



LAWRENCE GENERAL HOSPITAL

CREDIT & COLLECTION POLICY

Lawrence General Hospital Credit and Collection Policy

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Introduction

Purpose:

This Credit and Collection policy applies to Lawrence General Hospital (“the Hospital”) and specific locations and providers as identified in this policy.

The Hospital is the front line caregiver providing medically necessary care for all people regardless of ability to pay. The Hospital offers this care for *all* patients that come to our facility 24 hours a day, seven days a week and 365 days a year. As a result, the Hospital is committed to providing all of our patients with high-quality care and services. As part of this commitment, the Hospital works with individuals with limited incomes and resources to find available options to cover the cost of healthcare.

Mission Statement:

- To operate and maintain the acute care general hospital.
- Provide appropriate Hospital and other related health services to all patients regardless of race, color, national origin, citizenship, alienage, religion, creed, sex, sexual orientation, gender identity, age or disability.
- Provide access to medically necessary services to area residents regardless of ability to pay.
- Assure the ongoing process of continuously improving patient care quality delivered by skilled and caring health care professionals.
- Maintain and support health science education related to acute hospital services.
- Promote and support scientific research, related to the sick and injured.

General Principles:

- Fear of a hospital bill should never get in the way of patients receiving essential health services. Hospital personnel will communicate to patients regarding their ability to access medically necessary care and the availability of financial assistance.
- Financial assistance is intended to assist low-income patients who do not otherwise have the ability to pay for their healthcare services.
- The Hospital’s financial assistance policies are consistent with its mission and values and takes into account each individual’s ability to contribute to the cost of his or her care and the Hospital’s ability to provide this care.
- Financial assistance policies do not eliminate personal responsibility. Patients may or may not qualify for financial assistance from public programs. They may be expected to contribute to the cost of their care based upon their ability to pay.
- These policies are communicated in a clear and easy to understand manner.

Policy:

The Hospital 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 services provided as well as assist the patient in finding alternative coverage options if they are uninsured or underinsured, the Hospital follows the following criteria related to billing and collections 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. It is important to note that while the Federal and State government uses different names for policies that the hospital must follow to show how they are providing financial assistance to patients; the overall requirements are the same. As a result, this policy is designed to comply with both the State Health Safety Net regulations on “Credit and Collection Policies” and the Federal Health Care Reform Law’s “Financial Assistance Policy” requirements as recently clarified by the Internal Revenue Service in their February 23, 2011 instructions to the Form 990.

The hospital 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 credit and collection policy is developed to ensure compliance with applicable criteria required under (1) the Health Safety Net Eligibility Regulation (101 CMR 613.00 13.00), (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 as recently in the February 28, 2011 IRS clarification to reporting such information in the hospital IRS 990 returns.

The Hospital’s Credit and Collection policy covers the following locations where patients can also obtain information on the availability of public assistance programs:

LGH Hospital

Main Campus, 1 General Street, Lawrence, MA 01841

- Andover Medical Center, 323 Lowell Street, Andover, MA 01810
- 25 Marston Street, Lawrence, MA 01841
- 140 Haverhill Street, Andover, MA 01810
- YMCA, 165 Haverhill Street, Andover, MA 01810

Community Medical Associates – physician practices located at:

- Marston Medical Building, 25 Marston Street, Lawrence, MA 01841
- Doctors Park II, 138 Haverhill Street, Andover, MA 01841
- YMCA, 165 Haverhill Street, Andover, MA 01810

The Hospital’s Financial Assistance Programs are available on the Hospital’s website:

- ***lawrencegeneral.org***

The Hospital will electronically file a copy of its Credit and Collection Policy with the Health Safety Net Office as required by 101 CMR 613.00 formerly 114.6 CMR 13.08(l)(c).

I. Delivery of Health Care

Services

General Principle

The Hospital evaluates the delivery of health care services for all patients who present for services regardless of their ability to pay. However, non-emergent or non-urgent health care services (i.e., elective or primary services) may be delayed or deferred based on the consultation with the hospital's clinical staff and, if necessary and, if available, the patient's primary care provider. The hospital may decline to provide a patient with non-emergent, non-urgent services in those cases when the Hospital is unable to identify a payment source or eligibility in a financial assistance program. Such programs include MassHealth, Connector Care, Children's Medical Security Plan, Health Safety Net, or Medical Hardship. Choices related to delivery and access to care is often defined in either the insurance carrier's or the financial assistance program's coverage manual.

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

For those patients that are uninsured or underinsured, the hospital will work with patients to assist with finding a financial assistance program that may cover some or all of their unpaid hospital bill(s). For those patients with private insurance, the hospital must work through the patient and the insurer to determine what may be covered under the patient's insurance policy. As the hospital is often not able to get this information from the insurer in a timely manner, it is the patient's obligation to know what services will be covered prior to seeking non-emergency level and non-urgent care services.

Determination of treatment based on medical conditions is made according to the following definitions:

A. Emergent and Urgent Care Services Includes:

The Hospital will provide emergent and urgent services without regard to the patient's identification, insurance coverage or ability to pay. The evaluation of emergent or urgent care services as defined below is further used by the Hospital for purposes of determining allowable emergency and urgent bad debt coverage under the Health Safety Net Fund.

i. Emergent Services Includes:

Medically necessary services provided after the onset of a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in placing the health of the person or another person in serious jeopardy, serious impairment to body functions or serious dysfunction of any body organ or part or with respect to a pregnant woman, as further defined in section 1867 (e) (1) (B) of the Social Security Act 42 U.S.C. § 129 Sdd(e) (1) (B). A medical screening examination and any subsequent treatment for an existing emergency medical conditions or any other such service rendered to the extent required pursuant to the federal EMTALA (42 USC 139S (dd) qualities as an Emergency Level Service.

ii. Urgent Services 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) that a prudent layperson would believe that the absence of medical attention within 24 hours could reasonable expect to result in: placing the patient's health in jeopardy, impairment to bodily function, or dysfunction of any bodily organ or part. Urgent care services do not include elective or primary care.

iii. EMTALA Level Requirements:

In accordance with federal requirements, EMTALA is triggered for anyone who comes to the Hospital property requesting examination or treatment of an emergency level services (emergency medical condition) or who enters the emergency department requesting examination or treatment for a medical condition. Most commonly, unscheduled person 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. The determination that there is an emergency medical condition is made by the examining physician or other qualified medical personnel of the Hospital as documented in the medical record. The determination that there is urgent or primary medical condition is also made by the examining physician or other qualified medical personnel of the Hospital as documented in the medical record.

B. Non-Emergent, Non-Urgent Services:

For patients who either (1) arrive to the Hospital seeking non-emergent or non-urgent level care or (2) seek additional care following stabilization of an emergency medical condition, the hospital may provide elective services after consulting with the Hospital's clinical staff and reviewing the patient's coverage options.

- i. Elective Services:** Medically necessary services that do not meet the definition of Emergent or Urgent above. Typically, these services are either primary cares services or medical procedures scheduled in advance by the patient or by the healthcare provider (hospital, physician office, other).
- ii.** The Hospital may decline to provide a patient with non-emergent services in those cases when the Hospital 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 until suitable payment arrangements can be made.

C. Locations where Patients May Present for Services

All patients are able to seek emergency level and urgent care services when they come to the Hospital emergency department or designated urgent care areas. However, patients with emergent and urgent conditions may also present in a variety of other locations, including but not limited to labor and delivery, ancillary departments, hospital clinics and other areas. The Hospital also provides other elective services at the main facility, clinics, and other outpatient locations.

D. Collection and Verification of Patient Information

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

i. Emergent and Urgent Services

Registration and intake of emergent and urgent patients will be performed in accordance with requirements of EMTALA. Patient demographic and insurance information should be collected as soon as possible, however the collection of information should be deferred, when the collection of this information may delay medical screening or negatively impact the patient's clinical condition. When a patient is unable to provide demographic or insurance information at the time of service and the patient consents, every effort should be made to interview relatives or friends that may accompany or be otherwise identified by the patient. Every effort should be made to verify insurance information provided by the patient with the payer via EDI (electronic data interchange).

ii. Non-Emergent, Non-Urgent Services

Registration and intake of non-emergent, non-urgent patients should be performed prior to services being rendered. Every effort should be made to verify insurance information provided by the patient with the payer via EDI (electronic data interchange).

II. Documenting Eligibility for Financial Assistance Programs

A. General Principles

Financial assistance is intended to assist low income patients who do not otherwise have the ability to pay for their health care services. Such assistance takes into account each individual's ability to contribute to the cost of his or her care. For those patients that are uninsured or underinsured, the Hospital will work with them to assist with applying for available financial assistance programs that may cover all or some of their unpaid hospital bills. The Hospital provides this assistance for both residents and non-residents of Massachusetts; however, there may not be coverage in a state public assistance program for Massachusetts hospital's services for out-of-state residents. In order for the Hospital to assist uninsured and underinsured patients find the most appropriate coverage options, as well as determine if the patient is financially eligible for any discounts in payments, patients must actively work with the Hospital to verify the patient's documented family income, other insurance coverage and any other information that could be used in determining eligibility.

B. Hospital Screening and Eligibility Approval Process

The Hospital provides patients with information about financial assistance programs that are available through the Commonwealth of Massachusetts or through the Hospital's own financial assistance program, which may cover all or some of their unpaid hospital bill. For those patients requesting such assistance, the Hospital assists patients by screening them for eligibility in an available public programs and assisting them in applying for the program. These programs include, but are not limited to: MassHealth, Connector Care, Children's Medical Security Plan, Health Safety Net, and others. When applicable, the hospital may also assist patients in applying for coverage of services as a Medical Hardship based on the patient's documented family income, current and prior insurance coverage, and allowable medical expenses.

Patient's Responsibility:

It is the patient's obligation to provide the Hospital with accurate and timely information regarding their full name, address, date of birth, social security number (if available), telephone number, current health insurance coverage options, including any other insurance or coverage options (like motor vehicle policy, worker's compensation policy) that can cover the cost of the care received, and other applicable financial resources, and citizenship and residency information. This information will be used to determine coverage for the services provided to the patient. If there is no specific coverage for the services provided, the Hospital will use the information to determine if the services may be covered by an applicable program that will cover certain services deemed bad debt. In addition, the Hospital will use this information to discuss eligibility for certain health insurance programs. If the patient or guarantor is unable to provide the necessary information, the Hospital may (at the patient's request) make reasonable efforts to obtain any additional information from other sources. This will occur when the patient is scheduling their services, during pre-

registration, while the patient is admitted in the hospital, upon discharge, or for a reasonable time

following discharge from the hospital.

Information that the Hospital obtains will be maintained in accordance with applicable federal and state privacy and security laws.

C. Application Process

The screening and application process for public health insurance programs is done through either the Massachusetts Health Connector or through a standard paper application that is completed by the patient and also submitted directly to the Massachusetts Executive Office of Health and Human Services for processing. The Massachusetts Executive Office of Health and Human Services solely manages the application process for the programs listed above, which is available for children, adults, seniors, veterans, homeless, and disabled individuals.

In special circumstances, the hospital may apply for the patient for eligibility in the Health Safety Net program using a specific form designed by the Massachusetts Health Safety Net Office. Special circumstances include individuals seeking financial assistance coverage due to being incarcerated, victims of spousal abuse, or applying due to a medical hardship.

The Hospital specifically assists the patient in completing the Massachusetts Executive Office of Health and Human Services standard application and securing the necessary documentation to the Massachusetts Office of Medicaid and assists the patient in securing any additional documentation if such is requested by the state after completing the application. Massachusetts places a three day time limitation on submitting all necessary documentation following the submission of the application for a program. Following this three day period, the patient and the provider must work with the Mass Health Enrollment Centers to secure the additional documentation needed for enrollment in the applicable financial assistance program.

All Massachusetts Health Connector and paper applications are reviewed and processed by the Massachusetts Office of Medicaid, which uses the Federal Poverty Guidelines, asset information as well as necessary documentation listed above as the basis for determining eligibility for state sponsored public assistance programs. The eligibility for enrollment into the Health Safety Net program for full and partial Health Safety Net coverage is also determined through the Massachusetts Health Connector. The Hospital will also assist other patients such as minors receiving confidential services or individuals who have been battered or abused, obtain coverage through the Health Safety Net by using the Special Circumstance Application. A copy of the federal poverty guidelines that are used by the state is attached to this policy. Hospitals have no role in the determination of program eligibility made by the State, but at the patient's request may take a direct role in applying or seeking information related to the coverage decisions. It is the patient's responsibility to inform the Hospital of all coverage decisions made by the state to ensure accurate and timely adjudication of all hospital bills.

D. Future Programs

As future coverage options are developed, as discussed in both federal and state healthcare reform proposals, the Hospital will make appropriate changes to this credit and collection policy.

III. Determination of Patient Financial Responsibility

A. General Principles

The Hospital will make reasonable efforts to determine the patient's financial responsibility as reasonably possible during the patient's course of care. Where feasible, the Hospital will collect patient responsible balances, such as co-pays, deductibles, co-insurance amounts, or required deposits prior to any service delivery. Patients who are members of managed care health plans, or insurance plans with specific access requirements are responsible for understanding and complying with their insurance plan requirements, such as referrals, authorizations and other network restrictions. Under some circumstances, including Emergent and Urgent care services; these referral and authorizations may take

place after service delivery. All patients who are expected to incur a balance for services will be

informed of the availability of financial counseling services to assist them in meeting their financial responsibility to the Hospital. Screening consistent with EMTALA will be completed prior to activities to determine the patient's financial responsibility.

B. Insured Patients

The Hospital will make reasonable efforts to verify the patient's insurance status and assist the patient in complying with the requirements of their insurance plan. Whenever possible, this verification will include a determination of the patient's expected financial responsibility, including applicable co-insurance, deductibles, and co-payments. When feasible and clinically appropriate, payment of any predetermined amounts (co-payments, fixed deductibles) will be secured from the patient at time of registration. Patients who are unable to provide payment may be referred to Financial Counseling.

a. Contracted Insurance Plans:

The Hospital contracts with a number of insurance plans. In those cases, the hospital will seek payment from the insurance plan for all covered services. If a particular service is determined by the insurer to be non-covered or otherwise rejected for payment, then payment for that service will be sought directly from the patient in accordance with the relevant insurance contract. Whenever possible, the Hospital will assist the patient in appealing denials or other adverse judgments with their insurance plan recognizing that the insurance plan often requires these appeals to be made by the patient.

b. Non-Contracted Insurance Plans:

The Hospital will extend the courtesy of billing a patient's insurance company in those cases the Hospital does not have a contract with an insurer. While the Hospital will bill the patient's insurance plan, ultimate financial responsibility rests with the patient or guarantor. The insurer's failure to respond to the Hospital bill in a timely manner may result in the patient being billed directly for the services. Balances remaining after any insurance payment will be billed to the patient. Whenever possible, the Hospital will assist the patient in appealing denials or other adverse judgments with their insurance plan recognizing that the insurance plan often requires these appeals to be made by the patient.

c. Uninsured Patients

Patients who do not have health insurance, and have not been previously determined to be a "Low Income Patient" qualifying for the Health Safety Net (HSN), will be asked to provide a deposit in advance of services not required to be performed by EMTALA. The deposit will be equal to 100% of the estimated charges for the service to be provided, less any discount. In those cases where a precise estimate of the charges is not possible, the hospital may collect a pre-determined deposit amount or otherwise secure guarantees of payment. If the patient does not provide the deposit or indicates an inability to pay the deposit, then the patient may be referred to Financial Counseling. Uninsured Massachusetts's residents will be offered Financial Counseling to determine their eligibility for any of the available financial assistance programs as well as assisting the patient to apply for the program via the Commonwealth of Massachusetts Health Connector. These programs include, but are not limited to MassHealth, Connector Care, Children's Medical Security Plan, Health Safety Net, and others. If there is no immediate need to provide services, the admission or outpatient service may be deferred until such time as the patient is able to pay, make suitable financial arrangements, obtain insurance or become enrolled in a financial assistance program that will cover the service.

C. Low Income Patients – Health Safety Net Eligible

a. Eligibility:

A patient's eligibility status for coverage under the Health Safety Net will be verified at time of registration using the MassHealth Eligibility Verification System (EVS), NEHEN, or other hospital registration systems, as applicable, and any changes to the patient's status will be noted in the record.

b. Service Limitations:

Patients who are identified as a Low Income Patient according to the applicable Health and Human Services regulations 101 CMR 613.00 will, to the extent possible, be provided services consistent with the coverage guidelines of the Health Safety Net including “Eligible Service” limitations under State regulations.

D. Full Health Safety Net Primary

- a. A resident of the Commonwealth of Massachusetts who is uninsured and documents Mass Health MAGI Household income or Medical Hardship Family Countable Income as described in 101 CMR 613.04(4)(a)1 , between 0%-300% of the FPL subject to the following exceptions:
- b. Low Income Patients eligible for enrollment in the Premium Assistance Payment Program Operated by the Health Connector are not eligible for Health Safety Net - Primary except as provided in 101 CMR 613.01 (5) (a) through (c). The Health Safety Net does not pay copayments for this program.
- c. Students subject to the Qualifying Student Health Plan requirement of M.G.L 15, § 18 are not eligible for Health Safety- Primary.

E. Health Safety Net Secondary

A Massachusetts resident is eligible for Health Safety net- Secondary if he or she has other primary health insurance and documents MassHealth MAGI Household income or Medical Hardship Family Countable Income, as described in 101 CMR 613.04(4)(a)2 between 0-300% of the FPL, subject to the following exceptions:

- 1.) Low Income Patients enrolled in the Premium Assistance Payment Program Operated by the Health Connector are eligible only for dental services not otherwise covered by the Premium Assistance Payment Program Operated by the Health Connector after the date that coverage begins.
- 2.) For MassHealth members enrolled in Mass Health Standard, MassHealth CarePlus, CommonHealth, and Family Assistance excluding Mass Health Family Assistance- Children are eligible only for Adult Dental Services provided at a Community Health Center, Hospital Licensed Health Center, or other Satellite Clinic that are not covered by MassHealth.
- 3.) Low Income Patients enrolled in a qualifying Student Health Plan are eligible for Health Safety Net – Secondary. Health Safety Net will pay only for deductibles, coinsurance, and reimbursable health services not covered by the insurer.
- 4.) For MassHealth members enrolled in MassHealth Limited, EAEDC, CMSP, CMSP plus Limited, and for MassHealth Family Assistance-Children, the Health Safety Net pays only for reimbursable health services not covered by the member’s MassHealth benefit.
- 5.) Other Requirements:

a. Affordable Insurance:

An individual with MassHealth MAGI Household income or Medical Hardship Family Countable Income, as described in 101 CMR 613.01 (1) less than or equal to 400% of the FPL, and for whom insurance is deemed affordable as defined in 956 CMR 6.00: Determining Affordability for the Individual Mandate is not eligible for Health Safety Net- Primary. If such an individual’s employer offers employer-sponsored insurance, he or she is not eligible for Health Safety Net- Primary except during the employer’s waiting period before the employer-sponsored insurance becomes effective.

b. Pending Disability Determination:

Providers may submit claims for individuals whose MassHealth eligibility is determined eligible for MassHealth, the Provider must void Health Safety Net claims for the individual and submit claims for services to MassHealth.

F. Health Safety Net - Partial

A resident of the Commonwealth of Massachusetts eligible for either Health Safety Net –Primary or Health Safety Net-Secondary whose MassHealth MAGI Household income or Medical Hardship Family Countable Income, as described in 101 CMR 613.04 (1) between 150.1% to 300% of the Federal Poverty Level (FPL) is considered Health Safety Net- Partial and must meet the Health Safety Net- Partial Deductible as described in 101 CMR 613.04(4)(a)2 and 101 CMR 613.04(6)(c).

G. Health Safety Net- Partial Deductibles

For HSN- Partial patients with MAGI Household income or Medical Hardship Family Countable income between 150.1% to 300% of the FPL, there is an annual deductible if all members of the PBFG have an FPL above 150.1%. If any member of the PBFG has an FPL below 150.1% there is no deductible for any member of the PBFG. 40% of the difference between the lowest Mass Health MAGI household income or Medical Hardship Family Countable Income as described in 101 CMR 613.01 (1) in the applicant’s Premium Billing Family Group (PBFG) and 200% of the FPL. The patient is responsible for payment for all services provided up to this deductible amount. There is only one deductible per PBFG during the eligibility period. Each PBFG must be determined a Low Income Patient in order for his or her expenses for Reimbursable Health Services to be applied to the deductible. If more than one PBFG member is determined to be a Low Income Patient, or if the patient or PBFG members receive services from more than one provider, it is the patient’s responsibility to track the deductible and provide documentation to the Hospital that the deductible has been reached.

H. Medical Hardship

- a. Eligibility:** A resident of the Commonwealth of Massachusetts at any Countable income level may qualify for Medical Hardship if allowable medical expenses have so depleted his or her Countable income that he or she is unable to pay for Health services. Per regulations, this is a one-time determination and not an ongoing eligibility category (101 CMR 613.05(1)(a)).
- b. Application Process:** The Hospital will assist the patient in the collection of all applicable information and will submit the Medical Hardship application along with required documentation to the Health Safety Net Office within 5 business days for approval.
- c. Allowable Medical Expenses:** A Massachusetts resident at any Countable Income level may qualify for Medical Hardship if Allowable Medical Expenses have so depleted his or her Countable Income that he or she is unable to pay for Health Services. (101 CMR 613.05(1)(a) (1)). Allowable medical expenses may include only Medical Hardship family medical bills from any health care Provider that, if paid, would qualify as deductible medical expenses for federal income tax purposes. Allowable medical expenses include paid and unpaid bills for which the patient is responsible up to 12 months prior to the date of the Medical Hardship application. If the Health Safety Net Office approves two Medical Hardship applications during a 12- month period, it will prorate the required contribution amounts. (101 CMR 613.05)
- d. Determination:** The Health Safety Net Office notifies applicants of the determination. The Health Safety Net Office will determine the patient's qualification for the program and will notify the hospital as to which bills are the patient’s responsibilities and which bills may be submitted to the Health Safety Net under 101 CMR 613.05(2). Determination of Medical Hardship is limited to those bills that were included with the application. Bills included in a Medical Hardship determination will not be included in a subsequent Medical Hardship application. To be eligible for payment any such service, the Hospital must submit claims to the Health Safety Net within 18 months of the date of service.

I. Low Income Patient Financial Responsibility:

a. Cost Sharing Requirements:

Low Income Patients are responsible for paying co-payments in accordance with 101 CMR 613.04 (6)(b) and deductibles in accordance with 101 CMR 613.04(6)(c).

b. Deposits:

- 1.) A Provider may not require preadmission and/or pretreatment deposits from individuals that require Emergency Services or that are determined to be Low Income Patients.
- 2.) A Provider 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. All remaining balances are subject to the payment plan conditions established in 101 CMR 613.08(1) (f)
- 3.) A Provider may request a deposit from patients eligible for Medical Hardship. Deposits are limited to 20% of the Medical Hardship contribution up to \$1,000.00 All remaining balances are subject to the payment plan conditions established in 101 CMR 613.08(1)(f).

c. Payment Plans:

A Provider may request a deposit from Patients eligible for Medical Hardship. Deposits are limited to 20% of the Medical Hardship contribution up to \$1,000. All remaining balances are subject to the payment plan conditions established in 101 CMR 613.08(1)(f). A patient with a balance of \$1,000 or less, after initial deposit, must be offered at least a one-year, interest-free payment plan with a minimum monthly payment of no more than \$25.00. A patient with a balance of more than \$1,000 after initial deposit, must be offered at least a two-year, interest-free payment plan.

d. Deductible Tracking:

The annual deductible is applied to all reimbursable Health services provided to a Low Income Patient or PBFM during the eligibility period. Each PBFM member must be determined a Low Income Patient in order for his or her expenses for reimbursable health services to be applied to the deductible. The Hospital will track the patient's reimbursable health service to be applied to the deductible. If more than one PBFM member is determined to be a Low Income Patient, or if the patient or PBFM members receive services from more than one Provider, it is the patient's responsibility to track the deductible and provide documentation to the Hospital that the deductible has been reached.

e. Pending Determinations:

Patients for whom the Hospital has submitted a Massachusetts Health Connector application will be processed as Self Pay until MassHealth has made a determination.

IV. Notice of Availability of Financial Assistance and Other Coverage Options

A. General Principles

For those patients who are uninsured or underinsured the Hospital will work with them to assist with applying for available financial assistance programs that may cover some or all of their unpaid hospital bills. In order to help uninsured and underinsured patients find available and appropriate financial assistance programs, the Hospital will provide patients with a general notice of the availability of programs in both the bills that are sent to patients as well as general notices posted throughout the hospital.

The goal of these notices is to assist patients in applying for coverage within a financial assistance program, such as MassHealth, Connector Care, Children's Medical Security Plan and Health Safety Net. When applicable, the Hospital may also assist patients in applying for coverage of services such as a Medical Hardship based on the patient's documented income and allowable medical expenses. The Hospital will provide, upon request, specific information about the eligibility process to be a

Low Income Patient under either the Massachusetts Health Safety Net Program or additional assistance for patients who are low income through the Hospital's own financial assistance program. The Hospital will also notify the patient about available payment plans that may be available to them based on their family size and income.

B. Role of Hospital Patient Financial Counselors and Other Finance Staff

The Hospital will make reasonable efforts to identify available coverage options for patients who may be uninsured and underinsured with their current insurance program when the patient is scheduling their services, while the patient is in the Hospital, upon discharge, and for a reasonable time following discharge from the Hospital. The Hospital registration and admission staff will direct all patients seeking available coverage options, or financial assistance to the Hospital's Patient Financial Counseling office to determine if they are eligible and then to screen for eligibility in an appropriate coverage option. The Hospital will then assist the patient in applying for the appropriate coverage options that are available or notify them of the availability of financial assistance through the Hospital's own internal financial assistance program. The Hospital will also provide information on how to contact appropriate staff within the Hospital's finance office to verify the accuracy of the Hospital bill or to dispute certain charges.

Application for Programs

The Hospital will assist patients in the completion of all required applications for MassHealth and/or Low Income Patient determination in accordance with the current regulations. This may include:

- i. Completion of an Affordable Care Act application (ACA)
- ii. Completion of a Medical Hardship application.

C. Approval of Coverage

The Office of Medicaid is responsible for adjudication of applications for MassHealth and other Low Income Patient designations. This may include determination for coverage by the Health Safety Net or the Connector. The Office of Medicaid will issue all notices of eligibility.

D. Grievance Process

An individual may request that the Office review a determination of Low Income Patient status, or of Provider compliance with the provisions of 101CMR613.00. The Health Safety Net will conduct a review using the following process:

- a) The individual must send a written complaint to the Office with supporting documentation. To request review of a determination, the individual must send the review request within 30 days from the date the applicant received the official notification of determination. If the Office requests additional information it must be submitted within 30 days.
- b) The Office will issue a written decision and explanation of the reasons for its decision to the grievant and other relevant parties within 30 days of the receipt of all necessary information.

E. Notification Practices

The Hospital will post a notice (signs) of availability of financial assistance in the following locations:

- Service Delivery Areas (e.g., Inpatient, clinic, emergency department and/or waiting areas);
- Patient financial counselor areas;
- Central admission/registration areas; and /or
- Business office area that is open to patients.

Posted signs will be clearly visible and legible to patients visiting these areas. All signs and notices

shall be translated into languages other than English if 10% or more of the population residing in the Hospital's service area speaks such language. Currently the Hospital translates the notices into the following languages: English and Spanish. The Hospital will also include a notice about the availability of financial assistance in all initial bills.

When the patient contacts the hospital, the hospital finance staff will attempt to identify if a patient qualifies for a public financial assistance program or a payment plan. A patient who is enrolled in a public financial assistance program (e.g. MassHealth or the Health Safety Net) may qualify for certain plans.

Patients may also qualify for additional assistance based on the hospital's own internal criteria for financial assistance, or qualify for coverage of services as a Medical Hardship based on the patient's documented income and allowable medical expenses.

For cases where the hospital is using the ACA application, the hospital will assist the patient in completing the application for Mass Health, Connector Care, Children's Medical Security Plan, Health Safety Net, Medical Hardship or other forms of financial assistance programs as they become part of the Massachusetts Health Connector program.

V. Hospital Billing and Collection Practices

General Principles

The Hospital 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. The Hospital has a fiduciary duty to seek reimbursement for services it has provided from individuals who are able to pay, from third party insurers who cover the cost of care, and from other assistance programs 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 follows the following criteria related to billing and collecting from patients.

A. Collecting Information on Patient Financial Resources and Insurance Coverage

a. Patient Obligations:

The Hospital will work with the patient to advise them of their duty to provide the following 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 duty to provide timely and accurate information on their demographic information, current insurance status, changes in their family income or insurance status, information on any deductibles, or co-payments that are owed based on their existing insurance or financial program payment obligations. The detailed information for each item should include:

- 1) 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.
- 2) 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.
- 3) Other resources that may be used to pay their bill, including other insurance programs, such as 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 inheritances, gifts, or distributions from an available trust, among others.

The patient has a duty for keeping track of their unpaid hospital bill, 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 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 health insurance program of any changes in family income or insurance status. The Hospital may also assist the patient with updating their eligibility in a public program when there are changes in Family Income or insurance status, but only if the Hospital is made aware by the patient of facts that may indicate a change in the patient's eligibility status.

The hospital will work with the patient to ensure they are aware of their duty to notify the applicable public program in which they are enrolled (e.g., Office of Medicaid, 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 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, Connector, or Health Safety Net) to assign the right to recover the paid and unpaid amount for such services.

A Low Income Patient must:

- 1) File an insurance claim for compensation, if available.
- 2) Assign to the Health Safety Net office, 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.
- 3) Provide information about the claim or any other proceeding and cooperate fully with the Office, unless the Office determines that cooperation would not be in the best interest of, or would result in serious harm or emotional impairment to, the applicant or member.
- 4) Notify the Office or MassHealth in writing within 10 days of filing any claim, civil action or other proceeding.
- 5) Repay the Office from 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 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.

b. Hospital Obligations:

The Hospital will make all reasonable and diligent efforts to collect the patient's insurance and other information to verify coverage for the health care services to be provided by the Hospital. These efforts may occur when the patient is scheduling their services, during pre-registration, while the patient is admitted in the hospital, upon discharge, or during the collection process which may occur for a reasonable time following discharge from the hospital. In addition, the Hospital will notify the patient about the availability of coverage options through an available public assistance or hospital financial assistance program, 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, in billing invoices that are sent to the patient or the patient's guarantor following delivery of services. This information will be obtained prior to the delivery of any non-emergent and non-urgent health care services (i.e., elective procedures as defined in this credit and collection policy). The hospital will delay any attempt to obtain this information while the patient is being treated for an emergency medical condition or needed urgent care services.

The Hospital's due diligence efforts 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. For many patients coverage determinations are made by either asking for a copy of the patient's insurance card or checking the MassHealth Eligibility Verification System (EVS) for coverage under an applicable public program.

When Hospital registration or admission staff are made aware of any such information, they shall also inform the patients or their duty to inform the appropriate public assistance programs of any changes to family income, insurance status, other resources that may be used to pay for the patient's bill (such as Motor Vehicle, Homeowners, Workers Compensation or Student Insurance).

The Hospital will submit claims to all insurers with the insurer's designated service code for the service provided.

The Hospital will appeal any denied claim when the service is payable in whole or part by a known third party insurance company that may be responsible for the costs of the patient's recent health services. an insurer and return any payment received from MassHealth when any available 3rd party resource has been identified.

If the patient or guarantor/guardian is unable to provide the information needed, and the patient consents, the Hospital will make reasonable efforts to contact relatives, friends, guarantor/guardian, and/or third parties for additional information. This may occur when the patient is scheduling their services, during pre-registration, while admitted to the hospital, upon discharge, or for a reasonable time following discharge from the Hospital.

c) Motor Vehicle Accidents and Third Party Liability Claims

The Hospital will also make reasonable and diligent efforts to investigate whether a third party resource may be responsible for the services provided by the Hospital, including but not limited to: (1) a motor vehicle or home owner's liability policy, (2) general accident or personal injury protection policies, (3) worker's compensation programs, (4) student insurance policies, among others. In accordance with applicable state regulations or the insurance contract, for any claim where the hospital's reasonable and diligent efforts resulted in a payment from a private insurer or public program, the hospital will report the payment and offset it against any claim that may have been paid by the private insurer or public program. For state public assistance programs the Hospital is not required to secure assignment on a patient's right to a third party coverage on services provided due to an accident. In these cases the State of Massachusetts will attempt to seek assignment on the costs of the services provided to the patient and which was paid for by either the Office of Medicaid or the Health Safety Net.

The hospital further maintains all information in accordance with applicable federal and state privacy, security, and ID theft laws.

B. Hospital Billing Practices

The Hospital makes the same reasonable effort and follows the same reasonable process for collecting on bills owed by an uninsured patient as it does for all other patients. The Hospital will first show that it has a current unpaid balance that is related to services provided to the patient and not covered by a private insurer or a financial assistance program. The Hospital follows reasonable collection/billing procedures, which include:

a. The Hospital will send an initial bill 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 (including, but not limited to MassHealth, the premium assistance payment program operated by the Health Connector, the Children's Medical Security Program, the Health Safety Net and Medical Hardship) to cover the cost of the Hospital's bill.

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 and which will also include information on how the patient can contact the Hospital if they need financial assistance.

- c. Sending a final notice by certified mail for uninsured patients (those not enrolled in a program such as Mass Health or HSN) 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" and also notifying the patients of the availability of financial assistance in the communication.
- d. If possible, documentation of alternative efforts to locate the party responsible for the obligation or the correct address on billings returned by the United States Postal Service such as "incorrect address" or "undeliverable".
- e. 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 programs to verify these efforts.
- f. 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 either MassHealth, the premium assistance payment program operated by the Health Connector, the Children's Medical Security Program, Health Safety Net and Medical Hardship, prior to submitting claims to the Health Safety Net Office for Emergency Bad Debt coverage for Emergency or Urgent Care Services.

C. Hospital Financial Assistance Programs

Patients who are eligible for enrollment in a state public assistance program, (such as Mass Health, premium assistance payment programs operated by the Health Connector, the Children's Medical Security Program, Health Safety Net, or Medical Hardship), are deemed enrolled in a financial assistance program. For all patients that are enrolled in these state public assistance programs, the Hospital 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 (MMIS).

The Hospital will seek a specified payment for 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. For these patients, the Hospital will notify the patient if such additional resources are available based on the patient's income and other criteria, as outlined in the Hospital's financial assistance policy.

The Hospital, 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 financial assistance. Any such review shall be part of a separate Hospital 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 in ability 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.

D. Populations Exempt from Collection Activities

The Hospital will take reasonable steps to ensure that no collection actions, including telephone calls, statements or letters, are initiated for those patient balances that may be exempt from collection action. The following individuals and patient populations are exempt from 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's Medical Security Plan, if MAGI income is equal to or less than 300% of the FPL; Low Income Patients other than Dental-only 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% - 300% of the FPL; and Medical Hardship, subject to the following exceptions:

- 1.) 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.

- 2.) 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 the 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 and collection activities.
- 3.) 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 (EVS) or the Medicaid Management Information System. However, once a patient is determined eligible and enrolled in MassHealth, the Premium Assistant 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 exception of any copayments and deductibles) provided prior to the beginning of their eligibility.
- 4.) 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 the service. 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.

E. 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 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 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 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.

F. Outside Collection Agencies

The hospital 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 hospital 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 hospital sells or refers a patient's debt to another party, the agreement with the other party will be reasonably 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 application before the end of the application period, the party will suspend extraordinary collection actions;
- ii. 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 hospital together more than the patient is required to pay under the financial assistance policy and to reverse any extraordinary collection actions; and

- iii. 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 hospital will provide the patient 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 collection agency that it uses is operating in compliance with federal and state fair debt collection requirements

G. Bad Debt

The Hospital will make reasonable efforts to collect on outstanding balances. The Hospital will send an initial bill, follow-up with monthly statements for a period of 120 days. If at the end of this billing cycle the balance remains unpaid or installment payments have not been met, the patient or guarantor will be sent a Final Notice Letter. Accounts that remain unpaid (10) days from the date of the Final Notice Letter will be reviewed and at the discretion of the Hospital be written off to Bad Debt. The accounts will be placed with collection agencies for a designated period of time. At the end of the designated period of time the agent will return to the Hospital all accounts that are unpaid or installment payments have not been met. The agent will cease all collection efforts.

VI. Deposits and Payment 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 Medical Hardship, the Hospital provides the following deposits and payment plans. Any other plan will be based on the Hospital's own internal financial assistance program, and will not apply to patients who have the ability to pay.

a) Emergency Services

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

b) Low Income Patient Deposits

The Hospital 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. All remaining balances are subject to the payment plan conditions established in 101CMR 613.08(1)(f).

c) Deposits for Medical Hardship Patients

The 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)(f).

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

Payment plans are available to patients and will be determined through LGH Financial Counselors and in accordance with current Massachusetts Health Safety Net regulations. 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 off-campus locations

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.

VII. Patient Rights and Responsibilities

The Hospital will advise patients as established in 101CMR 613.08(2)

- a. The patient's right to apply for all Public Assistance Programs which includes; MassHealth, Health Connector programs, Health Safety Net, and Medical Hardship. The Hospital will assist in completing applications.
- b. The Hospital will advise patients of their right to a payment plan.
- c. The Hospital will advise the patient of their duty to provide all required documentation as required by the State for processing applications for Public Assistance Programs.
- d. The Hospital will advise the patient of their duty to inform the State of any change to eligibility status, Household Income and available Third Party Liability.
- e. The Hospital will advise the patient of their duty to track patient deductibles and provide documentation to the Provider when the deductible has been reached.
- f. The Hospital will advise the patient of their duty to inform MassHealth or the Health Safety Net Office if patient has been involved in an accident, or suffers from an illness or injury, or other loss that has or may result in a lawsuit or insurance claim and file a claim for compensation if available.
- g. The Hospital will advise the patient of their duty to assign to the Health Safety Net Office the right to recover an amount equal to the HSN payment provided from the proceeds of any claim or other proceeding against a third party.
- h. The Hospital will advise the patient of their duty to provide information about the claim or any proceeding and fully cooperate with the Health Safety Net Office or its contractor.
- i. The Hospital will advise the patient of their duty to notify the Health Safety Net Office or the MassHealth Agency in writing within ten days of filing any claim, civil action or other proceedings.
- j. The Hospital will advise the patient of their duty to repay the Health Safety Net from the money received from a third party for all eligible services provided on or after the date of the accident or incident after becoming a Low Income Patient for purposes of the Health Safety Net payment.
- k. The Hospital will advise the patient that the Health Safety Net Office recovers sums directly from the patient to the extent that the patient has received payment from a third party for the medical care paid by the Health Safety Net or to the extent specified in 101CMR 613.06(5)

Definitions

Bad Debt

An account receivable based on services furnished to a patient that is regarded as uncollectible, following reasonable collection efforts consistent with the requirements in 101CMR 613; charged as a credit loss; not the obligation of a governmental unit or the federal or state government or any agency thereof; not a Reimbursable Health Service; and is not a Low Income Patient as defined in this Policy.

Collection Action

Any activity by which the hospital, its entities or its designated agent requests payment for services from a patient or responsible party. A collection action shall include requesting pre-admission or pretreatment deposits, billing statements, collection letters, telephone contacts, personal contacts and activities of collection agencies and attorneys.

Elective Services

Medically necessary services that do not meet the definition of emergency or urgent. Typically, these services are either primary care services or medical procedures scheduled in advance by the patient or by the health care provider (hospital, physician office, other).

Emergency Bad Debt

The amount of uncollectible debt for emergency services that meets the criteria set forth in 114.6 CMR13.05.

EVS

The Mass Health Eligibility Verification System

Emergency Medical Condition

A medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in placing the health of the person or another person in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part, or with respect to pregnant woman, as further defined in 42 U.S.C.§1395dd(e)(1)(B).

Financial Assistance Programs

A financial assistance program is one that is intended to assist low-income patients, but who do not otherwise have the ability to pay for their health care services. Such assistance should take into account each individual's ability to contribute to the cost of his or her care, including a review of all sources of family income and other insurance status. Consideration is also given to patients who have exhausted their insurance benefits and/or who exceed financial eligibility criteria but face extraordinary medical costs. A financial assistance program is not a substitute for employer-sponsored, a public financial assistance, or an individually purchased insurance program.

HealthCare Services

Hospital 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). A patient meets the financial criteria for free or partial care under the Health Safety Net based on their income and assets for Massachusetts residents. Non-qualifying residents and non-residents of the state of Massachusetts will be screened against the Lawrence General Hospital supplemental financial assistance program.

Medically Necessary Service

A service that is reasonably expected to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions that endanger life, cause suffering, pain, cause physical deformity or malfunction, threaten to cause or aggravate a disability, or result in illness or infirmity. Medical Necessary Services shall include inpatient and outpatient services as authorized under title XIX of the Federal Social Security Act.

Primary or Elective Care

Medical care required by individuals or families that is appropriate for the maintenance of health and the prevention of illness. Primary care consists of health care services customarily provided by general or family practitioners, general internists, general pediatricians and primary care nurse practitioners or physician assistants. Primary Care does not require the specialized resources of a Hospital emergency department and excludes Ancillary Services and maternity care services.

Resident

A person living in Massachusetts with the intention to remain as defined by 130 CMR 503.002(A) through (D). Persons who are not considered residents are (a) individuals who came to Massachusetts for the purpose of receiving medical care in a setting other than a nursing facility, and who maintain a residence outside Massachusetts; (b) persons whose whereabouts are unknown; or (c) inmates of penal institutions except in the following circumstances:

1. They are inpatients of a medical facility; or
2. They are living outside of the penal institution, are on parole, probation, or home release, and not returning to the institution for overnight stays.

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.

Satellite Clinic

A facility that operates under the Acute Hospital's license, is subject to the fiscal, administrative and clinical management of the Acute Hospital, provides services solely on an outpatient basis, is not located at the same site as the Acute Hospital's inpatient facility, and has Provider-based status in accordance with 42 CFR 413.65.

State Public Assistance Programs include:

- Mass Health: public health insurance program for low income Massachusetts residents that covers all or a part of the healthcare services.
- Connector Care: health insurance for low income Massachusetts residents who do not have health insurance.
- CommonHealth: a MassHealth program for disabled adults and disabled children administered by the MassHealth Agency.
- Children's Medical Security Plan (CMSP): health insurance for uninsured Massachusetts residents under 19 and do not qualify for Mass Health.
- Prescription Advantage: prescription drug insurance plan for seniors and disabled residents for primary prescription drug coverage.
- Health Safety Net: a program for Massachusetts residents who are not eligible for health insurance or can't afford to pay for healthcare services.

Third Party

Any individual, entity or program that is or may be responsible to pay all or part of the cost for medical services.

Underinsured Patient

A patient whose Health Insurance plan or self-insured plan does not pay, in whole or in part, for health services that are eligible for payment from the Health Safety Net, provided that the patient meets the income eligibility standards set forth in 101 CMR 63.04.

Uninsured Patient

A patient who is a resident of the Commonwealth, who is not covered by a health insurance plan or a self-insurance plan and is not eligible for a medical assistance program. A patient who has a policy of health insurance or is a member of a health insurance or benefit program which requires the patient to make payment of deductibles, or co-payments, or fails to cover certain medical services or procedures is not uninsured.

Urgent Care Services

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 the patients' 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.

VIII. Attachments/Exhibits

- 1) Signage: posted in English and Spanish (ref. V. A.)
 - a) "Availability of Financial Assistance and Public Assistance Programs"
 - b) "Disponibilidad de Asistencia Financiera y de Programas Publicos de Asistencia"

- 2) MassHealth Permission to Share Information (PSI) Form
 - a) English
 - b) Spanish

- 3) Payment Plan Agreement Uninsured Discount
 - a) English
 - b) Spanish

- 4) Income Attestation Form Uninsured Discount
 - a) English
 - b) Spanish

- 5) Patient Itemized Statement (front and back)

- 6) Patient Billing Statements Patients with Insurance #1, #2, #3 (front and back)

- 7) Patient Billing Statements Self Pay Patients #1, #2, #3 (front and back)

- 8) Final Notice Letter to Patient (front and back)

- 9) Massachusetts 2016 Poverty Guidelines

- 10) Financial Assistance Program Brochure
 - a) English
 - b) Spanish