STANDARD PROCEDURE
GREATER NEW BEDFORD COMMUNITY HEALTH CENTER, INC.

Date Approved: 12/5/16 Department Head: [signature]
Department: Fiscal Division Head:
Director of Patient Access ______ CEO: [signature]

Title: Credit and Collection Policy Procedure Manual

Purpose: To establish a process for recording of revenue/billing for patients and third parties. To establish standards for determining Health Safety Net Care and a Bad Debt. To provide direction in the handling and disposition of self-pay balances. To establish billing cycle requirements and collection action when indicated. To record revenue, cash collections, and contra revenue to the General Ledger.

Accountability: President, Controller, Accounting, Benefits, Billing

Reference: FQHC Standards, MGL Ch. 112S. 12F, 114.6 CMR 12.00, Federal Poverty Income Guidelines

Forms: MassHealth Medical Benefit Request (MBR)

Description:

All attached as follows:

1. Letter of Acceptance from Division of Health Care Finance and Policy (DPH)
2. Credit and Collection (C&C) Policy Cross Reference Index
3. Credit and Collection Policy Procedure Manual Table of Contents
4. Greater New Bedford Community Health Center Credit and Collection Policy Procedure Manual
5. Sample Documents & Notices on Availability of Assistance (see #13)

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Credit and Collection Policy Procedure Manual

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1. Introduction

The purpose of this policy is to serve as a general guideline to ensure reasonable collection of accounts from all available services.

2. General Definitions

2.1 Emergency Care – N/A

2.2 Urgent Care: Medically necessary services provided in a Hospital or community health center after the sudden onset of a medical condition, whether physical or mental, manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent lay person would believe that the absence of medical attention within 24 hours could reasonably expect to result in: placing a 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. Urgent care services do not include elective or primary care.

3. General Collection Policies & Procedures

3.1 Standard Collection Policies and Procedures for patients

(a) The Greater New Bedford Community Health Center makes reasonable efforts prior to or during treatment to obtain the financial information necessary to determine responsibility for payment of the bill from the patient or guarantor. The center's staff provides all first-time patients with a registration form which includes questions on the patient's insurance status, residency status, and financial status, and provides assistance, as needed, to the patient in completing the form. A patient who states that they are insured will be requested to provide evidence of insurance sufficient to enable the center to bill the insurer. Health center staff will ask returning patients, at the time of visit, whether there have been any changes in their insurance coverage status. If there has been a change, the new information is recorded in the center's practice management system and the patient advised or assisted to inform MassHealth of the change.

(b) The health center undertakes the following reasonable collection efforts for patients who have not provided complete eligibility documentation, or for whom insurance payment may be available:

(1) an initial bill is sent to the party responsible for the patient's financial obligations;

(2) subsequent billings, telephone calls, and any subsequent notification method that constitute a genuine effort to contact the party which is consonant with patient confidentiality are sent;

(3) efforts to locate the patient or the correct address on mail returned as an incorrect address are documented, and

(4) a final notice is sent by certified mail for balances over $1000, where notices have not been returned as an incorrect address or as undeliverable.

(5) all accounts over 180 days that are deemed uncollectible after all efforts have failed will be reviewed monthly by the Patient Account Manager, CFO & CEO. The Finance Committee and Board of Directors will be notified of amounts and will approve the write off before billing does the final write off. (Addendum 04/16/2013.)

(c) Cost Sharing Requirements. Health center staff inform patients who are responsible for paying co-payments in accordance with 114.6 CMR 13.04(6)(b) and deductibles in accordance with 114.6 CMR 13.04(6)(c), that they will be responsible for these co-payments.
(d) Low Income Patient Co-Payment Requirements. The health center requests co-payments of $1 for generic drugs and $3 for single source drugs from all patients over the age of 18, up to a maximum pharmacy co-payment of $100 per year.
(e) Health Safety Net - Partial Deductibles/Sliding Fees: For Low Income Partial patients, the health center determines their deductible (40% of the difference between the applicant's Family Income and 201% of that year's FPL). The patient is responsible for 20% of the HSN payment for each visit, and this will be applied to the patient's annual deductible. Once the patient has incurred the Deductible, they are not longer responsible for the 20% payment during the duration period of the deductible.
The annual Deductible is applied to all Eligible Services provided to a Low Income Patient or Family member during the Eligibility Period. Each Family member must be determined to be a Low Income Patient in order for his or her expenses for Eligible Services to be applied to the Deductible. The health center will track the patient's Eligible Service expenses for services provided by the health center until the patient meets the Deductible. However, if more than one Family member is determined to be a Low Income Patient, or if the patient or Family members receive services from more than one Provider, it is the patient's responsibility to track the Deductible and provide documentation to the Provider that the Deductible has been reached.

3.2 Policies & Procedures for Collection Financial Information

All patients who wish to apply for HSN or other public coverage are required to complete and submit a MassHealth Application using the eligibility procedures and requirements applicable to MassHealth applications under 130 CMR 502.000 or 130 CMR 516.000.
(a) Determination Notice. The Office of Medicaid will notify the individual of his or her eligibility determination for MassHealth, Commonwealth Care, or Low Income Patient status.
(b) The Division's Electronic Free Care Application issued under 114.6 CMR 10.00 may be used for the following special application types:
a. Minors receiving Confidential Services may apply to be determined a Low Income Patient using their own income information and using the Division's Electronic Free Care Application. If a minor is determined to be a Low Income Patient, the health center will submit claims for confidential Services when no other source of funding is available to pay for the services confidentially. For all other services, minors are subject to the standard Low Income Patient Determination process.

b. An individual seeking eligible services who has been battered or abused, or who has a reasonable fear of abuse or continued abuse, may apply for Low Income Patient status using his or her own income information. Said individual is not required to report his or her primary address.

c. An individual who is incarcerated may apply for Low Income Patient status for services provided within six months prior to his or her application.

3.3 Emergency Care Classification - NA

3.4 Policy for Deposits and Payment Plans

The health center's billing department provides and monitors Deposits and Payment Plans as described in **Section 5** of this policy for qualified patients as described in 114.6 CMR 13.08. Each payment plan must be authorized by the Billing Manager or other Health center authorized person.

3.5 Copies of Billing Invoices and Notices of Assistance

(a) Billing Invoices: The following language is used in billing statements sent to low income patients: "If you are unable to pay this bill, please call (phone #). Financial assistance is available."

(b) Notices: The Health center provides all applicants with notices of the availability of financial assistance programs, including MassHealth, CommCare, HSN and Medical Hardship, for coverage of services exclusive of personal convenience items or services, which may not be paid in full by third party coverage. The center also includes a notice about Eligible Services and programs of public assistance to Low Income Patients in its initial invoices, and in all written Collection Actions. All applicants will be provided with written notice of approval for Health Safety Net or denial of Health Safety Net within 30 days of the application. The following language is used billing statements sent to low income patients: "If you are unable to pay this bill, please call (phone #). Financial assistance is available." The Health center will notify the patient that the Provider offers a payment plan if the patient is determined to be a Low Income Patient or qualifies for Medical Hardship.

(c) Signs: The Health center posts 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 and programs of public assistance and the office at which to apply for such programs. Signs will be large enough to be clearly visible and legible by patients visiting these areas. All signs and notices will in English and Spanish.

3.6 Discount/Charity Programs for Uninsured Patients

The health center offers Sliding Fee Discounts to patients who are ineligible for the Health Safety Net. For these patients, the health center offers full discount to patients under 100% of the Federal Poverty Income Guidelines (FPIG) and Sliding Fee Discounts to patients with incomes between 100% and 200% of the FPIG.

3.7 Hospital deductible payment option at HLHC - NA
3.8 Full vs. 20% deductible payment options at HLHC- NA
3.9 Offer of 20% deductible payment option to Partial patients at HLHC – NA

3.10 CHC charge of 20% of deductible per visit to all partial HSN patients

The health center charges HSN-Partial Low Income Patients 20% of the HSN payment for each visit, to be applied to the amount of the Patient's annual Deductible until the patient meets the Deductible.

4. Collection of Financial Information

4.1 Emergency, Inpatient, Outpatient & CHC Services: The Health center makes reasonable efforts, as soon as reasonably possible, to obtain the financial information necessary to determine responsibility for payment of the bill from the patient or guarantor.

4.2 Inpatient Verification - NA

4.3 Outpatient/CHC Financial Verification

The Health center makes reasonable efforts to verify patient-supplied information at the time the patient receives the services. The verification of patient-supplied information may occur at the time the patient receives the services or during the collection process as defined below:

1. Verification of gross monthly-earned income is mandatory and shall include, but not be limited to, the following:
a. Two recent pay stubs;
b. A signed statement from the employer; or
c. The most recent U.S. tax return.
2. Verification of gross monthly-unearned income is mandatory and shall include, but not be limited to, the following:
a. A copy of a recent check or pay stub showing gross income from the source;
b. A statement from the income source, where matching is not available;
c. The most recent U.S. Tax Return.
3. Verification of gross monthly income may also include any other reliable evidence of the applicant's earned or unearned income.

5. Deposits and Payment Plans

5.1 The health center does not require pre-treatment deposit from Low Income patients.

5.2 Deposit Requirement for Partial-HSN Low Income Patients: The Health center does not require a deposit from individuals determined to be Low Income Patients pursuant 114.6 CMR 13.04(1).

5.3 Deposit Requirement for Medical Hardship Patients: The Health center does not require a deposit from patients eligible for Medical Hardship.

5.4 Payment Plan on Balance less than $1000: The Health center will offer an individual with a balance of $1,000 or less an interest-free one year payment plan with a minimum monthly payment of $25.

5.5 Payment Plan on Balance greater than $1000: A patient that has a balance of more than $1,000, after an initial deposit, will be offered an interest-free payment plan with a duration of at least two years.

6. Populations Exempt from Collection Action

6.1 MassHealth, EAEDC, and Healthy Start Enrollees: The health center does not bill patients enrolled in MassHealth, patients receiving governmental benefits under the Emergency Aid to the Elderly, Disabled and Children program, participants in the Healthy Start program, except that the health center may bill patients for any required co-payments and deductibles. The Health center may initiate billing for a patient who alleges that he or she is a participant in any of these programs but fails to provide proof of such participation. Upon receipt of satisfactory proof that a patient is a participant in any of the above listed programs, and receipt of the signed application, the Health center will cease its collection activities.

6.2 Participants in CMSP with income equal or less than 400% FPL: Participants in the Children's Medical Security Plan whose Family Income is equal to or less than 400% of the FPL are also exempt from Collection Action. The Health center may initiate billing for a patient who alleges that he or she is a participant in the Children's Medical Security Plan, but fails to provide proof of such participation. Upon receipt of satisfactory proof that a patient is a participant in the Children's Medical Security Plan, the Health center will cease all collection activities.

6.3 Low Income Patients – Full HSN: Low Income Patients are exempt from Collection Action for any Eligible Services rendered by the Health center during the period for which they have been determined Low Income Patients, except for co-payments and deductibles. The Health center may continue to bill Low Income Patients for Eligible Services rendered prior to their determination as Low Income Patients, after their Low Income Patient status has expired or otherwise been terminated.

6.4 Low Income Patients – Partial HSN: Low Income Patients with Income between 201 to 400% of the FPL are exempt from Collection Action for the portion of their bill that exceeds the Deductible and may be billed for co-payments and deductibles as set forth in 114.6 CMR 13.04. The Health center may continue to bill Low Income Patients for services rendered prior to their determination as Low Income Patients, after their Low Income Patient status has expired or otherwise been terminated.

6.5 Low Income Patient Consent to billing for non-eligible services: The Health center may bill Low Income Patients for services other than Eligible Services provided at the request of the patient and for which the patient has agreed in writing to be responsible.

6.6 Low Income Patient Consent Exclusion – Medical Errors: The health center will not bill low income patients for claims related to medical errors occurring on the health center's premises.

6.7 Low Income Patient Consent Exclusion – Admin/Billing Errors: The health center will not bill Low Income Patients for claims denied by the patient's primary insurer due to an administrative or billing error.

6.8 Medical Hardship Patient & ERBD Eligible for Medical Hardship: The Health center will not undertake a Collection Action against an individual who has qualified for Medical Hardship with respect to the amount of the bill that exceeds the Medical Hardship contribution.

7. Minimum Collection Action on Hospital ERBD & CHC Bad Debt

The Health center makes the same effort to collect accounts for Uninsured Patients as it does to collect accounts from any other patient classifications. Any collection agency used by the health center is required to conform to the above policies.

The minimum requirements before writing off an account to the Health Safety Net include:

7.1 Initial Bill: The health center sends an initial bill to the patient or to the party responsible for the patient's personal financial obligations.

7.2 Collection action subsequent to Initial Bill: The health center will use subsequent bills, phone calls, collection letters, personal contact notices, and any other notification method that constitutes a genuine effort to contact the party responsible for the bill.

7.3 Documentation of alternative collection action efforts: The health center will document alternative efforts to locate the party responsible or the correct address on any bills returned by the USPS as "incorrect address" or "undeliverable."

7.4 Final Notice by Certified Mail: The health center will send a final notice by certified mail for balances over $1,000 where notices have not been returned as "incorrect address" or "undeliverable"

7.5 Continuous Collection Action: The health center documents that the required collection action has been undertaken on a regular basis and, to the extent possible, does not allow a gap in this action greater than 120 days.

7.6 Continuous Collection Action – no gap > 120 days If, after reasonable attempts to collect a bill, the debt for an Uninsured Patient remains unpaid for more than 120 days, the health center may deem the bill to be uncollectible and bill it to the Health Safety Net Office.

7.7 Collection Action File: The health center maintains a patient file which includes documentation of the collection effort including copies of the bill(s), follow-up letters, reports of telephone and personal contact, and any other effort made.

7.8 ERBD claim and EVS check - NA

7.9 HLHC Bad Debt claim and EVS check – NA

7.10 CHC Bad Debt claim and EVS check The health center may submit a claim for Urgent Care Bad Debt for Urgent Care Services if:

(a) The services were provided to:

1. An uninsured individual who is not a Low Income Patient. The health center will not submit a claim for a deductible or the coinsurance portion of a claim for which an insured patient is responsible. The health center will not submit a claim unless it has checked the REVS system to determine if the patient has filed an application for MassHealth; or

2. An uninsured individual whom the health center assists in completing a MassHealth application and who is subsequently determined into a category exempt from collection action. In this case, the above collection actions will not be required in order to file.

(b) The Health center provided Urgent Services as defined in 114.6 CMR 13.02 to the patient. The Health center may submit a claim for all Eligible Services provided during the Urgent Care visit, including ancillary services provided on site.

(c) The responsible provider determined that the patient required Urgent Services. The health center will submit a claim only for urgent care services provided during the visit.

(d) The Health center undertook the required Collection Action as defined in 114.6 CMR 13.06(1)(a) and submitted the information required in 114.6 CMR 13.06(1)(b) for the account; and

(e) The bill remains unpaid after a period of 120 days.

8. Available Third Party Resources

8.1 Diligent efforts to identify & obtain payment from all liable parties: The health center will make diligent efforts to identify and obtain payment from all liable parties.
8.2 Determining the existence of insurance, including motor vehicle liability:
In the event that a patient seeks care for an injury, the health center will inquire as to whether the injury was the result of a motor vehicle accident; and if so, whether the patient or the owner of the other motor vehicle had a liability policy. The health center will retain evidence of efforts to obtain third policy payer information
8.3 Verification of patient's other health insurance coverage: At the time of application, and when presenting for visits, patients will be asked whether they have private insurance. The health center will verify, through EVS, or any other health insurance resource available to the health center, on each date of service and at the time of billing.
8.4 Submission of claims to all insurers: In the event that a patient has identified that they have private insurance, the health center will make reasonable efforts to obtain sufficient information to file claims with that insurer; and file such claims.
8.5 Compliance with insurer's billing and authorization requirements: The health center will comply with the insurer's billing and authorization requirements.
8.6 Appeal of denied claim. The health center will appeal denied claims when the stated purpose of the denial does not appear to support the denial.
8.7 Return of HSN payments upon availability of 3rd-party resource: For motor vehicle accidents and all other recoveries on claims previously billed to the Health Safety Net, the health center will promptly report the recovery to the HSN. The recovery will be offset against the claim for Eligible Services.

9. Serious Reportable Events (SRE)

9.1 Billing & collection for services provided as a result of SRE: The health center shall not charge, bill, or otherwise seek payment from the HSN, a patient, or any other payer as required by 105 CMR 130.332 for services provided as a result of a SRE occurring on premises covered by a provider's license, if the provider determines that the SRE was: a. Preventable; b. Within the provider's control; and c. Unambiguously the result of a system failure as required by 105 CMR 130.332 (B) and (c).
9.2 Billing & collection for services that cause or remedy SRE: The health center shall not charge, bill, or otherwise seek payment from the HSN, a patient, or any other payer as required by 105 CMR 120.332 for services directly related to: a. The occurrence of the SRE; b. The correction or remediation of the event; or c. Subsequent complications arising from the event as determined by the Health Safety Net office on a case-by-case basis.
9.3 Billing an collection by provider not associated with SRE: The health center will submit claims for services it provides that result from an SRE that did not occur on its premises
9.4 Billing & collection for readmission or follow-up on SRE associated with provider: Follow-up Care provided by the health center is not billable if the services are associated with the SRE as described above.

10. Provider responsibilities

10.1 Non-discrimination: The health center shall not discriminate on the basis of race, color, national origin, citizenship, alienage, religion, creed, sex, sexual orientation, age, or disability, in its policies, or in its application of policies, concerning the acquisition and verification of financial information, pre-admission or pretreatment deposits, payment plans, deferred or rejected admissions, or Low Income Patient status.
10.2 Before seeking legal execution against the personal residence or motor vehicle of a Low Income Patient, the health center requires its Board of Directors to approve such action on an individual basis.
10.3 Advise patient on TPL duties and responsibilities: The health center will advise patients of the responsibilities described in 114.6 CMR 13.08(2)(b) at the time of application and at subsequent visits

11. Patient Rights and Responsibilities

11.1 Advise patient on right to apply for MassHealth, CommCare, HSN and Medical Hardship: The health center informs all patients of their right to apply for MassHealth, CommCare, HSN, and Medical Hardship.
11.2 Advise patient of the right to a payment plan: The health center informs all Low Income Patients and patients determined eligible for Medical Hardship of their right to a payment plan.
11.3 Advise patient on duty to provide all required documentation: The health center advises all patients that they have a duty to provide the health center all required eligibility and TPL verification at the time of application for coverage.
11.4 Advise patient on duty to inform of change in eligibility status and available TPL: The health center informs all patients that they have a responsibility to inform the health center or MassHealth when there has been a change in their eligibility, coverage, and/or TPL status.
11.5 Advise patient on duty to track patient deductible: A the time of application, Low Income Partial patients are advised that it is their responsibility to track expenses toward their deductible and provide documentation to the health center that the deductible has been reached when more than one family member has been determined to be a Low Income Patient or if the patient or family members receive Eligible Services from more than one provider.

In the event that a patient is identified as having been involved in an accident or suffers from an illness or injury that has or may result in a lawsuit or insurance claim, the health center advises the patient of his/her duty to
11.6 Inform the HSN Office or MassHealth of a TPL claim/lawsuit:
11.7 File TPL claim on accident, injury or loss:
11.8 Assign the right to recover HSN payments from TPL claim proceeds
11.9 Provide TPL claim or legal proceedings information
11.10 Notify HSN/MassHealth within 10 days of filing a TPL claim/lawsuit
11.11 Repay the HSN for applicable services from TPL Proceeds

11.12 Advise patient of HSN limit on recovery of TPL claim proceeds: The health center will advise the patient that the HSN can only recover amounts to the extent of the services it reimbursed.

12. Signs

12.1 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.
12.2 Size of the Signs: The signs are large enough to be clearly visible and legible by patients visiting these areas.
12.3 Multi-lingual signs when applicable: 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 Portuguese.
12.4 Wording in Signs: The health center signs notify patients of the availability of financial assistance and of programs of financial assistance. Copies of Signs can be found in the Section 12 of this Policy.

13. Sample Documents & Notices on Availability of Assistance

13.1 Assistance notice (non-billing invoice) – Attached
13.2 Assistance program notice in initial bill (billing invoice) – Attached
13.3 Assistance notice in collection actions (billing invoices) – Attached
13.4 Payment plan notice to Low Income or Medical Hardship patients – Attached
13.5 Posted Signs – Sample(s) attached