EFFECTIVE DATE

The effective date of this Billing and Collections Policy is January 1, 2025.

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.*, 22 California Code of Regulations section 96051 *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 Aurora Charter Oak Behavioral Health Care and any legal entity for which Aurora Charter Oak Behavioral Health Care is the sole member or directly or indirectly controls greater than 50% of the voting power or equity interest. This policy applies to any billing or Collection Agency working on behalf of the 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 Free Care and High Medical Cost/Discount Care, as those terms are defined in the Policy on Financial Assistance for Aurora Charter Oak Behavioral Health Care (Free & Discount Care Policy).

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.

PROCEDURES

A. Billing Third-Party Payers

1. **Obtaining Coverage Information**. Hospital 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**. Hospital 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. Hospital 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 individual responsible for finance, or designee, will pursue collections from patients.

1. **Billing Insured Patients**. Hospital 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, hospital 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.

3. **Financial Assistance Information**. All bills to patients shall include the Notice of Rights (see **Attachment B**), 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. **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. Hospital 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. **Notice of Right to Request GFE**. 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. **Content of GFE**. 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. **Delivery of GFE**. 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 provided 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 prior to 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) calendar days of receiving the initial 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**. Hospital 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. Hospital 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. **No Collection during Uninsured/Self-Pay Dispute Resolution Process**. Hospital may not move a bill into collection, or threaten to do so, if an Uninsured or Self-Pay Patient has initiated the CMS-sponsored patient-provider dispute resolution process, which allows an Uninsured or Self-Pay Patient to challenge a bill when the total Billed Charge is at least $400 more than the total amount of expected charges listed in the GFE. If a bill was previously moved into collection, and the Uninsured or Self-Pay Patient initiates the CMS-sponsored patient-provider dispute resolution process, Hospital and any Collection Agency must cease collection efforts until the conclusion of the dispute resolution process.

5. **Prohibition on Use of Information from Financial Assistance Application**. Hospital 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.

6. **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. Facility shall evaluate each patient's financial need based on the guidelines found in the applicable policies on financial assistance and free 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.

7. **Payment Plans**:

   a. **Eligible Patients**. Hospital 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. Hospital may also enter 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,

starting with the first day that the Patient misses a payment. 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 at least sixty (60) calendar days after the first missed payment 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. The patient shall be given at least thirty (30) calendar days, starting from the date the written notice of the missed payment was sent, to make a payment before the extended payment plan is declared inoperative. 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. If a payment plan is declared inoperative, and the patient has qualified for Financial Assistance, Hospital or Collection Agency shall limit the amount it seeks from the patient to the amount the patient was responsible to pay after any discounts.

F. Collection Agencies. Hospital may refer Patient accounts to a Collection Agency, subject to the following conditions:

1. Before sending a Patient account to a Collection Agency, the Hospital shall send a Patient the notice set forth in **Attachment A** (Notice of Assignment to Collection Agency).

2. The Collection Agency must have a written agreement with the hospital.

3. Hospital's written agreement with the Collection Agency must provide that the Collection Agency's performance of its functions shall adhere to Aurora Charter Oak Behavioral Health Care mission, vision, core values, the terms of the Policy on Financial Assistance for Aurora Charter Oak Behavioral Health Care (Free & Discount Care Policy), this policy, and the Hospital Fair Pricing Act, Health and Safety Code section 127400 through 127446.

4. The Collection Agency must agree that it will not engage in any Extraordinary Collection Actions to collect a Patient debt.

5. Hospital must maintain ownership of the debt (i.e., the debt is not "sold" to the Collection Agency).

6. 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 Aurora Charter Oak Behavioral Health Care (Free & Discount Care Policy) to these patients,

and refer patients who are seeking Financial Assistance back to the hospital's patient financial services at 626-966-1632 or at K.johnson@aurorabehavioral.com. 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.

7. 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.

8. The Collection Agency must send every Patient a copy of the Notice of Rights (see **Attachment B**).

9. At least one hundred-twenty (120) calendar days must have passed since the hospital sent the initial bill to the Patient on the account.

10. 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 sections 124700 through 127446
22 California Code of Regulations sections 96051 through 96051.37
Federal IDR Portal

Internal Revenue Code section 501(r)

Free & Discount Care Policy

Policy on Financial Assistance

Policy for Initiation of Litigation or Arbitration Involving Third Party Payers

ATTACHMENTS

Attachment A: Notice of Assignment to Collection AgencyAttachment B: Notice of Rights

Attachment C: Debt Collection

Attachment A

Notice of Assignment to Collection Agency

Patient Name: _____

Date(s) of Services: _____

Patient Account Number: _____

Date of Initial Bill: _____ (1)

Collection Agency: _____

Amount Due: _____

Date of Application for Financial Assistance (if applicable)" _____

Date of Determination of Eligibility for Financial Assistance (if applicable): _____

Health Coverage and Coverage Type (or N/A if patient is uninsured): _____

Thank you for choosing Aurora Charter Oak Behavioral Health Care. As of the date of this Notice of Assignment to Collection Agency, Aurora Charter Oak Behavioral Health Care has not received payment of the amount due that is set forth above. This Notice of Assignment to Collection Agency is to notify you that the patient account identified above is being assignment to a collection agency. The collection agency is identified above.
The collection agency may attempt to contact you in writing or by telephone concerning the amount that remains outstanding.

Itemized Bill. You can obtain an itemized bill regarding the amount owed. Please contact Patient Financial Services at 626-966-1632 if you would like to receive an itemized bill.

Financial Assistance. Aurora Charter Oak Behavioral Health Care 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 **or** 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; **or** (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.

Aurora Charter Oak Behavioral Health Care's application for Financial Assistance is included with this Notice of Assignment to Collection Agency.

Hospital Bill Compliant Program. The Hospital Bill Complaint Program is a state program, which reviews hospital decisions about whether you qualify for help paying your hospital bill. If you believe you were wrongly denied financial assistance, you may file a complaint with the Hospital Bill Complaint Program. Go to HospitalBillComplaintProgram.hcai.ca.gov for more information and to file a complaint.

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 626-966-1632. Our telephone hours are 8:00 A.M. to 5:00 P.M., Monday through Friday.

ATTENTION: If you need help in your language, please call 626-966-1632 or visit the Patient Financial Services office. Our telephone hours are 8:00 A.M. to 5:00 P.M., Monday through Friday. Aids and services for people with disabilities, like documents in braille, large print, audio, and other accessible electronic formats are also available. These services are free.

Attachment B
Notice of Rights

Thank you for selecting Aurora Charter Oak Behavioral Health Care 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.

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, 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 (382-4357) 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 626-966-1632 for a referral.

Aurora Charter Oak Behavioral Health Care 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 (Free Care): Aurora Charter Oak Behavioral Health Care 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 **or** 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; **or** (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 at located within the Patient Access/Registration Departments at the Hospital, or by calling Patient Financial Services at 626-966-1632. 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 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 626-966-1632.

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 person at our Patient Registration or Patient Financial Services offices, as well as at www.charteroakhospital.com 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 626-966-1632.

In accordance with Internal Revenue Code Section 1.501(r)-5, Aurora Charter Oak Behavioral Health Care 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 free 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/Medicaid, California Children's Services, or any other source of payment for this bill, please contact Patient Financial Services at 626-966-1632. 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/Medicaid 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.

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 626-966-1632.

California Health Benefit Exchange: You may be eligible for health care coverage under Covered California. Contact the hospital Patient Financial Services for more detail and assistance to see if you quality for health care coverage through Covered California.

Hospital Bill Complaint Program: The Hospital Bill Complaint Program is a state program, which reviews hospital decisions about whether you qualify for help paying your hospital bill. If you believe you were wrongly denied financial assistance, you may file a complaint with the Hospital Bill Complaint Program. Go to HospitalBillComplaintProgram.hcai.ca.gov for more information and to file a complaint.

Help Paying Your Bill. There are free consumer advocacy organizations that will help you understand the billing and payment process You may call the Health Consumer Alliance at 888- 804-3536 or go to https://healthconsumer.org for more information. Please contact Patient Financial Services for further information.

Price Transparency. Healthcare cost transparency is important to help consumers make informed decisions about their care. We post a list of standard charges. Please visit the following website for more information: www.charteroakhospital.com

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 626-966-1632. Our telephone hours are 8:00 A.M. to 5:00 P.M., Monday through Friday.

ATTENTION: If you need help in your language, please call 626-966-1632 or visit the Patient Financial Services office at the hospital. Our telephone hours are 8:00 A.M. to 5:00 P.M., Monday through Friday. Aids and services for people with disabilities, like documents in braille, large print, audio, and other accessible electronic formats are also available. These services are free.

Attachment C

Debt Collection

It is the policy of Sacramento Behavioral Healthcare Hospital to collect all appropriate self-pay liabilities as expeditiously as possible through the use of the following procedures:

- All self-pay liabilities (estimated or actual) are to be paid prior to discharge unless the financial counseling process determines that the patient/guarantor is either entitled to a discount or unable to pay the full amount.

- Payment arrangements cannot exceed 18 months.

- For balances greater than $500.00, follow-up should be performed every 21 working days. Balance less than $500.00 should receive follow-up every 30 working days.

- Patient statements are to be sent out each month. Do not place on a statement on hold unless there is a valid dispute regarding the bill.

- All follow-up activity must be documented clearly in the patient accounting notes.

- Follow-up must be a combination of telephone calls and statements/collections notices.

- Accounts that do not have suitable payment arrangements after 90 days should be placed with the appropriate collection agency. Placement of collections is authorized by the Business Office Manager/Director.

- All payment arrangements must be in writing.

- Prompt payments may be offered as an alternative.

- Information obtained from income tax returns, paystubs, or the monetary asset documentation collected for the discount payment or free care eligibility determination cannot be used for collection activities.


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