Southcoast Hospitals Group

Charlton Memorial Hospital
St. Luke's Hospital
Tobey Hospital

Credit and Collection Policy

Based on Mass. EOHHS Regulation 101 CMR 613.00
&
Internal Revenue Code Section 501(r)

Effective: October 1, 2016

Southcoast Hospitals Group

Policy: **CREDIT & COLLECTION POLICY**

Date Effective: **OCTOBER 1, 2016**

GENERAL POLICY

The mission of Southcoast is to care for and improve the health, and to promote the wellness, of the individuals and communities we serve. Southcoast will render medical care to all those seeking service at this facility in accordance with 613.08(1)(a). A Provider must not discriminate on the basis of race, color, national origin, citizenship, alien age, 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, preadmission or pretreatment deposits, payment plans, deferred or rejected admissions, or Low Income Patient status. The hospital will not defer or refuse emergent/urgent treatment to any patient.

The hospital reserves the right to refuse or defer treatment in a case where a patient is scheduled to receive services that are considered non-emergent or non-urgent by the patient's physician.

Prompt payment of all hospital bills is necessary in order to maintain the high quality of services and continue to provide them. The hospital will assist and advise the patients and their families of all health care assistance programs and financial benefits for which they may be eligible.

This credit and collection policy is based upon industry standards for patient accounting and is intended to comply with the criteria set forth by the Executive Office of Health and Human Services Policy regulations 101 CMR 613.00 (regulations governing criteria for credit and collection policies of acute care hospitals) and the Internal Revenue Code Section 501(r) as required under the Section 9007(a) of the federal Patient Protection and Affordable Care Act (PPACA) (Pub. L.No 111-148).

Our Credit and Collection Policies are filed in accordance with 101 CMR 613.08(1)(c)1 and Provider Affiliate lists (if applicable), as described in 101 CMR 613.08(1)(d), available on the Southcoast Health website.

Table of Contents

SECTION 1: INFORMATION ON PATIENT HEALTH COVERAGE AND RESOURCES

A. Acquisition of Information

1. It is the patient's responsibility to provide the Southcoast Hospitals Group (SHG) with accurate information regarding health insurance, address, and applicable financial resource information to determine whether the patient is eligible for coverage through existing private insurance or through available public assistance programs.

2. At the time a patient service is scheduled, or at the time of patient registration, the Patient Access area will obtain and verify the financial information necessary to determine responsibility for payment of the hospital bill from the patient or guarantor. Policies for gathering and verifying patient information are available in the Patient Access Procedure Manual. They address all registration areas, including inpatient and outpatient emergency services.

3. Southcoast will render medical care to all those seeking service at this facility in accordance with 613.08(1) (a). A Provider must not discriminate on the basis of race, color, national origin, citizenship, alien age, 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, preadmission or pretreatment deposits, payment plans, deferred or rejected admissions, or Low Income Patient status. The hospital will not defer or refuse emergent/urgent treatment to any patient.

4. If the patient or guarantor is unable to provide the information needed, and the patient consents, SHG will make reasonable efforts to contact the relatives or friends for additional information while the patient is in the hospital and/or at the time of the patient's discharge.

5. All information will be treated confidentially in accordance with applicable federal and state privacy laws.

6. A patient previously determined eligible for HSN that interacts with SHG registration personnel will be advised of their responsibilities described in 101 CMR 613.08(2)(b):

A. file an insurance claim for compensation, if available;

B. assign to the MassHealth Agency or its agent the right to recover an amount equal to the Health Safety Net benefits provided from the proceeds of any claim or other proceeding against a third party;

C. provide information about the claim or any other proceeding and cooperate fully with MassHealth Agency, unless the MassHealth Agency determines that cooperation would not be in the best interest of, or would result in serious harm or emotional impairment, to the Low Income Patient;

D. notify the Health Safety Net Office or MassHealth in writing within ten days of filing any claim, civil action or other proceeding;

E. repay the Health Safety Net Office from the money received from a third party for all Health Safety Net services provided on or after the date of the accident or other incident. If the Low Income Patient is involved in an accident or other incident after becoming Health Safety Net eligible, repayment will be limited to Health Safety Net services provided as a result of the accident or incident.

B. Submitting Claims to Insurance

1. SHG will comply with the insurer's billing and authorization requirements and will honor all contractual agreements with third parties.

2. SHG will appeal denied claims when the service is payable in whole or in part by the insurer.

3. If denial of payment from an insurer is the result of an SHG billing or administrative error, SHG will not seek payment from patient, HSN, or other third party.

4. SHG will return any payment received by the Office upon receipt of payment from a third party responsible for payment.

SECTION 2: PAYMENT ARRANGEMENTS

A. Expectations for Payment

1. 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. Deposits

1. SHG may reserve the right to require a deposit on any services believed to result in a self-pay liability. Patients who express an inability to meet the deposit requirements or who have prior balances indicating an inability to meet the deposit requirements will be referred to the Patient Financial Services Department to initiate a Common Intake application as early as possible in the admitting process or during the collection process.

2. SHG will not require pre-admission and/or pretreatment deposits from patients who require Emergency Care or that are determined to be Low Income patients.

3. SHG may request a deposit from individuals determined to be Low Income patients. Such deposits will 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)(f).

4. SHG 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 are subject to the payment plan conditions established in 101 CMR 613.08(1)(f).

5. SHG may bill Low Income Patients for services other than Reimbursable Health Services provided at the request of the Patient and for which the Patient has agreed to be responsible, with the exception of those services described in 101 CMR 613.08(3)(e)1 and 2. SHG must obtain the patient's written consent to bill for services.

C. Discounts

1. A qualifying patient is a patient who is not eligible for other financial assistance who is uninsured for medically necessary hospital services.

2. Eligible balances are those amounts for which a qualifying patient has full financial responsibility due to lack of insurance. These obligations do not include co-insurance, deductibles or balances due after insurance or for out-of-network services.

3. For the uninsured patients, a discount of 30% of the total charges will be applied to these accounts at the time of initial billing. **(Exhibit D)**

4. Additional discounts may be possible based on the size of the balance, timeliness of payment, and financial need. These will be given individual consideration.

5. SHG will seek to advise qualifying patients with respect to the availability of discounts pursuant to this policy, as well as the availability of Low Income and MassHealth Benefits.

D. Payment Plans

1. SHG will not require any payment plan for patients that are fully exempt from collection action**. (Exhibit C)**

2. Accounts not fully exempt from collection action will be considered eligible for a payment plan when there is no possibility of full third party reimbursement and a completed Low Income or Medical Hardship application indicates gross income in excess of 150% of the Federal Income Poverty Guidelines.

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

4. A patient who has a balance of more than $1,000, after initial deposit will be offered at least a two-year interest free payment plan.

5. Once a payment plan has been established, collection staff intervention will not be necessary if the established payments are received on time. However, delinquent payment plans are subject to the SHG collection process.

SECTION 3: DETERMINATION OF BAD DEBT

A. Third Party Billing Policy

1. When applicable, SHG will bill all third parties prior to Self Pay billing.

2. SHG will make reasonable efforts to gather and verify third party information (Section 1).

3. SHG will honor all contractual agreements with third parties.

4. Third party billing will be performed subsequent to a reasonable suspense period from the date of discharge.

B. Self Pay Determination

1. SHG will consider accounts to be Self Pay if they meet the following criteria.

   a. Is not eligible for Low Income assistance, MassHealth or assistance from other government programs; and

   b. Uninsured or has a balance after insurance; or

   c. Has defaulted on an established payment plan.

   d. If all necessary third party billing information is not available or the patient/guarantor is uncooperative in providing this information, the patient will be considered as Self Pay.

C. Billing and Collection Process

1. All bills are due and payable when an initial bill is rendered to the patient.

2. Telephone contact is initiated within the first thirty (30) days of self pay liability and larger balance accounts, requesting payment in full.

3. Further follow up by the collector occurs at a minimum of 120 days in the form of telephone contact whenever possible, statements and/or letters. **(Exhibit A & B)**

4. Every effort is made to assist the debtor in resolving billing questions, or insurance discrepancies.

5. If the patient is interested in applying for financial assistance, the patient will be referred to Patient Financial Services.

6. In addition to the collector's efforts, the debtor receives a minimum of three statements at 30 day intervals until the account is paid in full or written off as Bad Debt.

7. For uninsured self pay emergency room balances $1,000 and over, a final notice will be sent by certified mail.

8. Files will include documentation of alternative efforts to locate the party responsible for the obligation or the correct address on billings returned by the postal office service as "incorrect address" or "undeliverable".

9. If, after following steps 1 through 8, an account is considered to be uncollectible, the account is referred to the Manager of Patient Accounts or designee for Bad Debt write off review.

10. Documentation of continuous collection action will be maintained by paper and/or electronic media, primarily in the Billing & Collections System.

11. Southcoast shall not seek legal execution against the personal residence or motor vehicle of a Low Income patient determined pursuant to 101 CMR 613.04 without the express approval of the Southcoast Board of Trustees. All approvals by the Board must be made on an individual case basis.

D. Extraordinary Collection Actions (ECA)

1. ECA will not be taken before SHG has made reasonable efforts to determine whether the individual is eligible for financial assistance. SHG will provide a 120 day waiting period prior to pursing collections. During this time, the patients will be able to apply for financial assistance and begin the application process. SHG will make reasonable efforts to determine FAP-eligibility including the following:

- **a.** SHG will notify the individual about the FAP;
- **b.** In the case of an individual who submits an incomplete FAP application, SHG must provide the individual with information relevant to completing the FAP application; and
- **c.** In the case of an individual who submits a complete FAP application, SHG will make and document a determination as to whether the individual is FAP eligible.

2. Legal actions that require a legal or judicial process, including:

- **a.** Placing a lien on an individual's property;
- **b.** Foreclosing on real property;
- **c.** Attaching or seizing bank account or any other personal property;
- **d.** Commencing a civil action against an individual;
- **e.** Causing an individual's arrest;
- **f.** Causing an individual to be subject to a writ of body attachment; and garnishing an individual's wages.

E. Bad Debt Approval

1. The Manager of Patient Accounts or designee reviews the individual account to ensure that all collection efforts have been exhausted, a minimum of 120 days has elapsed and all policies and procedures were followed.

2. SHG will make a final check through the MassHealth system to ensure that the patient is not a Low Income Patient as defined by the Office of Medicaid and has not submitted an application for coverage of the services under a public program, prior to submitting claims to the Health Safety Net Office for emergency bad debt coverage of an emergency level or urgent care service.

3. Following steps 1 & 2, the Manager of Patient Accounts or designee and/or the Director of Patient Accounts will approve the Bad Debt write off.

E. Exceptions

1. Expired Patients

a. In the case of an account of an expired patient with no estate identified through the collection process, after one hundred and twenty (120) days, the balance may be deemed bad debt following standard collection practices.

2. Agency Assistance Pending Determination

a. The patient billing cycle will commence on accounts pending agency determination. The Hospital will not write off an account to Bad Debt until informed either verbally or in writing that the patient who has filed an application for medical assistance has been denied eligibility.

3. Incarcerated Patients

d. Patients verified to be incarcerated during the collection process will be written off as Bad Debt after one hundred and twenty (120) days after exhausting collection efforts from any existing Third Party insurers, following standard collections practices.

SECTION 4: Serious Reportable Events (SRE)

A. In compliance with 105 CMR 130.332, once an event has been deemed an (Serious Reportable Events (SREs) by the SHG Risk Management Department, SHG will not charge, bill or otherwise seek payment from HSN, the patient or any other payers. This includes the occurrence of the SRE, the correction or remediation of the event, or subsequent complications arising from the event.

B. Readmissions to the same hospital or follow-up care provided by the same Provider or a Provider owned by the same parent organization are not billable if the services are associated with the SRE as described in 101 CMR 613.03(1)(d)2.Re-admission of follow-up care to an SHG facility for an SRE that occurred at SHG are not billable.

C. SHG may submit a claim for services it provides that result from an SRE that did not occur on its premises only if the treating facility and the facility responsible for the SRE do not have common ownership or a common corporate parent.

D. A claim for services related to an SRE that did not occur on an SHG premises may be submitted to HSN.

SECTION 5: Documentation

A. Maintenance of Records

1. SHG will maintain records documenting claims for Eligible Services for Low Income Patients, Emergency Bad Debt services and Medical Hardship services.

Glossary:

Financial Assistance Programs
A Financial Assistance program is one that is intended to assist low-income patients, who do not otherwise have the ability to pay for their health care services. Such assistance should take into account each individual's ability to contribute to the cost of his or her care. Consideration is also given to patients who have exhausted their insurance benefits and/or who exceed financial eligibility criteria but face extraordinary medical cost. A financial assistance program is not a substitute for employer-sponsored, public financial assistance, or individually purchased insurance program.

Resident
A person living in Massachusetts with the intention to remain permanently or for an indefinite period. A resident is not required to maintain a fixed address. Enrollment in a Massachusetts institution of higher learning or confinement in a Massachusetts medical institution, other than a nursing facility, is not sufficient to establish residency.

Third Party
Any individual, entity or program that is or may be responsible to pay all or part of the cost for medical services.

EXHIBITS

A. Patient Statement

B. Final Demand Patient Letter

C. Payment Plan Letter

D. Discount Letter