

**ANNA JAQUES HOSPITAL  
ADMINISTRATIVE POLICY AND PROCEDURE MANUAL**

<b>Credit and Collections</b>	<b>Administrative</b>
Subject: Credit and Collection Policy	Policy Number: C-18
Category: Credit/Collection	<b>Effective Date: 10/98</b>
<b>Page 1 of 14</b>	<b>Revised Dates: 2/02, 11/04, 11/07, 11/10, 12/13, 8/14, 3/15, 9/16, 04/17</b>
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<b>References:</b>	

**POLICY**

**STATEMENT:** The Credit and Collection Policy serves as a guideline to assure that reasonable collection efforts are maintained for all accounts and that Low Income Person Program and bad debt accounts are recognized as quickly as possible.

**RESPONSIBILITY:** Patient Financial Services/Finance

**PROCESS:** The Anna Jaques Hospital shall not discriminate on the basis of race, color, national origin, citizenship, alienage, religion, creed, sex, sexual orientation, gender identity, age, or disability, in its policies, or in its application of policies, concerning the acquisition and verification of financial information, pre-admission or pretreatment deposits, payment plans, deferred or rejected admissions, Low Income Patient status determinations, or in its billing and collection practices.

**I) INTRODUCTION**

- A) Anna Jaques Hospital has a fiduciary responsibility to appropriately bill and collects for patient services provided. Our policy is to comply with state and federal law and regulations in performing this function. Anna Jaques hospital does not discriminate on the basis of race, color, national origin, citizenship, alienage, religion, creed, sex, sexual orientation, gender identity, age, or disability, in its policies, or in its application of policies, concerning the acquisition and verification of financial information, pre-admission or pretreatment deposits, payment plans, deferred or rejected admissions, Low Income Patient status as determined by the Massachusetts Office of Medicaid, determination that patient is low income, or in its billing and collection practices.
- B) Anna Jaques Hospital, in alliance with its Medical Staff, provides the highest quality medical care, preventive care and health education to our community. We provide personalized, compassionate care. We respect the dignity and privacy of those we serve. We recognize each patient’s right to have his/her pain assessed and effectively managed. We will strive to be the hospital of choice for our patients, physicians and employees. We are committed to continuously improve patient safety and reduce risk to patients.
- C) Anna Jaques Hospital has maintained and will continue to maintain an “open door” to those in need of medical care. No person will be denied medically necessary services due solely to an inability to pay for such services. In no case will the hospital deny emergency medical services based on ability to pay. The Credit and Collection Policy serves as a guideline to assure that financial assistance is available to all patients and all collection practices are in compliance with

criteria required under The Health Safety Net Eligibility Regulation 101 CMR 613.04, the Centers for Medicare and Medicaid Services Medicare Bad Debt Requirements (42CFR 413.89), and the Medicare Provider Reimbursement Manual (Part 1, Chapter 3). This credit and collection policy applies to Anna Jaques Hospital and all entities that are part of the hospital's license and or tax ID number.

## II) DEFINITIONS

For purposes of this policy, the following services are differentiated in the following manner for determining the medical care needed and what may be covered by a specific public or private coverage option for consideration of a patient's allowable bad debt:

- A) **Bad Debt** is defined as an account receivable based on services furnished to any patient which a) is regarded as uncollectible, following reasonable collection efforts, pursuant to 101 CMR 613.06 and pursuant to the hospital's established Credit and Collection policy, that conforms with 101 CMR 613.06, b) is charged as credit loss; c) is not obligation of any federal or state governmental unit; and d) is not a Reimbursable Health Care Service.
- B) **Collection Action** is defined as any activity by which the hospital or its designated agent requests payment for services from a patient or responsible party. Collection actions include activities such as pre-admission or pre-treatment deposits, billing statements, collection follow-up letters, telephone contacts, personal contacts and activities of collection agencies and attorneys.
- C) **Emergency Care** is defined as medically necessary services provided after the sudden onset of a medical condition, whether physical or mental, manifesting itself by acute symptoms of sufficient severity, including severe pain, which a prudent layperson would reasonably believe is an immediate threat to life or has high risk of serious damage to the individual's health. Conditions include, but are not limited to those which may result in jeopardizing the patient's health, serious impairment to bodily functions, serious dysfunction of any bodily organ or part, or active labor in women. Examination or treatment for emergency conditions or any such other service rendered to the extent required pursuant to the federal EMTALA 42 USC 1395 (dd) (e) (1)(B) qualifies as emergency care for Health Safety Net purposes.
- D) **Low Income Patient** is defined as an individual who meets the criteria of the Health Safety Net- Primary, Health Safety Net – Secondary or Health Safety Net- Partial under 101 CMR 613.04 (1)1
- E) **Reimbursable Health Services** is defined as eligible services provided by Acute Hospitals or Community Centers to Uninsured and Underinsured Patients who are determined to be financially unable to pay for their care, in whole or in part and who meet the criteria for Low Income Patient; provided that such services are not eligible for reimbursement by any other third party payer.
- F) **Medical Hardship** is defined as a situation in which major expenditures for health care and/or loss stemming from an individual's medical condition have depleted or can reasonably be expected to deplete the financial resources of the individual to the extent that he or she will be unable to pay for medical services.
- G) **Medically Necessary Service** is defined as a service that is reasonably expected to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a

handicap, or result in illness or infirmity. Medically necessary services shall include inpatient and outpatient services as mandated under Title XIX of the Federal Security Act. Medically necessary services shall not include: (a) non-medical services, such as social, education, and vocational services, (b) cosmetic surgery, (c) canceled or missed appointments, (d) telephone conversations and consultations, (e) court testimony, (f) research or the provision of experimental or unproven procedures including, but not limited to, treatment related to sex-reassignment surgery, and pre-surgery hormone therapy, and (g) the provision of whole blood; provided, however, that administrative and processing costs associated with the provision of blood and its derivatives shall be payable.

- H) **Resident** is defined as a person living in Massachusetts with the intention of remaining in the state indefinitely. A resident is not required to maintain a fixed address. The following conditions do not meet the requirements for residency; 1) confinement in a nursing home, hospital or other medical institution, and 2) relocation to Massachusetts for the sole purpose of receiving health care benefits.
- I) **Urgent Care** is defined as medically necessary services provided in a hospital or community health center after the sudden onset of a medical condition, whether physical or mental, manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson would believe that the absence of medical attention within 24 hours could reasonably be expected to result in: (a) placing a patient's health in jeopardy;( b) impairment to bodily function; or (c) dysfunction of any bodily organ or part. Urgent care services are provided for conditions that are not life-threatening and do not pose a high risk of serious damage to an individual's health.
- J) **Reasonable Collection Efforts** is defined as hospital will make the same effort to collect accounts for Emergency Care for Uninsured Patients as it does to collect accounts from any other patient classification. (a.) an initial bill to the party responsible for the patient's personal financial obligations, (b) subsequent billings, telephone calls, collection letters, personal contact notices, computer notification, and any other notification method that a genuine effort to contact the party responsible for the obligation. (c.) sending a final notice by certified mail for balances over \$1,000 where notices have not been returned as "incorrect address" or "undeliverable." (d.) documentation of continuous Collection Action undertaken on a regular, frequent basis, with no gaps greater than 120 days. (e.) all documentation of collection effort including copies of bill(s), follow-up letters, reports of telephone and personal contact, and any other effort made will be included in patient file.

### III) ACCESS TO CARE

#### A) Emergency and Urgent Services

- 1) The Hospital will always provide emergency services without regard to the patient's identification, insurance coverage or ability to pay. In all of its patient care activities, the Hospital shall act so as to remain in compliance with federal regulations such as Emergency Medical Treatment and Active Labor Act (EMTALA) 42 USC 1395 (dd) and the Balanced Budget Act of 1997 (Public Law no. 105-33). The Hospital shall determine Emergency and Urgent services as defined in 101 CMR 613.00 when billing the Health Safety Net under Emergency Bad Debt.
- 2) The urgency of treatment associated with each emergency room patient will be determined by a medical professional, usually a triage nurse. Classification of these patients' medical condition is for clinical management purpose only, and such classifications are intended for

- addressing the order in which physicians should see patients based on their presenting medical symptoms. These classifications do not reflect medical evaluation of the patient's medical condition that is reflected in final diagnosis. The classifications are as follows: a) Emergency – a condition which appears to be potentially life or limb threatening and to require immediate medical attention; there is a high danger to the patient if left medically unattended; presenting symptoms are acute to severe; b) Urgent – a condition which requires prompt care, but will not result in loss of life or limb if left untreated for several hours; c) Non-Urgent – which may include elective and scheduled services, a condition that requires evaluation and treatment, but time is not a critical factor, and does not include patients with complaints of severe pain or loss of function.
- 3) When providing medical screening examinations, Anna Jaques Hospital is unable to distinguish the charges provided after a qualified clinician determines that an emergency does not exist. The Hospital will bill the Health Safety Net for all services provided as part of the visit that includes the original EMTALA screening, after completing and documenting all collection activities conducted in compliance with the requirements of 101 CMR 613.00.
  - 4) Anna Jaques Hospital classifies as emergency care services for any person who enters the hospital seeking unscheduled treatment. Most commonly, unscheduled patients present themselves at the Anna Jaques Hospital emergency room; however, patient presenting at hospital clinics or in the radiology, laboratory and other ancillary departments may also be screened and treated subject to the EMTALA requirement. Emergency care also includes services requiring immediate, unscheduled admission and patients clinically requiring immediate transfer from another facility. Examination and treatment (including inpatient admission and care) for emergency medical conditions or any such other services rendered to the extent required pursuant to 42 USC 1395 (dd) will be provided to the patient, and will qualify as emergency care for Health Safety Net purposes.

#### B) Non –Emergency Services

- 1) The hospital may decline to provide non-emergency services to patients under certain circumstances arising from the Hospital's attempt to assure payment for its services but subject to a process to determine the extent to which prompt provision of the proposed services is medically necessary.

### IV) ACQUISITION AND VERIFICATION OF FINANCIAL INFORMATION

#### A) Emergency Services

- 1) **Inpatient Services** – For emergency inpatient services, the Hospital, through its Emergency, Registration, Scheduling and Patient Accounts Departments, will obtain and verify the financial information necessary to determine responsibility for payment of the hospital bill from the effort to obtain and record demographic and financial information, including name, address and sources of payment after the patient has been clinically screened and treated, when approved by the clinician. Whenever necessary, as soon as reasonably possible, the Financial Coordinator will interview the patient to obtain needed financial information. If the patient or responsible party is unable to provide the necessary information and the patient consents, the hospital will attempt to contact relatives to obtain financial information. The Financial Coordinator will also screen the uninsured patient for potential financial assistance program at that time. The Patient Accounts and Registration, Scheduling staff will verify the financial information supplied by the patient or responsible party prior to or at discharge, or anytime during the collection process.

- 2) **Outpatient Services** – For emergency outpatient services, the Hospital through its Emergency, Registration, Scheduling and Patient Accounts Departments, will obtain demographic and financial information at time of registration or upon cessation of the emergency condition, when approved by the clinician. Should sufficient financial or demographic information not be gathered at time of registration or during treatment, the Registration, Scheduling Department, the Financial Coordinator and/or Patient Accounts Department will seek to obtain and verify necessary information anytime during the collection process.

**B) Non-Emergency Services**

1) **Inpatient Services** –

- a) For non-emergency inpatient services, the Hospital, through the Registration, Scheduling and Patient Accounts Departments, will obtain, record and verify demographic and financial information including name, address and sources and estimated amount of payment prior to or as soon as reasonably possible after the patient arrives for services. Prior to the date of a patient's elective admission, Registration, Scheduling staff and/or the Financial Coordinator determine responsibility for payment of services by contacting the insurance carrier and/or the guarantor. The Financial Coordinator attempts to contact the uninsured patient or responsible party to obtain financial information to determine the responsibility of hospital charges. The physician's office is contacted if the patient cannot be reached.
- b) The Patient Accounts, Registration and Scheduling staff will attempt to verify the financial information supplied by the patient or responsible party prior to admission or during the patient's stay. While in-house, the Financial Coordinator and/or Registration/Access staff will seek prior approval from the clinical staff of the specific unit before interviewing the patient. Insurance companies are contacted via telephone, fax, point of service machine, or on-line to verify eligibility. Verification of financial information may occur at any time during provision of services or during the collection process. Should a patient be found not to have coverage, the Financial Coordinator will interview the patient or responsible party for additional information. The Financial Coordinator will also screen the uninsured patient for potential financial assistance program eligibility at that time.

2) **Outpatient Services** –

- a) Patients seeking outpatient services will be interviewed by the Registration staff and the collection of information and data necessary for billing shall include but not be limited to the patient's name and address, the responsible party's name and address and the third party data necessary for billing. Patient or responsible parties will be requested to provide third party insurance card(s). Patient Accounts, Scheduling and registration staff will verify the information supplied by the patient or responsibility party. Verification of financial information may take place at the time the patient receives the services or during the collection process.

## V) NOTIFICATION OF AVAILABILITY OF FINANCIAL ASSISTANCE

### A) Signs Posting

- 1) The hospital shall post signs in the Patient Accounts, Registration areas, and Scheduling departments on the availability of financial assistance and other government programs. Such signs are in large enough print to be clearly visible and legible by patients' visiting these areas. The notification is in both English and Spanish and reads as follows: Regulation 101 CMR 613.08(1) (d) and do not require this size or fonts in posted signs.  
  
**“If you are unable to pay your hospital bill, please contact a hospital financial counselor at (978) 463-1123 or (978) 463-1134 Monday through Friday between 8:30 am to 4:00 pm. Our counselors may be able to assist you with alternative coverage options.”**
- 2) Notice of availability of financial assistance and other government programs are posted in areas accessed by the general public, including:
  - a) Registration areas for inpatient units, clinics, and emergency and ancillary service areas.
  - b) Financial counseling office
  - c) Business office
  - d) Access/Scheduling office

### B) Notice on Initial Billing

- 1) The Hospital shall include a notice of the availability of financial assistance on patient bills. The information is a follows:  
  
**“Notice of Availability of Health Safety Net, Public Assistance, or Payment Plans”**
- 2) If your income falls within the Federal Income Poverty Guidelines and if your hospital bill will not be covered in full by an insurance company, you may qualify for assistance through the state. For information please call (978)463-1123 or visit our Financial Counselor Office.
- 3) In all other collection action, the Hospital shall include a brief message of the availability of Health Safety Net and other types of assistance and the telephone numbers to call for more information.
- 4) Anna Jaques Hospital screens for potential eligibility for government subsidized medical insurance and assists patients in the application process for these programs.

## VI) DEPOSITS AND INSTALLMENT PLANS

- A) Patients or their responsible parties are expected to pay their full liability for services rendered, within thirty (30) days of receipt of their first bill or in accordance with a mutually agreed upon installment payment plan.
- B) Anna Jaques Hospital may require “pre-admission” or “pretreatment” deposits. However, it will not require pre-admission and/or pretreatment deposits from patients who require Emergency Care or who are determined to be Low Income Patients. For Low Income Patients eligible only for Partial Health Safety Net, Hospital may request a deposit limited to 20% of the annual deductible amount up to \$500.
- C) An individual with a balance of \$1,000 or less, after initial deposit on request, will be offered a one-year [interest free] payment plan with a minimum monthly payment of \$25. A patient, who

has a balance of more than \$1,000, after initial deposit, will be offered at least a two-year payment plan.

- D) An individual will be exempt from collection action for the portion of the bill that exceeds the medical hardship contribution. The Medical Hardship deposit is 20% of the Medical Hardship contribution up to \$1000. The Hospital will offer the patient a one-year payment plan with a minimum of \$25 per month to be paid to the hospital. For balances over \$1,000 after the initial deposit, the Hospital will offer a two year payment plan.

## VII) ELIGIBILITY FOR FINANCIAL ASSISTANCE

- A) The Hospital will screen and evaluate patients for potential eligibility for government assistance programs and encourage patients to apply for coverage. The hospital will aid patients in submitting applications for health insurance and supplying the necessary verifications as required by the state.
- B) The state market place provides the general public, medical providers, and community-based organizations with either an online or standard paper application which when complete is submitted directly to the Health Insurance Processing Center for review. Determination for public assistance is managed solely by the State Exchange. Programs are available for families, children, adults, seniors, veterans, homeless, and disabled individuals.
- C) The Financial Counselors are available to assist patients in completing applications and securing the necessary documentation which may include: (1) Identity (2) Citizenship (3) Immigration Status (4) Annual Household Income, (payroll stubs, record of social security payments, and or federal tax returns). For persons over 65 years of age, proof of any and all assets will be needed. The hospital will then submit all documents to the state.
- D) Applications are reviewed and processed by the state, according to Federal Poverty Guidelines as well as other criteria. Eligibility for the Health Safety Net program as a special circumstance is reviewed and approved by the State also using the Federal Poverty Guidelines and asset information.
- E) Hospitals have no role in the determination of program eligibility made by the state. It is the patient's responsibility to inform the hospital of all coverage decisions made by the state to ensure accurate and timely adjudication of all hospital bills.
- F) The availability of free or discounted care is explained in this policy and determined under the Affordable Care Act (ACA) requirements of the State of Massachusetts. All patients eligible for financial assistance are required to apply for such programs using the standard ACA application. All forms of financial assistance are included in this policy and are limited to HSN, Medical Hardship, and government assistance programs.
- G) The hospital will seek a specified payment for those patients that do not qualify for enrollment in a Massachusetts state public assistance program such as out-of-state residents, but who may otherwise meet the general financial eligibility categories of a state public assistance program. For these patients, the discounted payment amount will be set at a percentage of charges based on an average of Anna Jaques' insurance contracts for both inpatient and outpatient services. For these patients, the final billed charges for services in Financial Year 2017 will be discounted by **52%**.
- H) Anna Jaques Hospital has employed the "Look Back Method" in determining the appropriate discount for patients ***not*** eligible for Health Safety Net and other financial assistance programs. Annually, AJH will calculate this discount using data from actual claims paid, and determine the

average discounted rate to apply to patient balances. Both Medicare and private healthcare insurance paid claims are reviewed, and will be updated 45 days following each fiscal year end. (Anna Jaques Financial Year is October 1<sup>st</sup> to September 30<sup>th</sup>)

For purposes of this policy, the following services are differentiated in the following manner for determining the medical care needed and what may be covered by a specific public or private coverage option for consideration of a patient's allowable bad debt:

**1) Eligibility for Health Safety Net Services to Low Income Patients**

- a) Massachusetts residents whose family income is equal to or less than the Federal Poverty Income Guidelines (FPIG). The FPIG is updated annually and is posted on the state Medicaid website: [www.mass.gov/eohhs](http://www.mass.gov/eohhs).

**2) Eligibility for Partial Health Safety Net for Eligible Services to Low Income Patients**

- a) Massachusetts residents whose family income is from 201% to 300% of the Federal Poverty Income Guidelines will be eligible for that portion of the bill which exceeds their family's annual deductible.
- b) Any participant in the Children's Medical Security Plan whose family income is from 201% and 300% of the Federal Poverty Income Guidelines will be eligible for that portion of the bill which exceeds their family's annual deductible.
  - (i) Annual Deductible: The annual deductible for Partial Health Safety Net equals 40% of the difference between the applicant's family income and 200% of the Federal Poverty Income Guidelines. The patient is responsible for payment for all services provided up to this deductible amount. The total amount of an individual's co-payment is capped in any given year by the annual deductible. There is only one deductible per family per approved period. The annual deductible is applied to all eligible services provided to Low Income Patient or family member during eligibility period. Each family member must be determined a Low Income Patient in order for their expenses for eligible services to be applied to the deductible. If more than one family member is determined to be Low Income Patient, or if the patient or family members are determined to be Low Income Patient by more than one hospital, it is the patient's responsibility to track the deductible and provide documentation to the hospital that the deductible has been reached.

**3) Medical Hardship**

- a) A Massachusetts resident at any income level may qualify for Medical Hardship if allowable medical expenses have so depleted the family's income and resources that he or she is unable to pay for eligible services. In order to qualify for Medical Hardship, the patient must meet both the expense and the resources qualifications.
- b) Expense Qualification – The patient's allowable medical expenses must be greater than 30% of the family income. Allowable medical expenses are the total of family medical bills that, if paid, would qualify as deductible medical expenses for Federal income tax purposes. Paid bills and unpaid bills for which the patient is still responsible may be included.

- c) Resources Qualification – The patient’s excess medical expenses must be greater than available assets.
- d) Excess medical expenses are the amount by which allowable medical expenses exceed 30% of the family income.
- e) Applicant Contribution – The applicant’s required contribution is the sum of 30% of family income and available assets. There is one Medical Hardship contribution per family per eligibility period. The applicant will remain responsible for all allowable medical expenses up to this Medical Hardship contribution.

**4) Special Circumstances**

- a) Co-payment and deductible for patients that qualify as Low Income Patients that are covered by other insurance programs will be considered as “eligible service”. (Note that Mass Health co-payments no longer qualify as a Health Safety Net reimbursable expense.)
- b) Eligible services to a Low Income Patient injured in a motor vehicle accident will be considered “eligible service” only if:
  - (i) It has been investigated whether the patient, driver, and/or owner of the motor vehicle had a motor vehicle liability policy;
  - (ii) Has made every effort to obtain the third party payer information and retained evidence of such efforts including documentation of phone calls and letter to the patient; and
  - (iii) Where applicable, has properly submitted a claim for payment to the motor vehicle liability insurer. Anna Jaques Hospital will offset any payment from the insurer against its claim for eligible services.

**5) Health Safety Net Eligible Services Exclusions**

- a) Services that are not medically necessary
- b) Services provided to out of state residents.
- c) Services provided in skilled nursing facilities
- d) Co-Payments AND DEDUCTIBLE FOR Low Income Patients enrolled in
- e) Mass Health, Children’s Medical Security Plan, Connector Care or CarePlus.
- f) Services to students who came from other states to enroll in institutions of higher learning.
- g) Services to individuals who came to Massachusetts for medical care in a facility other than a nursing facility who maintain residence outside of Massachusetts
- h) Cosmetic surgery

**6) Eligibility Approval Process**

- a) Anna Jaques will screen patients for other sources of coverage and potential for eligibility in government program. The hospital will document the results of each screening. If Anna Jaques hospital determines that a patient is potentially eligible for Medicaid or another government program, it shall encourage the patient to apply for such program and shall assist the patient in applying for benefits under such program.

- b) Anna Jaques Hospital will verify the annual patient deductible for those patients that qualify for Partial Health Safety Net. The hospital will track the patient's reimbursable health services expenses, which he or she receives at Anna Jaques Hospital, until the patient meets the deductible.
- c) Anna Jaques Hospital will verify the report assets as reflected on the patients Application for Health Safety Net-Medical Hardship Supplement.
- d) Anna Jaques Hospital will submit applications to determine eligibility for Health Safety Net, Partial Health Safety Net, and Medical Hardship.
- e) Applications will be processed, and determination made, by the Office of Medicaid and or the State Exchange. Patients will receive notice of eligibility from the state.

**7) Eligibility Period**

- a) The start date of eligibility is determined by the state and varies by program.
- b) Low Income Patient status is effective for a maximum of one year from the date of determination, subject to periodic re-determination that the patient's Family Income or insurance status has not changed to such an extent that the patient no longer meets eligibility requirements.

**8) Anna Jaques Hospital Self Pay Prompt Payment Discount Program**

- a) The Anna Jaques Hospital will screen and evaluate patients for possible eligibility for Health Safety Net, Partial Health Safety Net, Medical Hardship, and government assistance programs. The patient's eligibility will be processed by the financial counselors at AJH. The self-pay discount program would target those patients not eligible for one of the aforementioned financial assistance programs.
- b) A prompt pay discount will be offered at 51% off billed charges under the following criteria:
  - (i) Patient is uninsured
  - (ii) Patient is not eligible for any other form of financial assistance identified in Section VII A. to H. of this Credit and Collection Policy.
  - (iii) Excludes cosmetic and/or dental services (fixed fee by procedure).
  - (iv) Excludes deductibles and coinsurance amounts.
  - (v) Patient agrees to pay in full the balance due within 60 days.
  - (vi) If the patient does not pay in full the balance within 60 days, the prompt pay discount will be removed and 100% of the unpaid charges will be collected according to the guidelines set forth in Section VIII, Collection Policies, of this Credit and Collection Policy.

**VIII) COLLECTION POLICIES**

**A) Patient Exempt from Collection Action**

- 1) The following individuals and patient populations are exempt from any collection or billing procedures pursuant to state regulations and policies:
  - a) Patients enrolled in a public health insurance program, including but not limited to, MassHealth, Emergency Aid to the Elderly, Disabled and Children, Healthy Start,

Children's Medical Security Plan, "Low Income Patients" as determined by the Office of Medicaid – subject to the following exceptions:

- (i) The hospital may seek collection action against any patient enrolled in the above mentioned programs for their required co-payments and deductibles that are set forth by each specific program.
  - (ii) The hospital may also initiate billing or collection for a patient who alleges that he or she is a participant in a financial assistance program that covers the costs of the hospital services, but fails to provide proof of such participation. Upon receipt of satisfactory proof that a patient is a participant in a financial assistance program, (including receipt or verification of signed application) the hospital shall cease its billing or collection activities.
  - (iii) The hospital may continue collection action on any Low Income Patient for services rendered prior to the Low Income Patient determination, provided that the current Low Income Patient status has been terminated, expired, or not otherwise identified on the state Virtual Gateway or Eligibility Verification System. However, once a patient is determined eligible and enrolled in the Health Safety Net, MassHealth, or certain Commonwealth Care programs, the hospital will cease collection activity for services provided prior to the beginning of their eligibility.
  - (iv) The hospitals may seek collection action against any of the patients participating in the programs listed above for non-covered services that the patient has agreed to be responsible for, provided that the hospital obtained the patient's prior written consent to be billed for the service.
- b) The hospital will not undertake collection action against an individual that has been approved for Medical Hardship under the Massachusetts Health Safety Net program with respect to the amount of the bill that exceeds the Medical Hardship contribution. The hospital will further cease any collection efforts against an emergency bad debt claim that is approved for Medical Hardship under the Health Safety Net program.
  - c) The hospital will not garnish a Low Income Patient's (as determined by the Office of Medicaid) or their guarantor's wages or execute a lien on the Low Income Patient's or their guarantor's personal residence or motor vehicle unless: (1) the hospital can show the patient or their guarantor has the ability to pay, (2) the patient/guarantor did not respond to hospital requests for information or the patient/guarantor refused to cooperate with the hospital to seek an available financial assistance program, or (3) for purposes of the lien, it was approved by the hospital's Board of Trustees on an individual case by case basis.
  - d) The hospitals and its agents shall not continue collection or billing on a patient who is a member of a bankruptcy proceedings except to secure its rights as a creditor in the appropriate order. The hospital and its agents will also not charge interest on an overdue balance for a Low Income Patient or for patients who are low income based on the hospital's own internal financial assistance program. The hospital maintains compliance with applicable billing requirements, including the Department of Public Health regulations (105 CMR 130.332) for non-payment of specific services or readmissions that the hospital determines was the result of a Serious Reportable Events (SRE). SREs that do not occur at the hospital are excluded from this determination of non-payment. The hospital also does not seek payment from a low income patient determined eligible for

the Health Safety Net program whose claims were initially denied by an insurance program due to an administrative billing error by the hospital.

**B) Collection Process**

- 1) The hospital makes the same reasonable effort and follows the same reasonable process for collecting on bills owed by an uninsured patient as it does for all other patients. The hospital follows the regulations in 613.03(1)(c)3 including making all reasonable and diligent efforts to collect the patient's insurance and other information to verify coverage for the health care services. The hospital's reasonable and diligent efforts will include but is not limited to requesting information about the patient's insurance status, checking insurance databases and following the billings rules of third party payers.
- 2) The hospital will first show that it has a current unpaid balance that is related to services provided to the patient and not covered by a private insurer or a financial assistance program. The hospital follows reasonable collection/billing procedures, which include:
  - a) An initial bill sent to the patient or the party responsible for the patient's personal financial obligations, the initial bill will include information about the availability of a financial assistance program that might be able to cover the cost of the hospital's bill.
  - b) Subsequent billings, telephone calls, collection letters, personal contact notices, computer notifications, or any other notification method that constitutes a genuine effort to contact the party responsible for the obligation.
  - c) If possible, documentation of alternative efforts to locate the party responsible for the obligation or the correct address on billings returned by the postal service such as "incorrect address" or "undeliverable".
  - d) Sending a final notice by certified mail for uninsured patients (those who are not enrolled in a public program such as the Health Safety Net or MassHealth) who incur an emergency bad debt balance over \$1,000 on Emergency Level Services only, where notices have not been returned as "incorrect address" or "undeliverable."
  - e) Documentation of continuous billing or collection action undertaken on a regular, frequent basis is maintained. Such documentation is maintained until audit review by a federal and/or state agency of the fiscal year cost report in which the bill or account is reported.
  - f) All accounts with balances greater than or equal to \$5 will receive a minimum of four billing statements. If no response or reasonable payments are received, the account is referred to a collection agency or attorney within 30 days of the mailing of the last billing statement. Once an account has reached 120 days after referral to collection agency or attorney with no response or payments, the account is closed with the collection agency or attorney and returned to the hospital. As referenced, federal and state guidelines deem these accounts as Bad Debt. Any future payment on the account is considered a recovery of bad debt.
  - g) The hospital further maintains all information in accordance with applicable federal and state privacy, security, and ID theft laws.

**C) Emergency Bad Debt**

- 1) An account can be considered Emergency Bad Debt if the following conditions are met: services meet the criteria for emergency bad debt as previously defined; accounts with

balances greater than or equal to \$5 will receive a minimum of four billing statement. If the account is over \$1,000, a final notice by certified mail is sent to those patients/responsible parties. If mail return undeliverable by the post office it is checked for a change of address, phone call is attempted to patient, and a check of the local directory. Each account is checked by a credit representative to insure the REVS system has been checked to determine if the patient has filed an application for Mass Health, and all requirements are met prior to writing the account to Emergency Bad Debt.

#### **IX) RETURN MAIL**

- A) Mail which is undeliverable by the post office shall be reviewed for accuracy. Other accounts for the patient are checked for a change of address and phone call is attempted to patient to get correct address and a check of the local directory. Those accounts that can be corrected will be reprocessed for statements. Those accounts that cannot be corrected are eligible to be forwarded to a collection agency or attorney.

#### **X) LIENS AND ATTACHMENTS**

- A) The hospital or its legal representative will not seek the legal execution against the personal residence or motor vehicle of patient or responsible parties with income greater than 200% of the Federal Income Poverty Guidelines without an individual case by case review and approval by the Board of Trustees.

#### **XI) PROVIDER RESPONSIBILITIES**

- A) The hospital shall not discriminate on the basis of race, color, national origin, citizenship, alienate, religion, creed, sex, sexual preference, age, or disability, in its policies, or in its application of policies, concerning the acquisition and verification of financial information, pre-admission or pretreatment deposits, payment plans, deferred or rejected admissions, or Low Income Patient Status.
- B) The hospital or agent thereof shall not seek legal execution against the personal residence or motor vehicle of a patient or Guarantor without the express approval of the Provider's Board of Trustees. All approval by the Board must be made on an individual case basis.
- C) The hospital has made this Credit and Collection policy available and filed in accordance With 101 CMR 613.08 (1) as described in 101CMR 613.08 (1)d, available on the Anna Jaques website.

#### **XII) PATIENT RIGHTS & RESPONSIBILITIES**

- A) **Providers** must advise patient of the right to: (1) apply for Mass Health, Commonwealth Care, and Low Income Patient determination; (2) A payment plan, as described in 101CMR 613.08(1)(f), in the patient is determined to be Low Income Patient or qualifies for Medical Hardship; (3) A written notice of the eligibility determination; (4) A written notice of the right to file a grievance.
- B) A **Patient** that receives Eligible Services must: (1) Provide all required documentation; (2) Inform MA-21 or the Provider that determined the patient's eligibility status of any changes in Family Income or insurance status as described in 101 CMR 613.04(1) including but not limited to income, inheritances, gifts, distributions from trusts, ; (3) Track the patient deductible and provide documentation to the Provider that the deductible has been reached when more than one Family member is determined to be a Low Income Patient or if the patient or family members receive Eligible Services from more than one Provider.(4) inform the Health Safety Net Office or

the MassHealth Agency when the Patient is involved in an accident, or suffers from an illness or injury or other loss that has or may result in a lawsuit. File a claim for compensation if available and agree to comply with all requirements of M.G.L. c. 118E

**XIII) REPORTING REQUIREMENTS**

- A) The hospital will comply with all reporting requirements as defined by MGL c. 118G and related 114.6 CMR 13.07 and associated Administrative Bulletins.