



LAWRENCE GENERAL HOSPITAL CREDIT & COLLECTION POLICY

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Introduction

Purpose:

This Credit and Collection policy applies to Lawrence General Hospital, a voluntary private, not-for-profit, short-term acute care hospital in the Merrimack Valley. The Hospital is the front line caregiver providing medically necessary care for all people regardless of ability to pay. The Hospital offers this care for all patients that come to our facility 24 hours a day, seven days a week and 365 days a year.

Mission Statement:

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

Policy:

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 policies that the hospital must follow to show how they are providing financial assistance to patients; the overall requirements are the same. As a result, this policy is designed to comply with both the State Health Safety Net regulations on "Credit and Collection Policies" and the Federal Health Care Reform Law's "Financial Assistance Policy" requirements as recently clarified by the Internal Revenue Service in their February 23, 2011 instructions to the Form 990.

The hospital does not discriminate on the basis of race, color, national origin, citizenship, alienage, religion, creed, sex, sexual 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 is developed to ensure compliance with applicable criteria required under (1) the Health Safety Net Eligibility Regulation (101 CMR 613.00 13.00), (2) The Centers for Medicare and Medicaid Services Medicare Bad Debt Requirements (42 CFR 413.89), (3) The Medicare Provider Reimbursement Manual (Part 1, Chapter 3) and (4) the Internal Revenue Code Section 501(r) as required under the Section 9007 (a) of the Federal Patient Protection and Affordable Care Act (Pub. L. No. 111-148) and as recently in the February 28, 2011 IRS clarification to reporting such information in the hospital IRS 990 returns.

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

I. Delivery of Health Care Services

General Principle

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

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

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

A. Emergent and Urgent Care Services Includes:

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

a. Emergent Services Includes:

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

b. Urgent Services Includes:

Medically necessary services provided after the sudden onset of a medical condition, whether physical or mental, manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent

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

c. EMTALA Level Requirements:

In accordance with federal requirements, EMTALA is triggered for anyone who comes to the Hospital property requesting examination or treatment of an emergency level services (emergency medical condition) or who enters the emergency department requesting examination or treatment for a medical condition. Most commonly, unscheduled person present themselves at the emergency department. However unscheduled persons requesting services for an emergency medical condition while presenting at another inpatient unit, clinic, or other ancillary area may also be subject to an emergency medical screening examination in accordance with EMTALA. Examination and treatment for emergency medical conditions or any such other service rendered to the extent required under EMTALA, will be provided to the patient and will qualify as emergency care. The determination that there is an emergency medical condition is made by the examining physician or other qualified medical personnel of the Hospital as documented in the medical record. The determination that there is urgent or primary medical condition is also made by the examining physician or other qualified medical personnel of the Hospital as documented in the medical record.

B. Non-Emergent, Non-Urgent Services:

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

a. Elective Services: Medically necessary services that do not meet the definition of Emergent or Urgent above. Typically, these services are either primary cares services or medical procedures scheduled in advance by the patient or by the healthcare provider (hospital, physician office, other).

b. The Hospital may decline to provide a patient with non-emergent services in those cases when the Hospital is not successful in determining that payment will be made for its services. Services that are determined to be non-medically necessary may be deferred until suitable payment arrangements can be made.

C. Locations where Patients May Present for Services

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

D. Collection and Verification of Patient Information

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

a. Emergent and Urgent Services

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

b. Non-Emergent, Non-Urgent Services

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

II. Documenting Eligibility for Financial Assistance Programs

A. General Principles

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

B. Hospital Screening and Eligibility Approval Process

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

a. Patient's Responsibility:

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

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

C. Application Process

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

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

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

D. Future Programs

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

III. Determination of Patient Financial Responsibility

A. General Principles

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

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

B. Insured Patients

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

a. Contracted Insurance Plans:

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

b. Non-Contracted Insurance Plans:

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

c. Uninsured Patients

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

C. Low Income Patients – Health Safety Net Eligible

a. Eligibility:

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

b. Service Limitations:

Patients who are identified as a Low Income Patient according to the applicable Health and Human Services regulations 101 CMR 613.00 (formerly 114.6) will, to the extent possible, be provided services consistent with the coverage guidelines of the Health Safety Net including “Eligible Service” limitations under State regulations.

D. Full Health Safety Net - Primary

a. A resident of the Commonwealth of Massachusetts who is uninsured and documents MassHealth MAGI Household income or Medical Hardship Family Countable Income as described in 101 CMR 613.01 (1) , between 0%-400% of the FPL subject to the following exceptions:

b. Low Income Patients eligible for enrollment in the Premium Assistance Payment Program Operated by the Health Connector are not eligible for Health Safety Net - Primary except as provided in 101 CMR 613.01 (5) (a) through (c).

c. Students subject to the Qualifying Student Health Plan requirement of M.G.L 15, § 18 are not eligible for Health Safety- Primary.

E. Health Safety Net - Secondary

a. A Massachusetts resident is eligible for Health Safety net- Secondary if he or she has other primary health insurance and documents MassHealth MAGI Household income or Medical Hardship Family Countable Income, as described in 101 CMR 613.04 (1) between 0-400% of the FPL, subject to the following exceptions:

1.) Low Income Patients enrolled in the Premium Assistance Payment Program Operated by the Health Connector are eligible only for dental services not otherwise covered by the Premium Assistance Payment Program Operated by the Health Connector after the date that coverage begins.

2.) Low Income Patients enrolled in MassHealth Standard, MassHealth CarePlus, CommonHealth, and Family Assistance excluding MassHealth Family Assistance- Children are eligible only for Adult Dental Services provided at a Community Health Center, Hospital- licensed Health Center, or Satellite Clinic.

3.) Low Income Patients enrolled in a qualifying Student Health Plan are eligible for Health Safety Net - Secondary

4.) Other Requirements:

a. Affordable Insurance:

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

b. Pending Disability Determination:

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

F. Partial Health Safety Net

A resident of the Commonwealth of Massachusetts whose MassHealth MAGI Household income or Medical Hardship Family Countable Income, as described in 101 CMR 613.04 (1) is from 201% to 400% of the Federal Poverty Level (FPL) is considered Health Safety Net- Partial and must meet the Health Safety Net- Partial Deductible described in 101 CMR 613.01 (6) (c)

G. Health Safety Net- Partial Deductibles

For HSN- Partial patients with MAGI Household income or Medical Hardship Family Countable income between 201% to 400% of the FPL, there is an annual deductible equal to 40% of the difference between the lowest MassHealth MAGI household income or Medical Hardship Family Countable Income as described in 101 CMR 613.01 (1) in the applicant's Premium Billing Family Group (PBFPG) and 200.1% of the FPL. The patient is responsible for payment for all services provided up to this deductible amount. There is only one deductible per PBFPG during the eligibility period. Each PBFPG must be determined a Low Income Patient in order for his or her expenses for Reimbursable Health Services to be applied to the deductible. If more than one PBFPG members is determined to be a Low Income Patient, or if the patient or PBFPG members receive services from more than one provider, it is the patient's responsibility to track the deductible and provide documentation to the Hospital that the deductible has been reached.

H. Medical Hardship

a. Eligibility: A resident of the Commonwealth of Massachusetts at any Countable income level may qualify for Medical Hardship if allowable medical expenses have so depleted his or her Countable income that he or she is unable to pay for Health services. Per regulations, this is a one-time determination and not an ongoing eligibility category (101 CMR 613.05(1)(a)).

b. Application Process: The Hospital will assist the patient in the collection of all applicable information and will submit Medical Hardship applications to the Health Safety Net Office for approval.

c. Allowable Medical Expenses: A Massachusetts resident at any Countable Income level may qualify for Medical Hardship if Allowable Medical Expenses have so depleted his or her Countable Income that he or she is unable to pay for Health Services. (101 CMR 613.05(1)(a) (1)). Allowable medical expenses may include only Medical Hardship family medical bills from any health care Provider that, if paid, would qualify as deductible medical expenses for federal income tax purposes. Allowable medical expenses include paid and unpaid bills for which the patient is responsible up to 12 months prior to the date of the Medical Hardship application. If the Health Safety Net Office approves two Medical Hardship applications during a 12- month period, it will prorate the required contribution amounts. (101 CMR 613.05)

d. Determination: The Health Safety Net Office notifies applicants of the determination. The Health Safety Net Office will determine the patient's qualification for the program and will notify the hospital as to which bills are the patient's responsibility and which bills may be submitted to the Health Safety Net. Determination of Medical Hardship is limited to those bills that were included with the application. Bills included in a Medical Hardship determination will not be included in a subsequent Medical Hardship application.

I. Low Income Patient Financial Responsibility:

a. Cost Sharing Requirements:

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

b. Deposits:

- 1.) A Provider may not require preadmission and/or pretreatment deposits from individuals that require Emergency Services or that are determined to be Low Income Patients.
- 2.) A Provider may request a deposit from individuals determined to be Low Income Patients. Such deposits must be limited to 20% of the Deductible amount, up to \$500. All remaining balances are subject to the payment plan conditions established in 101 CMR 613.08(1) (f)
- 3.) A Provider may request a deposit from patients eligible for Medical Hardship. Deposits are limited to 20% of the Medical Hardship contribution up to \$1,000.00 All remaining balances are subject to the payment plan conditions established in 101 CMR 613.08(1)(f).

c. Payment Plans:

A Provider may request a deposit from Patients eligible for Medical Hardship. Deposits are limited to 20% of the Medical Hardship contribution up to \$1,000. All remaining balances are subject to the payment plan conditions established in 101 CMR 613.08(1)(f). A patient with a balance of \$1,000.00 or less, after initial deposit, must be offered at least a one-year, interest-free payment plan with a minimum monthly payment of no more than \$25.00. A patient with a balance of more than \$1,000, after initial deposit, must be offered at least a two-year, interest-free payment plan.

d. Deductible Tracking:

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

e. Pending Determinations:

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

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

A. General Principles

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

The goal of these notices is to assist patients in applying for coverage within a financial assistance program, such as MassHealth, Connector Care formerly Commonwealth Care, Children's Medical Security Plan and Health Safety Net. When applicable, the Hospital may also assist patients in applying for coverage of services such as a Medical Hardship based on the patient's documented income and allowable medical expenses. The Hospital will provide, upon request, specific information about the eligibility process to be a Low Income Patient under either the Massachusetts Health Safety Net Program or additional assistance for patients who are low income through the Hospital's own financial assistance program. The Hospital will also notify the patient about available payment plans that may be available to them based on their family size and income.

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

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

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

a. Application for Programs

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

- i. Completion of a MassHealth Benefit Request (MBR).
- ii. Completion of a Medical Hardship application.

C. Approval of Coverage

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

D. Grievance Process

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

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

E. Notification Practices

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

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

Posted signs will be clearly visible and legible to patients visiting these areas. All signs and notices shall be translated into languages other than English if 10% or more of the population residing in the Hospital's service area speaks such

language. Currently the Hospital translates the notices into the following languages: English and Spanish. The Hospital will also include a notice about the availability of financial assistance in all initial bills.

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

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

V. Hospital Billing and Collection Practices

General Principles

The Hospital does not discriminate on the basis of race, color, national origin, citizenship, alienage, religion, creed, sex, sexual 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. The Hospital has a fiduciary duty to seek reimbursement for services it has provided from individuals who are able to pay, from third party insurers who cover the cost of care, and from other assistance programs for which the patient is eligible. To determine whether a patient is able to pay for the services provided as well as to assist the patient in finding alternative coverage options if they are uninsured or underinsured, the Hospital follows the following criteria related to billing and collecting from patients.

A. Collecting Information on Patient Financial Resources and Insurance Coverage

a. Patient Obligations:

Prior to the delivery of any health care services (except for cases that are emergency or urgent care service level) the patient is expected to provide timely and accurate information on their demographic information, insurance status, changes in their family income or insurance status, information on any deductibles, or co-payments that are owed based on their existing insurance or financial program payment obligations. The detailed information 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.
- iii.** Other resources that may be used to pay their bill, including other insurance programs, such as Motor Vehicle or Homeowners Insurance policies if the treatment was due to an accident, worker's compensation programs, student insurance policies, and any other family income such as inheritances, gifts, or distributions from an available trust, among others.

It is ultimately the patient's obligation to keep track of and timely pay their unpaid hospital bill, including any existing co-payments and deductibles. The patient is further required to inform either the 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 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 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 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 applicable public program, such as the Office of Medicaid or the Health Safety Net. A Low Income Patient must:

- 1.) File an insurance claim for compensation, if available.
- 2.) Assign to the The Health Safety Net office, or its agent, the right to recover an amount equal to the Health Safety Net benefits provided from the proceeds of any claim or other proceeding against a third party.
- 3.) Provide information about the claim or any other proceeding and cooperate fully with the Office, unless the Office determines that cooperation would not be in the best interest of, or would result in serious harm or emotional impairment to, the applicant or member.
- 4.) Notify the Office or MassHealth in writing within 10 days of filing any claim, civil action or other proceeding
- 5.) Repay the Office from money received from a third party for all Health Safety Net services provided on or after the date of the accident or other incident. If the patient is involved in an accident or other incident after becoming Health Safety Net eligible, repayment will be limited to Health Safety Net services provided as a result of the accident or incident.

b. Hospital Obligations:

The Hospital will make all reasonable and diligent efforts to collect the patient's insurance 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 this credit and collection policy). The hospital will delay any attempt to obtain this information during the delivery of any EMTALA level 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.

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.

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

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

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.

c. Motor Vehicle Accidents and Third Party Liability Claims

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

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

B. Hospital Billing Practices

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

- a.** The Hospital will send an initial bill to the patient or the party responsible for the patient's personal financial obligations. The initial bill will include information about the availability of a financial assistance program that might be able to cover the cost of the Hospital's bill.
- b.** Subsequent billings, telephone calls, collection letters, personal contact notices, computer notifications, or any other notification method that constitutes a genuine effort to contact the party responsible for the obligation and informs the patient of the availability of financial assistance.
- c.** Sending a final notice by certified mail for uninsured patients (those not enrolled in a public program such as MassHealth or HSN) who incur an Emergency Bad Debt balance over \$1,000 on Emergency Level Services only, where notices have not been returned as "incorrect address" or "undeliverable".
- d.** If possible, documentation of alternative efforts to locate the party responsible for the obligation or the correct address on billings returned by the United States Postal Service such as "incorrect address" or "undeliverable".
- e.** Documentation of continuous billing or collection action undertaken 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 federal Medicare program and the Health Safety Net office, deems 120 days as appropriate for period of time representing continuous billing and collection actions.
- f.** 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 Massachusetts Health Connector 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.

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 (MMIS).

The Hospital will seek a specified payment for those patients that do not qualify for enrollment in a Massachusetts state public assistance program, such as out-of-state residents, but who may otherwise meet the general financial eligibility categories of a state public assistance program. Eligibility for financial assistance from the Hospital will be established using the person's income regardless to the state in which they reside.

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 Hospital will take reasonable steps to ensure that no collection actions, including telephone calls, statements or letters, are initiated for those patient balances that may be exempt from collection action by regulation. The following individuals and patient populations are exempt from collection or billing procedures pursuant to state regulations and policies:

- a.** Patients enrolled in a public health insurance program, including but not limited to, MassHealth, Emergency Aid to the Elderly, Disabled and Children's Medical Security Plan, "Low Income Patients" as determined by the Office of Medicaid - subject to the following exceptions:
 - i.** 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.
 - ii.** The Hospital may also initiate billing or collection for a patient who alleges that he or she is a participant in a financial assistance program that covers the costs of the hospital services, but fails to provide proof of such participation. Upon receipt of the satisfactory proof that a patient is a participant in a financial assistance program, (including receipt or verification of signed application) the Hospital shall cease its billing and collection activities.
 - iii.** The Hospital may continue collection action on any Low Income Patient for services rendered prior to the Low Income Patient determination, provided that the current Low Income Patient status has been terminated, expired, or not otherwise identified on the state Massachusetts Health Connector or Eligibility Verification System (EVS). However, once a patient is determined eligible and enrolled in the Health Safety Net, MassHealth, or Connector Care programs, the Hospital will cease collection activity for services provided prior to the beginning of their eligibility.
 - iv.** The Hospital may seek collection action against any of the patients participating in the programs listed above for non-covered services that the patient has agreed to be responsible for, provided that the Hospital obtained the patient's prior written consent to be billed for the service.

E. Standard Collection Actions

a. The Hospital will not undertake any "extraordinary collection activities" until such time as the Hospital has made a reasonable review of the patient's financial status, which will determine that a patient is entitled to financial assistance or exemption from any collection or billing activities under this credit and collection policy. The Hospital will keep any and all documentation that was used in this determination pursuant to the Hospital's applicable record retention policy. Extraordinary collection activities may include lawsuits, liens on residences, arrests, body attachments, or as otherwise described below in compliance with state requirements.

b. 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 Waiver the Health Safety Net program.

c. 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 refused to cooperate with the Hospital to seek an available financial assistance program.

(3) For purposes of the lien, it was approved by the Hospital's Board of Trustees on an individual case by case basis.

d. The Hospital and its agents shall not continue collection or billing on a patient who is a member of a bankruptcy proceeding except to secure its right as a creditor in the appropriate order, provided that the State of Massachusetts will file its own recovery action for these patients enrolled in MassHealth or the Health Safety Net.

e. 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.

f. The hospital maintains compliance with applicable billing requirements, including 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

F. Outside Collection Agencies

The Hospital contracts with outside collection agencies 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 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 agencies 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 agency also is in compliance with the Massachusetts Attorney General's Debt Collection Agency Regulations 940 C.M.R. 7.00.

G. Bad Debt

The Hospital will make reasonable efforts to collect on outstanding balances. The Hospital will send an initial bill, follow-up with monthly statements for a period of 120 days. If at the end of this billing cycle the balance remains unpaid or installment payments have not been met, the patient or guarantor will be sent a Final Notice Letter.

Accounts that remain unpaid (10) days from the date of the Final Notice Letter will be reviewed and at the discretion of the Hospital be written off to Bad Debt. The accounts will be placed with collection agencies for a designated period of time. At the end of the designated period of time the agent will return to the Hospital all accounts that are unpaid or installment payments have not been met. The agent will cease all collection efforts.

VI. Deposits and Payment Plans

Pursuant to the Massachusetts Health Safety Net regulations pertaining to patients that are either: (1) determined to be a "Low Income Patient" or (2) qualify for Medical Hardship, the Hospital provides the following deposits and payment plans. Any other plan will be based on the Hospital's own internal financial assistance program, and will not apply to patients who have the ability to pay.

A. Emergency Services

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

B. Low Income Patient Deposits

The Hospital may request a deposit from individuals determined to be Low Income Patients. Such deposits must be limited to 20% of the deductible amount, up to \$500. All remaining balances are subject to the payment plan conditions established in 101CMR 613.08(1)(f).

C. Deposits for Medical Hardship Patients

The Hospital may request a deposit from patients eligible for Medical Hardship. Deposits will be limited to 20% of the Medical Hardship contribution up to \$1,000. All remaining balances will be subject to the payment plan conditions established in 101 CMR 613.08(1)(f).

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

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

VII. 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 employer-sponsored, a public financial assistance, or an individually purchased insurance program.

Low Income Patient

An individual must be a Resident of the Commonwealth and document Family Income equal to or less than 400% of the Federal Poverty Limit (FPL)

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.
- Connector Care: health insurance for low income Massachusetts residents who do not have health insurance.
- Children's Medical Security Plan (CMSP): health insurance for uninsured Massachusetts residents under 19 and do not qualify for MassHealth.
- 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.

VIII. Attachments/Exhibits

1. Signage: posted in English and Spanish (ref. V. A.)
2. “Availability of Financial Assistance and Public Assistance Programs” “Disponibilidad de Asistencia Financiera y de Programas Publicos de Asistencia”
3. MassHealth Permission to Share Information (PSI) Form 4. Budget Payment Plan Letter
4. Payment Plan Agreement Uninsured Discount
5. Promised Payment Agreement Form
6. Income Attestation Form Uninsured Discount
7. Patient Itemized Statement
8. Patient Billing Statements Self Pay Patients #1, #2, #3, #4
9. Patient Billing Statements Patients with Insurance #1, #2, #3, #4
10. Final Notice Letter to Patient
11. Massachusetts 2015 Poverty Guidelines