HEALTHALLIANCE HOSPITALS, INC.

CREDIT AND COLLECTION POLICY

July 1, 2016

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Policy:

The Credit and Collection Policy sets forth the standards by which HealthAlliance Inc. will administer the collection of insurance/financial information from patients, the determination of eligibility for Financial Assistance, and the billing and collection processes, in accordance with Executive Office of Health and Human Services (EOHHS) regulations 101 CMR 613.00 Health Safety Net Eligible Services [(2)] the centers for Medicare and Medicaid services Medicare Bad Debt Requirements (42CFR 413.89), 13J the Medicare Providers Reimbursement Manual (Part 1, Chapter 3), and (3) The Internal Revenue Code Section 501 (R) as required under section 9007 (a) of the Federal Patient Protection and Affordable Care Act (Pub. L. No. 111-148) and as recently clarified in the December 29, 2015 IRS clarification to reporting such information in the hospital IRS 990 form. The Credit and Collection policy will be filed electronically with the Health Safety Net Office in accordance with the requirements of the regulation.

HealthAlliance, a member of UMMHC, does not discriminate on the basis of race, color, national origin, citizenship, alienage, religion, creed, sex, sexual orientation, gender identity, age or disability in any of its policies concerning the acquisition and verification of financial information, preadmission ore pretreatment deposits, payment plans, deferred or rejected admissions, or Low Income Patient status.

Mission Statement:

The mission of HealthAlliance, a member of UMMHC, is to provide clinical and service excellence to individuals in our diverse communities through each stage of their lives.

Delivery of Health Care Services:

I. Emergency and Urgent Care Services - Any patient who presents at the Hospital or Hospital Satellite Clinic will be evaluated as to determine if they require emergent or urgent care services, without regard to the patient's identification, insurance coverage, or ability to pay. The evaluation of emergency services or urgent care services as defined below is further used by HAH for purposes of determining emergency and urgent bad debt coverage under the Health and Safety Net Fund.

   a. Emergency Level 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, for which 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 any subsequent treatment for an existing emergency medical condition or any other such service rendered to the extent required pursuant to the federal EMTALA (42 USC 1395(d) qualifies as an Emergency Level Service.

   b. Urgent Care 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 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 Care Services are provided for conditions that are not life threatening and do not pose a high risk of serious damage to an individual's health, but for which prompt medical services are needed.

Note Regarding EMTALA:

In accordance with federal requirements, EMTALA is triggered for anyone who comes to the hospital property requesting examination or treatment of an emergency level service (emergency medical condition), or who enters the emergency department requesting examination or treatment for a medical condition. Most commonly, unscheduled persons present themselves at the emergency department. However, unscheduled persons requesting services for an emergency medical condition while presenting at another inpatient unit, clinic, or other ancillary area may also be subject to an emergency medical screening examination in accordance with EMTALA. Examination and treatment for emergency medical conditions or any such other service rendered to the extent required under EMTALA, will be provided to the patient and will qualify as emergency care. The determination that there is an emergency medical condition is made by the examining physician or other qualified medical personnel of the hospital as documented in the medical record. The determination that there is an urgent or primary medical condition is also made by the examining physician or other qualified medical personnel of the hospital as documented in the medical record.

II. Non-Emergent, Non-Urgent ("Elective") Medically Necessary Services - For patients who either (1) arrive to the hospital seeking non-emergent or non-urgent level care or (2) seek additional care following stabilization of an emergency medical condition, HAH will collect financial information from the patient, assist the patient with obtaining/verifying coverage for services and/or make other financial arrangements described herein.

Elective Services: Medically necessary services that do not meet the definition of Emergency or Urgent above. Typically, these services are either primary care/specialty services or medical procedures scheduled in advance by the patient or by the health care provider (hospital, physician office, other).

Serious Reportable Events

HAH maintains compliance with applicable billing requirements, such as the Department of Public Health requirements for non-payment of certain specific services or readmissions that the hospital determines was the result of a Serious Reportable Event, as well as maintains all information in accordance with applicable federal and state privacy, and security laws. HAH will not bill any patient, including Low Income Patients for claims related to Serious Reportable events 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 administrative or billing error by the hospital.

Collecting Financial Information from Patients- HAH will make reasonable efforts and attempt to obtain all relevant demographic and insurance information from patients prior to elective services being rendered or upon arrival at the facility. This information will be collected from patients requiring emergent/urgent care as soon as possible in accordance with EMTALA provisions.

I. **Patients with Insurance Coverage**- For patients with health insurance, or for patients covered by a Workers Compensation or Automobile Insurer, HAH will collect all information required to submit a claim to the insurance carrier for medical services rendered.

1. **Insurance Verification**- Whenever possible HAH will verify a patient's insurance eligibility via electronic or telephonic means as well as the MassHealth Eligibility Verification (EVS) System for verification of eligibility in a public assistance program, prior to the patient's arrival. When this does not occur, eligibility will be verified upon arrival, or as soon as possible thereafter, by electronic/telephonic means and/or review of the patient's insurance card.

2. **Referral and Authorization Requirements**- HAH will attempt to secure and/or verify all referrals and authorizations required by a patient's insurance carrier prior to services being rendered.

3. **Co-Payments/Co-Insurance/Deductibles/Non-Covered Services**- When an insured patient is responsible for a portion of the bill, HAH will attempt to collect that amount, or secure it via a credit card, either prior to services being rendered or upon completion of the service. The patient will be contacted at home to discuss payment of the deductible. If unable to collect the amount due prior or upon completion of the service, HAH will pursue amounts due via the billing and collection process.

4. **Required Forms**- All insured patients will be required to sign an Assignment of Benefits (AOB) form, HIPPA notice and any other forms required by their insurance carrier or by regulation in order to bill and collect from their third party insurer. If HAH is unable to obtain a signed EOB, the patient will be responsible for the total charges.

5. **Patients without Insurance Coverage**- HAH will attempt to assist patients registered as "Self pay" with identifying and securing health care coverage. When a patient is determined to be responsible for all or a portion of the bill, HAH will attempt to collect the amount due prior to service. HAH will pursue it via the billing and collection process.

II. Patients **without Insurance Coverage**- HAH will attempt to assist all patients registered as "Self pay" with identifying and securing coverage, and/or establishing a payment plan for amounts determined to be a patient responsibility

1. Signs will be posted in English, Portuguese and Spanish informing patients of the availability of Financial Assistance, and whom to contact for assistance in applying. The signs will be clearly visible and legible and posted in areas with high patient traffic including the following:

- All Admitting Offices and Waiting Areas
- All Outpatient Registration and Waiting Areas
- All Emergency Registration and Waiting Areas
- All Certified Application Counselor Offices

2. Individual flyers notifying patients that Financial Assistance is available for qualified patients will be available at all Admitting, Registration and Financial Counseling locations.

3. Patients scheduled for an elective procedure will be referred to a Certified Application Counselor to assist the patient in applying for medical assistance. All inpatients registered as Self pay will be visited by a Certified Application Counselor during their admission, or contacted post discharge.

4. Initial patient bills and all subsequent statements will include a notice alerting patients to the availability of Financial Assistance, and a phone number to contact the Certified Application Counselor.

Financial Assistance Programs of the Commonwealth of Massachusetts- HAH offers financial assistance to patients based on family income level and other criteria described below. HAH employs a staff of Certified Application Counselors, who are available by phone or by appointment to support patients in applying for financial assistance and resolving their medical bills. HAH has contracted with Executive Office of Health and Human Services (MassHealth) and the Commonwealth Health Insurance Connector Authority (Connector) and has been deemed a Certified Application Counselor Organization. Certified Application Counselors provide potentially eligible patients with the appropriate application(s) for Mass Health and/or Health Safety Net, and assist patients with the application process.

In order to assist patients with the appropriate financial assistance coverage CAC's will:

1. Provide information on all available programs.
2. Provide patients with the appropriate application(s) for MassHealth, Health Safety Net, and Children's Medical Security Program, Premium Assistance Payment Programs operated by the Health Connector, Medical Hardship and other types of financial assistance that may cover all or some of their unpaid medical bills.
3. Assist patients in the application and renewal process.
4. Work with patients to obtain any required documentation.
5. Make all efforts to follow up on the application status through the final determination.
6. Help patients enroll in a Health Insurance Plan.
7. Offer and provide voter registration assistance.

Customer Service representatives and Guarantor Collectors are available by phone to support patients in resolving their medical bills.

A. **Health Safety Net**-Massachusetts law provides for the provision of Health Safety Net to eligible patients based on Massachusetts residency, verification of identity, and documented MassHealth Modified Adjusted Gross Income (MAGI) equal to or less than 300% of the Federal Poverty Level. (FPIG)

a. Been determined eligible for MassHealth or a Premium Assistance Program operated by the Health Connector, including the premium assistance program and have failed to enroll or coverage has been terminated due to non-payment of premiums.

b. Access to health insurance coverage that is deemed affordable with the exception of an employer sponsored plans waiting period.

B .**Health Safety Net -Primary-**Uninsured patients with verified (MAGI) household income or Medical Hardship Family Countable Income of 0-300% of the Federal Poverty Income Guidelines (FPIG) may be determined to be Low Income Patients based on EOHHS Guidelines and eligible for Health Safety Net Reimbursable Services, subject to the stipulations below.

i. Low Income Patients eligible for enrollment in a the Premium Assistance Payment Program operated by the Health Connector are eligible for a period of 100 days beginning on the patient's Medical Coverage Date.
ii. Students subject to the Student Health Program requirements are not eligible for Health Safety Net - Primary.

C**. Health Safety Net - Secondary**. Patients with other primary health insurance, including students enrolled in a Qualifying Student Health Plan and verified MassHealth MAGI household income or Medical Hardship Family Income of 0-300% of the FPIG may qualify as a Low Income Patient and be eligible for Health Safety Net – Secondary, subject to the stipulations below.

i. Health Safety Net – Secondary will only cover dental services for individuals enrolled in and not covered by a Premium Assistance Program Operated by the Health Connector effective on the 101st day from the Medical Coverage Date.

ii. Health Safety Net – Secondary will only cover adult dental services provided by community health centers, hospital licensed health centers, or a satellite clinic for individuals enrolled in MassHealth Standard, CommonHealth, MassHealth CarePlus and Family Assistance, excluding MassHealth Family Assistance-Children.

D.**Health Safety Net -Partial** - A Low Income Patient eligible for either Health Safety Net Primary or Health Safety Net Secondary with verified MassHealth MAGI Household income or Medical Hardship Family Countable Income between 150.1% and 300% of the FPIG may be eligible for Health Safety Net-Partial with an annual family deductible. The annual deductible will only apply if all members of the Premium Billing Family Group (PBFG) 's income are greater than 105.01% of the FPL. If determined eligible the family's responsibility (annual deductible) is equal to the greater of

iii. 40% of the difference between the lowest MassHealth MAGI Household income or Medical Hardship Family Countable Income and the applicant's Premium Billing Family Group (PBFG) and 200% of the FPIG.
iv. The lowest cost Connector Care premium for the family size and income level at the start of the calendar year.

If any member of the PBFG has an income that is below 200% of the FPIG there is no deductible for any member of the PBFG. Expenses over this deductible amount will be exempt from billing and collection activity.

HAH collection staff tracks the allowed reimbursable expenses until the patient has met their and deductible payments. If the patient has received services from more than one provider,

it is the patient's responsibility to track the deductible amount and notify HAH when the deductible is met. Copayments will not be applied to the deductible.

Health Safety Net – Presumptive Eligibility- at times a patient may qualify for Health Safety Net and be unable to complete a full application on the date of service. HAH may determine the individual to be a Low Income Patient according to Health Safety Net income and household guidelines, for a limited period of time. The determination will be based on self-attested information provided by the patient on the form specified by the Health Safety Net office. The eligibility period will begin on the date that HAH makes the determination and will continue until the last day of the following month or the individual submits a full application and receives a determination from Mass Health or the Heath Connector.

E. **Application Process** – Patients seeking financial will assistance be required to apply for coverage for MassHealth, the Premium Assistance Program operated by the Health Connector, Health Safety Net and the Children's Medical Security Program. Patient's must complete and submit, with the assistance of a CAC an application via the Health Insurance Exchange located on the States Health Connector website, a paper application provided by MassHealth or by telephone with a customer service representative located at either MassHealth or the Connector, The MassHealth Agency or the Health Connector will process all applications and notify the individual of his or her eligibility determination for MassHealth or qualification for a Premium Assistance Payment Plan operated by the Health Connector or Low Income Patient (Health Safety Net) status.

In special circumstances, HAH may apply for the patient using a specific form designated by the Health Safety Net office for individuals seeking financial assistance coverage due to being incarcerated, victims of spousal abuse, deceased, confidential services, presumptive Low Income Patient status or applying due to a medical hardship.

F. **State Coverage Exclusions** (Note: Some of these services are covered through HAH additional Coverage and Discounted Care" described in Section F).

i. Non-medically necessary services

ii. MassHealth, Connector Care, and private insurance co pays

iii. Claims denied for any administrative or billing error, out of network services

iv. Services provided to a patient with private health insurance that are considered out of the health insurance provider network.

G. **Income Verification**-Household income may be verified either through electronic data matches, or paper verifications. MassHealth utilizes federal and state data sources to attempt to match income stated on the application. Income will be considered verified if through the state data match is reasonably compatible with the stated income. If MassHealth is unable to verify income through an electronic data match, it must be verified by one or more of the following:

Earned Income:

i. Recent paystubs

ii. A signed statement from the employer

iii. The most recent U.S. Tax Return

iv. iv. Other Comparable Source of income

Unearned Income:

v. A copy of a recent check or pay stub from the income source;

vi. A statement from the income source where matching is not available;

vii. The most recent Federal tax return; or

viii. Other Comparable Source of income

H. **Identity Verification**- Applicants must provide proof of their identity with, but not limited to documents that contain a photograph or other identifying information, such as name, age, sex, race, height, weight, eye color and address. Acceptable documents are:

i. Driver's license issued by a state or territory

ii. Identification card issued by a school, military, a federal, state or local government, a military dependent card or U.S. Coast Guard Merchant Marine.

iii. Clinic, doctor, hospital or school record for children under 19 years of age.

iv. Two documents that provide information that is consistent with the applicant's identity such as, but not limited to, high school and college diploma, marriage or divorce records, property deeds, rental agreements.

v. A finding of identity from a federal or state agency, if the agency has verified the identity.

vi. An affividavit signed, under penalty of perjury, by another person who can reasonably testify to a person's identity, if no other documentation is available.

I. **Medical Hardship**- A Massachusetts resident at any countable income level may apply for Medical Hardship if medical costs have so depleted the family's income that he or she is unable to pay for eligible services. The applicant's Allowable Medical Expenses must exceed a specified percentage of the applicant's Gross income as follows:

Income Level	Percentage of Gross Income
0 - 205% FPL	10%
205.1 - 305% FPL	15%
305.1 - 405%	20%

405.1 - 605% FPL	30%
>605.1% FPL	40%

The Health Safety Net Office will provide the application and process the Medical Hardship determinations based on documentation submitted by HAH and the patient. HAH will submit the Medical Hardship application within 5 business days of receipt of all required documentation provided by the patient. The Health Safety Net office will review and process an application for Medical Hardship if the applicant's allowable medical expenses exceed the percentage of countable income listed above. The Health Safety Net Office will not process a Medical Hardship application for anyone with income less than 405% unless the individual first submits an application to the MassHealth agency and receives a determination. Two Medical Hardship applications may be submitted in a 12 month period.

i. Allowable Medical Expenses- The total of Medical Hardship family medical bills from any health care provider that if paid, would qualify as deductible medical expenses for federal income tax purposes. This may include paid and unpaid bills for which the patient is still responsible and incurred up to twelve months prior to the date of application. This does not include bills incurred while an applicant is a Low Income Patient unless they are Dental-Only Low income patients on the date of service. If a patient has not received a bill for more than 9 months from the date of service, it may still be allowed if the Medical Hardship application is submitted within 90 days of the initial billing. Unpaid bills included in a Medical Hardship determination will not be included in a subsequent Medical Hardship application. This will not include bills for services that are incurred by patients while enrolled in MassHealth or a Premium Assistance Payment Program operated by the Health Connector.

ii. Applicant Contribution is the specified percentage of countable income as listed above. There is one Medical Hardship contribution per Family per Medical Hardship determination.

iii. Notification of Determination- the Health Safety Net Office will notify applicants of the determination. This will include the following:

    1. The dates for which allowable Medical Expenses may be include.

    2. The amount of the applicants Medical Hardship contribution.

    3. The services that do not qualify as eligible services.

    4. The denial notice will explain the denial reason.

    5. The name and number of a contact person for more information.

iv. Provider Notification- The Health Safety Net will notify the provider of the following:

    1. The determination with bills included in the applicant's Allowable Medical Expenses.

2. The applicant's contribution to each Health Safety Net Provider based on the gross charges and dates of services provided to the applicant's family.

v. HAH will submit claims for Medical Hardship Services that exceed the patient's Medical Hardship contribution.

vi. HAH will bill the applicant for Medical Hardship contributions unless they have a Low Income Patient status or eligible for MassHealth.

vii. HAH will cease any collection efforts against an emergency bad debt claim that is approved for Medical Hardship under the Health Safety Net program.

viii. HAH will cease collection efforts on bills that are listed on the Medical Hardship determination and would have been eligible for Medical Hardship payment if for any reason the application was not filed within 5 business days.

UMass Memorial Health Care System Financial Assistance Program – HAH has adopted the UMMHC Financial Assistance Program. It is the policy of HAH to offer free or discounted care to those that qualify for medically necessary, urgent or emergency care. The Financial Assistance Program applies to patients regardless of where they reside. For those that have determined eligible, HAH will not charge more than the amount generally billed to a patient that has insurance coverage.

1 Eligibility – in order to be determined eligible an applicant must meet the following criteria:

- Household income must be less than or equal to 600% of the Federal Poverty Income guidelines.
- Complete and sign a financial assistance application.
- Provide income verification for all applicable household members.
- Apply for any state or government medical assistance for which they may be eligible.
- Initiate the application process **240 days** from the date of the first bill/statement.

2 Income Verification – acceptable verification of income is as follows:

- 2 most recent pay stubs.
- A copy of the most recent pension, social security, unemployment or other income benefits statement or check.
- For the self-employed the last 3 months profit and loss statement.
- A copy of the most recent tax returns as long as it is not over 6 months old.
- A statement from an employer indicating gross weekly income.
- For alimony/child support a copy of a court decree or a check of payments received.
- A signed statement of support for an applicant/family member that does not have any income.

3 Eligibility period - The financial assistance eligibility will begin the date the signed completed application is received in the Patient Financial Counseling Department. Eligibility will be in effect for one year from the date of approval. An application will be deemed complete when all eligibility criteria have been met.

The eligibility period will also cover a period of 12 months retroactive from the date of approval. The same eligibility period will pertain to all eligible household family members listed on the application.

Financial Assistance will be terminated if at any time the criteria for eligibility have changed to the extent that the applicant would no longer be eligible. This may consist of changes to income, the number of household family members, or eligibility of state or government medical assistance programs. In such cases, the applicant will be notified via a letter of any termination of assistance. The reason for termination will be indicated

4. Eligible services - Financial Assistance discounts that have been approved for the Health Alliance Financial Assistance Program will only apply to urgent, emergency and medically necessary care. This will include but not be limited to inpatient, observation, and outpatient services.

5. Excluded services – Financial assistance does not apply to the following:
Non-medically necessary services will not be eligible for the Financial Assistance discount. These services include, but are not limited to, cosmetic surgery, infertility services, hearing aids, and social and vocation services. Financial assistance does not apply for services billed by other independent groups, such as private physicians and specialty groups. No-medically necessary services will be billed at full charges.

6. Basis for calculating - HAH will utilize the look back method to determine the percentage of the amount generally billed to patients as it applies to this Financial Assistance Policy. A combination of the previous year charges and payments for commercial and Medicare insurance products are used to determine the Payment on Account Factor (PAF). The PAF is used to determine the minimum discount applied to gross aggregate charges. The discount for 2016 will be 75 %.

7. Patients who qualify for the Financial Assistance Program and who have insurance coverage will have their financial obligations (such as copayments and deductibles) after payments by insurance, capped at no more than the gross aggregate charges reduced by the PAF.

8. How to apply - The Patient Financial Counseling Department will be the point of contact for patients to request and obtain, free of charge, a paper copy of the policy, a plain language summary of the policy and the application. All three may be requested by telephone, in person or email as noted below:

Health Alliance Patient Financial Counseling Contact Information:
- Telephone: 978-466-2329
- External email: financialcounsel@healthalliance.com
- Address: Patient Financial Counseling, 60 Hospital Road, Leominster, MA 01453

- The Financial Assistance policy, the plain language summary and the application may be accessed using the UMassMemorial Health Care web site: http://www.umassmemorialhealthcare.org/healthalliance-hospital, under the Patient & Visitors section, selects Financial Counseling.

I. **Additional Coverage and Discounted Care Provided by HAH to Patients**

1. **Prompt Payment Discount**- HAH may grant a discount to patients of any income level who pay or secure via credit card, their self-pay balance prior to, or immediately after services being rendered. The discount reflects the time value of money, the avoidance of billing and collection costs, and the avoidance

of credit risk. The discounted payment for prompt remittance should be received no later than 30 days from the date of the first statement. The standard discount will be 20% of the net patient obligation. No higher discount may be offered unless based in unique circumstances and approved by the Senior Director of Revenue Systems.

2. **Billing and Collection Procedures**

HAH must administer billing and collection processes that are efficient and effective in securing amounts due to HAH, in order to meet our financial obligations and continue our mission of providing excellent health care to the patients and communities we serve. We are committed to conducting our billing and collection practices in a manner that is fair and respectful of our patients and their families, as outlined below.

Billing Third Party Payers- HAH will submit claims for all covered services to a patient's health insurer or other responsible payer if the patient has provided such information timely and accurately. These claims will be submitted as soon as possible after discharge or service date. Patients remain financially responsible for any non-covered services, co-payments, co-insurance amounts and deductibles as determined by their health insurer. Patients are responsible for understanding and complying with the referral, authorization and other coverage requirements of their insurer. Patients are also responsible for payment of any services denied by their insurer to the extent permitted by contract and regulation

HAH Provider Accounting Department will make all reasonable efforts to resolve accounts with third party payers including the appeal of denied claims. Reports and work lists of outstanding accounts, including denied claims will be routinely generated, reviewed by the Provider Accounting Staff and Management, and pursued with the payers. If, despite such efforts, HAH has not received payment or other appropriate resolution from a non contracted payer within a reasonable amount of time, the guarantor may be contacted informing him/her that the insurer has failed to resolve the claim. If the account remains unpaid by a none contracted payer, the guarantor may be subject to the standard self pay Billing and Collection Process to the extent permitted by law. HAH will make the same effort to collect accounts for emergency care for uninsured patients as it does to collect accounts from any other patient classifications subject to the terms of this policy and applicable law.

II. **Self pay Billing and Collection Process**-

1. Patients with self pay responsibilities will receive an initial bill delineating the services and amounts due for which they are responsible.

2. For any self pay responsibilities that remain unpaid after the initial bill, the patient will receive a series of monthly statements for at least 3 months or until the balance is resolved. The last statement will indicate that it is a final notice. A final notice by certified mail will be sent to the patient for balances over $1000.00 for emergency care. The 4th statement indicated as a final notice.

3. Provider Accounting Staff will make a telephone call to any patient with an outstanding self pay balance of $1,000 or more during the normal self pay billing and collection process.

4. HAH will send a final notice by certified mail for balances over $1,000 where notices have not been returned as "incorrect address" or "undeliverable" for emergency care patients.

5. Additional notices and/or letters may be sent to debtor patients during the billing and collection process in an effort to resolve outstanding balances.

6. Returned mail and/or undeliverable mail will be researched by the Provider Accounting staff to obtained valid addresses. Databases and prior visit information will be utilized.

7. All such efforts to collect balances, as well as any patient initiated inquiries, will be documented on the guarantor's account and available for Management review.

8. Accounts that remain unresolved after 120 days and the collection efforts described above have been utilized, will be reviewed for write-off as Bad Debts, as follows:

Balance	Review Level
$0-$999	Collector
$1,000-$10,000	Supervisor
$10,001-$25,000	Manager
$25,000 and above	Director

9. External Collection Agencies- HAH may transfer Bad Debt Accounts to external collection agencies for further pursuit.

- All collection agencies working on behalf of HAH will commit in writing to abide by collection practices and standards approved by HAH
- HAH, may, with Board of Trustees approval, and a 30 day written notice, report to a credit rating service debts that remain unpaid after all reasonable attempts to identify available health care coverage, access discount programs and / or establish payment plans as described in this policy have been exhausted. Under no circumstances will patients who have met the State's criteria as Low Income Patients be considered for referral to a credit rating service.
- HAH will not sell a patient's debt to a third party agency without board approval

10. Medicare accounts that are deemed to be bad debt will be handled in accordance with the self pay billing and collection process as specified above. The external collection agencies will pursue further collection efforts for a period of no less than 60 days before returning the accounts to HAH as uncollectible.

11. HAH will submit a claim for Emergency Bad Debt if an uninsured patient has not been approved for Low Income status and all of the procedures indicated above have been followed and HA has confirmed through REVS that the patient is not eligible for Low Income status.

III. **Customer Service**- HAH employs a staff of Customer Service Representatives to

address patient concerns and questions regarding their bills. The staff are available by phone and in person Monday-Friday from 8:00 AM to 4:30 PM.

IV**. Payment Plans-** Patients expressing difficulty in meeting their financial obligations (after all coverage options have been exhausted) will be offered an interest free monthly budgeted payment plan with a minimum monthly payment of $25.00 and a duration as follows:

Balance	Length of Payment Plan *
≤ $1,000	≤ 1 Year
≥ $1,000	≥ 2 Years

*Longer payment plans may be granted with approval of fiscal management.

This payment plan will be offered to all patients including those who are determined to be a Low Income Patient or qualifies for Health Safety Net Medical Hardship.

Patients who cease making monthly budgeted payments without establishing an alternative arrangement will be subject to the normal self pay Billing and Collection Processes including referral to an external collection agency.

V. **Interest**-HAH will not assess interest on self pay balances outstanding during the normal billing process or during the course of a payment plan.

VI. **Deposit Requirements**- HAH shall not require pre-admission and/or pre-treatment deposits for patients who require emergency services or who are determined to be Low Income status patients. HAH reserves the right to request advance deposits in the following instances:

- Patients to receive elective cosmetic or non-medically necessary services may be required to pay an amount equal to 100% of expected charge prior to service
- Patients who do not have verifiable insurance coverage and do not qualify for Health Safety Net/Low Income Patient Status may be required to pay an advance deposit if the service to be performed is of an elective nature. Failure to meet the deposit requirement may result in postponement or deferral of the service with the attending physician's approval.
- Patients traveling from foreign countries to HAH for treatment may be required to pay the full estimated bill in advance.
- Partial Low Income patients may be requested to pay up to 20% of the deductible amount up to $500.00.
- Medical Hardship patients may be requested to pay up to 20% of the deductible amount, up to $1,000.00.
- Discounted Care patients may be requested to pay up to 20% of the amount due up to $5,000.00.

  Insured patients with co-insurance and deductible responsibilities may be required to pay such amounts, or secure them via a credit card, prior to service.

VII. **Liens**- As a routine course of business, HAH will only invoke liens to secure HAH's interest in 3rd Party Settlements or as otherwise required to secure HAH's interests during legal proceedings. No liens will be

initiated against a patient's primary residence or other personal assets without prior written approval from HAH's Board of Trustees. All approvals by the Board of Trustees will be made on an individual basis.

VIII. **Bankruptcy**- Patients who file for Bankruptcy will have all billing and collection activity discontinued upon receipt of a Notice of Bankruptcy.

IX. **Motor Vehicle Accidents -** HAH will submit a claim to Health Safety Net Office (HSNO) for a Low Income Patient injured in a motor vehicle accident only after investigating whether the patient, driver and/or owner of the motor vehicle had a motor vehicle insurance policy. HAH will make reasonable efforts to obtain any third party insurance information from the patient and retain evidence of such efforts, including documentation of phone calls and letters to the patient. HAH will refund the Health Safety Net Office any payment received by a third party resource that has been identified and HAH receives payment.

X. **Patients Rights and Responsibilities-**

A. HAH will advise certain patients of their rights and responsibilities at each point where the patient interacts with registration personnel as noted below:

   i. Apply for MassHealth, the Premium Assistance Payment Program Operated by the Health Connector, a Qualified Health Plan, Medical Hardship and Health Safety Net determination.
   ii. A payment plan, as outlined in our self pay billing and collection process.

B. HAH will advise patients that receive Health Safety Net eligible services of their responsibility to:

   i. Provide all required documentation.

   ii. Inform Mass Health or HAH of any change of family income or TPL insurance eligibility status.

   iii. Track the Annual family deductible as determined for patients with income between 150.1% and 300% of the Federal Poverty Guidelines and provide documentation to HAH that the deductible has been reached when more than one family member is determined to be a Low Income Patient or if the patient or family member receives Low Income eligible services from more than one provider.

   iv. File TPL claim on accident, injury or loss and notify the State public program (e.g. Office of Medicaid and Health Safety Net), within 10 days of filing a lawsuit or insurance claim that will cover the cost of the 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 service paid by the Office of Medicaid or the Health Safety Net and to repay the division for monies received for Health Safety Net covered services related specifically to the accident or other loss.

   v. Repay the Health Safety Net Offfice any money received from a third party related to an accident or incident for medical service paid b the Health Safety Net Office.

   vi. The Health Safety Net Office will recover directly from the patient, only when the patient has received payment from third party for medical services paid by the Health Safety Net Office.

vii. The Health Safety Net Office may request that the Department of Revenue intercept any payments to a patient for services provided for a claim submitted and paid by the Health Safety Net for Emergency Bad Debt.

XI. **Exemption from Self pay Billing and Collection Action**- HAH will not initiate self pay billing and collection activity in the following instances:

1. Upon sufficient proof that a patient is a recipient of Emergency Aid to the Elderly, Disabled and Children (EAEDC), or enrolled in MassHealth, Health Safety Net, Children's Medical Security Plan whose family income is equal to or less than 300% FPL,
   or low income patient designation with the exception of Dental-Only low income patients as determined by the office of Medicaid with the exception of co-pays and deductibles required under the Program of Assistance.

2. The hospital has placed the account in legal or administrative hold status and/or specific payment arrangements have been made with the patient or guarantor.

3. Medical Hardship bills that exceed the medical hardship contribution.

4. Medical Hardship contributions that remains outstanding during a patient's MassHealth or Low Income Patient eligibility period.

5. All approved Low Income Patients for the period of which they have been determined a low income patient.

6. Unless HAH has determined if the patient has filed an application for Mass Health.

7. Partial Health Safety Net eligible patients, with the exception of any deductibles required.

8. HAH may bill for Health Safety Net eligible and Medical Hardship patients for non- medically necessary services provided at the request of the patient and for which the patient has agreed by written consent.

9. HAH may bill a Low Income Patient at their request in order to allow the patient to meet the required CommonHealth One-Time deductible.