101 CMR 613.00: HEALTH SAFETY NET ELIGIBLE SERVICES

Section

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613.01: General Provisions

Scope, Purpose, and Effective Date. 101 CMR 613.00 governs the criteria applicable June 1, 2016, for determining the services for which Acute Hospitals and Community Health Centers may be paid by the Health Safety Net, including the types of services that are paid by the Health Safety Net, and the criteria to determine Low Income Patient status, to determine Medical Hardship, and to submit claims for Bad Debt. Payment rates for Eligible Services, as defined at 101 CMR 613.03, are set forth in 101 CMR 614.00: *Health Safety Net Payments and Funding*.

613.02: Definitions

As used in 101 CMR 613.00, unless the context otherwise requires, terms have the following meanings. All defined terms in 101 CMR 613.00 are capitalized.

340B Provider. An Acute Hospital or Community Health Center eligible to purchase discounted drugs through a program established by § 340B of United States Public Law 102-585, the Veterans Health Act of 1992, permitting certain grantees of federal agencies access to reduced cost drugs for their Patients, and registered and listed as a 340B Pharmacy within the United States Department of Health and Human Services, Office of Pharmacy Affairs database. Pharmacy services may be provided by a 340B Provider at on-site or off-site locations.

Acute Hospital. A hospital licensed under M.G.L. c. 111, § 51 that contains a majority of medical-surgical, pediatric, obstetric, and maternity beds, as defined by the Department of Public Health.

Administrative Day. A day of inpatient hospitalization on which a Patient's care needs can be provided in a setting other than an inpatient Acute Hospital in accordance with the standards in 130 CMR 415.000: *Acute Inpatient Hospital Services* and on which the Patient is clinically ready for discharge.

Adult Dental Services. Dental services provided to individuals 21 years of age and older and billed using the codes listed in the Health Safety Net claims specifications for Acute Hospitals and Community Health Centers.

Ancillary Services. Nonroutine services for which charges are customarily made in addition to routine charges, that include, but are not limited to, laboratory, diagnostic and therapeutic radiology, surgical services, and physical, occupational, or speech-language therapy. Generally, ancillary services are billed as separate items when the Patient receives these services.

Application. A request for health benefits that is received by the MassHealth Agency and includes all required information and a signature by the applicant or his or her authorized representative. The application may be submitted online at www.MAHealthConnector.org, or the applicant may complete a paper application, complete a telephone application, or apply in person at a MassHealth Enrollment Center (MEC). The date of application for an online, telephonic, or in-person application is the date the application is submitted to the MassHealth Agency. The date of application for a paper application that is either mailed or faxed is the date the application is received by the MassHealth Agency.

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Bad Debt. An account receivable based on services furnished to a Patient that is
(a) regarded as uncollectible, following reasonable collection efforts consistent with the requirements in 101 CMR 613.06;
(b) charged as a credit loss;
(c) not the obligation of a governmental unit or the federal government or any agency thereof; and
(d) not a Reimbursable Health Service.

Caretaker Relative. An adult who is the primary care giver for a child, is related to the child by blood, adoption, or marriage, or is a spouse or former spouse of one of those relatives, and lives in the same home as that child, provided that neither parent is living in the home.

Charge. The uniform price for a specific service charged by a Provider.

Children's Medical Security Plan (CMSP). A program of primary and preventive pediatric health care services for eligible children, from birth through age 18, administered by the MassHealth Agency pursuant to M.G.L. c. 118E, § 10F.

Collection Action. Any activity by which a Provider or designated agent requests payment for services from a Patient, a Patient's guarantor, or a third party responsible for payment. Collection Actions include activities such as preadmission or pretreatment deposits, billing statements, collection follow-up letters, telephone contacts, personal contacts, and activities of collection agencies and attorneys.

CommonHealth. A MassHealth program for disabled adults and disabled children administered by the MassHealth Agency pursuant to M.G.L. c. 118E.

Community Health Center. A health center operating in conformance with the requirements of § 330 of United States Public Law 95-926, including a Community Health Center that files a cost report as requested by the Center for Health Information and Analysis. Such a health center must
(a) be licensed as a freestanding clinic by the Massachusetts Department of Public Health pursuant to M.G.L. c. 111, § 51;
(b) meet the qualifications for certification (or provisional certification) by the MassHealth Agency and enter into a Provider agreement pursuant to 130 CMR 405.000: *Community Health Center Services*; and
(c) operate in conformance with the requirements of 42 U.S.C. § 254(c).

Confidential Services. Services for the treatment of sexually transmitted diseases provided under M.G.L. c. 112, § 12F and family planning services provided under M.G.L. c. 111, § 24E.

Countable Income. Income as defined in 101 CMR 613.05(1)(b).

Dental-only Low Income Patient. An uninsured Low Income Patient for whom payment from the Health Safety Net Trust Fund is only allowable for dental services, as specified in 101 CMR 613.04(4)(a)2.a.

Eligible Services. Services eligible for Health Safety Net payment pursuant to 101 CMR 613.03. Eligible Services include
(a) Reimbursable Health Services to Low Income Patients;
(b) Medical Hardship; and
(c) Bad Debt as further specified in 101 CMR 613.00 and 614.00: *Health Safety Net Payments and Funding*.

Emergency Aid to the Elderly, Disabled and Children (EAEDC). A program of governmental benefits under M.G.L. c. 117A.

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

Emergency Services. Medically Necessary Services provided to an individual with an Emergency Medical Condition.

EMTALA. The federal Emergency Medical Treatment and Active Labor Act under 42 U.S.C. § 1395dd.

EVS. The MassHealth Eligibility Verification System.

Federal Poverty Level (FPL). The federal poverty income guidelines issued annually in the *Federal Register*.

Fiscal Year. The time period of 12 months beginning on October 1st of any calendar year and ending on September 30th of the following calendar year.

Governmental Unit. The Commonwealth, any department, agency, board, or commission of the Commonwealth, and any political subdivision of the Commonwealth.

Gross Income. The total money earned or unearned, such as wages, salaries, rents, pensions, or interest, received from any source without regard to deductions.

Guarantor. A person or group of persons that assumes the responsibility of payment for all or part of a Provider's charge for services.

Health Connector. Commonwealth Health Insurance Connector Authority or Health Connector established pursuant to M.G.L. c. 176Q, § 2.

Health Insurance Plan. Medicare, MassHealth, the Premium Assistance Payment Program Operated by the Health Connector, a Qualified Health Plan, or an individual or group contract or other plan providing coverage of health care services issued by a health insurance company, as defined in M.G.L. c. 175, 176A, 176B, 176G, or 176I.

Health Safety Net. The payment program established and administered in accordance with M.G.L. c. 118E, §§ 8A, and 64 through 69 and regulations promulgated thereunder, and other applicable legislation.

Health Safety Net Office (Office). The office within the Office of Medicaid established under M.G.L. c. 118E, § 65.

Health Safety Net - Partial. A Low Income Patient eligible for either Health Safety Net - Primary or Health Safety Net - Secondary who documents MassHealth MAGI Household income or Medical Hardship Family Countable Income, as described in 101 CMR 613.04(1), between 150.1% and 300% of the FPL, is considered Health Safety Net - Partial as described in 101 CMR 613.04(4)(b)3.

Health Safety Net - Partial Deductible (Deductible). Annual deductible applied as described in 101 CMR 613.04(6)(c).

Health Safety Net - Primary. A Health Safety Net eligibility category for uninsured Low Income Patients as described in 101 CMR 613.04(4)(a)1.

Health Safety Net - Secondary. A Health Safety Net eligibility category for Low Income Patients with other primary health insurance as described in 101 CMR 613.04(4)(a)2.

Health Safety Net Trust Fund. The fund established under M.G.L. c. 118E, § 66.

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Health Services. Medically necessary inpatient and outpatient services as authorized under Title XIX of the Social Security Act. Health services do not include

(a) nonmedical services, such as social, educational, and vocational services;
(b) cosmetic surgery;
(c) canceled or missed appointments;
(d) telephone conversations and consultations;
(e) court testimony;
(f) research or the provision of experimental or unproven procedures; and
(g) the provision of whole blood, but the administrative and processing costs associated with the provision of blood and its derivatives are payable.

Hospital Licensed Health Center. A Satellite Clinic that

(a) meets MassHealth requirements for reimbursement as a Hospital Licensed Health Center as provided at 130 CMR 410.413: *Medical Services Required on Site at a Hospital-licensed Health Center*; and
(b) is approved by and enrolled with MassHealth's Provider Enrollment Unit as a Hospital Licensed Health Center.

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

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

Low Income Patient. An individual who meets the criteria under 101 CMR 613.04(1).

MassHealth. The medical assistance and benefit programs administered by the MassHealth Agency pursuant to Title XIX of the Social Security Act (42 U.S.C. 1396), Title XXI of the Social Security Act (42 U.S.C. 1397), M.G.L. c. 118E, and other applicable laws and waivers to provide and pay for medical services to eligible members.

MassHealth Agency. The Executive Office of Health and Human Services in accordance with the provisions of M.G.L. c. 118E.

MassHealth CarePlus. A program of health care services for eligible adults, age 21 to age 64, administered by the MassHealth Agency pursuant to 130 CMR 505.000: *Health Care Reform: MassHealth: Coverage Types*.

MassHealth Family Assistance. A program of health care services for eligible children and adults administered by the MassHealth Agency pursuant to 130 CMR 505.000: *Health Care Reform: MassHealth: Coverage Types*.

MassHealth Family Assistance - Children. Minors enrolled in Family Assistance/Premium Assistance whose MassHealth MAGI Household income, as described in 101 CMR 613.04(1), is between 150 and 300 % of the FPL and who reported to MassHealth that they are enrolled in health insurance.

MassHealth Limited. A program of emergency health care services for individuals administered by the MassHealth Agency pursuant to 130 CMR 505.000: *Health Care Reform: MassHealth: Coverage Types*.

MassHealth MAGI Household. A household as defined in 130 CMR 506.002(B): *MassHealth MAGI Household Composition*.

MassHealth Standard. A program of health care services for eligible individuals administered by the MassHealth Agency pursuant to 130 CMR 505.000: *Health Care Reform: MassHealth: Coverage Types*.

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Medical Coverage Date.

(a) The medical coverage date begins on the tenth day before the date the Application is received as described in 130 CMR 502.003(D): *Time Standards*, if all required verifications, including a completed disability supplement, have been received within 90 days of the receipt of the Request for Information, as described at 130 CMR 502.003(C): *Request for Information Notice*.

(b) If these required verifications listed on the Request for Information are received after the 90-day period referenced in 101 CMR 613.02, the begin date of medical coverage is ten days before the date on which the verifications were received, if such verifications are received within one year of receipt of the Application.

(c) For children younger than 21 years old and pregnant women receiving Provisional Eligibility as described in 130 CMR 502.003: *Verification of Eligibility Factors*, the medical coverage date begins ten days prior to the date of Application. For all other applicants receiving Provisional Eligibility as described in 130 CMR 502.003: *Verification of Eligibility Factors*, the medical coverage date begins on the date of the provisional eligibility determination. If all required verifications are received before the end of the provisional eligibility period, the medical coverage date of the verified coverage type will be ten days prior to the date of the Application.

Medical Hardship. Health Safety Net eligibility type available to Massachusetts Residents at any Countable Income level whose allowable medical expenses have so depleted his or her Countable Income that he or she is unable to pay for Eligible Services as described in 101 CMR 613.05.

Medical Hardship Family. Persons who live together, and consist of

(a) a child or children younger than 19 years old, any of their children, and their parents;

(b) siblings younger than 19 years old and any of their children who live together even if no adult parent or Caretaker Relative is living in the home; or

(c) a child or children younger than 19 years old, any of their children, and their Caretaker Relative when no parent is living in the home. A Caretaker Relative may choose whether or not to be part of the Medical Hardship Family. A parent may choose whether or not to be included as part of the Medical Hardship Family of a child younger than 19 years old only if that child is

1. pregnant; or
2. a parent.

A child who is absent from the home to attend school is considered as living in the home. A parent may be a natural, step, or adoptive parent. Two parents are members of the same family as long as they are both mutually responsible for one or more children that live with them.

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

Medicare Program. The medical insurance program established by Title XVIII of the Social Security Act.

Mental Health Services. A comprehensive group of diagnostic and psychotherapeutic treatment services to mentally or emotionally disturbed persons and their families by an interdisciplinary team under the medical direction of a psychiatrist.

Minor. A person younger than 19 years old.

Modified Adjusted Gross Income (MAGI). Income as defined in 130 CMR 501.001: *Definition of Terms*.

Patient. An individual who receives or has received Medically Necessary Services at an Acute Hospital or Community Health Center.

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Pharmacy Online Processing System (POPS). The MassHealth online, real-time computer network that adjudicates pharmacy claims, incorporating prospective drug utilization review, prior authorization, and Patient eligibility verification.

Premium Assistance Payment Program Operated by the Health Connector. An insurance subsidy program that provides state subsidies for low-income individuals and families administered by the Health Connector.

Premium Billing Family Group (PBFG). A group of persons who live together as defined in 130 CMR 501.001: *Definition of Terms*.

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

Provider. An Acute Hospital or Community Health Center that provides Eligible Services.

Provider Affiliate. An individual practitioner, practice group, or any other entity that provides emergency or medically necessary care in an Acute Hospital, including in affiliated Satellite Clinics or Hospital Licensed Health Centers.

Provisional Eligibility. Initial approval for Low Income Patient status when an applicant's certain self-attested circumstances show eligibility for the Health Safety Net, pending further eligibility verification for continued eligibility in accordance with 130 CMR 502.003: *Verification of Eligibility Factors*.

Qualified Health Plan (QHP). A health plan licensed under M.G.L. c. 175, 176A, 176B, or 176G that has received the Commonwealth Health Insurance Connector's Seal of Approval as meeting the criteria under 45 CFR 155.1000 and is offered through the marketplace in accordance with the provisions of 45 CFR 155.1010. QHPs are administered by the Commonwealth Health Insurance Connector Authority.

Reimbursable Health Services. Eligible Services provided by Acute Hospitals or Community Health Centers to Uninsured and Underinsured Patients who are determined to be financially unable to pay for their care, in whole or in part and who meet the criteria for Low Income Patient; provided that such services are not eligible for reimbursement by any other public or third party payer.

Resident. A person living in the Commonwealth of Massachusetts with the intention to remain as defined by 130 CMR 503.002(A) through (D). Persons who are not considered residents are

(a) individuals who came to Massachusetts for the purpose of receiving medical care in a setting other than a nursing facility, and who maintain a residence outside of Massachusetts;
(b) persons whose whereabouts are unknown; or
(c) inmates of penal institutions except in the following circumstances:
1. they are inpatients of a medical facility; or
2. they are living outside of the penal institution, are on parole, probation, or home release, and are not returning to the institution for overnight stays.

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

Student Health Plan. Student health insurance plan operated in compliance with M.G.L. c. 15A, § 18.

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

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Underinsured Patient. A Patient whose Health Insurance Plan or self-insurance plan does not pay, in whole or in part, for Health Services that are eligible for payment from the Health Safety Net Trust Fund, provided that the Patient meets income eligibility standards set forth in 101 CMR 613.04.

Uninsured Patient. A Patient who is a resident of the Commonwealth, who is not covered by a Health Insurance Plan or a self-insurance plan, and who is not eligible for a medical assistance program. A Patient who has a policy of health insurance or is a member of a health insurance or benefit program that requires such Patient to make payment of deductibles or copayments, or fails to cover certain medical services or procedures is not uninsured.

Urgent Care Services. Medically Necessary Services provided in an Acute Hospital or Community Health Center after the sudden onset of a medical condition, whether physical or mental, manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson would believe that the absence of medical attention within 24 hours could reasonably expect to result in placing a Patient's health in jeopardy, impairment to bodily function, or dysfunction of any bodily organ or part. Urgent Care Services are provided for conditions that are not life threatening and do not pose a high risk of serious damage to an individual's health. Urgent Care Services do not include Primary or Elective Care.

613.03: Eligible Services Requirements

(1) General. To qualify as a service eligible for payment, the service must meet the following criteria.

(a) Eligible Services Categories. There are three categories of services eligible for payment from the Health Safety Net, as follows:

1. Reimbursable Health Services to Low Income Patients as defined in 101 CMR 613.04;
2. Medical Hardship, pursuant to the requirements in 101 CMR 613.05; and
3. Bad Debt, pursuant to the requirements in 101 CMR 613.06.

(b) Eligible Services Limitations - General. The Health Safety Net does not pay for, and Providers may not submit claims to the Office for, services that are not medically necessary or for which another public or private payer is responsible. The Health Safety Net is the payer of last resort.

1. The Health Safety Net Office may request, and the Provider must provide, any and all medical records (or clear photocopies of such records) corresponding to or documenting the services claimed upon request of the Health Safety Net Office or its agent.
2. The medical record must contain sufficient data to document fully the nature, extent, quality, and necessity of the care provided to a Patient for each service claimed for payment.
3. For services for which MassHealth requires prior authorization, the Provider must ensure that current clinical standards are used to determine whether the service is medically necessary. The Health Safety Net Office or its agent may audit claims to verify medical necessity.
4. All Providers must make diligent efforts to obtain payment first from other resources, including personal injury protection (PIP) payments, to ensure that the Health Safety Net is the payer of last resort.
5. If the Health Safety Net Office, or its agent, identifies a third-party resource after the Provider has billed and received payment from the Health Safety Net, it will notify the Provider of this available third-party resource. Upon receipt of notification, the Provider must remit the Health Safety Net payment or provide documentation of diligent efforts as described in 101 CMR 613.03(1)(c)3. to obtain payment from the third-party resource. The Office, or its agent, will review the submitted documentation to determine whether the Provider made diligent efforts. If the Office, or its agent, determines the Provider did not make diligent efforts to receive payment from the third party, the Health Safety Net may recover the payment by deducting it from future payments.

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6. If the Office, or its agent, identifies a third-party resource, the Office may recover from the financially responsible third party the costs attributable to services provided to an individual that were paid by the Health Safety Net. A payment from the Health Safety Net for such services is recoverable from the third party and the payment, after notice to the third party, operates as a lien under M.G.L. c. 118E.

(c) Reimbursable Health Services Limitations - Low Income Patients.

1. For insured Low Income Patients, the Health Safety Net does not pay for, and Providers may not submit claims for, services for which the primary insurer has denied payment because of a technical billing error, because the Patient obtained out of network services, because the Patient failed to obtain required prior authorization for services, or because of other administrative reasons. The Health Safety Net does not pay claims for the balance of an insurer's contractual allowance or for late charges for a service that has been paid by another payer.

2. For insured Low Income Patients with other available resources, including but not limited to private health and casualty insurance, the Health Safety Net

a. does not pay a Provider if it determines that, among other things, the Provider has not made diligent efforts to obtain payment from those resources; and

b. recovers any payments made if it determines that the Provider has not made diligent efforts to obtain payment from those resources.

3. "Diligent efforts" is defined as making every effort to identify and obtain payment from all other liable parties, including insurers. Diligent efforts include, but are not limited to

a. determining the existence of insurance that could pay for medical expenses by asking the Patient if he or she has other insurance and by using insurance databases available to the Provider. In the event of a motor vehicle accident, this includes investigating whether the Patient, driver, and/or owner of any motor vehicle involved had a motor vehicle liability policy;

b. verifying the Patient's other health insurance coverage, currently known to the Health Safety Net, through EVS, or any other health insurance resource available to the Provider, on each date of service and at the time of billing;

c. submitting claims to all insurers with the insurer's designated service code for the service provided;

d. complying with the insurer's billing and authorization requirements;

e. appealing a denied claim when the service is payable in whole or in part by an insurer; and

f. immediately returning any payment received from the Office when any available third-party resource has been identified.

4. For insured Low Income Patients with private insurance, including Student Health Plans and Qualified Health Plans other than the Premium Assistance Payment Program Operated by the Health Connector, the Health Safety Net pays only for deductibles, coinsurance, and Reimbursable Health Services not covered by the insurer. The Health Safety Net does not pay for copayments required by a private insurer.

5. For MassHealth members enrolled in MassHealth Limited, EAEDC, CMSP, CMSP plus Limited, and for MassHealth Family Assistance - Children, the Health Safety Net pays only for Reimbursable Health Services not covered by the member's MassHealth benefit. A Provider may submit a claim for Reimbursable Health Services not covered by EAEDC only if the member's EAEDC eligibility is non-temporary. A Provider may submit a claim for Reimbursable Health Services not covered by CMSP only if the individual's MAGI income is less than or equal to 300% of the FPL.

6. For MassHealth members enrolled in MassHealth Standard, MassHealth CarePlus, CommonHealth, and Family Assistance, excluding MassHealth Family Assistance - Children, the Health Safety Net pays only for Adult Dental Services provided by a Community Health Center, Hospital Licensed Health Center, or other Satellite Clinic that are not covered by MassHealth.

7. For MassHealth members, the Health Safety Net does not pay for, and Providers may not submit claims to the Office for MassHealth copayments.

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8. For Low Income Patients enrolled in Medicare, including MassHealth members enrolled in Medicare Buy-in and Senior Buy-in, the Health Safety Net pays for Reimbursable Health Services not covered by Medicare, and for Medicare copayments, coinsurance, and deductibles.

9. The Health Safety Net does not pay copayments for the Premium Assistance Payment Program Operated by the Health Connector.

10. The Health Safety Net pays for Reimbursable Health Services provided to Low Income Patients for services provided during the Eligibility Period specified in 101 CMR 613.04(5).

(d) Eligible Services Limitations - Serious Reportable Events. The Health Safety Net does not pay for services directly related to a Serious Reportable Event (SRE) as defined in 105 CMR 130.332(A): *Definitions Applicable to 105 CMR 130.332*.

1. A Provider must not charge, bill, or otherwise seek payment from the Health Safety Net, a Patient, or any other payer as required by 105 CMR 130.332: *Serious Reportable Events (SREs)*, for services provided as a result of an SRE occurring on premises covered by a Provider's license, if the Provider determines that the SRE was

a. preventable;

b. within the Provider's control; and

c. unambiguously the result of a system failure as required by 105 CMR 130.332(B): *Reporting of SREs* and (C): *Preventability Determination*.

2. A Provider must not charge, bill, or otherwise seek payment from the Health Safety Net, a Patient, or any other payer as required by 105 CMR 130.332: *Serious Reportable Events (SREs)* for services directly related to

a. the occurrence of the SRE;

b. the correction or remediation of the event; or

c. subsequent complications arising from the event as determined by the Health Safety Net Office on a case-by-case basis.

3. A Provider may submit a claim for services it provides that result from an SRE that did not occur on its premises only if the treating facility and the facility responsible for the SRE do not have common ownership or a common corporate parent.

4. Readmissions to the same hospital or follow-up care provided by the same Provider or a Provider owned by the same parent organization are not billable if the services are associated with the SRE as described in 101 CMR 613.03(1)(d)2.

(2) Reimbursable Health Services.

(a) General. The Health Safety Net pays only for the Reimbursable Health Services listed below. Providers may submit claims only for Reimbursable Health Services provided by Acute Hospitals and Community Health Centers in accordance with the MassHealth Standard program using the payment codes as listed in Subchapter 6 of the *MassHealth Inpatient and Outpatient Provider Manuals* and other MassHealth Provider manuals unless otherwise specified in 101 CMR 614.00: *Health Safety Net Payments and Funding*. The Health Safety Net Office may add additional codes and Reimbursable Health Services by administrative bulletin, as described in 101 CMR 613.08(4).

(b) Pharmacy. The Health Safety Net pays only for prescribed drugs according to the coverage rules, including 130 CMR 406.411: *Prescription Requirements*; 406.412(A): *Drugs* and (B)(1): *Covered Drugs and Medical Supplies*; 406.413: *Limitations on the Coverage of Drugs*; and 406.422: *Prior Authorization*, established by MassHealth and processed through POPS. Providers may not submit claims for drugs excluded from the MassHealth Drug List.

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(c) 340B Pharmacies. A 340B Provider may submit a Health Safety Net claim only for outpatient pharmacy services provided through the Provider's 340B pharmacy unless the claim is submitted by a Provider that directly operates both a 340B pharmacy and a retail pharmacy and the claim is for a drug provided to an individual who cannot be seen by a Provider-based prescriber to obtain a prescription within a clinically appropriate time period. The Provider must inform the Patient that it may not fill future prescriptions unless the individual becomes a Patient of the Provider or is placed on a waiting list in the instance that the Provider is not accepting new patients. A Provider may submit a Health Safety Net claim only for the dispensing fee for covered prescribed drugs provided to Low Income Patients if that individual is using a pharmaceutical company sponsored free drug program and the drug is dispensed by the pharmacy. A Provider may not submit a Health Safety Net claim for free or donated prescribed drugs where the drugs are stored and dispensed from a site other than the pharmacy (*e.g.*, secured closet near exam room). A Provider is eligible for Health Safety Net payments for drugs provided through its 340B Pharmacy only if it provides prescribed drugs to MassHealth members under 114.3 CMR 31.07: *Special Provisions*.

(d) Utilization Review. The Health Safety Net Office conducts a utilization review program designed to monitor the appropriateness of services for which payments are made and to promote the delivery of care in the most appropriate setting.

(e) Noncovered Services. The Health Safety Net does not pay for any of the following services: nonmedical services, such as social, educational, and vocational services; cosmetic surgery; canceled or missed appointments; telephone conversations or consultations; court testimony; research or the provision of experimental, cosmetic, unproven, or otherwise medically unnecessary procedures or treatments; the provision of whole blood except for the administrative and processing costs associated with the provision of blood and its derivatives; the treatment of male or female infertility (including, but not limited to, laboratory tests, drugs, and procedures associated with such treatment; however, the Health Safety Net pays for the diagnosis of male and female infertility); vocational rehabilitation services; sheltered workshops; recreational services; life-enrichment services; alcohol or drug drop-in centers; drugs used for the treatment of obesity; cough and cold preparations; drugs related to the treatment of male or female infertility; absorptive lenses of greater than 25% absorption; photochromatic lenses, sunglasses, or fashion tints; treatment of congenital dyslexia; extended-wear contact lenses; invisible bifocals; and the Welsh 4-Drop Lens.

(3) Reimbursable Health Services - Acute Hospitals.

(a) The Health Safety Net pays Acute Hospitals only for the Reimbursable Health Services listed in 101 CMR 613.03(3)(a)1. through 34.

1. Abortion Services. The Health Safety Net pays for first and second trimester abortions performed by a licensed physician only when the abortion is performed in accordance with M.G.L. c. 112, §§ 12K through 12U and the abortion is medically necessary, according to the medical judgment of a licensed physician in light of all factors affecting the woman's health.

2. Administrative Days. The Health Safety Net pays for Administrative Days meeting the requirements set forth in 130 CMR 415.415: *Reimbursable Administrative Days* and 130 CMR 415.416: *Nonreimbursable Administrative Days*.

3. Ambulatory Surgery Services.

4. Audiologist Services.

5. Chiropractic Services.

6. Dental Services. The Health Safety Net pays only for dental services identified in Subchapter 6 of the *MassHealth Dental Manual* and for Adult Dental Services not covered by MassHealth.

7. Durable Medical Equipment. The Health Safety Net pays only for crutches and canes provided during a Hospital Visit.

8. Family Planning Services.

9. Hearing Instrument Services.

10. Inpatient Hospice Services.

11. Inpatient Services.

12. Inpatient Psychiatric. The Health Safety Net pays only for services provided in a Medicare certified psychiatric unit.

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13. Laboratory Services. The Health Safety Net does not pay separately for routine specimen collection and preparation for the purpose of clinical laboratory analysis. Specimen collection and preparation is considered part of the laboratory service.
14. Medical Supplies. The Health Safety Net pays for medical supplies used in the delivery of inpatient and outpatient care. It also pays for spacers used with metered dose inhalers, nebulizers, diabetic supplies, home glucose monitors, and portable peak flow monitors.
15. Mental Health Services. The Health Safety Net pays for mental health services except for noncovered services in 101 CMR 613.03(2)(e). The Health Safety Net pays only for mental health services that meet the requirements in the *MassHealth Acute Outpatient Hospital Manual* at 130 CMR 410.471: *Mental Health Services: Introduction* through 410.475: *Mental Health Services: Staffing Requirements*, and 410.479(A): *Length and Frequency of Sessions*.
16. Nurse Midwife Services.
17. Nurse Practitioner Services.
18. Observation Services. Outpatient hospital services provided anywhere in an Acute Hospital, to evaluate a Patient's medical condition and determine the need for an inpatient admission. Observation services are provided under order of a physician, consist of the use of a bed and intermittent monitoring by professional licensed clinical staff, and may be provided for more than 24 hours.
19. Orthotic Services.
20. Outpatient Services. Outpatient services are services provided by Acute Hospital outpatient departments and by Hospital Licensed Health Centers or other Satellite Clinics. Such services include, but are not limited to, Emergency Services, Primary or Elective Care, observation services, Ancillary Services, and day-surgery services.
21. Outpatient Psychiatric Services.
22. Pharmacy Services.
23. Physician Services. The Health Safety Net pays only for services provided at Acute Hospital sites by Acute Hospital-based physicians who are employed or contracted by the Acute Hospital and who receive payment from the Acute Hospital for their services.
24. Podiatrist Services.
25. Prosthetic Services.
26. Radiology Services.
27. Rehabilitation Services. For inpatient rehabilitation, the Health Safety Net pays only for services provided in a Medicare certified rehabilitation unit.
28. Renal Dialysis Services.
29. Speech and Hearing Services.
30. Sterilization Services.
31. Substance Use Disorder Services, including methadone treatment as described in 130 CMR 418.000: *Substance Abuse Treatment Services*, except for noncovered services in 101 CMR 613.03(2)(e).
32. Therapy Services. The Health Safety Net pays only for therapy services as defined in the *MassHealth Acute Outpatient Hospital Manual*, at 130 CMR 410.451(A) and (B). Before therapy is initiated, there must be a comprehensive evaluation of the Patient's medical condition, disability, and level of functioning to determine the need for treatment and, when treatment is indicated, to develop a treatment plan.
33. Tobacco Cessation. The Health Safety Net pays only for services as defined by Subchapter 6 of the *MassHealth Acute Hospital Outpatient Manual*.
34. Vision Care Services. The Health Safety Net pays only for services as defined by the *MassHealth Acute Hospital Outpatient Manual* at 130 CMR 410.485: *Vision Care Service Limitations: Dispensing Eyeglasses* through 410.488: *Vision Care Service Exclusions*.

(4) Reimbursable Health Services - Community Health Centers.

(a) General. Community Health Centers may submit claims only for Reimbursable Health Services set forth in 101 CMR 613.03(4)(b). The Reimbursable Health Services must meet the requirements set forth in 101 CMR 613.03(4)(c).

1. Community Health Centers may submit claims only for services provided under the Community Health Center's clinic license.

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2. A Community Health Center may submit claims only for Reimbursable Health Services provided on site, except for off-site 340B Pharmacy Services and certain Evaluation and Management visits provided to the Community Health Center's Patients at an Acute Hospital. A Community Health Center may submit claims for dentures provided on site but manufactured or repaired at an off-site contractor.

3. The Health Safety Net does not pay Community Health Centers for performing, administering, or dispensing experimental, cosmetic, unproven, or otherwise medically unnecessary procedures or treatments or treatment of male or female infertility (including, but not limited to, laboratory tests, drugs, and procedures associated with such treatment); however, the Health Safety Net pays for the diagnosis of male and female infertility.

(b) Reimbursable Health Services.

1. Audiology Services. The Health Safety Net pays for audiology services if the services were provided at the written request of a physician, nurse practitioner, or physician assistant who has found some indication of a hearing problem. Documentation of the request and of the hearing problem must be kept in the Patient's medical record.

2. Behavioral Health Services.

3. Cardiovascular and Pulmonary Diagnostic Services.

4. Dental Services. The Health Safety Net pays for dental services identified in Subchapter 6 of the *MassHealth Dental Manual* and for Adult Dental Services not covered by MassHealth.

5. Diabetes Self-management Training. The Health Safety Net pays for diabetes self-management training services as defined by Subchapter 6 of the *MassHealth Community Health Center Manual*.

6. Electrocardiogram (EKG) Services. The Health Safety Net pays for EKG services only when the service is provided at the written request of a Community Health Center staff physician who will interpret or review the interpretation of the EKG. Documentation of the physician's request must be kept in the Patient's medical record. A Community Health Center may claim payment for EKG services only when the Community Health Center owns or rents its own EKG equipment and the EKG is taken at the Community Health Center.

7. Family Planning Services. The Health Safety Net pays for family planning counseling, prescribed drugs, family planning supplies, and laboratory tests.

8. Individual Medical Visits. The Health Safety Net pays for face-to-face meetings at a Community Health Center between a Patient and a physician, physician assistant, nurse practitioner, nurse midwife, registered nurse, or paraprofessional for medical examination, diagnosis, or treatment.

9. Laboratory Services. The Health Safety Net pays only for laboratory services for which a written request for that service from an authorized subscriber is present in the Patient's medical record. The Office does not pay for the following laboratory services: routine specimen collection and preparation for the purpose of clinical laboratory analysis (for example, venipunctures, urine, fecal, and sputum samples; Pap smears; cultures; and swabbing and scraping for removal of tissue); laboratory tests associated with treatment of male or female infertility (however, the Health Safety Net pays for the diagnosis of male and female infertility); or such calculations as red cell indices, A/G ratio, creatinine clearance, and those ratios calculated as part of a profile. The Office does not pay a Community Health Center for a laboratory service when the Community Health Center bills separately for the professional component of that service.

10. Medical Nutrition Therapy. The Health Safety Net pays for medical nutrition therapy services as defined by Subchapter 6 of the *MassHealth Community Health Center Manual*. Medical nutrition therapy does not include enteral therapy.

11. Obstetrical Services.

12. Pharmacy Services.

13. Podiatry Services.

14. Radiology Services. The Health Safety Net pays for radiology services only when the services are provided at the written request of a licensed physician or dentist. The professional component of a radiology service is the component for interpreting a diagnostic test or image. The technical component of a radiology service is the component for the cost of rent, equipment, utilities, supplies, administrative and technical supplies and benefits, and other overhead expenses.

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15. Surgery Services.
16. Tobacco Cessation Services. The Health Safety Net pays for tobacco cessation services as defined by Subchapter 6 of the *MassHealth Community Health Center Manual*.
17. Vision Care Services.
18. Immunization Visits and Vaccines.

(c) Reimbursable Health Services Requirements. The Health Safety Net pays only for services provided by the licensed professionals listed in the HSN CHC Billable Procedure Codes list and pays in accordance with 101 CMR 614.00: *Health Safety Net Payments and Funding*.

613.04: Eligible Services to Low Income Patients

(1) General. Providers may submit claims for Reimbursable Health Services to Low Income Patients determined in accordance with the criteria below. Low Income Patients may be determined eligible for Health Safety Net - Primary or Health Safety Net - Secondary, in accordance with 101 CMR 613.04(4). In order to be determined a Low Income Patient an individual must be a Resident of the Commonwealth, provide proof of identity, and document that the Modified Adjusted Gross Income of his or her MassHealth MAGI Household is equal to or less than 300% of the FPL, provided that an individual may be determined a Low Income Patient if such individual applied for Medicaid assistance by completing a Senior Application as defined in 130 CMR 515.001: *Definition of Terms* and documents that the Countable Income of his or her Medical Hardship Family is equal to or less than 300% of the FPL. The following individuals are not eligible for Low Income Patient status:

(a) individuals who have been determined eligible for any MassHealth program, including any premium assistance program, but who have failed to enroll; and

(b) individuals whose enrollment in MassHealth or the Premium Assistance Payment Program Operated by the Health Connector has been terminated due to failure to pay premiums.

(2) Low Income Patient Determination. An individual must complete and submit an Application for benefits using the eligibility procedures and requirements under 130 CMR 502.000: *The Request for Benefits* or 516.000: *The Eligibility Process*.

(a) Determination Notice. The MassHealth Agency or the Commonwealth Health Insurance Connector notifies the individual of his or her eligibility determination for health care coverage or if the individual is a Low Income Patient.

(b) Verification of Income. Verification of income is mandatory. Income may be verified either through electronic data matches or paper verification.

1. Electronic Data Matches. MassHealth electronically matches with federal and state data sources described at 130 CMR 502.004: *Matching Information* to verify attested income. The income data received through an electronic data match is compared to the attested income amount to determine if the attested amount and the data source amount are reasonably compatible. If these amounts are reasonably compatible, the attested income is considered verified for purposes of an eligibility determination. To be considered reasonably compatible

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a. both the attested income and the income from the data sources must be above the applicable income standard for the individual; or

b. both the attested income and the income from the data sources must be below the applicable income standard for the individual; or

c. the attested income and the income from the data sources must be within a ten percent range of each other.

2. Paper Verification. If the attested income and the income from the electronic data source are not reasonably compatible, or if the electronic data match is unavailable, paper verification of income is required.

a. Paper verification of monthly earned income includes, but is not limited to

i. recent paystubs;

ii. a signed statement from the employer; or

iii. the most recent federal tax return.

b. Verification of monthly unearned income is mandatory and includes, but is not limited to

i. a copy of a recent check or paystub showing gross income from the source;

ii. a statement from the income source, where matching is not available; or

iii. the most recent federal tax return.

c. Verification of gross monthly income may also include any other reliable evidence of the Patient's earned or unearned income.

3. Confidential Services. The Health Safety Net Office's Application for Health Safety Net Confidential Services may be used for the following special application types. For these application types, five percentage points of the current FPL are subtracted from the applicable total Countable Income to determine the applicant's eligibility for Low Income Patient status.

a. Minors receiving Confidential Services may apply to be determined a Low Income Patient using their own Countable Income information and using the Office's application for Health Safety Net Confidential Services. If a minor is determined to be a Low Income Patient, the Provider may submit claims for Confidential Services when no other source of funding is available to pay for the services confidentially. For all other services, Minors are subject to the standard Low Income Patient determination process. Providers may submit claims for Eligible Services rendered to these individuals for Confidential Services only.

b. An individual who has been a victim of domestic violence, or who has a reasonable fear of domestic violence or continued domestic violence, may apply for Low Income Patient status using his or her own Countable Income information if he or she seeks medically necessary Eligible Services. An individual seeking these services is not required to report his or her primary address.

4. Presumptive Determination. An individual may be determined to be a Low Income Patient for a limited period of time, if on the basis of attested information submitted to a Provider on the form specified by the Health Safety Net Office, the Provider determines the individual is presumptively a Low Income Patient. An individual may not be determined to be a Low Income Patient pursuant to 101 CMR 613.04(2)(b)4. if the individual has already been determined to be a Low Income Patient pursuant to 101 CMR 613.04(2)(b)4. within the previous 12 months. Notwithstanding 101 CMR 613.04(5)(a), Providers may submit claims for Reimbursable Health Services provided to individuals with time-limited presumptive Low Income Patient determinations only for dates of service beginning on the date on which the Provider makes the presumptive determination and continuing until the earlier of:

a. The end of the month following the month in which the Provider made the presumptive determination if the individual has not submitted a complete Application, or

b. The date of the determination notice described in 101 CMR 613.04(2)(a) related to the individual's Application.

(c) Verification of Identity. The following are acceptable proof of identity.

1. The following are acceptable proof of identity, provided such documentation has a photograph or other identifying information including, but not limited to, name, age, sex, race, height, weight, eye color, or address:

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a. identity documents listed at 8 CFR 274a.2(b)(1)(v)(B)(1), except a driver's license issued by a Canadian government authority;
b. driver's license issued by a state or territory;
c. school identification card;
d. U.S. military card or draft record;
e. identification card issued by the federal, state, or local government;
f. military dependent's identification card; or
g. U.S. Coast Guard Merchant Mariner card;

2. for children younger than 19 years old, a clinic, doctor, hospital, or school record, including preschool or day care records;

3. two documents containing consistent information that corroborates an applicant's identity. Such documents include, but are not limited to

a. employer identification cards;
b. high school and college diplomas (including high school equivalency diplomas);
c. marriage certificates;
d. divorce decrees;
e. property deeds or titles;
f. a pay stub from a current employer with the applicant's name and address preprinted, dated within 60 days of the application;
g. census verification containing the applicant's name and address, dated not more than 12 months before the date of the application;
h. a pension or retirement statement from a prior employer or pension fund stating the applicant's name and address, dated within 12 months of the application;
i. tuition or student loan bill containing the applicant's name and address, dated not more than 12 months before the date of the application;
j. utility bill, cell phone bill, credit card bill, doctor's bill, or hospital bill containing applicant's name and address, dated not more than 60 days before the date of the application;
k. valid homeowner's, renter's, or automobile insurance policy with preprinted address, dated not more than 12 months before the date of the application, or a bill for such insurance with preprinted address, dated not more than 60 days before the date of the application;
l. lease dated not more than 12 months before the date of the application, or home mortgage identifying applicant and address; or
m. employment verification by means of W-2 forms or other documents bearing the applicant's name and address submitted by the employer to a government agency as a consequence of employment;

4. a finding of identity from a federal or state agency, including, but not limited to, a public assistance, law enforcement, internal revenue, or tax bureau, or corrections agency, if the agency has verified and certified the identity of the individual;

5. a finding of identity from an Express Lane agency, as defined in section 1902(e)(13)(F) of the Social Security Act; or

6. If the applicant does not have any document specified in 101 CMR 613.04(2)(c)1. through 3., and identity is not verified under 101 CMR 613.04(2)(c)4. or 5., the applicant may submit an affidavit signed, under penalty of perjury, by another person who can reasonably attest to the applicant's identity. Such affidavit must contain the applicant's name and other identifying information establishing identity, as described in 101 CMR 613.04(2)(c)1. This affidavit does not have to be notarized.

(d) Matching Information. The MassHealth Agency initiates information matches with other agencies and information sources when an application is received, at annual renewal and periodically, in order to update or verify eligibility. These agencies and information sources may include, but are not limited to, the following: the Federal Data Services Hub, the Division of Unemployment Assistance, Department of Public Health's Bureau of Vital Statistics, Department of Industrial Accidents, Department of Veterans' Services, Department of Revenue, Bureau of Special Investigations, Internal Revenue Service, Social Security Administration, Systematic Alien Verification for Entitlements, Department of Transitional Assistance, and health insurance carriers.

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(3) Grievance Process. An individual may request that the Office conduct a review of a determination of Low Income Patient status, Provider compliance with the provisions of 101 CMR 613.00, or Medical Hardship eligibility if exceptional circumstances outside of the individual's control had a material impact on the Medical Hardship eligibility determination. The Health Safety Net Office will conduct a review using the following process.

(a) In order to request a review, the individual must send a written request to the Office with supporting documentation. To request a review of a determination of Low Income Patient status, the individual must send the review request within 30 days from the date of the official notification of the determination. To request a review of a Medical Hardship eligibility determination, the individual must send the review request, including a description of the circumstances outside of the individual's control that had a material impact on the eligibility determination, within six months from the date of the official notification of the determination. For all grievances, the Office may request additional information as necessary from the grievant, other state agencies, and/or the Provider(s). Additional information requested from the grievant by the Office must be submitted within 30 days.

(b) The Office will provide an initial response to the grievant within 30 days of receipt of the grievance and will issue a written decision and explanation of the reasons for its decision to the grievant and other relevant parties within a reasonable time after receipt of all necessary information.

(4) Low Income Patient Eligibility Categories.

(a) The categories of Low Income Patient eligibility for Health Safety Net services are:

1. Health Safety Net - Primary. A Low Income Patient is eligible for Health Safety Net - Primary if he or she is uninsured and documents MassHealth MAGI Household income or Medical Hardship Family Countable Income, as described in 101 CMR 613.04(1), between 0% and 300% of the FPL, subject to the following exceptions.

a. 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 613.04(5)(a) and (b).

b. Low Income Patients subject to the Student Health Program requirements of M.G.L. c. 15A, § 18 are not eligible for Health Safety Net - Primary.

2. Health Safety Net - Secondary. A Low Income Patient is eligible for Health Safety Net - Secondary if he or she has other primary health insurance and documents MassHealth MAGI Household income or Medical Hardship Family Countable Income, as described in 101 CMR 613.04(1), between 0 and 300% of the FPL, subject to the following exceptions.

a. Effective 101 days after the Medical Coverage Date, Low Income Patients eligible for 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.

b. 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.

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

(b) Other Requirements.

1. Affordable Insurance. An individual with MassHealth MAGI Household income or Medical Hardship Family Countable Income, as described in 101 CMR 613.04(1), less than or equal to 300% of the FPL, and for whom insurance is deemed affordable as defined in 956 CMR 6.00: *Determining Affordability for the Individual Mandate*, is not eligible for Health Safety Net - Primary. If such an individual's employer offers employer-sponsored insurance, he or she is not eligible for Health Safety Net - Primary except during the employer's waiting period before the employer-sponsored insurance becomes effective.

2. Pending Disability Determination. Providers may submit claims for individuals whose MassHealth eligibility status is pending due to a MassHealth disability determination. If the individual is determined eligible for MassHealth, the Provider must void Health Safety Net claims for the individual and submit claims for services to MassHealth.

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3. Health Safety Net - Partial. A Low Income Patient eligible for either Health Safety Net - Primary or Health Safety Net - Secondary who documents MassHealth MAGI Household income or Medical Hardship Family Countable Income, as described in 101 CMR 613.04(1), between 150.1% and 300% of the FPL is considered Health Safety Net - Partial and must meet the Health Safety Net - Partial deductible described in 101 CMR 613.04(6)(c).

(5) Eligibility Period.

(a) Except as specified in 101 CMR 613.04(5)(b), providers may submit claims for Reimbursable Health Services effective on the Medical Coverage Date until the Patient's eligibility is terminated.

(b) For Low Income Patients eligible for the Premium Assistance Payment Program Operated by the Health Connector:

1. Providers may submit claims for Reimbursable Health Services for the period beginning on the Patient's Medical Coverage Date and ending 100 days after the Patient's Medical Coverage Date.

2. Effective 101 days after the Patient's Medical Coverage Date, providers may submit claims only for dental services not otherwise covered by the Premium Assistance Payment Program Operated by the Health Connector until the Patient's eligibility is terminated.

(c) Low Income Patient status is effective for a maximum of one year from the date of determination, subject to periodic redetermination and verification that the Patient's MassHealth MAGI Household income or Medical Hardship Family Countable Income, as described in 101 CMR 613.04(1), or insurance status has not changed to such an extent that the Patient no longer meets eligibility requirements.

(6) Low Income Patient Responsibilities.

(a) Cost Sharing Requirements. Low Income Patients are responsible for paying copayments in accordance with 101 CMR 613.04(6)(b) and deductibles in accordance with 101 CMR 613.04(6)(c).

(b) Low Income Patient Copayment Requirements. Low Income Patients are responsible for copayments for pharmacy services.

1. The copayments for pharmacy services are

a. $1 for each prescription and refill for each generic drug in the following drug classes: antihyperglycemics, antihypertensives, and antihyperlipidemics;

b. $3.65 for each prescription and refill for other generic drugs; and

c. $3.65 for each prescription and refill for brand-name drugs.

2. There are no copayments for services provided to Low Income Patients who are

a. younger than 21 years old; or

b. pregnant or in the postpartum period that extends through the last day of the second calendar month following the month in which their pregnancy ends (for example, if the woman gave birth on May 15th, she is exempt from the copayment requirement until August 1st).

3. There is an annual maximum of $250 per Patient on pharmacy copayments.

(c) Health Safety Net - Partial Deductibles.

1. Annual Deductible. For Health Safety Net - Partial Low Income Patients with MassHealth MAGI Household income or Medical Hardship Family Countable Income between 150.1% and 300% of the FPL, there is an annual deductible if all members of the PBFG have an FPL above 150.1%. If any member of the PBFG has an FPL below 150.1% there is no deductible for any member of the PBFG. The annual deductible is equal to the greater of

a. the lowest cost Premium Assistance Payment Program Operated by the Health Connector premium, adjusted for the size of the PBFG proportionally to the MassHealth FPL income standards, as of the beginning of the calendar year; or

b. 40% of the difference between the lowest MassHealth MAGI Household income or Medical Hardship Family Countable Income, as described in 101 CMR 613.04(1), in the applicant's Premium Billing Family Group (PBFG) and 200% of the FPL.

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2. Applying the Deductible. The Patient is responsible for payment for all services provided up to this deductible amount. Once the Patient has incurred the deductible, a Provider may submit claims for Reimbursable Health Services in excess of the deductible. There is only one deductible per PBFG per approval period. The deductible is not applied to pharmacy services. Copayments are not considered expenses to be included in the deductible amount.

3. Deductible Tracking. The annual deductible is applied to all Reimbursable Health Services provided to a Low Income Patient or PBFG member during the Eligibility Period. Each PBFG 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 Provider must track the Patient's Reimbursable Health Services expenses until the Patient meets the deductible. If more than one PBFG member is determined to be a Low Income Patient, or if the Patient or PBFG members receive services from more than one Provider, it is the Patient's responsibility to track the deductible and provide documentation to the Provider that the deductible has been reached.

4. Acute Hospitals. The Patient must incur expenses for Reimbursable Health Services in excess of the annual deductible before the Provider may submit a claim for Reimbursable Health Services. Once the Patient has incurred the deductible, the Provider may submit a claim for the remaining balance of Reimbursable Health Service expenses. The Acute Hospital may require a deposit and/or a payment plan in accordance with 101 CMR 613.08(1)(f).

5. Community Health Centers and Hospital Licensed Health Centers.

a. Health Safety Net - Partial Low Income Patients receiving Reimbursable Health Services from Community Health Centers are responsible for 20% of the Health Safety Net payment for each visit, to be applied to the amount of the Patient's annual deductible until the Patient meets his or her deductible. Health Safety Net - Partial Low Income Patients receiving Reimbursable Health Services from Hospital Licensed Health Centers, Satellite Clinics, and school-based health centers are responsible for either 20% of the Health Safety Net payment for each visit or the full amount of the service, as specified by the Provider. If the Provider specifies that a Health Safety Net - Partial Low Income Patient is responsible for 20% of the payment amount, the Provider may submit a claim for the remaining balance of each eligible service.

b. If a Hospital Licensed Health Center, Satellite Clinic, or school-based health center that provides Reimbursable Health Services specifies that any Health Safety Net - Partial Low Income Patient is responsible for only 20% of the payment amount, it must offer this option to all Health Safety Net - Partial Low Income Patients receiving Reimbursable Health Services at the location.

c. The Health Safety Net Office may require a Community Health Center to report when a Patient's deductible has been met or any other information regarding the Patient's deductible in a manner specified by the Health Safety Net Office.

(d) Assignment of Third-party Payments. A Low Income Patient must assign to the MassHealth Agency his or her rights to third-party payments for medical benefits provided under the Health Safety Net and must fully cooperate with and provide the MassHealth Agency with information to help pursue any source of third-party payment. A Low Income Patient must inform the Health Safety Net Office or MassHealth when he or she is involved in an accident or suffers from an illness or injury, or other loss that has resulted or may result in a lawsuit or insurance claim, other than a medical insurance claim. The Low Income Patient must

1. file an insurance claim for compensation, if available;

2. assign to the MassHealth Agency 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 MassHealth Agency, unless the MassHealth Agency determines that cooperation would not be in the best interests of, or would result in serious harm or emotional impairment to, the Low Income Patient;

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4. notify the Health Safety Net Office or MassHealth in writing within ten days of filing any claim, civil action or other proceeding; and
5. repay the Health Safety Net Office from the 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 Low Income 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.

613.05: Medical Hardship

(1) Eligibility.

(a) General. 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. A determination of Medical Hardship is a one-time determination and not an ongoing eligibility category. An applicant may submit no more than two Medical Hardship applications within a 12-month period.

(b) Countable Income.

1. Gross Earned Income.

a. Gross earned income is the total amount of compensation received for work or services performed without regard to any deductions.

b. Gross earned income for the self-employed is the total amount of business income listed on the most recently filed federal tax return or allowable on a federal tax return.

c. Seasonal income is income derived from an income source that is associated with a particular time of the year. Annual gross income is divided by 12 to obtain a monthly gross income with the following exception: if the Patient has a disabling illness or accident during or after the seasonal employment period that prevents the person's continued or future employment, only current income will be considered in the eligibility determination.

2. Gross Unearned Income.

a. Gross unearned income is the total amount of income that does not directly result from the individual's own labor before any income deductions are made.

b. Unearned income includes, but is not limited to, social security benefits, railroad retirement benefits, pensions, annuities, federal veterans' benefits, interest and dividend income, unemployment benefits, child support, and alimony.

3. Rental Income. Rental income is the total amount of gross income less any deductions listed or allowable on the Patient's most recently filed federal tax return or allowable on a federal tax return.

(c) Percentage of Countable Income. To qualify for Medical Hardship, the applicant's allowable medical expenses exceed a specified percentage of the applicant's Countable Income as follows.

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

(2) Eligibility Determination. An applicant for Medical Hardship must complete a Medical Hardship application and provide required documentation of Countable Income, documentation of Massachusetts residency, proof of identity, and detailed, itemized documentation of medical expenses. The Health Safety Net Office processes applications for Medical Hardship and verifies information contained in the application. Providers must assist the applicant to complete the Medical Hardship application and assemble the required documentation. Once the applicant has completed the application and assembled all of the required documentation, the Provider

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assisting the applicant must submit the completed application to the Health Safety Net office within five business days. If the Provider assisting the applicant fails to submit the completed application to the Health Safety Net Office within that time frame, the Provider may not undertake a Collection Action against the applicant with respect to any bills that would have been eligible for Medical Hardship payment had the application been submitted and approved. The Health Safety Net Office approves an application for Medical Hardship if the applicant's allowable medical expenses exceed the percentage of Countable Income listed above. If the applicant reports Countable Income less than or equal to 405% of the FPL, the applicant must submit an Application, with all required documentation. The Health Safety Net Office does not approve Medical Hardship applications for individuals reporting Countable Income less than or equal to 405% of the FPL unless the applicant has submitted an Application. The Health Safety Net Office does not make a determination on Medical Hardship applications for individuals reporting Countable Income less than or equal to 405% of the FPL until the Patient has received a determination related to the Application.

(3) Allowable Medical Expenses. The Health Safety Net Office determines the applicant's allowable medical expenses based on review of the submitted documentation. 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 services provided up to 12 months prior to the date of the Medical Hardship application for which the Patient is responsible. If a Patient does not receive an initial medical bill for more than nine months from when the services were provided, the bill may still be considered an allowable medical expense if a Medical Hardship application is submitted within 90 days of the date of the initial medical bill for the service. Allowable medical expenses do not include bills for services incurred while the applicant was a Low Income Patient unless the applicant was a Dental-only Low Income Patient on the date of service. Allowable medical expenses do not include bills for services incurred while the applicant was enrolled in MassHealth or the Premium Assistance Payment Program Operated by the Health Connector. Bills included in an approved Medical Hardship determination cannot be included in a subsequent Medical Hardship application.

(4) Payable Medical Expenses. The Health Safety Net pays only for the services described in 101 CMR 613.03(2) through (4). Other allowable medical expenses are not eligible for Health Safety Net payment.

(5) Medical Hardship Contribution.

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

(b) There is one Medical Hardship contribution for each Medical Hardship determination. If the applicant is determined a Low Income Patient or eligible for MassHealth, the applicant's required contribution will be deferred until the applicant's Low Income Patient status or MassHealth eligibility is ended. If the Health Safety Net Office approves two Medical Hardship applications during a 12-month period, it will prorate the required contribution amounts.

(6) Notification of Determination. The Health Safety Net Office notifies applicants of the determination.

(a) An approval notice explains that the person is eligible for Medical Hardship; includes the dates for which allowable medical expenses may be included; includes the amount of the applicant's Medical Hardship contribution; lists the services that do not qualify as Eligible Services; and includes a contact number for more information. The Office also notifies Providers with bills included in the applicant's allowable medical expenses of the determination and allocates the applicant's contribution to each Provider based on the dates of services and gross charges of services provided to the applicant's Medical Hardship Family.

(b) A denial notice explains that the person is not eligible for Medical Hardship and the reasons for the eligibility denial. Both the Patient and Provider are notified of the denial.

(7) Claims. When the Health Safety Net Office approves a Medical Hardship application, it notifies those Providers whose services were included in the documentation of medical expenses required under 101 CMR 613.05(2). To be eligible for payment for any such service, the

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Provider must submit a claim to the Health Safety Net Office within 18 months of the date of service. Payment of such claims is subject to all other requirements set forth in 101 CMR 613.00 and other applicable laws and regulations.

613.06: Allowable Bad Debt

(1) General Requirements. Acute Hospitals may submit claims for Emergency Bad Debt as defined in 101 CMR 613.06(2). Acute Hospitals and Community Health Centers may submit claims for Bad Debt for Urgent Care Services as defined in 101 CMR 613.06(3) and (4). Providers may not submit a claim for a deductible or coinsurance portion of a claim for which an insured Patient or Low Income Patient is responsible. Providers may only submit claims for the services described in 101 CMR 613.03(2) through (4).

(a) Required Collection Action. Providers may submit claims for Bad Debt only after required collection action, including the following.

1. Collecting Patient Information.

a. Inpatient Services. An Acute Hospital must identify the department responsible for obtaining the information from the Patient, and make reasonable efforts to obtain the financial information necessary to determine responsibility for payment of the Acute Hospital bill from the Patient or Guarantor. If the Patient or Guarantor is unable to provide the information needed, and the Patient consents, an Acute Hospital must make reasonable efforts to contact the relatives, friends, and Guarantor and the Patient for additional information while the Patient is in the Acute Hospital. If an Acute Hospital has not obtained sufficient Patient financial information to assess the ability of the Patient or the Guarantor to pay for services prior to the date of discharge, the Acute Hospital must make reasonable efforts to obtain the necessary information at the time of the Patient's discharge.

b. Emergency Room, Outpatient Services, and Community Health Center Services. A Provider must make reasonable efforts, as soon as reasonably possible, to obtain the financial information necessary to determine responsibility for payment of the bill from the Patient or Guarantor.

2. Verification of Patient-supplied Information.

a. Inpatient. An Acute Hospital must make reasonable efforts to verify the Patient-supplied information prior to the Patient discharge. The verification may occur at any time during the provision of services, at the time of the Patient discharge, or during the collection process.

b. Acute Hospital Outpatient and Community Health Centers. A Provider must make reasonable efforts to verify Patient-supplied information at the time the Patient receives the services. The verification of Patient-supplied information may occur at the time the Patient receives the services or during the collection process.

3. Reasonable Collection Efforts.

a. A Provider must make the same effort to collect accounts for uninsured individuals as it does to collect accounts from any other Patient classifications.

b. The minimum requirements before writing off an account to the Health Safety Net include

i. an initial bill to the party responsible for the Patient's personal financial obligations;

ii. subsequent billings, telephone calls, collection letters, personal contact notices, computer notifications, and any other notification method that constitutes a genuine effort to contact the party responsible for the obligation;

iii. documentation of alternative efforts to locate the party responsible for the obligation or the correct address on billings returned by the postal office service as "incorrect address" or "undeliverable";

iv. sending a final notice by certified mail for balances over $1,000 where notices have not been returned as "incorrect address" or "undeliverable"; and

v. documentation of continuous Collection Action undertaken on a regular, frequent basis. When evaluating whether a Provider has engaged in continuous Collection Action, the Health Safety Net Office may use a gap in Collection Action of greater than 120 days as a guideline for noncompliance, but may use its discretion when determining whether a Provider has made a reasonable effort to meet the standard.

c. If, after reasonable attempts to collect a bill, the debt for Emergency Services for an uninsured individual remains unpaid after a period of 120 days of continuous Collection Action, the bill may be deemed uncollectible and billed to the Health Safety Net Office.

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d. The Patient's file must include all documentation of the Provider's collection effort including copies of the bill(s), follow-up letters, reports of telephone and personal contact, and any other effort made.

(b) Reporting Requirements.

1. Claims Submission. Providers must submit claims in accordance with the requirements of 101 CMR 613.07. Acute Hospitals must submit a claim for each inpatient Bad Debt. Community Health Centers must submit a claim for each Bad Debt.

2. Additional Information. Providers must submit the following additional information for Community Health Center and Acute Hospital inpatient Bad Debt services in a form specified by the Health Safety Net Office. For outpatient services, Acute Hospitals must submit this information within 30 days of a request by the Health Safety Net Office.

Patient Identifiers:

Name
Address
Phone#
DOB
SSN#
TCN
Med Record#
MassHealth# (RID and/or RHN)
Date of Service
Total Charge for Services
Net Charge submitted to Health Safety Net

Evidence of Reasonable Collection Efforts:

Date of Initial Bill
Date of Second Bill
Date of Third Bill
Date of Fourth Bill
Date of Returned Mail
Date of Certified Letter for accounts over $1,000
Date of Initial Phone Contact
Date of Follow up Phone Contact
Dates of Other Efforts (other phone calls, letters to Patient, attorney or referral to collection agency)
Date Account was submitted to Health Safety Net Office

3. The Health Safety Net Office may deny payment for any claim for which required documentation is not submitted. If the Health Safety Net Office notifies a Provider that a claim will be denied due to insufficient documentation, the Provider must submit the required documentation within 30 days of the date of the notice that the claim will be denied.

(2) Acute Hospital Emergency Bad Debt Claims. An Acute Hospital may submit a claim for Emergency Bad Debt if

(a) the services were provided to

1. an uninsured individual who is not a Low Income Patient, unless the individual is a Dental-only Low Income Patient, and the Provider has verified through EVS that the individual has not submitted an Application for MassHealth; or

2. an uninsured individual whom the Acute Hospital assists in completing an Application and is determined to be a Low Income Patient or determined into a category exempt from collection action in accordance with 101 CMR 613.08(3). Bad Debt claims for these individuals are exempt from the requirements of 101 CMR 613.06(2)(c);

(b) the services provided were Emergency or Urgent Care Services;

(c) the Acute Hospital can document that it has undertaken the required Collection Action as defined in 101 CMR 613.06(1)(a) for the account; and

(d) the bill remains unpaid after a period of 120 days of continuous Collection Action.

(3) Hospital Licensed Health Center Bad Debt. An Acute Hospital or a Hospital Licensed Health Center may submit a claim for Bad Debt for Urgent Care Services if

(a) the services were provided at a Hospital Licensed Health Center;

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(b) the services were provided to

1. an uninsured individual who is not a Low Income Patient, unless the individual is a Dental-only Low Income Patient. The Provider may not submit a claim for a deductible or the coinsurance portion of a claim for which an insured Patient is responsible. The Provider may not submit a claim unless it has checked EVS to determine if the Patient has filed an Application for MassHealth; or

2. an uninsured individual whom the Provider assists in completing an Application is determined into a category exempt from Collection Action in accordance with 101 CMR 613.08(3). Bad Debt claims for these individuals are exempt from the requirements of 101 CMR 613.06(3)(e);

(c) the Provider provided Urgent Care Services as defined in 101 CMR 613.02 to the Patient. A Provider may submit a claim for all Eligible Services provided during the Urgent Care Services visit, including Ancillary Services provided on site;

(d) the responsible physician determined that the Patient required Urgent Care Services. A Provider may submit a claim for Urgent Care Services, but not for other services provided to Patients determined not to require Urgent Care Services;

(e) the Provider undertook the required Collection Action as defined in 101 CMR 613.06(1)(a) and submitted the information required in 101 CMR 613.06(1)(b) for the account; and

(f) the bill remains unpaid after a period of 120 days of continuous Collection Action.

(4) Community Health Center Bad Debt. A Community Health Center may submit a claim for Bad Debt for Urgent Care Services if

(a) the services were provided to

1. an uninsured individual who is not a Low Income Patient, unless the individual is a Dental-only Low Income Patient. The Provider may not submit a claim for a deductible or the coinsurance portion of a claim for which an insured Patient is responsible. The Provider may not submit a claim unless it has checked EVS to determine if the Patient has filed an application for MassHealth; or

2. an uninsured individual whom the Provider assists in completing an Application is determined into a category exempt from Collection Action in accordance with 101 CMR 613.08(3). Bad Debt claims for these individuals are exempt from the requirements of 101 CMR 613.06(4)(d);

(b) the Provider provided Urgent Care Services as defined in 101 CMR 613.02 to the Patient. A Provider may submit a claim for all Eligible Services provided during the Urgent Care Services visit, including Ancillary Services provided on site;

(c) the responsible physician determined that the Patient required Urgent Care Services. A Provider may submit a claim for Urgent Care Services, but not for other services provided to Patients determined not to require Urgent Care Services;

(d) the Provider undertook the required Collection Action as defined in 101 CMR 613.06(1)(a) and submitted the information required in 101 CMR 613.06(1)(b) for the account; and

(e) the bill remains unpaid after a period of 120 days of continuous Collection Action.

(5) Department of Revenue Intercept. The Health Safety Net Office initiates a match with the Massachusetts Department of Revenue for individuals for whom a Provider has submitted a claim for Bad Debt. The Health Safety Net Office may request that the Department of Revenue intercept payments to the individual up to an amount equal to the amount paid to the Provider for the Services.

613.07: Reporting Requirements

(1) General. Each Provider must file or make available information that the Health Safety Net Office deems necessary to verify that a service for which a Provider submits a claim is an Eligible Service.

(a) The Health Safety Net Office may revise the data specifications, the data collection scheduled, or other administrative requirements by administrative bulletin.

(b) Providers must maintain records sufficient to document compliance with all screening and documentation requirements of 101 CMR 613.00. Providers must maintain records documenting claims for Reimbursable Health Services to Low Income Patients, Bad Debt for Emergency or Urgent Care services, and Medical Hardship.

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(c) The Health Safety Net Office may deny payment for claims by any Provider that fails to comply with the reporting requirements of 101 CMR 613.00 or 614.00: *Health Safety Net Payments and Funding* until such Provider complies with the requirements. The Health Safety Net Office will notify such Provider of its intention to withhold payment.

(2) Medical and Professional Claims Submission Deadlines. The Health Safety Net pays only for claims that are submitted within the time frames listed in 101 CMR 613.07(2)(a) through (f).

(a) Unless otherwise specified in 101 CMR 613.07(2)(b) through (f), claims must be submitted within 90 days of the date of service. If a service is provided continuously on consecutive dates, the date from which the 90-day deadline is measured is the latest date of service.

(b) If the Health Safety Net is the primary payer, and Low Income Patient status is determined after services are provided, claims must be submitted within 90 days of Low Income Patient determination. A waiver may be requested if the Patient was determined to be a Low Income Patient after services are provided, and the claim cannot be submitted within 90 days of service.

(c) For claims that are not submitted within the 90-day period but that meet one of the exceptions specified in 101 CMR 613.07(2)(c)1. through 3., a Provider must request a waiver of the billing deadline pursuant to the billing instructions provided by the MassHealth Agency. The exceptions are as follows.

1. A medical service was provided to a person who was not a Low Income Patient on the date of service, but was later determined to be a Low Income Patient for a period that includes the date of service.

2. A medical service was provided to a Patient who failed to inform the Provider in a timely fashion of the member's eligibility for MassHealth or status as a Low Income Patient.

3. A medical service was provided to a Patient with health insurance and the Provider delayed submission of the claim in order to bill the Patient's insurer. Claims must be submitted by the later of 90 days of the date of service or 90 days after the date of the primary insurer's explanation of benefits, but no later than 18 months after the date of service.

(e) Claims for Emergency or Urgent Care Bad Debt may be written off by the Provider no earlier than 120 days after services are provided. Such claims must be submitted within 90 days after the date on which the claim is written off as uncollectible.

(f) Claims related to Medical Hardship must be submitted to the Health Safety Net Office by the deadline specified in 101 CMR 613.05(6).

(3) Final Deadline for Submission of Claims.

(a) If the Health Safety Net Office has denied a claim that was initially submitted within the 90-day deadline, the Provider may resubmit the claim with appropriate corrections or supporting information.

(b) The Health Safety Net does not pay any claim submitted or resubmitted for services provided more than 12 months before the date of submission or resubmission, except as provided in 101 CMR 613.07(2).

(4) Pharmacy Billing Deadlines. Pharmacy claims must be submitted to POPS by the later of 90 days after services are provided or 90 days after the date of the primary insurer's explanation of benefits.

(5) Dental Billing Deadlines.

(a) Unless otherwise specified, claims must be submitted to the Health Safety Net Office 90 days from the date of service or the date of the primary insurer's explanation of benefits. If a service is provided continuously on consecutive dates, the date from which the 90-day deadline is measured is the latest date of service.

(b) If the Health Safety Net is the primary payer, and Low Income Patient status is determined after services are provided, claims must be submitted within 90 days of Low Income Patient determination.

(c) Claims for Emergency or Urgent Care Bad Debt may be written off by the Provider no earlier than 120 days after services are provided. Such claims must be submitted within 90 days after the date on which the claim is written off as uncollectible.

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(d) Denied claims being resubmitted for payment must be submitted within 90 days of the original denial. The Health Safety Net, pursuant to M.G.L. c. 118E, § 38, does not pay any claim submitted or resubmitted for services provided more than 12 months before the date of submission or resubmission, except as provided in 101 CMR 613.07(2).

(6) Other Acute Hospital Claim Requirements.

(a) Each Acute Hospital claim must contain a site-specific identification number as assigned by the Health Safety Net Office. The Health Safety Net Office assigns individual identification numbers to each Acute Hospital, Hospital Licensed Health Center, Satellite Clinic, and school-based health center that provides Eligible Services.

(b) The Health Safety Net Office may require Acute Hospitals to submit interim data on revenues and costs to monitor compliance with federal upper payment limits and Safety Net Care payment limits, including cost limits. Such data may include, but not be limited to, gross and net patient service revenue for Medicaid non-managed care, Medicaid managed care, and all payers combined; and total Patient service expenses for all payers combined.

(7) Other Community Health Centers Claim Requirements.

(a) Each Community Health Center must submit claims to the Health Safety Net Office according to the requirements of 101 CMR 613.00 and 614.00: *Health Safety Net Payments and Funding* and the data specification requirements of the Office.

(b) Each Community Health Center must, upon request, provide the Health Safety Net Office with Patient account records and related reports as set forth in 101 CMR 613.03(1)(b).

(8) Audits. The Health Safety Net Office or its agent may audit claims and may adjust claims that are not in compliance with the provisions of 101 CMR 613.00.

(a) The Health Safety Net Office may adjust claims for services covered by MassHealth, another program of public assistance, or other Health Insurance Plan in which the Patient is enrolled, or may adjust claims for services that do not meet the criteria for Eligible Services including claims for Reimbursable Health Services to Low Income Patients, Bad Debt, or Medical Hardship.

(b) The Health Safety Net Office may adjust claims for which the Provider cannot provide documentation required by 101 CMR 613.00 or 614.00: *Health Safety Net Payments and Funding*.

(c) The Health Safety Net Office may adjust payments using a methodology to appropriately extrapolate the audit results of a representative sample of accounts.

(d) 1. Notification. The Health Safety Net Office will notify the Provider of its proposed audit adjustments. The notification will be in writing and will contain a complete listing of all proposed adjustments.

2. Objection Process.

a. A Provider may file a written objection to a proposed audit adjustment within 15 business days of the mailing of the notification letter.

b. The written objection must, at a minimum, contain

i. each adjustment to which the Provider is objecting;

ii. the Fiscal Year for each disputed adjustment;

iii. the specific reason for each objection; and

iv. all documentation that supports the Provider's position.

c. Upon review of the Provider's objections, the Health Safety Net Office will notify the Provider of its determination in writing. If the Health Safety Net Office disagrees with the Provider's objections, in whole or in part, the Health Safety Net Office will provide the Provider with an explanation of its reasoning.

d. The Provider may request a conference on objections after receiving the Health Safety Net Office's explanation of reasons. The Health Safety Net Office will schedule such conference on objections if it determines that further articulation of the Provider's position would promote resolution of the disputed adjustments.

(9) Grievances. A Provider must provide any information or documentation requested by the Health Safety Net Office related to a grievance request filed in accordance with 101 CMR 613.04(3) within 30 days of the request from the Office.

613.08: Other Requirements

(1) Provider Responsibilities.

(a) Nondiscrimination. A Provider must not discriminate on the basis of race, color, national origin, citizenship, alienage, religion, creed, sex, sexual orientation, gender identity, age, or disability in its policies or in its application of policies, concerning the acquisition and verification of financial information, preadmission or pretreatment deposits, payment plans, deferred or rejected admissions, or Low Income Patient status.

(b) Legal Execution. A Provider or agent thereof must not seek legal execution against the personal residence or motor vehicle of a Low Income Patient determined pursuant to 101 CMR 613.04 without the express approval of the Provider's Board of Trustees. All approvals by the Board must be made on an individual case basis.

(c) Credit and Collection Policies.

1. Filing Requirements. Each Provider must electronically file a Credit and Collection Policy that is reflective of its practices with the Health Safety Net Office in each of the following circumstances:

a. a new Provider must file a copy of its Credit and Collection Policy prior to Health Safety Net Office approval to submit claims for payments;

b. within 90 days of adoption of amendments to 101 CMR 613.00 that would require a change in the Credit and Collection Policy;

c. when a Provider changes its Credit and Collection Policy; or

d. when two Providers merge and request to be paid as a single merged entity.

2. Content Requirements. A Provider's Credit and Collection Policy must contain

a. standard collection policies and procedures;

b. policies and procedures for collecting financial information from Patients;

c. for Acute Hospitals, a detailed emergency care classification policy specifying

i. its practices for classifying persons presenting themselves for unscheduled treatment, the urgency of treatment associated with each identified classification;

ii. the location(s) at which Patients might present themselves; and

iii. any other relevant and necessary instructions to Acute Hospital personnel that would see these Patients.

iv. The policy must include the classifications that qualify as Emergency Services and other services including "elective" or "scheduled" services;

d. the policy on deposits and payment plans for qualified Patients as described in 101 CMR 613.08(1)(f);

e. copies of billing invoices, award or denial letters, and any other documents used to inform Patients of the availability of assistance;

f. description of any program by which the Acute Hospital offers discounts from charges for the uninsured;

g. for an Acute Hospital with Hospital Licensed Health Center, Satellite Clinic, or school-based health center locations that provide Eligible Services, an indication whether each location offers Patients a deductible payment plan for outpatient services per 101 CMR 613.04(6)(c)5.; and

h. direct website(s) or URL(s) where the Provider's Credit and Collection Policy, Provider Affiliate list (if applicable), and other financial assistance policies are posted.

(d) Provider Affiliate List. Acute Hospitals must establish a list of all Provider Affiliates. The list must clearly indicate or delineate which Provider Affiliates provide services that are eligible for reimbursement by the Health Safety Net.

1. For the purposes of this requirement, Acute Hospitals may use any method adequate to identify Provider Affiliates. This may include, but is not limited to:

a. listing the names of each individual practitioner;

b. listing the names of individual practitioners, practice groups, or any other entities that are providing emergency or medically necessary care in the Acute Hospital by the name used by such entities either to contract with the Acute Hospital or to bill patients for care provided; or

c. list by reference to a department or a type of service if the reference makes clear which Provider Affiliate services are and are not eligible to be reimbursed by the Health Safety Net.

2. If a Provider Affiliate is eligible to be reimbursed by the Health Safety Net in some circumstances but not in others, the Acute Hospital must describe the circumstances in which the emergency or other medically necessary care delivered by the Provider Affiliate will and will not be eligible for reimbursement by the Health Safety Net.

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3. Acute Hospitals must take reasonable steps to ensure that their Provider Affiliate lists are accurate by updating their Provider Affiliate lists at least quarterly to add new or missing information, correct erroneous information, and delete obsolete information.

4. The requirements set forth in 101 CMR 613.08(d)1. through 3. are effective as of the first day of the Acute Hospital's fiscal year beginning after December 31, 2016.

(e) Notices.

1. In the following circumstances, a Provider must provide individual notice of the availability of financial assistance programs to a Patient expected to incur charges, exclusive of personal convenience items or services, whose services may not be paid in full by third party coverage:

a. during the Patient's initial registration with the Provider;

b. on all billing invoices; and

c. when a Provider becomes aware of a change in the Patient's eligibility or health insurance coverage.

2. In the following circumstances, a Provider or its designee must provide notice about Eligible Services and programs of public assistance, including MassHealth, the Premium Assistance Payment Program Operated by the Health Connector, the Children's Medical Security Plan, and Medical Hardship:

a. during the Patient's initial registration with the Provider;

b. on all billing invoices; and

c. when a Provider becomes aware of a change in the Patient's eligibility or health insurance coverage.

3. A Provider must include a brief notice about the availability of financial assistance in all written Collection Actions. The following language is suggested, but not required, to meet the notice requirements of 101 CMR 613.08(1)(d): "If you are unable to pay this bill, please call [phone number]. Financial assistance is available."

4. A Provider must notify the Patient that the Provider offers a payment plan as described in 101 CMR 613.08(1)(f), if the Patient is determined to be a Low Income Patient or qualifies for Medical Hardship.

(f) Distribution of Financial Assistance Program Information.

1. Providers must post signs in the inpatient, clinic, and emergency admissions/ registration areas and in business office areas that are customarily used by Patients that conspicuously inform Patients of the availability of financial assistance programs and the Provider location at which to apply for such programs. Signs must be large enough to be clearly visible and legible by Patients visiting these areas. All signs and notices must be translated into languages other than English if such languages are the primary language of 10% or more of the residents in the Provider's service area. Signs must notify Patients of the availability of financial assistance and of other programs of public assistance. The following language is suggested, but not required:

a. "Are you unable to pay your hospital bills? Please contact a counselor to assist you with various alternatives."; or

b. "Financial assistance is available through this institution. Please contact _____."

2. Providers must make their Credit and Collection Policies filed in accordance with 101 CMR 613.08(1)(c)1. and Provider Affiliate lists (if applicable), as described in 101 CMR 613.08(1)(d), available on the Provider's website.

(g) Deposits and Payment Plans.

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

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4. A Patient with a balance of $1,000 or less, after initial deposit, must be offered at least a one-year, interest-free payment plan with a minimum monthly payment of no more than $25. 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.

(h) Patient Responsibilities. Providers must advise Patients of the responsibilities described in 101 CMR 613.08(2)(b) in all cases where the Patient interacts with registration personnel.

(2) Patient Rights and Responsibilities.

(a) Providers must advise Patients of the right to

1. apply for MassHealth, the Premium Assistance Payment Program Operated by the Health Connector, a Qualified Health Plan, Low Income Patient determination, and Medical Hardship; and

2. a payment plan, as described in 101 CMR 613.08(1)(f), if the Patient is determined to be a Low Income Patient or qualifies for Medical Hardship.

(b) A Patient who receives Reimbursable Health Services must

1. provide all required documentation;

2. inform MassHealth of any changes in MassHealth MAGI Household income or Medical Hardship Family Countable Income, as described in 101 CMR 613.04(1), or insurance status, including but not limited to, income, inheritances, gifts, distributions from trusts, the availability of health insurance, and third-party liability. The Patient may, in the alternative, provide such notice to the Provider that determined the Patient's eligibility status;

3. track the Patient deductible and provide documentation to the Provider that the deductible has been reached when more than one Premium Billing Family Group member is determined to be a Low Income Patient or if the Patient or Premium Billing Family Group members receive Reimbursable Health Services from more than one Provider; and

4. inform the Health Safety Net Office or the MassHealth Agency when the Patient is involved in an accident, or suffers from an illness or injury, or other loss that has or may result in a lawsuit or insurance claim. In such a case, the Patient must

a. file a claim for compensation, if available; and

b. agree to comply with all requirements of M.G.L. c. 118E, including but not limited to

i. assigning to the Health Safety Net Office the right to recover an amount equal to the Health Safety Net payment provided from the proceeds of any claim or other proceeding against a third party;

ii. providing information about the claim or any other proceeding, and fully cooperating with the Health Safety Net Office or its designee, unless the Health Safety Net Office determines that cooperation would not be in the best interests of, or would result in serious harm or emotional impairment to, the Patient;

iii. notifying the Health Safety Net Office or the MassHealth Agency in writing within ten days of filing any claim, civil action, or other proceeding; and

iv. repaying the Health Safety Net from the money received from a third party for all Eligible Services provided on or after the date of the accident or other incident after becoming a Low Income Patient for purposes of Health Safety Net payment, provided that only Health Safety Net payments provided as a result of the accident or other incident will be repaid.

(c) The Health Safety Net Office recovers sums directly from a Patient only to the extent that the Patient has received payment from a third party for the medical care paid by the Health Safety Net or to the extent specified in 101 CMR 613.06(5).

(3) Populations Exempt from Collection Action.

(a) A Provider must not bill Patients enrolled in MassHealth and Patients receiving governmental benefits under the Emergency Aid to the Elderly, Disabled and Children program except that the Provider may bill Patients for any required copayments and deductibles. The Provider may initiate billing for a Patient who alleges that he or she is a participant in any of these programs but fails to provide proof of such participation. Upon receipt of satisfactory proof that a Patient is a participant in any of the above listed programs, and receipt of the signed application, the Provider must cease its collection activities.

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(b) Participants in the Children's Medical Security Plan whose MAGI income is equal to or less than 300% of the FPL are also exempt from Collection Action. The Provider may initiate billing for a Patient who alleges that he or she is a participant in the Children's Medical Security Plan, but fails to provide proof of such participation. Upon receipt of satisfactory proof that a Patient is a participant in the Children's Medical Security Plan, the Provider must cease all collection activities.

(c) Low Income Patients, other than Dental-only Low Income Patients, are exempt from Collection Action for any Reimbursable Health Services rendered by a Provider receiving payments from the Health Safety Net for services received during the period for which they have been determined Low Income Patients, except for copayments and deductibles. Providers may continue to bill Low Income Patients for Eligible Services rendered prior to their determination as Low Income Patients after their Low Income Patient status has expired or otherwise been terminated.

(d) Low Income Patients with MassHealth MAGI Household income or Medical Hardship Family Countable Income, as described in 101 CMR 613.04(1), between 150.1 to 300% of the FPL are exempt from Collection Action for the portion of his or her Provider bill that exceeds the deductible and may be billed for copayments and deductibles as set forth in 101 CMR 613.04(6)(b) and (c). Providers may continue to bill Low Income Patients for services rendered prior to their determination as Low Income Patients after their Low Income Patient status has expired or otherwise been terminated.

(e) Providers may bill Low Income Patients for services other than Reimbursable Health Services provided at the request of the Patient and for which the Patient has agreed to be responsible, with the exception of those services described in 101 CMR 613.08(3)(e)1. and 2. Providers must obtain the Patient's written consent to be billed for the service.

1. Providers may not bill Low Income Patients for claims related to medical errors including those described in 101 CMR 613.03(1)(d).

2. Providers may not bill Low Income Patients for claims denied by the Patient's primary insurer due to an administrative or billing error.

(f) At the request of the Patient, a Provider may bill a Low Income Patient in order to allow the Patient to meet the required CommonHealth one-time deductible as described in 130 CMR 506.009: *The One-time Deductible*.

(g) A Provider may not undertake a Collection Action against an individual who has qualified for Medical Hardship with respect to the amount of the bill that exceeds the Medical Hardship contribution. If a claim already submitted as Emergency Bad Debt becomes eligible for Medical Hardship payment from the Health Safety Net, the Provider must cease collection activity on the Patient for the services.

(4) Administrative Bulletins. The Health Safety Net Office may issue administrative bulletins to clarify policies and understanding of substantive provisions of 101 CMR 613.00 and specify information and documentation necessary to implement 101 CMR 613.00.

(5) Severability. The provisions of 101 CMR 613.00 are severable. If any provision or the application of any provision is held to be invalid or unconstitutional, such invalidity shall not be construed to affect the validity or constitutionality of any remaining provisions of 101 CMR 613.00 or the application of such provisions other than those held invalid.

REGULATORY AUTHORITY

101 CMR 613.00: M.G.L. c. 118E.