The Cambridge Hospital

1493 Cambridge Street, Cambridge, Massachusetts 02139 (617) 498-1000

THE CAMBRIDGE HOSPITAL

CREDIT AND COLLECTION POLICY

EFFECTIVE JULY 1, 1986

APPROVED BY:

John J. O'Brien

Administrator

THE CAMBRIDGE HOSPITAL

CREDIT AND COLLECTION POLICY AND PROCEDURE

The Cambridge Hospital Credit and Collection Policy represents normal procedures. Deviation from normal will be made for a variety of extenuating reasons. It is our objective to maximize cash collections in order to match our expenditures with our revenues and to minimize bad debts while providing the highest possible level of care to patients from our service area regardless of their ability to pay. Also, as a matter of policy, the Cambridge City Council has stated that no undue hardship be placed on any Cambridge resident by the hospital in an attempt to recover payment for hospital services.

The Cambridge Hospital, having received assistance through the Department of Health and Human Services under Title VI of the Public Health Service Act, agrees to abide by all compliance and assurance regulations of the Hill Burton act.

Furthermore, The Cambridge Hospital agrees to comply with the Massachussetts Rate Setting Commission's criteria and standards for credit and collection policies as set forth in Regulation 114.1 CMR 30.00, as amended.

The Cambridge Hospital does not discriminate on the basis of race, color, national origin, allegiance, religion, creed, sex, age for persons beyond the age of majority, or handicap, in its' policies, or its' application of policies, concerning the acquisition and verification of financial information, preadmission or pretreatment deposits, payment plans, deferred or rejected admissions or eligibility for free care.

I. INPATIENT ACCOUNTS

1. Non-Emergency

A. Acquisition of Information

1. Preadmission

Patients who are admitted as elective patients will be contacted prior to admission, regarding patient's name and address, third party information, insurance numbers, credit data, and method of payment if other than by a third party. This information will be gathered through the preadmission questionnaire process.

2. At Time of Admission

a. All data not previously obtained, such as the third party number, signed insurance forms, and credit data, will be requested of the patient or responsible party. Signature for insurance assignment of benefits, where applicable, will be secured during the admission encounter interview.

b. Payment request will be made for insurance deductibles and private room rate differentials. Pre-arranged deposits will be collected and accounted for. If applicable, patients will be sent to the Credit office to fill out a financial application and set up a budget.

c. Patients who also appear to be indigent are referred to the office for assistance in applying for government aid. Patient Accounts Services Inpatient Office.

Patients who are unable to pay will be advised of the availability of Hill Burton funds.

3. In-House Patients

a. While a patient is in house , the Patient Accounts Services Inpatient Office will continue to verify and research third party coverage.

b. If incomplete information was provided at admission, the patient or a member of his/her family will be contacted to obtain complete billing information. The discharge clerk will go to the floors to obtain necessary signatures and determine third party coverage for these patients. If the patient is determined to be indigent, then the Social Service department will be informed. If the patient appears to be eligible for Hill Burton, and if the the hospital has not fulfilled its' annual obligation, then an application will be obtained for a determination.

4. At Time of Discharge

a. All patients are to be escorted from the units to the Discharge Office at the time of discharge. The Discharge Clerk will ensure that all financial information recorded on the patient's admission history is accurate and complete, that all necessary forms are signed, that all deductibles, co-insurance amounts, private room differentials and other non covered charges have been paid or arrangements made for payment.

Patients not covered by any or insufficient insurance will be referred to the Self pay/Budget clerk to make payment arrangements.

A weekly report of discharge activities will be prepared by the Discharge Clerk.

b. All patients referred to the Discharge Office will have their admitting forms rechecked for proper insurance assignment of benefits signature and other third party information missed or not verified from pre-admission, at admission or while in-house. If third party coverage has been determined to be inadequate or erroneous, then the patient will complete a financial statement to determine the method of payment which may be Budget payment, Hill Burton, regular collection cycle, or free care. Patients should be informed that the Hospital will accept requests for partial payments and settlements. These requests, plus applications for Hill Burton and free care will be forwarded to the Comptroller for determination. Patients who appear to be qualified for governmental aid will be referred to the Social Service Department.

5. Post-Discharge

a. All discharged accounts will be received from Data Processing within 6 days of discharge and should be completely processed to the appropriate third parties within 10 days barring extreme circumstances. Self pay patients will receive a bill within 10 days of discharge(an itemized bill will be provided upon request). Included in this bill will be a notice of free care outlining criteria for eligibilty and how to apply. A Self Pay committee consisting of the Comptroller, Patient Accounts Manager/Inpatient, the Budget clerk, and a member of the Social Service Department will meet weekly to determine the status of unresolved self pay accounts.

b. Any third party claims not paid within 60 days will be automatically rebilled. The third party payclass trials will be periodically reviewed to determine if third party payment has been exhausted, and the paylass changed.

c. After third party billing has been accomplished, the patient will be considerd a self pay patient for the balance due.

d. Medicaid claims that have been rejected due to delays in obtaining proper information from the patient will be abated as bad debt and referred to the Collection Agency.

e. All self pay patients will be billed on a three statement cycle, 30 and 60 days with a final notice after 90 days that the account will be referred to collection if payment is not received. A phone contact will also be made for those accounts whose balance is greater than $500.00. Each statement will contain a brief message on free care as well as a dunning message.

f. After the final notice, if payment is not received, the account will automatically be converted to bad debt status, and appear on the collection listing. The collection listing will be reviewed by inpatient billing personnel. Patients for whom settlement may be made will be contacted for partial payment. All accounts which have received 3 statements and have been deemed uncollectible, will be forwarded to a collection agency for collection. Mail returns will be examined, and if returned because of a false or incorrect address, will be forwarded to the collection agency after abatement as a bad debt.

g. The Collection agency works on a fee for collection basis only, which must be within the guidelines established in The Municipal Finance Act.

h. All monies collected by the collection agency will be posted as recoveries of bad debt.

i. All accounts, regardless of age that require legal action for collection or may be better handled by an attorney, will be forwarded to the Hospital Attorney, or his/her designee.

j. The Hospital at its' discretion after a reasonable but unsuccessful collection effort may write off a patient account where payment appears doubtful and the balance is not in excess of $75.00.

k. The Hospital at its' discretion may write off any small amounts , not to exceed $20.00, as bad debt without any collection effort.

l. All bad debt writeoffs will be accompanied, at a minimum, by documentation of all efforts made by the Hospital or its' agent to collect bad debt accounts.

m. All free care writeoffs will be accompanied, at a minimum, by documentation of all efforts made by the Hospital to determine free care eligibility.

6. Emergency Admissions

a. The Hospital policy for data collection of emergency patients will be the same as those previously outlined, except that Section I.1.A1, Preadmission procedures, will not apply.

B. Verification of Information

1. The "pre-discharge "time frame for verification of patient information will be 5 business days. The "post-discharge" time frame for verification of patient information will be 10 days.

2. Verification of information will include, but not be limited to, the patient's name and address, the guarantor's(if any) name and address, copying or observing personal identification, copying or observing paycheck stubs or tax returns, copying or observing third party payor identification cards, telephone contact with these organizations and, through bill submission to patients and/or their respective organizations.

3. The projected completion date of this process is expected to be within 10 business days of the submission of the required information. Any application for free care which is not accompanied by verifiable supporting documentation will be considered incomplete and will be denied within ten (10), days of the request by the hospital for the missing documentation.

4. During the verification process the Hospital will also assess the patient's ability to pay. The procedures for this will be discussed in Section IV of the policy.

II. OUTPATIENT ACCOUNTS

Non-Emergency

1. Acquisition of Information

a. A registration form will be completed prior to service being rendered. All pertinent information as outlined in Section I,B2, will be gathered at this time.

b. Verification- see procedures previously outlined in Section I,B.

c. The projected completion date of this process is expected to be within 10 business days of submission of the required information.

d. During the verification process the Hospital will also assess the patient's ability to pay. The procedures for this will be discussed in Section IV of this policy.

III. NOTICE OF AVAILABLE ASSISTANCE

a. Posted Notice

The Hospital will have posted signs in the inpatient, outpatient, and emergency admission/registration areas and in the billing office areas that are customarily used by patients, which conspicuously inform patients of the availabilty of free care and where to apply for such care. The following wording will be used:" Notice of Availability of Free care and Public Assistance: The Commonmwealth of Massachusetts Rate Setting Commission regulation 114.1 CMR 30.07 specifies that Massachusetts acute care hospitals provide free care to financially eligible persons and/or inform them of the availability of public assistance programs."

For further information about such eligibility please call 498-1045 (Inpatient Accounts) or 498-1048 (Outpatient Accounts).

A copy of this notice is included with this policy (see appendix A)

b. Individual Notice

The Hospital shall provide individual notice of the availability of free care where the hospital has been given an indication that a patient will incur charges, exclusive of personal convenience items or services, that may not be paid in full by third party coverage. The notice will be in the following format: "Notice of Availability of Free care and Public Assistance: You are responsible for payment of hospital charges or amounts not paid by your insurance unless your total family income is within poverty guidelines established by the U.S. Department of Health and Human Services, or income and resource standards established by the State Medicaid agency.

If you inquire at 498-1045 (Inpatient Accounts) or 498-1048 (Outpatient Accounts), your eligibilty will be established through a free care or public assistance application process and determined within 30 days of receipt of such application."

A copy of this notice is included with this policy (see appendix B)

c. Initial statement

The Hospital will provide a copy of the individual notice as outlined in section A and B with the initial statement.

d. Follow up wriiten notices

A brief message will be incorporated on the follow up statements sent out to patients. The message will be as follows: "You may qualify for Free care or other programs. Please call 498-1045 (Inpatient Accounts) or 498-1048 (Outpatient Accounts)."

e. These notices discussed in sections A through D will be translated into Portuguese, Spanish and, French Creole.

IV. DETERMINATION OF ABILITY TO PAY

A. Financial Analysis

In order to determine if a patient is eligible to meet their financial obligation, a financial application will be completed for analysis. A copy of this form is included with this policy.(see appendix c)

B. Deposit Plan-Preadmission

1. A pre-admission deposit will be requested from all patients for whom services to be provided will not be covered by insurance. The deposit amount will be equal to the estimated amount of uncovered charges. This estimate will be calculated by the Patient Accounts Services Managers. Patients who reside outside of the Hospital's service area (outside Cambridge and Somerville) will be rebooked if clinical approval is obtained from the attending physician, if unable to pay this deposit. Financial arrangements for patients within the Hospital's service area will be made for those patients with inadequate insurance. Deviations can be made in exceptional circumstances with the approval of Fiscal Administration.

2. Exclusion

Emergency admissions and persons with income up to 200% of the Income Poverty Guidelines (IPG) will be excluded from the policy described in Section 1.

C. Payment Plans

1. Based upon the financial application of the patient, a budget payment plan can be arranged whereby the patient pays a monthly installment equal to the amount monthly income exceeds monthly expenses. The budget payment plan is based upon the payment of the entire account balance due by the patient.

2. Exclusions

A sliding fee scale mechanism for patients whose income is between 200-400% of the IPG will be applicable as follows:

	Inpatients	Outpatients
Income > 200% but < 300%	50% abatement	25% abatement
Income > 300% but < 400%	25% abatement	No abatement

The abated amount will be considered free care.

D. Free Care Eligibility

1. All free care provided shall be accompanied by a signed application for free care by the patient, relative, or legal guardian.

2. The Hospital shall determine a patient's eligibility for free care within 30 days of initiation of the application.

3. Once the Hospital determines a patient to be eligible for free care hospital services the patient will be eligible for 6 months from the date of the initial determination.

4. All patients whose income is up to twice the eligible IPG will be eligible for free care

5. After all avenues have been exhausted to obtain income verification from the patient, the Hospital will accept a notarized statement from a community service agency from which the patient is also receiving services or other community source as to their actual income.

Proof of participation in either the WIC or Healthy Start programs, which require levels less than twice the IPG, will substantiate eligibility for free care.

6. The Hospital will exempt a patient from collection action if the major expenditure for health care and/or income loss stemming from an individual's medical condition have depleted or can reasonably be expected to deplete the financial resources of the individual to the extent that he or she will be unable to pay for needed medical services.

EXEMPTION FROM COLLECTION ACTION

a. There shall be no residency requirements for patients who are residents of the Commonwealth of Massachusetts.

b. The Hospital or its' agent shall not seek legal execution of a lien against the personal residence or automobile, of patients or guarantors with income less than or equal to 200% of the federal income poverty guidelines.

c. The Hospital or its' agent shall not seek legal execution against the personal residence or automobile, of patients or guarantors with income in excess of 200% of the federal income poverty guidelines without the express approval of the hospital's Health Policy Board on an individual case by case basis.

d. The Hospital shall not bill patients who are recipients of General Relief benefits. However the Hospital may initiate billing to a patient who alleges that he or she is a GR benefit recipient but fails to provide proof of such eligibility. Upon receipt of a GR card or upon verification of the patient's status with the Department of Public Welfare the Hospital shall cease its' activities to these patients.

VI. Documentations and Audit: Bad Debt and Free Care Accounts

1. The hospital shall maintain auditable records of its' activities made in compliance with the criteria and requirements of regulation 114.1 CMR 30.00. The Hospital's bad debt and free care write-offs as reported on RSC-404, RSC-403, and the Blue Cross (MAC) Appendix D reports, shall be documented.

2. The Hospital's bad debt write-offs shall be accompanied, at a minimum, by documentation of all efforts made by the hospital or its agent to collect bad debt accounts.

3. The Hospital's free care write-offs, shall be accompanied, at a minimum, by documentation of all efforts made by the hospital to determine free care eligibility.

AVAILABILITY OF FREE CARE AND PUBLIC ASSISTANCE

The Commonwealth of Massachusetts Rate Setting Commission Regulation 114.1 CMR 30.07 specifies that Massachusetts acute care hospitals provide free care to financially eligible persons and/or inform them of the availability of public assistance programs.

For further information about such eligibility please call 498-1045 (Inpatient Accounts) or 498-1048 (Outpatient Accounts).

NOTICE OF AVAILABILITY OF FREE CARE AND PUBLIC ASSISTANCE

You are responsible for payment of hospital charges or amounts not paid by your insurance unless your total family income is within poverty guidelines established by the U.S. Department of Health and Human Services, or income and resource standards established by the State Medicaid Agency.

If you inquire at 498-1045 (Inpatient Accounts) or 498-1048 (Outpatient Accounts), your eligibility will be established through a free care or public application process and determined within 30 days of receipt of such application.

☐ Hill Burton ☐ App ☐ Denied
☐ Abatement/Partial
☐ Free Care
☐ Budget
☐ Pkg. Plan

THE CAMBRIDGE HOSPITAL

FINANCIAL APPLICATION

Date of Application

PATIENT'S NAME: *(last Name first)*	ACCOUNT #	AMOUNT	AMOUNT APPROVED

Applicant's Name *(last)*	*(first)*	*(M.I.)*	Age	Telephone #

Address	City	State	Zip

INCOME & EMPLOYMENT HISTORY *(Last 12 month period)*

Employer's Name	Length of Employment	Number of Hours *(Weekly)*	Gross Income *(Weekly)*	Net *(Monthly)*
Present Employer *(Applicant)*				
Previous Employer *(Applicant)*				
Present Employer *(Patient)*				
Previous Employer *(Patient)*				

Explain reason of **NO** income periods:

☐ no unemployment benefits ☐ illness ☐ other: _____

Other Source of Income: Rent $_____ Interest $_____ Other: _____

FAMILY SIZE # _____

Name	Relationship	Age	Income

HILL BURTON APPLICANTS: *Read & Sign*

REQUEST FOR DETERMINATION OF ELIGIBILITY FOR UNCOMPENSATED SERVICES

As provided for in Federal Law, I hereby request that the Cambridge Hospital make a written determination of my eligibility for uncompensated services at The Cambridge Hospital. I understand that the information which I submit concerning my annual income and family size is subject to **verification** by the Cambridge Hospital; I also understand that if the information which I submit is determined to be false, such a determination will result in a denial of providing services as uncompensated services and that I will be liable for charges for services provided.

Type of Service Required _____

_____
Applicant's Signature Date

12 MONTH FINANCIAL HISTORY

FROM: , 19 **TO:** , 19 | **Number in Family**

INCOME

(Wages, self-employment, child support, public assistance, social security, unemployment benefits, workman's compensation, alimony, pension - - - etc.)

Source of Income	PERIOD	PATIENT	APPLICANT	OTHER
		Gross Amt.	Gross Amt.	Gross Amt.
TOTAL INCOME				

EXPENSES

(Loans, charge cards, medical bills)

	Monthly Payment	Balance
Rent/Mortgage		
Food $ weekly		
Gas $		
Elec. $		
Heating $		
Telephone $		
CLERK'S INITIALS: TOTAL		

(Average Monthly Income $) **VERIFICATION OF INCOME:** Yes ☐ No ☐

ASSETS

Property:	Value $
Vehicle:	Value $
Bank:	☐ Savings $
Bank:	☐ Checking $
Life Ins. Company:	Face Value $

I affirm that the information provided is true and correct to the best of my knowledge.

X _____
Applicant's Signature

HOSPITAL USE ONLY

DETERMINATION OF ELIGIBILITY

1. Income
   a. Total Income for last 3 months $ _____ x 4 = $ _____
   b. Total Income for last 12 months $ _____
2. If the patient's statement of income was verified by the time the determination was made, stipulate exactly what information was used; the content of the information, and the source (name and phone number) of the person providing verification.

   _____

   _____
3. The applicant is: Eligible ☐ Ineligible ☐
4. The type of Service requested: is ☐ will be ☐ was ☐ available to the patient _____ (date)
5. If uncompensated care is denied, state the reason for the denial:
   Ineligible _____
   Hospital Obligation Exhausted _____
   Other _____

Date of determination of eligibility or denial of uncompensated services _____

Signed _____
(Signature of person making determination)

Date applicant was provided with a copy of determination _____

TCH2

CITY OF CAMBRIDGE

CAMBRIDGE, MASSACHUSETTS 02139
TEL. 498-9011

EXECUTIVE DEPARTMENT
ROBERT W. HEALY
City Manager

RICHARD C. ROSSI
Deputy City Manager

June 2, 1986

To the Honorable, the City Council:

With respect to City Council Order No. 4 of May 19, 1986, enclosed please find copy of the Credit and Collection Policy of the Cambridge Hospital, effective July 1, 1986, as submitted by John O'Brien, Administrator.

Very truly yours,

Robert W. Healy
City Manager

RWH/mbf
Enc.

Agenda Item No. 22 P-223

Re: credit & collection policy of the Cambridge Hsoptial.

In City Council,

June 2, 1986

Placed on File