Caritas Christi Health Care
Charity Care and
Credit and Collection Policy

Good Samaritan Medical Center

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2. GENERAL DEFINITIONS

Meaning of Terms: As used in 114.6 CMR 13.00, unless the context otherwise requires, terms have the following meanings. All defined terms in 114.6 CMR 13.00 are capitalized.

340B Pharmacy. A Hospital or Community Health Center eligible to purchase discounted drugs through a program established by Section 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 is registered and listed as a 340B Pharmacy within the United States Department of Health and Human Services, Office of Pharmacy Affairs (OPA) database. 340B Pharmacy services may be provided at on-site or off-site locations.

Ancillary Services. Non-routine 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.

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

(a) is regarded as uncollectible, following reasonable collection efforts consistent with the requirements in 114.6 CMR 13.06;
(b) is charged as a credit loss;
(c) is not the obligation of a governmental unit or the federal government or any agency thereof; and
(d) is not a Reimbursable Health Care 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 Hospital.

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

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

CommonHealth. A MassHealth program for disabled adults and disabled children administered by the Executive Office of Health and Human Services - Office of Medicaid pursuant to M.G.L. c. 118E.

Commonwealth Care. An insurance program for low-income individuals administered by the Commonwealth Health Insurance Connector pursuant to M.G.L. c. 118H.

Community Health Center. A health center operating in conformance with the requirements of Section 330 of United States Public Law 95-926, including all community health centers which file cost reports as requested by the Division of Health Care Finance and Policy (Division). Such 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 Office of Medicaid and enter into a Hospital agreement pursuant to 130 CMR 405.000; and (c) operate in conformance with the requirements of 42 U.S.C. § 254(c).

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

Critical Access Services. Those health services which are generally provided only by acute hospitals, as further defined in 114.6 CMR 13.03.

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 woman, as further defined in section 1867(e) (1) (B) of the Social Security Act, 42 U.S.C. § 1395dd(e)(1)(B).

Emergency Services. Medically necessary services provided to an individual with an Emergency Medical Condition.

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

Family. Persons who live together, and consisting of:

(a) a child or children under age 19, any of their children, and their parents;

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

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

1. pregnant; or
2. a parent.

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

Family Income. Gross earned and unearned income as defined in 130 CMR 506.003.

Federal Poverty Limit (FPL). Income standards issued annually in the Federal Register.

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

Fund. The Health Safety Net Trust Fund, established by M.G.L. c. 118G, § 36.

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

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

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

Health Insurance Plan. The Medicare program, the MassHealth program, Commonwealth Care, 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.

Health Practitioner. An individual who can diagnose and treat medical problems whether by authority of his or her own license or by the delegated authority of a licensed medical professional.

Health Services. Medically necessary inpatient and outpatient services as mandated under Title XIX of the Federal Social Security Act. Health services shall not include:

(a) nonmedical services, such as social, educational and vocational services;
(b) cosmetic surgery;
(c) canceled or missed appointments;
(d) telephone conversations and consultations;
(e) court testimony;
(f) research or the provision of experimental or unproven procedures including, but not limited to, treatment related to sex-reassignment surgery and pre-surgery hormone therapy; and
(g) the provision of whole blood, but the administrative and processing costs association with the provision of blood and its derivatives shall be payable.

Healthy Start. A health care program for pregnant women and infants administered by the Executive Office of Health and Human Services - Office of Medicaid pursuant to M.G.L. c. 118E, § 10E.

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

Hospital. An acute 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.

Hospital Licensed Health Center. A facility that is not physically attached to the Hospital, or located on or proximate to the Hospital campus, that:

(a) operates under the Hospital 's license;
(b) meets MassHealth requirements for reimbursement as a Hospital Licensed Health Center under 130 CMR 410.413;
(c) is approved by and enrolled with the MassHealth Enrollment Unit as a Hospital Licensed Health Center;
(d) is subject to the fiscal, administrative and clinical management of the Hospital; and
(e) provides services solely on an outpatient basis.

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

Individual Medical Visit. A face-to-face meeting at a Community Health Center between a patient and a physician, physician assistant, nurse practitioner, nurse midwife, or registered nurse for medical examination, diagnosis or treatment.

Low Income Patient. An individual who meets the criteria under 114.6 CMR 13.04(1).

MassHealth. The medical assistance program administered by the Executive Office of Health and Human Services Office of Medicaid pursuant to M.G.L. c. 118E and in accordance with Titles XIX and XXI of the Federal Social Security Act, and a Section 1115 Demonstration Waiver.

MassHealth Application. A form prescribed by the Office of Medicaid to be completed by the Applicant or an Eligibility Representative, and submitted to the Office of Medicaid as a request for MassHealth benefits. It is either the Medical Benefits Request (MBR) or the common intake form designated by the Executive Office of Health and Human Services, or any other form designated by the Office of Medicaid.

Medical Coverage Date. The date established for MassHealth Standard as pursuant to 130 CMR 505.002:

(1) The medical coverage date for MassHealth Standard begins on the 10th day before the date a Medical Benefit Request is received at any MassHealth Enrollment Center or received by a MassHealth outreach worker at a designated outreach site, if all required verifications, including a completed disability supplement, have been received within 60 days of the date

of the Request for Information. However, the medical coverage date will in no event begin before January 1, 2004, for women described at 130 CMR 505.002(H).
(2) If these required verifications listed on the Request for Information are received after the 60-day period referenced in 130 CMR 505.002(J)(1), the begin date of medical coverage is 10 days before the date on which the verifications were received, if such verifications are received within one year of receipt of the MBR.
(3) The begin and end dates for medical coverage under Presumptive Eligibility are described in 130 CMR 502.003.

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.

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

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

Office of Pharmacy Affairs (OPA). The Office of Pharmacy Affairs, and any successor agencies, is a division within the United States Department of Health and Human Services that monitors the registration of 340B Pharmacies.

Patient. An individual who receives or has received medically necessary services at a Hospital or Community Health Center.

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

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

Hospital. A Hospital or Community Health Center that provides Eligible Services.

Reimbursable Health Services. Eligible Services provided to uninsured and underinsured patients who are determined to be financially unable to pay for their care, in whole or in part; provided that the health services are emergency, urgent and critical access services provided by Hospitals or

services provided by Community Health Centers; and provided further, that such services shall not be eligible for reimbursement by any other public or third-party payer.

Reimbursable Services. Eligible Services for which a Hospital may submit a claim to the Health Safety Net Trust Fund as defined in 114.6 CMR 13.00.

Resident. A person living in Massachusetts with the intention to remain permanently or for an indefinite period. A resident is not required to maintain a fixed address. Enrollment in a Massachusetts institution of higher learning or confinement in a Massachusetts medical institution, other than a nursing facility, is not sufficient to establish residency.

REVS System. The MassHealth Recipient Eligibility Verification System of the Office of Medicaid. After the implementation of NewMMIS all references to REVS shall refer to EVS, the system that will replace REVS.

Underinsured Patient. A patient whose Health Insurance Plan or self-insurance plan does not pay, in whole or in part, for health services that are eligible for payment from the Health Safety Net Trust Fund, provided that the patient meets income eligibility standards set forth in 114.6 CMR 13.03.

Uninsured Patient. A patient who is a resident of the Commonwealth, who is not covered by a health insurance plan or a self-insurance plan and who is not eligible for a medical assistance program. A patient who has a policy of health insurance or is a member of a health insurance or benefit program 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: placing a patient's health in jeopardy; impairment to bodily function; or dysfunction of any bodily organ or part. Urgent care services are provided for conditions that are not life threatening and do not pose a high risk of serious damage to an individual's health. Urgent care services do not include elective or primary care.

3. GENERAL COLLECTION POLICIES AND PROCEDURES

3.1 Standard collection policies and procedures

Non-Emergency Services and/or Balances after Insurance
The Accounts Receivable cycle for the patient/guarantor portion of a hospital bill generally follows the process listed below.

A. Account balance less than $500:
   1. The patient/guarantor receives a minimum of 4 statements/letters.
   2. If the account remains unpaid after 4 statements/letters the account may be written off to bad debt and referred to an outside agency or attorney for collection.
   3. Collection actions will occur on a regular, frequent basis (generally in 30 day increments) and will continue until such time as an account is deemed "uncollectible."

B. Account balance $500 and greater:
   1. The patient/guarantor receives a minimum of 4 statements/letters.
   2. A minimum of one (1) patient/guarantor telephone contact is attempted.
   3. If the account remains unpaid after 4 statements/letters and attempted telephone contact, the account may be written off to bad debt and referred to an outside agency or attorney for collection.
   4. Collection actions will occur on a regular, frequent basis (generally in 30 day increments) and will continue until such time as an account is deemed "uncollectible."

C. Returned Mail: Mail returned as undeliverable, etc. is processed as follows:

   1. All mail returns are documented and processed through locator software for a new address. If a new address is found the address is updated and the old address is documented in the comment field.
   2. All mail return accounts are put in a special telephone dialer campaign to attempt to contact patients by telephone.
   3. The Hospital information system database is searched to identify a more recent account, which may have a current valid address.
   4. Accounts with mail returned as "undeliverable," "addressee unknown", etc., which cannot be updated for current address by the steps listed above will be written off to bad debt and referred to a collection agency or attorney for skip tracing and if successful, collection action.

All efforts to collect an account are documented on the patient's electronic account file.

Account balance of $10.00 and over may be written off to bad debt and referred to a collection agency/attorney for collection.

Accounts referred to an agency or attorney for collection may be reported to a credit bureau, if the account remains unpaid.

Non performing accounts are defined as accounts 1) written off as bad debt 2) have had no payment activity for 45 days and 3) have not been disputed by the patient/guarantor or a dispute

has been adjudicated by the Hospital and the patient/guarantor has been determined to be responsible for the hospital charges.

Account balance under $10.00 may be written off and reported as bad debt but will not be referred to a collection agency.

Emergency Services - Uninsured Patients:
The Accounts Receivable for emergency care provided to uninsured patients follows the process listed below:

A. Account balance less than $500:
    1. The patient/guarantor receives a minimum of 4 statements/letters.
    2. Collection actions will occur on a regular, frequent basis (generally in 30 day increments) and will continue until such time as an account is deemed "uncollectible."
    3. If the account remains unpaid after a minimum of 4 statements/letters the account may be written off to bad debt and referred to an outside agency or attorney for collection providing that:
        a. the services were provided to an individual uninsured for the services provided and not a Low Income Patient, and
        b. the REVS system is checked to verify that the patient is not eligible for MassHealth for the date of service.
    4. If the account remains unpaid at the conclusion of steps 1-3 the account may be written off to bad debt and referred to an outside agency or attorney for collection at least 120 days from date of first billing notice.

B. Account balance $500 and greater:
    1. The patient/guarantor receives a minimum of 4 statements/letters.
    2. Collection actions will occur on a regular, frequent basis (generally in 30 day increments) and will continue until such time as an account is deemed "uncollectible."
    3. A minimum of one (1) patient/guarantor telephone contact is attempted. If the account remains unpaid after 4 statements/letters and attempted telephone contact, the account may be written off to bad debt and referred to an outside agency or attorney for collection providing that:
        (a) the services were provided to an individual uninsured for the services provided and not a Low Income Patient, and
        (b) the REVS system is checked to verify that the patient is not eligible for MassHealth for the date of service.
    4. If the account remains unpaid at the conclusion of steps 1-3 the account may be written off to bad debt and referred to an outside agency or attorney for collection at least 120 days from date of first billing notice.

C. Account Balances $1,000 & over:
    1. The patient/guarantor receives a minimum of 4 statements/letters.
    2. Collection actions will occur on a regular, frequent basis (generally in 30 day increments) and will continue until such time as an account is deemed "uncollectible."
    3. A minimum of one (1) patient/guarantor telephone contact is attempted.

4. A Final Notice is sent by certified mail where prior collection action notices have NOT been returned as "incorrect address" or "undeliverable".
5. If the account remains unpaid at the conclusion of steps 1-4 the account may be written off to bad debt and referred to an outside agency or attorney for collection at least 120 days from date of first billing notice providing that:
    (a) the services were provided to an individual uninsured for the services provided and not a Low Income Patient, and
    (b) the REVS system is checked to verify that the patient is not eligible for MassHealth for the date of service .

Emergency Room Account balances that remain unpaid for 120 days or greater are eligible to be written off as Emergency Bad Debt, provided all Credit & Collection Policy required collection action has occurred. All efforts to collect account balances will be documented on the patient's electronic account file.

Return mail procedures outlined in the previous Section C are applicable to Emergency Service Accounts.

3.2. Policies and Procedures for Collecting Financial Information from Patients.
Refer to Section 4.1, 4.2 and 4.3 for Policy on Requesting and Verifying Financial Information

3.3. 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 that would see these patients. The policy must include the classifications which qualify as Emergency Services and other services including "elective" or "scheduled" services;

Emergency Care Classification

The urgency of treatment associated with each patient will be determined by a medical professional responsible for triage (nurse or physician). Classification of patients' medical condition is for clinical management (or triage) purposes only, and such classifications are intended for addressing the order in which physicians should see patients based on their presenting clinical symptoms. These classifications do not reflect the medical evaluation of the patient's medical condition reflected in final diagnosis. The classifications are as follows:

1. Emergency – a condition that appears to be life or limb threatening and that requires immediate medical attention. There is a high danger to the patient if left medically unattended; presenting symptoms are acute to severe.
2. Urgent – a condition which requires prompt care within 24 hours, but will not result in loss of life or limb if left untreated for several hours.
3. Elective – a condition that requires evaluation and treatment, but time is not a critical factor, does not include patients with complaints of severe pain or loss of function. This classification includes scheduled patients.

Emergency Care may be provided in any area of the hospital so long as the care is provided to screen a person who enters the hospital seeking unscheduled treatment or to diagnose or treat an emergency medical condition of a patient consistent with EMTALA requirements. Most commonly, unscheduled persons present themselves at the Hospital emergency room. Patients presenting at hospital clinics or in the radiology, laboratory, and other ancillary areas, however, may also be screened and treated subject to the EMTALA requirement.

Examination and treatment for emergency medical conditions or any such other service rendered will be provided to the patient and will qualify as Emergency Care (for uncompensated care purposes) until the emergency condition has been ruled out or deemed stabilized by the treating physician.

3.4 Policy on Deposits and Payment Plans – <u>Refer to Section 5</u>

3.5 Copies of billing invoices, award or denial letters, and any other documents used to inform patients of the availability of assistance –
<u>Refer to Section 12 for Sample Documents # "A-N". Document "D" is the back side of all letters and statements.</u>

3.6 Description of Programs by which the Hospital Offers Discounted Charges for the Uninsured.

Patients who have self pay balances that are not deductibles, co-pays or co insurance balance not covered by their insurance may request a self pay discount up to 30%.

4. COLLECTION OF FINANCIAL INFORMATION

Collecting Patient Information - A Hospital shall identify the department responsible for obtaining the information from the patient, and make reasonable efforts to obtain the financial information necessary to determine responsibility for payment of the 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. If a Hospital has not obtained sufficient patient financial information to assess the ability of the patient or the Guarantor to pay for services prior to the date of discharge, the Hospital shall make reasonable efforts to obtain the necessary information at the time of the patient's discharge.

Acquisition and Verification of Financial Information – Inpatient Services

4.1 Inpatient Admissions

a) Elective Admissions:

Hospital personnel will obtain third-party coverage information from either the admitting physician's office and/or patient/guarantor interview. This information shall include, but shall not be limited to the patient's name, address and sources of available payments. Applicable HIPAA regulations will in all instances be adhered to.

Pre-Admission, Post-Admission and Discharge Procedures:

1. Hospital personnel shall take reasonable efforts to determine the accuracy of third-party coverage presented by the patient/guarantor. The following procedures are performed:

A. All patient demographic and insurance information is collected by the Patient Access Department staff prior to or at the time of admission. The Insurance Verification Staff/Financial counselors are responsible for verifying and obtaining insurance information not completed at time of admission. The Financial Counselor is responsible for initiating financial arrangements for payment of any self-pay balance prior to admission for elective admissions, or on or shortly after services are provided for urgent/emergency admissions. If the patient is unable to provide the necessary information, a spouse, relative, or legal guardian is contacted to obtain the necessary information, providing patient consent is obtained.

B. BLUE CROSS - Blue Cross benefits are verified via Emdeon or WebMD to determine coverage type, benefits, authorization/notification requirements, and any deductible/coinsurance amounts due.

C. MASSHEALTH AND PUBLIC ASSISTANCE - Verification and/or screening for eligibility is performed via REVS, Virtual Gateway or by contacting the applicable agency when feasible. MassHealth and other public assistance program applications are attempted at the time of scheduling, at time of admission or shortly thereafter to determine eligibility for MassHealth or other public assistance programs.

D. WORKER'S COMPENSATION - Verification of worker's compensation coverage is performed with the patient's employer or insurance carrier to determine if the injury requiring medical services is work related.

E. AUTO/TORT - Verification of auto/tort coverage is performed prior to or at time of admission or shortly thereafter to determine the availability of medical benefits and the coordination of benefits between auto/tort coverage and other available health insurance. Accounts may be referred to an outside vendor for collection. The hospital or its outside agent will investigate if the patient, driver and/or owner of the motor vehicle had a motor vehicle liability policy in effect at the time of the accident. All efforts to determine the availability of liability coverage will be documented in the patient's financial record. The hospital will submit a claim for payment to the motor vehicle liability insurer when it is apparent that the services may be related to a motor vehicle accident. Any payments received from the motor vehicle liability insurer will be offset against claim(s) submitted for eligible MassHealth services.

F. HMO/OTHER INSURANCE - Payor notification and/or pre-certification authorization is obtained and/or verified prior to admission for elective admissions and/or shortly thereafter for emergency admissions. An assignment of benefits and an authorization to release information is obtained on the standard assignment form. If a patient refuses to assign the benefits of his/her policy to the Hospital, he/she will be deemed "Self-Pay" and the necessary steps followed for collection of the account on that basis. Benefits will be verified via review of copies of insurance cards, telephone calls to the insurance companies, or through REVS or other on-line services available prior to, at time of admission, or shortly thereafter to determine any deductible/coinsurance amount due.

G. MEDICARE - Medicare benefits are verified via information networks. The standard Medicare assignment should be signed at the time of admission, if one has not been completed in the past. A Medicare secondary payor interview is performed to determine whether or not Medicare is the primary or secondary payor based on Medicare secondary payor guidelines. The patient is advised that he/she will be responsible for any deductible/coinsurance amount when applicable and he/she has no other insurance coverage or is not receiving public assistance.

H. SELF PAY - Uninsured patients will be expected to complete financial arrangements prior to admission for elective admissions or at the time of admission for urgent/emergency admissions. The Financial Counselor is responsible for interviewing the patient to screen for eligibility under MassHealth and/or other public assistance programs using the MassHealth guidelines.

2. Hospital personnel will notify HMOs and other insurers, as required by contract or regulation, that the patient has been admitted and authorization for coverage will be requested.

3. During hospitalization, hospital personnel will continue to seek third-party coverage until approval/denial is received. The Financial Counselor performs follow-up on all incomplete admission arrangements, including emergency admissions, as soon after admission as possible. The Financial Counselor obtains insurance information by interviewing the patient at the time of admission or during the inpatient stay or by reviewing insurance information previously obtained and stored in the hospital's information system. The Financial Counselor uses automated insurance verification resources to verify insurance coverage, benefit limitations and patient responsibilities for all patients. If a payer does not participate in

automated verification, the payer is contacted via telephone to verify insurance coverage, benefit limitations and co-payment amounts. The Case Management Department obtains Payor authorizations not obtained at time of admission by Patient Registration and/or by the Financial Counselor as soon after admission as possible.

Non-Massachusetts residents are ineligible for MassHealth services.

b) Emergency/Urgent Admissions:
Emergency/urgent admitted patients, by definition, may not be able to provide demographic and financial information prior to or immediately following admission. If a patient/guarantor is unable to provide the information needed to determine sources of payment or financial responsibility, the Hospital will, with the patient's consent, attempt to obtain such information from third parties, relatives or friends. Applicable HIPAA regulations will in all instances be adhered to. The following procedures are performed:

1. Hospital personnel shall take reasonable efforts to determine the accuracy of third-party coverage presented by the patient/guarantor. The following procedure is followed:
Refer to Section 4.1, Sub-Section A – H.

2. Post-Admission: If demographic and financial information is unavailable prior to patient admission, hospital personnel will seek to obtain third-party information as soon as reasonably possible after admission, will perform required third parties notifications of admission and will verify third-party coverage as outlined in Section II, Sub-Section A. Hospital personnel will screen for eligibility and assist with the completion of MassHealth applications.

3. At Discharge: If unable to obtain sources of payment information and/or policy numbers, signatures, or other pertinent information during the patient's admission, the hospital will make every effort to do so at the time of discharge or post-discharge via a patient/guarantor discharge or telephone interview.

4.2 Emergency Room, Outpatient Services and Community Health Center Services.

Acquisition and Verification of Financial Information - Outpatient Services

a) Routine Outpatient Diagnostic/Therapeutic:
Prior to or at the time of outpatient services, hospital personnel will obtain third-party coverage information from either the admitting physician's office and/or patient/guarantor interview. This information should include (but not be limited to) the patient's name, address and sources of available payments. Each patient should present a request form from their physician stipulating the service required and the diagnosis.

Hospital personnel will be available to notify uninsured or underinsured patients of the availability of Public Assistance programs and MassHealth. Hospital personnel will screen patients for eligibility and assist with the application process.

b) Elective Outpatient Procedures & Surgical Services:
Registration personnel will obtain third-party coverage information from either the admitting physician's office and/or patient/guarantor interview. This information shall include (but not be limited to) the patient's name, address and sources of available payments.

Prior to service, the hospital personnel shall take reasonable efforts to determine the accuracy of third-party coverage presented by the patient/guarantor including:

1. Telephone or fax confirmation that medical/surgical services have been authorized.
2. Confirm benefits via third-party/health plan communication. The following procedure will be adhered to:
   Refer to Section 4.1, Sub-Section A – H.

c) Emergency Outpatient Services:
At the time of service or as soon as reasonably possible, admission personnel will request financial information to determine sources of payments and/or financial responsibility for hospital services. Each hospital recognizes and observes EMTALA protocol. When available, the following financial related information may be gathered:

1. A copy of health insurance cards.
2. Third-party billing information, including responsible party name, policy number, subscriber name and address where claim may be submitted.

Where required by contract or regulation, a hospital resource will notify or contact the patient's health plan or primary care clinician (PCC) for treatment authorization/ notification.

Hospital personnel will notify uninsured or underinsured patients of the availability of Public Assistance programs and MassHealth. Hospital personnel will screen patients for eligibility and assist with the application process.

d) Motor Vehicle Accidents
Should the hospital have reason to know that a patient's injury or illness was caused by a motor vehicle accident (MVA), the hospital will make reasonable efforts to obtain any and all information required to establish the responsible party and/or submit a claim to the patient's motor vehicle insurance carrier. If the information is not available at registration, an auto accident report and assignment of benefits form will be given to the patient at registration or mailed to the patient by hospital personnel or authorized hospital representative (Exhibit A). All attempts and efforts made to determine whether motor vehicle liability policy benefits are available will be documented in the patient's financial records.

Provided required MVA information is obtained, the hospital may submit a hospital lien and/or assignment of benefits along with a claim to all auto insurance carriers identified by the patient/guarantor as financially responsible parties (Exhibit B).

If auto insurance carrier information is not obtained or other third-party identified, the patient will be billed for all hospital charges resulting from treatment of their injury or illness. If there is no medical insurance coverage in effect at the time of service, all unpaid ER treatment and related admissions are considered ER bad debt and will be written off to the Uncompensated Care Pool no sooner than 120 days from the date of service.

A HSN claim for a Low Income Patient injured in a motor vehicle accident will be submitted only if the hospital has investigated whether the patient, driver, and/or owner of the other motor vehicle had a motor vehicle liability policy and (2) where applicable, has properly submitted a claim for payment to the motor vehicle liability insurer. If the Hospital receives payment from the insurer, the income will be offset from the claim for Eligible Services.

If a Motor Vehicle claim remains unpaid, the Hospital may refer the account to an outside agency/attorney for further collection activity. All collection steps in Section 3.1 should be followed prior to the outside referral.

4.3 Inpatient Verification - 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. Insurance verification occurs daily.

Acquisition and Verification of Financial Information-Inpatient Services

a) Elective Admissions:

Hospital personnel will obtain third-party coverage information from either the admitting physician's office and/or patient/guarantor interview. This information shall include, but shall not be limited to the patient's name, address and sources of available payments. Applicable HIPAA regulations will in all instances be adhered to.

Pre-Admission, Post-Admission and Discharge Procedures:

1. Hospital personnel shall take reasonable efforts to determine the accuracy of third party coverage presented by the patient/guarantor. The following procedures are performed:
   Refer to Section 4.1, Sub-Section A – H.
2. Hospital personnel will notify HMO's and other insurers, as required by contract or regulation that the patient has been admitted and authorization for coverage will be requested.
3. During hospitalization, hospital personnel will continue to seek third-party coverage until approval/denial is received. The Financial counselor performs follow-up on all incomplete admission arrangements, including emergency admissions, as soon after admission as possible. The Financial counselor obtains insurance information by interviewing the patient at the time of admission or during the inpatient stay or by reviewing insurance information previously obtained and stored in the hospital's information system. The Financial counselor uses automated insurance verification resources such as REVS or other resources to verify insurance coverage, benefit limitations and patient responsibilities for all patients. If a payer does not participate in automated verification the payer is contacted via telephone to verify insurance coverage, benefit limitations and co-payment amounts. The Case Management Department obtains Payor authorizations not obtained at time of admission by Patient Registration and/or by the Financial counselor as soon after admission as possible.

Non-Massachusetts residents are ineligible for MassHealth services.

b) Emergency/Urgent Admissions:
Emergency/urgent admitted patients, by definition, may not be able to provide demographic and financial information prior to or immediately following admission. If a patient/guarantor is unable to provide the information needed to determine sources of payment or financial responsibility, the Hospital will, with the patient's consent, attempt to obtain such information from third parties, relatives or friends. Applicable HIPAA regulations will in all instances be adhered to. The following procedures are performed:

Hospital personnel shall take reasonable efforts to determine the accuracy of third-party coverage presented by the patient/guarantor. The following procedure is followed:
Refer to Section 4.1, Sub-Section A – H.

4.4 Outpatient/CHC Verification - Hospital Outpatient and Community Health Centers. A Provider 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

Acquisition and Verification of Financial Information- Hospital Outpatient Services

a) Routine Outpatient Diagnostic/Therapeutic:
Prior to or at the time of outpatient services, hospital personnel will obtain third-party coverage information from either the admitting physician's office and/or patient/guarantor interview. This information should include, but not be limited to the patient's name, address and sources of available payments. Each patient should present a request form from their physician stipulating the service required and the diagnosis.

Hospital personnel will be available to notify uninsured or underinsured patients of the availability of Public Assistance programs and MassHealth. Hospital personnel will screen patients for eligibility and assist with the application process.

b) Elective Outpatient Procedures & Surgical Services:
Registration personnel will obtain third-party coverage information from either the admitting physician's office and/or patient/guarantor interview. This information shall include, but not be limited to the patient's name, address and sources of available payments.

Prior to service, the hospital personnel shall take reasonable efforts to determine the accuracy of third-party coverage presented by the patient/guarantor including:

1. Telephone or fax confirmation that medical/surgical services have been authorized.
2. Confirm benefits via third-party/health plan communication. The following procedures will be adhered to:
   Refer to Section 4.1, Sub-Section A – H.

Massachusetts' non-residents are ineligible for MassHealth.

c) Emergency Outpatient Services:
At the time of service or as soon as reasonably possible, admission personnel will request financial information to determine sources of payments and/or financial responsibility for hospital services. Each hospital recognizes and observes EMTALA protocol. When available, the following financial related information may be gathered:

1. A copy of health insurance cards.
2. Third-party billing information, including responsible party name, policy number, subscriber name and address where claim may be submitted.

Where required by contract or regulation a hospital resource will notify or contact the patient's health plan or primary care clinician (PCC) for treatment authorization/ notification.

Hospital personnel will notify uninsured or underinsured patients of the availability of Public Assistance programs and MassHealth. Hospital personnel will screen patients for eligibility and assist with the application process.

d) Motor Vehicle Accidents
Should the hospital have reason to know that a patient's injury or illness was caused by a motor vehicle accident (MVA), the hospital will make reasonable efforts to obtain any and all information required to establish the responsible party and/or submit a claim to the patient's motor vehicle insurance carrier. If the information is not available at registration, an auto accident report and assignment of benefits form will be given to the patient at registration or mailed to the patient by hospital personnel or authorized hospital representative (Exhibit A). All attempts and efforts made to determine whether motor vehicle liability policy benefits are available will be documented in the patient's financial records.

Provided required MVA information is obtained, the hospital may submit a hospital lien and/or assignment of benefits along with a claim to all auto insurance carriers identified by the patient/guarantor as financially responsible parties (Exhibit B).

If auto insurance carrier information is not obtained or other third-party identified, the patient will be billed for all hospital charges resulting from treatment of their injury or illness. If there is no medical insurance coverage in effect at the time of service, all unpaid ER treatment and related admissions are considered ER bad debt and will be written off to Health Safety Net no sooner than 120 days from the date of service.

A HSN claim for a Low Income Patient injured in a motor vehicle accident will be submitted only if the hospital has investigated whether the patient, driver, and/or owner of the other motor vehicle had a motor vehicle liability policy and (where applicable) has properly submitted a claim for payment to the motor vehicle liability insurer. If the Hospital receives payment from the insurer, the income will be offset from the claim for Eligible Services.

5. DEPOSITS & PAYMENT PLANS

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

5.2 Except with respect to Emergency Services (see 5.1 above), a Hospital may request a deposit from individuals determined to be Low Income Patients. Such deposits must be limited to 20% of the Deductible amount, up to $500.

5.3 A Hospital may request a deposit from patients eligible for Medical Hardship. Deposits will be limited to 20% of the Medical Hardship contribution up to $1,000.

5.4 A Patient that has been approved for partial HSN coverage with a balance of $1,000 or less, after initial deposit, must be offered a one-year payment plan, interest free, with a minimum monthly payment of no less than
$25.

5.5 A Patient that has been approved for partial HSN coverage with a balance of more than $1,000, after initial deposit, must be offered at least a two-year interest free payment plan.

The following guidelines may be used in establishing a payment plan for all patients that do not qualify for any government programs. Any patient fully exempt from collection action will not be required to set up a payment plan.

A. A minimum payment of $25 is required for all approved payment plans.

B. The maximum term for a payment plan under $1000 will be 12 months.

C. The maximum term for a payment plan over $1000 will be 24 months.

Payment Plans Greater Than 24 months. Authorized financial manager/supervisor may grant extended repayment periods. However, anyone soliciting payment plans that exceed two years may be required to show that their gross annual family income less taxes, and expenses for housing, food, health care, dependent care/support, utilities, transportation and alimony would exhaust discretionary income, such that meeting the payment plans time frame would create financial hardship for the patient/family.

Failure to Make Scheduled Payments: Hospital staff will attempt to contact, by telephone, patients/guarantors who have defaulted on a payment plan. Failure to make scheduled payments may result in termination of the payment plan contract and a demand issued for payment in full. Payment plan contracts may be reinstated at the discretion of authorized financial manager/supervisor, and in all cases where a patient/guarantor pays all plan arrears within 15 days of default or approved date. Accounts not reinstated may be referred to a collection agency/attorney if full payment is not received by the date specified in the patient statement or collection action.

6. POPULATIONS EXEMPT FROM COLLECTION ACTION

6.1 The Hospital will not bill patients enrolled in the MassHealth Emergency Aid to the Elderly, Disabled and Children program and Healthy Start program, unless the bill is for a co-payment or deductible amount due. The Hospital may initiate billing to a patient if they fail to provide proof of participation in said program. Upon proof of eligibility in the above stated programs, or receipt of the signed application, the Hospital will cease all collection action.

6.2 The Hospital will not bill participants in the Children's Medical Security Plan whose Family Income is equal to or less than 400% of the FPL. The Hospital may initiate billing to a patient if they fail to provide proof of participation in said program. Upon proof of eligibility in the above stated program, the Hospital will cease all collection action.

6.3 That Hospital will not seek payment from Low Income Patients for any eligible services rendered during the period for which they have been determined Low Income Patients, except for co-payments and deductibles. The Hospital may continue to bill Low Income Patients for eligible services prior to their determination as Low Income Patients, after their Low Income Patient status has expired or otherwise been terminated.

6.4 The Hospital will not seek payment from Low Income Patients with income between 201 to 400% of the FPL, for the portion of the bill that exceeds the deductible. The Hospital may bill the patient for co-payments and deductibles as stated in 114.6 CMR 13.04. The Hospital may 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.

6.5 The Hospital may bill Low Income Patients for services other than eligible services provided at the request of the patient, and for which the patient has agreed to be responsible. The Hospital must obtain the patient's written consent in order to bill the patient for the service.

6.6 The Hospital will not bill or pursue collection against an individual that has qualified for Medical Hardship with respect to the amount of the bill that exceeds the Medical Hardship contribution.

7. MINIMUM COLLECTION ACTION ON HOSPITAL EMERGENCY BAD DEBT

7.1 The Hospital will send an initial bill to the party responsible for the patient's personal financial obligations.

7.2 The Hospital will generate 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.

7.3 The Hospital will maintain 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."

7.4 The Hospital will send a final notice by certified mail for balances over $1,000 where notices have not been returned as "incorrect address" or "undeliverable."

7.5 The Hospital will maintain documentation of continuous Collection Action undertaken on a regular, frequent basis.

7.6 Every effort will be made to avoid gaps in Collection Action of 120 days or more.

7.7 The patient's file, paper and electronic, will include all documentation, or the reproductions of, the Hospital's collection effort including copies of the bill(s), follow-up letters, reports of telephone and personal contact, and any other effort made.

7.8 The Hospital will include as Emergency Bad Debt services to a patient, who is not Low Income Patient, after it has verified through the REVS system that the individual has not submitted an application for MassHealth and/or Commonwealth Care.

8. MINIMUM COLLECTION ACTION ON MOTOR VEHICLE ACCIDENTS

8.1 Motor Vehicle Accidents and Other Recoveries: The hospital may submit a claim for a Low Income Patient injured in a motor vehicle accident only if the following is completed:

a. The hospital has investigated whether the patient, driver, and/or owner of the other motor vehicle had a motor vehicle liability policy;
b. The hospital has made every effort to obtain the third-party payer information from the patient;
c. The hospital has documented and retained evidence of efforts, including documentation of phone calls and letters to the patient; and
d. The hospital, where applicable, has properly submitted a claim for payment to the motor vehicle liability insurer. The hospital must report the recovery to the Health Safety Net, for all motor vehicle accidents and any other recovery on claims previously billed to the HSN. The hospital will offset the recovery against the claim for eligible services.

9. PROVIDER RESPONSIBILITES

9.1 The Hospital does not discriminate on the basis of race, color, national origin, citizenship, alienage, religion, creed, sex, sexual orientation, 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 Low Income Patient status. In accordance with regulatory guidelines, each facility will provide Health Safety Net coverage to uninsured and under-insured patients whose gross income does not exceed 200% of the Federal Poverty Income Guidelines. In addition, they will offer partial Health Safety Net coverage to patients whose gross income is from 201% to 400% of the Federal Poverty Income Guidelines.

9.2 The Hospital or its 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 Board of Trustees. All approvals by the Board must be made on an individual case basis.

10. PATIENT RIGHTS AND RESPONSIBILITIES

10.1 The Hospital will advise all uninsured or underinsured patients of the right to apply for MassHealth, Commonwealth Care, Health Safety Net and Medical Hardship.

10.2 The Hospital will advise patients of the right to a payment plan. Payment plans are extended to patients/guarantors requesting extended payment plans and those that qualify for Partial Health Safety Net and Medical Hardship.

10.3 Provide all required documentation necessary for the application process.

10.4 Inform MassHealth or the Provider that determined the patient's eligibility status of any changes in Family Income or insurance status; and

10.5 Track the patient Deductible and provide documentation to the Provider that the deductible has been reached when more than one Family member is determined to be a Low Income Patient or if the patient or Family members receive Eligible Services from more than one Provider.

11. SIGNS

11.1 Signs informing patients of the availability of Public Assistance & MassHealth programs are posted at all Registration points, the Emergency Department, Cashier's Window, and Financial Counselor offices.

11.2 All signs are large enough that they are clearly visible and legible by patients visiting these areas.

11.3 Said signage will be displayed in both English and any other language spoken by more then 10% of the population in the Hospital's service area.

11.4 See Section 12, Document "A" for text of signage.

12. SAMPLE DOCUMENTS AND ATTACHMENTS

All information included in the sample documents is fictional and does not represent any actual patients of this facility.