105 CMR 920.000: ESTABLISHING A UNIFORM SCHEDULE OF ASSESSMENTS FOR DIRECT PAY PATIENTS AT THE DEPARTMENT OF PUBLIC HEALTH HOSPITALS

Section

920.001: Statutory Authority and Purpose
920.002: Scope and Application
920.003: Definitions
920.004: Eligibility
920.005: Method of Determining the Patient's Assessment
920.006: Annual Maximum Assessments and Minimum Assessments
920.007: Application and Determination Procedures
920.008: Appeal from Computation of Adjusted Income and/or Determination of Assessment
920.009: Relationship to the Regulations Requiring a Minimum Level of Uncompensated Medical Services
920.010: Financial Information Form

920.001: Statutory Authority and Purpose

105 CMR 920.000 is promulgated under authority of M.G.L. c. 111, § 69I; c. 111, § 69E; c. 111, § 62I and c. 122, § 1. They are adopted to establish a uniform schedule of assessments for medical services rendered to needy patients at state hospitals who lack health insurance, who are not eligible for public assistance, and who are therefore required to make direct payments to the hospital to pay for health care.

920.002: Scope and Application

The assessment schedule and the method of computing "adjusted income" set forth in these regulations shall be followed and applied in the case of every inpatient and/or outpatient in the Massachusetts Hospital School, Lemuel Shattuck Hospital, Rutland Heights Hospital, Lakeville Hospital, the Western Massachusetts Hospital and Tewksbury Hospital who must make direct payments to the hospital to pay for his health care in whole or in part.

920.003: Definitions

Adjusted Income. The combined gross incomes as defined in 105 CMR 920.003(E) herein of the patient and all financially responsible persons related to him as adjusted to the patient's prospective fiscal year in accordance with the following:

(1) The following expenses, hereinafter referred to as exceptional expenses are to be subtracted from the gross income figure if they will be paid during the patient's prospective fiscal year.

(a) Second mortgage payments, if the second mortgage is secured for rehabilitation purposes.

(b) Loan payments for loan secured due to unemployment or sickness.

(c) Special educational expenses, such as tuition for private school for special needs students.

(d) Special transportation expenses for handicapped or special needs members of the household.

(e) Child care or day care expenses.

(f) Health insurance premiums.

(g) Medical costs (other than those to be paid to the hospital) not covered by health insurance, Medicaid or Medicare.

(h) Payments for dependents who do not reside with the payor pursuant to court order or by agreement.

(i) Bankruptcy expenses.

(j) Dental expenses.

(k) Funeral expenses.

(2) If the combined gross income of the patient and the financially responsible persons related to him has changed since the gross income year, the change should be added to or deducted from gross income in computing adjusted income.

920.003: continued

(3) The liquid assets of the patient and the financially responsible persons related to him shall be added to the gross income.

Assessment. This shall refer to the amount of money billed to patient and/or the financially responsible persons related to him who must make direct payments to the hospital for the patient's health care. An assessment shall represent the portion of the full charge for medical service which the direct pay patient is obligated to pay. Such assessment shall be computed according to the schedule adopted by these regulations.

Direct Payment. A payment for medical care made directly by the patient to the hospital, including payment of co-insurance and payment for services not covered by the patient's health insurance policy. Payment of a deductible under an insurance policy shall not be considered a direct payment for the purposes of 105 CMR 720.000.

Family of "0" Individuals. This term refers to an unmarried patient who is permanently institutionalized and does not maintain a private household.

Financially Responsible Individuals. This term refers to the spouse of patients and the parents of minor patients.

Gross Income. The before-tax income of the patient and all financially responsible individuals related to the patient for the tax year terminating the December 31 prior to the date of the patient's hospitalization.

(1) In computing gross income, all income, from whatever source, shall be combined. Sources of income shall include:

(a) Wages or salaries;

(b) Earnings from self-employment;

(c) Unearned income including:

1. Social Security Benefits
2. Black Lung Benefits
3. Federal Civil Service Annuity
4. Railroad Retirement Benefits
5. State or Local Government Pensions
6. Unemployment Compensation Benefits
7. Workmen's Compensation Benefits
8. Private Pension
9. Insurance Annuity or Proceeds
10. Cash Support or Expenses Paid by Another including Alimony and Child Support
11. Rent, Dividends, Interest or Royalties
12. Veteran's Administration Pension
13. Veteran's Administration Compensation
14. Assistance Payments Based on Need (AFDC and GR)
15. SSI
16. Any other Income

Gross Income Year. The tax year terminating the December 31 prior to the date that medical service is rendered to the patient.

Liquid Assets. This term shall refer to the following assets: Cash, bank deposits, stocks, bonds or other securities.

Number of Persons in Family. The number of persons in the family (referred to in 105 CMR 920.005(A)(2)) shall be the number reached by adding the patient, the financially responsible persons related to the patient, and the number of their dependents as defined in the Internal Revenue Code as it now reads and as it may hereafter be amended. This term shall have the same meaning as the term "family size" appearing in 105 CMR 920.006(A)(1).

Prospective Fiscal Year. This term shall refer to the 365 day period commencing with the first day that the patient is hospitalized, and/or is rendered outpatient services.

920.003: continued

Outpatient Services. Outpatient services refers to those services rendered to ambulatory patient in the outpatient clinic, the dialysis unit and/or the adult day care program.

920.004: Eligibility

Any patient (inpatient or outpatient) who must make direct payments to the hospital to pay for his health care is eligible for an assessment in accordance with the schedule set forth herein.

(A) Patients who are eligible for and actually do receive Medicaid, Medicare or other third party coverage are not eligible for an assessment to the extent that the third party coverage is actually received.

(1) Patients who seek an assessment must apply for third party coverage whenever it appears that they are able to receive it. Failure to apply may result in denial of an assessment.

(2) Hospital personnel shall assist patients in applying for third party coverage whenever necessary.

(3) Patients who by themselves or by financially responsible persons knowingly and intentionally withhold information lawfully requested pursuant to 105 CMR 920.000 may be charged the full rate for medical services rendered to them.

920.005: Method of Determining the Patient's Assessment

The following steps shall be taken in order to determine the patient's assessment:

(A) The "Low Budget of Family of Four" published by the U.S. Department of Labor Statistics for Boston for the most current period available shall be used as a starting figure.

(1) This figure shall be multiplied by .92 to remove the medical care factor in this budget.

(2) The figure resulting from the calculation performed under CMR 920.005(A)(1) above shall be multiplied by the following factors depending upon the number of persons in the family.

(a)

Number in Family	Factor
0	.04
1	.04
2	.05
3	.07
4	.08
5	.09
6	.11
7+	Add .01 or each additional family member.

(b) The figure resulting from this calculation represents the low monthly budget for a family of one, two, three, *etc.* persons.

(B) Exceptional Method for Computing Low Budget for a Family of "0" Individuals. According to statistics published by the U.S. Department of Labor 30.8% of the low budget for a family of four is spent for food 19.4% of the low budget for a family of four is spent for housing. Because a person constituting a family of "0" individuals does not maintain a household he does not have these expenses. They are, therefore, to be subtracted, in the appropriate percentages, from the "low budget of family of four" figure prior to performing the calculations in 105 CMR 920.005(A).

(C) The gross income of the patient and the financially responsible individuals related to him shall be computed in accordance with 105 CMR 920.003(F).

(D) The gross income is then adjusted in accordance with the adjustments outlined in 105 CMR 920.003(A), resulting in a figure representing the patient's (and financially responsible persons') adjusted yearly income.

920.005: continued

(E) The adjusted yearly income is then divided by 12 in order to calculate the adjusted income on a monthly basis.

(F) The low monthly budget figure (calculated pursuant to 105 CMR 920.005(A) and/or 920.005(B)) is then subtracted from the patient's adjusted monthly income.

(1) The figure resulting represents the maximum amount of money the individual will be required to pay for inpatient and/or outpatient medical services in any given month, no matter what service is rendered.

(a) If the full charge for the inpatient and/or outpatient medical care rendered to the patient is less than the monthly maximum, the patient may be required to pay the full charge and may be denied an assessment, at the discretion of the Superintendent or his designee(s), by authority of the Commissioner of Public Health or upon the findings of the Committee as set forth in the outlined appeal procedures in 105 CMR 920.008.

(b) A schedule of monthly maximums to be assessed direct pay patients is appended hereto as exhibit A. The schedule is based upon the "Low Budget of Family of Four" for 1978, $12,500. Because this figure may change from year to year, the schedule will also change. New schedules may be issued without hearing and will be deemed to be approved by the Department of Public Health, provided that the procedures set forth herein are followed in establishing the new schedule, (including the percentages stated in 105 CMR 920.005(B).)

(G) Example to illustrate computation of Assessment for a family of four:

Low budget for family of four		$12,500.00
Family's adjusted income		$13,500.00
Monthly adjusted income (13,500 : 12)	=	$ 1,125.00
Monthly low budget ($12,500 x .92 x .08)	=	$ 920.00
Assessment ($1,125 - $920)	=	$ 205.00

(1) For the month in which the service is rendered, the maximum amount that can be assessed the patient is $205.00, even though the charge for the care may be in excess of $205.00.

(2) If the full charge for the care rendered to the patient is less than $205.00, the patient will be required to pay the full charge.

(3) The determination of a monthly Assessment does not require the patient to pay the amount assessed within the month the service is rendered. (Nor is full payment in the service month precluded.) 105 CMR 920.000 does not alter the practices of the hospitals with respect to the establishment of payment plans allowing for payment of bills over an extended period of time.

920.006: Annual Maximum Assessments and Minimum Assessments

(A) Notwithstanding the foregoing provisions, no eligible direct pay patient shall be required to pay more for his health care during the prospective fiscal year than an amount calculated in accordance with the schedule set forth below:

920.006:   continued

(1) The maximum yearly figure shall be determined by multiplying the family's adjusted yearly income by the following percentages:

Family Size	Percentage of Income
0	65.2 *
1	15.0
2	12.5
3	10.0
4	7.5
5	5.0
6+	5.0

(2) Example: The maximum yearly charge for a family of four persons with an adjusted family income of 13,500.00 will be computed as follows:

$13,500 x 7.5 = $1,013

(a) Even though this family's monthly assessment is $205 (which when multiplied by 12 equals $2,460), the maximum they can be assessed over a 12-month period is $1,013.

(B) Except in those public hospitals that are subject to the Regulations Requiring a Minimum Level of Uncompensated Medical Services in Massachusetts, and notwithstanding other provisions of these regulations, there shall be a minimum charge of $1.00 per day or $1.00 per outpatient visit.

(C) In the Department of Public Health Hospitals that are subject to the Regulations Requiring a Minimum Level of Uncompensated Medical Services Regulations in Massachusetts, patients who fall within the eligibility category set forth in 105 CMR 133.700(A)(1) shall not be required to pay an assessment for their medical care, but shall be provided free medical care.

(1) The above provision shall be in effort so long as the hospital has not met its Hill-Burton obligation for the year in question.

(2) After the yearly Hill-Burton obligation has been met, direct pay patients within the 105 CMR 133.700(A)(1) eligibility category cited above may be assessed in accordance with 105 CMR 920.000.

920.007:   Application and Determination Procedures

(A) The superintendent of each hospital shall appoint an employee or employees to inform direct pay patients about the availability of an assessment, to distribute, monitor and evaluate the applications and to make the calculations and determinations required under these regulations.

(1) Such hospital personnel shall inform patients or prospective patients, either personally or in writing of the availability of an assessment, shall answer questions about the program that patients may have, shall deliver application forms to all direct pay patients, and shall accept and process all applications submitted.

(2) The application form to be used by all hospitals is incorporated herein as exhibit B.

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* 65.2% consists of 50.2% which as stated in 105 CMR 920.005(B), a family of "0" does not have housing and food expenses. 15.% is the adjustment factor or percentage of income for a family of "0" if the individual had housing and food expenses. These two percentages summed together equals 65.2%.

920.007: continued

(B) Determinations of the assessment shall be made prior to the rendering of care so that patients will not be discouraged from seeking medical care for fear they will not be able to pay a hospital bill. The following exceptions are allowed:

(1) Determinations may be made after the provision of services in the case of emergency admissions.

(a) An emergency admission shall be an admission in which the patient requires immediate medical attention and is therefore unable to complete an application prior to the rendering of medical care.

(2) Determinations may be made after the provision of services in case of a change in circumstances as a result of the illness or injury occasioning such services (*e.g.* the patient's financial condition has changed due to loss of wages resulting from the illness) or in the case of insurance coverage or other resources being less than anticipated or the costs of services being greater than anticipated. (The hospital personnel as designated in 105 CMR 920.007(A) shall review and update determinations made for patients who are still receiving services from (the hospital) on a periodic basis. Said period of time shall be set at the discretion of the superintendent or his designee(s). And shall follow the procedures set forth in 105 CMR 920.007(C),(D) and (E).

(3) Determinations may be made after the provision of services if the determinations was delayed by reason of erroneous or incomplete information furnished by or on behalf of the patient.

(C) Determinations of the amount of an assessment (or of eligibility for free care) shall not be delayed by an application for medicaid, or other third party coverage.

(1) Whenever such an application is pending, the employee designated by the superintendent in accordance with 105 CMR 920.007(A) shall proceed to determine the amount of the patient's assessment (for his eligibility for free care).

(2) The patient shall be informed in writing of the results of the above determination and shall receive assurance from the designated employee that if the application for medicaid, medicare or other third party payment is denied, the patient will be assessed (or given free care, as the case may be) in accordance with the determination.

(D) The patient shall be informed in writing of the determination made by the designated hospital employee of his monthly and yearly maximum, his annual minimum payment. (Written notice of a denial of an assessment shall also be given together with a written statement of reasons.) This written determination shall be given to the patient prior to the rendering of services in the situations set forth in 105 CMR 920.007(B)(1), (2) and (3) of 105 CMR 920.000.

(E) Verification. Verification of the information submitted on the application shall not be required prior to the determination of the assessment or prior to the provision of medical services.

(1) The application must be signed under the pains and penalties of perjury. If information on the application is intentionally falsified, the matter shall be brought to the attention of the Assistant Commissioner for Health Services who may refer the case to the Attorney General for perjury prosecution.

(2) Calculations shall be verified by the Treasurer of the hospital or his designate. He shall initial the application in the appropriate space if the calculations are correct. If the calculations are incorrect, the form shall be revised and resigned by the patient and/or the financially responsible individuals.

(3) For Hill-Burton patients, verification in the nature of substantiation of the information on an application shall be permitted only to the extent permitted under the Regulations Requiring a Minimum Level of Uncompensated Medical Services in Massachusetts.

(4) For direct pay patients who do not receive Hill-Burton uncompensated service, verification in the nature of substantiation shall be permitted in accordance with the following guidelines:

(a) Verification shall not be required of all direct pay patients. Rather, a sampling of direct pay patients shall be selected for verification.

920.007: continued

(b) The gross and adjusted incomes shall be verified by written documentation within the possession of the patient and the financially responsible individuals related to him, including W-2 forms, pay stubs, internal revenue forms, bank books, canceled checks.
(c) The employer of the patient and/or the financially responsible person related to him shall not be contacted either orally or in writing.
(d) If the patient and his financially responsible persons lack written documentation to substantiate the application, the hospital may seek the written permission of the patient or financially responsible persons to contact the internal revenue service regarding income earned in the gross income year and the period of time up to the date of hospitalization, and to contact the bank(s) where such persons hold accounts.

920.008: Appeal from Computation of Adjusted Income and or Determination of Assessment

A patient who is aggrieved by a computation of adjusted income or by a determination of reduced charge assessment or by the denial of free care shall have the right to appeal to an intra-hospital committee composed of the superintendent of the hospital, a member of the social service department and three other persons appointed by the superintendent.

(A) The patient shall receive written notice of this appeal right along with the written determination of assessment, (or denial of assessment) required by 105 CMR 920.007(D). The notice shall briefly outline the appeal procedure set forth herein.

(B) The patient shall submit a written statement to the committee explaining his disagreement with the determination. He shall include any other written documentation that he believes to be relevant.

(C) The patient shall not be granted a hearing before this committee unless he requests the opportunity to appear personally or through a representative.

(D) The Committee may, considering all available evidence, make a determination of reduced charge assessment, using either the methods set forth in 105 CMR 920.005 and 105 CMR 920.006, and/or any other relevant factors relating to ability to pay.

(E) If the Committee upholds the initial determination made with respect to the patient, no further appeals shall be granted.

920.009: Relationship to the Regulations Requiring a Minimum Level of Uncompensated Medical Services

Lakeville Hospital, and Massachusetts Hospital School are subject to the Regulations Requiring a Minimum Level of Uncompensated Medical Services in Massachusetts. Said regulations shall prevail over the instant regulations in the event of conflict with the instant regulations.

920.010:   Financial Information Form

EXHIBIT A

Adj. Annual Income	In Family	0	1	2	3	4	5	6	7+
Under 2000		30	30	30	30	30	30	30	30
2000 To 2999		30	30	30	30	30	30	30	30
3000 To 3999		83	30	30	30	30	30	30	30
4000 To 4999		166	30	30	30	30	30	30	30
5000 To 5999		249	30	30	30	30	30	30	30
6000 To 6999		333	82	30	30	30	30	30	30
7000 To 7999		416	165	50	30	30	30	30	30
8000 To 8999		449	248	133	30	30	30	30	30
9000 To 9999		583	332	217	30	30	30	30	30
10000 To 10999		666	415	300	70	30	30	30	30
110000 To 11999		749	498	383	38	30	30	30	30
12000 To 12999		833	582	467	237	122	30	30	30
13000 To 13999		916	665	550	320	205	90	30	30
14000 To 14999		999	748	633	403	288	173	30	30
15000 To 15999		1083	832	717	487	372	257	30	30

920.010: continued

Adj. Annual Income	In Family	0	1	2	3	4	5	6	7+
16000 To 16099		1166	832	800	570	455	340	110	30
17000 To 17999		1249	998	883	653	338	423	193	78
18000 To 18999		1333	1082	967	737	622	507	277	162
19999 To 19999		1416	1165	1050	820	705	590	360	245
20000 To 20999		1499	1248	1133	903	788	673	443	328
21999 To 22999		1583	1332	1217	987	872	757	527	412
23000 To 23999		1749	1498	1383	1153	1038	923	693	578
24000 To 24999		1833	1582	1467	1237	1122	1007	777	662
25000 To 25999		1916	1665	1550	1320	1205	1090	860	745
Add *83.00 for each additional $1,000		+83	+83	+83	+83	+83	+83	+83	+83

920.010: continued

EXHIBIT B

HUMAN SERVICES
FINANCIAL INFORMATION FORM

Name: ________________________ SS No. ___________________

Birth date: ______________________ Sex: ___________________

Former Patient: ___________________ Marital Status: _____________

Patient Address: ____

Name Financially Responsible Individual #1 ____________________________
(if different from above)

Address: ____

Relationship: __________________________ SS No. __________________

Name Financially Responsible Individual #2 _____________________

Address: ____

Relationship: __________________________ SS No. __________________

If there are any additional number of Financially Responsible Individuals list names, addresses, relationships and social security numbers on an attached sheet.

____

____

THIRD PARTY INFORMATION Check types of coverage the patient is eligible for:

Blue Cross/Blue Shield ___________________ Medicaid _________________

Commercial Insurance Carrier ___________________ Veteran's _________________

SSI ____________________

Medicare ___________________________ Other ___________________

Have these sources been billed to the full extent possible? YES _____ NO _____
If no, patient is not eligible for reduced rate.

____

____

PART A
Gross Income (Enumerate in Part B) $ ______________________
Total Exceptional Expenses (Enumerate in Part C) $ ______________________
Change in Income (Describe circumstances and proof in Part D) $ ______________________
Liquid Assets (Enumerate in Part E) $ ______________________
TOTAL Adjusted Annual Income $ ______________________
Number of Dependents ___________
Locate amount individual responsible for in a given calendar month on the "Financial Responsibility Table".

Individual responsible for a maximum of $ ______ in a given month.

Using the "Annual Maximum Table" calculate the maximum amount the individual will be responsible for paying in any given twelve month period:
________ % X $ ________ = $ ________

920.010: continued

PART B

WAGES

	NAME OF EMPLOYERS	ADDRESSES	ANNUAL INCOME
PATIENT			
FINANCIALLY RESPONSIBLE INDIVIDUAL #1			
FINANCIALLY RESPONSIBLE INDIVIDUAL #2			

UNEARNED INCOME

	SOURCE	AMOUNT
PATIENT		
FINANCIALLY RESPONSIBLE INDIVIDUAL #1		
FINANCIALLY RESPONSIBLE INDIVIDUAL #2		
TOTAL INCOME		

PART C - Exceptional Expenses. In the space below, enumerate exceptional expenses:

Expense	Amount
TOTAL	$ _____

920.010: continued

PART D - Change in income. Describe reason for change in income and proof of such change. Include extraordinary sources of income.

____
____

PART E - LIQUID ASSETS

Cash	$ __________
Bank Deposits	$ __________
Securities	$ __________
TOTAL	$ __________

List names of banks funds held in:

____
Signature

____
____

I hereby attest, under penalties of perjury, that to the best of my knowledge the above information is correct.

____
Signature

____
____

I, ________________________ , understand that I am responsible for contributing $ ____________ per month to my health care but no more than $ ________________ per year. If I do not fulfill this responsibility I understand that my bill will be sent to the Attorney General of the Commonwealth of Massachusetts for appropriate action. I further attest that I have been advised and understand the purposes and uses of this information (listed on attached sheet) and therefore consent to this information being held by the Department of Public Health.

____
Signature Patient or Financially Responsible Individual

____
Date

____
Signature Patient or Financially Responsible Individual

____
Treasurer's Initials

____
Signature of Interviewing Individual

920.010: continued

PART F - Was the patient denied on assessment? If so, state reasons for denial.

____
____

PART G

Was review asked for? YES ___ NO ___ Was hearing requested? YES ____ NO ___

What was the result: ____

____

____

____

____

REGULATORY AUTHORITY

105 CMR 920.000: M.G.L. c. 111, §§ 69I, 69E, 62I; c. 122, § 1.

NON-TEXT PAGE