, within thirty (30) days of such

event, CMC and any Collection Agency acting on its behalf shall take all reasonably available measures to reverse any Extraordinary Collection Actions taken against the individual, including but not limited to vacating any judgment. After January 1, 2025, no levies or liens will be placed on Patient's property and no adverse information will be reported to any consumer reporting agency. If any levy or lien remains or credit reporting made prior to January 1, 2025 remains on a patient's credit report, CMC will remove the lien or remove the credit reporting information.

N. Recordkeeping
    1. Community Medical Centers shall maintain all records relating to money owed to CMC by a Patient or a Patient's guarantor for five (5) years, including, but not limited to, all of the following records:
        a. Documents related to litigation filed by CMC;
        b. A contract and related records for any entity to whom CMC assigned or sells medical debt;
        c. A list, updated at least annually, of every person, including name and contact information, that meets the following criteria:
            i. The person is a debt collector (as defined in Cal. Civ. Code § 1788.2) to whom CMC sold or assigned a debt that a Patient owed to CMC; and
            ii. The person is retained by CMC to pursue litigation for debts owned by a Patient on behalf of CMC.
            iii. Any contract CMC enters into related to the assignment or sale of medical debt shall require such entity to also maintain such records for five (5) years.

O. Miscellaneous
    1. Submission to California Department of Health Care Access and Information (HCAI): CMC will submit this Billing and Collection Policy and the Financial Assistance Policy to the Department of Health Care Access and Information (HCAI) (formerly the Office of Statewide Planning and Healthcare Development ("OSHPD")) biennially and each time this policy or the Financial Assistance Policy are updated. Policies can be located on the HCAOI website located here: www.hdc.hcai.ca.gov.

V. REFERENCES

26 Code of Federal Regulations 1.501(r)

California Health and Safety Code sections 124700-127446

References

Reference Type	Title	Notes
Documents referenced by this document		
Referenced Documents	Financial Assistance Policy	
Referenced Documents	Summary of the Financial Assistance Policy	
Referenced Documents	Notice of Rights and Summary of Financial Assistance Policy	
Referenced Documents	https://healthconsumer.org	
Referenced Documents	www.hdc.hcai.ca.gov	

Financial Assistance

Policy & Procedure Number	24817
Policy Manual	Administrative
Type	Policy & Procedure
Document Owner	Silva, Natalie
Effective Date	12/16/2024
Next Review Date	12/16/2027
Application Scope (Applies to)	All Community Medical Centers (CMC) Entities
Approved By / Approved Date	Christopher Neuman, SVP Chief Financial Officer: 12/05/2024 01:46PM PST Craig Wagoner, EVP Chief Operating Officer: 12/06/2024 06:54AM PST Craig S. Castro, President and Chief Executive Officer: 12/16/2024 02:33PM PST Finance and Planning (A): 12/16/2024 02:56PM PST
Status / Rev #	Official (Rev 5)
Submitted by	Burnett, Brandon M

I. PURPOSE

A. To define the forms of Financial Assistance available to Patients.
B. To describe the eligibility criteria for each form of Financial Assistance.
C. To establish the procedure that Patients must follow in applying for Financial Assistance.
D. To establish the process that Community Medical Centers (CMC) will follow in reviewing applications for Financial Assistance.
E. To provide a means of review in the event of a dispute over a Financial Assistance determination.
F. To provide administrative and accounting guidelines to assist with identifying, classifying and reporting Financial Assistance.
G. To establish the process that Patients must follow to request an estimate of their financial responsibility for services, and the process CMC shall follow to provide Patients with these estimates.

II. DEFINITIONS

A. Financial Assistance: Full Charity Care, Partial Charity Care, High Medical Costs Charity Care, Bankruptcy Charity Care, and Uninsured Discounts, as these terms are defined below. Guidelines for determining when Financial Assistance should be provided to Patients are set forth in this policy.
B. Community Medical Centers Licensed Hospital Facilities: Community Regional Medical Center, including its remote location of Fresno Heart & Surgical Hospital, and Clovis Community Medical Center.
C. Patient: An individual who received services at CMC.
D. Uninsured Patients: 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 healthcare benefit programs or third-party liability. Patients whose benefits under insurance have been exhausted prior to the admission will also be considered uninsured for purposes of this policy.
E. Insured Patients: A Patient who has a third-party source of payment which has paid for a portion of their medical expenses.

F. Covered Service(s): Covered Services for Full Charity Care, High Medical Costs Charity Care, Bankruptcy Charity Care, and Uninsured Discounts are all inpatient services, emergency care and other medically necessary care provided by CMC.
G. Covered Services (Partial Charity Care): Covered Services for Partial Charity Care Patients, are all hospital services.
H. Full Charity Care: Full Charity Care is free care, which means it is a complete write-off of CMC's undiscounted charges for Covered Services. Full Charity Care is available to Patients:
    1. Who are Uninsured, as defined above; and
    2. Who have a family income at or below 400% of the most recent Federal Poverty Level (FPL); or
    3. Who are able to provide proof of eligibility and current enrollment in a form acceptable to CMC in one of the following government programs: Medicare Savings Program, CalWORKS, CalFresh (Food Stamps), SSI/SSP, or WIC.
I. Partial Charity Care: Partial Charity Care is a partial write-off of CMC's undiscounted charges for Covered Services available to Patients:
    1. Who have a family income between 401-450% of the FPL; and
    2. Who are Uninsured, as defined above.
    3. For Partial Charity Care, CMC shall limit the expected payments for inpatient services to the Medicare inpatient Diagnosis-Related Group (DRG) for the Covered Service(s) provided (or the highest rate CMC would expect in good faith to be paid by a government program in which CMC participates), or for services where there is no established Medicare DRG, an appropriate discounted amount, provided the services are not already discounted.
    4. For Partial Charity Care for outpatient services, CMC shall limit expected payments to the Medicare fee schedule, or where there is no Medicare fee schedule rate, CMC's undiscounted charges multiplied by CMC's Medicare to cost charge ratio for outpatient services.
J. Bankruptcy Charity Care: Community Medical Centers will allow Uninsured Patients who are currently in bankruptcy proceedings or whose debts have been discharged in bankruptcy within three (3) months of their last date of service to receive a full write-off of CMC's undiscounted charges for Covered Services.
K. High Medical Costs for Insured Patients Charity Care ("High Medical Costs Charity Care"): A complete write-off of the Patient Responsibility Amount for Covered Services. This discount is available to Patients who meet the following criteria:
    1. The Patient is an Insured Patient;
    2. The Patient's family income is less than 400% of the FPL; and
    3. The Patient's, or the Patient's family's out of pocket expenses for Covered Services (incurred at CMC or other providers in the past twelve (12) months,) exceed the lesser of 10% of the Patient's family income or the Patient's family income in the last twelve (12) months. ("High Medical Costs"). Out of pocket expenses include 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.
L. Uninsured Discount: A partial write-off of undiscounted charges for Patients that meet the following criteria:
    1. The Patient is an Uninsured Patient;
    2. The Patient has not previously negotiated a fee with CMC for the services that are the subject of the current charges;
    3. The Patient does not have medical insurance provided by an insurer outside of the United States; and
    4. The Patient does not qualify for other types of Charity Care outlined in this policy or the Patient has not returned a Financial Assistance Application for other types of Charity Care outlined in this policy.
M. Medicare Denied Services: Income-eligible Medicare Patients may apply for Financial Assistance for denied stays, denied days of care, and non-covered services.

N. Medi-Cal Denied Services: Income-eligible Medi-Cal Patients may apply for Financial Assistance for denied stays, denied days of care, and non-covered services. Patients may receive Financial Assistance for their Medi-Cal share of cost.
O. Emergency Physician: A physician who provides emergency medical services in a hospital.
P. Federal Poverty Level (FPL): The measure of income level that is published annually by the United States Department of Health and Human Services (HHS) and is used by CMC for determining eligibility for Financial Assistance.
Q. Patient Responsibility Amount: 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.
R. Patient's Family: The Patient's Family shall be determined as follows:
    1. Adult Patients: For Patients 18 years of age or older, the Patient's Family includes their spouse, domestic partner, and dependent children under 21 years of age, or any age if disabled (consistent with Section 1614(a) of Part A of Title XVI of the Social Security Act, whether living at home or not.
    2. Minor Patients: For Patients under 18 years of age, or a dependent child 18 to 20 years of age, the Patient's Family includes their parents, caretaker relatives, and parent's or caretaker relatives' other dependent children under 21 years of age, or any age if disabled (consistent with Section 1614(a) of Part A of Title XVI of the Social Security Act.
S. Plain Language Summary of the Financial Assistance Policy: A written statement that notifies a Patient that CMC offers financial assistance and provides the following additional information in language that is clear, concise and easy to understand, including but not limited to:
    1. A brief description of the eligibility requirements, which advises the Patient of the maximum gross monthly household income per family size to qualify for Financial Assistance, as well as the assistance offered;
    2. A brief summary of how to apply for assistance;
    3. Contact information, including telephone number, website and physical location of the hospital department that can provide information about CMC's policy and assistance with the application process;
    4. The internet address for the Health Consumer Alliance (https://healthconsumer.org);
    5. An explanation that there are organizations that can help the Patient understand the billing and payment process;
    6. Information regarding Covered California and Medi-Cal presumptive eligibility; and
    7. The internet address for CMC's list of shoppable services, under 45 CFR § 180.60.
T. Reasonable Payment Plan: 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 all of the following, as applicable to the Patient's individual circumstances: 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, the availability of a health savings account held by the Patient or Patient's Family, and other extraordinary expenses.
U. Tortfeasor: A person who commits a tort (civil wrong), intentionally or through negligence.
V. Extraordinary Collection Action: Any of the following actions to collect a debt:
    1. Deferring or denying, or requiring a payment before providing medically necessary care because of an individual's nonpayment of one or more bills for previously provided care covered under CMC's Financial Assistance Policy.
    2. Actions that require a legal or judicial process, including but not limited to:
        a. Attaching or seizing an individual's bank account or any other personal property.
        b. Commencing a civil action against an individual.

c. Causing an individual's arrest.
d. Causing an individual to be subject to a writ of body attachment.
e. Garnishing an individual's wages.

W. Financially Qualified Patient: (Also known as a FAP-eligible Patient in IRS rules and regulations): A Patient who, according to CMC's Financial Assistance Policy, is a Patient for whom both of the following are true:
   1. The Patient is an Uninsured Patient or a Patient with High Medical Costs; and
   2. The Patient has a family income that does not exceed 400% of the FPL.

X. Notice of Rights: A clear and conspicuous notice drafted by CMC that includes all of the items required by California Health & Safety Code 127420(b)(1) -(5).

III. POLICY

A. Community Medical Centers shall provide Financial Assistance, consistent with this policy, in the form of discounted medical care, to Patients who are eligible under the terms of this policy.

B. Community Medical Centers shall provide Patients with an application enabling them to apply for Financial Assistance if they indicate at any time the financial inability to pay a bill for hospital services or if CMC is aware their household income is less than 400% FPL.

C. Community Medical Centers shall provide low-income Patients and Patients with High Medical Costs information required by law regarding their estimated financial responsibility for services and the availability of Financial Assistance and discounts, consistent with this policy.

D. Financially Qualified Patients who are able to establish eligibility for Financial Assistance in accordance with this policy by providing insurance status and income information shall receive Financial Assistance. Financially Qualified Patients who do not apply for Financial Assistance but are uninsured may qualify for Full Charity Care based on demographic analysis performed by CMC.

E. This policy applies to all CMC Licensed Hospital Facilities. Unless otherwise specified, this policy does not apply to physicians or other medical providers whose services are not included in CMC's bill. In California, an Emergency Physician who provides emergency medical services in a hospital is required to provide discounts to Uninsured Patients or Patients with high medical costs who are at or below 400% of the FPL.

IV. PROCEDURE

A. Eligibility
   1. Eligibility Criteria: During the application process, CMC shall apply the following eligibility criteria for Financial Assistance:

Financial Assistance Category	Patient Eligibility Criteria	Available Discount
Full Charity Care	a. Patient is an Uninsured Patient; and	Complete write-off of CMC's undiscounted charges for Covered Services.

		b. Patient has a family income at or below 400% of the most recent FPL; or c. Patient can provide proof of eligibility and current enrollment in a form acceptable to CMC in one of the following government programs: Medicare Savings Program, CalWORKS, CalFresh (Food Stamps), SSI/SSP, or WIC.	
Partial Charity Care		a. Patient is an Uninsured Patient; and b. Patient has a family income between 401% and 450% of the most recent FPL.	Partial write-off of CMC's undiscounted charges for Covered Services. For Inpatient Services: CMC shall limit the expected payments to the Medicare inpatient Diagnosis-Related Group (DRG) for the Covered Service(s) provided (or the highest rate CMC would expect in good faith to be paid by a government program in which CMC participates), or for services where there is no established Medicare DRG, an appropriated discounted amount, provided the services are not already discounted. For Outpatient Services, CMC shall limit expected payments to the Medicare fee schedule, or where there is no Medicare

		fee schedule rate, CMC's undiscounted charges multiplied by CMC's Medicare to cost charge ratio for outpatient services.
High Medical Costs Charity Care (for Insured Patients)	a. Patient is an Insured Patient; b. Patient's family income is at or below 400% of the most recent FPL; c. Out of pocket expenses for Patient or their Family (incurred at CMC or other providers in the past 12 months) exceeds the lesser of 10% of the Patient's current family income or Patient's family income in the last 12 months. Out of pocket expenses include 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.	Complete write-off of the Patient Responsibility Amount for Covered Services.
Bankruptcy Charity Care	a. Patient is an Uninsured Patient; and b. Patient is currently in bankruptcy or completed bankruptcy within the last three (3) months of their last	Full write-off of CMC's undiscounted charges for Covered Services.

		date of service at CMC.	
Uninsured Discount		a. Patient is an Uninsured Patient; and b. Patient has not previously negotiated a fee with CMC for the services that are the subject of the current charges; and c. Patient does not have medical insurance provided by an insurer outside of the United States; and d. Patient does not qualify for other types of Charity Care outlined in this policy; or e. Patient has not returned an Application for Financial Assistance for other types of Charity Care outlined in this policy.	35% write-off of CMC's undiscounted charges for Covered Services.

B. Calculating Patient's family income: To determine a Patient's eligibility for Financial Assistance, CMC shall first calculate the Patient's family income, as follows:
    1. Patient's family income is the annual earnings of the members of the Patient's Family, as defined in Section II.R. above, from the prior twelve (12) months or prior tax year as shown by the recent pay stubs or income tax returns, less payments made for alimony and child support. Monetary assets will not be considered when determining family income. Annual income may be determined by annualizing year-to-date family income.
        a. Calculating family income for Deceased Patients: Deceased Patients with no surviving spouse, may be deemed to have no income for purposes of calculation of Patient's family income. Documentation of income is not

required for deceased Patients; however, documentation of estate assets may be required. The surviving spouse of a deceased Patient may apply for Financial Assistance.

b. For purposes of calculating the Patient's current family income to determine High Medical Costs, as defined in Section II. K. above, certain situations may be based on three (3) months to determine the Patient's current family income.

2. Calculating Patient's family income as a Percentage of FPL: After determining a Patient's family income, CMC shall calculate the Patient's family income level in comparison to the FPL, expressed as a percentage of the FPL. For example, if the FPL for a family of three is $20,000, and a Patient's family income is $60,000, CMC shall calculate the Patient's family income to be 300% of the FPL. This calculation shall be used to determine whether a Patient meets the criteria for Financial Assistance.
3. Calculating family income to determine presumptive eligibility for Financial Assistance: In the event that an Uninsured Patient does not request or return a completed Application for Financial Assistance, at no less than 150 days after providing the Patient with a post-discharge billing statement, CMC may screen the Patient for Presumptive Eligibility for Financial Assistance using demographic software of an external service provider. If the demographic software indicates the Patient likely qualifies for Full Charity Care, CMC will provide the Patient with a complete write-off of CMC's undiscounted charges for Covered Services.
4. Proof of family income: Patients shall only be required to provide recent pay stubs or tax returns as proof of income (except in the case of enrollment in government programs, as outlined in this policy).

C. Financial Assistance Exclusions/Disqualification: The following are circumstances in which Financial Assistance is not available under this policy:
    1. Medi-Cal Patients with Share of Cost: Medi-Cal Patients who are responsible to pay share of cost may be eligible for Financial Assistance for the purpose of reducing the amount of Share of Cost owed. Community Medical Centers shall seek to collect these amounts from Patients.
    2. Insured Patient Does Not Cooperate with Third-Party Payer: An Insured Patient who is insured by a third-party payer that refuses to pay for services because the Patient failed to provide information to the third-party payer necessary to determine the third-party payer's liability is not eligible for Financial Assistance unless insured Patient shows good cause for the failure at any point through and including participation in an Extraordinary Collection Action.
    3. Payer Pays Patient Directly: If a Patient receives payment for services directly from an indemnity, Medicare Supplement, or other payer, the Patient is not eligible for Financial Assistance for the amounts paid by that payer.
    4. Information Falsification: Community Medical Centers may refuse to award Financial Assistance to Patients who falsify information regarding income, household size, or other information in their eligibility application.
    5. Third Party Recoveries: If the Patient receives a financial settlement or judgment from a third-party Tortfeasor that caused the Patient's injury, the Patient must use the settlement or judgment amount to satisfy any Patient account balances, and is not eligible for Financial Assistance.
    6. Professional (Physician) Services: Services of physicians such as anesthesiologists, radiologists, hospitalists, pathologists, etc. are not covered under this policy, though medical debt to such providers will be included in calculating High Medical Costs. Many physicians have charity care policies that allow Patients to apply for free or discounted care. Patients should obtain information about a physician's charity care policy directly from their physician.

D. Application Process

1. Community Medical Centers shall provide the Plain Language Summary of the Financial Assistance Policy and the Application for Financial Assistance when it provides the good faith estimate prior to services.
2. Community Medical Centers shall make all reasonable efforts to obtain from the Patient or his/her representative, information about whether private or public health insurance may fully or partially cover the charges for care rendered by CMC to Patient. If CMC bills a Patient who has not provided proof of coverage by a third party at the time the care is provided or upon discharge, as a part of that billing, CMC shall provide the Patient with a Notice of Rights.
3. A Patient who indicates at any time, through and including referral for Extraordinary Collections Action, that they are financially unable to pay a bill for hospital services shall promptly be given the opportunity to have their eligibility for Financial Assistance evaluated by CMC's Patient Financial Services Department. Community Medical Centers shall attempt to contact the Patient by mail and by telephone to attempt to determine if Patient's household income is less than 400% of the FPL. If the Patient indicates his/her household income is less than 400% of the FPL, CMC shall notify Patient of availability and potential eligibility for financial assistance and promptly provide an application.
4. In order to qualify as an Uninsured Patient, the Patient or the Patient's guarantor must verify that he/she is not aware of any right to insurance or government program benefits that would cover or discount the bill.
5. All Patients will be encouraged to investigate their potential eligibility for government program assistance if they have not already done so. Community Medical Centers or its authorized representatives will provide an application for the Medi-Cal program or other government funded programs if the Patient indicates they do not have coverage by a third-party payer or requests Financial Assistance. Community Medical Centers will also attempt to assist Patients in determining whether they are eligible to enroll with plans in the California Health Benefit Exchange (i.e., Covered California). However, application in any of these programs is not required to apply for or receive financial assistance.
6. Patients are required to make every reasonable effort to provide CMC with documentation of income and health benefits coverage. Patients who are insured but fail to provide CMC with necessary insurance and/or income information may be denied Financial Assistance.
7. Patients who wish to apply for Financial Assistance shall use the CMC standardized application form "Application for Financial Assistance".
8. Patients may request assistance with completing the Application for Financial Assistance in person at the Admitting Department of any CMC Licensed Hospital Facilities or over the phone by contacting Patient Financial Services at (559) 459-3939.
9. Copies of the Application for Financial Assistance may also be found by visiting the Admitting Department of any CMC hospital, through the mail, or via the CMC website, (https://www.communitymedical.org/for-patients-families/billing-insurance/help-paying-your-bill).
10. Patients should complete the Application for Financial Assistance as soon as possible after receiving treatment at CMC. Applications received at any time will be considered for acceptance.
11. Patients should mail Applications for Financial Assistance to: Community Medical Centers, Patient Financial Services Department, P.O. Box 1232, Fresno, CA 93715, Attn: Financial Assistance Application.

E. Financial Assistance Determination
1. Community Medical Centers will consider each application for Financial Assistance and grant Financial Assistance when the Patient meets the eligibility criteria set forth in this policy.

2. Information concerning income obtained as part of the eligibility process shall be maintained separately from the files used to collect the debt, and shall not be used for collections activities either by CMC or by any collection agency engaged by CMC, unless independently obtained by CMC or the collection agency.
3. Community Medical Centers will not make Financial Assistance determinations based on information that CMC and any collection agencies acting on its behalf have reason to believe is unreliable, incorrect or obtained from the Patient under duress or through the use of coercive practices.
4. If a Patient applies, or has a pending application for another health coverage program at the same time that he or she applies for Financial Assistance, the application for coverage under another health coverage program shall not preclude the Patient's eligibility for Financial Assistance.
5. Financial Assistance Applications should be reviewed promptly. Community Medical Centers shall complete its determination of eligibility within 45 days of receipt of the application. A determination will be postponed while insurance or other sources of payment are still pending.
6. Once a Financial Assistance determination has been made, a notification will be sent to each applicant advising them of CMC's decision.
7. If a Patient is approved for Financial Assistance under this policy, CMC and any collection agencies acting on its behalf shall take all reasonably available measures to reverse any Extraordinary Collection Actions taken against the individual, including but not limited to vacating any judgment, lifting any levy or lien on the Patient's property, and removing any adverse information reported to any consumer reporting agency from the individual's credit report that was reported prior to January 1, 2025, after which no reporting to consumer reporting agencies will be made.
8. If a Patient is approved for Financial Assistance under this policy, but after the initial application and approval process it is determined that Patient is ineligible due to a third-party payer, the charges shall be reinstated and CMC shall pursue the third-party payer to obtain payment on the Patient's account. If it is later determined that the third-party payer is not responsible for payment of the Patient's charges, the Patient's eligibility shall be reinstated without requiring a new Application for Financial Assistance.
9. Once a determination is made that a Patient is eligible for Financial Assistance, the Patient is presumed eligible for Financial Assistance covering all outstanding bills for Covered Services as of the date CMC issues the Notification Form to the Patient, as well as Covered Services for a period of six (6) months following that date. After this six-month period has ended, Patients must re-apply for Financial Assistance.
10. If the Financial Assistance determination creates a credit balance in favor of the Patient, the refund of the credit balance shall be made within thirty (30) days from the date of the Patient's payment and must include interest on the amount of the overpayment from the date of the Patient's payment at the statutory rate (currently 10% per annum) pursuant to Health and Safety Code section 127440. Refunds under this section are not required if: (a) five years or more since the Patient's last payment to CMC or (b) the debt was sold prior to January 1, 2022.
11. If a Patient is determined eligible for Partial Charity Care, CMC will provide the Patient with a billing statement that indicates the amount the Patient owes and how that amount was determined.
12. Reasonable Payment Plans: Financially Qualified Patients who do not qualify for Full Charity Care shall be eligible for a Reasonable Payment Plan. Community Medical Centers and the Patient shall negotiate the terms of the plan, taking into consideration the Patient's family income and essential living expenses. If CMC and the Patient cannot agree on the Reasonable Payment Plan, CMC shall use the formula described in Section II. T. of this policy to create a Reasonable Payment

Plan. Payment plans shall be offered and negotiated per CMC's Billing and Collections Policy.

F. Disputes
    1. A Patient may seek review of any decision by CMC to deny Financial Assistance by notifying Patient Financial Services of the basis for the dispute and the desired relief within thirty (30) days of the Patient receiving the notice of the circumstances giving rise to the dispute. Patients may submit the dispute orally by calling Patient Financial Services at (559) 459-3939, or in writing by mailing the above information to Community Medical Centers, Patient Financial Services Department, P.O. Box. 1232, Fresno, CA 93715. A designated Patient Financial Services manager shall review the Patient's dispute as soon as possible and inform the Patient of any decision in writing.

G. Availability of Financial Assistance Information
    1. Languages: This policy shall be available in the primary language(s) of CMC's Service Area. In addition, all notices and communications required by all federal and state laws and regulations regarding Financial Assistance shall be available and distributed in primary language(s) of CMC's Service Area and in a manner consistent with all applicable federal and state laws and regulations. When CMC has reason to know that a Patient's primary language is not English, all notices/communications provided the Patient and written correspondence to the Patient shall be in the language spoken by the Patient, provided it is one of the Primary Language(s) of CMC's Service Area. For purposes of these policies, a Primary Language of CMC's Service Area is a language used by the lesser of 1,000 people or 5% of the community served by CMC or the population likely to be affected or encountered by CMC. Community Medical Centers may determine the percentage or number of limited English proficiency individuals in CMC's community or likely to be affected or encountered by CMC using any reasonable methods.
    2. Information Provided to Patients During the Provision of Hospital Services:
        a. Community Medical Centers or an authorized representative of CMC shall provide all Patients with a copy of a plain language summary of the Financial Assistance Policy which advises the Patient of the maximum gross monthly household income per family size to qualify for Financial Assistance as follows:
            i. At Registration: During registration (or as soon thereafter as practicable).
            ii. Emergency Services: In the case of emergency services, as soon as practicable after stabilization of the Patient's emergency medical condition or upon discharge.
            iii. Outpatient Services: At the outpatient appointment before the procedure takes place.
            iv. At Discharge: At the time of discharge, when CMC or an authorized representative of CMC shall also provide or offer to provide all Uninsured Patients applications for Medi-Cal, California Children's Services or any other potentially applicable government program.
            v. For notices provided pursuant to Section IV.G.2.A.2 and A.3, the plain language summary will be provided to Patients who are conscious. If the Patient is unconscious or not able to receive the plain language summary, then the notice must be provided at discharge.
            vi. For Patients not admitted to CMC, the plain language summary will be provided when the Patient is leaving the facility.
            vii. If a Patient leaves CMC without receiving the plain language summary, CMC will mail the notice to the patient within seventy-two (72) hours of providing the services.

b. Community Medical Centers shall provide every Uninsured Patient with a written estimate of the amount CMC will require the person to pay, pursuant to California Health & Safety Code Section 1339.585. The plain language summary of the Financial Assistance Policy and an Application for Financial Assistance will accompany the written estimate required by California Health & Safety Code Section 1339.585.

3. Information Provided to Patients at Other Times:
    a. Contact Information: Patients may contact CMC's Patient Financial Services Department by phone at (559) 459-3939 or in person at the locations listed on the Financial Assistance - Locations document, to obtain additional information about Financial Assistance and to receive assistance with the application process.
    b. Billing Statements: Community Medical Centers shall bill Patients in accordance with CMC's Billing and Collections Policy. Billing statements to Patients shall include a Notice of Rights. A summary of the Patient's legal rights shall also be included on the Patient's final billing statement before engaging in Extraordinary Collection Actions.
    c. Upon Request: Community Medical Centers shall provide Patients with paper copies of the Financial Assistance Policy, the Application for Financial Assistance, and the plain language summary of the Financial Assistance Policy upon request and without charge.
4. Publicity of Financial Assistance Information:
    a. Community Medical Centers shall widely publicize the Financial Assistance Policy in a manner that is reasonably calculated to reach, notify and inform those Patients in our communities who are most likely to require Financial Assistance, including at a minimum, the following ways:
        i. Public Displays: Community Medical Centers shall clearly and conspicuously post public displays (or other measures reasonably calculated to attract Patients' attention) that notify and inform Patients about this policy in public locations at CMC including, at a minimum, the emergency department, billing office, admissions office, and outpatient settings, including observation units. These shall be posted in English, Spanish and Hmong.
        ii. Website: The Financial Assistance Policy, Application for Financial Assistance, and plain language summary of the Financial Assistance Policy shall be available on the home page and main billing page, as well as other prominent places on CMC's website, (https://www.communitymedical.org/for-patients-families/billing-insurance/help-paying-your-bill). Persons seeking information about Financial Assistance shall not be required to create an account or provide any personal information before receiving information about Financial Assistance.
        iii. Mail: Patients may request a free copy of the Financial Assistance Policy, Application for Financial Assistance and plain language summary of the Financial Assistance Policy be sent by mail.
        iv. Other Efforts: Community Medical Centers will provide a digital kit to relevant community organizations who will widely publicize the availability of this policy to affected Patients in the community.

H. Miscellaneous
1. Recordkeeping: Records relating to Financial Assistance must be readily accessible. Community Medical Centers must maintain information regarding the number of Uninsured Patients who have received services from CMC, the number of Applications for Financial Assistance completed, the number approved, the estimated dollar value of the benefits provided, the number of applications denied,

and the reasons for denial. In addition, notes relating to a Patient's approval or denial for Financial Assistance should be entered into the Patient's account.

2. Billing and Collections: Community Medical Centers may employ reasonable collection efforts to obtain payment from Patients. Information obtained during the application process for Financial Assistance may not be used in the collection process, either by CMC, or by any collection agency engaged by CMC. General collection activities may include issuing Patient statements, phone calls, and referral of statements that have been sent to the Patient or guarantor. Affiliates and Revenue Cycle departments must maintain procedures to ensure that Patient questions and complaints about bills are researched and corrected where appropriate, with timely follow up with the Patient. Neither CMC, nor any collection agency engaged by CMC, will engage in any Extraordinary Collection Actions, except as allowed by CMC's Billing and Collection Policy. Copies of CMC's Billing and Collection policy may be obtained free of charge upon written request or obtained on CMC's website), (https://www.communitymedical.org/for-patients-families/billing-insurance/help-paying-your-bill). Translations of the Financial Assistance Policy and the Billing and Collections Policy are available upon request.
3. Submission to California Department of Health Care Access and Information (HCAI): Community Medical Centers will submit this Financial Assistance Policy and the Billing and Collection Policy to HCAI (formerly the Office of Statewide Planning and Healthcare Development (OSHPD)) biennially and each time this policy or the Billing and Collection Policy are updated. Policies can be located on the HCAI website located here: www.hdc.hcai.ca.gov.

I. Amounts Generally Billed

1. In accordance with the Internal Revenue Code Section 1.501(r)(5), CMC adopts the prospective Medicare methods for amounts generally billed. Patients who are eligible for Financial Assistance are not financially responsible for more than the amounts generally billed.

V. REFERENCES

Internal Revenue Code section 501(r)

26 Code of Federal Regulations 1.501(r)

California Health and Safety Code sections 124700-127446

References

Reference Type	Title	Notes
Documents referenced by this document		
Referenced Documents	www.communitymedical.org	
Referenced Documents	Financial Assistance - Provider List	
Referenced Documents	Financial Assistance Application	
Related Documents	Notification Form	
Referenced Documents	Summary of the Financial Assistance Policy	
Referenced Documents	Notice of Rights and Summary of Financial Assistance Policy	
Referenced Documents	Financial Assistance - Locations	
Referenced Documents	Billing and Collections	
Referenced Documents	https://healthconsumer.org	

Referenced Documents	https://www.communitymedical.org/for-patients-families/billing-insurance/help-paying-your-bill
Referenced Documents	www.hdc.hcai.ca.gov