114.6 CMR 10.00: CRITERIA FOR DETERMINING ELIGIBILITY FOR FREE CARE AT ACUTE CARE HOSPITALS AND FREESTANDING COMMUNITY HEALTH CENTERS

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10.01: General Provisions

(1) Scope, Purpose, and Effective Date.

(a) 114.6 CMR 10.00 implements the provisions of M.G.L. c. 118G, regarding eligibility determination for free care at acute care hospitals and freestanding community health centers.

(b) The purpose of 114.6 CMR 10.00 is to specify:

1. the standards and procedures for determining patients' eligibility for free care,

2. the standards and criteria for notifying patients of the availability of free care and public assistance programs, and

3. the standards and criteria that credit and collection policies must meet for bad debt and free care accounts.

(c) 114.6 CMR 10.00 shall be effective on and after May 7, 2004.

(2) Authority: 114.6 CMR 10.00 is adopted pursuant to M.G.L. c. 118G.

10.02: Definitions

Meaning of Terms: As used in 114.6 CMR 10.00, unless the context otherwise requires, terms shall have the meanings ascribed in 114.6 CMR 10.00.

Acute Hospital. Any hospital licensed under M.G.L. c. 111, § 51 and the teaching hospital of the University of Massachusetts Medical School, which contains a majority of medical-surgical, pediatric, obstetric, and maternity beds as defined by the Department of Public Health.

Acute Hospital Services. Services listed on an acute hospital's license by the Department of Public Health.

Allowable Medical Expenses. Family medical bills from any provider that, if paid, would qualify as deductible medical expenses for federal income tax purposes. Unpaid bills for which the patient is still responsible, incurred prior to or after the date of a free care application, may be used. Paid bills, incurred after the date of the free care application, may also be included in the allowable medical expenses.

Bad Debt. An account receivable based on services furnished to any patient which:

(a) is regarded as uncollectible, following reasonable collection efforts, pursuant to 114.6 CMR 10.05, and pursuant to the hospital's or community health center's established Credit and Collection policy, that conforms with 114.6 CMR 10.09;

(b) is charged as a credit loss;

(c) is not the obligation of any federal or state governmental unit; and

(d) is not free care.

10.02: continued

CenterCare Program. An ambulatory managed care program that offers primary and preventive health care services to low-income, uninsured adult patients of independently licensed community health centers, administered by the Department of Public Health, pursuant to M.G.L., c.111, § 24H.

Charge. The uniform price for a specific service charged by a hospital or community health center.

Children's Medical Security Plan. A program of primary and preventive pediatric health care services for eligible children, from birth to age 18, administered by the Department of Public Health pursuant to M.G.L. c. 111, § 24G.

Collection Action. Any activity by which a hospital, community health center or a 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 pre-admission or pretreatment deposits, billing statements, collection follow-up letters, telephone contacts, personal contacts and activities of collection agencies and attorneys.

Commissioner. The Commissioner of the Division of Health Care Finance & Policy or designee.

CommonHealth. A Medicaid program for disabled adults and disabled children administered by the Division of Medical Assistance pursuant to M.G.L. c. 118E.

Community Health Center. A clinic which provides comprehensive ambulatory services and which:

(a) is licensed as a freestanding clinic by the Massachusetts Department of Public Health pursuant to M.G.L. c.111, § 51;

(b) meets the qualifications for certification (or provisional certification) by the Division of Medical Assistance and enters into a provider agreement pursuant to 130 CMR 405.000;

(c) operates in conformance with the requirements of 42 U.S.C. § 254c; and

(d) files cost reports as requested by the Division.

Credit and Collection Policy. A statement, in compliance with 114.6 CMR 10.09, of a hospital's or community health center's general policy and the principles that guide its billing and collection practices and procedures, as approved by its governing board.

Deductible. The patient's liability to the provider for partial free care purposes.

Division. The Division of Health Care Finance and Policy established under M.G.L. c. 118G.

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

Emergency Care. Medically necessary services provided after the sudden onset of a medical condition, whether physical or mental, manifesting itself by acute symptoms of sufficient severity, including severe pain, which a prudent lay person would reasonably believe is an immediate threat to life or has a high risk of serious damage to the individual's health. Conditions include, but are not limited to those which may result in jeopardizing the patient's health, serious impairment to bodily functions, serious dysfunction of any bodily organ or part, or active labor in women. Examination or treatment for emergency medical conditions or any such other service rendered to the extent required pursuant to 42 USC 1395(dd) qualifies as emergency care for Pool purposes.

EMTALA. The federal Emergency Medical Treatment and Active Labor Act under 42 USC 1395(dd).

Family. The patient, spouse and any minor dependents living in the household, and unborn children.

10.02: continued

Family Income. The sum of annual earnings and cash benefits from all sources before taxes, less payments made for alimony and child support.

Federal Poverty Income Guidelines. The Federal Poverty Income Guidelines published annually by the federal Department of Health and Human Services.

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

Free Care. Unpaid hospital or community health center charges for medically necessary services which are eligible for reimbursement from the Pool pursuant to the criteria set forth in 114.6 CMR 10.03. Types of free care include: full free care, partial free care, medical hardship, and emergency bad debt.

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

Guarantor. A person or group of persons who assumes the responsibility of payment for all or part of a hospital or community health center's charge for services.

Health Insurance Plan. The Medicare program, the Medicaid program, or an individual or group contract or other plan providing coverage of health care services which is issued by a health insurance company, as defined in M.G.L. c. 175, c. 176A, c. 176B, c. 176G, or c. 176I.

Healthy Start. A health care program for pregnant women and infants administered by the Department of Public Health pursuant to M.G.L. c. 111, § 24D.

Hospital. An acute hospital.

MassHealth. A Medicaid program administered by the Division of Medical Assistance pursuant to M.G.L. c. 118E and in accordance with Title XIX of the Federal Social Security Act, and a § 1115 Demonstration Waiver.

Medicaid Program. The medical assistance program administered by the Division of Medical Assistance pursuant to M.G.L. c. 118E and in accordance with Title XIX of the Federal Social Security Act.

Medical Assistance Program. The Medicaid program, the Veterans Administration health, hospital, and community health programs and any other medical assistance program operated by a Governmental Unit for persons categorically eligible for such program.

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 handicap, or result in illness or infirmity. Medically necessary services shall include inpatient and outpatient services as mandated under Title XIX of the Federal Social Security Act. Medically necessary services shall not include:

(a) non-medical 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 including, but not limited to, treatment related to sex-reassignment surgery, and pre-surgery hormone therapy, and
(g) the provision of whole blood; provided, however, that administrative and processing costs associated with the provision of blood and its derivatives shall be payable.

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

10.02: continued

Pool. The Uncompensated Care Pool established pursuant to M.G.L. c. 118G, §18.

Provider. Any person, corporation, partnership, governmental unit, state institution and other entity qualified under the laws of the commonwealth to perform or provide health care services.

Publicly Aided Patient. A person who receives hospital or community health center care and services for which a Governmental Unit is liable in whole or in part under a statutory program.

Resident. A person living in Massachusetts with the intention of remaining in the state indefinitely. A resident is not required to maintain a fixed address. The following conditions do not meet the requirements for residency:
(a) confinement in a nursing home, hospital or other medical institution, and
(b) relocation to Massachusetts for the sole purpose of receiving health care benefits.

Uninsured Patient. A patient who does not have a policy of health insurance or is not a member of a health insurance or benefit program. A patient who has a policy of health insurance or is a member of a health insurance or benefit program which requires such patient to make payment of deductibles, or co-payments, or fails to cover certain medical services or procedures is not uninsured.

Urgent Care. Medically necessary services provided in a 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 lay person would believe that the absence of medical attention within 24 hours could reasonably expect to result in:
(a) placing a patient's health in jeopardy;
(b) impairment to bodily function; or
(c) 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.

10.03: Eligibility Categories

(1) Full Free Care.
(a) Eligibility.
1. a Massachusetts Resident whose Family Income is equal to or less than 200% of the Federal Poverty Income Guidelines;
2. a non-Massachusetts Resident who receives Emergency or Urgent Care and whose Family Income is equal to or less than 200% of the Federal Poverty Income Guidelines;
3. a person who receives benefits from the CenterCare or Emergency Aid to the Elderly, Disabled and Children (EAEDC) programs for Medically Necessary Services not covered by these programs; or
4. participants in the Children's Medical Security Plan or Healthy Start whose Family Income is equal to or less than 200% of the Federal Poverty Income Guidelines.
(b) Payment. The entire financial liability of a Resident whose income meets these criteria may be billed to the Pool for the period of Free Care eligibility described in 114.6 CMR 10.04. The entire financial liability for Emergency Care or Urgent Care of a non-Resident whose income meets these criteria may be billed to the Pool for the period of Free Care eligibility described in 114.6 CMR 10.04.

(2) Partial Free Care.
(a) Eligibility.
1. a Massachusetts Resident whose Family Income is from 201% to 400% of the Federal Poverty Income Guidelines;
2. a non-Massachusetts Resident receiving Emergency or Urgent Care whose Family Income is from 201% to 400% of the Federal Poverty Income Guidelines.
3. participants in the Children's Medical Security Plan whose Family Income is from 201% to 400% of the Federal Poverty Income Guidelines.
4. participants in Healthy Start whose Family Income is from 201% to 225% of the Federal Poverty Income Guidelines.

10.03: continued

(b) Annual Patient Deductible.

1. The patient's Deductible equals 40% of the difference between the patient's Family Income and 200% of the Federal Poverty Income Guidelines. The following formula must be used in determining the amount of the Deductible:

[Family Income - (2 x Federal Poverty Income Guidelines)] x 40% = Annual Patient Deductible

The total amount of a patient's co-payments is capped in any given year at the Deductible amount calculated in 114.6 CMR 10.03(2)(b)1.. The patient will remain responsible for all expenses for Medically Necessary Services that would otherwise be billed to the Pool up to this Deductible amount. There is only one partial Free Care Deductible per Family per eligibility period. If the patient is approved for partial Free Care at more than one Provider, or if additional members of a Family are approved for partial Free Care at the same or another Provider, the Medically Necessary Services from the other Provider(s) or for the additional Family members must be applied to a single partial Free Care Deductible for the Family. Family members must be approved for partial Free Care in order for their expenses for Medically Necessary Services to be applied towards the Deductible. Once a Hospital or Community Health Center has calculated the patient's Deductible pursuant to 114.6 CMR 10.03(2)(b)1., the Hospital or Community Health Center must track the patient's Free Care expenses until the patient meets the Deductible. If more than one Family member is approved for Free Care, or if the patient or Family members are approved for Free Care at more than one Hospital or Community Health Center, it is the patient's responsibility to track the Deductible and provide documentation to the Hospital or Community Health Center that the Deductible has been reached.

(c) Payment.

1. Hospitals. The patient must incur expenses for Medically Necessary Services to meet the Deductible before receiving partial Free Care. Once the patient has met the Deductible, the remaining balance for Medically Necessary Services may be billed to the Pool for the period of Free Care eligibility described in 114.6 CMR 10.04. Based on the guidelines established in 114.6 CMR 10.05, the Hospital may require a deposit and/or a payment plan.

2. Community Health Centers. A person who is eligible for partial Free Care must pay a percentage of the bill based on a sliding fee scale until the patient meets the Deductible as calculated pursuant to 114.6 CMR 10.03(2)(b)1.. The remaining balance may be billed to the Pool. Once the patient meets the Deductible, the entire visit may be billed to the Pool for the period of Free Care eligibility described in 114.6 CMR 10.04. Community Health Centers must report the co-payment amount as Free Care income, regardless of whether the payment was actually received.

The sliding fee scale appears below:

Income as a Percentage of Federal Poverty Income Guidelines	Percentage of Rate Paid by Patient
201% to 250%	20%
251% to 300%	40%
301% to 350%	60%
351% to 400%	80%

(3) Medical Hardship.

(a) Eligibility.

1. A Massachusetts Resident at any income level may qualify for Medical Hardship if Allowable Medical Expenses have so depleted the family's income and resources that he or she is unable to pay for Medically Necessary Services. In order to qualify for Medical Hardship, the patient must meet both the expense and the resource qualifications described below.

10.03: continued

2. A non-Massachusetts Resident receiving Emergency or Urgent Care, at any income level, may qualify for Medical Hardship if Allowable Medical Expenses have so depleted the family's income and resources that he or she is unable to pay for Medically Necessary Services. In order to qualify for Medical Hardship, the patient must meet both the expense and the resource qualifications described below.

(b) Patient Contribution.

1. Expense Qualification. The patient's Allowable Medical Expenses must exceed 30% of his or her Family Income determined as follows:

a. The Hospital or Community Health Center will determine the Family Income. If a member of the Family is temporarily unemployed, the Hospital or Community Health Center will estimate the amount that Family member might reasonably be expected to earn over the next year. This amount plus the gross income of all other Family members shall be considered the Family Income.

b. The Hospital or Community Health Center will multiply the Family Income, as determined in 114.6 CMR 10.03(3)(b)1.a., by 30%.

c. The Hospital or Community Health Center will determine the patient's Allowable Medical Expenses, as defined in 114.6 CMR 10.02.

d. The Hospital or Community Health Center will compare 30% of the Family Income, determined pursuant to 114.6 CMR 10.03(3)(b)1.b., to the total amount of the patient's Allowable Medical Expenses, determined pursuant to 114.6 CMR 10.03(3)(b)1.c.. If the total of Allowable Medical Expenses is greater than 30% of the Family Income, then the patient meets the expense qualification. The Hospital or Community Health Center will subtract 30% of the Family Income from the Allowable Medical Expenses to determine the amount by which the Allowable Medical Expenses exceed the available income, or the "excess medical expenses" for the resource qualification test below.

2. Resource Qualification. The patient's available assets must be insufficient to cover the cost of Allowable Medical Expenses that exceed 30% of the Family Income.

a. The Hospital or Community Health Center will calculate total available Family assets. Available assets do not include the primary residence, the first motor vehicle, and a resource exclusion of the first $4,000 of other assets for an individual, or $6,000 for a Family of two, and $1,500 for each additional Family member.

b. The Hospital or Community Health Center will compare the available assets determined pursuant to 114.6 CMR 10.03(3)(b)2.a.. to the excess medical expenses, determined pursuant to 114.6 CMR 10.03(3)(b)1.d.. If the available assets are greater than the excess medical expenses, the patient is not eligible for Medical Hardship. If the available assets are less than the excess medical expenses, the patient is eligible for Medical Hardship. The Hospital or Community Health Center will determine the patient's Medical Hardship contribution by adding 30% of the patient's Family Income, determined pursuant to 114.6 CMR 10.03(3)(b)1.b., to the patient's available assets, determined pursuant to 114.6 CMR 10.03(3)(b)2.a. This is the amount of the patient's Medical Hardship contribution. There is one Medical Hardship contribution per Family per eligibility period.

c. The patient will remain responsible for all Allowable Medical Expenses up to this Medical Hardship contribution. The patient is eligible for Free Care for all expenses for Medically Necessary Services in excess of the Medical Hardship contribution for the period of Free Care eligibility described in 114.6 CMR 10.04.

(c) Payment.

1. The Hospital or Community Health Center will first apply the Allowable Medical Expenses billed by other Providers to the patient's Medical Hardship contribution. If the Medical Hardship contribution exceeds the Allowable Medical Expenses billed by other Providers, the Hospital or Community Health Center will then apply its own Allowable Medical Expenses to the Medical Hardship contribution. The patient must pay that portion of the bill that the Hospital or Community Health Center applied to the Medical Hardship contribution.

2. The Hospital or Community Health Center may bill any balance above the patient's Medical Hardship contribution to the Pool.

10.03: continued

(4) Emergency Bad Debt.

(a) Eligibility. To be eligible for emergency Bad Debt, an account must meet the following conditions.

1. The patient must be uninsured for the services provided.

2. The patient must have received Emergency Care as defined in 114.6 CMR 10.02.

3. The patient's condition must be determined by the responsible physician to require Emergency Care, as defined in 114.6 CMR 10.02 and in the Hospital's Credit and Collection Policy.

4. The Hospital establishes that appropriate collection action was taken pursuant to 114.6 CMR 10.05.

(b) Payment.

1. A Hospital may bill to the Pool all charges resulting from the emergency visit, including any ancillary services, and any charges for an inpatient or observation stay.

2. A Hospital may bill the Pool for Emergency Care screening and services, but not for other services provided to patients determined not to require Emergency Care. If a Hospital cannot distinguish charges for screening services from charges for other Medically Necessary Services, the Hospital may bill the Pool for the amount paid by the Medicaid program for emergency screening services.

10.04: Eligibility Process

(1) MassHealth Enrollment. If a patient is enrolled in MassHealth on the date that the service is provided, the Hospital or Community Health Center may not bill the Pool for that service. Therefore, for any patient requesting Free Care, Hospitals and Community Health Centers must check Division of Medical Assistance eligibility verification systems to determine the patient's MassHealth enrollment status.

(2) Screening for Alternative Programs. Hospitals and Community Health Centers must screen patients for other sources of coverage and potential for eligibility in government programs before approving them for Free Care. Hospitals and Community Health Centers are required to document the results of each screening. If an Acute Hospital or Community Health Center determines that a patient is potentially eligible for Medicaid or another government program, said Acute Hospital or Community Health Center shall encourage the patient to apply for such program and shall assist the patient in applying for benefits under such program. A patient who declines to apply for another government program may apply and, if eligible, be approved for Free Care.

(3) Application. Hospitals and Community Health Centers will use the appropriate application form provided by the Division to determine eligibility for Free Care, partial Free Care, and Medical Hardship. Copies of the application forms are attached hereto and incorporated herein by reference. Each application form must be signed by the patient or an authorized representative authorizing the release of information to the Division of Health Care Finance & Policy, and attesting that all information is correct. Hospitals and Community Health Centers may use the Free Care application guide, which contains specific lists of acceptable forms of documentation, to assist with the Free Care application and eligibility determination process.

(a) The Free Care Application (DHCFP-FC1).

1. All applicants for Free Care, except those patients who meet the conditions of 114.6 CMR 10.04(3)(b) or 114.6 CMR 10.04(3)(d), must complete the Free Care application (DHCFP-FC1) and provide the required supporting documentation.

2. Supporting documentation is not required with the application for a single visit to a Hospital or Community Health Center when the total charge is $500 or less, but documentation must be provided in order to receive Free Care for subsequent visits.

(b) The Condensed Free Care Application (DHCFP-FC2). In order to prevent patients from having to provide duplicative information, patients in the categories described below may apply for Free Care using a condensed Free Care form.

10.04: continued

1. Patients Eligible for MassHealth, but not yet Enrolled. Any patient determined eligible for MassHealth by the Division of Medical Assistance may complete the condensed Free Care application to receive Free Care for Medically Necessary Services provided before the patient's MassHealth enrollment date. Patients enrolled in the EAEDC program may receive Free Care for Medically Necessary Services provided before the patient's MassHealth enrollment date without signing an application form only if the Hospital or Community Health Center includes a copy of the EAEDC card with the application and verifies EAEDC eligibility.
2. Patients Ineligible for MassHealth. A patient who applied for and was subsequently denied MassHealth may submit a completed Medical Benefit Request (MBR) and a condensed Free Care application, provided that the MBR was submitted to the Division of Medical Assistance within six months of the Free Care application.
3. Members of Children's Medical Security Plan or Healthy Start. A patient enrolled in any or all of these programs who meets the Free Care income eligibility criteria is eligible for Free Care for those Medically Necessary Services not covered by the program, provided that the patient completes a condensed Free Care application and provides the Hospital or Community Health Center with a copy of his or her valid membership card. With the patient's consent, Providers may obtain verification of enrollment in these programs by mail or fax from the agency that administers the program. If the patient provides a valid program enrollment card, Hospitals and Community Health Centers must include a copy of the card with the patient's signed application form; both sides of the card must be copied if both sides are used.
4. Members of CenterCare. Patients enrolled in the CenterCare program may receive Free Care for Medically Necessary Services not covered by the CenterCare program without signing a condensed Free Care application form only if the Hospital or Community Health Center verifies that the patient has signed the Division's Assignment of Rights statement on the CenterCare application and includes a copy of the CenterCare card (front and back) with the Free Care application. If the patient has not signed the Assignment of Rights, the patient must complete and sign a condensed Free Care application form, and the Hospital or Community Health Center must attach a copy of the card (front and back) to the patient's signed application form.
5. Patients who have been approved for Free Care at another Hospital or Community Health Center. Patients who have been determined eligible for Free Care at one Hospital or Community Health Center may use the Condensed Free Care Application when applying for Free Care elsewhere. The second Hospital or Community Health Center must obtain a copy of the full Free Care application and supporting documentation from the first Hospital or Community Health Center, and is responsible for making its own eligibility determination and verifying that the shared information is still reflective of the applicant's eligibility status.

(c) The Medical Hardship Supplement (DHCFP-FC3). The Hospital or Community Health Center must use the Medical Hardship supplement to determine the Allowable Medical Expenses and available assets to be used in calculating eligibility for Medical Hardship. The Medical Hardship supplement is a supplement to the Free Care application. Patients applying for Medical Hardship must complete both forms and provide the required supporting documentation in order to be eligible for Medical Hardship assistance.

(d) The Family Supplement (DHCFP-FC4). When one Family member has completed the Free Care application and supplied the necessary documentation, additional Family members may apply for Free Care using the Family supplement form. The eligibility dates for Family members using the Family supplement form will be the same as those for the applicant who completed the Free Care application.

(e) Facility Use Only Section. The Hospital or Community Health Center must document the process used to determine Free Care eligibility by completing the Facility Use Only section of each application described in 114.6 CMR 10.04.

10.04: continued

(4) Special Circumstances.

(a) Balances after insurance. A copy of the insurance program or policy's Explanation of Benefits (EOB) must be included with the Free Care application. If this is not available, a copy of the bill from the Provider indicating the balance due from the patient, or a copy of the patient's insurance card or policy, may be substituted. A patient may apply for Free Care to cover his or her financial liability after any insurance program or policy has paid the amount for which it is responsible.

(b) Medicare Bad Debt is eligible for payment from the Pool to the extent that:

1. such charges are related to Medicare co-payments and deductibles or to Medically Necessary Services that are not covered by the Medicare program,

2. such charges are for a patient who otherwise qualifies for Free Care pursuant to 114.6 CMR 10.03,

3. such charges were properly submitted for payment to the Medicare intermediary and were rejected by the intermediary as failing Medicare substantive rules. A Hospital need not submit for payment to the Medicare intermediary any charges for services for which Title XVIII of the Federal Social Security Act does not allow payment, and

4. the Hospital establishes that reasonable collection efforts were made pursuant to Title XVIII of the Federal Social Security Act and 114.6 CMR 10.05.

(c) Patients injured in motor vehicle accidents may be eligible for Free Care if the Hospital or Community Health Center documents that it investigated whether the patient, driver, and/or owner of the other motor vehicle had a motor vehicle liability policy and, where applicable, properly submitted a claim for payment to the motor vehicle liability insurer.

(d) Hospitals and Community Health Centers that recover payments for charges which were previously billed to the Pool must report such payments to the Division. These recoveries will be offset against Free Care charges to the Pool.

(5) Time Frame.

(a) Prior to billing the Pool, Hospitals must obtain a completed Free Care application and all supporting documentation from the patient within one year of determining the patient's financial liability, unless the Hospital documents continuous Collection Action or regular patient payments during the intervening time. Patients are eligible to apply for Free Care for an account over one year old if the Hospital can document continuous collection action or patient payments during the intervening time.

(b) Prior to billing the Pool, Community Health Centers must obtain a completed Free Care application and all supporting documentation from the patient within ninety days of determining the patient's financial liability, unless the Community Health Center documents continuous Collection Action or regular patient payments during the intervening time. Patients are eligible to apply for Free Care for an account over ninety days old if the Hospital can document continuous collection action or patient payments during the intervening time.

(c) Hospitals and Community Health Centers must give the patient written notice of an eligibility determination within 30 days of receipt of a complete application.

(d) The patient will remain eligible for Free Care for one year from the date of the eligibility determination, unless over the course of that year the patient's Family Income or insurance status changes to such an extent that the patient becomes ineligible.

10.05: Collection Action

(1) Obtaining Information. Hospitals and Community Health Centers must have written Credit and Collection Policies that comply with 114.6 CMR 10.09.

(a) Inpatient Services.

1. Non-Emergency Admissions. A Hospital shall make reasonable efforts to obtain the financial information necessary to determine responsibility for payment of the Hospital bill from the patient or Guarantor prior to the date of the patient admission.

10.05: continued

2. Emergency Admission. A Hospital shall make reasonable efforts, after the patient is admitted and as soon as reasonably possible, to obtain the financial information necessary to determine responsibility for payment of the Hospital bill from the patient or Guarantor. If the patient or Guarantor is unable to provide the information needed, and the patient consents, a Hospital shall make reasonable efforts to contact the relatives, friends and Guarantor and the patient for additional information while the patient is in the Hospital.

3. Requirements for Obtaining Additional Information During the Patient's Hospital Stay. A Hospital shall identify the department that is responsible for obtaining the information from the patient, and explain any clinical approval process required in contacting the patient for additional information. If no clinical approval process is required prior to contacting patients, the Credit and Collection Policy must so specify.

4. Requirements for Obtaining Information at the Time of the Patient's Discharge. If a Hospital has not obtained sufficient patient financial information to assess the ability of the patient or the patient Guarantor to pay for Hospital services prior to the date of discharge, the Hospital shall make reasonable efforts to obtain the necessary information at the time of the patient's discharge.

(b) Outpatient Services.

1. Non-Emergency Service. A Hospital or Community Health Center shall make reasonable efforts, prior to treatment, to obtain the financial information necessary to determine responsibility for payment of the bill from the patient or Guarantor.

2. Emergency Service. A Hospital or Community Health Center shall 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.

(c) Verification of Patient-Supplied Information.

1. Inpatient. A Hospital shall 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.

2. Outpatient. A Hospital or Community Health Center shall 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.

(2) Populations exempt from Collection Action.

(a) A Hospital or Community Health Center shall not bill patients receiving governmental benefits under the Emergency Aid to the Elderly, Disabled and Children program, participants in the Healthy Start program, or participants in the CenterCare Program. However, the Hospital or Community Health Center may initiate billing for a patient who alleges that he or she is a participant in any of the programs listed in 114.6 CMR 10.04, but fails to provide proof of such participation, or who fails to sign a condensed Free Care application. Upon receipt of satisfactory proof that a patient is a participant in any of the above listed programs, and receipt of the signed condensed Free Care application, the Hospital or Community Health Center shall cease its collection activities.

(b) Participants in the Children's Medical Security Plan whose Family Income is equal to or less than 200% of the Federal Poverty Income Guidelines are also exempt from collection action. The Department of Public Health (DPH) may issue periodic notices to the Hospitals and Community Health Centers regarding billing of the participants in the Children's Medical Security Plan. However, the Hospital or Community Health Center 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, or who fails to sign a condensed Free Care application. Upon receipt of satisfactory proof that a patient is a participant in the Children's Medical Security Plan and receipt of the signed condensed Free Care application, the Hospital or Community Health Center shall cease its collection activities.

(c) If a Hospital or Community Health Center provides inpatient or outpatient services to a person who meets the standard for full Free Care, pursuant to 114.6 CMR 10.03 and 10.04, such person shall be exempt from Collection Action.

10.05: continued

(d) If a Hospital or Community Health Center provides inpatient or outpatient services to a person who meets the standard for partial Free Care, pursuant to 114.6 CMR 10.03 and 10.04, such person shall be exempt from Collection Action for the portion of his or her Hospital or Community Health Center bill that exceeds the Deductible.
(e) If a Hospital or Community Health Center provides inpatient or outpatient services to a person who meets the standard for Medical Hardship, pursuant to 114.6 CMR 10.03 and 10.04, the Hospital or Community Health Center shall exempt such person from Collection Action with respect to the amount of the bill that exceeds the Medical Hardship contribution, calculated pursuant to 114.6 CMR 10.03(3).

(3) Deposits and Payment Plans.
(a) The Hospital or Community Health Center shall not require pre-admission and/or pretreatment deposits from patients who require Emergency Care or who are determined to be eligible for full Free Care.
(b) Hospitals and Community Health Centers may request a deposit from patients eligible for partial Free Care. Deposits will be limited to 20% of the Deductible amount up to $500. All remaining balances will be subject to the payment plan conditions established in 114.6 CMR 10.05(3)(d).
(c) Hospitals and Community Health Centers may request a deposit from patients eligible for Medical Hardship. Deposits will be limited to 20% of the Medical Hardship contribution up to $1,000. All remaining balances will be subject to the payment plan conditions established in 114.6 CMR 10.05 (3)(d).
(d) Payment Plans. A patient who has a balance of $1,000 or less, after initial deposit, must be offered a one- year payment plan with a minimum monthly payment of $25. A patient who has a balance of more than $1,000, after initial deposit, must be offered at least a two-year payment plan.

(4) Reasonable Collections Efforts.
(a) To be considered a reasonable collection effort, in compliance with 114.6 CMR 10.05, a Hospital or Community Health Center must make the same effort to collect accounts for Emergency Care for Uninsured Patients as it does to collect accounts from any other patient classifications. The minimum requirements before writing off an account to the Pool include:
1. an initial bill to the party responsible for the patient's personal financial obligations,
2. 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,
3. 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,"
4. sending a final notice by certified mail for balances over $1,000 where notices have not been returned as "incorrect address" or "undeliverable."
(b) If after reasonable attempts to collect a bill, the debt for Emergency Care for an Uninsured Patient remains unpaid for more than 120 days, the bill may be deemed uncollectible and billed to the Pool.
(c) 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.

10.06: Patient Rights and Responsibilities

(1) Patient Rights. Hospitals and Community Health Centers must advise patients of the following rights to:
(a) apply for Free Care within one year of determining the patient's financial liability at a Hospital, or within 90 days of determining the patient's financial liability at a Community Health Center, unless the Hospital or Community Health Center can document continuous collection action or patient payments during the intervening time,
(b) a payment plan, as described in 114.6 CMR 10.05, if the patient is determined to be eligible for partial Free Care or Medical Hardship,

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(c) a written notice of the eligibility decision within 30 days of completion of a written Free Care application and submission of the required supporting documentation,
(d) notice of the right to file a grievance pursuant to 114.6 CMR 10.07, and
(e) file a grievance as outlined in 114.6 CMR 10.07 of an eligibility or scope of services determination.

(2) Patient Responsibilities.
(a) to provide all necessary documentation,
(b) to inform the Provider of changes in Family Income and insurance status,
(c) to track the patient Deductible and provide documentation to the Hospital or Community Health Center that the Deductible has been reached when more than one Family member is approved for Free Care or if the patient or Family members are approved for Free Care at more than one Hospital or Community Health Center.

(3) Other.
(a) A Hospital or Community Health Center shall not discriminate on the basis of race, color, national origin, citizenship, alienage, religion, creed, sex, sexual preference, age, or disability, in its policies, or in its application of policies, concerning the acquisition and verification of financial information, pre-admission or pretreatment deposits, payment plans, deferred or rejected admissions, or eligibility for Free Care.
(b) A Hospital or Community Health Center or agent thereof shall not seek legal execution against the personal residence or motor vehicle of a patient or Guarantor without the express approval of the Hospital's or Community Health Center's Board of Trustees. All approvals by the Board must be made on an individual case basis.

10.07: Patient Grievances

There shall be an administrative review process for any person aggrieved by a Hospital's or Community Health Center's denial of Free Care. The Division will review cases involving eligibility and covered services. The grievance process must follow these steps:

(1) The person must send a written complaint to the Division. The patient may include supporting documentation with the complaint.

(2) The Division will send a copy of the complaint to the Hospital or Community Health Center and may ask the Hospital or Community Health Center for additional information.

(3) The Hospital or Community Health Center has 30 days to answer the complaint in writing.

(4) When the Division has received all necessary information, it will review the complaint and the Hospital's or Community Health Center's answer. The Division will issue a written decision to the person and to the Hospital or Community Health Center within 30 days of the receipt of all necessary information. The decision will contain a brief explanation of the reasons for the Division's actions.

10.08: Notification

Hospitals and Community Health Centers must meet certain criteria regarding notification of the availability of Free Care and other programs of public assistance to patients.

(1) Signs.
(a) Hospitals and Community Health Centers shall post signs, in the inpatient, clinic, 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 location at the Hospital or Community Health Center to apply for such programs.
(b) Signs and print fonts shall be large enough to be clearly visible and legible by patients visiting these areas.

10.08: continued

(c) All signs and notices shall be translated into language(s) other than English if such language(s) is primarily spoken by 10% or more of the residents in the Hospital's or Community Health Center's service area.
(d) Signs must notify patients of the availability of financial assistance and of the availability of both Free Care and other programs of public assistance. The following language is suggested, but not required:
1. "Are you unable to pay your hospital bills? Please contact a counselor to assist you with various alternatives." or
2. "Financial assistance is available through this institution. Please contact ______________."

(2) Notification Practices.
(a) A Hospital or Community Health Center will provide individual notice of availability of Free Care and other programs of public assistance to a patient expected to incur charges, exclusive of personal convenience items or services, that may not be paid in full by third party coverage.
(b) A Hospital or Community Health Center or its designee will include a notice of Free Care availability and other programs of public assistance in its initial bill.
(c) In all other written collection actions, a Hospital or Community Health Center or its designee will include a brief notice of Free Care availability. The following language is suggested, but not required, to meet the notice requirements of this section: "If you are unable to pay this bill, please call (phone #). Financial assistance is available."

(3) Decision letters. Within 30 days of receiving a completed application, a Hospital or Community Health Center must give the applicant written notice of its decision on the application. The decision letter must contain the information that appears below. Samples of decision letters appear in the Free Care application guide.
(a) Free Care approval letters must:
1. explain that the person is eligible for full Free Care for all Medically Necessary Services, or only Free Care for Emergency and Urgent Care if the person is not a Massachusetts resident
2. include the dates of eligibility
3. list the services that Free Care does not cover
4. explain how to re-apply for free care at the end of the eligibility period
5. include the name and telephone number of a contact person for more information about Free Care
6. explain how to file a grievance with the Division
7. include the signature of an authorized person.
(b) Partial Free Care approval letters must:
1. explain that the person is eligible for partial Free Care for all Medically Necessary Services, or only partial Free Care for Emergency and Urgent Care if the person is not a Massachusetts resident
2. include the dates of eligibility
3. include the amount of the patient Deductible
4. inform the patient of any required deposit for non-emergency services
5. include information about written payment plans pursuant to 114.6 CMR 10.05
6. explain how to apply for Medical Hardship
7. explain how to re-apply at the end of the eligibility period
8. list the services that Free Care does not cover
9. include the name and number of a contact person for more information
10. explain how to file a grievance with the Division
11. include the signature of an authorized person.
(c) Medical Hardship approval letters must:
1. explain that the person is eligible for Medical Hardship for all Medically Necessary Services, or only for Emergency and Urgent Care if the person is not a Massachusetts resident
2. include the dates of eligibility
3. include the amount of the patient's Medical Hardship contribution

10.08: continued

4. inform the patient of any required deposit for non-emergency services
5. include information about written payment plans pursuant to 114.6 CMR 10.05
6. explain how to re-apply at the end of the eligibility period
7. list the services that Free Care does not cover
8. include the name and number of a contact person for more information
9. explain how to file a grievance with the Division
10. include the signature of an authorized person.

(d) Free Care denial letters must:
1. explain why the patient is not eligible for Free Care or partial Free Care
2. explain how to apply for Medical Hardship
3. include the name and number of a contact person for more information
4. explain how to file a grievance with the Division
5. include the signature of an authorized person.

(e) Medical Hardship denial letters must:
1. explain why the patient is not eligible for Medical Hardship
2. include the name and number of a contact person for more information
3. explain how to file a grievance with the Division
4. include the signature of an authorized person.

10.09: Credit and Collection Policies

A Hospital or Community Health Center's Credit and Collection Policy must meet all the requirements specified in 114.6 CMR 10.00. The Division may deny or withhold reimbursement for Free Care to any Hospital or Community Health Center which fails to comply with the requirements of 114.6 CMR 10.00 until such Hospital or Community Health Center complies with the requirements. The Division will notify Hospitals or Community Health Centers of its intention to deny or withhold reimbursement.

(1) Filing Requirements. Hospitals and Community Health Centers shall file their Credit and Collection Policies with the Division:

(a) by October 1, 1998. Hospitals and Community Health Centers are encouraged to submit draft Credit and Collection Policies by August 1, 1998. Hospitals and Community Health Centers may request an extension for cause by submitting a written request to the Division. Hospitals and Community Health Centers may request an extension of no more than 60 days from October 1, 1998. Hospitals and Community Health Centers are subject to the requirements set forth in 114.6 CMR 10.00 during any extension periods.

(b) within 90 days of adoption of amendments to 114.6 CMR 10.00 that would require a change in Credit and Collection Policies.

(c) when a Hospital or Community Health Center makes changes in its Credit and Collection Policy.

(d) when two Hospitals or Community Health Centers merge and request to be paid as a single merged entity.

(2) Content Requirements.

(a) Table of Contents noting the location in the document of, at least, the items listed below.

(b) Standard collection policies and procedures

(c) Policies and procedures for collecting financial information from patients

(d) Statement on whether the patient Deductible calculation is based on a calendar year, the Hospital or Community Health Center's fiscal year, the patient's eligibility year, or the Pool Fiscal Year.

(e) Emergency Care Classification. A Hospital must provide a detailed policy on its practices for classifying persons presenting themselves for unscheduled treatment, the urgency of treatment associated with each identified classification, the location(s) at which patients might present themselves, and any other relevant and necessary instructions to Hospital personnel who would see these patients. The policy must include the classifications which qualify as Emergency Care and as Urgent Care, as defined in 114.6 CMR 10.02, and other services including "elective" or "scheduled" services.

10.09: continued

(f) The policy on deposits and payment plans for qualified patients as described in 114.6 CMR 10.05(3).
(g) Designation of the person or persons responsible for approving all types of Free Care determinations
(h) Language used in signs notifying patients of the availability of Free Care and other programs of public assistance, the locations of those signs and the size and the type of signs used pursuant to 114.6 CMR 10.08.
(i) Copies of individual notices of Free Care, including billing invoices, award or denial letters, and any other documents used to inform patients of the availability of assistance pursuant to 114.6 CMR 10.08.

(3) Division Response. The Division will review amended policies submitted in accordance with 114.6 CMR 10.09 within 90 days of receipt to determine whether they comply with 114.6 CMR 10.00.

(4) Board Approval. Within 60 days of notification that the Credit and Collection Policy has been accepted by the Division for filing, Hospitals and Community Health Centers must provide to the Division proof that the Credit and Collection Policy has been approved by the Hospital or Community Health Center's governing board.

10.10: Documentation and Audit

(1) Hospitals and Community Health Centers must maintain auditable records of their activities made in compliance with the criteria and requirements of regulation 114.6 CMR 10.00, including documentation of Free Care accounts and Free Care applications. Hospitals must also document their activities as required in 114.6 CMR 7.00. Community Health Centers must also document their activities as required in 114.6 CMR 8.00.

(2) The Division may, through various mechanisms, audit Free Care accounts of Acute Hospitals and Community Health Centers to determine compliance with this section and shall deny Pool payment for any audited account that fails to comply. These audit mechanisms may include verification of Free Care eligibility and ensuring that other coverage options are utilized fully before Free Care is granted.

(3) The Division may disallow payment for services covered by MassHealth, another program of public assistance, or other health insurance plan in which the patient is enrolled.

(4) The Division will disallow payment from the Pool for non-Medically Necessary Services.

(5) The Division will determine the level of payment that will be disallowed from the Pool using a methodology to appropriately extrapolate the amount of audited accounts that fail to comply with 114.6 CMR 10.00 as compared to all of the Hospital's or Community Health Center's Free Care accounts.

(6) A Hospital aggrieved by any action or failure to act by the Division may seek a review pursuant to the provisions of 114.6 CMR 7.05.

(7) A Community Health Center aggrieved by any action or failure to act by the Division may seek a review pursuant to the provisions of 114.6 CMR 8.00.

10.11: Special Provisions

(1) Penalties for Diversion of Free Care Patients.
(a) Diversion Subject to Penalty. A diversion is subject to a penalty if:
1. the Division finds that an eligible patient was transferred from one Hospital to another Hospital without the consent of the receiving Hospital; and
2. the transfer was in violation of EMTALA.

10.11: continued

(b) Eligible Patient. An eligible patient is either:
1. a patient that the transferring Hospital knows is eligible for free care, or
2. a patient subsequently appropriately determined by the receiving Hospital to be eligible for free care.

(c) Penalties. The Division may assess a penalty, not to exceed $10,000, for each improper diversion of a free care patient. Any amount collected pursuant to 114.6 CMR 10.00 shall be deposited into the Uncompensated Care Fund.

(d) Hospitals must maintain records sufficient to document consent for transfers of free care patients to other Hospitals and must make such records available to the Division upon request.

(e) The Division will review complaints of improper diversion of free care patients and may initiate an investigation based on such complaints. The Division may also initiate an investigation based on Department of Public Health findings of EMTALA violations, or its review of Free Care applications and claims data that either indicates possible diversion of free care patients or demonstrates a significant decrease in the volume of a hospital's free care claims.

(2) Administrative Bulletins. The Division may, from time to time, issue Administrative Information Bulletins to clarify its policy and understanding of substantive provisions of 114.6 CMR 10.00. In addition, the Division may issue Administrative Information Bulletins which specify the information and documentation necessary to implement 114.6 CMR 10.00.

10.12: Severability

The provisions of 114.6 CMR 10.00 are hereby declared to be severable. If any such provisions or the application of such provisions to any Hospital or Community Health Center or circumstances shall be held to be invalid or unconstitutional, such invalidity shall not be construed to affect the validity or constitutionality of any remaining provisions of 114.6 CMR 10.00 or the application of such provisions to Hospitals or Community Health Centers or circumstances other than those held invalid.

REGULATORY AUTHORITY

114.6 CMR 10.00: M.G.L. c. 118G.