



Codman Square
Health Center

Codman Square Health Center Billing and Collections Policy

Purpose:

The health center 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 health center follows the following criteria related to billing and collecting from patients. In obtaining patient and family personal financial information, the health center maintains all information in accordance with applicable federal and state privacy, security, and ID theft laws

A. Collecting Information on Patient Financial Resources and Insurance Coverage

- a) The health center 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 health center bill, including any existing co-payments, co-insurance, and deductibles, and contacting the health center 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 health center 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 health center of any such changes in the patient's eligibility status.

The health center will work with the patient to ensure they are aware of their duty to notify the health center and the applicable program in which they are receiving assistance (e.g., Mass Health, 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 health center. 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 health center or applicable program (including, but not limited to, Mass Health, Connector, or Health Safety Net) to assign the right to recover the paid or unpaid amount for such services.

b) Health center Obligations:

The health center 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 health center. These efforts may occur during the patient's initial in-person registration at the health center location for a service, or may occur at other times. In addition, the health center will notify the patient about the availability of coverage options through an available public assistance or health center 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 health center 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 health center will attempt to collect such information prior to the delivery of any non-emergent and non-urgent health care services. The health center 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 health center'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 the health center registration's 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 health center.

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

The health center'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 health center 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 health center 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 health center 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 health center is not required to secure assignment on a patient's right to third party coverage of services. In these cases, the patient should be aware that the applicable state program may attempt to seek assignment on the costs of the services provided to the patient.

B. Health Center Billing and Collection Practices

The health center 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 health center 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 health center '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 health center 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 Mass Health) who incur a urgent bad debt balance over \$1,000 on urgent 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 365 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) For all patients who are enrolled in a public assistance programs, the health center 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.
 - g)

The health center 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 health center will notify the patient if such additional resources are available based on the patient's income and other criteria, as outlined in the health center's *Financial Assistance Policy, the Patient Payment and Collection's policy and Sliding Fee Discount Program policy*.

The health center, 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 health center is consistent with federal and state requirements, and does not influence a patient to receive services from the health center as outlined in the health center's *Sliding Fee Discount Program policy*.

C. Populations Exempt from Collection Activities

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

- a) The health center 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 health center 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 health center 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 health center shall cease its billing or collection activities;
- c) The health center 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 Mass Health, the Premium Assistance Payment Program Operated by the Health Connector, the Children's Medical Security Plan, or Medical Hardship, the health center will cease collection activity for services (with the exception of any copayments and deductibles) provided prior to the beginning of their eligibility.
- d) The health center 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 health center obtained the patient's prior written consent to be billed for such service(s). However, even in these circumstances, the health center may not bill the patient for claims related to medical errors or claims denied by the patient's primary insurer due to an administrative or billing error.

D. Extraordinary Collection Actions

- a) The health center will not undertake any “extraordinary collection actions.
- b) 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 health center’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) 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 health center bill for the care.

E. 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 health center 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 health center’s own internal financial assistance program, and will not apply to patients who have the ability to pay. *See Patient Payment and Collection policy.*

The health center may not require deposits from patients that require Urgent Level Services or that are determined to be Low Income Patients.

a) Urgent Services

CSHC may not require pre-treatment deposits from patients that require Urgent Level Services or that are determined to be Low Income Patients.

b) Low Income Patient Deposits

CSHC 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

CSHC 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 Health Safety Net Partial Low Income Patients pursuant to the Massachusetts Health Safety Net Program, for services rendered in a Licensed Health Center. A patient with a balance of \$1,000 or less, after initial deposit, must be offered at least a one-year payment plan interest free with a minimum monthly payment of no more than \$25. A patient that has a balance of more than \$1,000, after initial deposit, must be offered at least a two-year interest free payment plan.

e) CommonHealth One-Time Deductible

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

f) The health center also offers the Health Safety Net Partial Low Income Patient a co-insurance plan, that allows the patient to pay 20% of the Health Safety Net payment for each visit until the patient meets their annual deductible. The remaining balance will be written off to the Health Safety Net.

F. Location of the signs

The Health center has posted signs in the clinic and registration areas and in business office areas that are customarily used by patients that conspicuously inform patients of the availability of financial assistance programs and the health center location at which to apply for such programs. The signs are large enough to be clearly visible and legible by patients visiting these areas. All signs and notices have been translated into the languages spoken by 10% or more of the residents in our health center's service area. These are: English, Spanish and Haitian Creole. The health center signs notify patients of the availability of financial assistance and of programs of financial assistance.

Responsible

Finance Team

Applicable

All patients

Exceptions

None