Manet Community Health Center
Credit & Collection Policy

Effective 02/23/2018
Revised 02/20/ 2021
Finance Committee Review 09/21/2021

Table of Contents

Collection of Financial Information from Patients

Federal Sliding Fee Discount Program

No patient will be denied care due to her/his ability to pay for such services. There is, however, assistance available to eligible patients. The federal sliding fee discount program is open to all patients. A schedule of sliding fees and discounts is available for patients who are determined to be at or below 200% of the federal poverty guidelines (FPG) as published annually by the U.S. Department of Health and Human Services.

A patient applying for a sliding fee scale discount completes a paper application. The information gathered on income and family size is entered into the practice management system which automatically assigns a sliding fee scale. Based on family size the health center offers full federal sliding fee discounts to patients with incomes under 100% of the FPL, and federal sliding fee discounts to patients with incomes between 100.1% and 200% of the FPL. (See Manet Sliding Fee Discount Schedule.) A federal sliding fee patient must notify the health center of any change in family size and income. Eligibility is subject to annual redetermination based on family size and income.

All patients at or below 100% of the federal poverty guideline receive a full discount of the health center's established fees for services rendered, with the exception of any out-of-pocket acquisition costs for supplies and equipment purchased from and owed to third parties such as prescription drugs. These are discounted to an amount sufficient to recover the health center's cost. Pharmaceuticals are provided to patients eligible for the federal sliding fee discount program at 340B acquisition cost.

If a federal sliding fee patient also has third party insurance coverage, Manet compares the amount of the insurance co-payment with the sliding fee discount amount due. The patient must pay the lower of the two amounts.

State Health Safety Net Program/MassHealth Low Income Patient Status

All patients who wish to apply for HSN or other state public coverage are required to complete and submit a MassHealth/Connector Care Application using the eligibility procedures and requirements based on family size and income applicable to MassHealth applications in accordance with 101 CMR 613.04. The MassHealth Agency or the Commonwealth Health Insurance Connector will notify the individual of his or her eligibility determination for health care coverage or Low-Income Patient status.

In order to be determined a Low-Income Patient, an individual must be a resident of Massachusetts and document that the Modified Adjusted Gross Income (MAGI) of her or his MassHealth MAGI household is equal to or less than 300% of the FPL.

a. Verification of income is mandatory. Income may be verified either through electronic data matches or paper verification. If the attested income and the income from the electronic data source are not reasonably compatible, or if the electronic data match is unavailable, paper verification of income is required. Paper verification includes, but is not limited to:
    1. recent pay stubs;
    2. a signed statement from the employer; or
    3. the most recent federal tax return.
b. Verification of gross monthly unearned income is mandatory and includes, but is not limited to:
    1. a copy of a recent check or pay stub showing gross income from the source;
    2. a statement from the income source, where matching is not available; or
    3. the most recent federal tax return.
c. Verification of gross monthly income may also include any other reliable evidence of the applicant's earned or unearned income.

An individual may be determined to be a Low-Income Patient for a limited period of time, if on the basis of attested information submitted to the health center on the form specified by the Health Safety Net Office, the health center determines the individual is presumptively a Low-Income Patient. The health center will submit claims for reimbursable health services provided to individuals with time-limited presumptive Low-Income Patient determinations for dates of service beginning on the date on which the health center makes the presumptive determination and continuing until the earlier of:

a. the end of the month following the month in which the provider made the presumptive determination if the individual has not submitted a complete application, or
b. the date of the determination notice related to the individual's application.

The Division's Electronic Self Pay Application issued under 101 CMR 613.04(2)(b)(3)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 Health Safety Net Office's application for Health Safety Net Confidential Services. 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 who has been a victim of domestic violence, or who has a reasonable fear of domestic violence or continued domestic violence may apply for Low Income Patient status using his or her own countable income information if he or she seeks medically necessary eligible services.

Patients with MassHealth Modified Adjusted Gross Income (MAGI) Household Income greater than 150% and less than or equal to 300% of the Federal Poverty Level (FPL), there is an annual deductible if all members of the Premium Billing Family Group (PBFG) have an FPL above 150%. If any member of the PBFG has an FPL equal to or below 150% there is no deductible for any

member of the PBFG. The patient is responsible for 20% of the Health Safety Net payment for each visit, to be applied to the amount of the patient's annual deductible until the patient meets his or her deductible. There is only one deductible per PBFG per approval period. The deductible is not applied to pharmacy services. Copayments are not considered expenses to be included in the deductible amount. The annual deductible is applied to all reimbursable health services provided to a low-income patient or PBFG member during the eligibility period. Each PBFG member must be determined a Low-Income Patient in order for his or her expenses to be applied to the deductible.

Low-Income Patient status is effective for a maximum of one year from the date of determination, subject to periodic redetermination and verification that the patient's income or insurance status has not changed to such an extent that the patient no longer meets eligibility requirements.

The following individuals are not eligible for Low-Income Patient status:

a. individuals who have been determined eligible for any MassHealth program, including any premium assistance program, but who have failed to enroll, and
b. individuals whose enrollment in MassHealth or the premium assistance payment program operated by the Health Connector has been terminated due to failure to pay premiums.

Standard Collection Policies and Procedures for Patients

The health center will maintain a schedule of fees for the provision of all its services which will be designed to cover reasonable costs of providing services, and which is consistent with locally prevailing rates or charges. The schedule of fees will be reviewed and revised as needed at least on an annual basis.

Any fees or payments required by the health center for health care services will be reduced or waived in order to assure that no patient will be denied such services due to an individual's inability to pay.

The health center makes reasonable efforts to verify patient-supplied information prior to or at the time the patient receives services. It makes diligent efforts to identify and obtain payment from all other liable parties, including insurers. Diligent efforts include, but are not limited to

a. determining the existence of insurance that could pay for medical expenses by asking the patient if he or she has other insurance and by using insurance data bases available to the provider;
b. verifying the patient's other health insurance coverage through EVS or any other health insurance resource available to the provider on each date of service and at the time of billing;
c. submitting claims to all insurers with the insurer's designated service code for the service provided;
d. complying with the insurer's billing and authorization requirements; and
e. appealing a denied claim when the service is payable in whole or in part by an insurer.

Health center staff asks returning patients, at the time of visit, whether there have been any changes in their income or insurance coverage status. If there has been a change, the new information is recorded in the health center's practice management system and, if applicable, the patient advised or assisted to inform MassHealth of the change.

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:

a. an initial bill is sent to the party responsible for the patient's financial obligations;
b. subsequent billings, telephone calls, and any subsequent notification method that constitute a genuine effort to contact the party responsible for the obligation;
c. efforts to locate the patient or the correct address on mail returned as an incorrect address are documented, and
d. a final notice is sent by certified mail for balances over $1,000 where notices have not been returned as an incorrect address or as undeliverable.

Deposits and Payment Plans

The health center's billing department provides and monitors deposits and payment plans. Each payment plan must be authorized by the Director of Revenue Cycle and Billing.

a. The health center does not require pre-treatment deposits from Low-Income Patients.
b. The health center may request a deposit from individuals determined to be Low-Income Patients with incomes above 100% of FPL. 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 below.
c. The health center may request a deposit from patients eligible for Medical Hardship. Deposits are limited to 20% of the Medical Hardship contribution up to $1,000. All remaining balances are subject to the payment plan conditions established below.
d. A patient with a balance of $1,000 or less, after initial deposit, must be offered at least a one-year, interest-free payment plan with a minimum monthly payment of no more than $25. A patient with a balance of more than $1,000, after initial deposit, must be offered at least a two-year, interest-free payment plan.

Populations Exempt from Collection Action

The health center must not bill patients enrolled in MassHealth and patients receiving governmental benefits under the Emergency Aid to the Elderly, Disabled and Children program except that the health center may bill patients for any required copayments 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 must cease its collection activities.

Participants in the Children's Medical Security Plan whose MAGI income is less than or equal to 300% 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 must cease all collection activities.

Low-Income Patients are exempt from collection action for any reimbursable health services rendered by the health center receiving payments from the Health Safety Net for services received during the period for which they have been determined Low-Income Patients, except for copayments 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.

Low-Income Patients with MassHealth MAGI household income or Medical Hardship Family Countable Income greater than 150% and less than or equal to 300% of the FPL are exempt from collection action for the portion of his or her health center bill that exceeds the deductible and may be billed for copayments and deductibles. 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.

The health center may bill Low-Income Patients for services other than reimbursable health services provided at the request of the patient and for which the patient has agreed to be responsible. The health center must obtain the patient's written consent to be billed for the service.

The health center may not bill Low-Income Patients for claims related to medical errors.

The health center may not bill Low-Income Patients for claims denied by the patient's primary insurer due to an administrative or billing error.

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.
The health center may 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.

Minimum Collection Action on 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:

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

b. The health center will use subsequent bills, telephone calls, collection letters, personal contact notices, and any other notification methods that constitute a genuine effort to contact the party responsible for the obligation.
c. The health center will document alternative efforts to locate the party responsible for the obligation or the correct address on any bills returned by the USPS as "incorrect address" or "undeliverable."
d. 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."
e. The health center will document that the required collection action has been undertaken on a regular and frequent basis and, to the extent possible, will not allow a gap in this action greater than 120 days.
f. If, after reasonable attempts to collect a bill, the debt for an uninsured patient remains unpaid after a period of 120 days of continuous collection action, the health center may deem the bill to be uncollectible and bill it to the Health Safety Net Office.
g. 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.

The health center may submit a claim for urgent care bad debt for urgent care services if:

1. The services were provided to:
   a. 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 EVS to determine if the patient has filed an application for MassHealth; or
   b. an uninsured individual whom the health center assists in completing an 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.
2. The health center provided urgent services 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.
3. 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.
4. The health center undertook the required collection action as defined and submitted the information required for the account; and
5. The bill remains unpaid after a period of 120 days of continuous collection action.

Billing Invoices and Notices of Assistance

The health center notifies the individual of the availability of financial assistance programs to a patient expected to incur charges, exclusive of personal convenience items or services, whose services may not be paid in full by third party coverage. It notifies the individual about eligible services and programs of public assistance, including MassHealth, the Premium Assistance Payment Program operated by the Massachusetts Health Connector, the Children's Medical Security Plan, and Medical Hardship:

a. during the patient's initial registration at the health center;

b. on all billing invoices; and
c. when the health center becomes aware of a change in the patient's eligibility or health insurance coverage.

The health center posts signs in the clinic, registration areas, and in business office areas that are customarily used by patients that conspicuously inform patients of the availability of financial assistance and of other programs of public assistance and the office at which to apply for such programs. Signs are large enough to be clearly visible and legible by patients visiting these areas. All signs and notices will be in English.

The health center posts its Credit & Collection Policies at: **www.manetchc.org.**

Serious Reportable Events (SRE)

The health center will not charge, bill, or otherwise seek payment from the HSN, a patient, or any other payer for services provided as a result of a serious reportable event (SRE) occurring on premises covered by the health center's license, if the health center determines that the SRE was:

a. preventable;
b. within the health center's control; and
c. unambiguously the result of a system failure

The health center will not charge, bill, or otherwise seek payment from the HSN, a patient, or any other payer 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.

The health center may submit claims for services it provides that result from an SRE that did not occur on its premises only if the treating facility and the facility responsible for the SRE do not have common ownership or a common corporate parent.

Follow-up care provided by the same health center or a health center owned by the same parent organization is not billable if the services are associated with the SRE.

Health Center Responsibilities

The health center will not discriminate on the basis of race, color, national origin, citizenship, alienage, religion, creed, sex, sexual orientation, gender identity, age, or disability in its policies or in its application of policies, concerning the acquisition and verification of financial information, pretreatment deposits, payment plans, deferred or Low- Income Patient status.

A health center or its agent will not seek legal execution against the personal residence or motor vehicle of a Low-Income Patient without the express approval of the health center's Board of Directors. All approvals by the Board must be made on an individual case basis.

The health center will advise patients of the rights and responsibilities in all cases where the patient interacts with registration personnel.

Patient Rights and Responsibilities

Patients have the right to
1. apply for MassHealth, the Premium Assistance Payment Program operated by the Health Connector, a Qualified Health Plan, Low-Income Patient determination, and Medical Hardship, and
2. a payment plan if the patient is determined to be a Low-Income Patient or qualifies for Medical Hardship.

A patient who receives reimbursable health services must
1. provide all required documentation;
2. inform MassHealth of any changes in income or insurance status, including but not limited to, income, inheritances, gifts, distributions from trusts, the availability of health insurance, and third-party liability. The patient may, in the alternative, provide such notice to the health center that determined the patient's eligibility status;
3. track the patient deductible and provide documentation to the health center that the deductible has been reached when more than one Premium Billing Family Group (PBFG) member is determined to be a Low-Income Patient or if the patient or PBFG members receive reimbursable health services from more than one health center; and
4. inform the Health Safety Net Office or the MassHealth agency when the patient is involved in an accident, or suffers from an illness or injury, or other loss that has or may result in a lawsuit or insurance claim.

General Filing Requirement

The Manet Community Health Center will electronically file its Credit & Collection Policy with the Health Safety Net (HSN) Office within 90 days of adoption of amendments to 101 CMR 613.00 that would require a change in the Credit & Collection Policy; when the health center changes its Credit & Collection Policy; or when requested by the HSN Office.