Cambridge Health Alliance

Billing and Collections Policy

April 1st, 2025

Cambridge Health Alliance

Billing and Collections Policy

Table of Contents

Table of Contents for Hospital Billing and Collections Policy 1

I. Collecting Information on Patient Financial Resources & Insurance Coverage 2

II. Hospital Billing and Collection Practices 5

III. Population Exempt from Collection Activities 6

IV. Extraordinary Collection Actions 7

V. Outside Collection Agencies 8

VI. Deposits and Installment Plans 9

Hospital Billing and Collections Policy

The hospital has a fiduciary responsibility to secure all possible sources of reimbursements for services it has provided, and will work with each patient to obtain essential personal and financial information prior to the delivery of any health care services, except in instances where the services are being provided to a patient determined to be having an emergency medical condition or needing urgent medical care services.

Those sources typically include, but are not limited to, third party insurers, private and public programs of assistance for which the patient or organization is eligible, and the patient. Financial assistance services are available for uninsured patients, as well as under-insured patients, needing support in determining their ability to pay for the services. Any patient, or family, personal and/or financial information is strictly maintained and protected by the hospital in accordance with all applicable federal and state privacy, security, and ID theft laws. The hospital uses the following criteria for the purpose of billing and collecting from patients:

I. Collecting Information on Patient Financial Resources and Insurance Coverage

A. The patient is obligated to provide timely and accurate information on their most recent demographic information, insurance status, changes to their family income or group policy coverage (if any), and, if known, information on deductibles or copayments that are required by their applicable insurance or financial program. The detailed information for each item should include, but not be limited to:

1. 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.

2. 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.

3. Other resources that may be used to pay their bill, including other insurance programs, motor vehicle or homeowners insurance policies when the services rendered were related to an accident, workman compensation programs, student insurance policies, and any other family income such as an inheritances, gifts, or distributions from an available trust, among others.

B. The patient is responsible to track their unpaid hospital bills, including any existing co-payments, co-insurance, and deductibles, and contacting the hospital should they need assistance in paying for some or all of their outstanding balance.

C. The patient is responsible to inform 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 in the event of 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.

D. 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.

E. In the event a third party like, but not limited to, home or auto insurance 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.

F. 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.

   1. Obtaining personal or financial information for patients being treated for an emergency medical condition or needed urgent care services will be delayed until treatment has been rendered

   2. Efforts may occur before a scheduled appointment, during the patient's initial in-person registration at a hospital location for a service, or at other times.

   3. Patients will receive notice from the hospital about the availability of coverage options through available public assistance programs (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) on the billing invoices sent to the patient or the patient's guarantor following the delivery of services.

   4. The hospital will also perform its due diligence through existing public or private financial verification systems to determine 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.

5. 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 a 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.

6. When hospital registration staff are informed by the patient of changes to their family income or insurance status, including any lawsuit or insurance claim that may cover the cost of the services provided by the hospital, they will work with the patient to ensure that the relevant information is communicated to the appropriate public programs.

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

8. 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, but not limited to:
   a) motor vehicle or homeowners liability policy
   b) general accident or personal injury protection policy
   c) worker’s compensation programs
   d) student insurance policies

9. In the event 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

A. The hospital has a uniform and consistent process for collecting the necessary information for the submission of claims and bills regardless of the patient's insurance status. Specifically, in the instance where the patient has a current unpaid balance that is related to services not covered by a public or private coverage option, the hospital will follow the following reasonable collection/billing procedures, which include:

1. An initial bill (statement) 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;

2. Subsequent communications including billings (statements), 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 and includes information on how the patient can contact the hospital for financial assistance;

3. Documentation of alternative efforts to locate the party responsible for the financial obligation, or their correct mailing address on billings or statements returned by the postal service for such reasons as "incorrect address" or "undeliverable;"

4. For patients without any insurance coverage, the hospital will send a final notice by certified mail for those uninsured patients whose balance exceed $1,000 for any emergent or urgent services only, or 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;

5. Documentation of continuous billing or collection action undertaken for 120 days from the date of the service is maintained and available to demonstrate compliance with all applicable federal and/or state program to verify these efforts; and

6. 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.

7. For all patients who are enrolled in 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.

8. 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 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

A. Pursuant to state regulations & policies, patients enrolled in the following public health insurance programs will be exempt from collections subject to exceptions noted below. Those public health insurance programs include, but is not limited to:

1. MassHealth
2. Emergency Aid to the Elderly, Disabled and Children (EAEDC)
3. Children's Medical Security Plan (CMSP) MAGI income =< 300% FPL)
4. Low Income Patients as determined by MassHealth and Health Safety Net including MAGI Household income or Medical Hardship Family Countable Income between 150.1 to 300% of the FPL
5. Medical Hardship

B. The hospital may seek collection action against any patient enrolled in the above mentioned programs for their required copayments and deductibles that are set forth by each specific program;

C. 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;

D. 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.

E. 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.

IV. Extraordinary Collection Actions (ECAs)

A. The hospital does ***NOT*** use any Extraordinary Collection Actions (ECAs) as defined by the IRS in Section 501(c)(3) as actions taken by a hospital facility against an individual related to obtaining payment of a bill for care covered under the hospital facility's Financial Assistance Plan (FAP).

B. Specifically, the hospital will ***NOT***:
1. sell an individual's debt to another party;
2. report adverse information about an individual to consumer credit reporting agencies or credit bureaus (collectively, "credit agencies");
3. defer or deny, or require a payment before providing, medically necessary care because of an individual's non-payment of one or more bills for previously provided care covered under the hospital facility's FAP;
4. Place a lien on an individual's property;
5. Foreclose on an individual's real property;
6. Attach or seize an individual's bank account or any other personal property;
7. Commence a civil action against an individual;
8. Cause an individual's arrest;
9. Cause an individual to be subject to a writ of body attachment;
10. Garnish an individual's wages;

C. A claim filed by a hospital facility in any bankruptcy proceeding is not an ECA.

D. A lien placed on the proceeds of a judgment, settlement, or compromise owed to an individual (or his or her representative) as a result of personal injuries caused by a third party for which the hospital facility provided care is not an ECA.

E. While the hospital does refrain from the use of extraordinary collection actions against patients, the hospital may utilize the services of a credit bureau to identify the credit rating of a patient to determine a patient's ability to fulfill their financial obligations.

F. The hospital and its agents shall not continue collection or billing efforts related to a patient who is a member of a bankruptcy proceeding except to secure its rights as a creditor in the appropriate order (similar actions may also be taken by the applicable public assistance program that has paid for services). The hospital and its agents will also not charge interest on an overdue balance for a Low Income Patient.

G. The hospital maintains compliance with applicable billing requirements and follows applicable state and federal requirements related to the non-payment for specific services that were the result of, or directly related, to a Serious Reportable Event (SRE), the correction of the SRE, a subsequent complication arising from the SRE, or a readmission to the same hospital for services associated with the SRE. SREs that do not occur at the hospital are excluded from this determination of non-payment as long as the treating facility and the facility responsible for the SRE do not have common ownership or a common corporate parent.

H. 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

A. 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. All outside collection agencies contracted by the hospital will provide the patient with an opportunity to contest their balance or file a complaint which will be resolved collaboratively with hospital patient financial leadership. The hospital requires that any outside collection agency complies with all federal and state fair debt collection requirements.

VI. Deposits and Installment Plans

A. 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.

1. **Emergency Services**: The hospital does 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.

2. **Low Income Patients:** The hospital does not request a deposit from patients determined to be Low Income Patients.

3. **Medical Hardship Patients:** The hospital does not request a deposit from patients eligible for Medical Hardship.

4. **Payment Plans for Low Income Patients pursuant to the Massachusetts Health Safety Net Program:** The hospital does not restrict payment plans for low income patients.

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

6. **Payment Plans for HSN Partial Low Income Patients pursuant to the Massachusetts Health Safety Net Program, for services rendered in a Hospital Licensed Health Center:**
   a) CHA charges the full amount of the service of the HSN net payment for each visit.
   b) 20% deductible payment option is not offered to HSN partial low income patients.