



# South Shore Hospital

55 Fogg Road  
South Weymouth, MA 02190

## ***Hospital Credit & Collection Policy***

*May 2011*

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## I. INTRODUCTION

South Shore Hospital, Inc. (SSH or the “Hospital”) exists to benefit the people of our region by promoting good health, healing, caring and comforting. SSH aspires to be *The Choice* – trusted as the first place to turn for quality health care services. SSH is proud of its not-for-profit public mission to provide quality care to all in need 24 hours a day, 365 days a year. SSH seeks ways of fulfilling our moral, ethical, and legal obligations to ensure that everyone gets the care they need regardless of ability to pay. To successfully provide this assistance, SSH asks that patients actively cooperate with us.

SSH is the frontline caregiver providing medically necessary care for all people regardless of ability to pay. SSH offers this care for **all** patients that come into our facility 24 hours a day, seven days a week, and 365 days a year.

SSH assists patients in obtaining financial assistance from public programs and other sources whenever appropriate. To remain viable as it fulfills its mission, SSH must meet its fiduciary responsibility to appropriately bill and collect for medical services provided to patients. This credit and collection policy is designed to comply with state and federal law and regulations in performing this function.

This Credit and Collection Policy (“CCP”) of SSH is concerned with preserving assets and maintaining a sound financial basis for operations while balancing the needs of our community and the patients that we serve. The CCP is intended to provide management with general guidelines for classifying patients according to their ability to pay, and for acquiring and verifying information and collecting payment from patients, their guarantors, third party insurance companies, and others financially responsible for payment of health care services. This CCP applies to the hospital and any entity that is listed on the hospital’s license. The Hospital’s policy is to comply with state and federal law and regulations in performing these functions. SSH updates its CCP whenever there are significant changes in state and federal regulations and will present to its Board of Directors those changes as needed for approval. As future coverage options are developed, as discussed in both federal and state healthcare reform proposals, the hospitals will make appropriate changes to this credit and collection policy.

The Hospital shall not discriminate on the basis of race, color, national origin, citizenship, alienage, religion, creed, gender, sexual preference, age, or disability in providing its services. This applies to the substance and application of Hospital 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 determinations, and billing and collection practices.

In accordance with applicable Division of Health Care Finance and Policy (“DHCFP”) regulations, SSH will provide uncompensated or free care to uninsured and underinsured patients whose income is less than 400% of the Federal Poverty Limit (FPL) as established annually by the Department of Health and Human Services (“DHHS”). SSH assists uninsured patients in applying

for health care coverage from publicly funded sources whenever appropriate and DHCFP determines whether or not a patient qualifies for uncompensated or free care.

This Credit and Collection Policy is developed to ensure compliance with applicable criteria required under (1) the Health Safety Net Eligibility Regulation (114.6 CMR 13.00), (2) the Centers for Medicare and Medicaid Services Medicare Bad Debt Requirements (42 CFR 413.89), and (3) The Medicare Provider Reimbursement Manual (Part 1, Chapter 3). The information contained and referenced in this policy applies solely to hospital based services provided at SSH or at any entity that is part of the hospital's license or tax ID number. It does not extend to affiliates or other physician practice groups that may routinely do business with SSH.

## **A. Definitions**

Meaning of Terms. As used in 114.6 CMR 13.00, unless the context otherwise requires, the following terms shall have the following meanings and be used as a reference point for this policy and the requirements thereof.

<u>Administrative Day</u>	A day of inpatient hospitalization on which a member's care needs can be provided in a setting other than an acute inpatient hospital in accordance with the standards in 130 CMR 415.000 and on which a member is clinically ready for discharge.
<u>Allowable Medical Expenses</u>	Family medical bills from the Hospital that, if paid, would qualify as deductible medical expenses for federal income tax purposes. Unpaid bills for which the patient is still responsible, incurred prior to or after the date of a MassHealth application, may be used. Paid bills incurred after the date of the MassHealth application may also be included in Allowable Medical Expenses.
<u>Ancillary Services</u>	Non-routine services for which charges are customarily made in addition to routine charges, that include, but are not limited to, laboratory, diagnostic, and therapeutic radiology surgical services, and physical, occupational, and speech language therapy. Generally ancillary services are billed as separate items when the patient receives these services.
<u>Application</u>	The electronic application form issued by the Division pursuant to 114.6 CMR 10.00.
<u>Bad Debt</u>	An account receivable based on services furnished to a patient that: (a) is regarded as uncollectable, following reasonable collection efforts, consistent with 114.6 CMR 13.06 and the Hospital's established Credit and Collection Policy; (b) is charged as a credit loss; (c) is not the obligation of a governmental unit or the federal or state government or any agency thereof; (d) is not a Reimbursable Health Care Service and (e) is not a Low Income Patient as defined in this Policy.

<u>Caretaker Relative</u>	An adult that is the primary care giver for a child, is related to the child by blood, adoption or marriage or is a spouse or former spouse of one of those relatives, and lives in the same home as that child, provided that neither parent is living in the home.
<u>Charge</u>	The uniform price set for a specific service charged by a Provider.
<u>Children’s Medical Security Plan (CMSP)</u>	A program of primary and preventive pediatric health care services for eligible children, from birth to age 18, administered by the Executive Office of Health and Human Services – Offices of Medicaid, pursuant to M.G.L. c. 118E, §10F.
<u>Collection Action</u>	Any activity by which a Provider or designated agent requests payment for services from a patient, a patient’s guarantor or a third party responsible for payment. Collection Actions include activities such as pre-admission or pre-treatment deposits, billing statements, collection follow-up letters, telephone contacts, personal contacts, and activities of collection agencies and attorneys.
<u>Commissioner</u>	The Commissioner of the Division of Health Care Finance and Policy or designee.
<u>CommonHealth</u>	A MassHealth program for disabled adults and disabled children administered by the Executive Office of Health and Human Services – Office of Medicaid, pursuant to M.G.L. c. 118E.
<u>Commonwealth Care</u>	An insurance program for low-income individuals administered by the Commonwealth Health Insurance Connector pursuant to M.G.L. c. 118H.
<u>Community Health Center (CHC)</u>	A health center operating in conformance with the requirements of Section 330 of United States Public Law 95-926, including all community health centers which file cost reports as requested by the Division of Health Care Finance and Policy (“Division”). Such health center must (a) be licensed as a freestanding clinic by the Massachusetts Department of Public Health pursuant to M.G.L. c. 111 §51; (b) meet the qualifications for certification (or provisional certification) by the Office of Medicaid and enter into a provider agreement pursuant to 130 CMR 405.00; and (c) operate in conformance with the requirements of 42 U.S.C. §254(c).
<u>Confidential Services</u>	Services for the treatment of sexually transmitted diseases provided under M.G.L. c. 112, §12F and family planning services provided under M.G.L. C. 111, §24E.
<u>Credit and</u>	A statement in compliance with 114.6 CMR 13.00, of a Hospital’s general policy and the principles that guide its billing and

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<u>Collection Policy</u>	Collections practices and procedures, as approved by its governing Board.
<u>Critical Access Services</u>	Those health services which are generally provided only by acute hospitals, as further defined in 114.6 CMR 13.03.
<u>Division</u>	The Division of Health Care Finance and Policy established under M.G.L. C. 118G.
<u>Elective Services</u>	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).
<u>Eligible Services</u>	Reimbursable Health Services for which Providers may submit a claim for Health Safety Net Payments in accordance with 114.6 CMR 13.00. Eligible Services include “Eligible Services to Low Income Patients” that meet the criteria in 114.6 CMR 13.03; “Medical Hardship” services that meet criteria in 114.6 CMR 13.04; and “Bad Debt” that meet the criteria in 114.6 CMR 13.05.
<u>Emergency Aid to the Elderly, Disabled and Children (EAEDC)</u>	A program of governmental benefits under M.G.L. c. 117A.
<u>Emergency Bad Debt</u>	The amount of uncollectible debt for emergency services that meets the criteria set forth in 114.6 CMR 13.05.
<u>Emergency Level Services</u>	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 <i>prudent layperson who possesses an average knowledge of health and medicine</i> 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 a pregnant woman, as further defined in section 1867(e)(1)(B) of the Social Security Act, 42 U.S.C. §1395dd(e)(1)(B). A medical screening examination and any subsequent treatment for an existing emergency medical condition or any other such service rendered to the extent required pursuant to the federal EMTALA (42 USC 1395(dd)) qualifies as an Emergency Level Service.

<u>EMTALA</u>	The federal Emergency Medical Treatment and Active Labor Act under 42 U.S.C. §1395(dd).
<u>EMTALA Level Requirements</u>	In accordance with federal requirements, EMTALA is triggered for anyone who comes to the hospital property requesting examination or treatment of an emergency level service (emergency medical condition), or who enters the emergency department requesting examination or treatment for a medical condition. Most commonly, 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 an 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.
<u>EVS System</u>	The MassHealth Eligibility Verification System of the Office of Medicaid.
<u>Family</u>	Persons who live together and consist of: (1) a child or children under age 19, any of their children and their parents; (2) siblings under age 19 and any of their children that live together or even if no adult parent or Caretaker Relative is living in the home; or (3) a child of children under age 19, any of their children, and the Caretaker Relative when no parent is living in the home. A Caretaker Relative may choose whether or not to be part of the Family. A parent may choose whether or not to be included as part of the family of a child under age 19 only if that child is: (a) pregnant, or (b) a parent. A child that is absent from the home to attend school is considered as living in the home. A parent may be a natural, step, or adoptive parent. Two parents are members of the same family group as long as they are both mutually responsible for one or more children that live with them.
<u>Family Income</u>	Gross earner and unearned income as defined in 130 CMR 506.003.
<u>Federal Poverty Limit (FPL)</u>	Income standards issued annually in the Federal Register

<u>Fiscal Year</u>	The time period of 12 months beginning October 1 of any calendar year and ending on September 30 of the immediately following calendar year.
<u>Free Care</u>	Unpaid Hospital or Community Health Center charges for medically necessary services which are eligible for reimbursement from the Health Safety Net Fund pursuant to 114.6 CMR 13.03. Types of free care include: full free care, partial free care, medical hardship, and emergency bad debt.
<u>Free Care Application</u>	The application form DHCFCP-FC1 issued by the Division pursuant to 114.6 CMR 10.00.
<u>Fund</u>	The Health Safety Net Trust Fund, established by M.G.L. c. 118G, §36.
<u>Governmental Unit</u>	The Commonwealth, any department, agency, board, or commission of the Commonwealth, and any political subdivision of the Commonwealth.
<u>Gross Income</u>	The total money earned or unearned, such as wages, salaries, rents, pensions or interest received from any source without regard to deductions.
<u>Guarantor</u>	A person or group of persons that assumes the responsibility of payment for all or part of the Hospital's charge for services.
<u>Health Insurance Plan</u>	The Medicare Program, the MassHealth Program, Commonwealth Care, or an individual or group contract or other plan providing coverage of health care services which is issued by a health insurance company, as defined in M.G.L. c. 175, c. 176A, c. 176B, c. 176G, or c. 176I.
<u>Health Practitioner</u>	An individual who can diagnose and treat medical problem whether by authority of his own license or by the delegated authority of a licensed medical professional.
<u>Healthy Start</u>	A health care program for pregnant women and infants administered by the Executive Office of Health and Human Services – Office of Medicaid, pursuant to M.G.L. c. 118E, §10E.
<u>Hospital</u>	An acute hospital licensed under M.G.L. c. 111, §51 that contains a majority of medical-surgical, pediatric, obstetric, and maternity beds as defined by the Department of Public Health.
<u>Hospital Licensed Health Center</u>	A facility that is not physically attached to the Hospital, or located on or proximate to the Hospital campus that: (1) operates under the Hospital's license; (2) meets MassHealth requirements for reimbursement as a Hospital Licensed Health Center under 130 CMR 410.413; (3) is approved by and enrolled with the MassHealth

Enrollment Unit as a hospital licensed health center; (4) is subject to the fiscal, administrative and clinical management of the Hospital; and (6) provides services solely on an outpatient basis.

Hospital Services Services listed the Hospital's license by the Department of Public Health. This does not include services provided in transitional care units; services provided in skilled nursing facilities; and home health services, or separately licensed services, including residential treatment programs and ambulance services.

Hospital Visit A face-to-face meeting between a patient and a physician, physician assistant, nurse practitioner, or registered nurse when the patient has been admitted to a hospital by a physician on a Community Health Center's staff.

Individual Medical Visit A face-to-face meeting at a Community Health Center between a patient and a physician, physician assistant, nurse practitioner, nurse midwife, or registered nurse for medical examination, diagnosis or treatment.

Low Income Patients An individual who meets the criteria under 114.6 CMR 1304(1).

MassHealth The medical assistance program administered by the Executive Office of Health and Human Services – Office of Medicaid, pursuant to M.G.L. c. 118E and in accordance with Titles XIX and XXI of the Federal Social Security Act, and a Section 1115 Demonstration Waiver.

MassHealth Application A form prescribed by the Office of Medicaid to be completed by the Applicant or an Eligibility Representative, and submitted to the Office of Medicaid as a request for MassHealth benefits. It is either the Medical Benefits Request (MBR) or the common intake form designated by the Executive Office of Health and Human Services, or any other form designated by the Office of Medicaid.

Medical Coverage Date The date established for MassHealth Standard as pursuant to 130 CMR 505.002:

(1) The Medical Coverage Date is the tenth day before the date MassHealth receives a Medical Benefit Request (MBR) if Mass Health receives all required verifications, including a completed disability supplement, within 60 days of the date of any Request for Information.

(2) If Mass Health receives the certifications listed on any request for Information after the 60-day period references in 130 CMR 505.002 (J)(1), but within one year receipt of the MBR, the Medical Coverage Date is the tenth day before the date MassHealth receives the verifications.

<u>Medically Necessary Service</u>	A service 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. Medically Necessary Services shall include inpatient and outpatient services as mandated under Title XIX of the Federal Social Security Act.
<u>Medicare Program</u>	The medical assistance program established by Title XVIII of the Federal Social Security Act.
<u>Minor</u>	Person under age 19.
<u>Outlier Day</u>	Each day beyond 20 acute days, during a single admission, for which a patient remains hospitalized at acute status, other than in a DMH-Licensed Bed.
<u>Patient</u>	An individual who receives or has received medically necessary services at a Hospital or Community Health Center.
<u>Primary or Elective Care</u>	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 practitioners, 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.
<u>Provider</u>	A Hospital or Community Health Center that provides Eligible Services.
<u>Reimbursable Health Services</u>	Eligible Services provided to uninsured and underinsured patients who are determined to be financially unable to pay for their care, in whole or in part; provided that the health services are emergency, urgent and critical access services provided by Hospitals or services provided by Community Health Centers; and provided further, that such services shall not be eligible for reimbursement by any other public or third party payer.
<u>Reimbursable Services</u>	Eligible Services for which a Provider may submit a claim to the Health Safety Net Trust Fund as defined in 114.6 CMR 13.00.
<u>Resident</u>	A person living in Massachusetts with the intention to remain permanently or for an indefinite period. A resident is not required to maintain a fixed address. Enrollment in a Massachusetts institution of higher learning or confinement in a Massachusetts medical institution, other than a nursing facility, is not sufficient to establish residency.

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<u>State Public Assistance Programs include:</u>	<p>Mass Health: public health insurance program for low income Massachusetts residents that covers all or a part of the healthcare services.</p> <p>Commonwealth Care: health insurance for low income Massachusetts residents who don't have health insurance.</p> <p>Commonwealth Choice: a health insurance program for uninsured adult Massachusetts residents that do not qualify for MassHealth.</p> <p>Insurance Partnership: provide health insurance for uninsured employees as well as self-employed.</p> <p>Children's Medical Security Plan: health insurance for uninsured Massachusetts residents under 19 and do not qualify for MassHealth.</p> <p>Healthy Start: prenatal and postpartum care for uninsured women.</p> <p>Prescription Advantage: prescription drug insurance plan for seniors and disabled residents for primary prescription drug coverage.</p> <p>Health Safety Net: a program for Massachusetts residents who are not eligible for health insurance or can't afford to pay for healthcare services.</p>
<u>Third Party</u>	<p>Any individual, entity or program that is or may be responsible to pay all or part of the cost for medical services.</p>
<u>Underinsured Patient</u>	<p>A patient whose Health Insurance Plan or self-insurance plan does not pay, in whole or in part, for health services that are eligible for payment from the Health Safety Net Trust Fund, provided that the patient meets income eligibility standards set forth in 114.6 CMR 13.03.</p>
<u>Uninsured Patient</u>	<p>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 such patient to make payment of deductibles, or co-payments, or fails to cover certain medical services or procedures is not uninsured.</p>
<u>Urgent Care Services</u>	<p>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 <i>prudent lay person would believe that the absence of medical attention within 24 hours</i> could reasonably expect to</p>

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result in: (a) placing a patient's health in jeopardy; (b) impairment to bodily function, or (c) 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, but prompt medical services are needed.

## B. General Principles

- *Fear of a hospital bill should never get in the way of patients receiving essential health services. Hospital personnel should develop and communicate messages 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 set forth herein are consistent with its charitable mission and values and take 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.*
- *These policies should be communicated in a clear and easy to understand manner.*
- *Financial assistance policies do not eliminate personal responsibility. Patients may or may not qualify for financial assistance from public programs, so they may be expected to contribute to the cost of their care based on their individual ability to pay. In addition, it is the patient's responsibility to provide the Hospital with the necessary financial and personal documentation that is required in determining eligibility for applicable financial assistance programs.*

## II. DELIVERY OF HEALTH CARE SERVICES

SSH 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 care 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, Commonwealth Care, Children's Medical Security Plan, Healthy Start, Health Safety Net, and others. Choices related to the 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, all hospitals follow the federal Emergency Medical Treatment and Active Labor Act (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). The Hospital provides this assistance for both residents and non-residents of Massachusetts; however, there may not be coverage for a Massachusetts hospital's services through an out-of-state program. 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 definitions found in section VII. H. of this CCP.

### **III. COLLECTING PATIENT INFORMATION ON HEALTH COVERAGE AND FINANCIAL RESOURCES**

#### **A. General**

It is the patient's responsibility to provide the hospital with accurate information regarding health insurance (including primary and secondary carriers), address, and applicable financial resources to determine whether the patient is eligible for coverage through private insurance or through available public assistance programs. SSH asks each patient to work cooperatively with Hospital personnel on these items to facilitate the consistent application of its policies.

In most cases, the Scheduling Department, Patient Access Department or other Hospital designee will obtain and verify the financial information necessary to determine the responsibility for payment of the hospital bill from the patient or guarantor at the time the patient service is scheduled, or at the time of patient registration.

Financial information for emergency visits and outpatient visits will only be verified if SSH has an electronic solution that allows verification. The hospital will delay any attempt to obtain this information during the delivery of any EMTALA emergency level or urgent care services, if the process to obtain this information will delay or interfere with either the medical screening examination or the services undertaken to stabilize an

emergency medical condition. If the patient or guarantor is unable to provide the information needed, and the patient consents, the Hospital will make reasonable efforts to contact relatives and friends for additional information while the patient is in the Hospital and at the time of the patient's discharge. All information gathered pursuant to this policy will be treated confidentially in accordance with applicable federal and state privacy laws.

The Hospital will make reasonable and diligent efforts to investigate whether a third party resource may be responsible for the services provided 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 recovery on the health care claim billed to a private insurer or public program, the hospital will report the recovery and offset it against the claim paid by the private insurer or public program. If the hospital has prior knowledge and is legally able, it will attempt to secure assignment on a patient's right to a third party coverage on services provided to an accident.

While the Hospital will generally complete insurance verification and other requirements as set forth by individual third party payers, the patient has the ultimate responsibility in understanding their specific insurance benefits and requirements and needs to remain actively involved in notifying or obtaining the proper prior authorization(s) and referral(s) or other requirements of the health insurance source as required by the patient's policy of insurance. SSH uses industry wide and general acceptable means of insurance verification via electronic media and web based applications such as Passport.

Outlined below are specific instructions by major type of service provided at the Hospital.

**B. Pre-Admission Activity for Elective Services Including Inpatient Surgery and Surgical Day Care Procedures**

1. On elective admissions, a valid payment source must be identified and in place before the booking is complete. Self-pay patients must show a payment source before the booking is done. This may be facilitated by working with a Financial Counselor and/or a patient accounts representative who will help the patient seek alternative funding sources, advise the patient of available programs, explain SSH policies, or set up a payment plan as appropriate. In the event that appropriate payment options have not been identified, SSH reserves the right to defer the service to a later time so long as such deferral does not jeopardize the patient's health. This includes services determined to be cosmetic in nature or not medically necessary.
2. Upon receipt of an advance booking, the Scheduling or Patient Access Department will review the insurance information provided and complete the

pre-certification process. A follow-up call is placed to the patient as needed when information is missing or inaccurate.

3. SSH will verify insurance for most major payers including Blue Cross, commercial insurance, preferred provider organizations, and health maintenance organizations and will obtain, whenever possible, the prior authorization and/or second opinion requirements as dictated by the third party payer. SSH utilizes tools such as Passport software to help facilitate the identification, confirmation, and eligibility status of the information provided by the patient.
4. MassHealth recipients must present their current eligibility card/information both at the time of booking and on the date(s) of service. All prior authorization forms and consent requirements mandated by the Commonwealth must be in place prior to admission. SSH will check EVS to confirm eligibility for a given date of service, program a patient is enrolled in, and/or the richest benefit currently available to the patient. Virtual Gateway transitioned patients and patients older than 65 years of age enrolled in the listed programs (EAEDC, CenterCare, Children's Medical Security Plan, or Healthy Start) are eligible for uncompensated care for Medically Necessary Services not covered by the program (exclusive of fertility treatments). For those patients under the 200% FPIG guidelines, the system will automatically wrap coverage to free care/uncompensated care. For those patients greater than the 200% FPIG, additional information may be needed from the patient to determine deductibles. In these instances, the Hospital will require a copy of his or her membership card and will then follow any screening or completion of the intake form as needed.
5. Worker's compensation patients are requested to provide evidence of prior approval from their employer's worker's compensation insurer or self-insurer or the utilization review agent. If available, full disclosure is requested regarding accident or injury date, utilization review agent, insurance carrier, claim number, status of claim, and attorney.
6. Non-standard third party plans and foreign insurance will be addressed on a case by case basis with the expectation that requirements are met and in place prior to the booking of the elective service.
7. Elective cosmetic surgery patients must either pay the estimated charges for the requested surgery or provide proof of third party coverage in effect prior to admission. The definition used to determine this type of admission can be found in the Medicare Hospital Manual, Section 250.11. *"Cosmetic surgery includes any surgical procedure directed at improving appearance, except when required for the prompt (i.e., as soon as medically feasible) repair of accidental injury or for improvement of functioning of malformed body member."* Due to the requirement of medical necessity, the free care or Uncompensated Care Program does not apply to elective cosmetic surgery.

8. Financial Counselors are available during regular business hours or by appointment to discuss any financial questions, which may arise. SSH may also rely on the use of external assistance to help facilitate the identification and processing of accounts for MassHealth and/or free care/uncompensated services and may also utilize external resources in processing specialized services such as worker's compensation and automobile related coverage. When external agencies require a patient signature to authorize the disclosure of information including, but not limited to, the release of records from the hospital, place of employment, banks, insurance and others, SSH will inform the patient that these signature(s) are not a requirement of the DHCFP's intake or MA-21 process.

**C. Maternity Admission**

1. Patients receive a "Maternity Packet" from their physician's office. Contained in the packet is general information, a request to provide insurance and demographic information, and a questionnaire that SSH requests the patient return to the Admissions/Patient Access Office as prescribed.
2. Personnel from the Admitting/Patient Access Office will review patient activity based on the return of the completed questionnaire and the anticipated/pre-registered delivery. Hospital personnel will complete insurance verifications on the information provided and identify the copayment due from the patient, if applicable.
3. Patients are requested to pay their copayment in advance of their service whenever possible or upon discharge. Financial Counselors may contact the patient during their stay to follow-up on unpaid copayments, to review payment plan options, and/or to offer additional information for those patients that may be eligible for other forms of public assistance.
4. Financial Counselors will identify those self-pay patients to counsel them on various funding sources and payment options. This includes screening patients' status for eligibility in programs such as MassHealth or Health Safety Net. Self-pay patients who are not eligible for assistance will be asked for payment up front or to work with the Hospital in establishing a payment or budget plan.
5. No patient who presents to the Hospital in active labor or is believed to be in active labor will for any reason have her treatment delayed due to her inability to pay for her service.
6. It is the responsibility of the parents or insured to promptly ad their newborn to their insurance policy as soon as possible. Failure to do so may delay benefits and/or payment to the Hospital. This could result in unexpected or unintentional out of pocket expenses from the guarantor.

**D. Emergency and Urgent Inpatient Admissions or Observation Services**

1. The Hospital shall obtain the financial information necessary to determine responsibility for payment of the bill from the patient or guarantor.
2. Upon Admission, an Admitting Officer or Financial Counselor will obtain from the patient, guarantor or family member, with the patient's permission, demographic and insurance information including specific details as to the types of insurance coverage available.
3. A Hospital representative will perform third party eligibility verification and insurance notifications, if necessary. As outlined in Section III B, this will vary depending on the type of insurance. SSH will use electronic verification means when possible and available. This includes the use of Passport or NEHEN to complete such verifications and individual payer websites (i.e., HPConnect for Harvard Pilgrim Healthcare patients).
4. Financial Counselors will be available or may seek to speak with the patient or family member once they are medically stable and it is appropriate to do so to complete the financial and insurance review process.
5. If a patient does not have insurance, a Financial Counselor will be notified. The patient or guarantor will be given a "*Patient Notice – Availability of Financial Assistance*" information sheet (see Exhibit A). This information sheet will help communicate the options available to the patient and how to access further assistance through SSH.
6. For these patient classifications, SSH may attempt to contact the patient's employer to see if patients are covered by insurance as a consequence of employment. This will be done only if other avenues have not identified an appropriate payment source.

#### **E. During Hospitalization**

1. The Hospital will make reasonable efforts to verify the information supplied by the patient early on in the admission process and prior to the patient discharge. Many third party payers require that the information be verified and that they are notified prior to or at the time the admission occurs or within a defined period of time. For scheduled and planned admissions, the Hospital prefers to complete this verification prior to the actual hospitalization or at minimum as early on in the inpatient hospitalization process as possible so as to avoid any delay in approval or payment from a third party payer. The verification process may, however, occur at any time during the provision of services or at the time of patient discharge as necessary and will be adjusted during the collection process as necessary. For planned admissions, the verification of information and insurance is the same as outlined in section B. For unscheduled or emergent admissions, see sections D and H. SSH has expanded its use of electronic verification systems and has increased the number of staff, hours and skill level

for the role of Financial Counselors with the intent of offering more timely support for patients, particularly those without apparent healthcare coverage.

2. The Hospital will review and verify all insurance information, including foreign health insurance coverage and foreign government health care plans for foreign residents and motor vehicle coverage for victims of automobile accidents. The Hospital will request that patients who are foreign residents provide the name and address of any foreign health plan, and/or the name and address of the appropriate consulate. For patients who are automobile accident victims, the Hospital requests they provide the name and address of the applicable automobile insurance carrier and other accident related information if needed. SSH also requires that these patients assign such benefits to the Hospital for direct payment.
3. A Financial Counselor will discuss insurance information and financial arrangements with the patient as appropriate or with a family member, and will evaluate the patient's ability to pay. The Hospital or its agent will assist patients in applying for MassHealth and other state sponsored health insurance and free care/uncompensated care programs. Patients may be interviewed with prior approval from clinical personnel, or at the patient's request.
4. Automobile accident cases will be identified and details of the accident obtained from the police department if needed. Claims for payment will be submitted to the appropriate automobile insurance carriers and where appropriate Hospital liens will be filed with motor vehicle liability insurers (and in other types of accident cases). The liens are not filed against an individual's personal assets. These liens only relate to payment from motor vehicle liability insurers and are done to help ensure that the Hospital receives appropriate payment from the third party payers involved. A Hospital representative will provide forms to automobile accident/workers comp patients in order to obtain complete automobile and health insurance information, adhering to the regulations pertaining to the individual insurance. For patients also eligible for MassHealth or free care/uncompensated care, the Hospital will investigate, document and submit to the automobile insurer in accordance with the requirements of 114.6 CMR 13.04(7).
5. Hospital liens may be placed on automobile, accident and other third party liability cases by the Hospital or its agent, with the exception of MassHealth patients, for which the Hospital also has the option of billing MassHealth.
6. In instances where the patient states worker's compensation is responsible for covering the service but where the name of the carrier is unknown, the Hospital will attempt to contact employers and request their worker's compensation insurance information.
7. The Hospital reserves the right to utilize outside agencies to help obtain information, verify eligibility for MassHealth or free care/uncompensated care,

or pursue claims for services related to worker's compensation or automobile cases.

#### **F. At Discharge**

1. All insurance verifications should be completed prior to discharge where possible.
2. The Financial Counselor may seek to establish payment options with the self-pay patient prior to or at the time of discharge. Hospital personnel should strongly encourage patients to see or make an appointment with the Financial Counselor at or shortly after discharge to ensure appropriate information is in place.
3. Payment or budget arrangements can be established in accordance with SSH payment and budget criteria and will also follow the guidelines set by DHCFP 114.6 CMR 12.08(1).

#### **G. Outpatient Service**

1. The Hospital shall make reasonable efforts to verify patient supplied information when services are scheduled or at the time the patient receives services. This includes use of such things as Passport or NEHEN and/or proof of identification. This will be monitored or adjusted during the collection process if new information becomes available.
2. Registration staff will obtain all demographic and insurance information including specific details as to the types of insurance coverage available, prior to or at the time services are rendered. Patients may be requested to provide identification such as driver's license to insure accuracy of demographics and will also be required to provide proof of insurance coverage by presenting a valid insurance card. The Registration staff will review and verify all insurance information including foreign health insurance coverage, foreign government health care plans, for foreign residents and motor vehicle coverage for victims of automobile accidents. The Hospital will request that patients who are foreign residents provide the name and address of the foreign health plan, and/or the name and address of the appropriate consulate. For patients who are automobile accident victims, the Hospital requests that the patient provide the name and address of the applicable automobile insurance carrier and other accident related information if needed. SSH also requires that these patients assign such benefits to the Hospital for direct payment.
3. Automobile accident cases will be identified and details of the accident obtained from the police department if needed and claims for payment submitted to the appropriate automobile insurance carriers and, where appropriate, hospital liens filed with motor vehicle liability insurers. A Hospital Representative will obtain complete automobile and health insurance information. For patients also eligible for free care/uncompensated care, the Hospital will investigate,

document and submit to the appropriate automobile insurer in accordance with the requirements of 114.6 CMR 13.04(7).

4. Hospital liens are placed on automobile, accident and other third party liability cases by the Hospital or its agent, with the exception of MassHealth patients, for which the Hospital also has the option of billing MassHealth. Such decisions will be made on a case by case basis by Credit and Collections Manager or the Director of Patient Financial Services.
5. In worker's compensation cases, where the name of the carrier is unknown, the Hospital will contact employers, if appropriate, and request their worker's compensation insurance information.
6. The Hospital reserves the right to utilize outside agencies to help obtain information, verify eligibility for MassHealth, or pursue claims for services related to worker's compensation or automobile cases.

#### **H. Other Information on Emergency Related Services**

1. Financial Counselors are available daily from 7:30am until 7:30pm. During these hours of operation, Financial Counselors will work with all types of emergency related patients. This includes those patients that present in the Emergency Room, Urgent Care Center, or those patients seen in other Hospital locations on an emergency basis. The patient can be classified as an outpatient, inpatient, or emergency room patient.
2. In all emergency related instances, the patient will be given a "*Patient Notice – Availability of Financial Assistance*" information sheet (see Exhibit A) during the registration process. This is especially intended and helpful for those patients treated in the off hours when Financial Counselors are not available. If the patient does not have insurance, a Financial Counselor will be notified. The intent is for the Financial Counselor to contact the patient at the time of service and prior to discharge. If this does not occur, the Financial Counselor will make every effort to contact the patient the following day regardless of whether the patient has been discharged or admitted. If the patient has been discharged, the Financial Counselor will check self pay patients via EVS for existing MassHealth coverage or via the Virtual Gateway for potential applications. The Financial Counselor will attempt to contact the patient directly. If the patient is not available by phone the next day, a letter will be mailed to them outlining available programs of assistance.
3. Other communications and follow-up will occur if the patient cannot be contacted or has not responded. These items are outlined further in section VI.

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## **IV. PATIENT NOTICE OF AVAILABILITY OF ASSISTANCE**

## A. Signs

Information on the availability of financial assistance and other programs of public assistance is posted in key public areas in the Hospital, including the following locations: Central Admitting/Patient Access, Emergency Room admission/registration Area, Clinic admission/registration locations, inpatient admission/registration areas, financial counselor locations and the Business Office/Patient Accounting Department. Signs inform the patient of the availability of free care and other forms of public assistance and include instructions on how to apply for or obtain additional information.

The language is intended to be straightforward and will include similar language as outlined below. All signs and notices shall be translated into languages other than English if such language is primarily spoken by 10% or more of the residents in the hospital service area, which is based on the hospital admissions and/or discharge information.

- *Availability of Financial Assistance: "If you are unable to pay your hospital bill, you and other family members may be eligible for financial assistance through a public assistance program and/or the State's Uncompensated Care Program. Our financial counselors can help you find a program that meets your needs and to assist you in enrolling in that program. For more information, please contact a hospital financial counselor at 781-624-4329. The office is open daily from 7:30am to 7:30pm."*
- *"Financial assistance for your hospital bill may be available through this institution. Please contact a financial counselor at 781-624-8726 daily from 7:30 and to 7:30pm. Our counselors may be able to enroll you and other family members in a free or low cost health insurance public assistance program. It is your responsibility to contact us to obtain information and to work with our counselors in completing the application for these programs."*
- *"Are you unable to pay your hospital bills? Please contact a Financial Counselor to assist you with various alternatives."*
- *"Financial assistance is available through this institution. Please call 781-624-4329 and ask to speak with a Financial Counselor."*

The signs are visible and legible. The above language is intended to be used in signage as indicated and other correspondence and informational items available to our patients.

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

The Hospital will try to identify available coverage options for patients who may be uninsured or 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 will direct all

patients seeking available coverage options, or those that the hospital determines may be eligible, to the hospital's patient financial counseling 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 availability of financial assistance through the hospital's own internal financial assistance program, if available.

The hospital will also provide information on how to contact the appropriate staff within the hospital's finance office to verify the accuracy of the hospital bill or to dispute certain charges.

### **C. Notification Practices**

Individual printed notices are available by contacting a Financial Counselor or through the Business Office. Notices indicate the criteria used to determine eligibility for MassHealth and the Health Safety Net Trust Fund and where or how patients may apply. The goal of these notices is to assist patients in applying for coverage within a financial assistance program, such as MassHealth, Commonwealth Care, Children's Medical Security Plan, Healthy Start, and Health Safety Net. When applicable, the hospital may also assist patients in applying for coverage of services as a Medical Hardship based on the patient's documented income and allowable medical expenses. When a patient contacts the hospital, Patient Accounting, Financial Counseling, or Social Service Staff will attempt to identify if a patient qualifies for a public financial assistance program or a payment plan. Patients who are already enrolled in a public financial assistance program such as MassHealth or Health Safety Net may qualify for certain plans. SSH staff will be available to advise patients as to their eligibility for federal, state, and private assistance agencies. 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. The following items outline more specifically the notification process, criteria, and availability of information beyond the signs that are posted in the Hospital.

1. The Hospital will provide an individual notice of the availability of financial assistance programs and other programs of public assistance to a patient expected to incur charges for which he/she will be personally responsible, exclusive of personal convenience items or services that may not be paid in full by third party coverage.
2. The Hospital or its agent will include a notice or statement about Eligible Services to Low Income Patients and other programs of public assistance in its initial bill and subsequent correspondence with the patient. All correspondence will direct the patient where and how they can receive more information or additional assistance and will inform the patient that they may apply or reapply for financial and public assistance before, during, or after care, or after collection agency assignment if their situation changes.

3. The Hospital will include a notice regarding the availability of financial assistance and other programs of public assistance to Low Income Patients in all written collection actions. The Hospital will notify the patient that it offers a payment plan if the patient is determined to be eligible for MassHealth or free care/uncompensated care through the Health Safety Net Trust Fund as a low income patient or due to Medical Hardship. These payment plans are consistent with 114.6 CMR 13.08(1)(f)(4). The Hospital will also offer payment plan options for those individuals who do not qualify for Low Income Patient status.
4. SSH will include language on its written notices that approximately reads *“If you are unable to pay this bill, please call 781-624-4329 for additional information about financial assistance options.”* or *“If you are unable to pay this bill, please call 781-624-4329. Financial Assistance may be available.”*
5. There is no primary language other than English that is spoken by 10% or more of the Hospital’s service area. Signage and other documentation will be provided in English. The Hospital provides translator services for several other languages and this service may be accessed for those individuals whose primary language is not English.
6. For cases where the hospital continues to determine eligibility for free care/uncompensated care through the Health Safety Net Trust Fund application, then MassHealth will provide a written notice of determination that the patient is or is not eligible within 30 days of receiving a completed application and the required supporting documentation. The vast majority of patients will however be screened via the common intake process and processed through the Virtual Gateway and MA-21 system.
7. Whether the Hospital is using the MassHealth application process through the Virtual Gateway or submitting a MassHealth application directly, the Hospital will assist the patient in completing the application or intake process for enrollment and eligibility screening.

## **V. DEPOSITS AND INSTALLMENT/PAYMENT PLANS**

SSH expects patients to adhere to the following guidelines in paying their outstanding balances in a timely manner. There are many instances where payment will be required in advance or at the time of service, particularly for non-covered services, copayments, and other deductibles, or selected services such as cosmetic procedures. The general expectation is that payments for elective services will be secured in advance of the service delivery and that payment in full is due within 30 days of the initial patient billing statement. The Hospital realizes that there may be a number of instances where payment in full is not financially feasible and may necessitate an appropriate payment or budget plan. The items listed below provide additional guidelines and criteria for deposits and installment plans.

**A. Deposits – General**

1. Patients or their responsible parties are expected to pay their full liability for services rendered, within thirty (30) days of receipt of their first bill or in accordance with a mutually agreed upon installment payment plan. SSH and its agents will not charge interest on co-payments or deductibles.
2. The Hospital requests “pre-admission” or “pretreatment” deposits for any identified out of pocket expense due from the patient for most elective services. Deposit amounts vary based on type of service and the estimated amount due from the patient (i.e. 100% of the estimated amount due is requested for cosmetic services; 50-100% is requested for the estimated amount due for elective service with acceptable payment terms for any remaining balance prior to the delivery of the service, i.e. subject to the balance being paid on an established installment/payment plan).
3. Routine copayments will be requested at the time of service. Copayments related to Emergency Care will be requested of the patient post assessment and after they are medically stable. This may occur prior to or at the time of discharge.

**B. Deposits – Low Income Patients/Medical Hardship**

1. SSH does not require pre-admission and/or pretreatment deposits from individuals that require Emergency Services or that are determined to be Low Income Patients pursuant to 114.6 CMR 13.04(2).
2. SSH may request a deposit from individuals determined to be Low Income Patients pursuant 114.6 CMR 13.08(1)(f). Such deposits are limited to 20% of the Deductible amount, up to \$500. All remaining balances are subject to the payment plan conditions established in 114.6 CMR 13.08.
3. SSH 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 will be subject to the payment plan conditions established in 114.6 CMR 13.08.
4. An individual with a balance of \$1,000 or less, after the initial deposit, must be offered at least a 1 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 a 2-year interest free payment plan.

**C. Installment or Payment Plans (Self-Pay/No Insurance/Balance after Insurance)**

1. Patients or their responsible parties are expected to pay their full liability for services rendered, within thirty (30) days of receipt of their first bill or in accordance with a mutually agreed upon installment payment plan.
2. Patients will be informed of the rights to payment plans, options to apply for MassHealth and Low Income determination with a written notice of eligibility determination, and options to file a grievance if so desired. This information will be communicated verbally when meeting with a Financial Counselor, in discussions with Credit and Collection staff from the Business Office, and via various correspondences the Hospital uses to educate and communicate with patients regarding their rights.
3. Where alternate financial sources for payment have failed, budget arrangements may be extended by the Hospital (“installment or payment plan”).
4. Patients who do not otherwise qualify for free care/uncompensated care, Low Income Status, the Health Safety Net Fund, or Medical Hardship and feel that they can not reasonably make payment in full within thirty (30) days of the initial bill are required to contact the Business Office. The Business Office will work with individuals in establishing a prescribed monthly payment plan until the balance has been paid in full. The payment plan or budget contract is based on the outstanding amount due and is requested to be resolved within 2 years or less. Alternative arrangements will be discussed for those individuals whose self-pay balances exceed \$10,000 and will also require approval from the Chief Financial Officer for extended arrangements. Individuals who do not enter into a formalized payment plan process with the Hospital and/or do not meet the minimum monthly payments are subject to referral to an external collection agency for additional collection activities.
5. Patients are expected to make payments on time based on the agreement that the Hospital has established.
6. If a patient is on an installment payment plan and he/she anticipates missing a payment, the patient should notify the Credit and Collection Department/Business Office in advance and the payment should be made-up no later than the following month.
7. The Credit and Collections Department may contact patients via mail or telephone if payment is not made or is less than the scheduled amount. Telephone contact is generally attempted on balances greater than \$25.
8. If payment is not made due to a change in the patient’s financial position, the patient will be advised of available options and will be supported in completing a common intake form and advised of their rights to be screened for MassHealth and Low Income determination. This includes setting up an appointment to meet with a Financial Counselor.

9. If no satisfactory response is received, the account will be placed for referral to an outside collection agency for additional follow-up in accordance with the billing and notification guidelines of this policy. See Section VI D for standard referral, collection procedures, and notification practices.

#### **D. Notice of Contract Payment Plan**

The following represents contract payment criteria/guidelines for patients with balances after insurance as well as Self Pay patients.

1. Uninsured patients that qualify for any SSH discount policies will receive a discount and contract arrangements will be made on balances after the discount has been applied.
2. In order to give uninsured and underinsured the same opportunity for discount as other payers, a discount of 30% of total charges will be applied to self-pay accounts. This discount will not be applied to deductibles, co-insurance or for elective cosmetic surgeries.
3. Any patient whose balance exceeds \$10,000 or financial situation needs additional consideration should contact our Business Office at 781-624-8632.

Note: The Hospital does not employ interest penalties or accruals on outstanding balances due from patients. There may, however, be associated filing and court fees applied by the State or parties collecting on behalf of the Hospital in instances where appropriate payment arrangements were not made in a timely fashion and the account had been transferred to an external collection agency by the Hospital. These fees, however, do not represent interest penalties imposed by the Hospital.

At this time, the Hospital does not have an established relationship with a third party to extend credit for payment of healthcare debt. Use of personal loans, credit cards, and other payment sources are strongly encouraged as means of paying for or financing the self-pay portion due to the Hospital.

#### **E. Other Payment Related Policies**

SSH recognizes that some patients have limited means and may not qualify for other forms of public assistance referred to in this policy. In those rare instances, the Hospital may entertain a discretionary discounting of charges or financial assistance to the uninsured patient. The hospital's financial assistance program is applied on a uniform basis to patients and takes into consideration the patient's documented financial situation and the patient's inability to make payment after reasonable collection actions. Any discount that is provided by the hospital is consistent with federal and state requirements, and is not based on an effort to induce a patient to receive services from the hospital or to generate business that is payable by a federal or state program. Patients ineligible for coverage under the uncompensated care pool should contact a Business Office representative to discuss current applicable policies on discounting.

## **VI. SERVICES ELIGIBLE FOR PAYMENT FROM THE UNCOMPENSATED CARE TRUST FUND**

Patients may or may not qualify for financial assistance in public programs and are expected to contribute to the costs of their care based on their individual ability to pay.

SSH policies are based upon industry standards for patient accounting and are intended to comply with the criteria set forth by Massachusetts law in 114.6 CMR 13.00. This section of the CCP provides guidelines for patients who are deemed unable to pay for all or part of their own health care expenses due to extenuating circumstances surrounding their illness or financial situation. The following guidelines are also intended to ensure the Hospital's compliance with applicable state and federal regulations to provide for uncompensated care and cover the areas of free care/uncompensated care, MassHealth, Low Income Status, the Health Safety Net Trust Fund, or Medical Hardship as defined by Massachusetts law.

#### **A. Standards and General Procedures**

1. Any patient who feels that he/she may be eligible for free care/uncompensated care shall be given the opportunity to apply for such an allowance.
2. All patients seeking free care/uncompensated care are required to discuss the available options with a Financial Counselor or Business Office Representative and submit all required information needed to process the screening or common intake process. Application for such available services must be completed by the patient or legal guardian of the patient. Full disclosure of all personal assets and financial resources is required for Medical Hardship Applications.
3. The Hospital reserves the right to defer or reject the elective admission of patients whose income and family size is within 200% of the Federal Poverty Income Guidelines (FPIG), if it is determined that the services to be rendered are not medically necessary.
4. The Hospital shall not defer or reject the admission of patients who are CenterCare Recipients solely due to financial considerations.
5. Patients who do not fully comply with the screening or common intake process (or application as necessary) along with all other financial requirements as requested, or misrepresent demographic or financial information as provided by them, will be denied eligibility to the MassHealth program or the Health Safety Net Trust Fund. If additional information is required to process the screening or common intake form and the patient does not comply, the patient will be informed that the application is being placed on hold, denied, or closed. Note: with the transition to the Virtual Gateway and MA-21 process, the State maintains the responsibility in notifying the patient of outcomes and other required information. SSH and its representatives will actively work with patients in keeping them informed of their rights, responsibilities and status when appropriate.
6. Determination letters and notification come from the State under the MA-21 and Virtual Gateway process.
7. The Patient Accounting Department and/or Admitting/Patient Access Department/ Financial Counseling will be responsible for providing information to patients regarding the availability of MassHealth and free care/uncompensated care or other programs of public assistance.
8. All health insurance benefits and coverage of any type, including automobile benefits, are expected to be assigned to the Hospital for direct payment before any screening or common intake process is completed.

## **B. Eligible Services to Low Income Patients**

1. Providers may submit claims for Eligible Services that:
  - a. are permissible Services as defined in 114.6 CMR 13.03(2); and
  - b. are provided to a Low Income Patient as defined in 114.6 CMR 13.04(2); and
  - c. meet the billing criteria in 114.6 CMR 13.04(6).
2. Permissible Services
  - a. SSH may submit claims only for services that are Medically Necessary.
  - b. Site of Service:
    1. Hospitals. – The Health Safety Net Office will pay Hospitals only for the Hospital Services listed in 114.6 CMR 13.03 (3)(a) and subject to the limitations specified in 114.6 CMR 13.03 (3)(b).
    2. Community Health Centers
      - a. Community Health Centers may submit claims only for Reimbursable Services set forth in 114.6 CMR 13.04(4)(b). The Services must meet the requirements set forth in 114.6 CMR 13.04(4)(c).
        1. Community Health Centers may submit claims only for services provided under the Center's clinic license.
        2. A Community Health Center may submit claims only for Services provided on site, except for off site 340B Pharmacy Services and certain Evaluation and Management visits provided to that Center's patients at an acute hospital. A Community Health Center may submit claims for dentures provided on site but manufactured or repaired at an off-site contractor.
      3. The Health Safety Net Office will not pay Community Health Centers for performing, administering, or dispensing experimental, unproven, or otherwise medically unnecessary procedures or treatments, specifically including, but not limited to, sex-reassignment surgery, thyroid cartilage reduction and any other related surgeries and treatments, including pre-and post-sex-reassignment surgery hormone therapy, and treatment of male or female infertility (including, but not limited to,

laboratory tests, drugs and procedures associated with such treatment).

- c. Reimbursable Services – The Health Safety Net will pay for services as specified in 114.6 CMR 13.03 (4)(b). Services will be provided in accordance with the specifications listed in 14.6 CMR 13.03 (4)(c). The Health Safety Net Office will pay only for services provided by the licensed professional listed in this section and will only pay in accordance with the specified codes.

### **C. Criteria to Submit Claims for All Eligible Services to Low Income Patients**

1. Patients are eligible for free care/uncompensated care if the services are: (a) Medically Necessary; (b) meet the criteria listed under “Reimbursable Services” as defined in 114.6 CMR 13.03(2); (c) are provided to Low Income Patients as defined in 114.6 CMR 13.04(1); and (d) meet the billing criteria in 114.6 CMR 13.04(6).
2. A Low Income Patient must be a resident of the Commonwealth of Massachusetts and determined to be a Low Income Patient pursuant to 114.6 CMR 13.04(1). In order to be determined a Low Income Patient; an individual must be a Resident of the Commonwealth and document Family Income equal to or less than 400% of the FPL, subject to the following conditions. The following individuals are not eligible for Low Income Patient status:
  - a. Individuals enrolled in MassHealth Standard and MassHealth Family Assistance/Direct Coverage programs;
  - b. Individuals who have been determined eligible for any MassHealth program including MassHealth Premium Assistance but who have failed to enroll; and
  - c. Individuals whose enrollment in MassHealth or Commonwealth Care has been terminated due to failure to pay premiums.

Note: A Massachusetts resident is a person living in Massachusetts with the intention to remain in the state permanently. A resident is not required to maintain a fixed address. A student who came to Massachusetts from another state to enroll in an institution of higher learning is not a resident. An individual who came to Massachusetts for the purpose of receiving medical care in a setting other than a nursing facility, and who maintains a residence outside of Massachusetts is not a resident.

3. The FPL is updated annually and is posted on the state’s Division of Health Care Finance and Policy website at <http://www.mass.gov>. SSH also makes available this criteria and routinely includes the criteria in its communications with patients.

#### **D. Criteria to Submit Partial Claims for Eligible Services for Low Income Patients**

**Low Income Patient Eligibility Categories.** There are three categories of Low Income Patient eligibility for Health Safety Net services:

1. Health Safety Net - Primary. A Low Income Patient is eligible for Health Safety Net - Primary if he or she is uninsured and documents Family Income between 0 and 200% of the FPL.
  - a. Individuals eligible for enrollment in MassHealth Basic, MassHealth Essential, and Commonwealth Care are not eligible for Health Safety Net - Primary except as provided in 114.6 CMR 13.04 (5) (a), (b) and (c).
  - b. Students subject to the Qualifying Student Health Plan requirements of M.G.L. c. 15, § 18 are not eligible for Health Safety Net - Primary.
2. Health Safety Net - Secondary. A Low Income Patient is eligible for Health Safety Net - Secondary if he or she has other primary health insurance and documents Family Income between 0 and 200% of the FPL.
  - a. Individuals enrolled in Commonwealth Care are not eligible for Health Safety Net - Secondary except for dental services not otherwise covered by Commonwealth Care after the date that coverage begins.
  - b. Individuals enrolled in MassHealth Standard, CommonHealth, MassHealth Essential, MassHealth Basic, or Family Assistance/Direct Coverage are not eligible for Health Safety Net - Secondary.
  - c. Students enrolled in a Qualifying Student Health Plan are eligible for Health Safety Net - Secondary.
3. Health Safety Net - Partial. A Low Income Patient is eligible for Health Safety Net - Partial if he or she documents Family Income between 201% to 400% of the FPL. The individual is responsible for a deductible under 114.6 CMR 13.06.

#### Other Requirements

1. **Affordable Insurance.** Effective April 1, 2009, an individual with income less than or equal to 400% of the FPL, and for whom insurance is deemed affordable as defined in 956 CMR 6.00, 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.
2. Providers may submit claims for individuals whose MassHealth eligibility status is pending due to a disability determination. If the individual is determined eligible for MassHealth, the provider must void Health Safety Net claims for the individual and submit claims for services to MassHealth.

SSH will notify the patient that the Hospital offers a payment plan as required by 13.08 (1)(f)(4).

Note: An insured patient may complete a screening or file an application for MassHealth or Low Income status to cover his or her financial liability after any insurance program or policy has paid the amount for which it is responsible. An individual must submit a copy of the insurance program or policy's Explanation of Benefits (EOB) with the application. Non-medically necessary or excluded services will not be covered.

#### **E. Criteria Exclusions**

1. An individual may not be determined to be a Low Income Patient if he or she:
  - a. has been terminated from MassHealth due to failure to pay a MassHealth premium or deductible; or
  - b. is eligible for Premium Assistance for Employer Sponsored Insurance, but fails to enroll or apply for ESI.

#### **F. Copayments and Deductibles**

1. Cost Sharing Requirements. Low Income Patients are responsible for paying copayments in accordance with 114.6 CMR 13.04(6)(b) and deductibles in accordance with 114.6 CMR 13.04(6)(c).
2. Low Income Patient Co-Payment Requirements. Effective March 3, 2008, all Low Income Patients over the age of 18 are responsible for a co-payment of \$1 for generic drugs and \$3 for single source drugs. There are no co-payments for Reimbursable Services provided to children aged 18 and under. There is an annual maximum of \$200 on pharmacy co-payments.
3. Health Safety Net - Partial Deductibles. For Health Safety Net - Partial patients with Family Income between 201% and 400% of the FPL, there is an annual Deductible equal to 40% of the difference between the applicant's Family Income and 201% of the FPL. The patient is responsible for payment for all services provided up to this Deductible amount. Once the patient has incurred the Deductible, a Provider may submit claims for Eligible Services in excess of the Deductible.
  - a. There is only one Deductible per Family per approval period. The Deductible is not applied to pharmacy services. Co-payments are not considered expenses to be included in the Deductible amount.
  - b. Deductible Tracking. The annual Deductible is applied to all Eligible Services provided to a Low Income Patient or Family member during the Eligibility Period. Each Family member must be determined a Low Income Patient in order for his or her expenses for Eligible Services to be applied

to the Deductible. The Provider must track the patient's Eligible Service expenses until the patient meets the Deductible. If more than one Family member is determined to be a Low Income Patient, or if the patient or Family members receive services from more than one Provider, it is the patient's responsibility to track the Deductible and provide documentation to the Provider that the Deductible has been reached.

- c. Hospitals. The patient must incur expenses for Eligible Services in excess of the Annual Deductible before the Provider may submit a claim for Eligible Services. Once the patient has incurred the Deductible, the Provider may submit a claim for the remaining balance of Eligible Service expenses. The Hospital may require a deposit and/or a payment plan in accordance with 114.6 CMR 13.08.
- d. Community Health Centers and Hospital Licensed Health Centers. Community Health Centers must offer Low Income Patients a sliding fee scale. Hospital Licensed Health Centers may offer a sliding fee scale for outpatient services. A Low Income Patient must incur a percentage of the Health Safety Net payment rate for eligible services based on the sliding fee scale until the patient meets his or her Deductible. The Provider may submit a claim for the remaining balance of each eligible service. The sliding fee scale appears below:

Income as a Percentage of Federal Poverty Income Guidelines	Percentage of Rate Paid by Patient
201% to 250%	20%
251% to 300%	40%
301% to 350%	60%
351% to 400%	80%

#### G. Eligibility Approval Process – MassHealth or Low Income Patient Determination

As of October 1, 2008, the Commonwealth of Massachusetts implemented changes to a number of items related to processing of MassHealth and Free Care applications 114.6 CMR 13.00 governs the criteria for determining the services for which hospitals and community health centers may be paid from the Health Safety Net Office, including the types of services that will be paid by the Office and the criteria to determine Low Income Patient status; to determine medical hardship; and to submit claims for bad debt. Payment rates for Eligible Services are set forth in 114.6 CMR 14.00.

Note: An individual must complete and submit a MassHealth Application using the eligibility procedures and requirements applicable to MassHealth applications under 130 CMR 502.000 or 130 CMR 516.000. Applications will be processed by Office of Medicaid MA-21 system. Unless otherwise specified by CMR 114.6 13.00, Providers will use the standards and procedures in 114.6 CMR 10.00 to process such Applications. This includes Applications filed during the transition period on applicants who are 65 or

over. This information is noted throughout the CCP as to when SSH made such transitions.

It is the patient's obligation to provide the hospital with accurate and timely information regarding their full name, address, telephone number, date of birth, social security number (if available), current health insurance coverage options, the patient's applicable financial resources, and citizenship and residency information – all to determine if the patient is eligible to apply for certain health insurance programs. 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. 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.

The screening and application process for a public health insurance programs is done through either the Virtual Gateway (which is an internet portal designed by the Massachusetts Executive Office of Health and Human Services to provide the general public, medical providers, and community-based organizations with an online application for the programs offered by the state) 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 Division of Health Care Finance and Policy. 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 required by the applicable financial assistance program (specified below). The hospital will then submit this documentation to the Massachusetts Office of Medicaid and assist the patient in securing any additional documentation if such is requested by the state after completing the application.

All Virtual Gateway and paper applications are reviewed and processed by the Massachusetts Office of Medicaid, which uses the Federal Poverty Guidelines as well as the necessary documentation listed below as the basis for the determination eligibility for state sponsored public assistance programs. The eligibility for enrollment into the Health Safety Net program as a special circumstance is reviewed and approved by the

Massachusetts Division of Health Care Finance and Policy also using the Federal Poverty Guidelines and asset information.

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 appealing or seeking information related to the coverage decisions. It is still 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.

1. The hospital will check MassHealth Recipient Eligibility Verification System (EVS) to determine if a patient is enrolled or eligible for MassHealth, Low Income Patient status for the Pool, Emergency Aid for Elderly, Disabled and Children (EAEDC); Healthy Start, Children's Medical Security Plan (CMSP), or other programs. Please note, CenterCare is not eligible on EVS and patients are required to provide proof of enrollment or work with hospital staff to submit an application.
2. If EVS does not report eligibility and enrollment in any of the above, then the hospital will screen patients for potential eligibility in a public assistance program and shall encourage the patient to apply for such program. The hospital shall assist the patient in applying for benefits under any such program.
3. In order to be determined a Low Income Patient, an individual must complete a MassHealth application and submit all documentation required under 130 CMR 502.00. As of May 2005, applications applying at SSH will be processed by the Office of Medicaid MA-21 system. The office of Medicaid will notify the individual whether he or she has been determined
  - a. Eligible for MassHealth;
  - b. Ineligible for MassHealth but determined to be a Low Income Patient; or
  - c. Ineligible for MassHealth and determined not to be a Low Income Patient.
4. Providers will continue to determine eligibility using the Health Safety Net Trust Fund application for individuals that apply for Medical Hardship pursuant to 114.6 CMR 13.05.
5. Verification of gross monthly earned income is mandatory and shall include, but not be limited to the following:
  - a. Verification of gross monthly earned income is mandatory and shall include, but not be limited to, the following:
    1. two recent pay stubs;
    2. a signed statement from the employer; or

3. the most recent U.S. tax return.
- b. Verification of gross monthly unearned income is mandatory and shall include, but not be limited to, the following:
  1. a copy of a recent check or pay stub showing gross income from the source;
  2. a statement from the income source, where matching is not available;
  3. the most recent U.S. Tax Return.
- c. Verification of gross monthly income may also include any other reliable evidence of the applicant's earned or unearned income.

*Note: 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 MassHealth Enrollment Centers to secure the additional documentation needed for enrollment in the applicable financial assistance program.*

- d. Verification of citizenship and identity or immigration status for non-citizens (if applicable) is mandatory.
- e. Verification of assets of those individuals who are also enrolled in the Medicare program is mandatory.
- f. The Division's Electronic Free Care Application issued under 114.6 CMR 10.00 may be used for the following special application types until the Division issues a revised Application.
  1. Confidential Services. Minors receiving Confidential Services may apply to be determined a Low Income Patient using their own income information and using the Division's Electronic Free Care Application issued under 114.6 CMR 10.00 until the release of the Application for Health Safety Net Confidential Services. If a minor is determined to be a Low Income Patient, the Provider may submit claims for Confidential Services when no other source of funding is available to pay for the services confidentially. For all other services, minors are subject to the standard Low Income Patient Determination process. Providers may submit claims for Eligible Services rendered to these individuals for Confidential Services only.
  2. An individual who has been battered or abused, or who has a reasonable fear of abuse or continued abuse, may apply for Low Income Patient status using his or her own income information if he or she seeks

medically necessary Eligible Services. An individual seeking these services is not required to report his or her primary address.

3. An individual who is incarcerated may apply for Low Income Patient status for services provided within six months prior to his or her application.
6. The Division will calculate the annual patient deductible for patients that qualify for Partial eligibility of covered services through the Health Safety Net Trust Fund. The Division will track the patient's Fund expenses until the patient meets the deductible.
7. The hospital will verify the reported assets as reflected on the patients Application for Fund-Medical Hardship Supplement.
8. The hospital will use the required application forms provided by the DHCFP to determine eligibility for Fund services.
9. SSH may choose to use external agents to assist the Hospital and patients with this process, particularly for over 65 applicants and Medical Hardship applications.

#### **H. Eligibility Period**

1. Except for individuals eligible for MassHealth Essential, MassHealth Basic, and Commonwealth Care, Providers may submit claims for individuals determined to be Low Income Patients on or after October 1, 2007, for Reimbursable Services, except pharmacy services, for the period beginning six months prior to the date that Low Income Patient status begins. Providers may submit claims for pharmacy services provided to a Low Income Patient effective on the Medical Coverage Date.
2. For Low Income Patients eligible for MassHealth Essential and MassHealth Basic who are required to enroll in a managed care plan in order to receive MassHealth coverage, Providers may submit claims for Reimbursable Services for the period beginning on the Medical Coverage Date, and ending on the earlier of 100 days after the patient's Medical Coverage Date or the date of enrollment in MassHealth Basic or MassHealth Essential.
3. Low Income Patients eligible for Commonwealth Care.
  - a. Providers may submit claims for Reimbursable Services for the period beginning on the patient's Medical Coverage Date and ending on the earlier of 100 days after the patient's Medical Coverage Date or the coverage effective date of the patient's Commonwealth Care plan.

- b. If a Low Income Patient determined eligible for Commonwealth Care enrolls in Commonwealth Care plan, Providers may submit claims for services provided between the date of enrollment and the coverage effective date.
- c. Low Income Patient status is effective for a maximum of one year from the date of determination, subject to periodic redetermination by MA-21 and verification that the patient's Family Income or insurance status has not changed to such an extent that the patient no longer meets eligibility requirements.

## **I. Claims for Eligible Services**

- 1. SSH follows the criteria set forth in 114.6 CMR 13.04 for submitting eligible claims to the Health Safety Net Trust Fund.. This includes the following:
  - a. Providers may submit claims for Eligible Services to Low Income Patients determined in accordance with the criteria below. Low Income Patients may be determined eligible for Health Safety Net - Primary; Health Safety Net - Secondary; or Health Safety Net - Partial in accordance with 114.6 CMR 13.04(4). In order to be determined a Low Income Patient; an individual must be a Resident of the Commonwealth and document Family Income equal to or less than 400% of the FPL, subject to the following conditions. The following individuals are not eligible for Low Income Patient status:
    - 1. Individuals enrolled in MassHealth Standard and MassHealth Family Assistance/Direct Coverage programs;
    - 2. Individuals who have been determined eligible for any MassHealth program including MassHealth Premium Assistance but who have failed to enroll; and Individuals whose enrollment in MassHealth or Commonwealth Care has been terminated due to failure to pay premiums..
- 2. Emergency Bad Debt Services. A Hospital may submit a claim for emergency bad Hospital Services to an uninsured patient under the following conditions:
  - a. the services were provided to:
    - 1. an uninsured individual who is not a Low Income Patient and the Provider has verified through the EVS system that the individual has not submitted an application for MassHealth; or
    - 2. an uninsured individual whom the Hospital assists in completing a MassHealth application and is determined to be a Low Income Patient or determined into a category exempt from collection action in accordance with 114.6 CMR 13.08(3). Bad Debt claims for these individuals are exempt from the requirements of 114.6 CMR 13.06(3)(a)(4).

- b. The services provided were Emergency or Urgent Care Services;
- c. The Hospital can document that it has undertaken the required Collection Action as defined in 114.6 CMR 13.06(1) for the account; and
- d. the bill remains unpaid after a period of 120 days.

**J. Eligible Service Exclusions**

- 1. Services provided to out-of-state residents may not be eligible for free care/uncompensated care.
- 2. Services that are not medically necessary.
- 3. Non-critical access services on or after January 1, 2005 are not eligible for free care/uncompensated care. In general terms, Hospital services that are not Emergency Care or Urgent Care would be considered non-critical access services. Hospital outpatient clinic services for primary care that is not emergent or urgent would be considered non-critical access services. Ancillary services provided incident to a non-emergent or urgent primary care visit are considered critical access services. Note; exceptions for patients whose condition is too complex to be shifted to a community health center at the time care is sought as determined and documented by the hospital clinician.
- 4. Other service exclusions include the following:
  - a. Services provided in transitional care units
  - b. Services provided in skilled nursing facilities
  - c. Home health services
  - d. Separately licensed services including residential treatment programs and ambulance services
  - e. Services to students who came from other states to enroll in institutions of higher learning
  - f. Services to individuals who came to Massachusetts for medical care in a facility other than a nursing facility who maintain residence outside of Massachusetts

**K. Medical Hardship**

A Massachusetts resident at any income level may qualify for Medical Hardship if Allowable Medical Expenses have so depleted his or her family's income that he or she is unable to pay for Eligible Services. A determination of Medical Hardship is a one-time determination

and not an ongoing eligibility category. An applicant may submit only two Medical Hardship applications within a twelve-month period.

1. To qualify for Medical Hardship the applicant must be a Massachusetts Resident, the applicant's available assets must be insufficient to cover the cost of Allowable Medical Expenses that exceed a specified percentage of the applicant's income (below), and the applicant's Allowable Medical Expenses exceed a specified percentage of the applicant's gross income as follows:

Income Level	Percentage of Gross Income
0-200% FPL	0%
201-300% FPL	15%
301-400% FPL	20%
401-600% FPL	30%
>601% FPL	40%

2. Eligibility Determination – An applicant for Medical Hardship must complete a Medical Hardship application and provide required documentation of income and medical expenses. The Health Safety Net Office will process applications for Medical Hardship and verify information contained in the application. The Hospital will assist the applicant to complete the Medical Hardship application and assemble the required documentation. The Health Safety Net Office will approve an application for Medical Hardship if the applicant's Allowable Medical Expenses exceed the percentage of Family Income listed above. If the applicant reports income less than 400% of the FPL, the applicant must submit an application, with all required documentation, for Low Income Patient determination in accordance with 114.6 CMR 13.04(2). The Health Safety Net Office will not approve Medical Hardship applications for individuals reporting income less than 400% of the FPL unless the applicant has submitted an application for Low Income Patient determination. The Division will not make a determination on Medical Hardship applications for individuals reporting income less than 400% of the FPL until the patient's Low Income status has been determined..
3. Allowable Medical Expenses. The Division will determine the applicant's Allowable Medical Expenses based on review of the submitted documentation. Allowable Medical Expenses may include only 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 twelve months prior to the date of the Medical Hardship application. Allowable Medical Expenses do not include bills for services incurred while the applicant was a Low Income Patient. Bills included in a Medical Hardship determination will not be included in a subsequent Medical Hardship application.

4. Applicant Contribution - The applicant's required contribution is the specified percentage of Family Income in 114.6 CMR 13.05(2). There is one Medical Hardship contribution per Family per Medical Hardship determination. The applicant will remain responsible for Allowable Medical Expenses equal to the required contribution, including bills from health care providers other than Massachusetts Hospitals and Community Health Centers. If the applicant is determined a Low Income Patient, the applicant's required contribution will be deferred until the applicant's Low Income Patient status is ended. If the Health Safety Net Office approves two Medical Hardship applications during a twelve-month period, it will prorate the required contribution amounts.
5. Notification of Determination. The Health Safety Net Office will notify applicants of the determination. The notice will explain that the person is eligible for Medical Hardship; include the dates for which allowable Medical Expenses may be included; include the amount of the applicant's Medical Hardship contribution; list the services that do not qualify as Eligible Services; include the name and number of a contact person for more information. The Office will also notify Providers with bills included in the applicant's Allowable Medical Expenses of the determination and will allocate the applicant's Contribution to each Health Safety Net Provider based on the dates of services and gross charges of services provided to the applicant's family.
6. Claims. Providers may submit claims for Medical Hardship Services upon notification of an approved Medical Hardship application. The Provider may submit a claim for any balance for Eligible Medical Expenses above the patient's Medical Hardship contribution, noting the Applicant's Medical Hardship contribution on the claim. All Medical Hardship claims must be submitted using the 837 formats. The Provider may bill the Applicant for the Medical Hardship contribution in accordance with the Health Safety Net Office notice of determination.

#### **L. Special Circumstances**

##### Motor Vehicle Accidents and Other Recoveries

A Provider may submit a claim for a Low Income Patient injured in a motor vehicle accident only if it:

1. has investigated whether the patient, driver, and/or owner of the other motor vehicle had a motor vehicle liability policy;
2. has made every effort to obtain the third party payer information from the patient;
3. has retained evidence of such efforts, including documentation of phone calls and letters to the patient; and

3. where applicable, has properly submitted a claim for payment to the motor vehicle liability insurer. For motor vehicle accidents and all other recoveries on claims previously billed to the Health Safety Net, the Provider must report the recovery to the HSN. The recovery will be offset against the claim for Eligible Services.

#### **M. Grievance Process**

An individual may request that the Division conduct a review of the MA-21 determination of Low Income Patient Status, or of Provider compliance with the provisions of 114.6 CMR 13.00. The Health Safety Net Office will conduct a review using the following process.

1. In order to request a review, the individual must send a written complaint to the Office with supporting documentation. To request a review of an MA-21 determination, the individual must send the review request within 30 days from the date the applicant received the official notification of the determination. For all grievances, the Office may request additional information as necessary from the grievant, other state agencies, and/or the Provider. Additional information requested by the Office must be submitted within 30 days.
2. 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.

#### **N. Matching Information**

The Office of Medicaid initiates data matches with other agencies and information sources when a MassHealth application is received. These agencies and information sources may include, but are not limited to, the following: the Department of Employment and Training, Department of Public Health's Bureau of Vital Statistics, Department of Industrial Accidents, Department of Veteran's Services, Department of Revenue, Bureau of Special Investigations, Internal Revenue Service, Social Security Administration, Alien Verification Information System, Department of Transitional Assistance, and health insurance carriers.

## **VII. HOSPITAL 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 programs of assistance for which the patient is eligible. The SSH Credit and Collection Policy (CCP) is based upon industry standards for patient accounting and is intended to comply with the criteria set forth by the Commonwealth of Massachusetts. See 114.6 CMR 13.00. The purpose of the CCP is to provide general guidelines to assure reasonable collection of accounts from all available sources and to recognize as soon as possible when an individual requires assistance and/or that an account may qualify for MassHealth or free care/uncompensated care or as Bad Debt. It is also intended to ensure that the Hospital complies with applicable

State and Federal requirements as well as those set forth in the Fair Debt Collections Practices Act.

#### **A. Filing Requirements**

Each Provider must file a copy of its Credit and Collection Policy with the Health Safety Net Office in accordance with the following schedule. The Credit and Collection Policy must conform to the requirements of the regulation.

1. A new Provider must file a copy of its Policy prior to Health Safety Net Office approval to submit claims for payments for Eligible Services;
2. Within 90 days of adoption of amendments to this regulation that would require a change in the Credit and Collection Policy;
3. When a Provider changes its Credit and Collection Policy; or
4. When two Providers merge and request to be paid as a single merged entity.

#### **B. Provider Rights and Responsibilities**

Patients will be informed of the rights to payment plans, options to apply for MassHealth and Low Income determination with a written notice of eligibility determination (from the Hospital or MA-21 process as applicable), and options to file a grievance if so desired. This information will be communicated verbally when meeting with a Financial Counselor, in discussions with Credit and Collection staff from the Business Office, and via various correspondences the Hospital uses to educate and communicate with patients regarding their rights. See also section IV C (2) and the information listed below:

1. As outlined in the introduction of this CCP, SSH will not discriminate on basis of race, color, national origin, citizenship, alienage, religion, creed, gender, sexual preference, 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 admission, or Low Income Patient Status.
2. SSH will advise patients of the right to:
  - a. apply for MassHealth, Commonwealth Care, Low Income Patient determination and Medical Hardship; and
  - b. a payment plan, as described in 114.6 CMR 13.08(1)(f), if the patient is determined to be a Low Income Patient pursuant to 114.6 CMR 13.04(2) or qualifies for Medical Hardship;
  - c. a written notice of the eligibility determination
  - d. a written notice of the right to file a grievance.

3. SSH or its agent shall not garnish the wages or seek legal execution against the personal residence or motor vehicle of a Low Income Patient determined pursuant to 114.6 CMR 13.03 unless: (a) SSH can show the patient or their guarantor has the ability to pay, (b) 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, or (c) for purposes of the lien, it was approved by the Board of Trustees. All approvals by the Board will be made on an individual case basis.
4. SSH shall maintain compliance with applicable billing requirements, such as the Department of Public Health regulations (105 CMR 130.332) for non-payment of specific services or readmissions that the hospital determines was the result of a Serious Reportable Events (SRE). SREs that do not occur at the hospital are excluded from this determination of non-payment. The hospital also does not seek payment from a low income patient determined eligible for the Health Safety Net program whose claims were initially denied by an insurance program due to an administrative billing error by the hospital. The hospital further maintains all information in accordance with applicable federal and state privacy, security, and ID theft laws.

### **C. Patient Rights and Responsibilities**

While SSH has responsibilities in notifying patients of their options for forms of public assistance and other programs that are offered, patients will also be informed by SSH personnel of their responsibilities and requirements that they as patients must meet in order to be eligible for these offerings. The patient must inform MA-21 or the Hospital that determined the patient's eligibility status of any changes in Family income or insurance status. This applies to patients that are deemed Low Income Patients as well as patients that were determined to be eligible under Free Care under 114.6 CMR 13.00. Prior to the delivery of any health care service (except for cases that are an emergency or urgent care service level), a patient must:

1. provide all required documentation including demographics;
2. inform MassHealth or the Provider that determined the patient's eligibility status of any changes in Family Income or insurance status; and
3. track the patient deductible and provide documentation to the Provider that the deductible has been reached when more than one Family member is determined to be a Low Income Patient or if the patient or Family members receive Eligible Services from more than one Provider.
4. inform the Division or MassHealth when the patient is 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. The patient must:
  - a. file a claim for compensation; and

- b. agree to comply with all requirements of M.G.L. c. 118G, including but not limited to:
  - i. assigning to the Division the right to recover an amount equal to the Health Safety Net payment provided from the proceeds of any claim or other proceeding against a third party;
  - ii. providing information about the claim or any other proceeding, and fully cooperating with the Division or its contractor, unless the Division determines that cooperation would not be in the best interests of, or would result in serious harm or emotional impairment to, the patient;
  - iii. notifying the Division or MassHealth in writing within 10 days of filing any claim, civil action, or other proceeding; and
  - iv. repaying the Health Safety Net from the money received from a third party for all Health Safety Net eligible services provided on or after the date of the accident or other incident after becoming a Low Income Patient for purposes of Health Safety Net payment, only Health Safety Net payment provided as a result of the accident or other incident will be repaid.

It is ultimately the patient's obligation to keep track of and timely pay their unpaid hospital bill, including any existing co-payments, co-insurance, and deductibles. The patient is further required to inform either their current health insurer (if they have one) or the agency that determined the patient's eligibility status in a public health insurance program of any changes in family income or insurance status.

Patients are required to notify the state public program (e.g., Office of Medicaid and the Health Safety Net) within ten days, information related to any lawsuit or insurance claim that will cover the cost of the services provided by the hospital. A patient is further required to assign the right to a third party payment that will cover the costs of the services paid by the Office of Medicaid or the Health Safety Net. Patients are required to repay the Health Safety Net fund for applicable services from any third party liability proceeds.

#### **D. Documentation and Audit**

SSH will maintain records documenting claims for Eligible Service to Low Income Patients, Emergency Bad Debt services and Medical Hardship Services.

1. The SSH Finance Department shall make reasonable efforts to maintain auditable patient accounting records or credit and collection activities made in compliance with Regulation 114.6 CMR 13.00.
2. Prior to sending an account to Bad Debt, SSH will make sure that EVS has been checked for potential eligibility.

#### **E. Standard Collection Principles**

1. The Hospital will provide prompt and courteous financial counseling to all patients in need and will assist these patients in obtaining available financial assistance from federal, state, or private agencies in order to meet their financial obligations to the Hospital. Various Hospital representatives, including Financial Counselors, Outreach Workers, Social Services, or Patient Account Representatives may handle this process and interactions with patients.
2. Options for MassHealth or free care/uncompensated care will be made available to any patients who are unable to pay all or part of their accounts, provided they meet the criteria set forth in the Health Safety Net Trust Fund, as amended from time to time.
3. Individual clinical departments, in conjunction with the Patient Accounting Department, are responsible for the prompt processing and aggregation of charges for services provided to patients in order to provide for the timely collection of charges and to maintain the financial solvency of the institution. Billing procedures are maintained and intended to result in prompt payment of each account by the patient prior to or at the time services are rendered or through third party sources in a timely manner. This is true unless the patient is otherwise determined to be eligible for certain governmental programs or eligible for participation in the MassHealth or free care/uncompensated care programs.
4. The Patient Accounting Department may authorize special financial arrangements when all health insurance benefits and covered services, including first party automobile benefits, and foreign health insurance plans for foreign resident patients, if applicable, have been assigned to the Hospital for direct payment and/or when a determination has been made as to the patient's ability to pay for services. In addition to Medical Hardship, a patient's self-pay balance must generally be greater than \$10,000 to be considered for alternative payment arrangements outside the Hospital's standard payment plans.
5. The Patient Accounting Department will submit a universal billing forms and assist the patient in filing all necessary forms with third party insurers or responsible parties. However, the patient is expected to assign benefits due from their health insurance carriers and/or their automobile insurance carriers and pay the account in full or the balance after insurance sources.
6. In the event of a denial of benefits from the insurance carrier or other responsible party, the patient is obligated to appeal and cooperate by taking all steps necessary to obtain payment and have payment made directly to the Hospital. The patient has the responsibility to obtain payment and have payment made directly to the Hospital. The patient has the responsibility to obtain proper physicians referral(s) or other authorizations and is obligated to notify his/her health maintenance organization (HMO) or other insurance source, as required by the patient's policy of insurance.

7. A collection agency will be used when the Patient Accounting Department has exhausted all reasonable collection efforts on the accounts, except for patients who are exempt from collection action pursuant to 114.6 CMR 13.00.
8. The Hospital will not force the sale or foreclosure of a patient's primary residence to pay an outstanding medical bill. The legal execution of real estate attachments on the patient's personal residence or on a patient's other assets (e.g., automobile) to secure the patient's debts is an extraordinary action that will only be used in truly exceptional circumstances. At a minimum, liens are permitted only where there is evidence that the patient or responsible party has income and/or assets to meet his or her obligations. Such action will require prior express authorization from the Hospital's Board of Trustees in each case, in accordance with Massachusetts regulations.
9. The Hospital will not use body attachment (i.e., a third-party that uses physical or legal means to compel an action) to require the patient or responsible party to appear in court.
10. All collection agents of SSH are required by contract to comply with the Credit and Collection policies of SSH. Collection agents will use any patient contact as an opportunity to encourage the patients to discuss any need for financial assistance directly with the Hospital.

#### **F. Hospital Billing and Collection Procedures**

1. An initial bill will be sent to the responsible party for the patient's personal financial obligations.
2. The Hospital will issue subsequent billings at least every 30 days and for a minimum of 120 days after the initial bill before referring an account to an external collection agency. The patient will receive at least 3 billing statements and a "final notice" indicating that the account will be referred to an external collection agency when an acceptable payment has not been received or when an appropriate payment plan has not been established.
3. The statement or billing notices will be accompanied by telephone calls, collection letters, personal contact notices, and any other notification method that constitutes a genuine and reasonable effort to contact the party responsible for the obligation.
4. The Hospital will document alternative efforts to locate the party responsible for the obligation or the correct address on billings returned by the postal office service as "incorrect address" or "undeliverable" that is otherwise considered a "bad address." Alternative efforts may include use of skip tracing methods, use of the internet, post office records or other purchased or widely available means of tracing a patient or guarantors residence or point of contact with the intent of

collecting outstanding debt or notifying them of options and other programs of public assistance that may be available to them.

5. For Emergency Care services (services that could qualify as emergency bad debt) with balances over \$1,000 where notices have not been returned as “incorrect address” or “undeliverable,” the Hospital will send a final collection notice by certified mail (see 114.6 CMR 13.06(1)(a)(3)(b)(iv)). In these instances where, after reasonable effort, an account has been deemed as undeliverable, the account shall be referred to an external collection agency for additional follow-up prior to the exhaustion of the 120 days from the attempt of the initial bill.
6. Documentation of continuous collection action undertaken on a regular, frequent basis will be maintained by paper or electronic media.
7. The patient’s file will include documentation of collection effort including bills, follow-up letter, telephone and personal contact, will be maintained until an audit is complete.

#### **G. Reasonable Collection Efforts**

1. The Hospital must make the same effort to collect accounts for Uninsured Patients as it does to collect accounts from any other patient classification.
2. The minimum requirements before writing off an account to the Health Safety Net include:
  - a. An initial bill to the party responsible for the patient’s personal financial obligations
  - b. Subsequent billings, telephone calls, collection letters, personal contact notices, computer notifications, and any other notification method that constitutes a genuine effort to contact the party responsible for the obligation
  - c. Documentation of alternative efforts to locate the party responsible for the obligation or the correct address on billings returned by the postal office service as “incorrect address” or “undeliverable”
  - d. Sending a final notice by certified mail for balances over \$1,000 where notices have not been returned as “incorrect address” or “undeliverable”
  - e. Documentation of continuous Collection Action undertaken on a regular, frequent basis. When evaluating whether a Provider has engaged in continuous Collection Action, the Health Safety Net Office may use a gap in Collection Action of greater than 120 days as a guideline for noncompliance, but may use its discretion when determining whether a Provider has made a reasonable effort to meet the standard.

- f. Checking EVS to ensure that the patient is not a Low Income Patient as determined by the Office of Medicaid and has not submitted an application to the Virtual Gateway system for coverage of the services under a public program, prior to submitting claims to the Health Safety Net Office for emergency bad debt coverage of an emergency level or urgent care service.
3. If, after reasonable attempts to collect a bill, the debt for Emergency Care for an Uninsured Patient remains unpaid for more than 120 days, the bill may be deemed uncollectible and billed to the Health Safety Net Office.
4. The patient's file must include all documentation of the Provider's collection effort including copies of the bill(s), follow-up letters, reports of telephone and personal contact, and any other effort made.

#### **H. Emergency Care Classification**

Pursuant to EMTALA, the Hospital classifies as emergency care any persons who enters the hospital requesting emergency treatment or who enters the emergency department requesting medical treatment. These patients may be walk-ins or may arrive by ambulance. Most commonly, unscheduled persons present themselves at the Hospital's emergency room or urgent care center. However, unscheduled persons requesting emergency services while presenting at another inpatient unit, clinic, or other ancillary area such as laboratory of radiology may also be subject to an emergency medical screening examination pursuant to EMTALA. Examination and treatment for emergency medical conditions or any such other service rendered to the extent required pursuant to EMTALA, will be provided to the patient and will qualify as emergency care for uncompensated care purposes.

A medical professional (usually a Triage Nurse), will determine the urgency of treatment associated with each patient that presents in our emergency room or urgent care area. Classification of these patients' medical conditions is for clinical management or triage purposes only, and such classifications are intended for addressing the order in which physicians should see patients based on their presenting clinical symptoms. This triage classification projects resources needed for each patient based on the level of triage. Resources include tests, EKG, CAT Scans, X-Rays, IV fluids, IM or IV medications, specialty consultations, and other procedures. These classifications do not reflect medical evaluation of the patient's medical condition. SSH has adopted a 5 level triage system and the classifications are as follows:

- Level 1: cardiac arrest, stroke, trauma, need multiple resources.
- Level 2: vital signs unstable, need multiple resources, chest pain.
- Level 3: vital signs stable, need two or more resources.
- Level 4: vital signs stable, need one resource.
- Level 5: vital signs stable, non urgent conditions, ear aches, bruises.

These classifications were adapted from the Emergency Nurses Association's ESI {Emergency Severity Index} five-level triage system. The following classifications are generally used in this context:

1. Emergent (or Emergency) Care: Medically necessary services provided after the onset of a medical condition, whether physical or mental, manifesting itself by acute symptoms of sufficient severity, including severe pain, which a prudent lay person would reasonably believe is an immediate threat to life or has a high risk of serious damage to the individual's health. Conditions include, but are not limited to those which may result in jeopardizing the patient's health, serious impairment to bodily functions, serious dysfunction of any bodily organ or part, or active labor in women. Examination or treatment for emergency medical conditions or any such other service rendered to the extent required pursuant to EMTALA qualifies as Emergency Care.
2. Urgent Care: Medically necessary services provided in a 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 lay person 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. Most urgent services are unscheduled, however, if time permits a scheduled appointment will be made for the patient.
3. Elective or Scheduled Services: represent a condition that requires evaluation and/or treatment but time is not a critical factor; does not include patients with complaints of severe pain or loss of function. Elective care is generally a scheduled service. Scheduled services include appointments made over the phone by calling the Hospital or departments within the Hospital, are scheduled as a follow-up visit from a previous service, and can result from a referral by an outside clinician or other healthcare entity. Examples of this include services of diagnostic labs, elective surgical day services, cosmetic procedures, diagnostic imaging and other outpatient therapeutic services.

#### **I. Population Exempt from Routine Collection Action**

The following individuals and patient populations are exempt from any collection or billing procedures pursuant to state regulations and policies:

1. SSH will not bill patients enrolled in MassHealth, patients receiving governmental benefits under the Emergency Aid to the Elderly, Disabled and Children program, participants in the Healthy Start program, except that SSH may bill patients for any co-payments and deductibles required under the program of assistance. SSH may initiate billing for a patient who alleges that he or she is a participant in any of these programs but fails to provide proof of such participation. Upon receipt

of satisfactory proof that a patient is a participant in any of the above listed programs, and receipt of the signed application, the Provider shall cease its collection activities.

2. Participants in the Children's Medical Security Plan whose Family Income is equal to or less than 400% of the FPL are also exempt from Collection Action. SSH may initiate billing for a patient who alleges that he or she is a participant in the Children's Medical Security Plan, but fails to provide proof of such participation. Upon receipt of satisfactory proof that a patient is a participant in the Children's Medical Security Plan, the Provider shall cease all collection activities.
3. Low Income Patients determined pursuant to 114.6 CMR 13.04(2) are exempt from Collection Action for any Eligible Services rendered by the Hospital, except for co-payments and deductibles that are not Eligible Services under 114.6 CMR 12.03(6)(b). SSH may continue to bill Low Income Patients for Eligible Services rendered prior to their determination as Low Income Patients after their Low Income Patient status has expired or otherwise been terminated.
4. Low Income Patients determined pursuant to 114.6 CMR 12.03(3)(b) within 201 – 400% of the FPL are exempt from Collection Action for the portion of his or her Provider bill that exceeds the Deductible and may be billed for co-payments and deductibles as set forth in 114.6 CMR 13.04. SSH may continue to bill Low Income Patients for services rendered prior to their determination as Low Income Patients.
5. Providers may bill Low Income Patients for services other than Eligible Services provided at the request of the patient and for which the patient has agreed to be responsible. Providers must obtain the patient's written consent to be billed for the service.
6. SSH will not undertake a Collection Action against an individual that has qualified for Medical Hardship with respect to the amount of the bill that exceeds the Medical Hardship contribution.
7. SSH and its agents shall not continue collection or billing on a patient who is a member of a bankruptcy proceedings except to secure its rights as a creditor in the appropriate order. Finally, the hospital and its agents will not charge interest on an overdue balance for a Low Income Patient or for patients who are low income based on the hospital's own internal financial assistance program.

The Hospital or its agent will not garnish the wages or seek legal execution against the personal residence or automobile of patients or guarantors except as outlined in Section VI B (3) of the CCP.

Notwithstanding anything in this section to the contrary, the Hospital will bill patients who allege that they are a participant in one of the above-named programs who fail to provide

proof of such participation or who, upon the Hospital's verification, fail to actually participate in such program.

#### **J. Outside Collection Agencies**

The hospital contracts with an outside collection agency to assist in the collection of certain accounts, including patient responsible amounts not resolved after issuance of hospital bills or final notices. However, as determined through this credit and collection policy, the hospital may assign such debt as bad debt or charity care (otherwise deemed as uncollectible) prior to 120 days if it is able to determine that the patient was unable to pay following the hospital's own internal financial assistance program.

The hospital has a specific authorization or contract with the outside collection agency and requires such agencies to abide by the hospital's credit and collection policies for those debts that the agency is pursuing. 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 licensed by the Commonwealth of Massachusetts and that the outside collection agency also is in compliance with the Massachusetts Attorney General's Debt Collection Regulations at 940 C.M.R. 7.00.

#### **K. Reporting to Credit Bureaus**

In instances where the patient or debtor has not met the criteria and standards set forth in this Policy, and all reasonable means have been exhausted, it is the practice at SSH to have collection agents report to credit bureaus regarding outstanding and unresolved debt. Any account or collective balance of several accounts with combined balances greater than \$50 and no activity or arrangement in place after 45 days at a collection agency, is reported to a credit bureau. The Credit Bureaus notified include Trans Union, Equifax, and Experian. Once an account is paid in full, the collection agency will close, remove from credit report and return the account to South Shore Hospital.

### **VIII. NOTICES, FORMS AND OTHER EXHIBITS**

- A. Exhibit I:** Patient Notice - Availability of Financial Assistance
- B. Exhibit II:** Patient Statement with Notice of Financial Assistance
- C. Exhibit III:** Sample Patient Letter
- D. Exhibit IV:** Medical Hardship Application Instructions
- E. Exhibit V:** Sample Medical Hardship Forms