

**SIGNATURE HEALTHCARE
BROCKTON HOSPITAL**

Subject: Credit and Collection Policy		Page 1 of 9
Original Effective Date: 7/86	Revised Date: 4/90, 3/05 Reviewed Date: 4/12, 4/14, 2/18, 9/19, 12/23	Classification Code: 400.301
References: 101 CMR 613.00	Policy Section: IV Issuing Department/Committee: Finance	

PURPOSE:

To provide sound financial policies and practices to ensure compliance with applicable Federal and state law and to insure that the Hospital is reimbursed for medical services rendered.

POLICY:

It is the policy of the Hospital to seek reimbursement for services rendered to patients who are able to pay, from responsible third party insurers who cover the patient's cost of care, and from governmental and non-governmental programs of assistance for which a patient may be eligible. Further, the Hospital will provide free or reduced cost services to patients who may be medically indigent but who are ineligible for other forms of assistance. In addition, the Hospital will provide resources and guidance to assist patients in applying for assistance. The hospital maintains the confidentiality of all patient medical and financial information in accordance with applicable federal and state privacy, security, and ID theft laws.

RESPONSIBILITY:

It is the responsibility of the Patient Financial Systems Department to implement and administer the Credit and Collection Policy.

PROCEDURE:

A. Collecting Information on Patient Financial Resources and Insurance Coverage

- a) The hospital will work with the patient to advise them of their duty to provide the following key information:
Prior to the delivery of any health care services (except for services that are provided to stabilize a patient determined to have an emergency medical condition or needing urgent care services), the patient has duty to provide timely and accurate information on their current insurance status, demographic information, changes to their family income or group policy coverage (if any), and, if known, information on deductibles or co-payments that are required by their applicable insurance or financial program. The detailed information for each item should include, but not be limited to:
 - i) Full name, address, telephone number, date of birth, social security number (if

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available), current health insurance coverage options, citizenship and residency information, and the patient's applicable financial resources that may be used to pay their bill;

- ii) If applicable, the full name of the patient's guarantor, their address, telephone number, date of birth, social security number (if available), current health insurance coverage options, and their applicable financial resources that may be used to pay for the patient's bill; and
- iii) Other resources that may be used to pay their bill, including other insurance programs, motor vehicle or homeowners insurance policies if the treatment was due to an accident, worker's compensation programs, student insurance policies, and any other family income such as an inheritances, gifts, or distributions from an available trust, among others.

The patient also has a duty to keep track of their unpaid hospital bill, including any existing co- payments, co-insurance, and deductibles, and contacting the hospital should they need assistance in paying for some or their entire bill. The patient is further required to inform either their current health insurer (if they have one) or the state agency that determined the patient's eligibility status in a public program of any changes in family income or insurance status. The hospital may also assist the patient with updating their eligibility in a public program when there are any changes in family income or insurance status, provided that the patient informs the hospital of any such changes in the patient's eligibility status.

The hospital will work with the patient to ensure that they are aware of their duty to notify the hospital and the applicable program in which they are receiving assistance (e.g., MassHealth, Connector, Health Safety Net, or Medical Hardship), of any information related to a change in family income, or if they are part of an insurance claim that may cover the cost of the services provided by the hospital. If there is a third party (such as, but not limited to, home or auto insurance) that is responsible to cover the cost of care due to an accident or other incident, the patient will work with the hospital or applicable program (including, but not limited to, MassHealth, Connector, or Health Safety Net) to assign the right to recover the paid or unpaid amount for such services.

b) Hospital Obligations:

The hospital will make all reasonable and diligent efforts to collect the patient's insurance and other information to verify coverage for the health care services to be provided by the hospital. These efforts may occur during the patient's initial in-person registration at a hospital location for a service, or may occur at other times. In addition, the hospital will notify the patient about the availability of coverage options through an available public assistance or hospital financial assistance program, including coverage through MassHealth, the premium assistance payment program operated by the Health Connector, the Children's Medical Security Program, Health Safety Net, or Medical Hardship, in billing invoices that are sent to the patient or the patient's guarantor following delivery of services. Further, the

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hospital will also perform its due diligence through existing public or private financial verification systems to determine if it is able to identify the patient's eligibility status for public or private insurance coverage. The hospital will attempt to collect such information prior to the delivery of any non-emergent and non-urgent health care services. The hospital will delay any attempt to obtain this information while a patient is being treated for an emergency medical condition or needed urgent care services.

The hospital's due diligence efforts will include, but are not limited to, requesting information about the patient's insurance status, checking any available public or private insurance databases, following the billing and authorization rules, and as appropriate, appealing any denied claim when the service is payable in whole or in part by a known third party insurance company that may be responsible for the costs of the patient's recent healthcare services. When hospital registration or admission staff are informed by the patient, they shall also work with the patient to ensure that relevant information is communicated to the appropriate public programs, such as any changes to family income or insurance status, including any lawsuit or insurance claim that may cover the cost of the services provided by the hospital.

If the patient or guarantor/guardian is unable to provide the information needed, and the patient consents, the hospital will make reasonable efforts to contact relatives, friends, guarantor/guardian, and/or other appropriate third parties for additional information.

The hospital's reasonable due diligence efforts to investigate whether a third party insurance or other resource may be responsible for the cost of services provided by the hospital shall include, but not be limited to, determining from the patient if there is an applicable policy to cover the cost of the claims, including: (1) motor vehicle or home owner's liability policy, (2) general accident or personal injury protection policy, (3) worker's compensation programs, and (4) student insurance policies, among others. If the hospital is able to identify a liable third party or has received a payment from a third party or another resource (including from a private insurer or another public program), the hospital will report the payment to the applicable program and offset it, if applicable per the program's claims processing requirements, against any claim that may have been paid by the third party or other resource. For state public assistance programs that have actually paid for the cost of services, the hospital is not required to secure assignment on a patient's right to third party coverage of services. In these cases, the patient should be aware that the applicable state program may attempt to seek assignment on the costs of the services provided to the patient.

B. Hospital Billing and Collection Practices

The hospital has a uniform and consistent process for submitting and collecting claims submitted to patients, regardless of their insurance status. Specifically, if the patient has a current unpaid balance that is related to services provided to the patient and not covered by a public or private coverage

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option, the hospital will follow the following 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 financial assistance (including, but not limited to MassHealth, the premium assistance payment program operated by the Health Connector, the Children's Medical Security Program, the Health Safety Net and Medical Hardship) 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 unpaid bill, which will also include information on how the patient can contact the hospital if they need financial assistance;
- 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 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," and also notifying the patients of the availability of financial assistance in the communication;
- e) Documentation of continuous billing or collection action undertaken for 120 days from the date of the service is maintained and available to the applicable federal and/or state program to verify these efforts; and
- f) Checking the Massachusetts Eligibility Verification System (EVS) to ensure that the patient is not a Low Income Patient and has not submitted an application for coverage for either MassHealth, the premium assistance payment program operated by the Health Connector, the Children's Medical Security Program, Health Safety Net, or Medical Hardship, prior to submitting claims to the Health Safety Net Office for bad debt coverage.
- g) For all patients who are enrolled in a public assistance programs, the hospital may only bill those patients for the specific co-payment, co-insurance, or deductible that is outlined in the applicable state regulations and which may further be indicated on the state Medicaid Management Information System.

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 hospital will notify the patient if such additional resources are available based on the patient's income and other criteria, as outlined in the hospital's financial assistance policy.

The hospital, when requested by the patient and based on an internal review of each patient's financial status, may also offer a patient an additional discount or other assistance following its own internal financial assistance program that is applied on a uniform non-discriminatory basis to patients, and which takes into consideration the patient's documented financial situation and the patient's inability to make a payment after reasonable collection actions. Any discount that

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is provided by the hospital is consistent with federal and state requirements, and does not influence a patient to receive services from the hospital.

C. Populations Exempt from Collection Activities

The following patient populations are exempt from any collection or billing procedures pursuant to state regulations and policies: Patients enrolled in a public health insurance program, including but not limited to, MassHealth, Emergency Aid to the Elderly, Disabled and Children (EAEDC); Children's Medical Security Plan (CMSP), if MAGI income is equal to or less than 300% of the FPL; Low Income Patients as determined by MassHealth and Health Safety Net, including those with MAGI Household income or Medical Hardship Family Countable Income between 150.1 to 300% of the FPL; and Medical Hardship, subject to the following exceptions:

- a) 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;
- b) 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;
- c) 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 Eligibility Verification System or the Medicaid Management Information System. However, once a patient is determined eligible and enrolled in MassHealth, the Premium Assistance Payment Program Operated by the Health Connector, the Children's Medical Security Plan, or Medical Hardship, the hospital will cease collection activity for services (with the exception of any copayments and deductibles) provided prior to the beginning of their eligibility.
- d) The hospital 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 such service(s). However, even in these circumstances, the hospital may not bill the patient for claims related to medical errors or claims denied by the patient's primary insurer due to an administrative or billing error.

D. Hospital Collection Processes

- a) The hospital will not engage in any "extraordinary collection actions". The hospital will accept and process an application for financial assistance under its financial assistance policy submitted by a patient for the entire "application period." The "application period" begins

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on the date care is provided and ends on the later of the 240th day after the date that the first post-discharge billing statement for the care is provided, subject to the following special additional requirements. The application period does not end before 30 days after the hospital has provided the patient with the 30-day notice described below. In the case of a patient who the hospital facility has presumptively determined to be eligible for less than the most generous assistance under the financial assistance policy, the application does not end before the end of a reasonable period for the patient to apply for more generous financial assistance, as further described below.

- b) The hospital (i) provides the patient with a written notice that indicates that financial assistance is available for eligible patients, (ii) provides the patient with a plain language summary of the financial assistance policy; and (iii) makes a reasonable effort to orally notify the patient about the financial assistance policy and how the patient may obtain assistance with the financial assistance policy application process; except that special requirements apply to deferring or denying necessary medically necessary care as described below.
- c) If a patient submits a complete or incomplete application for financial assistance under the hospital's financial assistance policy during the application period, (i) the hospital will determine whether the patient is eligible for financial assistance under the financial assistance policy or (ii) in the case of an incomplete application for financial assistance, the hospital will request for additional information and/or documentation within a reasonable period of time. The hospital will also take further action, depending on whether the application is complete or incomplete, as described below.
- d) In the event that a patient submits a complete application for financial assistance during the application period, the hospital will in addition make a determination as to whether the patient is eligible for financial assistance. If the hospital determines that the patient is eligible for assistance other than free care, the hospital will (i) provide the patient with a billing statement that indicates the amount the patient owns for the care as a patient eligible for financial assistance and states, or describes how the patient can get information regarding, the Amounts Generally Billed for the care, (ii) refund to the patient any amount that the patient paid for the care that exceeds the amount the patient is determined to be personally responsible for paying and In the event that a patient submits an incomplete application for financial assistance during the application period, the hospital will in addition provide the patient with written notice that describes the additional information and/or documentation required under the financial assistance policy and that includes contact information.
- e) The hospital may make presumptive determinations that a patient is eligible for financial assistance under the financial assistance policy based on information other than that provided by the patient or based on a prior determination of eligibility. In the event that a patient is determined to be eligible for less than the most generous assistance available under the financial assistance policy, the hospital will: (i) notify the patient regarding the basis for the presumptive eligibility determination and the way to apply for more generous assistance available under the financial assistance policy; (ii) give the patient a reasonable period of time to apply for more generous assistance and (iii) if the patient

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submits a complete application seeking more generous financial assistance during the application period, determine whether the patient is eligible for the more generous discount.

- f) The hospital and its agents shall not continue collection or billing efforts related to a patient who is a member of a bankruptcy proceeding except to secure its rights as a creditor in the appropriate order (similar actions may also be taken by the applicable public assistance program that has paid for services). The hospital and its agents will also not charge interest on an overdue balance for a Low Income Patient or for patients who meet the criteria for coverage through the hospital's own internal financial assistance program.
- g) The hospital maintains compliance with applicable billing requirements and follows applicable state and federal requirements related to the non-payment for specific services that were the result of or directly related to a Serious Reportable Event (SRE), the correction of the SRE, a subsequent complication arising from the SRE, or a readmission to the same hospital for services associated with the SRE. SREs that do not occur at the hospital are excluded from this determination of non-payment as long as the treating facility and the facility responsible for the SRE do not have common ownership or a common corporate parent. The hospital also does not seek payment from a Low Income Patient through the Health Safety Net program whose claims were initially denied by an insurance program due to an administrative billing error by the hospital.

E. Outside Collection Agencies

The hospital may contract with an outside collection agency to assist in the collection of certain accounts, including patient responsible amounts not resolved after 120 days of continuous collection actions. Effective Oct. 1st 2020, the 120-day period will reset after each time the hospital receives a partial payment. The hospital may also enter into binding contracts with outside collection agencies. Any such contract permitting the sale of debt that is not treated as an extraordinary collection action will meet the requirements described above. All outside collection agencies hired by the hospital will provide the patient with an opportunity to file a grievance and will forward to the hospital the results of such patient grievances. The hospital requires that any outside collection agency that it uses is operating in compliance with federal and state fair debt collection requirements.

F. Deposits and Installment Plans

Pursuant to the Massachusetts Health Safety Net regulations pertaining to patients that are either: (1) determined to be a "Low Income Patient" or (2) qualify for Medical Hardship, the hospital will provide the patient with information on deposits and payment plans based on the patient's documented financial situation. Any other plan will be based on the hospital's own internal financial assistance program, and will not apply to patients who have the ability to pay.

- a) Emergency Services

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A hospital may not require pre-admission and/or pre-treatment deposits from patient that require Emergency Level Services or that are determined to be Low Income Patients.

b) Low Income Patient Deposits

A hospital may request a deposit from patients determined to be Low Income Patients. Such deposits must be limited to 20% of the deductible amount, up to \$500. All remaining balances are subject to the payment plan conditions established in 101 CMR 613.08(1)(g).

c) Deposits for Medical Hardship Patients

A hospital may request a deposit from patients eligible for Medical Hardship. Deposits will be limited to 20% of the Medical Hardship contribution up to \$1,000. All remaining balances will be subject to the payment plan conditions established in 101 CMR 613.08(1)(g).

d) Payment Plans for Low Income Patients pursuant to the Massachusetts Health Safety Net Program

A patient with a balance of \$1,000 or less, after initial deposit, must be offered at least a one-year payment plan interest free with a minimum monthly payment of no more than \$25. A patient that has a balance of more than \$1,000, after initial deposit, must be offered at least a two-year interest free payment plan.

e) CommonHealth One-Time Deductible

At the request of the patient, the hospital may bill a Low Income Patient in order to allow the Patient to meet the required CommonHealth One-time Deductible.

f) Payment Plan for HSN Partial Low Income Patients pursuant to the Massachusetts Health Safety Net Program, for services rendered in a Hospital Licensed Health Facility, including the following locations:

- *Brockton Hospital Outpatient Care Center*
 - *130 Quincy Avenue, 1st and 2nd Floors, Brockton, MA*
- *Signature Healthcare Brockton Hospital*
 - *110 Liberty Street, 1st Floor, Suite #1B & 1C, Brockton, MA*
- *Signature Healthcare Brockton Hospital Imaging*
 - *31 Roche Brothers Way, Easton, MA*
- *Signature Healthcare Brockton Hospital Rehabilitation Services*
 - *1215 Broadway, 1st and 2nd Floors, Raynham, MA*
- *Signature Healthcare Brockton Hospital @430 Liberty Street*
 - *430 Liberty Street, Suite #7, Hanson, MA*
- *Signature Healthcare Brockton Hospital Rehabilitation Services East Bridgewater*
 - *635 Plymouth Street, East Bridgewater, MA 02333*
- *Signature Healthcare Greene Cancer Treatment Center*
 - *25 Libby Street, 1st and 2nd Floors, Brockton, MA*

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- *Brockton Radiation Oncology, LLC*
 - *25 Libby Street, Brockton, MA*
 - *Shields Signature Imaging, LLC*
 - *680 Centre Street, Brockton, MA*
 - *Signature Healthcare Urgent Care*
 - *650 Centre Street, Brockton, MA*
 - *Signature Healthcare Urgent Care*
 - *1 Compass Way, 1st Floor, Suites #102, #104 & #105, East Bridgewater, MA*
- g) The hospital also offers the Health Safety Net Partial Low Income Patient a co-insurance plan, that allows the patient to pay 20% of the Health Safety Net payment for each visit until the patient meets their annual deductible. The remaining balance will be written off to the Health Safety Net.

REFERENCES:

101 CMR 613.00 Credit & Collection Regulatory Requirements
I.R.C SOL(r)

REVIEWED BY:

Chief Financial Officer
Administrative Policy Committee
Finance Committee

DATE:

12/2023
01/2024
12/2023