马萨诸塞州眼耳专科医院计费与催收政策

目录

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马萨诸塞州眼耳专科医院（“本院”）负有内建的受托人职责，针对已为无法付费患者提供的服务，向承保该患者医护费用的第三方保险业者以及患者符合其资格的其他援助计划寻求赔付。为了裁定患者是否无法支付已提供服务的费用，以及协助该名如果是没有保险或保险不足的患者找到替代的承保选项，本院遵守以下有关计费和向患者催收的标准。 在获得患者和家人的个人财务信息时，本院会按照适用的联邦和州立隐私、保安、身份盗窃等法规，保存所有信息。

A. 收集有关患者财务资源和保险承保的信息

a) 本院将和患者合作，告知他们负有提供以下关键信息的义务：
在为患者提供任何医护服务之前（为了稳定已被裁定为有急诊病情或需要紧急医护服务的患者时除外），患者有义务提供有关其当前保险状态、个人基本信息、家庭收入或团体保险承保的变更（如果有）等适时、准确的信息，以及任何有关其适用保险或财务计划的免赔额或共付额的已知信息。 每一项的详细信息应当包括，但不限于：

i) 全名、住址、电话号码、生日、社安号（如果有）、当前健康保险的承保选项、公民身份和居留信息等，以及患者可以用来支付其账单的适用财务资源：

ii)适用时，包括患者保证人的全名、其住址、电话号码、生日、社安号（如果有）、当前健康保险的承保选项、以及他们可以用来支付患者的账单的适用财务资源；和

iii) 或可用来支付其账单的其他财务资源，包括其他保险计划、汽车或屋主保单（如果治疗是因为意外导致)、工伤计划、学生保险保单、以及任何其他家庭收入，如遗产、礼物、或可用信托的分配等。

患者也有义务记录他们未付的医院账单，包括任何现有的共付额、共同保险和免赔额，并且有义务在他们需要援助以支付其部分或整个账单时，联系本院。患者还必须在家庭收入或保险状态有任何变动时，通知他们当前的健康保险业者（如果有），或是裁定该患者符合政府计划资格的州级机构。本院也可以在患者的家庭收入或保险状态有任何变动时，协助患者更新他们在政府计划中的合格身份，只要患者通知本院其合格身份有任何这类变动。

本院会和患者合作，确保他们知道他们有义务就有关家庭收入变动的任何信息，或是如果他们参与了任何可能会支付本院所提供服务的费用的保险理赔，通知医院和他们从中收到援助的适用计划（例如MassHealth (麻州医保补助)、健康联结、健康安全网、或医疗困境)。 如果有因为意外或其他事故而负责支付医护费用的第三方(例如，但不限于，住家或汽车保险），患者将和本院或适用的计划合作（包括，但不限于,MassHealth、健康联结、健康安全网)，让与收复这些服务的已付和未付金额的权利。

b) 医院的义务：
本院将尽一切合理的努力收集患者的保险和其他信息,以核实对将由本院提供的医护服务的承保。这些努力可能会发生在患者在医院某地的设施初次亲自登记接受服务时，或者也可能发生在其他时间。 此外，本院将会在提供了服务后，在发给患者或其保证人的计费发票里，通知患者可以通过可用的政府援助或医院财务援助计划获得的承保选项，包括通过 MassHealth、由健康联结运作的保费援助付款计划、儿童医疗保障计

划、健康安全网、和医疗困境计划的承保。 此外，本院还会通过政府或私人财务核实系统执行其尽职调查，以决定它是否能够指出患者对享有政府或私人保险承保的合格状态。 本院将试图在提供任何非急诊和非紧急的医护服务前，收集此类信息。本院会在患者正因急诊病情接受治疗或需要紧急医护服务期间推迟取得这些信息的努力作业。

本院的尽职调查努力将包括，但不限于，要求有关患者保险桩体的信息、查看任何可用的政府或私人保险的数据库、遵守以下计费和授权规定、以及在适当时上诉任何被拒的理赔，当部分或全部的服务应由一家已知的第三方保险公司付费，而该公司或许还应负责支付该名患者最近的医护服务费用。 当医院挂号和住院处员工被患者告知时，他们也应和患者合作，确保有关信息会被传达给适当的政府计划，例如家庭收入或保险状态的任何变动，包括可能会支付有本院所提供服务的费用的任何诉讼或保险理赔。

如果患者或保证人/监护人不能提供所需信息，并且经过患者同意,本院将做出合理的努力，联系其亲朋好友、保证人/监护人、以及/或其他适当的第三方，以取得额外信息。

本院尽合理的努力以尽职调查是否有第三方保险业者或其他资源应当负责本院所提供服务的费用应包括，但不限于,依病患裁定是否有适用的保单可支付理赔的费用，包括：(1) 汽车或屋主的责任险保单，(2) 一般意外或人身伤害保护保单,(3) 工伤计划，和(4)学生保险保单等。 如果本院能够指出一名应当承担责任的第三方，或是已经从第三方或另一来源(包括从私人保险公司或另一个政府计划）收到了付款，本院将向适用的计划报告这项付款，并且在适用时按照该计划的理赔处理要求,从任何或许已经由该第三方或其他来源支付的任何理赔中抵消它。至于已经支付了服务费用的州政府援助计划，本院不需取得患者有关第三方服务承保的权利的让与。在这些情况下，患者应当知道，适用的州计划可能会试图寻求对为患者提供服务的费用的让与。

B. 医院的计费和催收实践 4

本院设有一个统一、一致的过程，用以提交理赔和催收交给患者的理赔，不论其保险状态如何。明确地说，如果患者有一些关于已经为患者提供，但并没有政府或私人承保选项承保的服务的当前未付余款，本院将会遵守以下这些合理的催收/计费程序，包括：

a) 寄给患者或承担患者个人财务义务者的初步账单；这份初步账单将包括有关可用的财务援助（包括，但不限于 MassHealth、由健康联结运作的保费援助付款计划、儿童医疗保障计划、健康安全网、和医疗困境计划）的信息，以便于支付本院账单的费用。
b) 随后寄发的账单、电话、催收信、个人联系通知、计算机通告、或任何其他构成纯粹基于未付账单而联系应当负责者的努力，它也将包括有关患者在需要财务援助时，如何联系本院的信息；
c) 如果可能，记录有关寻找应当负责者，或是因为注明“地址错误”或“无法投递”而被邮局退回的账单的正确地址所做其他努力的文件；
d) 以保证邮件寄出一份最终通知给造成单在急诊级别的服务方面超过$1,000元的急诊坏账余额,并且没有保险的患者（没有登记加入任何计划如健康安全网或MassHealth的人），同时在邮件里通知所有患者有哪些可用的财务援助；
e) 针对从提供服务日起120天的持续计费或采取的催收行动而保存的记录文件，以便于提供适用的联邦和/或州立计划，借以核实这些努力; 以及
f) 查看马萨诸塞州的资格核实系统（EVS）以确保患者并非低收入患者，并且在向健康安全办公室申请坏账承保之前有没向 MassHealth、由健康联结运作的保费援助付款计划、儿童医疗保障计划、健康安全网、和医疗困境计划等提交承保申请。
g) 对所有登记加入政府援助计划者而言，本院只能向这些患者收取在麻州规则里概述的特定共付额、共同保险、或免赔额，并且可能会在麻州的Medicaid管理信息系统上进一步显示这些收费。

对于没有资格登记加入麻州政府援助计划的人，例如来自外州的居民但除此之外可能符合州政府援助计划的一般财务资格类别者，本院将会寻求收取指定的款项。 对于这些患者，如果基于患者的收入和其他要求条件，按照本院财务援助政策的概述，有可用的额外资源时，本院将会通知他们。

本院在患者提出要求并且基于对每位患者的财务状况所做内部审核后，也可能会按照医院本身统一适用于所有患者的内部财务援助计划，为患者提供额外的折扣或其他援助，该计划会考虑患者记录在案的财务状况和在进行合理的催收后，该患者无法付款的事实。 本院提供的任何折扣都符合联邦和州的要求，并且不会影响患者获得本院提供的服务。

C. 豁免被催收者

The following patient populations are exempt from any collection or billing procedures pursuant to state regulations and policies:Patients enrolled in a public health insurance program, including but not limited to, MassHealth, Emergency Aid to the Elderly, Disabled and Children (EAEDC); Children’s Medical Security Plan (CMSP), if MAGI income is equal to or less than 300% of the FPL; Low Income Patients as determined by MassHealth and Health Safety Net, including those with MAGI Household income or Medical Hardship Fami

ly Countable Income between 150.1 to 300% of the FPL; and Medical Hardship, subject to the following exceptions:

a) The Hospital may seek collection action against any patient enrolled in the above mentioned programs for their required co-payments and deductibles that are set forth by each specific program;
b) The Hospital may also initiate billing or collection for a patient who alleges that he or she is a participant in a financial assistance program that covers the costs of the hospital services, but fails to provide proof of such participation.Upon receipt of satisfactory proof that a patient is a participant in a financial assistance program, (including receipt or verification of signed application) the Hospital shall cease its billing or collection activities;
c) The Hospital may continue collection action on any Low Income Patient for services rendered prior to the Low Income Patient determination, provided that the current Low Income Patient status has been terminated, expired, or not otherwise identified on the state Eligibility Verification System or the Medicaid Management Information System.However, once a patient is determined eligible and enrolled in MassHealth, the Premium Assistance Payment Program Operated by the Health Connector, the Children's Medical Security Plan, or Medical Hardship, the Hospital will cease collection activity for services (with the exception of any copayments and deductibles) provided prior to the beginning of their eligibility.
d) The Hospital may seek collection action against any of the patients participating in the programs listed above for non-covered services that the patient has agreed to be responsible for, provided that the Hospital obtained the patient's prior written consent to be billed for such service(s).However, even in these circumstances, the Hospital may not bill the patient for claims related to medical errors or claims denied by the patient's primary insurer due to an administrative or billing error.

D. Extraordinary Collection Actions

a) The Hospital will not undertake any "extraordinary collection actions" until such time as the Hospital has made reasonable efforts and followed a reasonable review of the patient's financial status and other information necessary to determine eligibility for financial assistance, which will determine that a patient is entitled to financial assistance or exemption from any collection or billing activities under this credit and collection policy.The Hospital will keep any and all documentation that was used in this determination pursuant to the Hospital's applicable record retention policy.
b) The Hospital will accept and process an application for financial assistance under its financial assistance policy submitted by a patient for the entire "application period." The "application period" begins on the date care is provided and ends on the later of the 240th day after the date that the first post-discharge billing statement for the care is provided, subject to the following special additional requirements.The application period does not end before 30 days after the Hospital has provided the patient with the 30-day notice described below.In the case of a patient who the Hospital facility has

presumptively determined to be eligible for less than the most generous assistance under the financial assistance policy, the application does not end before the end of a reasonable period for the patient to apply for more generous financial assistance, as further described below.

c) Extraordinary collection actions include:

i) Selling a patient's debt to another party (except if the special requirements set forth below are met);

ii) Reporting to credit reporting agencies or credit bureaus;

iii) Deferring, denying, or requiring a payment before providing, medically necessary care because of nonpayment of one or more bills for previously covered care under the Hospital's financial assistance policy (which is considered an extraordinary collection action for the previously provided care)

iv) Actions that require legal or judicial process, including:

(1) Placing a lien on a patient's property;

(2) Foreclosing on real property;

(3) Attaching or seizing bank account or any other personal property;

(4) Commencing a civil action against a patient;

(5) Causing a patient's arrest;

(6) Causing a patient to be subject to a writ of body attachment; and

(7) Garnishing a patient's wages.

v) The Hospital will treat the sale of a patient's debt to another party as an extraordinary collection action unless the Hospital enters into a binding written agreement with the purchaser of the debt pursuant to which (i) the purchaser is prohibited from engaging in any extraordinary collection actions to obtain payment for care; (ii) the purchaser is prohibited from charging interest on the debt at a rate higher than the applicable IRS underpayment rate; (iii) the debt is returnable to or recallable by the Hospital upon a determination that the patient is eligible for financial assistance; and (iv) if the patient is determined to be eligible for financial assistance and the debt is not returned to or recalled by the Hospital, the purchaser is required to adhere procedures that ensure that the patient does not pay the purchaser more than the patient is personally responsible to pay under the financial assistance policy.

vi) Extraordinary collection actions include actions taken to obtain payment for care against any other patient who has accepted or is required to accept responsibility for the patient's Hospital bill for the care.

d) The Hospital will refrain from initiating any extraordinary collection actions against a patient for a period of at least 120 days from the date the Hospital provides the first post-discharge billing statement for the care; except that special requirements apply to deferring or denying medically necessary care because of nonpayment as described below.

e) In addition to refraining from initiating any extraordinary collection actions for the 120-day period described above, the Hospital will refrain from initiating any extraordinary collection actions for a period of at least 30 days after it has notified the patient of its financial assistance policy in the following manner:the Hospital (i) provides the patient with a written notice that indicates that financial assistance is available for eligible patie

nts, that identifies the extraordinary collection actions that the Hospital (or other authorized party) intends to initiate to obtain payment for the care, and that states a deadline after which extraordinary collection actions may be initiated that is no earlier than 30 days after the date that written notice is provided:(ii) provides the patient with a plain language summary of the financial assistance policy; and (iii) makes a reasonable effort to orally notice the patient about the financial assistance policy and how the patient may obtain assistance with the financial assistance policy application process; except that special requirements apply to deferring or denying necessary medically necessary care as described below.

f) The Hospital will meet the following special requirements in the event that it defers or denies care due to nonpayment for prior care that was eligible for financing assistance.The Hospital may provide less than the 30 days' notice described above if it provides the patient with a financial assistance application form and a written notice indicating financial assistance is available for eligible patients.The written notice will state a deadline after which the Hospital will no longer accept and process an application for financial assistance, which will be no earlier than the end of the application period or 30 days after the date the written notice is first provided.If the patient submits an application before the deadline, the Hospital will process the application on an expedited basis.

g) If a patient submits a complete or incomplete application for financial assistance under the Hospital's financial assistance policy during the application period, the Hospital will suspend any extraordinary collection actions to obtain payment for care.In such event, the Hospital will not initiate, or take further action on any previously initiated extraordinary collection actions until either (i) the Hospital has determined whether the patient is eligible for financial assistance under the financial assistance policy or (ii) in the case of an incomplete application for financial assistance, the patient has failed to respond for requests for additional information and/or documentation within a reasonable period of time.The Hospital will also take further action, depending on whether the application is complete or incomplete, as described below.

h) In the event that a patient submits a complete application for financial assistance during the application period, the Hospital will in addition make a determination as to whether the patient is eligible for financial assistance.If the Hospital determines that the patient is eligible for assistance other than free care, the Hospital will (i) provide the patient with a billing statement that indicates the amount the patient owns for the care as a patient eligible for financial assistance and states, or describes how the patient can get information regarding, the Amounts Generally Billed for the care, (ii) refund to the patient any amount that the patient paid for the care that exceeds the amount the patient is determined to be personally responsible for paying and (iii) take all reasonable measures to reverse any extraordinary collection action (with the exceptions of a sale of debt and deferring or

denying, or requiring a payment before providing, medically necessary care because of a patient's nonpayment of prior bills for previously provided care for which the patient was eligible for financial assistance) taken against the patient to obtain payment for care. Reasonable measures to reverse such an extraordinary collection action will include measures to vacate any judgment, lift any levy or lien, and removing from the patient's credit report any adverse information that was reported to a consumer reporting agency or credit bureau.

i) In the event that a patient submits an incomplete application for financial assistance during the application period, the Hospital will in addition provide the patient with written notice that describes the additional information and/or documentation required under the financial assistance policy and that includes contact information.

j) The Hospital may make presumptive determinations that a patient is eligible for financial assistance under the financial assistance policy based on information other than that provided by the patient or based on a prior determination of eligibility. In the event that a patient is determined to be eligible for less than the most generous assistance available under the financial assistance policy, the Hospital will: (i) notify the patient regarding the basis for the presumptive eligibility determination and the way to apply for more generous assistance available under the financial assistance policy; (ii) give the patient a reasonable period of time to apply for more generous assistance before initiating extraordinary collection actions to obtain the discounted amount owed; and (iii) if the patient submits a complete application seeking more generous financial assistance during the application period, determine whether the patient is eligible for the more generous discount.

k) The Hospital will not garnish a Low Income Patient's or their guarantor's wages or execute a lien on the Low Income Patient's or their guarantor's personal residence or motor vehicle unless: (1) the Hospital can show the patient or their guarantor has the ability to pay, (2) the patient/guarantor did not respond to hospital requests for information or the patient/guarantor refused to cooperate with the Hospital to seek an available financial assistance program, and (3) for purposes of the lien, it was approved by the Hospital's Board of Trustees on a patient's case by case basis.

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

m) The Hospital maintains compliance with applicable billing requirements and follows applicable state and federal requirements related to the non-payment for specific services that were the result of or directly related to a Serio

us Reportable Event (SRE), the correction of the SRE, a subsequent complicat ion arising from the SRE, or a readmission to the same hospital for services associated with the SRE.SREs that do not occur at the Hospital are excluded from this determination of non-payment as long as the treating facility and the facility responsible for the SRE do not have common ownership or a commo n corporate parent.The Hospital also does not seek payment from a Low Income Patient through the Health Safety Net program whose claims were initially de nied by an insurance program due to an administrative billing error by the H ospital.

E. Outside Collection Agencies

The Hospital may contract with an outside collection agency to assist in the colle ction of certain accounts, including patient responsible amounts not resolved afte r 120 days of continuous collection actions.The Hospital may also enter into bindi ng contracts with outside collection agencies.Any such contract permitting the sal e of debt that is not treated as an extraordinary collection action will meet the requirements described above.In all other cases, if the Hospital sells or refers a patient’s debt to another party, the agreement with the other party will be reaso nably designed to ensure that no extraordinary collection actions are taken until reasonable efforts have been made to determine whether the patient is eligible for financial assistance, including the following:(i) if a patient submits an applicat ion before the end of the application period, the party will suspend extraordinary collection actions; (ii) if the patient submits an application for financial assis tance before the end of the application period and is determined to be eligible fo r financial assistance, the party will adhere to procedures to ensure that the pat ient does not pay the party and the Hospital together more than the patient is req uired to pay under the financial assistance policy and to reverse any extraordinar y collection actions; and (iii) if the party refers or sells the debt to another p arty, the party will obtain a written agreement meeting all of the foregoing requi rements.All outside collection agencies hired by the Hospital will provide the pat ient with an opportunity to file a grievance and will forward to the Hospital the results of such patient grievances.The Hospital requires that any outside collecti on agency that it uses is operating in compliance with federal and state fair debt collection requirements.

F. Deposits and Installment Plans

Pursuant to the Massachusetts Health Safety Net regulations pertaining to patients that are either:(1) determined to be a “Low Income Patient” or (2) qualify for M edical Hardship, the Hospital will provide the patient with information on deposit s and payment plans based on the patient’s documented financial situation.Any oth er plan will be based on the Hospital’s own internal financial assistance progra m, and will not apply to patients who have the ability to pay.

a) Emergency Services

A hospital may not require pre-admission and/or pre-treatment deposits from patients that require Emergency Level Services or that are determined to be Low Income Patients.

b) Low Income Patient Deposits

A hospital may request a deposit from patients determined to be Low Income Patients.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 in 101 CMR 613.08(1)(g).

c) Deposits for Medical Hardship Patients

A hospital may request a deposit from patients eligible for Medical Hardship.Deposits will be limited to 20% of the Medical Hardship contribution up to $1,000.All remaining balances will be subject to the payment plan conditions established in 101 CMR 613.08(1)(g).

d) Payment Plans for Low Income Patients pursuant to the Massachusetts Health Safety Net Program

A patient with a balance of $1,000 or less, after initial deposit, must be offered at least a one-year payment plan interest free with a minimum monthly payment of no more than $25.A patient that has a balance of more than $1,000, after initial deposit, must be offered at least a two-year interest free payment plan.

e) CommonHealth One-Time Deductible

At the request of the patient, the Hospital may bill a Low Income Patient in order to allow the Patient to meet the required CommonHealth One-time Deductible

f) Payment Plans for HSN Partial Low Income Patients pursuant to the Massachusetts Health Safety Net Program, for services rendered in a Hospital Licensed Site

The Hospital also offers the Health Safety Net Partial Low Income Patient a co-insurance plan, that allows the patient to pay 20% of the Health Safety Net payment for each visit until the patient meets their annual deductible.The remaining balance will be written off to the Health Safety Net.Those sites include:

- Boston (Main Campus) - 243 Charles Street Boston, MA 02114
- Mass Eye and Ear Braintree - 250 Pond Street, 1st Floor Braintree, MA 02184
- Mass Eye and Ear Concord - 54 Baker Street Extension, Suite #303 Concord, MA 01742
- Mass Eye and Ear East Bridgewater - One Compass Way, Suite #100 East Bridgewater, MA 02333
- Mass Eye and Ear Longwood - 800 Huntington Avenue Boston, MA 02115
- Mass Eye and Ear Quincy - 500 Congress Street, Suite #1C Quincy, MA 02169

- Mass Eye and Ear Plainville - 30 Man Mar Drive, Suite #2 Plainville, MA 0276 2
- Mass Eye and Ear Stoneham - One Montvale Avenue, 5th floor Stoneham, MA 0218 0