

Holyoke Medical Center, Inc.
575 Beech Street
Holyoke, MA 01040

Credit and Collection Policy
FY 2016

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Hospital Billing and Collections Policy

The hospital has an internal fiduciary duty to seek reimbursement for services it has provided to patients who are able to pay, from responsible third party insurers who cover the patient's cost of care, and from other programs of assistance for which the patient is eligible. To determine whether a patient is able to pay for the services provided as well as to assist the patient in finding alternative coverage options if they are uninsured or underinsured, the hospital follows the following criteria related to billing and collecting from patients. In obtaining patient and family personal financial information, the hospital maintains all information in accordance with applicable federal and state privacy, security, and ID theft laws.

I. Collecting Information on Patient Financial Resources and Insurance Coverage

a) Patient Obligations:

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 a 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 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 for keeping 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 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 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.

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

III. 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.
- e) 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 as described in 130 CMR 506.009: The One-time Deductible

IV. Extraordinary Collection Actions

- a) The hospital will not undertake any "extraordinary collection actions" until such time as the hospital has made reasonable efforts and followed a reasonable review of the patient's financial status and other information necessary to determine eligibility for financial assistance which will determine that a patient is entitled to financial assistance or exemption from any collection or billing activities under this credit and collection policy. The hospital will keep any and all documentation that was used in this determination pursuant to the hospital's applicable record retention policy.
- b) 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 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.

- c) Extraordinary collection actions include:
 - i) Selling a patient's debt to another party (except if the special requirements set forth below are met);
 - ii) Reporting to credit reporting agencies or credit bureaus;
 - iii) Deferring, denying, or requiring a payment before providing, medically necessary care because of nonpayment of one or more bills for previously covered care under the hospital's financial assistance policy (which is considered an extraordinary collection action for the previously provided care)
 - iv) Actions that require legal or judicial process, including:
 - (1) Placing a lien on a patient's property;
 - (2) Foreclosing on real property;
 - (3) Attaching or seizing bank account or any other personal property;
 - (4) Commencing a civil action against a patient;
 - (5) Causing a patient's arrest;
 - (6) Causing a patient to be subject to a writ of body attachment; and
 - (7) Garnishing a patient's wages.
 - v) The hospital will treat the sale of a patient's debt to another party as an extraordinary collection action unless the hospital enters into a binding written agreement with the purchaser of the debt pursuant to which (i) the purchaser is prohibited from engaging in any extraordinary collection actions to obtain payment for care; (ii) the purchaser is prohibited from charging interest on the debt at a rate higher than the applicable IRS underpayment rate; (iii) the debt is returnable to or recallable by the hospital upon a determination that the patient is eligible for financial assistance; and (iv) if the patient is determined to be eligible for financial assistance and the debt is not returned to or recalled by the hospital, the purchaser is required to adhere procedures that ensure that the patient does not pay the purchaser more than the patient is personally responsible to pay under the financial assistance policy.
 - vi) Extraordinary collection actions include actions taken to obtain payment for care against any other patient who has accepted or is required to accept responsibility for the patient's hospital bill for the care.
- d) The hospital will refrain from initiating any extraordinary collection actions against a patient for a period of at least 120 days from the date the hospital provides the first post-discharge billing statement for the care; except that special requirements apply to deferring or denying medically necessary care because of nonpayment as described below.
- e) In addition to refraining from initiating any extraordinary collection actions for the 120-day period described above, the hospital will refrain from initiating any extraordinary collection actions for a period of at least 30 days after it has notified the patient of its financial assistance policy in the following manner: the hospital (i) provides the patient with a written notice that indicates that financial assistance is available for eligible patients, that identifies the extraordinary collection actions that the hospital (or other authorized party) intends to initiate to obtain payment for the care, and that states a deadline after which extraordinary collection actions may be initiated that is no earlier than 30 days after the date that written notice is provided; (ii) provides the patient with a plain language summary of the financial assistance policy; and (iii) makes a reasonable effort to orally notice 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.

- f) The hospital will meet the following special requirements in the event that it defers or denies care due to nonpayment for prior care that was eligible for financing assistance. The hospital may provide less than the 30 days' notice described above if it provides the patient with a financial assistance application form and a written notice indicating financial assistance is available for eligible patients. The written notice will state a deadline after which the hospital will no longer accept and process an application for financial assistance, which will be no earlier than the end of the application period or 30 days after the date the written notice is first provided. If the patient submits an application before the deadline, the hospital will process the application on an expedited basis.
- g) If a patient submits a complete or incomplete application for financial assistance under the hospital's financial assistance policy during the application period, the hospital will suspend any extraordinary collection actions to obtain payment for care. In such event, the hospital will not initiate, or take further action on any previously initiated extraordinary collection actions until either (i) the hospital has determined 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 patient has failed to respond for requests 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.
- h) 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 (iii) take all reasonable measures to reverse any extraordinary collection action (with the exceptions of a sale of debt and deferring or denying, or requiring a payment before providing, medically necessary care because of a patient's nonpayment of prior bills for previously provided care for which the patient was eligible for financial assistance) taken against the patient to obtain payment for care. Reasonable measures to reverse such an extraordinary collection action will include measures to vacate any judgment, lift any levy or lien, and removing from the patient's credit report any adverse information that was reported to a consumer reporting agency or credit bureau.
- i) 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.
- j) 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 before initiating extraordinary collection actions to obtain the discounted amount owed; and (iii) if the patient submits a complete application

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

- k) The hospital will not garnish a Low Income Patient's or their guarantor's wages or execute a lien on the Low Income Patient's or their guarantor's personal residence or motor vehicle unless: (1) the hospital can show the patient or their guarantor has the ability to pay, (2) the patient/guarantor did not respond to hospital requests for information or the patient/guarantor refused to cooperate with the hospital to seek an available financial assistance program, and (3) for purposes of the lien, it was approved by the hospital's Board of Trustees on a patient's case by case basis.
- l) 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.
- m) 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.

V. 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. 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. In all other cases, if the hospital sells or refers a patient's debt to another party, the agreement with the other party will be reasonably designed to ensure that no extraordinary collection actions are taken until reasonable efforts have been made to determine whether the patient is eligible for financial assistance, including the following: (i) if a patient submits an application before the end of the application period, the party will suspend extraordinary collection actions; (ii) if the patient submits an application for financial assistance before the end of the application period and is determined to be eligible for financial assistance, the party will adhere to procedures to ensure that the patient does not pay the party and the hospital together more than the patient is required to pay under the financial assistance policy and to reverse any extraordinary collection actions; and (iii) if the party refers or sells the debt to another party, the party will obtain a written agreement meeting all of the foregoing requirements. 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.

VI. 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

A hospital may not require pre-admission and/or pre-treatment deposits from patients 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.

VII. Prompt Pay Discount

Holyoke Medical Center offers a 30% prompt pay discount for uninsured patients on medically necessary services. Patient must pay balance in full (minus the discount) within 30 days from the date of the initial bill. The discount cannot be used in conjunction with any other discount or financial assistance. This discount does not apply to hearing aids or repairs, or cosmetic surgery.

***This document can be translated upon request and without charge.**

VIII. Attachments/Exhibits

- a) Example of payment plan notice to Low Income or Medical Hardship patients (English & Spanish)

Example payment plan notice to Low
Income or Medical Hardship patients
(English)

August 2, 2016

"Patient Name"
"Account Number"
"Date of Service"

Dear "Patient Name" :

Holyoke Medical Center has approved your request for a payment plan to pay your outstanding balance of \$ ____.

Your payment plan shall be \$ ____ per month for ____ months.

Please note:

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 by The Executive Office of Health and Human Services in 101 CMR 613.08(1)(g).

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.

If you have any questions about this payment plan, please call the Financial Counselors Office at (413) 534-2603 or (413) 535-4723, Monday through Friday, 8:00am to 4:00pm.

Sincerely,

[Your Name]
Financial Counselor
Holyoke Medical Center

Example payment plan notice to Low
Income or Medical Hardship patients
(Spanish)

August 2, 2016

"Nombre del Paciente"
"Numero de Cuenta"
"Fecha del Servicio"

Estimado "Nombre del Paciente" :

Holyoke Medical Center ha aprobado su solicitud para un plan de pago para pagar su deuda pendiente de \$ _____.

Su plan de pago será de \$ _____ al mes por _____ meses.

Por favor note:

Depósitos para pacientes con Medical Hardship

Un hospital puede pedir un depósito de pacientes que cualifiquen para Medical Hardship. Los depósitos serán limitados a 20% de la contribución del Medical Hardship hasta \$1,000. Todo balance restante estará sujeto a las condiciones del plan de pago establecidas por la Oficina Ejecutiva de Salud y Servicios Humanos 101CMR613.08(1)(g).

Plan de Pago para Pacientes de Bajo Ingreso de acuerdo con el programa de Massachusetts Health Safety Net.

Un paciente con un balance de \$1,000 o menos, después del depósito inicial, se le debe ofrecer al menos un plan de pago de un año libre de intereses con un pago mínimo mensual de no más de \$25. Un paciente con un balance de más de \$1,000, después del depósito inicial, se le debe ofrecer un plan de pago de al menos dos años libre de intereses.

Si usted tiene alguna pregunta sobre esta decisión, favor de llamar a la Oficina de Consejeros Financiero al (413) 534-2603 o (413) 535-4723, de Lunes a Viernes, de 8:00am a 4:00pm.

Sinceramente,

[Your Name]
Consejero Financiero
Holyoke Medical Center

APPROVALS

This policy was approved by the Holyoke Medical Center's Board of Directors on August 25, 2016.