101 CMR 613.00: HEALTH SAFETY NET ELIGIBLE SERVICES

Section

613.01: General Provisions

Scope and Purpose. 101 CMR 613.00 governs the criteria applicable April 1, 2024, 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 in 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.

(Mass. Register #1519, 4/12/2024, emergency reg.)

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Assets. As defined in 130 CMR 515.001: *Definition of Terms*.

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 18 years old, 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.

Community Health Center. A health center operating in conformance with the requirements of § 330 of United States Public Law 95-626, 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 101 CMR 405.000: *Community Health Center Services*; and
(c) operate in conformance with the requirements of 42 U.S.C. § 254b.

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(6)(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 101 CMR 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.

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 individual, as further defined in 42 U.S.C. § 1395dd(e)(1)(B).

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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(2), or insurance status has not changed to such an extent that the Patient no longer meets eligibility requirements.

(8) Low Income Patient Responsibilities.

(a) Cost Sharing Requirements. Low Income Patients are responsible for paying deductibles in accordance with 101 CMR 613.04(8)(c).

(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 greater than 150% and less than or equal to 300% of the FPL, there is an annual deductible if all members of the PBFG have an FPL above 150%. If any member of the PBFG has an FPL equal to or below 150% 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(2), in the applicant's Premium Billing Family Group (PBFG) and 200% of the FPL.

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.

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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)(g).

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;
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 Eligible Services provided as a result of the accident or incident.

(e) Patients are obligated to return money to the Health Safety Net Office, and the Health Safety Net Office may recover such 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).

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 exceed a certain percentage of his or her Countable Income as specified in 101 CMR 613.05(1)(c). 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.

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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)(e): "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)(g).

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).

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 rights and responsibilities described in 101 CMR 613.08(2) in all cases where the Patient interacts with registration personnel.

(2) Patient Rights and Responsibilities.

(a) Patients have 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)(g), 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;

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2. inform MassHealth of any changes in MassHealth MAGI Household income or Medical Hardship Family Countable Income, as described in 101 CMR 613.04(2), 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.

(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.

(b) Participants in the Children's Medical Security Plan whose MAGI income is less than or equal to 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, other than Dental-only Low Income Patients, with MassHealth MAGI Household income or Medical Hardship Family Countable Income, as described in 101 CMR 613.04(2), greater than 150% and less than or equal 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 deductibles as set forth in 101 CMR 613.04(8)(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.