CAPE COD HEALTHCARE
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Cape Cod Hospital, Falmouth Hospital Credit and Collection Policy

INTRODUCTION

The Hospital is the frontline caregiver providing medically necessary care for all people regardless of ability to pay. The Hospital offers this care for *all* patients that come to our facility 24 hours a day, seven days a week, and 365 days a year.

The Hospital assists patients in obtaining financial assistance from public programs whenever appropriate. To remain viable as it fulfills its mission, the Hospital must meet its fiduciary responsibility to appropriately bill and collect for medical services provided to patients. This credit and collection policy is designed to comply with State and Federal law and regulations in performing this function. The Hospital does not discriminate on the basis of race, color, national origin, citizenship, alien status, religion, creed, sex, sexual orientation, gender identity, age, or disability, in its policies, or in its application of policies, concerning the acquisition and verification of financial information, preadmission or pretreatment deposits, payment plans, deferred or rejected admissions, Low Income Patient status determinations, or in its billing and collection practices.

These credit and collection policies are developed to ensure compliance with applicable criteria required under (1) the Health Safety Net Eligibility Regulation (101 CMR 613.00), (2) the Centers for Medicare and Medicaid Services Medicare Bad Debt Requirements (42 CFR 413.89), and (3) The Medicare Provider Reimbursement Manual (Part I, Chapter 3).

More information about this policy and the hospital's financial assistance program, including the application form and a plain language summary of the financial assistance policy, are available on the hospital's website:

- www.capecodhealth.org

SECTION 1: Delivery of Health Care Services

The Hospital evaluates the delivery of health care services for all patients who present for services regardless of their ability to pay. However, non-emergent or non-urgent healthcare services (i.e., elective, or primary care services) may be delayed or deferred based on the consultation with the Hospital's clinical staff and, if necessary and if so available, the patient's primary care provider. The Hospital may decline to provide a patient with non-emergent services in those cases when the Hospital is unable to identify a payment source or eligibility in a financial assistance program. Such programs include MassHealth, Health Connector, Children's Medical Security Plan, Healthy Start, Health Safety Net, and others. Choices related to the delivery and access to care is often defined in either the insurance carrier's or the financial assistance program's coverage manual.

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The urgency of treatment associated with each patient's presenting clinical symptoms will be determined by a medical professional in accordance with local standards of practice, national and state clinical standards of care, and the Hospital medical staff's policies and procedures. Further, this Hospital follows the Federal Emergency Medical Treatment and Active Labor Act (EMTALA) requirements by conducting a medical screening examination to determine whether an emergency medical condition exists and the severity of the medical condition. It is important to note that the medical screening examination is for clinical management purposes only, and such examinations are intended for determining the order in which physicians should see patients based on their presenting clinical symptoms. These examinations do not reflect the final diagnosis in the evaluation of the patient's medical condition.

For those patients who are uninsured or underinsured, the Hospital will work with patients to assist with finding a financial assistance program that may cover their unpaid Hospital bill(s). For those patients with private insurance, the Hospital will attempt to assist the patients in understanding what may be covered under their existing insurance policy. However, any assistance will be limited to the ability of the Hospital to find each insurer's applicable covered services list and medical coding criteria, which are often different for each insurance policy. Determination of treatment based on medical conditions is made according to the following definitions:

A. Emergency Care Services:

Any patient who comes to the Hospital will be evaluated as to the level of emergency care and services required, all without regard to the patient's identification, insurance coverage, or ability to pay.

1. ***Emergency Level Services*** include medically necessary services provided after the onset of 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. § I 295dd(e)(l)(B). A medical screening examination and any subsequent treatment for an existing emergency medical condition or any other such service rendered to the extent required pursuant to the Federal EMTALA (42 USC 1395(dd)) qualifies as an Emergency Level Service.

2. ***Medically Necessary Services*** are those provided after sudden onset of a medical condition, whether physical or mental, manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson would believe that the absence

of medical attention within 24 hours could reasonably expect to result in: placement of the patient's health in jeopardy, impairment to bodily function, or dysfunction of any bodily organ or part.

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

4. ***EMTALA Level Requirements:*** EMTALA is triggered for anyone who comes to the hospital property presenting with and/or requesting examination or treatment of an emergency level service (emergency medical condition). Unscheduled persons requesting services for an emergency medical condition while presenting at another inpatient unit, clinic, or other ancillary area may also be subject to an emergency medical screening examination in accordance with EMTALA. Examination and treatment for emergency medical conditions or any such other service rendered as required under EMTALA, will be provided to the patient and will qualify as emergency care. The determination that there is (or is not) an emergency medical condition is made by the examining physician or other qualified medical personnel of the hospital as documented in the medical record.

B. Non-Emergent Services

Non-emergent Services are for patients who either (1) arrive to a hospital seeking non-emergent or non-urgent level care or (2) desire additional care following stabilization of an emergency medical condition. The Hospital may provide elective services after consulting with the Hospital's clinical staff and reviewing the patient's coverage options.

Elective Services are medically necessary services that do not meet the definition of Emergency Care Services. Typically, these services are either primary care services or medical procedures scheduled in advance by the patient or by the health care provider (hospital, physician office, or other provider).

C. Locations that Patients may Present

All patients are able to seek emergency level services and urgent care services when they come to the Hospital Emergency Department. However, patients with emergent conditions can also present in a variety of other locations, including but not limited to Labor and Delivery, ancillary departments, Hospital clinics, and other areas. The Hospital also provides other elective services at the main hospital, clinics and other outpatient locations and entities listed on the Hospitals' licenses.

SECTION 2: Eligibility for Financial Assistance Programs

A. General Principles

Financial assistance is intended to assist low-income patients who do not otherwise have the ability to pay for their health care services. Such assistance takes into account each individual's ability to contribute to the cost of his or her care. For those patients that are uninsured or underinsured, the Hospital will work with them to assist with applying for available financial assistance programs that may cover their unpaid Hospital bills. The Hospital provides this assistance for both residents and non-residents of Massachusetts; however, there may not be coverage for a Massachusetts hospital's services through an out-of-state program. In order to assist uninsured and underinsured patients in finding the most appropriate coverage options, patients must actively work with hospitals to verify the patient's financial and other information that could be used in determining eligibility.

B. Hospital Screening and Eligibility Approval Process

The Hospital provides patients with information about the availability of financial assistance programs that are available through the Commonwealth of Massachusetts (MassHealth, Heath Connector programs, HSN, Medical Hardship, et al.) and through the Hospital's own financial assistance program, which may cover all or a portion their Hospital bill. For those patients that request such assistance, the Hospital assists patients by screening them for eligibility in an available state program as well as assisting the patient with applying for the program. When applicable, the Hospital may also assist patients in applying for coverage of services such as Medical Hardship based on the patient's documented income and allowable medical expenses.

It is the patient's obligation to provide the hospital with accurate and timely information regarding their full name, address, telephone number, date of birth, social security number (if available), current health insurance coverage options, the patient's applicable financial resources, and citizenship and residency information. This information will be used to determine coverage for the services provided to the patient. If there is no specific coverage for the services provided, the hospital will use the information to determine if the services may be covered by an

applicable program that will cover certain services deemed bad debt. In addition, the hospital will use this information to discuss eligibility for certain health insurance programs. If the patient or guarantor is unable to provide the necessary information, the hospital may (at the patient's request) make reasonable efforts to obtain any additional information from other sources. This will occur when the patient is scheduling their services, during pre-registration, while the patient is admitted in the hospital, upon discharge, or for a reasonable time following discharge from the hospital. Information that the hospital obtains will be maintained in accordance with applicable federal and state privacy and security laws.

The screening and application process for state health insurance programs is performed through the Virtual Gateway, which is an internet portal designed by the Massachusetts Executive Office of Health and Human Services to provide the general public, medical providers, and community-based organizations with an online application for the programs offered by the State or through a standard paper application that is completed by the patient and also submitted directly to the Massachusetts Executive Office of Health and Human Services for processing. The Massachusetts Executive Office of Health and Human Services solely manages the application process for the programs listed above, which is available for children, adults, seniors, veterans, homeless, and disabled individuals.

In special circumstances, the Hospital may apply on behalf of the patient using a specific form designed by the Massachusetts Division of Health Care Finance and Policy for those individuals seeking financial assistance coverage due to being incarcerated, victims of spousal abuse, deceased, or applying due to a Medical Hardship.

The Hospital specifically assists the patient in completing the application and securing the necessary documentation required by the applicable financial assistance program. Necessary documentation includes proof of: (1) annual household income (payroll stubs, record of social security payments, letter from your employer, tax returns, or bank statements), (2) citizenship and identity, and (3) immigration status for non-citizens (if applicable). The hospital will then submit this documentation to the state Office of Medicaid as well as assist the patient in securing any additional documentation if such is requested by the State after completing the application. The State places a three-day time limitation on submitting all necessary documentation following the submission of the application for a program. Beyond this three-day period, the patient and the provider must work with other vendors.

All Virtual Gateway applications are reviewed and processed by the Commonwealth of Massachusetts' Office of Medicaid, which uses the Federal Poverty Guidelines as well as the necessary documentation listed above as the basis for the determination of eligibility for state sponsored public assistance programs. The eligibility for enrollment into the Health Safety Net program as a special circumstance is reviewed and approved by the Massachusetts Division of Health Care Finance and Policy also using the Federal Poverty Guidelines and asset information.

The Hospital has no role in the determination made by the Commonwealth, but may, at the patient's request, take a direct role in appealing or seeking information related to coverage decisions. It is still the patient's responsibility to inform the Hospital of all coverage decisions made by the State to ensure accurate and timely adjudication of all Hospital bills.

C. Future State or Federal Programs

As future coverage options are developed and implemented by the Commonwealth and the Federal Government, that are in addition to, or that amend the programs listed above, the Hospital will evaluate their availability for its patients and include them within the list of programs that are discussed with patients.

SECTION 3: Notice of Availability of Financial Assistance and Other Coverage Options

A. General Principles

For those patients that are uninsured or underinsured, the Hospital will work with them to assist with applying for available financial assistance programs that may cover their unpaid Hospital bills. In order to assist uninsured and underinsured patients in finding available and appropriate financial assistance programs, the Hospital will provide all patients with a general notice of the availability of programs in both the initial bill that is sent to patients as well as in general notices posted throughout the Hospital.

The goal of these notices is to inform patients that they may be eligible to apply for coverage within a financial assistance program, such as, but not limited to, MassHealth, Commonwealth Care, Children's Medical Security Plan, Healthy Start, Health Safety Net, or Medical Hardship through the Health Safety Net. The Hospital will provide, upon request, specific information about the eligibility process to be designated a Low Income Patient under either the state Health Safety Net Program or through the Hospital's own internal charity care program. The Hospital will also notify the patient about payment plans that may be available to him or her based on the size of his or her family and family income.

B. Role of Hospital Patient Financial Counselors and Other Finance Staff

The Hospital will try to identify available coverage options for patients who may be uninsured or underinsured at the time the patient is scheduling services, is in the Hospital, or is being discharged, and for a reasonable time following discharge from the Hospital. The Hospital will direct all patients seeking available coverage options, and those that the Hospital determines may be eligible for coverage, to the Hospital's Patient Financial Counselors to screen for eligibility

in an appropriate coverage option. The Hospital will then assist the patient in applying for the appropriate coverage options that are available including, if appropriate, the availability of financial assistance through the Hospital's own internal financial assistance program.

The Hospital will also provide patients with information on how to contact the appropriate staff within the Hospital's Finance Office if the patient is seeking to verify the accuracy of a bill or dispute certain charges.

C. Notification Practices

The Hospital will provide notice of availability of financial assistance through the posting of signs in the following locations:

1. Inpatient, clinic, and emergency department admission and registration areas.
2. Patient Financial Counselor areas;
3. Central admission and registration areas; and
4. Business office areas open to patients.

Posted signs will be clearly visible and legible to patients visiting these areas.

The Hospital will notify the patient that it offers a payment plan if the patient is determined to be eligible for either a state financial assistance program (e.g., MassHealth, Health Safety Net, or Medical Hardship) or the Hospital's own internal program for financial assistance.

For cases where the Hospital is using the Virtual Gateway application, the Hospital will assist the patient in completing the application for MassHealth, Health Connector, Children's Medical Security Plan, Healthy Start, Health Safety Net, and other financial assistance programs as they are incorporated into the Virtual Gateway program.

All signs and notices shall be posted in languages other than English if such language is spoken by 10% or more of the residents residing in the Hospital service area.

SECTION 4: Hospital Collection Practices

A. General Principles

The Hospital has a fiduciary duty to seek reimbursement for services it has provided to individuals who are able to pay, from third party insurers who cover the cost of care, and from other programs of assistance for which the patient is eligible. To carry out this fiduciary duty, the Hospital follows established billing and collections protocol.

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B. Collecting Information on Patient Health Coverage and Financial Resources

1. Patient Obligations:

Prior to the delivery of any elective health care services, the patient is expected to provide accurate information on his or her insurance status, demographic information, changes to family income or insurance status, and information on any deductibles or co-payments that are owed based on his or her existing insurance or financial program's payment obligations. This detailed information will include:

a. Full name, address, telephone number, date of birth, social security number (if available), current health insurance coverage, citizenship and residency information, and the patient's applicable financial resources that may be used to pay a bill;
b. If applicable, full name of the patient's guarantor, as well as the guarantor's address, telephone number, date of birth, social security number (if available), current health insurance coverage, and applicable financial resources that may be used to pay for the patient's bill; and
c. Any other options that may be used to pay a bill, which may include other insurance programs, motor vehicle or homeowners insurance policies when treatment is the result of an accident, workers' compensation programs, student insurance policies, etc.

It is also the patient's responsibility to keep track of and pay in a timely manner any existing deductibles, co-insurance or co-payments that are owed; provide documentation to the Hospital when individual or family deductibles have been reached; notify the Hospital when one or more family members are designated a Low Income Patient; and disclose if the patient or family members receive Eligible Services from more than one provider.

The patient is further required to inform his or her current health insurer, if applicable, or the agency that determined the patient's eligibility status in a state health insurance program, of any changes in family income or insurance status.

When applicable, patients are further required to notify the state public program (Office of Medicaid, Health Safety Net, et al.) of information related to any lawsuit or insurance claim that may cover the cost of the services provided by the Hospital, and to notify the state program or MassHealth Office within ten (10) days of filing a third-party claim or lawsuit. A patient is further required to assign his or her rights to a third-party payment that will cover the costs of services paid by the Office of Medicaid, Health Safety Net, etc.

2. Hospital Obligations:

The Hospital will make diligent but reasonable efforts to collect the patient's insurance status

and other information to verify coverage, including, as part of the routine screening process, checking the Eligibility Verification System, or EVS, for verification of eligibility for public assistance programs, for the health care services to be provided by the Hospital. All information will be obtained prior to the delivery of any non-emergent and non-urgent health care services (i.e., elective procedures as defined in this credit and collection policy). The Hospital will delay any attempt to obtain this information during the delivery of any EMTALA-classified emergency level or urgent care services, if the process to obtain this information will delay or interfere with either the medical screening examination or the services undertaken to stabilize an emergency medical condition.

The Hospital's reasonable and diligent efforts will include but are not limited to: requesting information about the patient's insurance status; checking any available public or private insurance databases; submitting and following the billing and authorization rules of all known third party payers; and exhibiting due diligence with regard to appealing denied services. The Hospital will retain evidence of all such efforts.

If there is no specific coverage for the services provided, the hospital will work with the patient to determine if a different state program option, such as applying for Medical Hardship through the Health Safety Net, would be available following the Health Safety Net regulations. It is the patient's obligation to provide all necessary information as requested by the hospital in an appropriate timeframe to ensure that the hospital can submit a completed application. The hospital will endeavor to submit the total and completed application within five (5) business days of receiving all necessary information from the patient. If the total and completed application is not submitted within five business days of receiving all necessary information in the timeframe requested by the hospital, collection actions may not be taken against the patient with respect to bills eligible for Medical Hardship.

If the patient or guarantor/guardian is unable to provide the information needed, and the patient consents, the Hospital will make reasonable and diligent efforts to contact relatives, friends, and possible additional guarantors or guardians for additional information. These efforts can be made when the patient is scheduling services, pre-registering for services, during admission for services, upon discharge, or for a reasonable time thereafter. The Hospital will also attempt to investigate whether a third-party payer may be responsible for the services provided by the Hospital, including but not limited to: (1) a motor vehicle or homeowner's liability policy, (2) a general accident or personal injury protection policy, (3) a worker's compensation program, or (4) a student insurance policy, among others. In accordance with applicable state regulations and insurance contracts, for any claims where the Hospital's reasonable and diligent efforts resulted in a recovery on the health care claim billed to a private insurer or public program, the Hospital will report the recovery and offset it against the claim paid by the private insurer or public program. If the Hospital has prior knowledge and is legally able, it will attempt to secure assignment of a patient's right to a third-party coverage on services provided due to an accident.

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

C. Standard Collection Procedures for Patients and Guarantors

The Hospital makes the same reasonable effort and follows the same reasonable process for collections on patient bills regardless of ability to pay. If the Hospital has a current unpaid patient balance for services provided to the patient which are neither covered by a private insurer nor a financial assistance program, the Hospital follows a reasonable billing and collection process:

1. An initial bill is sent to the patient or responsible party which provides notice about financial assistance programs that may help cover the cost of the hospital bill;
2. Subsequent bills, phone calls, collection letters, personal letters and e-mails, and other genuine efforts may be made to contact the party responsible for the patient's obligation;
3. Additional efforts to locate the responsible party will be made and documented when Hospital mailings are returned by the Postal Service stamped with "Incorrect Address" or "Undeliverable".
4. Sending a final notice by certified mail for uninsured patients (those who are not enrolled in a public program such as the Health Safety Net or MassHealth) who incur an emergency bad debt balance over $1,000 on Emergency Level Services only, where notices have not been returned as "incorrect address" or "undeliverable.";
5. Documentation of continuous billing and collection activities undertaken on a regular, frequent basis is maintained until an Audit Review by a Federal and/or State agency of the fiscal-year Cost Report in which the bill or patient account is reported. The Federal Medicare program and the State Division of Health Care Finance and Policy (for purposes of the Health Safety Net Program) deem 120 days as an appropriate period of time to conduct regular, frequent billing and collection activities on a patient account;
6. Checking the Eligibility Verification System (EVS) to ensure that the patient is not a Low-Income Patient as determined by the Office of Medicaid and has not submitted an application to the Virtual Gateway system for coverage of the services under a public program, prior to submitting claims to the health Safety Net Office for emergency bad debt coverage of an emergency level or urgent care service.

The Hospital will also maintain compliance with applicable billing requirements for non-payment of specific services or re-admissions that the Hospital determines were the result of a Serious Reportable Event (SRE) as defined by Department of Public Health regulations 101 CMR 613.05(5). SREs that do not occur at the Hospital are excluded from this determination of non-payment. The Hospital also does not seek payment from a Low-Income Patient determined eligible for the Health Safety Net program whose claims were initially denied by an insurance program due to an administrative billing error by the Hospital. The Hospital further maintains all

information in accordance with applicable Federal and State privacy, security, and ID-theft laws.

D. Populations Exempt from Collection Activities

There are several situations where a patient can be exempted from further billing and collection procedures once the determination is made that the patient is exempt pursuant to State regulations:

1. Patients enrolled in MassHealth and Patients receiving governmental benefits under the Emergency Aid to the Elderly, Disabled and Children program except that the Provider may bill Patients for any required copayments and deductibles. The Provider may initiate billing for a Patient who alleges that he or she is a participant in any of these programs but fails to provide proof of such participation. Upon receipt of satisfactory proof that a Patient is a participant in any of the above listed programs, and receipt of the signed application, the Provider must cease its collection activities.
2. Participants in the Children's Medical Security Plan whose MAGI income is equal to or less than 300% of the FPL are also exempt from Collection Action. The Provider may initiate billing for a Patient who alleges that he or she is a participant in the Children's Medical Security Plan, but fails to provide proof of such participation. Upon receipt of satisfactory proof that a Patient is a participant in the Children's Medical Security Plan, the Provider must cease all collection activities.
3. Low Income Patients, other than Dental-Only Low-Income Patients, are exempt from Collection Action for any Reimbursable Health Services rendered by a Provider receiving payments from the Health Safety Net for services received during the period for which they have been determined Low Income Patients, except for copayments and deductibles. Providers may continue to bill Low Income Patients for Eligible Services rendered prior to their determination as Low Income Patients after their Low-Income Patient status has expired or otherwise been terminated.
4. Low Income Patients with MassHealth MAGI Household income or Medical Hardship Family Countable Income, as described in 101 CMR 613.04(2), between 150.1 to 300% of the FPL are exempt from Collection Action for the portion of his or her Provider bill that exceeds the deductible and may be billed for copayments and deductibles as set forth in 101 CMR 613.04(8)(b) and (c). Providers may continue to bill Low Income Patients for services rendered prior to their determination as Low Income Patients after their Low-Income Patient status has expired or otherwise been terminated.
5. The Hospital may bill Low Income Patients for services other than Reimbursable Health Services provided at the request of the Patient and for which the Patient has agreed to be responsible, with the exception of those services described in 101 CMR 613.08(3)(e)1. and 2. Providers must obtain the Patient's written consent to be billed for the service.
    a. Providers may not bill Low Income Patients for claims related to medical errors including those described in 101 CMR 613.03(1)(d).

   b. Providers may not bill Low Income Patients for claims denied by the Patient's primary insurer due to an administrative or billing error.
6. At the request of the Patient, the Hospital may bill a Low-Income Patient in order to allow the Patient to meet the required CommonHealth one-time deductible as described in 130 CMR 506.009: *The One-time Deductible*.
7. The Hospital may not undertake a Collection Action against an individual who has qualified for Medical Hardship with respect to the amount of the bill that exceeds the Medical Hardship contribution. If a claim already submitted as Emergency Bad Debt becomes eligible for Medical Hardship payment from the Health Safety Net, the Provider must cease collection activity on the Patient for the services.
8. For a patient in one of the State's health insurance programs, the Hospital can still bill and collect for non-covered services for which the Hospital has obtained the patient's prior written consent to be financially responsible for these services;
9. When a patient has been approved for Medical Hardship under the Massachusetts Health Safety Net program, the Hospital will not attempt to bill and collect for the amount of the bill that exceeds the Medical Hardship contribution. In addition, the Hospital will cease billing and collection efforts on an emergency bad debt claim that is approved for Medical Hardship;
10. Pursuant to an internal financial assistance program, the Hospital may cease any billing and collection actions for a patient who is unable to pay the hospital bill at any time during the billing and collection process. In these cases, the Hospital will maintain all documentation showing that the patient met the Hospital's requirements for its internal financial assistance program;
11. The Hospital and its agents shall cease billing and collection efforts for a patient who is the subject of a bankruptcy proceeding except to secure the Hospital's rights and position as a creditor in the proceeding.
12. The Hospital will not engage in extraordinary collection activities.

E. Outside Collection Agencies

The Hospital may contract with an outside collection agency to assist in the collection of certain accounts, including patient obligations not resolved after the issuance of several hospital bills and a final notice. The Hospital may assign these accounts, and others deemed uncollectible, to bad debt or charity care and forward them to an outside collection agency. The Hospital could do this prior to 120 days of diligent and reasonable billing and collection efforts if the Hospital determines the patient is not able to pay by following the Hospital's own internal financial assistance program.

The Hospital requires specific authorization or a contract with the outside collection agency and compels these agencies to follow the Hospital's credit and collection policies for debts that the agency is pursuing on the Hospital's behalf. All outside collection agencies hired by the Hospital

will provide the patient with an opportunity to file a grievance. Results of such patient grievances will be forwarded to the Hospital. The Hospital requires that any outside collection agency used by the Hospital is licensed by the Commonwealth of Massachusetts and is in compliance with the Massachusetts Attorney General's Debt Collection Regulations 940 CMR 7.00.

A Low-Income Patient, as determined by the Office of Medicaid, will not have his or her account assigned to an outside collection agency prior to 120 days after the initial bill, unless the Hospital can show that it was unable to contact the patient or any documented guarantor (e.g. has received a bad address notice or through skip tracing).

SECTION 5: Deposits, Payment Plans, Discounts, and Adjustments

Pursuant to the Massachusetts Health Safety Net regulations pertaining to patients that are either: (1) determined to be a "Low Income Patient" or (2) qualify for Medical Hardship, the hospital will provide the patient with information on deposits and payment plans based on the patient's documented financial situation. Any other plan will be based on the hospital's own internal financial assistance program, and will not apply to patients who have the ability to pay.

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

A. Deposits

The Hospital reserves the right to require a deposit for services believed to result in a self-pay liability or other patient or guarantor responsibility as indicated by a third-party insurance program at the time of verification. Patients who express an inability to comply with deposit requirements, or who have prior balances that indicate an inability to meet deposit requirements, will be referred to one of the Hospital's Financial Counselors or Pre-Service Specialists. In the case of non-emergent treatments or procedures, the patient may be required to pay a pre-service deposit and/or enter into a payment plan. Under no circumstances will the Hospital require pre-admission and/or pre-treatment deposits from a patient requiring Emergency Care Services.

The Hospital may request a deposit from a patient determined to be a Low-Income Patient by the Office of Medicaid. Such deposits must be limited to 20% of the deductible amount, up to $500. All remaining balances are subject to the payment plan conditions established in 101 CMR 613.08 (1)(G)

The Hospital may also request a deposit from a patient eligible for Medical Hardship. The deposit may not exceed 20% of the Medical Hardship contribution, or $1,000, whichever is less. Again,

all remaining balances are subject to the payment plan conditions established in 101 CMR 613.08(1)(F)

B. Payment Plans

The Hospital shall not require payment plans for patients that are fully exempted from collection action. Accounts not fully exempt from collection will be considered eligible for a payment plan when there is no possibility of a full reimbursement by a third party.

Patients may have a payment plan arranged by the Hospital. Patients with a balance greater than or equal to $150 will be offered an interest free payment plan.

C. Hospital Financial Assistance Programs

The Hospital offers a prompt pay discount to patients who pay amounts identified as patient responsibility at or before the date of service. Any financial assistance is meant to supplement and not replace other coverage for services in order to ensure the financial assistance is provided when needed. No assistance will be based on an effort to induce a patient to receive services from the Hospital or generate business payable by a Federal or State program.

D. Provider Responsibilities

Neither the Hospital nor its authorized representatives and agents shall seek legal execution against the personal residence or motor vehicle of a patient or guarantor without the advance written approval of the Hospital's Board of Trustees. All approvals sought from and made by the Board will be done on a case-by-case, individualized basis.

E. Determination of Patient Financial Responsibility

The Hospital will make diligent efforts to determine the patient's financial responsibility as soon as reasonably possible during the patient's course of care. Where feasible, the Hospital will collect co-pays, deductible, co-insurance amounts, or required deposits prior to any service delivery. Patients, who are members of managed care health plans, or insurance plans with specific access requirements, are responsible for understanding and complying with all of their insurance plan requirements, including referrals, authorizations, or other "network" restrictions. The Hospital will request any necessary pre-approval, authorization or guarantees of payment from the insurer whenever possible.

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SECTION 6: Glossary

Bad Debt

An account receivable based on services furnished to a patient which is (1) regarded as uncollectible, following reasonable collection efforts, (2) charged as a credit loss, (3) not an obligation of a governmental unit or the federal government or any agency thereof, and (4) is not a reimbursable healthcare 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.

Collection Action

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

Eligible Services

Those services that meet the criteria of 101 CMR 613.03.

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 s 1395(dd).

EVS

The MassHealth Eligibility Verification System of the Office of Medicaid.

Family

Family shall include persons who live together, and consisting of: a child or children under the

age of 19, and any of their children and their parents; 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 a child 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 pregnant or 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.

Financial Assistance Program

A program that is intended to assist low-income patients who do not otherwise have the ability to pay for their health care services. Such assistance should take into account each individual's ability to contribute to the cost of his or her care. Consideration is also given to patients who have exhausted their insurance benefits and/or who exceed financial eligibility criteria but face extraordinary medical costs. A financial assistance program is not a substitute for employer sponsored, public financial assistance, or individually purchased insurance programs.

Health Care Services

Hospital-level services (provided in either an inpatient or outpatient setting) 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.

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.

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 provider may submit a claim to the Health Safety Net Trust Fund as defined in 101 CMR 613.00.

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 residence.