Hebrew Rehabilitation Center Billing and Collections Policy

Hebrew Rehabilitation Center (HRC) has an internal fiduciary duty to seek reimbursement for services it has provided to patients who are able to pay, from responsible third party insurers who cover the patient's cost of care, and from other programs of assistance for which the patient is eligible. To determine whether a patient is able to pay for the services provided as well as to assist the patient in finding alternative coverage options if they are uninsured or underinsured, the hospital adheres to the following criteria related to billing and collecting from patients. In obtaining patient and family personal financial information, the hospital maintains all information in accordance with applicable federal and state privacy, security, and ID theft laws. HRC does not discriminate on the basis of race, color, national origin, citizenship, alienage, religion, creed, sex, sexual orientation, gender identity, age or disability in its policies or in its application of policies concerning the acquisition and verification of financial information pre-admission or pre-treatment deposits, payment plans, deferred or rejected admissions, Low Income Patient status as determined by the Massachusetts Office of Medicaid, determination that a patient is low-income, or in its billing and collection practices.

This Billing and Collections Policy applies to Hebrew Rehabilitation Center and any entity that is part of the hospital's license.

Pre Admission Collecting Information on Patient Financial Resources and Insurance Coverage

Prior to admission HRC strives to counsel prospective patients (and/or their representatives, guarantors, and family members) regarding the HRC services they will receive, and the insurance coverage and private pay expectations for those services. HRC services may be fully or only partly covered by insurance, and there may be significant private pay liability. Patients and families are counseled on what Medicare covers, what Medicaid (called MassHealth in Massachusetts) covers, and what is expected to be paid from available private funds. For services that can be covered by MassHealth, the counseling includes a full detailed explanation of the requirements to qualify for MassHealth, and how MassHealth calculates the ongoing monthly Patient Paid Amount (PPA) based on the patient's income (such as Social Security, pensions, annuities, and investment income).

The detailed information for each item should include, but not be limited to:

i) Full name, address, telephone number, date of birth, social security number (if available), current health insurance coverage options, citizenship and residency information, and the patient's applicable financial resources that may be used to pay their bill;

ii) If applicable, the full name of the patient's guarantor, their address, telephone number, date of birth, social security number (if available), current health insurance coverage options, and their applicable financial resources that may be used to pay for the patient's bill; and

iii) Other resources that may be used to pay their bill, including other insurance programs, motor vehicle or homeowners insurance policies if the treatment was due to an accident, worker's

compensation programs, student insurance policies, and any other family income such as an inheritances, gifts, or distributions from an available trust, among others.

HRC will advise the patient that they have a duty to keep track of their unpaid hospital bills, including any existing co-payments, co-insurance, and deductibles, and contacting the hospital should they need assistance in paying for some or their entire bill. The hospital will advise the patient of their requirement to inform either their current health insurer (if they have one) or the state agency that determined the patient's eligibility status in a public program of any changes in family income or insurance status.

HRC will work with the patient to ensure they are aware of their duty to notify the hospital and the applicable program in which they are receiving assistance (e.g., MassHealth), of any information related to a change in family income, or if they are part of an insurance claim that may cover the cost of the services provided by the hospital. If there is a third party (such as, but not limited to, home or auto insurance) that is responsible to cover the cost of care due to an accident or other incident, the patient will work with the hospital or applicable program (including, but not limited to, MassHealth) to assign the right to recover the paid or unpaid amount for such services to secure assignment on a patient's right to third party coverage of services. In these cases, the patient should be aware that the applicable state program may attempt to seek assignment on the costs of the services provided to the patient.

Insurance Coverage by Medical Service:

For short term inpatient care that is deemed medically necessary, most insurance policies will provide some level of coverage. At HRC those services are:

The Rehabilitative Services Unit (RSU) – at Roslindale and NewBridge locations – is typically a covered service when skilled nursing level of care is required. Services on the RSU are generally covered by:

Medicare Part A Skilled Nursing Benefit - when the patient has a qualifying hospital stay, has SNF benefit days left in the benefit period, and meets level of care requirements. Note that daily coinsurance may apply. See Medicare.gov for more information on Medicare coverage.

Commercial and managed care plans when the care is specifically authorized in advance by the plan.

Private Pay

Please note that Hebrew Rehabilitation Center does not have a contract with MassHealth (Medicaid) for the RSU units. Medicare coinsurance, when the patient has MassHealth as supplementary coverage, is not honored by MassHealth and is therefore a private liability.

The Medical Acute Care Unit (MACU) – for complex medical care when hospital level of care is required. Services on the MACU are generally covered by:

Medicare Part A Hospital Benefit - when the Medicare A eligible beneficiary has hospital

benefit days left in the benefit period, or chooses to use lifetime reserve days, and meets level of care requirements. Note that daily coinsurance may apply. See Medicare.gov for more information on Medicare coverage.

Commercial, managed care and Medicaid cover care in the MACU if the care is specifically authorized in advance.

Long-term Chronic Care (LTC) service is considered custodial, not skilled, and is not covered by Medicare A or commercial and managed care plans.

Payment options for Long-term Chronic Care services are private pay funds, and MassHealth (Medicaid) once eligible, meaning private assets have been spent down. When receiving Long-term Chronic Care services, Medicare Part D, Medicare Part B, and supplemental plans may cover certain HRC services such as MD visits, prescription drugs, physical therapy, labs, and radiology services. If a Long-term Chronic Care patient does not have these insurance coverage in place, some or all of those ancillary services are an additional private liability, until such time as the patient becomes covered by MassHealth.

Regulations for MassHealth eligibility and coverage are complex and the application process can be lengthy and time consuming. HRC Fiscal Services staff may directly assist with the application, or often HRC will refer a patient/family to obtain the services of an outside service, a reputable and expert Medicaid eligibility consultant, to assist with the application process until coverage is obtained. If the patient has funds to pay for the outside service consultant as part of spending down towards MassHealth eligibility, patient funds will typically pay the fee for this service (an allowable cost in a MassHealth spenddown). HRC will work with the patient and family to ensure the process goes smoothly and that coverage is obtained.

Financial counseling regarding financial assistance program begins at the time of inquiry and initial meetings and interviews. HRC's application package and website include information on contacting financial services staff. Financial assistance policy is posted in the admissions registration and outpatient clinic areas. Phone numbers are on the statements and patients are invited to call with any concerns or questions. A financial questionnaire is sent periodically to the patient's financial representative to update their financial status and ensure that financial assistance planning starts early so that the process goes smoothly.

Hospital Billing and Collection Practices

HRC has a uniform and consistent process for submitting and collecting claims submitted to patients, regardless of their insurance status. Specifically, if the patient has a current unpaid balance that is related to services provided to the patient and not covered by a public or private coverage option, the hospital will follow the following reasonable billing/collection procedures, which include:

a) An initial bill sent to the patient or the party responsible for the patient's personal financial obligations;

b) Subsequent billings, telephone calls, collection letters, personal contact notices, computer

notifications, or any other notification method that constitutes a genuine effort to contact the party responsible for the unpaid bill, which will also include information on how the patient can contact the hospital if they need financial assistance;

c) If possible, documentation of alternative efforts to locate the party responsible for the obligation or the correct address on billings returned by the postal service such as "incorrect address" or "undeliverable;"

d) Documentation of continuous billing or collection action undertaken for 120 days from the first billing statement for care is maintained and available to the applicable federal and/or state program to verify these efforts; and

e) Checking the Massachusetts Eligibility Verification System (EVS) to ensure that the patient is not a Low Income Patient and has not submitted an application for coverage for either MassHealth, the premium assistance payment program operated by the Health Connector, the Children's Medical Security Program, Health Safety Net, or Medical Hardship, prior to submitting claims to the Health Safety Net Office for bad debt coverage.

f) For all patients who are enrolled in a public assistance program, HRC will only bill those patients for the specific co-payment, co-insurance, or deductible that is outlined in the applicable state regulations and which may further be indicated on the state Medicaid Management Information System.

HRC, when requested by the patient and based on an internal review of each patient's financial status, may also offer a patient an additional discount or other assistance following its own internal financial assistance program that is applied on a uniform basis to patients, and which takes into consideration the patient's documented financial situation and the patient's inability to make a payment after reasonable collection actions. Any discount that is provided by the hospital is consistent with federal and state requirements, and does not influence a patient to receive services from the hospital.

Populations Exempt from Collection Activities

The following patient populations are exempt from any billing or collection procedures pursuant to state regulations and policies: Patients enrolled in a public health insurance program, including but not limited to, MassHealth subject to the following exceptions:

a) HRC 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) HRC 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) HRC shall cease its billing or collection activities;

c) HRC 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, HRC will cease collection activity for services beginning with the eligibility date.

d) HRC 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, HRC will 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.

e) At the request of the patient, HRC may bill a Low Income Patient in order to allow the Patient to meet the required CommonHealth one-time deductible as described in 130 CMR 506.009.

Extraordinary Collection Actions

a) HRC will not undertake any "extraordinary collection actions" until such time as it 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 billing or collection activities under this credit and collection policy. HRC will keep any and all documentation that was used in this determination pursuant to the hospital's applicable record retention policy.

b) HRC 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 has been 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) Reporting to credit reporting agencies or credit bureaus;

ii) 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)

iii) 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 a 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.

d) HRC 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 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, HRC 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 patients, 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 verbally notify 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) HRC 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 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, HRC 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. HRC 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, HRC will 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 owes 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) 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) HRC 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) HRC 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) HRC and its agents shall not continue billing or collection 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) HRC 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 Serious Reportable Event (SRE), the correction of the SRE, a subsequent

complication 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 common corporate parent. The hospital also does not seek payment from a Low Income Patient through the Health Safety Net program whose claims were initially denied by an insurance program due to an administrative billing error by the hospital.