

Sisters of Providence Health System Credit and Collection Policy

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Introduction

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

The hospital assists patients in obtaining financial assistance from public programs and other sources whenever appropriate. To remain viable as it fulfills its mission, the hospital must meet its fiduciary responsibility to appropriately bill and collect for medical services provided to patients. It is important to note that while the federal and state government uses different names for the policies that hospital must follow to show how they are providing financial assistance to patients; the overall requirements are the same. As a result, this policy is designed to comply with both the state Health Safety Net regulations on "Credit and Collection Policies" and the federal HealthCare Reform Law's "Financial Assistance Policy" requirements as recently clarified by the Internal Revenue Service in their February 23, 2011 instructions to the Form 990.

The hospital does not discriminate on the basis of race, color, national origin, citizenship, alienage, religion, creed, sex, sexual 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 admissions, Low Income Patient status as determined by the Massachusetts Office of Medicaid, determination that a patient is low-income, or in its billing and collection practices.

This credit and collection policy are 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),(3) The Medicare Provider Reimbursement Manual (Part 1, Chapter 3), and (4) the Internal Revenue Code Section 501(r) as required under the Section 9007(a) of the federal Patient Protection and Affordable Care Act (Pub. L. No. 111-148) and as recently clarified in the February 28, 2011 IRS clarification to reporting such information in the hospital IRS 990 returns.).

Scope: This credit and collection policy applies to the hospital and any entity that is part of the hospital's license or tax ID number.

Guiding Principles: SPHS will treat persons whom we serve and with whom we work with respect and compassion, calling forth their best human potential.

SPHS provides a full range of services that support health communities, including quality medical care and holistic approaches to healing body, spirit and mind.

SPHS collaborates with others who share a common mission and vision; we continually seek ways to assure access to services to persons most in need.

I. Delivery of Health Care Services

The hospital evaluates the delivery of health care services for all patients who present for services regardless of their ability to pay. However, non-emergent or non-urgent health care services (i.e., elective or primary 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). For those patients with private insurance, the hospital must work through the patient and the insurer to determine what may be covered under the patient's insurance policy. As the hospital is often not able to get this information from the insurer in a timely manner, it is the patient's obligation to know what services will be covered prior to seeking non-emergency level and non-urgent care services. Determination of treatment based on medical conditions is made according to the following definitions:

A. Emergency and Urgent Care Services

Any patient who comes to the Hospital will be evaluated as to the level of emergency level or urgent care services without regard to the patient's identification, insurance coverage, or ability to pay.

a. Emergency Level Services includes:

- i. Medically necessary services provided after the onset of a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity including severe pain, that the absence of prompt medical attention could reasonably be expected by a *prudent layperson who possesses an average knowledge of health and medicine* to result in placing the health of the person or another person in serious

jeopardy, serious impairment to body 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. § 1295dd(e)(1)(B). A medical screening examination and any subsequent treatment for an existing emergency medical conditions or any other such service rendered to the extent required pursuant to the federal EMTALA (42 USC 1395(dd) qualifies as an Emergency Level Service.

b. Urgent Care Services include:

- i. Medically necessary services provided after sudden onset of a medical condition, whether physical or mental, manifesting itself by acute symptoms of sufficient severity (including severe pain) that a *prudent layperson would believe that the absence of medical attention within 24 hours* could reasonably expect to result in: placing the 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, but prompt medical services are needed.

c. EMTALA Level Requirements:

- i. 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 present themselves at the emergency department. However, unscheduled persons requesting services for an emergency medical condition while presenting at another inpatient unit, clinic, or other ancillary area may also be subject to an emergency medical screening examination in accordance with EMTALA. Examination and treatment for emergency medical conditions or any such other service rendered to the extent required under EMTALA, will be provided to the patient and will qualify as emergency care. The determination that there is an emergency medical condition is made by the examining physician or other qualified medical personnel of the hospital as documented in the medical record. The determination that there is 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.

B. Non-Emergent, Non-Urgent Services:

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

- a. Elective Services: Medically necessary services that do not meet the definition of Emergent or Urgent above. 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).

C. Locations where patients may present:

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

II. Documenting Eligibility for Financial Assistance Programs

A. General Principles

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

B. Hospital Screening and Eligibility Approval Process

The hospital provides patients with information about financial assistance programs that are available through the Commonwealth of Massachusetts or through the hospital's own financial assistance program, which may cover all or some of their unpaid hospital bill. For those patients that request such assistance, the hospital assists patients by screening them for eligibility in an available public program and assisting them in applying for the program. These programs include, but are not limited to: MassHealth, Commonwealth Care, Children's Medical Security Plan, Healthy Start, and the 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 family income, current and prior insurance coverage, income and allowable medical expenses.

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 (including any other insurance or coverage options (like a motor vehicle policy or worker's compensation policy) that can cover the cost of the care received), any other, the patient's applicable financial resources, and citizenship and residency information. This information will be used to determine coverage for the services provided to the patient. If there is no specific coverage for the services provided, the hospital will use the information to determine if the services may be covered by an applicable program that will cover certain services deemed bad debt. In addition, the hospital will use this information to discuss eligibility for certain health insurance programs. If the patient or guarantor is unable to provide the necessary information, the hospital may (at the patient's request) make reasonable efforts to obtain any additional information from other sources. This will occur when the patient is scheduling their services, during pre-registration, while the patient is admitted in the hospital, upon discharge, or for a reasonable time following discharge from the hospital.

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

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. Necessary documentation includes proof of: (1) annual household income (payroll stubs, record of social security payments, and a letter from the employer, tax returns, or bank statements), (2) citizenship and identity, (3) immigration status for non-citizens (if applicable), and (4) assets of those individuals who are also enrolled in the Medicare program. 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. 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.

All Virtual Gateway and paper applications are reviewed and processed by the Massachusetts Office of Medicaid, which uses the Federal Poverty Guidelines, asset information, as well as the necessary documentation listed above as the basis for determining the determination eligibility for state sponsored public assistance programs. The eligibility for enrollment into the Health Safety Net program for full or partial Health Safety Net coverage as a special circumstance is also determined through the Virtual Gateway. The hospital will also assist other patients, such as minors receiving confidential services or individuals who have been battered or abused, obtain coverage through the Health Safety Net by using the reviewed and approved by the Massachusetts Division of Health Care Finance and Policy Special Circumstance Application. A copy of the federal poverty guidelines that are used by the state is attached to this policy

Hospitals have no role in the determination of program eligibility made by the state, but at the patient's request may take a direct role in 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.

C. Future Programs

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

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

1) General Principles:

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

The goal of these notices is to assist patients in applying for coverage within a financial assistance program, such as MassHealth, 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. The hospital will provide, upon request, specific information about the eligibility process to be a Low Income Patient under either the Massachusetts Health Safety Net Program or additional assistance for patients who are low income through the hospital's own internal financial assistance program. The hospital will also notify the patient about available payment plans that may be available to them based on their family size and income.

2) Role of Hospital Patient 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 registration and admission staff will direct all patients seeking available coverage options, or financial assistance those that the hospital determines may be eligible, to the hospital's patient financial counseling office to determine if they are eligible and then to screen for eligibility in an appropriate coverage option. The hospital will then assist the patient in applying for the appropriate coverage options that are available or notify them of the availability of financial assistance through the hospital's own internal financial assistance program.

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

3) Notification Practices:

The hospital will post a notice (signs) of availability of financial assistance as outlined in this credit and collection policy in the following locations:

- i. Service Delivery Areas (e.g., Inpatient, clinic, emergency department, admission and/or waiting registration areas);
- ii. Patient financial counselor areas;
- iii. Central admission/registration areas; and/or

iv. Business office areas that is open to patients.

Posted signs will be clearly visible and legible to patients visiting these areas. The hospital will also include a notice about the availability of financial assistance in all initial bills.

When the patient contacts the hospital, the hospital finance staff will attempt to identify if a patient qualifies for a public financial assistance program or a payment plan. A patient who is enrolled in a public financial assistance program (e.g., MassHealth or the Health Safety Net) may qualify for certain plans. Patients may also qualify for additional assistance based on the hospital's own internal criteria for financial assistance, or qualify for coverage of services as a Medical Hardship based on the patient's documented income and allowable medical expenses.

For cases where the hospital is using the Virtual Gateway application, the hospital will assist the patient in completing the application for MassHealth, Commonwealth Care, Children's Medical Security Plan, Healthy Start, Health Safety Net, or other forms of financial assistance programs as they become part of the Virtual Gateway program.

All signs and notices shall be translated into languages other than English if such language is spoken by 10% or more of the residents in the hospital service area, which is based on the hospital admissions and/or discharge information.

IV. Hospital Billing and Collection Practices

The hospital has a fiduciary duty to seek reimbursement for services it has provided from individuals who are able to pay, from third party insurers who cover the cost of care, and from other programs of assistance for which the patient is eligible. To determine whether a patient is able to pay for the services provided as well as to assist the patient in finding alternative coverage options if they are uninsured or underinsured, the hospital follows the following criteria related to billing and collecting from patients.

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

a) Patient Obligations:

Prior to the delivery of any health care services (except for cases that are an emergency or urgent care service level), the patient is expected to provide timely and accurate information on their insurance status, demographic information, changes to their family income or insurance status, and information on any deductibles or co-payments that are owed based on their existing insurance or financial program's payment obligations. The detailed information will include:

- i) Full name, address, telephone number, date of birth, social security number (if available), current health insurance coverage options, citizenship and residency information, and the patient's applicable financial resources that may be used to pay their bill;
- ii) Full name of the patient's guarantor, their address, telephone number, date of birth, social security number (if available), current health insurance coverage options, and their applicable financial resources that may be used to pay for the patient's bill; and
- iii) Other resources that may be used to pay their bill, including other insurance programs, motor vehicle or homeowners insurance policies if the treatment was due to an accident, worker's compensation programs, and student insurance policies, and any other family income such as an inheritances, gifts, or distributions from an available trust, among others.

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. The hospital may also assist the patient with updating their eligibility in a public program when there are any changes in Family Income or insurance status, but only if the hospital is made aware by the patient of facts that may indicate a change in the patient's eligibility status.

Patients are required to notify the applicable state public program in which they are enrolled (e.g., Office of Medicaid and the Health Safety Net), of any information related to a change in family income or any lawsuit or insurance claim that may/will cover the cost of the services provided by the hospital, within

10 days of filing the lawsuit or claim. 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 applicable public program, such as the Office of Medicaid or the Health Safety Net.

b) Hospital Obligations:

The hospital will make all reasonable and diligent efforts to collect the patient insurance status and other information to verify coverage for the health care services to be provided by the hospital. These efforts may occur when the patient is scheduling their services, during pre-registration, while the patient is admitted in the hospital, upon discharge, or during the collection process which may occur for a reasonable time following discharge from the hospital. This information will be obtained prior to the delivery of any non-emergent and non-urgent health care services (i.e., elective procedures as defined in the credit and collection policy). The hospital will delay any attempt to obtain this information during the delivery of any EMTALA level emergency 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.

The hospital's reasonable and diligent efforts will include, but is not limited to, requesting information about the patient's insurance status, checking any available public or private insurance databases, and following the billings rules of a known third party payer. When hospital registration or admission staff are made aware of any such information, they shall also inform patients of their responsibility to inform the appropriate public program of any changes to family income or insurance status, including any lawsuit or insurance claim that may cover the cost of the services provided by the hospital.

If the patient or guarantor/guardian is unable to provide the information needed, and the patient consents, the hospital/department will make reasonable efforts to contact relatives, friends, guarantor/guardian, and/or other appropriate third parties for additional information.

The hospital will also make reasonable and diligent efforts to investigate whether a third party resource may be responsible for the services provided by the hospital, including but not limited to: (1) a motor vehicle or home owner's liability policy, (2) general accident or personal injury protection policies, (3) worker's compensation programs, (4) student insurance policies, among others. In accordance with applicable state regulations or the insurance contract, for any claim where the hospital's reasonable and diligent efforts resulted in a payment from recovery on the health care claim billed to a private insurer or public program, the hospital will report the payment recovery and offset it against any claim that may have been paid by the private insurer or public program. For state public assistance programs, if the hospital has prior knowledge and is not required legally able, it will attempt to secure assignment on a patient's right to a third

party coverage on services provided due to an accident. In these cases the State of Massachusetts will attempt to seek assignment on the costs of the services provided to the patient and which was paid for by either the Office of Medicaid or the Health Safety Net.

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

B. Hospital Billing Practices

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

- (1) An initial bill sent to the patient or the party responsible for the patient's personal financial obligations, the initial bill will include information about the availability of a financial assistance program that might be able to cover the cost of the hospital's bill
- (2) Subsequent billings, telephone calls, collection letters, personal contact notices, computer notifications, or any other notification method that constitutes a genuine effort to contact the party responsible for the obligation and informs the patient of the availability of financial assistance;
- (3) If possible, documentation of alternative efforts to locate the party responsible for the obligation or the correct address on billings returned by the postal service such as "incorrect address" or "undeliverable;"
- (4) Sending a final notice by certified mail for uninsured patients (those who are not enrolled in a public program such as the Health Safety Net or MassHealth) who incur an emergency bad debt balance over \$1,000 on Emergency Level Services only, where notices have not been returned as "incorrect address" or "undeliverable." And also notifying the patients of the availability of financial assistance in the communication;
- (5) Documentation of continuous billing or collection action undertaken on a regular, frequent basis is maintained. Such documentation is maintained until audit review by a federal and/or state agency of the fiscal year cost report in which the bill or account is reported. The Medicare program and the state Division of Health Care Finance and Policy for purposes of the Health Safety Net Program, deems 120 days as appropriate for period of time representing continuous billing or collection actions.
- (6) Checking the Massachusetts Eligibility Verification System (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 service under a public program, prior to submitted claims to the Health Safety Net Office for emergency bad debt coverage of an emergency level or urgent care service.

C. Hospital Financial Assistance Programs

Patients who are eligible for enrollment in a state public assistance program, like the Massachusetts MassHealth or Health Safety Net programs, are deemed enrolled in a financial assistance program. For all patients that are enrolled in these state public assistance programs, the hospital may only bill those patients for the specific co-payment, co-insurance, or deductible that is outlined in the applicable state regulations and which may further be indicated on the state Medicaid Management Information System.

The hospital will seek a specified payment for those patients that do not qualify for enrollment in a Massachusetts state public assistance program, such as out-of-state residents, but who may otherwise meet the general financial eligibility categories of a state public assistance program. For these patients, the payment amount will be set at:

| <u>Income as a Percentage of Federal Poverty Income Guidelines</u> | <u>Percentage of Bill Paid by Patient</u> |
|--|---|
| 201% to 250% | 20% |
| 251% to 300% | 40% |
| 301% to 350% | 60% |
| 351% to 400% | 80% |

The hospital, when requested by the patient and based on an internal review of each patient’s financial status, may offer a patient an additional discount on an unpaid bill. Any such review shall be part of a separate hospital financial assistance program that is applied on a uniform basis to patients, and which takes into consideration the patient’s documented financial situation and the patient’s inability to make a payment after reasonable collection actions. Any discount that is provided by the hospital is consistent with federal and state requirements, and does not influence a patient to receive services from the hospital.

D. Populations Exempt from Collection Activities

The following individuals and patient populations are exempt from any collection or billing procedures beyond the initial bill pursuant to state regulations:

- a) Patients enrolled in a public health insurance program, including but not limited to, MassHealth, Emergency Aid to the Elderly, Disabled and Children, Healthy Start, Children’s Medical Security Plan, “Low Income Patients” as determined by the Office of Medicaid – subject to the following exceptions:
 - (1) The hospital may seek collection action against any patient enrolled in the above mentioned programs for their required co-payments and deductibles that are set forth by each specific program.
 - (2) The hospital may also initiate billing or collection for a patient who alleges that he or she is a participant in a financial assistance program that covers the costs of the hospital services, but fails to provide proof of such participation. Upon receipt of satisfactory proof that a patient is a participant in a financial

- assistance program, (including receipt or verification of signed application) the hospital shall cease its billing or collection activities.
- (3) The hospital may continue collection action on any Low Income Patient for services rendered prior to the Low Income Patient determination, provided that the current Low Income Patient status has been terminated or expired, or not otherwise identified on the state Virtual Gateway or Eligibility Verification System. However, once a patient is determined eligible and enrolled in the Health Safety Net, MassHealth, or certain Commonwealth Care programs, the hospital will cease collection activity for services provided prior to the beginning of their eligibility.
 - (4) The hospitals may seek collection action against any of the patients participating in the programs listed above for non-covered services that the patient has agreed to be responsible for, provided that the hospital obtained the patient's prior written consent to be billed for the service.
 - (5) The hospital will not undertake collection action against an individual that has been approved for Medical Hardship under the Massachusetts Health Safety Net program with respect to the amount of the bill that exceeds the Medical Hardship contribution. The hospital will further cease any collection efforts against an emergency bad debt claim that is approved for Medical Hardship under the Health Safety Net program.
 - (6) The hospital will not bill Low Income Patients for claims related to medical errors including those described in 13.03(1)(d).
 - (7) The hospital may not bill Low Income Patients for claims denied by the patient's primary insurer due to administrative or billing error.
- b) The hospital will not garnish a Low Income Patient's (as determined by the Office of Medicaid) or their guarantor's wages or execute a lien on the Low Income Patient's or their guarantor's personal residence or motor vehicle unless: (1) the hospital can show the patient or their guarantor has the ability to pay, (2) the patient/guarantor did not respond to hospital requests for information or the patient/guarantor refused to cooperate with the hospital to seek an available financial assistance program, or (3) for purposes of the lien, it was approved by the hospital's Board of Trustees on an individual case by case basis.
- c) Pursuant to its internal financial assistance program, the hospital may cease any collection or billing actions against a patient who is unable to pay the hospital bill at any time during the billing process. The hospital will keep any and all documentation that shows that the patient met the hospital's internal financial assistance program.
- d) The hospitals 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.

E. 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, including the obligation to refrain from "extraordinary collection activities" until such time as the hospital has made a reasonable effort and followed a reasonable process for determining that a patient is entitled to assistance or exemption from any collection or billing procedures under this credit and collection policy.. 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.

V. Deposits and Installment Plans

Pursuant to the Massachusetts Health Safety Net regulations pertaining to patients that are either: (1) determined to be a “Low Income Patient” or (2) qualify for Medical Hardship, the hospital will provide the patient with information on deposits and payment plans based on the patient’s documented financial situation. Any other plan will be based on the hospital’s own internal financial assistance program, and will not apply to patients who have the ability to pay.

A. Emergency Services

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

B. Low Income Patient Deposits

A hospital may request a deposit from individuals determined to be Low Income Patients. Such deposits must be limited to 20% of the deductible amount, up to \$500. All remaining balances are subject to the payment plan conditions established in 114.6 CMR 13.08.

C. Deposits for Medical Hardship Patients

A hospital may request a deposit from patients eligible for Medical Hardship. Deposits will be limited to 20% of the Medical Hardship contribution up to \$1,000. All remaining balances will be subject to the payment plan conditions established in 114.6 CMR 13.08.

D. Payment Plans for Low Income Patients pursuant to the Massachusetts Health Safety Net Program

An individual with a balance of \$1,000 or less, after initial deposit, must be offered at least a one-year payment plan interest free with a minimum monthly payment of no more than \$25. A patient that has a balance of more than \$1,000, after initial deposit, must be offered at least a two-year interest free payment plan.

VI. Glossary

Financial Assistance Programs

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

Low Income Patient

Hospitals should either use the HSN definition or the hospital specific financial assistance criteria. Note the HSN definition relates to a Massachusetts resident only.

HealthCare Services

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

Resident

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

State Public Assistance Programs include:

- MassHealth: public health insurance program for low income Massachusetts residents that covers all or a part of the healthcare services.
- Commonwealth Care: health insurance for low income Massachusetts residents who don't have health insurance.
- Commonwealth Choice: a health insurance program for uninsured adult Massachusetts residents that do not qualify for MassHealth
- Insurance Partnership: provide health insurance for uninsured employees as well as self-employed workers.
- Children's Medical Security Plan: health insurance for uninsured Massachusetts residents under 19 and do not qualify for MassHealth.
- Healthy Start: prenatal and postpartum care for uninsured women
- Prescription Advantage: prescription drug insurance plan for seniors and disabled residents for primary prescription drug coverage.

Health Safety Net: a program for Massachusetts residents who are not eligible for health insurance or can't afford to pay for healthcare services.

VII. Attachments/Exhibits

- 1. Copies of Patient Financial Notices contained within**
 - a. first, second, third, and/or final billing invoices**
 - b. Copies of the general notices from Hospitals and/or agents on the availability of financial assistance, *if hospital develops such notices***
 - c. Copies of posted signs as well as general flyers and other handouts (if any) regarding the availability of financial assistance (e.g., Financial Assistance Brochure by MHA)**
- 2. Payment plan notices to low income patients and medical hardship patients**
- 3. Copy of the Federal Poverty Guidance that is used by the State of Massachusetts to determine eligibility for public financial assistance program**