Lawrence General Hospital

Financial Assistance Policy for Healthcare Services

Introduction

This policy applies to Lawrence General Hospital ("the hospital") and specific locations and providers as identified in this policy.

The hospital is the frontline caregiver providing medically necessary care for all people who present to its facility and locations 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 their healthcare.

The hospital will help uninsured and underinsured individuals apply for health coverage through a public assistance program or the hospital's financial assistance program (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), and work with individuals to enroll as appropriate. Assistance for these programs is determined by reviewing, among other items, an individual's household income, assets, family size, expenses, and medical needs.

While the hospital assists patients in obtaining health coverage through public programs and financial assistance through other sources whenever appropriate including the hospital, the hospital may also be required to appropriately bill for and collect specific payments, which may include but not be limited to, applicable co-payments, deductibles, deposits, and other amounts for which the patient agrees to be responsible. When registering for services or if receiving a bill, the hospital encourages patients to contact our financial counseling staff to determine if they and/or a family member are in need of and eligible for financial assistance.

In working with patients to find available public assistance or coverage through the hospital's financial assistance, 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, preadmission or pretreatment deposits, payment plans, deferred or rejected admissions, determination that an individual qualifies for Low Income Patient status as determined by the Massachusetts MassHealth/Connector eligibility system, or attestation of information to determine Low Income patient status. As such, this policy was reviewed and approved by:

- *The Chief Executive Officer, the Chief Financial Officer, the Finance Committee of the Board of Directors and the Board of Directors*

While we understand that each individual has a unique financial situation, information and assistance regarding eligibility for public assistance programs and/or coverage through the hospital's financial assistance program may be obtained by contacting the hospital staff:

- *Financial Counselors are available to speak with patients and are located at Lawrence General Hospital's main campus Admitting Office located at 1 General Street, Lawrence MA 01841; telephone number is 978-683-4000 extension 2069, 2174, 2820 or 2833. Hours of operation are Monday through Friday 8:00 am until 4:30 pm.*

More information about this policy and the hospital's financial assistance program, including the application form and a plain language summary of the financial assistance policy, are available on the hospital's website:

- ***lawrencegeneral.org***

The actions that the hospital may take in the event of nonpayment are described in the hospital's separate billing and collections policy. Members of the public may obtain a free copy of the billings and collections policy:

- *Copies will be available on the Hospital's website, lawrencegeneral.org. The documents can also be obtained from the Financial Counselors located at the Hospital's main campus.*

I. Coverage for Medically Necessary Health Care Services

The hospital provides medically necessary medical and behavioral health care services for all patients who present at a hospital location regardless of their ability to pay. Medically necessary services includes 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 treating medical professional will determine the type and level of care and treatment that is necessary for each patient based on their presenting clinical symptoms and following applicable standards of practice. The hospital follows the federal Emergency Medical Treatment and Active Labor Act (EMTALA) requirements by conducting a medical screening examination for patients who present at a hospital location seeking emergency services to determine whether an emergency medical condition exists.

Classification of emergency and nonemergency services is based on the following general definitions, as well as the treating clinician's medical determination. The definitions of emergency or urgent care services provided below are further used by the Hospital for purposes of determining allowable emergency and urgent bad debt coverage under the hospitals financial assistance program, including the Health Safety Net.

A. Emergency and Urgent Care Services

Any patient who presents at a hospital requesting emergency assistance will be evaluated based on the presenting clinical symptoms without regard to the patient's identification, insurance coverage, or ability to pay. The hospital will not engage in actions that discourage individuals from seeking emergency medical care, such as demanding that patients pay before receiving treatment for

emergency medical conditions, or interfering with the screening for and providing of emergency medical care by first discussing the hospital financial assistance program or eligibility for public assistance programs.

a. Emergency Level Services includes treatment for:
    i. A medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, such *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 bodily functions, or serious dysfunction of any bodily organ or part,* or, with respect to a pregnant woman, as further defined in 42 U.S.C. § 1395dd(e)(1)(B).
    ii. In accordance with federal requirements, EMTALA is triggered for anyone who presents to a hospital's property requesting examination or treatment of an emergency (as defined above) or who enters the emergency department requesting examination or treatment for a 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/outpatient unit, clinic, or other ancillary area will also be evaluated for and possibly transferred to a more appropriate location for 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 level care. The determination that there is an emergency medical condition is made by the treating clinician or other qualified medical personnel of the hospital as documented in the hospital medical record.

b. Urgent Care Services include treatment for the following:
    i. Medically Necessary Services provided in an Acute Hospital after the sudden onset of a medical condition, whether physical or mental, manifesting itself by acute symptoms of sufficient severity (including severe pain) such *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.

B. Non-Emergent, Non-Urgent Services:

For patients who (1) the treating clinician determines is non-emergent or non-urgent level care or (2) seek care and treatment following stabilization of an emergency medical condition, the hospital may deem that such care is primary or elective services.

a. Primary or Elective Services includes medical care that is not an Urgent or Emergency level of care and is required by individuals or families for the maintenance of health and the prevention of illness. Typically, these services are medical or behavioral health procedures/visits scheduled in advance or on the same day by the patient or by the health care provider at a hospital location including but not limited to the main campus, a remote site or location, as well as an affiliated physician office, clinic, or community health center. Primary Care consists of health care services customarily provided by general practitioners, family practitioners, general internists, general pediatricians, and primary care nurse

practitioners or physician assistants in a primary care service. Primary Care does not require the specialized resources of an Acute Hospital emergency department and excludes Ancillary Services and maternity care services.

b. Non-emergent or non-urgent health care services (i.e., primary or elective care) may be delayed or deferred based on the consultation with the hospital's clinical staff, as well as the patient's primary care or treating provider if available and as appropriate. The hospital may further decline to provide a patient with non-emergent, non-urgent services if the patient is medically stable and the hospital is unable to obtain from the patient or other sources appropriate payment source or eligibility information for a public or private health insurance to cover the cost of the non-emergent and non-urgent care. Coverage for healthcare services, including medical and behavioral health, is determined and outlined in a public and private health insurer's medical necessity and coverage manuals. While the hospital will attempt to determine coverage based on the patient's known and available insurance coverage, it may bill the patient if the services are not a reimbursable service and the patient has agreed to be billed.

c. Coverage from a public, private, or hospital based financial assistance program may not apply to certain primary or elective procedures that are not reimbursable by such coverage options. If the patient is not sure if a service is not covered, they should contact the hospital financial counseling staff located at 1 General Street, Lawrence, Ma 01841 to determine what coverage options are available.

C. Hospital Locations providing medically necessary services and covered by the Financial Assistance Policy:

The hospital's financial assistance 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*
  - *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 01810*
  - *YMCA, 165 Haverhill Street, Andover, MA 01810*

In addition, the hospital financial assistance policy covers those Emergent, Urgent, and Primary care services provided by the following departments and/or providers within the hospital locations listed above:

Anesthesia
Bariatric and Weight Loss Center
Cancer Care
Cardiac Center
Diabetes & Nutrition
Emergency Center
Endoscopy Services
Hospitalists

Imaging and Radiology
Intensive Care Unit
Inpatient Units\Floors
Infusion Services
Laboratory Services
Maternal Child Health
MITS Clinic – Minimally Invasive Thoracic Surgery
Occupational Health
Outpatient Services
Palliative Care
Pediatric Services
Post Anesthesia Care Unit
Rehabilitation Services - Physical Therapy, Occupational Therapy, Speech Language Pathology
Services for Growing Families
Sleep Center
Special Care Nursery
Surgery
Thoracic Surgery Clinic
Women's Health Imaging
Community Medical Associates – Primary Care Physicians

Those Emergent, Urgent and Primary Care physicians who are independent third-party providers and not employed by the hospital will bill for and collect the professional services fees associated with these services are not covered by LGH's financial assistance policy as follows:

Andover Surgical Group
Andover OB\Gyn
Associates in Orthopedics
Associates in Cardiology
Boston Children's Hospital
Center for Behavioral Medicine
Greater Lawrence Family Health Center
L&M Radiology
Lahey Hospital
Lahey Behavioral Health
Lawrence Anesthesia Services
Mass General Hospital
Mass General Physician Organization
Mass General Hospital for Children
Merrimack Valley Pulmonology Associates
Muto Surgical
New England Cardiology
New England ENT (previously Andover ENT)
New England Neurological
Neurocare
Northeast Urological Surgery

Patient First Pathology
Pentucket Medical Associates
Pratt Pediatrics\Tufts Medical
Center Orthopedics Northeast
Tufts Medical Center
Vascular and Vein Associates
Dr. Ali Mobayen, OB\Gyn
Dr. William Cook, General Surgery

Public Assistance Programs and Hospital Financial Assistance

A. General Overview of Health Coverage and Financial Assistance Programs

Hospital patients may be eligible for free or reduced cost of health care services through various state public assistance programs as well as the hospital financial assistance programs (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). Such programs are intended to assist low-income patients taking into account each individual's ability to contribute to the cost of his or her care. For those individuals that are uninsured or underinsured, the hospital will, when requested, help them with applying for either coverage through public assistance programs or hospital financial assistance programs that may cover all or some of their unpaid hospital bills.

B. State Public Assistance Programs

The Hospital is available to assist patients in enrolling into state health coverage programs. These include MassHealth, the premium assistance payment program operated by the state's Health Connector, and the Children's Medical Security Plan. For these programs, applicants can submit an application through an online website (which is centrally located on the state's Health Connector Website), a paper application, or over the phone with a customer service representative located at either MassHealth or the Connector. Individuals may also ask for assistance from hospital financial counselors (also called certified application counselors) with submitting the application either on the website or through a paper application.

C. Hospital Financial Assistance

The Hospital also provides financial assistance to patients whose income demonstrates an inability to pay for all or a portion of services provided. Patients who are Massachusetts residents and/or in the Hospital's service area may be required to complete their state's application for Medicaid coverage or subsidized health insurance prior to seeking coverage through the hospital's own financial assistance options. Qualifying patients are eligible for the Hospital's Financial Assistance Policy based on the below criteria:

C.1. Hospital Financial Assistance through the Health Safety Net

Through its participation in the Massachusetts Health Safety Net, the Hospital provides financial assistance to low-income uninsured and underinsured patients who are Massachusetts residents and who meet income qualifications. The Health Safety Net was created to more equitably distribute the cost of providing uncompensated care to low income uninsured and underinsured patients through free or discounted care across acute hospitals in Massachusetts. The Health Safety Net pooling of uncompensated care is accomplished through an assessment on each hospital to cover the cost of care

for uninsured and underinsured patients with incomes under 300% the federal poverty level. It is the hospital's policy that all patients who receive financial assistance under the hospital's financial assistance policy includes the health safety net services as part of the uncompensated care provided to low income patients.

Through its participation in the Health Safety Net, low-income patients receiving services at the Hospital may be eligible for financial assistance, including free or partially free care for Health Safety Net eligible services defined in 101 CMR 613:00.

(a) Health Safety Net - Primary
Uninsured patients who are Massachusetts residents with verified MassHealth MAGI household Income or Medical Hardship Family income, as described in 101 CMR 613.04(1), between 0-300% of the Federal Poverty Level (FPL) may be determined eligible for Health Safety Net Eligible Services.

The eligibility period and type of services for *Health Safety Net - Primary* is limited for patients eligible for enrollment in the Premium Assistance Payment Program operated by the Health Connector as described in 101 CMR 613.04(5)(a) and (b). Patients subject to the Student Health Program requirements of M.G.L. c. 15A, § 18 are not eligible for *Health Safety Net – Primary*.

(b) Health Safety Net – Secondary
Patients that are Massachusetts residents with primary health insurance and MassHealth MAGI Household income or Medical Hardship Family Countable Income, as described in 101 CMR 613.04(1), between 0 and 300% of the FPL may be determined eligible for Health Safety Net Eligible Services. The eligibility period and type of services for *Health Safety Net - Secondary* is limited for patients eligible for enrollment in the Premium Assistance Payment Program operated by the Health Connector as described in 101 CMR 613.04(5)(a) and (b). Patients subject to the Student Health Program requirements of M.G.L. c. 15A, § 18 are not eligible for *Health Safety Net – Primary*.

(c) Health Safety Net - Partial Deductibles
Patients that qualify for *Health Safety Net Primary* or *Health Safety Net - Secondary* with MassHealth MAGI Household income or Medical Hardship Family Countable Income between 150.1% and 300% of the FPL may be subject to an annual deductible if all members of the Premium Billing Family Group (PBFG) have an income that is above 150.1% of the FPL. This group is defined in 130 CMR 501.0001.

If any member of the PBFG has an FPL below 150.1% there is no deductible for any member of the PBFG. The annual deductible is equal to the greater of:

1. the lowest cost Premium Assistance Payment Program Operated by the Health Connector premium, adjusted for the size of the PBFG proportionally to the MassHealth FPL income standards, as of the beginning of the calendar year; or
2. 40% of the difference between the lowest MassHealth MAGI Household income or Medical Hardship Family Countable Income, as described in 101 CMR 613.04(1), in the applicant's Premium Billing Family Group (PBFG) and 200% of the FPL.

(d) Health Safety Net - Medical Hardship
A Massachusetts resident of any income may qualify for *Medical Hardship* through the Health Safety Net if allowable medical expenses have so depleted his or her countable income that he or

she is unable to pay for health services. To qualify for *Medical Hardship*, the applicant's allowable medical expenses must exceed a specified percentage of the applicant's Countable Income defined in 101 CMR 613 as follows:

Income Level	Percentage of Countable Income
0 - 205% FPL	10%
205.1 - 305% FPL	15%
305.1 - 405%	20%
405.1 - 605% FPL	30%
>605.1% FPL	40%

The applicant's required contribution is calculated as the specified percentage of Countable Income in 101 CMR 613.05(1)(b) based on the *Medical Hardship* Family's FPL multiplied by the actual Countable Income less bills not eligible for Health Safety Net payment, for which the applicant will remain responsible. Further requirements for *Medical Hardship* are specified 101 CMR 613.05.

C.2. Hospital Additional Financial Assistance

In addition to the Health Safety Net, the hospital provides financial assistance for those patients who meet its criteria as outlined below. This financial assistance is meant to supplement and not replace other coverage for services in order to ensure the financial assistance is provided when needed. The hospital will not deny financial assistance under its financial assistance policy based on the applicant's failure to provide information or documentation unless that information or documentation is described in and necessary for the determination of financial assistance through the application form.

- *The hospital may provide free or discounted care to patients who may qualify for uninsured and do not qualify for financial assistance through a federal or state assistance program. The hospital has a credit and collection policy which outlines the policies.*
- *Patients who are uninsured and have a household income at or below 300% of the Federal Poverty Guidelines (FPG) may receive financial assistance.*
- *Eligibility is determined on the patient's family household income.*

D. Limitations on Charges

The hospital will not charge any individual who is eligible for assistance under its financial assistance policy for emergency and medically necessary care more than the "amount generally billed" (AGB) to individuals who have insurance for such care. For this purpose the "amount generally billed" is determined using the following method:

- *Medicare fee for service rates based on a look-back method or 12 months of paid claims for patients covered under the Medicare Program sourced from the Medicare Provider Statistical and Reimbursement ("PS&R") Report.*

The "amounts generally billed", stated as a percentage of gross charges for each hospital facility, is as follows:

- *For patients qualifying for financial assistance, the Hospital will reduce the charges by 55%, the current AGB discount percentage.*

The hospital will charge any individual who is eligible for assistance under its financial assistance policy for all other care an amount less than gross charges for such care.

E. Notices & Application for Hospital Financial Assistance and Public Assistance Programs

E.1 Notices of Available Hospital Financial Assistance & Public Assistance Options

For those individuals who are uninsured or underinsured, the hospital will work with patients to assist them in applying for public assistance and/or hospital financial assistance programs that may cover some or all of their unpaid hospital bills. In order to help uninsured and underinsured individuals find available and appropriate options, the hospital will provide all individuals with a general notice of the availability of public assistance and financial assistance programs during the patient's initial in-person registration at a hospital location for a service, in all billing invoices that are sent to a patient or guarantor, and when the provider is notified or through its own due diligence becomes aware of a change in the patient's eligibility status for public or private insurance coverage.

In addition, the hospital also posts general notices at service delivery areas where there is a registration or check-in area (including, but not limited to, inpatient, outpatient, emergency departments, and affiliated community health center locations), in Certified Application Counselor ("CAC") offices, and in general business office areas that are customarily used by Patients (e.g., admissions and registration areas, or patient financial services offices that are actively open to the public). The general notice will inform the patient about the availability of public assistance and hospital financial assistance (including MassHealth, the premium assistance payment program operated by the Health Connector, the Children's Medical Security Program, the Health Safety Net and Medical Hardship) as well as the location(s) within the hospital and/or the phone numbers to call to schedule an appointment with a CAC. The goal of these notices is to assist individuals in applying for coverage within one or more of these programs.

E.2. Application for Hospital Financial Assistance and Public Assistance Programs

The Hospital is available to assist patients in enrolling into a state public assistance program. These include MassHealth, the premium assistance payment program operated by the state's Health Connector, and the Children's Medical Security Plan. Based on information provided by the patient, the hospital will also identify available coverage options though its financial assistance program, including the Health Safety Net and Medical Hardship programs.

For programs other than Medical Hardship, applicants can submit an application through an online website (which is centrally located on the state's Health Connector Website), a paper application, or over the phone with a customer service representative located at either MassHealth or the Connector. Individuals may also ask for assistance from the hospital's certified application counselor with submitting the application either on the website or through a paper application.

For Medical Hardship, hospital will work with the patient to determine if a program like Medical Hardship would be appropriate and submit a Medical Hardship application to the Health Safety Net. It is the patient's obligation to provide all necessary information as requested by the hospital in an appropriate timeframe to ensure that the hospital can submit a completed application. If the patient is able to provide all information in a timely manner, the hospital will endeavor to submit the total and completed application within five (5) business days of receiving all necessary and requested information. If the total and completed application is not submitted within five business days of receiving all necessary information, collection actions may not be taken against the patient with respect to bills eligible for Medical Hardship.

The hospital may also assist patients with enrolling in the Health Safety Net using a presumptive determination process, which provides a limited period of eligibility. This process is conducted by hospital and community health center staff, who, on the basis of self-attestation of financial information from the patient, will deem a patient as meeting the low income patient definition and will be covered for Health Safety Net services only. Coverage will begin on the date that the provider makes the determination through the end of the following month in which the presumptive determination is made. However, coverage may be terminated sooner if the patient submits a full application as described above.

For financial assistance provided through the hospital the following documentation:,

- *Attestation of Income Verification*

The hospital will not deny financial assistance under its financial assistance policy for information or documentation unless the information or documentation is described in its financial assistance policy or application form.

E.3 Role of the Hospital Financial Counselor

The hospital will help uninsured and underinsured individuals apply for health coverage through a public assistance program (including but not limited to MassHealth, the premium assistance payment program operated by the Health Connector, and the Children's Medical Security Program), and work with individuals to enroll them as appropriate. The hospital will also help patients that wish to apply for financial assistance from the hospital, which includes coverage through the Health Safety Net and Medical Hardship.

The hospital will:

a) provide information about the full range of programs, including MassHealth, the premium assistance payment program operated by the Health Connector, the Children's Medical Security Program, Health Safety Net, and Medical Hardship;
b) help individuals complete a new application for coverage or submit a renewal for existing coverage;
c) work with the individual to obtain all required documentation;
d) submit applications or renewals (along with all required documentation);
e) interact, when applicable and as allowed under the current system limitations, with the Programs on the status of such applications and renewals;
f) help to facilitate enrollment of applicants or beneficiaries in Insurance Programs; and
g) offer and provide voter registration assistance.

The hospital will advise the patient of their obligation to provide the hospital and the applicable state agency with accurate and timely information regarding their full name, address, telephone number, date of birth, social security number (if available), current insurance coverage options (including home, motor vehicle, and other liability insurance) that can cover the cost of the care received, any other applicable financial resources, and citizenship and residency information. This information will be submitted to the state as part of the application for public program assistance to determine coverage for the services provided to the individual.

If the individual or guarantor is unable to provide the necessary information, the hospital may (at the individual's request) make reasonable efforts to obtain any additional information from other sources.

Such efforts also include working with individuals, when requested by the individual, to determine if a bill for services should be sent to the individual to assist with meeting the one-time deductible. This will occur when the individual is scheduling their services, during pre-registration, while the individual is admitted in the hospital, upon discharge, or for a reasonable time following discharge from the hospital. Information that the CAC obtains will be maintained in accordance with applicable federal and state privacy and security laws.

The hospital will also notify the patient during the application process of their responsibility to report to both the hospital and the state agency providing coverage of healthcare services any third party that may be responsible for paying claims, including a home, auto, or other insurance liability policy. If the patient has submitted a third party claim or filed a lawsuit against a third party, the CAC will notify the patient of the requirement to notify the provider and the state program within 10 days of such actions. The patient will also be informed that they must repay the appropriate state agency the amount of the healthcare covered by the state program if there is a recovery on the claim, or assign rights to the state to allow it to recover its applicable amount.

When the individual contacts the hospital, the hospital will attempt to identify if an individual qualifies for a public assistance program or through the hospital financial assistance program. An individual who is enrolled in a public assistance program may qualify for certain benefits. Individuals may also qualify for additional assistance based on the hospital's financial assistance program based on the individual's documented income and allowable medical expenses.

E.4. Procedure for Applying Discounts

For a Domestic (US Citizen) Patient, the hospital will provide the patient/Guarantor with an estimate of the charges for any requested self-pay of medical services. For those patients who meet the criteria under this policy, the hospital will apply a 62% self-pay discount to the estimate. The patient/ Guarantor must pay the amount set forth in the Estimate (after applying the discount), in full, forty-five (45) days prior to the provision of services; provided however payment will not be required prior to the provision of emergency services.

For an International Patient, the hospital will provide the patient/Guarantor with an estimate of the charges for the services and will apply a 25% self-pay discount to the estimate. The patient/Guarantor must pay the amount set forth in the estimate, in full, forty-five (45) days prior to the provision of medically necessary services;; provided however that payment will not be required prior to the provision of emergency services.

Upon completion of the patient's course of treatment any payments that result in a credit balance will result in a refund to the patient/Guarantor.