

**DANA-FARBER CANCER INSTITUTE  
PATIENT CARE AND ADMINISTRATIVE POLICY MANUAL**

**CREDIT AND COLLECTION POLICY  
GENERAL POLICY OF DANA-FARBER CANCER INSTITUTE**

Revised October 2020

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## 1. Introduction

Dana-Farber Cancer Institute (“the Institute”) accepts Patients for treatment without discrimination on the basis of race, color, national origin and citizenship, religion, creed, sex and sexual preference, gender identity, age or disability. This is true in the Institute’s policies, and in its application of policies, concerning the acquisition and verification of financial information, pre-admission or pretreatment deposits, payment plans, deferred or rejected admissions, as well as Low Income Patient status as determined by the Massachusetts MassHealth/Eligibility system, or attestation of information to determine Low Income status.

## 2. Purpose

It is the Institute’s 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 Institute follows the following criteria related to billing and collecting from Patients. In obtaining Patient and family personal financial information, the Institute maintains all information in accordance with applicable federal and state privacy, security, and ID theft laws.

This Credit and Collection policy is developed to ensure compliance with applicable criteria required under (1) the Health Safety Net Eligible Services Regulation (101 CMR 613.00), (2) the Centers for Medicare and Medicaid Services Medicare Bad Debt Requirements (42 CFR 413.89), (3) The Medicare Provider Reimbursement Manual (Part 1, Chapter 3), and (4) 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) and the Treasury Regulations thereunder (Treas. Reg. Sec. 1.501(r)-1 through -7).

## 3. Scope

This policy applies to all eligible patients receiving medically necessary services at DFCI. DFCI considers all inpatient and outpatient services billed by DFCI to be medically necessary and therefore covers those services under this policy. Medically necessary services include those that are reasonably expected to prevent, diagnose, prevent the worsening of, alleviate, correct or cure conditions that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a disability, or result in illness or infirmity. Medically necessary services include inpatient and outpatient services as authorized under Title XIX of the Social Security Act. The following services are excluded from the Credit and Collection Policy: Retail Pharmacy, Friends’ Place, Leonard P. Zakim Center for Integrative Therapies, and Telegenetics.

DFCI’s Credit and Collection policy covers medically necessary services rendered in the DFCI Outpatient Hospital Locations and the DFCI Inpatient Hospital, including the following DFCI locations:

- Dana-Farber Cancer Institute (main campus)
- Dana-Farber Cancer Institute at Londonderry
- Dana-Farber Cancer Institute at Milford
- Dana-Farber Cancer Institute at Merrimack Valley
- Dana-Farber Cancer Institute at Brighton
- Dana-Farber Cancer Institute at Weymouth
- Dana-Farber Cancer Institute at Whittier Street Health Center
- Dana-Farber Cancer Institute Mobile Mammography Service Van
- Dana-Farber Cancer Institute - Chestnut Hill (Opening January 2021)

## 4. Policy

**A. Collecting Information on Patient Financial Resources and Insurance Coverage**

- 1) The Institute will work with the Patient to advise them of their duty to provide key information. Prior to the delivery of any health care services (except for services that are provided to stabilize a Patient determined to have an emergency medical condition or needing urgent care services), the Patient has a responsibility to provide timely and accurate information regarding their current insurance status, demographic information, changes to their family income or group policy coverage (if any), and, if known, information on deductibles or co-payments that are required by their applicable insurance or financial program. The detailed information for each item should include, but not be limited to:
  - a) 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;
  - b) 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
  - c) Other resources that may be used to pay their bill, including other insurance programs, motor vehicle or homeowner's 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 inheritance, gifts, or distributions from an available trust, among others.
- 2) The Patient also has a duty to keep track of their unpaid Institute bill, including any existing co-payments, co-insurance, and deductibles, and to contact the Institute should they need assistance in paying for some or their entire bill. The Patient is further required 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. The Institute may also assist the Patient with updating their eligibility in a public program when there are any changes in family income or insurance status, provided that the Patient informs the Institute of any such changes in the Patient's eligibility status.

The Institute will work with the Patient to ensure they are aware of their duty to notify the Institute and the applicable program in which they are receiving assistance (e.g., MassHealth, Connector, Health Safety Net, or Medical Hardship), 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 Institute. 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 Institute or applicable program (including, but not limited to, MassHealth, Connector, or Health Safety Net) to assign the right to recover the paid or unpaid amount for such services.

- 3) A Low Income Patient must assign to the MassHealth agency his or her rights to third-party payments for medical benefits provided under the Health Safety Net and must fully cooperate with and provide the MassHealth agency with information to help pursue any source of third-party payment. A Low Income Patient must inform the Health Safety Net Office or MassHealth when he or she is involved in an accident or suffers from an illness or injury, or other loss that has resulted or may result in a lawsuit or insurance claim, other than a Medical insurance claim. The Low Income Patient must:
  - a) File an insurance claim for compensation if available;
  - b) Assign to the MassHealth agency or its agent, the right to recover an amount equal to the Health Safety Net benefits provided from the proceeds of any claim or other proceeding against a third-party;
  - c) Provide information about the claim or any other proceeding and cooperate fully with the MassHealth agency, unless the MassHealth agency determines that cooperation would not be in the best interests of, or would result in serious harm or emotional impairment to, the Low Income Patient;
  - d) Notify the Health Safety Net Office or MassHealth in writing within 10 days of filing any claim, civil action or other proceeding; and

- e) Repay the Health Safety Net Office from the money received from a third-party for all Health Safety Net services provided on or after the date of the accident or other incident. If the Low Income Patient is involved in an accident or other incident after becoming Health Safety Net eligible, repayment will be limited to Health Safety Net services provided as a result of the accident or incident.
- 4) The Institute is obligated to make all reasonable and diligent efforts to collect the Patient's insurance and demographic information to verify coverage for the health care services to be provided by the Institute. These efforts may occur during the Patient's initial in-person registration at Dana-Farber Cancer Institute, or may occur at other times through Patient Accounting or Access Management. As of 15 February 1997, Dana-Farber Cancer Institute's inpatient care is located at our Inpatient Hospital within Brigham and Women's Hospital. Patient's insurance and demographic information may also be collected through the Emergency, Admitting, Clinical Services, and Patient Accounting departments of Brigham and Women's Hospital.
- 5) In addition, the Institute will notify the Patient about the availability of coverage options through the Institute's Patient Financial Assistance (PFA) Program and available public assistance, including coverage through MassHealth, the premium assistance payment program operated by the Health Connector, the Children's Medical Security Program, Health Safety Net, or Medical Hardship. Patients who receive direct financial assistance under the PFA are receiving uncompensated care as defined under the cost reporting instructions for Worksheet S-10 (Medicare Provider Reimbursement Manual, Part 2, Chapter 40, Form CMS 2552-10 § 4012). Notification of direct financial assistance will be included in the billing invoices that are sent to the Patient or the Patient's guarantor following delivery of services and posted in the following location:
  - a) Central Registration on Yawkey 2
  - b) Pediatric Registration on Dana 3
  - c) Registration Offices at the Massachusetts-based Satellite locations

The posted signs are clearly visible and legible to Patients visiting these areas. The posted signs are size 8.5" by 11", and read (30-point font size, in English and Spanish to accommodate our Patients): "Financial counseling is available to assist Patients in applying for DFCI Financial Assistance, Massachusetts Medicaid, and Health Safety Net. If you think you may be eligible for these programs or would like more information about these programs, please contact the Institute's Financial Counselor's Office at (617) 632-3455."

- 6) Dana-Farber's Certified Financial Counselors, available by telephone at (617) 632-3455 or in person on the 2nd floor of the Yawkey Building on Main Campus, will assist uninsured or underinsured Patients with applying for available financial assistance, including the Dana-Farber Patient Financial Assistance program. Patients may access this policy and other financial assistance information at [www.dana-farber.org/PFA](http://www.dana-farber.org/PFA). Financial Counselors are also available to help Patients complete and submit state sponsored program application(s) using the Health Insurance Exchange system or submitting to the Massachusetts Executive Office of Health and Human Services for processing.
  - a) The Institute also assists Patients in securing the necessary documentation required by the applicable financial assistance program. Necessary documentation includes 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 over 65 years of age.
  - b) In special circumstances, the Institute may apply, on behalf of a Patient, for eligibility in the Health Safety Net program using a specific form designed by the Massachusetts Division of Health Care Finance and policy. Special circumstances include individuals seeking financial assistance coverage due to being incarcerated, victims of spousal abuse, or those applying due to a Medical Hardship.

- c) The Institute will also notify Patients about payment plans that may be available to them, as well as how to contact the appropriate staff within the Institute to verify the accuracy of the Institute bill or to dispute certain charges.
- 7) Further, the Institute will also perform its due diligence through existing public or private financial verification systems to determine if it is able to identify the Patient's eligibility status for public or private insurance coverage. The Institute will attempt to collect such information prior to the delivery of any non-emergent and non-urgent health care services.
- a) Dana-Farber Cancer Institute does not have an Emergency Department nor the ability to treat most emergency medical conditions. Patients who present at the Institute with an emergent care need are generally directed to the Emergency Department of the closest Acute Care Hospital, although consistent with federal law, the Institute will provide the care for emergency medical conditions that it is required to provide under Subchapter G of Chapter IV of Title 42 of the Code of Federal Regulations (or any successor regulations). The Institute will delay any attempt to obtain this information while a Patient is being treated for an emergency medical condition or needed urgent care services. Determination of treatment based on medical conditions is made, by the examining physician or other qualified medical personnel of the Institute as documented in the medical record, according to the following definitions:
    - i) Emergent Care includes medically necessary services provided after the sudden onset of a medical condition, whether physical or mental, manifesting itself by acute symptoms of sufficient severity including severe pain, which a prudent layperson would reasonably believe is an immediate threat to life or has a high risk of serious damage to the individual's health. Conditions include, but are not limited to, those that may result in jeopardizing the Patient's health, serious impairment to bodily function, serious dysfunction of any bodily organ or part, or active labor in women. A medical screening examination and treatment for emergency medical conditions or any other such care rendered to the extent required pursuant to EMTALA (42 USC 1395 (dd)) qualifies as Emergency Care. In accordance with federal requirements, EMTALA is triggered for anyone who comes to the Institute requesting examination or treatment of an emergency level service (emergency medical condition). Most commonly, unscheduled persons present themselves at the emergency department. However, unscheduled persons requesting services for an emergency medical condition while presenting at another inpatient unit, clinic, or other ancillary area may also be subject to an emergency medical screening examination in accordance with EMTALA. Examination and treatment for emergency medical conditions or any such other service rendered to the extent required under EMTALA, will be provided to the Patient and will qualify as emergency care.
    - ii) Urgent Care Services include medically necessary services provided in an Acute Hospital or Community Health Center after the 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 24 hours could reasonably expect to result in placing a Patient's health in jeopardy, impairment to bodily function, or dysfunction of any bodily organ or part. Urgent Care 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. Urgent Care Services do not include Primary or Elective Care.
    - iii) Non-Emergent, Non-Urgent Care includes all services that do not qualify as Emergent or Urgent Care services based on the assessment of the examining physician or other qualified medical personnel of the Institute.
  - b) The Institute will provide Emergent and Urgent care without regard to the Patient's identification, insurance coverage, or ability to pay for services in accordance with the requirements of Dana-Farber Cancer Institute's policy. In all of its Patient care activities, the

- Institute shall remain in compliance with federal regulations such as Title 42 Chapter 7 USC 1395(dd) and The Balanced Budget Act of 1998 (Public Law No. 105-33).
- c) The Institute may decline to provide a Patient with Non-Emergent, Non-Urgent Care in those cases when the Institute is not successful in determining that payment will be made for its services. Services that are determined to be non-medically necessary may be deferred indefinitely until suitable payment arrangements can be made. These include but are not limited to: cosmetic surgery as well as non-medical services, such as social, educational, and vocational services.
  - 8) For Non-Emergent and Non-Urgent Care, the Institute's due diligence to collect Patient and demographic information will include, but is not limited to, requesting information about the Patient's insurance status, checking any available public or private insurance databases, following the billing and authorization rules, and as appropriate appealing any denied claim when the service is payable in whole or in part by a known third-party insurance company that may be responsible for the costs of the Patient's recent healthcare services. High-risk Patients, such as self-pay Patients and Patients with out of state insurance, are required to speak with a Financial Counselor to discuss coverage and/or payment options prior to Non-Emergent, Non-Urgent Care services being rendered. Financial Counselors will also work with the Patient to ensure that relevant information, such as changes to family income or insurance status (including any lawsuit or insurance claim that may cover the cost of the services provided by the Institute), is communicated to the appropriate public programs. If the Patient or guarantor/guardian is unable to provide the information needed, and the Patient consents, the Institute will make reasonable efforts to contact relatives, friends, guarantor/guardian, and/or other appropriate third parties for additional information.
  - 9) The Institute's reasonable due diligence efforts to investigate whether a third-party insurance or other resource may be responsible for the cost of services provided by the Institute shall include, but not be limited to, determining from the Patient if there is an applicable policy to cover the cost of the claims, including: (1) motor vehicle or home owner's liability policy, (2) general accident or personal injury protection policy, (3) worker's compensation programs, and (4) student insurance policies, among others. If the Institute is able to identify a liable third-party or has received a payment from a third-party or another resource (including from a private insurer or another public program), the Institute will report the payment to the applicable program and offset it, if applicable per the program's claims processing requirements, against any claim that may have been paid by the third-party or other resource. For state public assistance programs that have actually paid for the cost of services, the Institute is not required 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.

#### B. Institute Billing and Collection Practices

The Institute 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 Institute will follow the below reasonable collection/billing procedures, which include:

- 1) An initial itemized bill sent to the Patient or the party responsible for the Patient's personal financial obligations; the initial bill will include information about the availability of financial assistance to cover the cost of the Institute's bill;
- 2) 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 Institute if they need financial assistance;
- 3) 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;"

- 4) Delivery of a final notice by certified mail for uninsured Patients (those who are not enrolled in a program such as the Health Safety Net or MassHealth) who incur an emergency bad debt balance over \$1,000 on Emergency Level Services only, where notices have not been returned as “incorrect address” or “undeliverable,” as well as notifying the Patients of the availability of financial assistance in the communication;
- 5) Documentation of continuous billing or collection action undertaken for 120 days from the date of the service is maintained and available to the applicable federal and/or state program to verify these efforts;
- 6) 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; and
- 7) The Institute’s Self-Pay discount policy is developed for those Patients who are uninsured. A 25% discount will be applied to all inpatient and outpatient self-pay charges, with the exception of Retail Pharmacy, Friends’ Place, Leonard P. Zakim Center for Integrative Therapies, and Telegenetics

For all Patients who are enrolled in a public assistance program, the Institute may 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.

Patients that do not qualify for enrollment in a Massachusetts state public assistance program, such as out-of-state residents, may otherwise meet the general financial eligibility categories of a state public assistance program. The Institute will notify the Patient if such additional resources are available based on the Patient’s income and other criteria, as outlined in the Institute’s Patient Financial Assistance policy.

Patients eligible for DFCI’s PFA program (both Direct Financial Assistance and assistance under the Health Safety Net) will not be charged more than the AGB. DFCI determines AGB on an annual basis using the “look-back method,” described under Treasury Regulation Section 1.501(r)- 5(b)(3). Specifically, DFCI’s annual AGB percentage is equal to the sum of amounts paid by Medicare fee-for-service, Medicaid and all private health insurers on claims divided by the sum of all gross charges for those claims during the prior fiscal year. Pursuant to this calculation, DFCI’s AGB will always be less than the maximum amount permitted to be charged under state and federal law. DFCI’s Finance Department will determine the current AGB percentage, and DFCI will begin applying the current AGB percentage, within 120 days of the end of each fiscal year. The current AGB percentage and a written description of how the AGB percentage was calculated can be obtained, in writing and free of charge, by contacting Customer Service at 866-408-4669; billing prompt #1 or visiting [www.dana-farber.org/PFA](http://www.dana-farber.org/PFA).

The Institute, when requested by the Patient and based on an internal review of each Patient’s financial status, may also offer a Patient a discount under its own internal Patient Financial Assistance policy. Discounts are applied on a uniform basis to Patients and take into consideration the Patient’s documented financial situation and the Patient’s inability to make a payment. Any discount that is provided by the Institute is consistent with federal and state requirements, and does not influence a Patient to receive services from the Institute.

### C. Populations Exempt from Collection Activities

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, Health Safety Net (including partial), Emergency Aid to the Elderly, Disabled and Children (EAEDC); Children’s Medical Security Plan (CMSP), if Modified Adjusted Gross Income (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 Family Countable Income between 150.1 and 300% of the FPL; and Medical Hardship, subject to the following exceptions:

- 1) The Institute 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;
- 2) The Institute 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 Institute 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 Institute shall cease its billing or collection activities;
- 3) The Institute 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 Institute will cease collection activity for services (with the exception of any copayments and deductibles) provided prior to the beginning of their eligibility.
- 4) The Institute 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 Institute obtained the Patient's prior written consent to be billed for such service(s). However, even in these circumstances, the Institute 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.
- 5) If a Patient submits a complete or incomplete application for financial assistance under the Institute's Patient Financial Assistance program during the application period, the Institute will suspend any extraordinary collection actions to obtain payment for care. In such event, the Institute will not initiate, or take further action on any previously initiated extraordinary collection actions until either (i) the Institute has determined whether the Patient is eligible for financial assistance under the Patient Financial Assistance policy or (ii) in the case of an incomplete application for financial assistance, the Patient has failed to respond to requests for additional information and/or documentation within a reasonable period of time.
- 6) At the request of the Patient, the Institute 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.
- 7) The Institute will assist the Patient in the collection of all application 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 Institute is required to submit applications to HSN within 5 days of receiving all documentation and verification from the Patient.

#### D. Standard Collection Actions

- 1) The Institute will not undertake any "extraordinary collection actions," as defined in Treas. Reg. Sec. 1.501(r)-6(b)(1) or any successor provision, until such time as the Institute 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 Institute will keep any and all documentation that was used in this determination pursuant to the Institute's applicable record retention policy. Final determination as to whether reasonable efforts have been taken will be made by the Institute's Chief Financial Officer.
- 2) The Institute will accept and process an application for financial assistance under its Patient 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 240<sup>th</sup> day after the date that the first post-discharge billing statement for the care is provided. This is subject to the special additional requirement that the application period does not end before 30 days after the Institute has provided the Patient with the 30-day notice described below.
- 3) The Institute reserves the right to use any of the following extraordinary collection actions:

- a) Selling a Patient's debt to another party (except if the special requirements set forth below are met);
  - b) Reporting to credit reporting agencies or credit bureaus;
  - c) 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 Institute's Patient Financial Assistance policy (which is considered an extraordinary collection action for the previously provided care)
  - d) Actions that require legal or judicial process, including:
    - i. Placing a lien on a Patient's property;
    - ii. Foreclosing on real property;
    - iii. Attaching or seizing bank account or any other personal property;
    - iv. Commencing a civil action against a Patient;
    - v. Causing a Patient's arrest;
    - vi. Causing a Patient to be subject to a writ of body attachment; and
    - vii. Garnishing a Patient's wages.
- 4) 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.
  - 5) The Institute will refrain from initiating any extraordinary collection actions against a Patient for a period of at least 120 days from the date the Institute 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.
  - 6) In addition to refraining from initiating any extraordinary collection actions for the 120-day period described above, the Institute will refrain from initiating any extraordinary collection actions for a period of at least 30 days after it has notified the Patient of its Patient Financial Assistance policy in the following manner: the Institute (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 Institute (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 Patient Financial Assistance policy; and (iii) makes a reasonable effort to orally notify the Patient about the Patient Financial Assistance policy and how the Patient may obtain assistance with the Patient Financial Assistance policy application process; except the special requirements that apply to deferring or denying necessary medically necessary care as described below.
  - 7) The Institute 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 Institute 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 Institute will no longer accept and process an application for financial assistance, which will be no earlier than the later of 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 Institute will process the application on an expedited basis.
  - 8) As mentioned previously, if a Patient submits a complete or incomplete application for the Institute's Patient Financial Assistance policy during the application period, the Institute will suspend any

extraordinary collection actions to obtain payment for care. The Institute will also take further action depending on whether the application is complete or incomplete, as described below.

- a) In the event that a Patient submits a complete application for financial assistance during the application period, the Institute will make an eligibility determination. If the Institute determines that the Patient is eligible for assistance other than free care, the Institute will:
    - i) Provide the Patient with a billing statement indicating the amount due on account of the Patient being determined to be eligible for financial assistance and describing how to obtain information regarding the Amounts Generally Billed for the care;
    - ii) Refund any amount that the Patient paid for the care that exceeds the determined amount for which the Patient is responsible; and
    - iii) Take all reasonable measures to reverse any extraordinary collection action taken against the Patient to obtain payment for care.
  - b) In the event that a Patient submits an incomplete application for financial assistance during the application period, the Institute will provide the Patient with written notice that describes the additional information and/or documentation required under the Patient Financial Assistance policy, including contact information.
- 9) The Institute 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 Institute can show the Patient or their guarantor has the ability to pay, (2) the Patient/guarantor did not respond to Institute requests for information or the Patient/guarantor refused to cooperate with the Institute to seek an available financial assistance program, and (3) for purposes of the lien, it was approved by the Institute's Board of Trustees on a Patient's case by case basis.
- 10) The Institute 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 Institute 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 Institute's own internal financial assistance program.
- 11) The Institute 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 Institute 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 Institute 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 Institute.

#### E. Outside Collection Agencies

The Institute may contract with an outside collection agency to assist in the collection of certain accounts, including Patient responsible amounts not resolved after 120 days of continuous collection actions. The Institute may also enter into binding contracts with outside collection agencies. Any such contract permitting the sale of debt that is not treated as an extraordinary collection action will meet the requirements described above. In all other cases, if the Institute sells or refers a Patient's debt to another party, the agreement with the other party will 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:

- 1) If a Patient submits an application before the end of the application period, the party will suspend extraordinary collection actions;
- 2) If the Patient submits an application for financial assistance before the end of the application period and is determined to be eligible for financial assistance, the party will adhere to procedures to ensure that the

- Patient does not pay the party and the Institute together more than the Patient is required to pay under the Patient Financial Assistance policy and to reverse any extraordinary collection actions; and
- 3) If the party refers or sells the debt to another party, the party will obtain a written agreement meeting all of the foregoing requirements. All outside collection agencies hired by the Institute will provide the Patient with an opportunity to file a grievance and will forward to the Institute the results of such Patient grievances. The Institute requires that any outside collection agency that it uses is operating in compliance with federal and state fair debt collection requirements.

#### F. Deposits and Installment Plans

The Institute will seek a deposit from those Patients that do not qualify for enrollment in a Massachusetts state public assistance program, such as out-of-state residents, but who may otherwise meet the general financial eligibility categories of a state public assistance program.

The Institute may require a deposit based on the follow internal criteria:

- 1) For non-bone marrow transplant Patients, International self-pay Patients are required to make a 100% minimum deposit of estimated charges for initial treatment plan. Domestic self-pay Patients are required to make a minimum deposit of 25% of the estimated charges prior to the date of service.
- 2) Self-pay bone marrow transplant Patients will be required to make a minimum deposit of 50% of the estimated bone marrow transplant charges once the transplant process is initiated. The Patient will be required to pay the balance of the estimated charges seven days prior to the actual transplant date.
- 3) Deposits will not be collected from Patients who have applied for Massachusetts public assistance and/or financial assistance while the application is pending a decision.
- 4) The Institute will seek the specified deposits for those Patients that do not qualify for enrollment in a Massachusetts state public assistance program, such as out-of-state residents.
- 5) The Institute will not require pre-admission and/or pretreatment deposits from individuals that require Emergency Care.
- 6) The Institute may request a deposit from individuals determined to be Low Income Patients. Such deposits must be limited to 20% of the deductible amount, up to \$500. This is also applicable to the Institute's satellites when collecting the Patient liability for partial Health Safety Net coverage; including both inpatient and outpatient services. All remaining balances are subject to the payment plan conditions established in 101 CMR 613.08(1)(f)2.
- 7) The Institute 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)(f)3.
- 8) An individual 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 \$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

Policy Name:	Credit and Collection Policy – General Policy of Dana-Farber Cancer Institute
Policy Number:	9.13
Contact Dept/Title:	Finance, V.P.
Sponsor:	Melissa Shore, V.P.
Content Experts:	Sr. Director, Patient Financial Services
Approved By:	<p>Approved: Finance, 7/2014, 9/2016, 11/2016            Policy Review Team 9/2016            Michael Reney 11/2016, 5/2017, 9/2020            Executive Committee of the Board of Trustees            9/2016</p> <p>Revised: Finance, 9/2016, 11/2016, 5/2017, 9/2020</p> <p>Reviewed: Policy Review Team, 7/2014, 9/2016</p>

## 5. Glossary

### Health Connector:

Commonwealth Health Insurance Connector Authority or Health Connector or Connector established pursuant to M.G.L. c. 176Q. § 2

### HealthCare Services:

Institute level services (provided in either an inpatient or outpatient setting) that is reasonably expected to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity.

### Low Income Patient:

An individual who meets the criteria under 101 CMR 613.04(1).

### Massachusetts Resident:

A person living in Massachusetts with the intention to remain permanently or for an indefinite period. A resident is not required to maintain a fixed address. Enrollment in a Massachusetts institution of higher learning or confinement in a Massachusetts medical institution, other than a nursing facility, is not sufficient to establish residence

### MassHealth MAGI Household:

A household as defined in 130 CMR 506.002: MassHealth MAGI Household Composition.

### Medical Hardship:

A Massachusetts Resident at any income level may qualify for Medical Hardship if Allowable Medical Expenses have so depleted his or her family's income that he or she is unable to pay for Eligible Services. A determination of Medical Hardship is a one-time determination and not an ongoing eligibility category. An applicant may submit only two Medical Hardship applications within a twelve-month period. An individual who meets the criteria under 101 CMR 613.05.

### State Public Assistance Programs include:

- A. Children's Medical Security Plan: health insurance for uninsured Massachusetts residents under 19 and do not qualify for MassHealth.
- B. Commonwealth Care: health insurance for Low Income Massachusetts residents who don't have health insurance.
- C. Commonwealth Choice: a health insurance program for uninsured adult Massachusetts residents that do not qualify for MassHealth
- D. Health Safety Net: a program for Massachusetts residents who are not eligible for health insurance or can't afford to pay for healthcare services.
- E. Insurance Partnership: provide health insurance for uninsured employees as well as self-employed workers.
- F. MassHealth: public health insurance program for Low Income Massachusetts residents that covers all or a part of the healthcare services.
- G. Prescription Advantage: prescription drug insurance plan for seniors and disabled residents for primary prescription drug coverage.

### Virtual Gateway:

Internet portal designed by the Massachusetts Executive Office of Health and Human Services to provide the general public, medical providers, and community-based organizations with an online application for the programs offered by the state.

6. Attachments and Exhibits [*For copies of the exhibits listed below, please contact Customer Service by calling 866-408-4669; billing prompt #1.*]

- A. Sample of assistance notice on billing invoice
- B. Sample of Eligible Services and programs of assistance notice on back of billing invoice
- C. Sample of assistance notice in collection actions (billing invoices)
- D. Sample of payment plan notice to Low Income or Medical Hardship Patients
- E. Sample of currently posted signs
- F. Dana-Farber's Mammography Van locations
- G. Provider affiliate listing
- H. Patient Financial Assistance policy