



Hospital Credit & Collection Policy

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FOUNDED BY BRIGHAM AND WOMEN'S HOSPITAL
AND MASSACHUSETTS GENERAL HOSPITAL

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1. SCOPE

This Credit & Collection policy is intended to cover all hospital entities within Partners HealthCare System, Inc. ("Partners" or "PHS"), as well as any entity that is part of the named hospital's license, including: Massachusetts General Hospital (MGH), Brigham and Women's Hospital (BWH), Brigham and Women's Faulkner Hospital (BWFH), Cooley Dickinson Hospital (CDH), Newton-Wellesley Hospital (NWH), Martha's Vineyard Hospital (MVH), McLean Hospital (MH), Nantucket Cottage Hospital (NCH), North Shore Medical Center (NSMC), Spaulding Rehabilitation Hospital Boston (SRH), Spaulding Hospital for Continuing Medical Care North Shore (SNS), Spaulding Hospital for Continuing Medical Care Cambridge (SHC), and Spaulding Rehabilitation Hospital Cape Cod (SCC), hereby otherwise known as "Hospital". Included in this are all physicians who are employed directly by the hospital entity. Complete Provider Affiliate lists will be made available for review by October 1, 2017 per 101 CMR 613.08(d).

2. GOVERNANCE ISSUES

This Policy has been developed in consultation with representatives of each entity and is designed to meet the needs of each entity. There are areas, however, where local conditions may support a need for unique, entity-specific provisions. Entity-specific provisions should receive prior approval from either (1) the PHS Executive Vice President of Finance or (2) the PHS Vice President of Revenue Cycle Operations. Submissions of the Hospital Credit & Collection Policy to the Health Safety Net will be coordinated by PHS Patient Billing Solutions with any required supporting documentation or exhibits.

3. STATEMENT OF PRINCIPLE

Partners' hospitals are tax-exempt entities, whose underlying mission is to provide services to all in need of medical care.

Patients requiring urgent or emergent services (as defined in section 4B) at the Hospitals shall not be denied those services based on ability to pay. However, in order for Partners hospitals (including the post-acute and behavioral health hospitals) to continue to provide high quality services and support community needs, each entity has a responsibility to seek prompt payment for services provided.

These policies are intended to help ensure compliance with Massachusetts legislation dictating the administration of the Health Safety Net Trust Fund and the criteria for credit and collection policies under MGL c.58 and related regulations specifically promulgated by the MA Executive Office of Health and Human Services, 101 CMR 614 and 101 CMR 613, hereafter referred to as "State Regulations". In addition, this policy addresses the requirements for The Medicare Provider Reimbursement Manual (Part 1, Chapter 3) the Centers for Medicare and Medicaid Services, Medicare Bad Debt Requirements (42 CFR 413.89 and the Internal Revenue Code Section 501 (r) as required under the Section 9007 (a) of the Federal Patient Protection and Affordable Care Act (Pub. L. No. 111-148).

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4. CLASSIFICATION & ACCESS TO CARE

A. GENERAL PRINCIPLE

All patients presenting for unscheduled treatment will be evaluated according to the classifications included in this Section. Urgent or Emergent hospital services shall not be denied or delayed based on the Hospital's ability to identify a patient, their insurance coverage or ability to pay. However, Non-emergent or Non-urgent health care services may be delayed or deferred based on the consultation with the hospital's clinical staff in those cases when the Hospital is unable to determine a payment source for its services.

The urgency of treatment associated with each patient's presenting clinical symptoms will be determined by a medical professional as determined by local standards of practice, national and state clinical standards of care, and the hospital medical staff policies and procedures. Further, all hospitals follow the federal Emergency Medical Treatment and Active Labor Act (EMTALA) requirements by conducting a medical screening examination to determine whether an emergency medical condition exists. It is important to note that classification of patients' medical condition is for clinical management purposes only, and such classifications are intended for addressing the order in which physicians should see patients based on their presenting clinical symptoms. These classifications do not reflect medical evaluation of the patient's medical condition reflected in final diagnosis.

Determination of medical urgency is made according to the following definitions:

B. EMERGENT AND URGENT SERVICES

The Hospital will provide emergent and urgent services without regard to the patient's identification, insurance coverage or ability to pay.

Emergent Services include:

Medically necessary services provided after the onset of a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in placing the health of the person or another person in serious jeopardy, serious impairment to body function or serious dysfunction of any body organ or part or, with respect to a pregnant woman, as further defined in section 1867(e)(1)(B) of the Social Security Act, 42 U.S.C. § 1295dd(e)(1)(B). A medical screening examination and treatment for emergency medical conditions or any other such service rendered to the extent required pursuant to EMTALA (42 USC 1395(dd) qualifies as Emergency Care.

Emergent services also include:

- *Services determined to be an emergency by a licensed medical professional;*
- *Inpatient medical care which is associated with the outpatient emergency care; and,*
- *Inpatient transfers from another acute care hospital to a PHS hospital for the provision of inpatient care that is not otherwise available.*

Urgent Services include:

Medically necessary services provided after 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

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reasonably expect to result in: placing the patient's health in jeopardy, impairment to bodily function, or dysfunction of any bodily organ or part. Urgent 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.

C. NON-EMERGENT, NON-URGENT SERVICES

Non-emergent, non-urgent services can generally be sub-classified as either:

“Elective Services”: Medically necessary services that do not meet the definition of Emergent or Urgent above. The patient typically, but not exclusively, schedules these services in advance.

“Other Services”: Services where medical necessity has not been demonstrated to the reviewing clinician.

“Post-Acute Care”: Medically necessary services provided at a Hospital that is classified as post-acute care including rehabilitation services.

“Behavioral Health Services”: Medically necessary services provided in a number of settings focused on the patient's psychological and mental health.

The Hospital may decline to provide a patient with non-emergent, non-urgent services in those cases when the Hospital is not successful in determining that payment will be made for its services. Services that are determined to be non-medically necessary may be deferred indefinitely until suitable payment arrangements can be made. These include, but are not limited to: cosmetic surgery; social, educational, and vocational services; telehealth and evisit services; treatment related to sex reassignment surgery, and pre-surgery hormone therapy; services provided at several specialized residential facilities at McLean Hospital including the Pavilion, the Appleton Residence at McLean, The Gunderson Residence, The McLean Center at Fernside, McLean Borden Cottage, McLean Residence at Lincoln and McLean 3East.

D. LOCATIONS THAT PATIENTS MAY PRESENT FOR SERVICES

All patients are able to seek Emergent level services and Urgent care services when they come to the hospital emergency department or designated urgent care areas. However, patients with emergent and urgent conditions may also present in a variety of other locations, including but not limited to Labor and Delivery, ancillary departments, hospital clinics and other areas. The Hospital also provides other elective services at the main facility, affiliated community health centers, clinics and other outpatient locations.

5. ACQUISITION AND VERIFICATION OF PATIENT INFORMATION

The Hospital will make diligent efforts to positively identify all patients and obtain, record and verify complete demographic and financial information for every patient seeking care. The information to be obtained will include demographic information (such as patient name, address, telephone number, social security number if applicable, gender, date of birth and applicable patient identification), and health insurance information (including name and address, subscriber information, and benefit information such as co-payment, deductible and co-insurance amounts) sufficient to secure payment for services. The requirement for the Hospital to obtain complete

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information will always be tempered by the patient's condition, with the patient's immediate health care needs taking priority.

It is the patient's obligation to provide complete and timely insurance and demographic information and to know what services are covered by their insurance policy.

A. EMERGENT AND URGENT SERVICES

Registration and intake of emergent and urgent patients will be performed in accordance with the requirements of EMTALA. Generally, patient demographic and insurance information should be collected as soon as possible; collection of information should be deferred, however, when collection of this information may delay medical screening or negatively impact the patient's clinical condition. Where a patient is unable to provide insurance or demographic information at the time of service and the patient consents, every effort should be made to interview friends or relatives that may accompany or be otherwise identified by the patient. Where practical, insurance information provided by the patient should be confirmed with the payer via a payer website or an electronic data interchange (EDI).

B. NON-EMERGENT, NON-URGENT SERVICES

Registration and intake of Non-emergent/Non-urgent patients should be performed prior to services being rendered. Returning or established patients will also have the demographic, financial and insurance information reviewed and updated as needed, including where applicable, verification of their insurance status via EDI or other available methods.

6. DETERMINATION OF PATIENT FINANCIAL RESPONSIBILITY

A. GENERAL PRINCIPLES

The Hospital will make diligent efforts to determine the patient's financial responsibility as soon as reasonably possible during the patient's course of care. Where feasible, the Hospital will collect co-pays, deductibles, co-insurance amounts, or required deposits prior to any service delivery. Patients, who are members of managed care health plans, or insurance plans with specific access requirements, are responsible for understanding and complying with all of their insurance plan requirements, including referrals, authorizations or other 'network' restrictions. The Hospital will request any necessary pre-approval, authorization or guarantees of payment from the insurer whenever possible. Under some circumstances, including Emergent and Urgent service delivery, these referral and authorizations may take place after service delivery. All patients who incur a balance for services will be informed of the availability of Financial Counseling services to assist them in fulfilling their financial responsibility to the Hospital. The Hospital will make its best efforts to advise all patients of any significant financial responsibility prior to service delivery to the extent that this information is available to the Hospital. Screening consistent with EMTALA will be completed prior to activities to determine the patient's financial responsibility.

There are service limitations for McLean Hospital and hospitals in the Spaulding Rehabilitation Network based on the patient's medical status, the necessity for the particular service setting and the type and intensity of the services required.

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B. PREPARATION OF ESTIMATES

In accordance with Chapter 224, the Hospital is responsible for providing all estimates to patients upon request. The estimate information is gathered and then calculated using internal Inpatient and Outpatient estimate calculators (which include rates for the academic medical centers and community hospitals). These internal estimate calculators will be updated once per year. The specific department responsible for providing the estimates will vary by location but generally involves some or all of the following: Patient Access, Financial Counseling, Patient Billing, and Patient Billing Solutions.

The Hospital has 2 business days from the date of request to finalize the estimate and respond to the patient. The final estimate is provided to the patient along with payment options.

C. INSURED PATIENTS

The Hospital will make diligent efforts to verify the patient's insurance status and assist the patient in complying with the requirements of their health insurance plan. This verification will occur in accordance with the principles previously outlined in Section 5. Whenever possible, this verification will include a determination of the patient's expected financial responsibility, including applicable co-insurance, deductibles, and co-payments. Where feasible and clinically appropriate, payment of any predetermined amounts (co-payments, fixed deductibles) will be requested from the patient before or at the time of service. In some cases, the patient's insurance plan and type of coverage may not allow for an exact determination of the patient's financial responsibility for services at the time of registration. In those cases, the Hospital may request a deposit equal to the best estimate of the expected patient financial responsibility. Patients who are unable to provide payment may be referred to Financial Counseling.

- 1) Contracted Insurance Plans. The Hospital contracts with a number of insurance plans. In those cases, the Hospital will seek payment from the insurance plan for all covered services. Patient payment of all co-payments, deductibles, and co-insurance amounts will be requested prior to service delivery. If a particular service is determined by the insurer to be non-covered or otherwise rejected for payment, then payment for that service will be sought directly from the patient in accordance with the relevant insurance contract. Whenever possible, the Hospital will assist the patient in appealing denials or other adverse judgments with their insurance plan recognizing that the insurance plan often requires these appeals to be made by the patient.
- 2) Non-contracted Insurance Plans. The Hospital will extend the courtesy of billing a patient's insurance company in those cases where the Hospital does not have a contract with an insurer. While the Hospital will bill the patient's insurance plan, ultimate financial responsibility rests with the patient or guarantor and the insurer's failure to respond to the Hospital bill in a timely manner may result in the patient being billed directly for the services except in those cases where the patient is protected from collection actions (Section 9.B.3). Balances remaining after any insurance payment will be billed to the patient. Whenever possible, the Hospital will assist the patient in appealing denials or other adverse judgments with their insurance plan recognizing that the insurance plan requires the appeal to be made by the patient.

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D. UNINSURED PATIENTS (SELF PAY)

Patients who do not have health insurance, and have not been previously determined to be a Low Income Patient as further described in section 6(E) below, will be asked to provide a deposit in advance of services not required to be performed by EMTALA. The deposit will be equal to 100% of the estimated charges for the service to be provided, less any discount (see Section 8). In those cases, where a precise estimate of the charges is not possible, the Hospital may collect a pre-determined deposit amount or otherwise secure guarantees of payment. If the patient does not provide the deposit or indicates an inability to pay the deposit, then the patient may be referred to Financial Counseling. All patients will be provided information on any hospital discount programs that are available to them. Uninsured Massachusetts residents will be offered Financial Counseling to determine their eligibility for any of the available State Programs or other government sponsored programs as well as assisting the patient in applying for those programs. State Programs include, but are not limited to: MassHealth, ConnectorCare, Children's Medical Security Plan, Health Safety Net, and any other program that may be offered via the Health Connector in the future. Financial Counselors will also typically assist patients in applying for non-subsidized insurance programs offered through the Health Connector (Qualified Health Plans). If there is no immediate need to provide services, the admission or outpatient service may be deferred or canceled until such time as the patient is able to pay, make suitable financial arrangements, obtain insurance or become enrolled in a financial assistance program that will cover the service.

E. LOW INCOME PATIENTS

- 1) Definition and Eligibility: Low Income Patients are defined as meeting the criteria in 101 CMR 613.04(1). This generally includes patients who are residents of Massachusetts who have applied for coverage with EOHHS and have a verified MA MAGI equal to or less than 300% of the FPL. A Patient's eligibility status for coverage under any program (MassHealth, Health Safety Net, and CMSP under 400%) will be verified at time of registration using the Office of Medicaid's MMIS system, NEHEN or other Hospital registration systems, as applicable, and any changes to the patient's status will be noted in the record.
- 2) Service Limitations: Patients who are identified as Low Income Patients will, to the extent possible, be provided services consistent with the coverage guidelines of either HSN or MassHealth including "Eligible Service" limitations under state regulations and the applicable drug formulary. A patient seeking to receive a "Non-Eligible" service will be informed in writing of the maximum cost of that service and must sign an acknowledgement that they accept financial responsibility prior to service delivery. The list of programs qualifying patients as "Low Income" is in 9 B (3) – Patients Protected from Collection Action.
- 3) Low Income Patient Financial Responsibility: The annual deductible for Partial HSN equals 40% of the difference between the applicant's family income and 200% of the FPG. The patient is responsible for payment for all services provided up to this deductible amount. Any applicable co-payment requirements of a patient's primary insurance coverage are not applicable to the patient's HSN annual deductible for patients who have Partial HSN as secondary coverage. 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

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- family members are determined to be Low Income Patients 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.
- 4) **HSN Medical Hardship:** A Massachusetts resident at any income level may qualify for HSN Medical Hardship if their allowable medical expenses exceeded the family's income beyond their ability to pay for eligible services. This retrospective program is per regulations, limited in scope, is a onetime determination and is not a coverage category (101 CMR 613.05). This program may only be applied for after service delivery when the patient has incurred a financial liability.
- (a) **Expense Qualification:** The type and amount of allowable medical expenses are specified in 101 CMR 613.05. Paid and unpaid bills with service dates up to 12 months prior to the date of application may be submitted with a limit of 2 applications within a 12 month period.
 - (b) **Application Process:** The hospital will assist the patient in the collection of all applicable information and will submit Medical Hardship applications to HSN for review and approval. Patients have the responsibility to collect and submit documentation of all qualifying medical expenses. The Hospital is required to submit applications to HSN within 5 days of receiving all documentation and verifications from the patient.
 - (c) **Determination:** HSN will determine the patient's qualification for the program and will notify the hospital as to which bills are the patient's responsibilities and which bills may be submitted to the HSN. Determination of Medical Hardship is limited to those bills that were included with the application. There is no eligibility period and bills may only be used once to support an application.
 - (d) **Protection from Collection:** All collection actions will be discontinued for all balances that are determined by HSN to be eligible for coverage under Medical Hardship. This includes balances that may have been assigned to an external agent or collection agency working on behalf of the Hospital. If a Hospital fails to submit an application within 5 days after receiving all verifications from the patient, then all balances which might have qualified under Medical Hardship are protected from collection actions.
- 5) **Low Income Patient Financial Responsibility**
- (a) The financial responsibility for a Low Income Patient is limited to copayments (from any payer except Medicare), deductibles determined by HSN or a CommonHealth Spend Down provided in the latter case that the patient has agreed to be billed for the CommonHealth Spend Down.
 - (b) **Pharmacy Co-Payments:** Low Income patients over the age of 18 are responsible for co-payments for pharmacy services. Consistent with general policies, co-payments will be requested at time of services. Unpaid co-payments will be treated as a patient liability and collected in accordance with the typical self-pay collections process. There is an annual maximum of \$250 on pharmacy co-payments.
 - (c) **Deposits for Low Income Patients designated as Partial HSN or Medical Hardship:** Deposits will be requested from these patients provided this is the primary coverage for the open balances for all Non-Emergency or Non-Urgent medically necessary services. The current status of the patient's annual family deductible will be reviewed and a

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deposit of up to 20% of the patient's annual deductible, or Hardship contribution, up to a maximum of \$500 may be collected from the patient.

- (d) **Payment Plans:** Low Income Patients will be notified of the availability of payment plans to satisfy all open balances per the terms specified in Section 9 D 4).
 - (e) **Non-Eligible Services:** Low Income Patients will be required to pay for any Non-Eligible Services, including but not limited to Infertility Services, TeleHealth, eHealth, Cosmetic Services or non-medically necessary podiatry services, in advance, provided that the patient is informed of the maximum cost of these services in advance and signs an acknowledgement that the services are not covered by HSN or any other Massachusetts assistance programs. Services will be deferred until payment is made according to the guidelines in 4 A.
- 6) **Pending Low Income Status Determinations:** Patients for whom the hospital has submitted an application for a state or other government sponsored program will have the bills held for up to 30 days pending determination. After 30 days they will be processed as Self Pay until a determination has been made. However, requirements for deposits may be waived pending a determination by a Financial Counselor that a patient's application is complete and expected to be approved.

F. SPECIAL SITUATIONS – REGISTRATION AND PATIENT FINANCIAL RESPONSIBILITY

Under some circumstances, additional information or procedures may be needed to support processing of the patient's claims.

- 1) **Workers Compensation:** Services related to industrial accidents should be appropriately labeled in the registration record. Additional information that is required includes the date and time of accident, employer name and phone number, and employer's workers compensation carrier and phone number. (See 10, F, 4 regarding submission of claims to Workers Compensation carriers prior to HSN submission.)
- 2) **Motor Vehicle Accidents (MVA) and Third Party Liability:** Services related to a motor vehicle accident or other third party liability should be appropriately labeled in the registration record. Diligent efforts will be made to collect additional information that is required for submission of MVA claims including the date and time of accident, the location for third party liability cases, and any known automobile insurer. The name of any attorney associated with the claim should also be noted in the registration system if it is available. (See 10, F, 3 regarding submission of claims to MVA liability carriers prior to HSN submission.)
- 3) **Victims of Violent Crimes:** Services related to victims of violent crimes should be appropriately labeled in the registration record, with the time and place of the incident. In some cases, limited funds are available from the Attorney General's office to offset medical expenses that are not otherwise covered by medical insurance or the Health Safety Net. When indicated, patients should be referred to Financial Counseling for completion of the appropriate documentation for compensation from the Victims of Violent Crimes Fund.
- 4) **HITECH (Health Information Technology for Economic and Clinical Health Act of 2010)** provides patients the right at the time of service to request that their PHI (Patient Health Information) regarding a specific item or service not be sent to their health insurance for

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purposes of payment. The patient is expected to pay any outstanding balance in full at time of service or upon receiving statements. HITECH only allows the patient to not have insurance billed. It does not negate the patient's financial responsibility for payment of accounts. Accounts should be noted per procedure to guard against inappropriate release.

- 5) HSN Confidential Applications: Confidential applications may be submitted under two circumstances.
 - (a) Minors: Confidential applications may be submitted for minors presenting for family planning services and services related to sexually transmitted diseases. These applications may be processed under the minor's income without any regard to the family income. These patients should be referred to Financial Counseling.
 - (b) Battered or Abused individuals: These individuals may also apply for HSN coverage on the basis of their individual income. These patients may be approved for the full range of services covered by HSN. These patients should be referred to Financial Counseling.
- 6) Undocumented Persons. Patients may be concerned about the immigration implications of applying for Low Income Patient status. Patients with limited means should be encouraged to apply for a state or other government sponsored program. If patients continue to express concern, patients may be referred to outside agencies for counsel. Patients refusing to apply for assistance will continue to be treated as self-pay. Urgent and Emergent services (including up to two weeks of drugs required to respond to immediate threats to patient's health) should continue to be provided. Non-urgent, Non-emergent services may be deferred or canceled until such time as the patient is able to pay, make suitable financial arrangements, obtain insurance or become enrolled in a financial assistance program that will cover the service.
- 7) Research Studies: Services related to research studies should be noted at time of registration for that service and labeled to insure that charges for these services are submitted to the designated research fund.
- 8) Organ Donors: The Hospital will identify organ donors at the time of service and ensure that claims for these services are applied to the appropriate insurance or other funding source.
- 9) International Patients: In addition to following the procedures stated for Insured and Uninsured patients, the Hospital will make every reasonable effort to gather local and permanent address information for residents of foreign countries, and take whatever appropriate additional actions are needed in order to secure pre-payment for all uninsured services.

7. FINANCIAL COUNSELING SERVICES

A. GENERALLY

The Hospital will seek to identify patients who may be uninsured or inadequately insured in order to provide counseling and assistance. The Hospital will provide financial counseling to these patients and their families, including screening for eligibility for other sources of coverage, such as State

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Programs and other government programs (including to the extent possible, Medicaid programs in states other than Massachusetts), and providing information regarding all acceptable methods of payment of the Hospital bill. The Hospital will encourage patients who are potentially eligible for coverage from State Programs or other government programs to apply for coverage and shall assist the patient in applying for benefits. Patients may also apply for and be approved for coverage by the HSN for co-insurance or deductibles not covered by their primary insurance plan.

B. COMMUNICATION OF AVAILABILITY OF FINANCIAL COUNSELING SERVICES

The Hospital will post a notice (signs) of the availability of financial assistance programs and describe where to go to for assistance in the following locations:

1. Inpatient, clinic, emergency department, and community health center admission and/or registration areas;
2. Financial Counseling waiting areas
3. Central admission/registration areas that are open to patients
4. Business office waiting areas that are open to patients

Signs will be translated into other languages to the extent that the language is the primary language of more than 10% of residents in the Hospital's service. Signs will generally be posted in English and Spanish. Posted signs will be clearly visible and legible to patients visiting these areas. Signage will also include instructions on access to translation services for patients who have other language needs.

Standard notices will be provided to all patients at the time of their initial registration with Partners HealthCare. These notices will also be made widely available throughout all hospitals and health centers and routinely offered to existing patients whenever they are expected to have an out-of-pocket liability. Complete copies of this policy and the PHS Financial Assistance Policy and PHS Uninsured Patient Discount Policy will also be made available to patients as required. Both policies will also be posted on the internet at www.partners.org/patientbilling with links to the homepages of all hospital entities in readily identifiable locations.

C. RESIDENCY REQUIREMENTS FOR STATE PROGRAMS

Eligibility for most State Programs is generally limited to patients who can demonstrate residency in the Commonwealth of Massachusetts according to applicable regulations. In general, patients who have temporarily relocated to Massachusetts for the sole purpose of receiving health care benefits do not meet the residency requirements. The Hospital will work with Low-Income Patients who do not qualify for Commonwealth of Massachusetts programs to identify other alternatives and advise them of their responsibilities.

D. APPLICATION FOR STATE PROGRAMS

The Hospital assists the patient in completing the application for a State Program and securing and submitting the necessary documentation required by the applicable State Program. Individuals apply for coverage through a single uniform application that is submitted through the state's enrollment system (hCentive). Through this process, the individual can submit an application through an online website (which is centrally located on the state's Health Connector website), a paper application, or over the phone with a customer service representative located at either MassHealth or the Health Connector. Necessary documentation may include, but is not limited to

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proof of: (1) annual household income (payroll stubs, record of social security payments, and a letter from the employer, tax returns, or bank statements), (2) citizenship and identity, (3) immigration status for non-citizens (if applicable), and (4) assets of those individuals who are 65 and over. The State will notify the patient of any documentation that needs to be submitted for final verification. The patient may receive provisional coverage if the applicable program guidelines are met.

- 1) Submission of an Application for a State Program. All applications for a State Program, including paper and online applications must be signed by the patient or their legal representative. Verifications should be submitted only after the application has been processed and the State has requested documentation. During the application process, patients will be advised that HSN may report details of the patient's HSN utilization to the patient's employer. This disclosure is part of the State Program application.
- 2) Determination of Eligibility. All State Program applications are reviewed and processed by the Office of Medicaid, which uses the Federal Poverty Guidelines as well as the necessary documentation listed above as the basis for determining eligibility for all state programs.
- 3) Completion of a Medical Hardship application. The designated Special Circumstances Application will be completed by the Hospital and submitted to HSN via the INET system for their determination.
- 4) Notification of patient responsibilities. The financial counselors will make their best effort to notify any HSN patients of their responsibilities as outlined in 13 A including the requirement to report any proceeds or refund HSN for any Third Party recoveries they may receive.

E. APPROVAL FOR COVERAGE

The Hospital has no role in the determination of program eligibility made by the Office of Medicaid but at the patient's request may take a direct role in appealing or seeking information related to the coverage decisions. The Office of Medicaid will issue all notices of eligibility. It is still 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. APPEAL OF OUTCOME

Patients may request a review of the determination from the Office of Medicaid that he or she is not a Low Income Patient. The request must be sent to the Office of Medicaid with supporting documentation. Requests for additional information made to the Hospital will be completed within 30 days.

8. DISCOUNTS, ADJUSTMENTS AND CHARITY CARE

A. GENERALLY

The Hospital may extend discounts or other adjustments to patients if they qualify under the PHS Uninsured Discount Policy, the PHS Financial Assistance Policy or on a case-by-case basis, provided that the Hospital Chief Financial Officer, the PHS Vice President of Revenue Cycle Operations, the PHS Director of Patient Billing Solutions or their respective designees authorize

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such discounts. Discounts should be clearly defined, documented, and consistent with good business practice, existing state and federal statutes and in accordance with guidance that might, from time-to-time, be issued by state or federal authorities.

Discounts will not be based upon any relationship that the patient or his/her family may have with any Hospital employee or member of the governing body.

Discounts will not be extended based upon any consideration of "professional courtesy" for a clinician or his/her family.

Discounts will not be offered to patients to induce the patient to receive services or otherwise be linked in any manner to the generation of business payable by a federal healthcare program nor will they be redeemable for cash for items or services provided by the Hospital, or any other Partners entity (this includes discounts to the gift shop, cafeteria, etc.).

In general, co-payments, co-insurance or deductibles will not be waived or discounted.

Reasons for waiving or discounting co-payments, co-insurance or deductibles:

- Demonstrated financial hardship generally based on applicable patient income and asset information
- The occurrence of a serious reportable event or other clinical issue causing the entire visit of stay to be waived. Any co-payments and deductibles collected in advance of the event (e.g. at check-in) would also be refunded. (For additional details, see the Partners Non-Payment Policy for Quality and Safety Events.)
- In rare cases, exceptions may be authorized by the Hospital Chief Financial Officer, the PHS Vice President of Revenue Cycle Operations or their respective designee(s).

Reasons for extending other types of discounts include:

- To encourage prompt payment,
- To recognize unique cases of financial hardship,
- To minimize the administrative costs of collection,
- Special case rate arrangements negotiated prior to service delivery, and,
- As needed for the maintenance of positive patient relations, including but not limited to items such as an unexpected delay in service or other sub-optimal care delivery events. Any service recovery credit will be recorded as such and monitored so as to not exceed \$50 annually.

B. OTHER DISCOUNTS, ADJUSTMENTS AND CHARITY CARE

The Hospital will maintain programs for Uninsured Patient Discounting and a Financial Assistance Policy for additional discounts. These discounts will generally be recognized as Charity Care by the Hospital. Such programs will be approved by the Partners Executive Vice President for Finance, and filed as provided in Section 2. The Hospital may also recognize as Charity Care those balances which may not be collected from a patient due to their protection from collection actions as outlined in 101 CMR 13.08 (3) and section 9 B (3) of this policy. Patient balances that qualify under the Hospital's Charity Care policies may be reported as Medicare Bad Debt.

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9. PATIENT BILLING AND COLLECTIONS

A. OVERVIEW

The Hospital will make diligent efforts to collect all charges that are due from insurers according to established industry standards and will seek to apply payments and contractual adjustments on a timely basis to the patient's account. These efforts include billing all available insurance plans according to the payers' requirements and timely follow up of denied claims. Patients or other guarantors will be held responsible for all account balances that remain after application of all insurance payments, contractual adjustments, and agreed on discount/adjustments in accordance with any remittance advice received from the payer except where the balance may be submitted to the HSN or deemed exempt from collection actions per state regulation. Collection actions may include patient statements, patient letters, telephone contacts and certified final collection notices.

B. PATIENT STATEMENTS, LETTERS, AND CALLS

The Hospital, either directly or through its designated agents, will prepare or mail statements to patients on a regular basis to advise them of balances owed to the Hospital. To the degree possible, the patient will receive a summary of all charges, payments and adjustments included with the initial billing for each date of service. In general, patients should receive three (3) or more statements or letters over the course of a billing cycle that is expected to last 120 days provided that other actions do not occur which indicate that additional billing is inadvisable. A record of all account actions and communications, including bills, is typically reflected in the billing system transaction registers and/or account comments. Staff is required to document all contacts with the patient (or guarantor) in the applicable billing system or self-pay collection system.

- 1) Suspension of billing. In certain situations, continued billing and collection activity may be inappropriate and may be suspended or discontinued. Such situations include, but are not limited to: Bad Address (section 7 below), Bankruptcy cases (section F (1)), deceased patient, patient complaint or customer service issue, Small Balances (section 10(B) (8)), or pending MassHealth or Low Income determinations.
- 2) Notification of Availability of Financial Assistance. Patient statements will include any notices required by regulations to inform patients of the availability and means to access financial assistance. The language and content of these notices will conform to current EOHHS and IRS 501(r) regulations. Notices regarding the availability of financial assistance will also be included in all other written and verbal patient communications to the degree feasible.
- 3) Patients Protected from Collection Action. The Hospital will take reasonable steps to ensure that no collection actions, including telephone calls, statements or letters, are initiated for those patient balances that may be exempt from collection action by regulation, including patients determined to be a Low Income Patient by the Office of Medicaid (except for Dental-Only Low Income Patients), or enrolled in MassHealth, Children's Medical Security Plan (CMSP) with a MAGI family income equal to or less than 300% of the FPG, Emergency Aid to the Elderly, Disabled, and Children (EAEDC), and Health Safety Net (Full or Partial) excepting deductibles and co-payments determined by those programs to be a patient responsibility, and copayments from any third-party payer except Medicare.. If it is determined that a patient was enrolled in one of those categories, then all collection actions (except applicable co-payments and HSN deductibles) with the patient will be closed for services that occurred during the patient's period of eligibility. Collection actions will also

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cease for as long as the patient is determined to be Low Income if the balance is from a period when the patient was not enrolled in a qualifying program. The Hospital may continue to send letters requesting information or action by the patient to resolve coverage and/or eligibility issues with a primary payer, Workers Compensation Program or to obtain any Third Party Liability or MVA carrier information.

- 4) Final Collection Notice. The Hospital will make reasonable efforts to send each patient a final collection notice prior to the account being written off as Bad Debt. In most cases, the final collection notice will be included on the guarantor statement.
- 5) Emergent Bad Debt. For those cases where an account is being considered by the Hospital for application to the HSN as Emergent Bad Debt, the Hospital will ensure the following conditions are met:
 - (a) The account was subject to continuous collection action for a minimum of 120 days.
 - (b) An eligibility inquiry was made to MMIS to screen for coverage.
 - (c) The services provided qualify as Emergent or Urgent per the definitions in this policy.
 - (d) A final collection notice was sent by certified mail for balances of \$1,000 or more. Accounts that are properly documented as Bad Address accounts may be submitted to the HSN without the mailing of a final collection notice via certified mail provided that 120 days have elapsed from initial billing and that after a reasonable effort, the hospital was unable to obtain an updated address. Reasonable attempts will be made to notify Massachusetts residents that the Health Safety Net may provide details of any claims submitted to the HSN to the patient's employer.
- 6) Collection Calls and Letters. The Hospital will make reasonable efforts to collect all outstanding balances due to the Hospital. The collection effort expended will vary depending on a number of factors including, but not limited to, the balance of the accounts and the patient's previous collection history. Additional collection efforts may include patient calls, and letters to supplement the routine patient statement process as described in section 10 B. To the degree possible, these calls and letters will include reminders regarding the availability of financial assistance.
- 7) Bad Address Returns. The Hospital will make reasonable efforts to track and respond to all patient statements returned by the USPS that are not deliverable. Where possible, accounts will be identified as "Bad Address Accounts" in the billing system, and address information will be verified and corrected using "skip trace" programs that may be available from third parties. Generally, once an account has been flagged as Bad Address, no further statements or letters should be processed unless a new address has been identified. Continued mailing of statements to incorrect addresses is both fiscally inappropriate and could result in a HIPAA privacy breach. Bad Address accounts will be flagged in the Registration system to alert any staff involved in the registration process to obtain a new address from the patient. Accounts whose most recent demographic information contains a Bad Address may be referred to outside agencies as Bad Debt for additional follow up except that potential Emergent Bad Debt accounts will be followed for 120 days prior to placement.
- 8) Small Balance Adjustment. Recognizing the cost of statement processing and collection activities, the Hospital may suppress statements on accounts below its "small dollar billing"

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threshold. Similarly, after billing, the Hospital may limit collection and research activity on small balances and adjust accounts below its "small balance write-off" threshold. In no case will small balance adjustments taken under this section be billed to the HSN. The typical low balance threshold applies to guarantor account balances of less than \$10.00.

C. SURCHARGE NOTICE

The Hospital will maintain a process to identify all patient balances that are subject to the Health Safety Net Trust Fund Surcharge as specified in 101 CMR 614. Surcharge amounts will be billed to the patient and the funds collected remitted to HSN per their requested schedule.

D. PAYMENT ARRANGEMENTS

- 1) Overall. Payments may be made in a variety of settings at all Partners Hospitals. Arrangements for deferred payment, payment plans or partial payment of deposits are typically only made by Hospital Admitting Services or PHS Patient Billing Solutions. All payment arrangements will conform to pre-determined criteria and be recorded appropriately in the Hospital's billing and registration systems.
- 2) Forms of Payment
 - (a) Prepayments may be made by certified/bank check, wire transfer, or credit/debit cards. Cash is not accepted at most hospital locations. Personal checks from US banks are typically accepted for balances of less than \$5,000 unless there is a history of checks failing for insufficient funds. Personal checks may be requested sufficiently in advance of a scheduled service in order to allow time for verification of the check. Patients who have a history of bad debt may be reviewed individually to determine the appropriate mode of payment.
 - (b) Bank Lock Box. Payments by personal check may be made to the Hospital's bank lockbox. Credit Card payments are not accepted by mail.
 - (c) Partners electronic billing and payment. Many locations provide electronic access to bills and payment of those bills electronically using credit/debit cards or a Bank ACH transfer.
 - (d) Payments are accepted by calling the PHS Patient Billing Solutions Call Center or other designated Customer Service centers.
 - (e) The Hospital will maintain a process to track 'bad' checks, and reverse any payments that may have been applied to the patient's account. Submission of a 'bad' check may be grounds for applying the account to Bad Debt.
- 3) Currency. Unless otherwise agreed to, payment will be made in U.S. Currency. Payment made in non-U.S. currency will be applied at the conversion rate specified by the Hospital's bank, less any conversion fees.
- 4) Payment Plans. Payment Plans are available to all patients on request provided that their accounts are up to date. Final acceptance of a payment plan is subject to a complete review of the patient's status and payment history. PHS Patient Billing Solutions will process and monitor all patient payment plans. Plans will generally cover open balances at all Partners Hospitals that are enrolled on Partners eCare. Wherever possible, payment plans will be coordinated across all entities.
 - (a) Payment Plans for HSN Partial Deductibles and Medical Hardship:

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- (i) An initial payment of the lesser of \$500 or 20% of the deductible balance may be required inclusive of all deposits accepted prior to service deliver in non-urgent/non-emergent events.
 - (ii) One-year Payment Plans will be offered on balances of \$1,000 or less and up to two years on all other balances. These patients will be offered a monthly payment amount of \$25 for these plans.
- (b) Payment plans for all other Patients
- (i) Maximum of one year for balances of \$1,000 or less
 - (ii) Maximum of two years for balance over \$1,000.
 - (iii) Longer payment plans may be offered under exceptional circumstances with senior management approval.
 - (iv) No plans will be offered with a monthly payment of less than \$25
- (c) No interest will be charged on balances where a patient has agreed to a payment plan and the patient is current with payments.
- (d) Plans should be reviewed on a regular basis to ensure that all payments are up to date. If a patient misses two consecutive payments, the Hospital may place the account in Bad Debt. Upon notification from the patient of changed financial circumstances, the Hospital may reevaluate the patient's outstanding payment obligation.

E. SPECIAL SITUATIONS

- 1) Patient Bankruptcy. The Hospital will make reasonable efforts to track all Bankruptcy notifications, and maintain them on file to ensure that all approved court procedures are followed, including filing of claims with the Court as appropriate, or forgiveness of debt.
- 2) Deceased Patients. When appropriate and cost effective, the Hospital will perform estate searches, bill estates, and file liens against the estate.
- 3) Motor Vehicle Accidents (MVA) and Third Party Liability: Reasonable efforts will be made to bill the MVA/TPL carrier to collect any Personal Injury Protection (PIP) amounts available. Insurance claims will be processed after the PIP is exhausted. The Hospital may also file a lien against future Bodily Injury payments made by the MVA carrier to the patient if we are able to establish the name of the patient's attorney managing the claim. Claims will not be submitted to HSN until the completion of diligent efforts to collect balances from other parties are exhausted. To the degree possible, patients will be reminded that they have a duty to report any potential TPL claim within 10 days of opening a claim to the Office of Medicaid or HSN. Any recoveries received after the submission of a claim to HSN will be offset against the original claim and reported to HSN inclusive of required voids or returns.
- 4) Workers Compensation: A WCA claim is generally settled entirely with the WCA carrier if the coverage is valid. The Hospital will make reasonable attempts to pursue the WCA coverage including filing of legal claims. If there is no WCA coverage, then the claim is managed in the typical manner.

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- 5) HSN Secondary Coverage: The Hospital will make diligent efforts to limit claims submission to HSN as a secondary carrier to those balances deemed covered by HSN, including deductibles, co-insurance, and non-covered services including those cases where a patient has exhausted their benefit or whose enrollment with the payer was not active at the time the services were rendered. Claims for services denied due to a technical fault with the claim or other technical denial as outlined in 101 CMR 613.03(1)(c) will not be submitted to HSN. If the Hospital receives an additional or corrected payment on a claim previously submitted to HSN then a corrected claim will be submitted to HSN.
- 6) Partial HSN Deductible: The Hospital will bill patients for 100% of their annual Partial HSN Deductible until charges equal to the annual deductible have been billed to the patient, inclusive of any balances included in payment plans. Claims will not be submitted to the HSN until the patient's deductible has been satisfied. This includes all satellite facilities and Hospital Health Centers that are operating as part of the Hospital's license.
- 7) Victims of Violent Crimes: The Hospital will assist the patient in filing claims with the MA Attorney General's Victims of Violent Crime program. In most cases, billing to the patient will be suspended while a VVC claim is pending. These payments are generally considered to be payments in full with no residual amounts billed to the patient.

10. BAD DEBT PLACEMENT

Once internal collection efforts have been exhausted, accounts may be written off to Bad Debt. This will typically occur after the account has completed its 120-day billing cycle with some exceptions due to Bad Address or other mitigating circumstances. Accounts in Bad Debt will generally receive additional collection effort through a number of sources including internal staff, external Collection Agencies, or collection attorneys. The Hospital will ensure that all follow-up of Bad Debt, whether by internal staff or an external agency, adheres to the following:

A. CREDIT REPORTING

Generally, while the Hospital does not typically report patient Bad Debt to any credit bureau, this policy is not intended to restrict the Hospital from taking this action in specific cases or to limit the hospital from doing so in the future. The Hospital and its agents may, however, utilize the services of a credit bureau to identify the credit rating of a patient with a view to determining the patient's ability to fulfill their financial obligations.

B. LITIGATION

The Hospital and its agents may pursue litigation against a patient to secure a court judgment, for debts owed to the Hospital. In no case shall a writ of capias (known as a "body attachment" in the popular press) be used as part of a collection effort.

C. PROPERTY LIENS

The Hospital may only pursue the attachment, execution, and sale of property upon the review and approval of the Hospital's CFO. In addition, for all cases involving a patient designated by the Office of Medicaid as Low Income or qualifying for any assistance program, the Hospital will not seek legal execution against the personal residence of a patient or Guarantor without the specific approval of the Hospital's Board of Trustees.

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D. COLLECTION AGENCIES

Any agency seeking to collect patient balances on behalf of the Hospital will be required to conform to this Credit and Collection Policy. Any substantive patient complaints will be reported to the Hospital for review and tracking. All agents will fully comply with applicable Federal Fair Debt Collection regulations as well as debt collection regulations that may be determined by the Massachusetts Attorney General. All agencies will report any collections or other account actions, including the decision to cease collection efforts, on a timely basis. In general, agencies will cease collection efforts on any account placed with them for one year that has had no action, payment or any current potential for payment.

11. CREDIT BALANCES AND REFUNDS

Generally, the Hospital will refund to patients any credit balances, which may result from excess funds having been collected from the patient. In cases where efforts to refund a patient/guarantor credit balance are unsuccessful the Hospital will remit credit balances to the Treasurer of the Commonwealth of Massachusetts in accordance with the state's Abandoned Property regulations.

12. SERIOUS REPORTABLE EVENTS (SRE)

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. The Hospital also maintains all information in accordance with applicable federal and state privacy, security and ID theft laws.

13. PATIENT RIGHTS AND RESPONSIBILITIES

A. PATIENT RESPONSIBILITY

It is the patient's obligation to:

- Provide complete and timely insurance and demographic information, and to inform the Hospital, and the State if patient is on a State Program, of any changes in their status including, but not limited to, changes in income or insurance status,
- For Massachusetts residents, apply for and maintain coverage through any government sponsored programs for which they may qualify, including submission of all required documentation within the required timeframes. All patients should obtain and maintain insurance coverage if affordable coverage is available to them. Notify the Hospital of any potential Motor Vehicle Accident coverage, Third Party Liability coverage or Workers compensation coverage. For patients covered by a State Program, file a claim for compensation, if available, with respect to any accident, injury or loss and notify the State Program (e.g. Office of Medicaid and the Health Safety Net) within ten days of information related to any lawsuit or insurance claim that will cover the cost of services provided by the hospital. A patient is further required to assign the right to a third party payment that will cover the costs of the services paid by the Massachusetts Office of Medicaid or the Health Safety Net.

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- Make reasonable efforts to understand the limits of their insurance coverage including network limitations, service coverage limitations and financial responsibilities due to limited coverage, co-payments, co-insurance and deductibles.
- Conform to insurance referral, pre-authorization and other medical management policies.
- Conform to other insurance requirements, including completion of coordination of benefits forms, updating membership information, updating physician information and other payer requirements,
- Pay co-pays, deductibles and co-insurance amounts in a timely manner.
- Provide timely updates of demographic, insurance and HSN eligibility and annual deductible data.

B. NON-DISCRIMINATION POLICY

The Hospital will not discriminate on the basis of race, color, national origin, citizenship, alienage, religion, creed, sex, gender identity, sexual orientation, age, or disability, in its policies, or in its application of policies, concerning the acquisition and verification of financial information, preadmission or pretreatment deposits, payment plans, deferred or rejected admissions, or eligibility for the Health Safety Net.

14. REPORTING, AUDIT AND COMPLIANCE WITH REGULATIONS

The Hospital will comply with all reporting requirements as defined by MGL c. 118G and related 101 CMR 613, 614 and associated Administrative Bulletins.

The Hospital will maintain auditable records of activities made in compliance with the criteria and requirements of 101 CMR 613 and 101 CMR 614.

The Hospital will file this Credit & Collection Policy electronically with the Office of Medicaid, Health Safety Net as required when the policy is changed or when there are regulatory changes promulgated by the Office of Medicaid, Health Safety Net mandating a new policy submission.

OTHER APPLICABLE PARTNERS HEALTHCARE POLICIES:

Partners Financial Assistance Policy
Partners Uninsured Patient Discount Policy

REFERENCE:

MA Regulations 101 CMR 613, 614 and MGL c. 118G.
IRS 501 (r) c