Emerson Hospital

CREDIT AND COLLECTIONS POLICY

July 2022

1. SCOPE

This Credit & Collection policy is intended to cover Emerson Hospital, as well as any entity that is part of the named hospital's license.

2. GOVERNANCE ISSUES

This Policy has been developed in consultation with representatives of each entity and is designed to meet the needs of each entity. There are areas, however, where local conditions may support a need for unique, entity-specific provisions. Entity-specific provisions should receive prior approval from either (1) the Emerson Hospital Senior Vice President & Chief Financial Officer or (2) the Emerson Hospital Senior Director of Revenue Cycle Operations. Submissions of the Hospital Credit & Collection Policy to the Health Safety Net will be coordinated by Emerson Hospital Patient Accounts Department with any required supporting documentation or exhibits.

3. STATEMENT OF PRINCIPLE

Emerson Hospital is a tax-exempt entity, whose underlying mission is to provide services to all in need of medical care.

Patients requiring Emergent Services or Urgent Services (as defined in Section 4B) at the Hospital shall not be denied those services based on ability to pay. However, in order for Emerson Hospital to continue to provide high quality services and support community needs, each entity has a responsibility to seek prompt payment for services provided.

These policies are intended to help ensure compliance with applicable state laws and regulations, including but not limited to, the Massachusetts Health Safety Net (HSN) Eligibility regulations at 101 CMR 613.00 et seq., 101 CMR 614.00 et seq., and hereafter referred to as the "State Regulations." In addition, this policy addresses the requirements for The Medicare Provider Reimbursement Manual (Part 1, Chapter 3) for the Centers for Medicare and Medicaid Services, Medicare Bad Debt Requirements (42 CFR 413.89), and the Internal Revenue Code Section 501(r) as required under the Section 9007(a) of the Federal Patient Protection and Affordable Care Act (Pub. L. No. 111-148).

4. CLASSIFICATION & ACCESS TO CARE

A. GENERAL PRINCIPLE

All patients presenting for unscheduled treatment will be evaluated according to the classifications included in this Section. Emergent Services and Urgent Services shall not be denied or delayed based on the Hospital's ability to identify a patient, their insurance coverage, or ability to pay. However, Non-Emergent or Non-Urgent Services may be delayed or deferred based on the consultation with the Hospital's clinical staff in cases when the Hospital is unable to determine a payment source for its services.

The urgency of treatment associated with each patient's presenting clinical symptoms will be determined by a medical professional as determined by local standards of practice, national and state clinical standards of care, and the Hospital Medical Staff policies and procedures. Further, all hospitals follow the federal Emergency Medical Treatment and Active Labor Act (EMTALA) requirements by conducting a medical screening examination to determine whether an emergency medical condition exists. It is important to note that classification of patients' medical condition is for clinical management purposes only, and such classifications are intended for addressing the order in which physicians should see patients based on their presenting clinical symptoms. These classifications do not reflect medical evaluation of the patient's medical condition reflected in final diagnosis.

Determination of medical urgency is made according to the following definitions:

B. EMERGENT AND URGENT SERVICES

The Hospital will provide Emergent Services and Urgent Services to all patients, without regard to the patient's identification, insurance coverage, or ability to pay. The Hospital prohibits any actions that serve to discourage individuals from seeking Emergent Services or Urgent Services.

<u>Emergent Services</u> include:

Medically necessary services provided after the onset of a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in placing the health of the person or

another person in serious jeopardy, serious impairment to body function or serious dysfunction of any body organ, or with respect to a pregnant woman, as further defined in Section 1867(e)(1)(B) of the Social Security Act (42 U.S.C. § 13295dd(e)(1)(B)). A medical screening examination and treatment for emergency medical conditions or any other such service rendered to the extent required pursuant to EMTALA (42 U.S.C. § 1395dd) qualifies as Emergency Care.

Emergent services also include:

- Services determined to be an emergency by a licensed medical professional;
- Inpatient medical care which is associated with outpatient emergency care; and
- Inpatient transfers from another acute care hospital to Emerson Hospital for the provision of inpatient care that is not otherwise available.

Urgent Services include:
Medically necessary services provided after sudden onset of a medical condition, whether physical or mental, manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson would believe that the absence of medical attention within twenty-four (24) hours could reasonably expect to result in: placing the patient's health in jeopardy, impairment to bodily function, or dysfunction of any bodily organ or part. Urgent 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.

C. NON-EMERGENT, NON-URGENT SERVICES

Non-Emergent, Non-Urgent Services can generally be sub-classified as either:

"Elective Services": Medically necessary services that do not meet the definition of Emergent or Urgent Services above. The patient typically, but not exclusively, schedules these services in advance.

"Other Services": Services where medical necessity has not been demonstrated to the reviewing clinician.

"Post-Acute Care": Medically necessary services provided at a Hospital that is classified as post-acute care including rehabilitation services.

"Behavioral Health Services": Medically necessary services provided in a number of settings focused on the patient's psychological and mental health.

The Hospital may decline to provide a patient with Non-Emergent, Non-Urgent Services in those cases when the Hospital is unsuccessful in determining that payment will be made for its services. Such services may be deferred indefinitely until suitable payment arrangements can be made.

D. LOCATIONS THAT PATIENTS MAY PRESENT FOR SERVICES

All patients are able to seek Emergent Services and Urgent Services when they come to the Hospital's emergency department or designated urgent care areas. However, patients with emergent and urgent conditions may also present in a variety of other locations, including but not limited to Labor and Delivery, ancillary departments, hospital clinics and other areas. The Hospital also provides other Elective Services at the main facility, clinics, and other outpatient locations.

5. ACQUISITION AND VERIFICATION OF PATIENT INFORMATION

The Hospital will make diligent efforts to positively identify all patients and obtain, record, and verify complete demographic and financial information for every patient seeking care. The information to be obtained will include demographic information (such as patient name, address, telephone number, social security number if applicable, gender, date of birth, and other applicable patient identification) and health insurance information (including name and address, subscriber information, and benefit information such as co-payment, deductible and co-insurance amounts) sufficient to secure payment for services. The requirement for the Hospital to obtain complete information will always be tempered by the patient's condition, with the patient's immediate health care needs taking priority.

It is the patient's obligation to provide complete and timely insurance and demographic information and to know what services are covered by their insurance policy.

A. EMERGENT AND URGENT SERVICES

Registration and intake of patients seeking Emergent Services or Urgent Services will be performed in accordance with the requirements of EMTALA. Generally,

patient demographic and insurance information should be collected as soon as possible; collection of information should be deferred, however, when collection of this information may delay medical screening or negatively impact the patient's clinical condition. Where a patient is unable to provide insurance or demographic information at the time of service and the patient consents, every effort should be made to interview friends or relatives that may accompany or be otherwise identified by the patient. Where practical, insurance information provided by the patient should be confirmed with the payer via a payer website or an electronic data interchange (EDI).

B. NON-EMERGENT, NON-URGENT SERVICES

Registration and intake of Non-Emergent/Non-Urgent patients should be performed prior to services being rendered. Returning or established patients will also have their demographic, financial, and insurance information reviewed and updated as needed, including where applicable, verification of their insurance status via EDI or other available methods.

6. FINANCIAL CLEARANCE

A. GENERAL PRINCIPLES

The Hospital will make diligent efforts to determine the patient's financial responsibility as soon as reasonably possible during the patient's course of care. Where feasible, the Hospital will collect co-pays, deductibles, co-insurance amounts, or required deposits prior to any service delivery. Patients who are members of managed care health plans, or health insurance plans with specific access requirements, are responsible for understanding and complying with all of their health insurance plan requirements, including referrals, authorizations, or other network restrictions. The Hospital will request any necessary pre-approval, authorization, or guarantees of payment from the insurer whenever possible. Under some circumstances, including Emergent and Urgent Service delivery, these referral and authorizations may take place after service delivery. All patients who incur a balance for services will be informed of the availability of Financial Counseling services to assist them in fulfilling their financial responsibility to the Hospital. The Hospital will make its best efforts to advise all patients of any significant financial responsibility prior to service delivery to the extent that this information is available to the Hospital. Screening consistent with

EMTALA will be completed prior to activities to determine the patient's financial responsibility.

B. PREPARATION OF ESTIMATES

The Hospital complies with federal law regarding the provision of a "Good Faith Estimate" of charges to an uninsured or self-pay patient in advance of scheduled items or services or upon request in accordance with 45 C.F.R. § 149.610. All other patients will receive a Good Faith Estimate of the expected charges within two (2) days of the date of the request. The Good Faith Estimate will be provided to the patient along with payment options.

C. INSURED PATIENTS

The Hospital will make diligent efforts to verify the patient's insurance status and assist the patient in complying with the requirements of their health insurance plan. This verification will occur in accordance with the principles previously outlined in Section 5. Whenever possible, this verification will include a determination of the patient's expected financial responsibility, including applicable co-insurance, deductibles, and co-payments. Where feasible and clinically appropriate, payment of any predetermined amounts (co-payments, fixed deductibles) will be requested from the patient before or at the time of service. In some cases, the patient's health insurance plan and type of coverage may not allow for an exact determination of the patient's financial responsibility for services at the time of registration. In those cases, the Hospital may request a deposit equal to the Good Faith Estimate. Patients who are unable to provide payment may be referred to Financial Counseling.

1) Contracted Insurance Plans. The Hospital contracts with a number of health insurance plans. In those cases, the Hospital will seek payment from the health insurance plan for all covered services. Patient payment of all co-payments, deductibles, and co-insurance amounts will be requested prior to service delivery. If a particular service is determined by the insurer to be non-covered or otherwise rejected for payment, then payment for that service will be sought directly from the patient in accordance with the relevant insurance contract. Whenever possible, the Hospital will assist the patient in appealing denials or other adverse judgments with their health insurance plan recognizing that the health insurance plan often requires these appeals to be made by the patient.

2) Non-contracted Insurance Plans. The Hospital will extend the courtesy of billing a patient's insurance company in those cases where the Hospital does not have a contract with an insurer. While the Hospital will bill the patient's health insurance plan, ultimate financial responsibility rests with the patient or guarantor and the insurer's failure to respond to the Hospital bill in a timely manner may result in the patient being billed directly for the services except in those cases where the patient is protected from collection actions (Section 9(B)(3)). Balances remaining after any insurance payment will be billed to the patient. Whenever possible, the Hospital will assist the patient in appealing denials or other adverse judgments with their health insurance plan, recognizing that the health insurance plan requires the appeal to be made by the patient.

D. UNINSURED PATIENTS (SELF PAY)

Patients who are not exempt from collection actions, do not have health insurance, and have not been previously determined to be (i) approved for Financial Assistance or (ii) a Low Income Patient as further described in Section 6(E) below, will be asked to provide a deposit in advance of services not required to be performed under EMTALA. The deposit will be equal to Good Faith Estimate provided, less any discount (see Section 8). Patients who are either uninsured or not planning to submit a claim to their insurance for the services they are seeking will be provided with a Good Faith Estimate upon request, or when scheduling such services. Patient rights to a Good Faith Estimate, including the timeframes for receiving a response from the Hospital can be found in the Hospital's Notice of Right to Good Faith Estimate. All patients will be provided information on any hospital discount programs that are available to them. Uninsured patients will be offered Financial Counseling to determine their eligibility for any of the available State Programs or other government-sponsored programs as well as assisting the patient in applying for those programs. State Programs include, but are not limited to: MassHealth, ConnectorCare, Children's Medical Security Plan (CMSP), HSN, and any other program that may be offered via the Health Connector in the future. Financial Counselors will also assist patients with applying for non-subsidized insurance programs offered through the Health Connector (Qualified Health Plans). If there is no immediate need to provide services, the admission or outpatient service may be deferred or canceled until such time as the patient is

able to pay, make suitable financial arrangements, obtain insurance, or become enrolled in a financial assistance program that will cover the service.

E. LOW INCOME PATIENTS (MASSACHUSETTS RESIDENTS)

1) Definition and Eligibility: Low Income Patients are defined as meeting the criteria set forth in 101 CMR 613.04. This generally includes patients who are residents of Massachusetts who have applied for coverage with Executive Office of Health and Human Services (EOHHS) and have a verified MassHealth Modified Adjusted Gross Income (MassHealth MAGI) equal to or less than 300% of the Federal Poverty Guidelines (FPG). A Patient's eligibility status for coverage under any State Program (MassHealth, HSN, and CMSP) will be verified at time of registration using the MA Office of Medicaid's electronic verification system (EVS) or other Hospital registration systems, as applicable, and any changes to the patient's status will be noted in the record. The limitations outlined in this section for Low Income Patients are required for services at acute care hospitals in Massachusetts.

2) Service Limitations: Patients who are identified as Low Income Patients will, to the extent possible, be provided services consistent with the coverage guidelines of either HSN or MassHealth including "Eligible Service" limitations under state regulations and the applicable drug formulary. A patient seeking to receive a "Non-Eligible" service will be informed in writing of the maximum cost of that service and must sign an acknowledgement that they accept financial responsibility prior to service delivery. The list of programs qualifying patients as "Low Income" is in Section 9(B)(3) – Patients Protected from Collection Action.

3) HSN Medical Hardship: A Massachusetts resident at any income level may qualify for HSN Medical Hardship if their allowable medical expenses exceeded the family's income beyond their ability to pay for Eligible Services. This retrospective program is per HSN regulations, limited in scope, is a onetime determination, and is not a coverage category. This program may only be applied for after delivery of the service when the patient has incurred a financial liability.

(a) Expense Qualification: The type and amount of allowable medical expenses are specified in 101 CMR 613.05. Paid and unpaid bills with service dates up to twelve (12) months prior to the date of application may be submitted with a limit of two (2) applications within a twelve (12) month period.

(b) Application Process: The hospital will assist the patient in the collection of all applicable information and will submit Medical Hardship applications to HSN for review and approval. Patients have the responsibility to collect and submit documentation of all qualifying medical expenses. The Hospital is required to submit applications to HSN within five (5) business days of receiving all documentation and verifications from the patient.

(c) Determination: HSN will determine the patient's qualification for the program and will notify the hospital as to which bills are the patient's responsibility and which bills may be submitted to the HSN. Determination of Medical Hardship is limited to those bills that were included with the application. There is no eligibility period and bills may only be used once to support an application.

(d) Protection from Collection: All collection actions will be discontinued for all balances that are determined by HSN to be eligible for coverage under Medical Hardship. This includes balances that may have been assigned to an external agent or collection agency working on behalf of the Hospital. If a Hospital fails to submit an application within five (5) business days after receiving all verifications from the patient, then all balances which might have qualified under Medical Hardship are protected from collection actions.

4) Low Income Patient Financial Responsibility:

(a) The financial responsibility for a Low Income Patient is limited to (i) co-payments (from any payer except Medicare), (ii) deductibles determined by HSN, or (iii) a CommonHealth Spend Down, provided that the patient has agreed to be billed for the CommonHealth Spend Down.

(b) Deposits for Low Income Patients designated as Partial HSN or Medical Hardship: Deposits will be requested from these patients provided this is the primary coverage for the open balances for all Non-Emergent or Non-Urgent medically necessary services. The current status of the patient's annual family deductible will be reviewed and a deposit of up to 20% of the patient's annual deductible, or a Hardship contribution, up to a maximum of $500, may be collected from the patient.

(c) Payment Plans: Low Income Patients will be notified of the availability of payment plans to satisfy all open balances per the terms specified in Section 9(D)(4).

(d) Non-Eligible Services: Low Income Patients will be required to pay for any Non-Eligible Services, including but not limited to TeleHealth, eHealth, Cosmetic Services, or non-medically necessary services in advance. The patient will be informed of the maximum cost of these services in advance and must sign an acknowledgement that the services are not covered by HSN or any other State Programs. Services will be deferred until payment is made according to the guidelines in Section 4(A).

5) Low Income Patient Financial Responsibility for Behavioral Health and Post-Acute Care Services: Financial responsibility for these services are covered in the Uninsured Patient and Financial Assistance Policy (FAP).

6) Pending Status Determinations: Patients for whom the hospital has submitted an application for a state or other government sponsored program will generally have their bills held for up to thirty (30) days pending determination. After thirty (30) days they will be processed as Self Pay until a determination has been made. Requirements for deposits may be waived pending a determination by a Financial Counselor that a patient's application is complete and expected to be approved.

F. SPECIAL SITUATIONS – REGISTRATION AND PATIENT FINANCIAL RESPONSIBILITY

Under some circumstances, additional information or procedures may be needed to support processing of the patient's claims.

1) Workers' Compensation: Services related to industrial accidents must be appropriately labeled in the registration guarantor record. Additional information is required, including the date and time of accident, employer name and phone number, and employer's worker's compensation carrier and phone number. (See Section 10(F)(4) regarding submission of claims to workers compensation carriers prior to HSN submission.)

2) Motor Vehicle Accidents (MVA) and Third Party Liability (TPL): Services related to a motor vehicle accident or other third party liability should be appropriately labeled in the registration record. Diligent efforts will be made to collect additional information that is required for submission of MVA claims, including the date and time of accident, the location for TPL cases, and any known automobile insurer (except in New Hampshire where the Hospital may not submit claims to the MVA carrier). The name of any attorney associated with the claim should also be noted in the registration system if it is available. (See Section 10(F)(3) regarding submission of claims to MVA liability carriers in MA prior to HSN submission.) In NH, the claim will be filed with the patient's medical insurance or billed directly to the patient based on the patient's direction. Services billed to the patient for an MVA are not subject to discounts.

3) Victims of Violent Crimes (MA): Services related to victims of violent crimes should be appropriately labeled in the registration record, with the time and place of the incident. In some cases, limited funds are available from the MA Attorney General's office to offset medical expenses that are not otherwise covered by health insurance or the HSN. When indicated, patients should be referred to Financial Counseling for assistance with completing an application for compensation from the Victim Compensation Fund.

4) The Health Information Technology for Economic and Clinical Health Act (HITECH): The HITECH Act of 2010 provides patients the right at the time of service to request that their Protected Health Information (PHI) regarding a specific item or service not be sent to their health insurance for purposes of

payment. The patient is expected to pay any outstanding balance in full at time of service or upon receiving statements. HITECH only allows the patient to not have insurance billed. It does not negate the patient's financial responsibility for payment of accounts. Accounts should be noted per procedure to guard against inappropriate release.

5) HSN Confidential Applications: Confidential applications may be submitted under two (2) circumstances.

(a) Minors: Confidential applications may be submitted for minors presenting for family planning services and services related to sexually transmitted diseases. These applications may be processed under the minor's income without any regard to the family income. These patients should be referred to Financial Counseling.

(b) Battered or Abused Individuals: These individuals may also apply for HSN coverage on the basis of their individual income. These patients may be approved for the full range of services covered by HSN. These patients should be referred to Financial Counseling.

6) Undocumented Persons: Patients may be concerned about the immigration implications of applying for Low Income Patient status. Patients with limited financial means should be encouraged to apply for State Programs. If patients continue to express concern, patients may be referred to outside agencies for counsel. Patients refusing to apply for assistance will continue to be treated as self-pay. Urgent and Emergent services (including up to two (2) weeks of drugs required to respond to immediate threats to a patient's health) should continue to be provided. Non-Urgent, Non-Emergent services may be deferred or canceled until such time as the patient is able to pay, make suitable financial arrangements, obtain insurance, or become enrolled in a financial assistance program that will cover the service.

7) Research Studies: Services related to research studies should be noted at time of registration for that service and labeled to ensure that charges for these services are submitted to the designated research fund.

8) Organ Donors: The Hospital will identify organ donors at the time of service and ensure that claims for these services are applied to the appropriate insurance or other funding source.

9) International Patients: In addition to following the procedures stated for Insured and Uninsured patients, the Hospital will make every reasonable effort to gather local and permanent address information for residents of foreign countries and take whatever appropriate additional actions are needed in order to secure pre-payment for all uninsured services.

7. FINANCIAL COUNSELING SERVICES

A. GENERALLY

The Hospital will seek to identify patients who may be uninsured or inadequately insured in order to provide counseling and assistance. The Hospital will provide financial counseling to these patients and their families, including screening for eligibility for other sources of coverage, such as State Programs and other government programs, and providing information regarding all acceptable methods of payment of the Hospital bill. The Hospital will encourage patients who are potentially eligible for coverage from State Programs or other government programs to apply for coverage and shall assist the patient in applying for benefits. MA Residents may also apply for and be approved for coverage by the HSN for co-insurance or deductibles not covered by their primary health insurance plan.

B. COMMUNICATION OF AVAILABILITY OF FINANCIAL COUNSELING SERVICES

The Hospital will post a notice (signs) of the availability of financial assistance programs and describe where to go to for assistance in the following locations:

1) Inpatient, clinic and emergency department, and/or registration areas;
2) Financial Counseling waiting areas;
3) Central admission/registration areas that are open to patients; and
4) Business office waiting areas that are open to patients.

Signs will be translated into other languages to the extent that the language is the primary language of more than 10% of residents in the Hospital's service. Posted signs will be clearly visible and legible to patients visiting these areas. Signage will

also include instructions on access to translation services for patients who have other language needs.

Standard notices will be provided to all patients at the time of their initial registration with Emerson Hospital. These notices will also be made widely available throughout the hospital and routinely offered to existing patients whenever they are expected to have an out-of-pocket liability. Complete copies of this policy and the Emerson Hospital FAP will also be made available to patients as required. Both policies will also be posted on the internet at www.emersonhospital.org/patients-visitors/insurance-financial.

C. RESIDENCY REQUIREMENTS FOR STATE PROGRAMS

Eligibility for most State Programs is generally limited to patients who can demonstrate residency in the applicable state. In general, patients who have temporarily relocated for the sole purpose of receiving health care benefits do not meet the residency requirements. The Hospital will work with limited income patients that do not qualify for a State Program to identify other alternatives and advise them of their responsibilities.

D. APPLICATION FOR STATE PROGRAMS

The Hospital assists the patient in completing the application for a State Program and securing and submitting the necessary documentation required by the applicable State Program. Individuals apply for coverage through a single uniform application that is submitted through the State's Health Connector enrollment system. Through this process, the individual can submit an application through an online website (which is centrally located on the State's Health Connector website), a paper application, or over the phone with a customer service representative located at either MassHealth or the Health Connector. Necessary documentation may include, but is not limited to, proof of: (1) annual household income (payroll stubs, record of social security payments, and a letter from the employer, tax returns, or bank statements), (2) citizenship and identity, (3) immigration status for non-citizens (if applicable), and (4) assets of those individuals who are 65 and over. The State will notify the patient of any documentation that needs to be submitted for final verification. The patient may receive provisional coverage if the applicable program guidelines are met.

1) Submission of an Application for a State Program: All applications for a State Program, including paper and online applications must be signed by the patient or their legal representative. Verifications should be submitted only after the application has been processed and the State has requested documentation. During the application process, patients will be advised that HSN may report details of the patient's HSN utilization to the patient's employer. This disclosure is part of the State Program application.

2) Determination of Eligibility: All State Program applications are reviewed and processed by the Office of Medicaid, which uses the Federal Poverty Guidelines as well as the necessary documentation listed above as the basis for determining eligibility for all state programs.

3) Completion of a Medical Hardship Application: The designated Special Circumstances Application will be completed by the Hospital and submitted to HSN via the HSN-INET system for their determination.

4) Notification of Patient Responsibilities: The financial counselors will notify any HSN patients of their responsibilities as outlined in Section 13(B) including the requirement to report any proceeds or refund HSN for any Third Party recoveries they may receive.

E. APPROVAL FOR COVERAGE

The Hospital has no role in the determination of program eligibility made by the MA Office of Medicaid but at the patient's request may take a direct role in appealing or seeking information related to the coverage decisions. All notices of eligibility will be issued by the applicable State office. It is the patient's responsibility to inform the hospital of all coverage decisions made by the State to ensure accurate and timely adjudication of all hospital bills.

F. APPEAL OF OUTCOME

Patients may request a review of the determination from the applicable State program regarding their status. The request must be sent to the Office of Medicaid with supporting documentation. Requests for additional information made to the Hospital will be completed within thirty (30) days.

8. DISCOUNTS, ADJUSTMENTS AND CHARITY CARE

A. GENERALLY

The Hospital may extend discounts or other adjustments to patients if they qualify under the Emerson Hospital FAP or on a case-by-case basis, provided that the Hospital Senior Vice President & Chief Financial Officer, Senior Director of Revenue Cycle Operations, the Emerson Hospital Manager of Patient Accounts Department, or their respective designees authorize such discounts. Discounts should be clearly defined, documented, and consistent with good business practice, existing state and federal statutes, and in accordance with guidance that might, from time-to-time, be issued by state or federal authorities.

Discounts will not be based upon any relationship that the patient or their family may have with any Hospital employee or member of the governing body.

Discounts will not be extended based upon any consideration of "professional courtesy" for a clinician or their family.

Discounts will not be offered to patients to induce the patient to receive services or otherwise be linked in any manner to the generation of business payable by a federal healthcare program, nor will they be redeemable for cash for items or services provided by the Hospital, or any other Emerson Hospital entity (this includes discounts to the gift shop, cafeteria, etc.).

In general, co-payments, co-insurance, or deductibles will not be waived or discounted.

Reasons for waiving or discounting co-payments, co-insurance, or deductibles:

- Demonstrated financial hardship generally based on applicable patient income and asset information.
- The occurrence of a serious reportable event or other clinical issue causing the entire visit of stay to be waived. Any co-payments and deductibles collected in advance of the event (e.g., at check-in) would also be refunded.
- In rare cases, exceptions may be authorized by the Hospital Senior Vice President & Chief Financial Officer, Senior Director of Revenue Cycle Operations, or their respective designee(s).

Reasons for extending other types of discounts include:

- To encourage prompt payment;
- To recognize unique cases of financial hardship;
- To minimize the administrative costs of collection;
- Special case rate arrangements negotiated prior to service delivery; and
- As needed for the maintenance of positive patient relations, including but not limited to items such as an unexpected delay in service or other sub-optimal care delivery events.

B. OTHER DISCOUNTS, ADJUSTMENTS, AND CHARITY CARE

The Hospital maintains programs for Uninsured Patient Discounting and a Financial Assistance Policy for additional discounts. Financial Assistance discounts will generally be recognized as Charity Care by the Hospital. Such programs will be approved by the Emerson Hospital Senior Vice President & Chief Financial Officer or Senior Director of Revenue Cycle Operations and filed as provided in Section 2. The Hospital may also recognize as Charity Care those balances which may not be collected from a patient due to their protection from collection actions as outlined in 101 CMR 613.08(3) and Section 9(B)(3) of this policy. Patient balances that qualify under the Hospital's Charity Care policies may be reported as Medicare Bad Debt.

9. PATIENT BILLING AND COLLECTIONS

A. OVERVIEW

The Hospital will make diligent efforts to collect all charges that are due from insurers according to established industry standards and will seek to apply payments and contractual adjustments on a timely basis to the patient's account. These efforts include billing all available health insurance plans according to the payers' requirements and timely follow up of denied claims. Patients or other guarantors will be held responsible for all account balances that remain after application of all insurance payments, contractual adjustments, and applicable discounts or adjustments in accordance with any remittance advice received from the payer except where the balance may be submitted to the HSN or deemed exempt from collection actions per State Regulation. Collection actions may include patient statements, patient letters, telephone contacts, and certified final collection notices. Emerson Hospital will make reasonable efforts to determine whether a patient is eligible for assistance under its FAP before engaging in

extraordinary collection actions (ECA) against any patient or guarantor. For the purposes of this policy, ECAs are defined as actions taken by the Hospital against a patient related to obtaining payment of a bill for care covered under the Hospital's FAP that:

- Involve selling an individual's debt to another party,
- Involve reporting adverse information about an individual to consumer credit reporting agencies or credit bureaus (collectively, "credit agencies"),
- Involve deferring or denying, or requiring 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's FAP, or
- require a legal or judicial process.

B. PATIENT STATEMENTS, LETTERS, AND CALLS

The Hospital, either directly or through its designated agents, will prepare or mail statements to patients on a regular basis to advise them of balances owed to the Hospital. To the degree possible, the patient will receive a summary of all charges, payments and adjustments included with the initial billing for each date of service. In general, patients will receive three (3) or more statements or letters over the course of a billing cycle that is expected to last one hundred and twenty (120) days provided that other actions do not occur which indicate that additional billing is inadvisable. A record of all account actions and communications, including bills, is typically reflected in the billing system transaction registers and/or account comments. Staff is required to document all contacts with the patient (or guarantor) in the applicable billing system or self-pay collection system.

1) Suspension of Billing: In certain situations, continued billing and collection activity may be inappropriate and may be suspended or discontinued. Such situations include, but are not limited to: Bad Address (Section 7 below), Bankruptcy cases (Section F(1)), deceased patient, patient complaint or customer service issue, Small Balances (Section 10(B)(8)), or pending MassHealth or Low Income determinations. In addition, after the receipt of a completed financial assistance application, the Hospital will suspend any ECAs taken against the patient until the Hospital makes a

determination of eligibility for financial assistance and notifies patient in writing of the determination and the basis for the determination. If a patient is determined eligible for financial assistance under the Hospital's FAP, the Hospital will refund any excess payments and reverse any collection actions taken.

2) Notification of Availability of Financial Assistance: Patient statements will include notices to inform patients of the availability and means to access financial assistance. The language and content of these notices will conform to current EOHHS and IRS 501(r) regulations. Notices regarding the availability of financial assistance will also be included in all other written and verbal patient communications to the degree feasible. Before initiating ECAs, the Hospital must be able to demonstrate that notice of the availability of financial assistance was provided to the patient at least thirty (30) days prior to initiating any such ECA.

3) Patients and Guarantors Exempt from Collection Action: The Hospital will not engage in collection actions, including telephone calls, statements, or letters, for medically necessary services provided to those patients or guarantors who establish the following:

    a. Patient is enrolled in MassHealth or receiving governmental benefits under the Emergency Aid to the Elderly, Disabled and Children Program, except co-payments or deductibles;
    b. Patient is participating in CMSP whose MassHealth MAGI is equal to or less than 300% FPG;
    c. Low Income Patients (except for Dental-Only Low Income Patients) with regard to reimbursable services received during the period for which they have been determined Low Income Patients, except for copayments and deductibles;
    d. Low Income Patients (except for Dental-Only Low Income Patients) with MassHealth MAGI household income or Medical Hardship Family Countable Income, as described in 101 CMR 613.04(2), greater than 150% and equal to or less than 300% of the FPG with regard to the portion of the patient's bill that exceeds the deductible.

If it is determined that a patient was enrolled in one of the above categories, then all collection actions (except applicable co-payments and HSN deductibles) with the patient will cease for services that were provided during the patient's period of eligibility. Collection actions will also cease for as long as the patient is determined to be Low Income if the balance is from a period when the patient was not enrolled in a qualifying program. The Hospital may continue to send letters requesting information or action by the patient to resolve coverage and/or eligibility issues with a primary health insurance plan, workers' compensation program, or to obtain any TPL or MVA carrier information.

4) Final Collection Notice: The Hospital will send each patient a final collection notice prior to the account being written off as Bad Debt. In most cases, the final collection notice will be included on the guarantor statement. Such notice will include information regarding the availability of financial assistance (including a plain language summary of the FAP), identify the types of ECA(s) that the Hospital or third party intends to initiate to obtain payment, and the deadline after which such ECA(s) may initiated that is no earlier than thirty (30) days after the date that the written notice is provided. The Hospital will also make reasonable efforts to provide oral notification of the availability of the FAP and how patients may apply at least thirty (30) days prior to first initiating any ECAs.

5) Emergent Bad Debt: For those cases where an account is being considered by the Hospital for application to the HSN as Emergent Bad Debt, the Hospital will ensure the following conditions are met:

   (a) The account was subject to continuous collection action for a period of at least one hundred and twenty (120) days.

   (b) An eligibility inquiry was made through EVS to screen for coverage.

   (c) The services provided qualify as Emergent or Urgent per the definitions in this policy.

   (d) The Hospital can demonstrate compliance with the State Regulations regarding Bad Debt, including but not limited to, the

collection and verification of patient information and reasonable collection efforts.

6) Collection Calls and Letters: The Hospital will make reasonable efforts to collect all outstanding balances due to the Hospital. The collection effort expended will vary depending on a number of factors including, but not limited to, the balance of the accounts and the patient's previous collection history. Additional collection efforts may include patient calls and letters to supplement the routine patient statement process as described in Section 10(B). These calls and letters will include reminders regarding the availability of financial assistance.

7) Bad Address Returns: The Hospital will make reasonable efforts to track and respond to all patient statements returned by the USPS that are not deliverable. Where possible, accounts will be identified as "Bad Address Accounts" in the billing system, and address information will be verified and corrected using "skip trace" programs that may be available from third parties. Generally, once an account has been flagged as "Bad Address," no further statements or letters should be processed unless a new address has been identified. Continued mailing of statements to incorrect addresses is both fiscally inappropriate and could result in a Health Insurance Portability and Accountability Act (HIPAA) privacy breach. Accounts for patients whose most recent demographic information contains a Bad Address may be referred to outside agencies as Bad Debt for additional follow up, except that potential Emergent Bad Debt accounts will be followed for one hundred and twenty (120) days prior to placement.

8) Small Balance Adjustment: Recognizing the cost of statement processing and collection activities, the Hospital may suppress statements on accounts below its "small dollar billing" threshold. Similarly, after billing, the Hospital may limit collection and research activity on small balances and adjust accounts below its "small balance write-off" threshold. In no case will small balance adjustments taken under this section be billed to the HSN. The typical low balance threshold applies to guarantor account balances of less than $10.00.

C. SURCHARGE NOTICE

The Hospital will maintain a process to identify all patient balances that are subject to the HSN Trust Fund Surcharge as specified in 101 CMR 614. Surcharge amounts will be billed to the patient and the funds collected remitted to HSN per their requested schedule.

D. PAYMENT ARRANGEMENTS

1) Overall: Payments may be made in a variety of settings at all Emerson Hospital locations. Arrangements for deferred payment, payment plans, or partial payment of deposits are typically only made by Patient Access Services or the Emerson Hospital Patient Accounts Department. All payment arrangements will conform to pre-determined criteria and be recorded appropriately in the Hospital's billing and registration systems.

2) Forms of Payment:

    a) Prepayments may be made by certified/bank check, wire transfer, or credit/debit cards. Cash is not accepted at most hospital locations. Personal checks from U.S. banks are typically accepted for balances of less than $5,000, unless there is a history of checks failing for insufficient funds. Personal checks may be requested sufficiently in advance of a scheduled service in order to allow time for verification of the check. Patients who have a history of Bad Debt may be reviewed individually to determine the appropriate mode of payment.

    b) Bank Lock Box: Payments by personal check may be made to the Hospital's bank lock box.

    c) Emerson Hospital electronic billing and payment: Many locations provide electronic access to bills and payment of those bills electronically using credit/debit cards or a Bank ACH transfer.

    d) Payments are accepted by calling the Emerson Hospital Patient Accounts Department.

e) The Hospital will maintain a process to track 'bad' checks and reverse any payments that may have been applied to the patient's account. Submission of a 'bad' check may be grounds for applying the account to Bad Debt.

3) Currency: Unless otherwise agreed to, payment will be made in U.S. Currency. Payment made in non-U.S. currency will be applied at the conversion rate specified by the Hospital's bank, less any conversion fees.

4) Deposits and Payment Plans: Payment Plans are available to all patients upon request provided that their accounts are up to date. Final acceptance of a payment plan is subject to a complete review of the patient's status and payment history. Emerson Hospital Patient Accounts Department will process and monitor all patient payment plans. The Hospital will not require preadmission and/or pretreatment deposits from individuals requiring Emergent Services or that are determined to be Low Income Patients.

   a) Payment Plans/Deposits for HSN Partial Deductibles and Medical Hardship:
      (i) For Low Income Patients, an initial deposit of the lesser of $500 or 20% of the deductible balance may be required inclusive of all deposits accepted prior to Non-Urgent or Non-Emergent service delivery.
      (ii) For patients eligible for Medical Hardship, an initial deposit of the lesser of $1000 or 20% of the deductible balance may be required inclusive of all deposits accepted prior to Non-Urgent or Non-Emergent service delivery.
      (iii) One-year Payment Plans will be offered on balances of $1,000 or less and up to two (2) years on all other balances. These patients will be offered a monthly payment amount of $25 for these plans.

   b) Payment plans for all other Patients:
      (i) Maximum of one (1) year for balances of $1,000 or less.
      (ii) Maximum of two (2) years for balance over $1,000.

(iii) Longer payment plans may be offered under exceptional circumstances with senior management approval.
(iv) No plans will be offered with a monthly payment of less than $25.

c) No interest will be charged on balances where a patient has agreed to a payment plan and the patient is current with payments.

d) Plans should be reviewed on a regular basis to ensure that all payments are up to date. If a patient misses two (2) consecutive payments, the Hospital may place the account in Bad Debt. Upon notification from the patient of changed financial circumstances, the Hospital may reevaluate the patient's outstanding payment obligation.

E. SPECIAL SITUATIONS – BILLING

1) Patient Bankruptcy: The Hospital will make reasonable efforts to track all bankruptcy notifications and maintain them on file to ensure that all approved court procedures are followed, including filing of claims with the Court as appropriate, or forgiveness of debt. Upon receipt of legal notification of a patient's or guarantor's bankruptcy, all collection actions will cease and the account will be adjusted accordingly.

2) Deceased Patients: When appropriate and cost effective, the Hospital will perform estate searches, bill estates, and file liens against the estate.

3) Motor Vehicle Accidents (MVA) and Third Party Liability (MA): Reasonable efforts will be made to bill the MVA/TPL carrier to collect any Personal Injury Protection (PIP) amounts available. Insurance claims will be processed after the PIP is exhausted. The Hospital may also file a lien against future Bodily Injury payments made by the MVA carrier to the patient if we are able to establish the name of the patient's attorney managing the claim. Claims will not be submitted to HSN until the completion of diligent efforts to collect balances from other parties are exhausted. Patients will be reminded that they have a duty to report any potential TPL claim within ten (10) days of opening a claim to the Office of

Medicaid or HSN. Any recoveries received after the submission of a claim to HSN will be offset against the original claim and reported to HSN inclusive of required voids or returns.

4) Motor Vehicle Accidents (MVA) and Third Party Liability (NH): Patients with health insurance coverage may choose to have the Hospital bill their health insurance plan. Balances billed to the patient will not be subject to any routine discounting or adjustment.

5) Workers' Compensation: A claim filed under the Workers' Compensation Act (WCA) is generally settled entirely with the WCA carrier if the coverage is valid. The Hospital will make reasonable attempts to pursue the WCA coverage including filing of legal claims. If there is no WCA coverage, then the claim is managed in the according to the standard process outlined above.

6) HSN Secondary Coverage: The Hospital will make diligent efforts to limit claims submission to HSN as a secondary carrier to those balances deemed covered by HSN, including deductibles, co-insurance, and non-covered services including those cases where a patient has exhausted their benefit or whose enrollment with the primary health insurance plan was not active at the time the services were rendered. Claims for services denied due to a technical fault with the claim or other technical denial as outlined in 101 CMR 613.03(1)(c) will not be submitted to HSN. If the Hospital receives an additional or corrected payment on a claim previously submitted to HSN then a corrected claim will be submitted to HSN.

7) Partial HSN Deductible: The Hospital will bill patients for 100% of their annual Partial HSN Deductible until charges equal to the annual deductible have been billed to the patient, inclusive of any balances included in payment plans. Claims will not be submitted to the HSN until the patient's deductible has been satisfied. This includes all satellite facilities and Hospital health centers that are operating under the Hospital's license.

8) Victims of Violent Crimes (MA): In most cases, billing to the patient will be suspended while the application for Crime Victim Compensation is pending

with the MA Attorney General. These payments are generally considered to be payments in full with no residual amounts billed to the patient.

10. BAD DEBT PLACEMENT

Once internal collection efforts have been exhausted, accounts may be written off to Bad Debt. This will typically occur after the account has completed its one hundred and twenty (120) day billing cycle with some exceptions due to Bad Address or other mitigating circumstances. Accounts in Bad Debt will generally receive additional collection effort through a number of sources including internal staff, external Collection Agencies, or collection attorneys. The Hospital will ensure that all follow-up efforts regarding Bad Debt, whether such efforts are made by internal staff or an external agency, adhere to the following:

A. CREDIT REPORTING

Generally, while the Hospital does not typically report patient Bad Debt to any credit bureau, this policy is not intended to restrict the Hospital from taking this action in specific cases or to limit the hospital from doing so in the future. The Hospital and its agents may, however, utilize the services of a credit bureau to identify the credit rating of a patient with a view to determining the patient's ability to fulfill their financial obligations.

B. LITIGATION

The Hospital and its agents may pursue litigation against a patient to secure a court judgment, for debts owed to the Hospital. In no case shall a writ of capias (known as a "body attachment" in the popular press) be used as part of a collection effort.

C. PROPERTY LIENS

The Hospital may only pursue the attachment, execution, and sale of property upon the review and approval of the Hospital's CFO. In addition, for all cases involving a patient designated by the Office of Medicaid as Low Income or qualifying for any State Program, the Hospital will not seek legal execution against the personal residence of a patient or Guarantor without the specific approval of the Hospital's Board of Trustees.

D. COLLECTION AGENCIES

Any agency seeking to collect patient balances on behalf of the Hospital will be required to conform to this Credit & Collection Policy. Any substantive patient complaints will be reported to the Hospital for review and tracking. All agents will fully comply with applicable Federal Fair Debt Collection regulations as well as debt collection regulations that may be determined by the MA Attorney General. All agencies will report any collections or other account actions, including the decision to cease collection efforts, on a timely basis. In general, agencies will cease collection efforts on any account placed with them for one (1) year that has had no action, payment or any current potential for payment.

11. CREDIT BALANCES AND REFUNDS

The Hospital will refund to patients any credit balances which may result from excess funds having been collected from the patient. In cases where efforts to refund a patient/guarantor credit balance are unsuccessful the Hospital will remit credit balances to the Treasurer of the Commonwealth of Massachusetts in accordance with the state's Abandoned Property regulations.

12. SERIOUS REPORTABLE EVENTS (SRE)

The Hospital maintains compliance with applicable billing requirements, including the Department of Public Health regulations (105 CMR 130.332) for non-payment of specific services or readmissions that the hospital determines was the result of a SRE. SREs that do not occur at the Hospital or a related entity under common ownership of the Hospital are excluded from this determination of non-payment. The Hospital also maintains all information in accordance with applicable federal and state privacy, security, and identity theft laws.

13. PATIENT RIGHTS AND RESPONSIBILITIES

A. PATIENT RIGHTS

Patients have the right to:

(1) Apply for MassHealth, Low Income Patient determination, Medical Hardship, any other applicable State Program, or a Qualified Health Plan; and

(2) A payment plan, as described in 101 CMR 613.08(1)(g), if the Patient is determined to be a Low Income Patient or qualifies for Medical Hardship.

B. PATIENT RESPONSIBILITIES

Patients have a responsibility to:

(1) Provide complete and timely insurance and demographic information, and to inform the Hospital, and the State if patient is on a State Program, of any changes in their status including, but not limited to, changes in income or insurance status.

(2) For Massachusetts residents, notify the Hospital of any potential MVA, TPL, or workers' compensation coverage.

(3) For patients covered by a State Program, file a claim for compensation, if available, with respect to any accident, injury or loss and notify the State Program (e.g., Office of Medicaid and the HSN) within ten (10) days of information related to any lawsuit or insurance claim that will cover the cost of services provided by the hospital. A patient is further required to assign the right to a third party payment that will cover the costs of the services paid by the Massachusetts Office of Medicaid or the HSN.

(4) Make reasonable efforts to understand the limits of their insurance coverage including network limitations, service coverage limitations and financial responsibilities due to limited coverage, co-payments, co-insurance and deductibles.

(5) Conform to insurance referral, pre-authorization and other medical management policies.

(6) Conform to other insurance requirements, including completion of coordination of benefits forms, updating membership information, updating physician information and other payer requirements.

C. NON-DISCRIMINATION POLICY

The Hospital will not discriminate on the basis of race, color, national origin, citizenship, alienage, religion, creed, sex, gender identity, sexual orientation, age, or disability, in its policies, or in 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 the HSN.

14. REPORTING, AUDIT AND COMPLIANCE WITH REGULATIONS

The Hospital will comply with all reporting requirements as defined by MGL c. 118G and related 101 CMR 613 and 101 CMR 614 and associated Administrative Bulletins.

The Hospital will maintain auditable records of activities made in compliance with the criteria and requirements of 101 CMR 613 and 101 CMR 614.

The Hospital will file this Credit & Collection Policy electronically with the Office of Medicaid, HSN as required when the policy is changed or when there are regulatory changes promulgated by the Office of Medicaid, HSN mandating a new policy submission.

15. OTHER APPLICABLE EMERSON HOSPITAL HEALTHCARE POLICIES:

Emerson Hospital Uninsured Patient Discount and Financial Assistance Policy

16. REFERENCE:

MA Regulations 101 CMR 613.00 et seq., 101 CMR 614 et seq.
IRS 501(r)