POLICY: Patient Billing and Collection Policy
EFFECTIVE DATE: 1-1-2025
REVISED DATE(S): 12-28-21, 1-1-24, 12-17-24

Southern Mono Healthcare District d/b/a Mammoth Hospital ("MH" or "Hospital") to maintain the highest level of commitment to providing excellence in Customer Service. We recognize patients usually seek medical services out of necessity. We also recognize that the costs associated with this care are generally not budgeted for in advance. In addition to having to adjust to the physical, emotional, and spiritual elements associated with an illness or injury, patients and their families must also face an unforeseen financial burden. MH is committed to providing a compassionate and caring approach in helping our patients resolve their financial obligations associated with the hospital services they receive.

This policy, together with the Financial Assistance Policy, is intended to satisfy the requirements related to hospital billing and collection activities including California's Hospital Fair Billing Law codified at Health and Safety Code section 127400-127446, et seq. and the associated implementing regulations at California Code of Regulations section 96051-96051.37, et seq., California's Rosenthal Fair Debt Collection Practices Act as applicable to hospitals codified at Civil Code section 1788, et seq., section 501(r)(6) of the federal Internal Revenue Code, and the federal Fair Debt Collection Practices Act, Regulation F codified at 12 C.F.R. part 1006. A copy of the published Patient Billing and Collection Policy, and all amended or revised Policies, shall be provided to the State of California Department of Health Care Access and Information or
"HCAI" (f/k/a the Office of Statewide Health Planning and Development) in accordance with HCAI state filing procedures (See generally, Title 22 of the California Code of Regulations (CCR) section 96040-96051.37, et seq.).

Purpose

This policy establishes reasonable procedures regarding billing and collection of patient accounts in accordance with applicable federal and state laws. Billing and collections actions may be taken by MH or contracted external companies and law firms.

Scope / Applicability

This policy applies to all Hospital inpatient and outpatient services in which MH performs billing (in most cases it includes physician professional fees).

Definitions

Extraordinary Collection Action (ECA): Actions taken by a hospital facility against an individual related to obtaining payment of a bill for care covered under the hospital's Financial Assistance Policy that (i) involve selling an individual's debt to another party, (ii) involve reporting adverse information about an individual to consumer credit reporting agencies or credit bureaus, (iii) involve deferring or denying, or requiring a payment before providing, medically necessary care because of an individual's non-payment of one or more bills for previously provided care

covered under the hospital facility's Financial Assistance Policy, or (iv) require a legal or judicial

process. Examples of actions that may require a legal or judicial process include, but are not limited to (a) placing a lien on an individual's property, (b) foreclosing on an individual's real property, (c) attaching or seizing an individual's bank account or any other personal property, (d) commencing a civil action against an individual, (e) causing an individual's arrest, (f) causing an individual to be subject to a writ of body attachment, and (g) garnishing an individual's wages. A claim filed by a hospital facility in any bankruptcy proceeding is not an ECA. Also, a lien placed on the proceeds of a judgment, settlement, or compromise owed to an individual (or his or her representative) as a result of personal injuries caused by a third party for which the hospital facility provided care is not an ECA.

Policy

Reasonable Efforts to Identify Patients Eligible for Financial Assistance
At least 30 days prior to engaging in ECAs (either directly or indirectly through an authorized vendor) to obtain payment for the care provided, MH will notify individuals that financial assistance is available to eligible individuals by doing the following:

1. Provide written notice to the individual indicating that financial assistance is available to eligible individuals, indicating that MH intends to initiate or have a third party initiate to obtain payment for the care, and provides a deadline after which ECAs may be pursued and which is no later than 30 days after the date of this written notice;
2. Provide the individual a Plain Language Summary of the Financial Assistance Policy with this written notice; and
3. Make reasonable efforts to orally notify individuals about the Mammoth Hospital's financial assistance policy.

Prior to engaging in ECAs, MH staff will confirm that reasonable efforts were made to determine whether an individual is eligible for financial assistance.

Notification Period
ECAs for hospital services will not commence for a period of 180 days after the date of the initial billing statement for the applicable medically necessary or emergency medical care. Where there is a pending appeal (as hereinafter defined) regarding coverage of the services and the patient makes a reasonable effort to communicate with the hospital about the progress of any pending appeal, this period will be extended until a final determination of that appeal is made. A "pending appeal" includes a grievance against a contracting health care service plan or against an insurer, an independent medical review, a MediCal claim review fair hearing, or an appeal regarding Medicare coverage consistent with federal law and regulations.

Financial Assistance Application Period
. MH widely publicizes the availability of financial assistance and make reasonable efforts to identify individuals who may be eligible. The eligibility criteria and application process is set forth in MH's Financial Assistance Policy.

If a patient submits a complete financial assistance application after the account has been referred to a collection agency, MH will suspend ECAs and make an eligibility determination before resuming applicable ECA activity. Once a determination on eligibility for financial assistance has been made, a "Financial

Assistance Eligibility Determination Letter" will be sent to each applicant advising them of the MH decision. If a patient submits an incomplete application, MH will notify the patient about how to complete the application and give the patient a reasonable opportunity to do so.

Financial Expectations
Consistent with this Policy and the Financial Assistance Policy, MH will clearly communicate with patients regarding financial expectations as early in the appointment and billing process as possible.

- Patients are responsible for understanding their insurance coverage and for providing needed documentation to aid in the insurance collection process.
- Patients may be required to pay a pre-service deposit or estimated co-pays, co-insurance and deductibles prior to services (except in the Emergency Department and other emergent situations).
- Patients are generally responsible for paying self-pay balances, including any amounts not paid by insurance companies or applicable third party payers.

Insurance Collections
MH will maintain and comply with policies and procedures to ensure the timely and accurate submission of claims to all known primary health plans or insurance payers ("Payer") clearly identified by the patient. If MH timely receives from the patient complete and accurate information about the Payer but does not timely submit a claim to the Payer and the Payer denies the claim based on that untimely filing, the patient will be responsible for only the amount that the patient would be liable to pay had the Payer paid the claim. However, if MH determines that it either timely filed the claims or was provided inaccurate or incomplete information, then the patient will be held responsible.

MH shall not refer any bill to a third-party collection agency or attorney for collection activity while a claim for payment of the services is pending with a contracted payer. MH may refer a bill to a third-party collection agency or attorney following an initial denial or untimely denial of the claim by a Payer.

MH will not refer any bill to a third-party collection agency or attorney for collection activity when a claim is denied by a third-party payer due to MH's error and such error results in the patient becoming liable for the debt when they would not otherwise be liable. MH reserves the right to substantiate that an error has been made and if MH determines that it has not made an error, then the patient may be held liable. Patients must sign an authorization allowing MH to bill the patient's health plan, insurance company or any other third party payer, and must cooperate with MH in a reasonable manner by providing requested information to facilitate proper billing to a patient's health plan or insurance company.

MH makes every reasonable attempt to collect from all known Payers, with whom MH has a contract and non-contracted payers for services provided to assist patients in resolving their bills.

Self-Pay Balance Resolution
MH will employ reasonable procedures in a fair and consistent manner to collect patient self-pay balances, maintaining confidentiality and patient dignity. Financial assistance will be offered those patients whose income will not allow full payment of services within a reasonable time.

Self-pay collection procedures and process flows are followed by MH and must fully comply with this Policy. MH and its affiliates have developed a process for patients to question or dispute bills, including a toll-free phone number patients may call and an address to which they may send written correspondence. The phone number and address shall be listed on all patient bills and collection notices sent by MH. MH will make reasonable attempts to return telephone calls made by patients to this number as promptly as possible, but in no event later than five business days after the call is received.

Collection AgencyMH does not sell debt to collection agencies. Third-party debt collection agencies may be enlisted only after all reasonable collection and payment options have been exhausted. Agencies may help resolve accounts for services that have been qualified and assigned to bad debt due to patients being uncooperative in making payments, not making appropriate payments, or being unwilling to provide reasonable financial and other data to support their request for financial assistance.

Collection agency staff will uphold the confidentiality and individual dignity of each patient. All agencies will meet all HIPAA requirements for handling protected health information.

When reviewing the account for referral to a collection agency, the responsible person will confirm that:

- There is a reasonable basis to believe that the patient owes the debt.
- All known Payers have been properly billed such that any remaining debt is the financial responsibility of the patient. Where the patient has indicated an inability to pay the full amount of the debt in one payment, consideration of a reasonable payment plan is required provided that MH may require the patient to provide reasonable verification of the inability to pay the full amount of the debt in one payment.
- The patient has been given a reasonable opportunity to submit an application for Financial Assistance. Particular attention should be given when a patient is uninsured or is currently on Medical Assistance, or other relief based on need.

If a patient submits a complete application for Financial Assistance after an account has been referred for collection activity, MH will suspend ECAs until the patient's application has been processed and the patient notified of MH determination.

When an extended payment plan as referenced in the Financial Assistance Policy has been established, ECAs will not commence prior to the time the extended payment plan is declared to be no longer operative. An extended payment plan may be declared no longer operative when the patient fails to make all consecutive payments for 90 days and fails to renegotiate a payment plan.

After the hospital has been notified that the patient has filed a complaint with HCAI, MH will not send the unpaid bill to any collection agency, debt buyer, or other assignee unless that entity has agreed to comply with the Hospital Fair Pricing Act. This shall apply only to the bill(s) for which the patient has filed a complaint with HCAI.

Responsible Department

Implementation, training, and monitoring compliance with this policy and procedure are the responsibilities of Revenue Cycle Management Director.

Renewal/Review

This policy and procedure shall be reviewed at planned intervals and evaluated as necessary, but at least every two years to determine if it complies with current recommendations, guidelines, mandates, statutes, practices, and MH operations. If changes are required, the policy and procedure will be updated as needed.