Saint Vincent Hospital

Hospital Credit and Collection Policy

September 8, 2016
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Introduction

Saint Vincent Hospital is committed to providing you with high-quality care and services. As part of this commitment, Saint Vincent Hospital works with individuals with limited incomes and resources to find coverage for their care. Our financial assistance program helps low-income, uninsured, and underinsured individuals determine if they are eligible for public assistance or through other sources, including Saint Vincents Hospital financial assistance.

Financial assistance is available from the hospitals for uninsured and underinsured individuals who cannot get public assistance and cannot afford to pay for their medical care. The premise of the program is that all individuals are expected to contribute to their care, based on their ability to pay. Assistance is given based on the individual's household income, assets, family size, expenses, and medical needs. We understand that each individual has a unique financial situation and encourage you to contact our certified application counselors for more information at (508-363-6459, between 8 AM and 4:30 PM, Monday through Friday, located in the Hospital facility.

Each request for assistance is handled confidentially and requires the cooperation of the applicant. The Credit and Collection Policy and More information on applying for this program, can also be found on our website at: www.stvincenthospital.com

This policy was developed to ensure compliance with the Massachusetts Health Safety Net Eligible Services Regulation (101 CMR 613.000) and generally meets the IRS regulations (Internal Revenue Code Section 501(r)) which are effective for hospitals starting in December of 2016.

The Provider does not discriminate on the basis of race, color, national origin, citizenship, alienage, 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, or Low Income Patient status.

The COO/CFO is the approver of our policy.
Delivery of healthcare services as it applies to Financial Assistance

Saint Vincent Hospital will provide, without exception, care for emergency medical conditions to all individuals seeking such care, regardless of your ability to pay for or to qualify for financial assistance in accordance with the requirements of the federal Emergency Medical Treatment and Labor Act (EMTALA). Financial assistance is available for an individual who is seeking emergent, urgent, or medically necessary care. The hospital financial assistance program may not apply to certain elective procedures or services that are covered by a third party (such as a private insurance or a public assistance program).

It is important to note that classification of individuals’ medical conditions is for clinical management purposes only, and such classifications are intended for addressing the order in which physicians should see individuals based on their presenting clinical symptoms. These classifications do not impact the order in which an individual is provided financial assistance. For those individuals that are uninsured or underinsured, the hospital will work with individuals to assist with finding a financial assistance program that may cover some or all of their unpaid hospital bill(s). For those individuals with private insurance, the hospital must work through the individual and the insurer to determine what may be covered under the individual’s insurance policy. As the hospital is often not able to get this information from the insurer in a timely manner, it is the individual’s obligation to know what services will be covered prior to seeking elective or scheduled services. For purposes of this policy, the following services are differentiated in the following manner for determining the medical care needed and what may be covered by a specific public or private coverage option for consideration of a patient’s allowable bad debt:

• Emergency Level Services includes 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. § 1295dd(e)(1)(B). A medical screening examination and any subsequent treatment for an existing emergency medical conditions 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.

• 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.
• Primary or Elective Care services are provided to individuals who either (1) arrive to the hospital seeking non-emergent or non-urgent level care or (2) seek additional care following stabilization of an emergency medical condition. Primary or Elective scheduled services are medical procedures scheduled in advance by the individual or by the health care provider (hospital, physician office, other).

Documenting Eligibility for Enrollment in Massachusetts Public Assistance Programs

A. General Principles
Financial assistance is intended to assist low-income individuals 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 individuals that are uninsured or underinsured, the hospital will, when requested, help them with applying for available financial assistance programs that may cover all or some of their unpaid hospital bills. The Hospital provides this assistance for both residents and non-residents of Massachusetts; however, there may not be coverage through a Massachusetts public assistance program for an out-of-state resident. In order for the hospital to assist uninsured and underinsured individuals find the most appropriate coverage options as well as determine if the individual is financially eligible for any discounts in payments, individuals must actively work with hospitals to verify their documented family income, other insurance coverage, and any other information that could be used in determining eligibility.

B. Enrollment in a Public Assistance Program
Hospitals have no role in specifically determining the eligibility for enrollment within a public assistance program. In Massachusetts, individuals apply for coverage in MassHealth, the premium assistance payment program offered through the Health Connector (including ConnectorCare), Health Safety Net, the Children’s Medical Security Program, or Medical Hardship must do so through a single uniform application that is submitted through the state’s new enrollment system called the Health Insurance Exchange (HIX). Through this process, the individual can submit an application through an online website (which is centrally located on the state’s Health Connector Website), a paper application, or over the phone with a customer service representative located at either MassHealth or the Connector. Individuals may also ask for assistance from the hospital’s certified application counselor with submitting the application either on the website or through a paper application.

In order to apply for coverage, the following process occurs:

1. An individual is requested to develop an online account for use by the state to conduct an identity verification of the individual. Once this is completed, the individual is then able to submit a completed application through the hCentive system on the Connector Website. If the individual does not want to go through the online identity verification system, they can submit a paper application. Other verification may still be needed, including proof of income, residency, and citizenship.

2. Once the application is received, the state will verify the eligibility by comparing the individuals financial and other demographic information to a federal data site as well as conducting an income review using a modified adjusted gross income review. If
necessary, the individual will also submit additional verification as requested by the system. Once this occurs, the individual is deemed:

a. Eligible for MassHealth coverage, upon which the individual is notified by mail from MassHealth, which includes eligibility information including start date and other pertinent information; or

b. If the individual is eligible for a qualified health plan through the Health Connector Program, they are notified of their eligibility and directed to take additional steps. This includes: (1) choosing a plan, (2) paying their monthly premium, (3) enrolling and receiving their proof of coverage.

More information regarding the MassHealth and Connector program benefits and application process can be found at [www.mass.gov/masshealth](http://www.mass.gov/masshealth) and [www.mahealthconnector.org](http://www.mahealthconnector.org).

**Locations where patients may present:**
All patients are able to seek emergency level services and urgent care services when they come to the hospital emergency department or designated urgent care areas. The hospital also provides other elective services at the main hospital, clinics and other outpatient locations. This includes our satellites in Auburn, Sterling, Worcester sites.
Assisting Individuals seeking coverage through a Massachusetts public assistance program

A) General Principles:
For those individuals who are uninsured or underinsured, the hospital will work with them to assist with applying for available financial assistance programs that may cover some or all of their unpaid hospital bills. In order to help uninsured and underinsured individuals find available and appropriate financial assistance programs, the hospital will provide all individuals with a general notice of the availability of programs in both the bills that are sent to individuals as well as in general notices that are posted throughout the hospital. The goal of these notices is to assist individuals in applying for coverage within a public assistance program, including MassHealth, premium assistance payment program offered through the Health Connector (including ConnectorCare), Health Safety Net, the Children’s Medical Security Program, and Medical Hardship.

B) Role of Hospital Certified Application Counselor
The hospital provides individuals with information about financial assistance programs that are available through the Commonwealth of Massachusetts. By contracting with the Executive Office of Health and Human Services (MassHealth) and the Commonwealth Health Insurance Connector Authority (Connector) the hospital has been deemed a Certified Application Counselor Organization. Through this authority, the hospital works with its staff, contractors and volunteers to be trained in the eligibility and benefit rules and regulations and be certified as a Certified Application Counselor (CAC) to assist individual with enrollment in MassHealth, premium assistance payment program offered by the Health Connector (including ConnectorCare), Health Safety Net, the Children’s Medical Security Program, and Medical Hardship.

As a Certified Application Counselor (CAC), the hospital staff will inform the individual of the functions and responsibility of a CAC, seek that the individual sign a Certified Application Counselor Designation Form, and assist the individual find applicable public assistance by:
   a) providing information about the full range of programs, including MassHealth, premium assistance payment program offered by the Health Connector (including ConnectorCare), Health Safety Net, the Children’s Medical Security Program, and Medical Hardship, advise patient the right to a payment plan.
   b) helping individuals complete an application or renewal;
   c) working with the individual to provide required documentation;
   d) submitting applications and renewals to the specific programs;
e) interacting, when applicable and as allowed under the current system limitations, with the Programs on the status of such applications and renewals;
f) helping to facilitate enrollment of applicants or beneficiaries in Insurance Programs;
g) Offer and provide voter registration assistance.
h) 1. In the following circumstances, as the Provider we provide individual notice of the availability of financial assistance programs to a Patient expected to incur charges, exclusive of personal convenience items or services, whose services may not be paid in full by third party coverage:
   a. during the Patient’s initial registration with the Provider;
   b. on all billing invoices; and
   c. when a Provider becomes aware of a change in the Patient’s eligibility or health insurance coverage.

2. In the following circumstances, as the Provider or its designee provide notice about Eligible Services and programs of public assistance, including MassHealth, the Premium Assistance Payment Program Operated by the Health Connector, the Children’s Medical Security Plan, and Medical Hardship:
   a. during the Patient’s initial registration with the Provider;
   b. on all billing invoices; and
   c. when a Provider becomes aware of a change in the Patient’s eligibility or health insurance coverage.

The hospital may also assist patients with enrolling in the Health Safety Net using a presumptive determination process, which provides a limited period of eligibility. This process is conducted by hospital and community health center staff, who, on the basis of self-attestation of financial information from the patient, will deem a patient as meeting the low income patient definition and will be covered for Health Safety Net services only. Coverage will begin on the date that the provider makes the determination through the end of the following month in which the presumptive determination is made. However, coverage may be terminated sooner if the patient submits a full application as described above.
It is the individual’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 insurance coverage options (including motor vehicle liability insurance) that can cover the cost of the care received, any other applicable financial resources, and citizenship and residency information. This information will be submitted to the state as part of the application for public program assistance to determine coverage for the services provided to the individual. It is the Patient's responsibility to track the Deductible and provide documentation that the deductible has been reached.

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 individual or guarantor is unable to provide the necessary information, the hospital may (at the individual’s request) make reasonable efforts to obtain any additional information from other sources. Such efforts also include working with individuals, when requested by the individual, to determine if a bill for services should be sent to the individual to assist with meeting the One-time Deductible. This will occur when the individual is scheduling their services, during pre-registration, while the individual 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 hospital will also conduct reasonable efforts to investigate whether a third party resource may be responsible for the services provided by the hospital, including but not limited to: (1) a motor vehicle or home owner’s liability policy, (2) general accident or personal injury protection policies, (3) worker's compensation programs, (4) student insurance policies, submitting claims to all insurers for service provided. In accordance with applicable state regulations or the insurance contract, for any claim where the hospital’s reasonable efforts resulted in a payment from such sources listed above, the hospital works with each individual to notify them of their responsibility to report the payment and offset it against any claim made to MassHealth, the Health Safety Net, or other applicable programs. A patient is also advised to notify HSN/Masshealth in writing within ten days of filing TPL claim, lawsuit. Advise patient of HSN limit on recovery of TPL claim proceeds. Appeal a denied claim when the service is payable by an insurer.

C) Notification Practices:
The hospital will post a notice (signs) of availability of financial assistance as outlined in this credit and collection policy in the following locations:

a) Service Delivery Areas (e.g., Inpatient, Emergency, and Outpatient, areas);
b) Certified Application Counselor offices;
c) Admission/registration areas; and/or
d) Financial offices that is open to individuals.
Posted signs will be clearly visible and legible to individuals visiting these areas. The hospital will also include a notice about the availability of financial assistance in all initial bills. Currently the hospital translates the notices in the following languages Spanish, Portuguese.

When the individual contacts the hospital, the hospital CACs will attempt to identify if an individual qualifies for a public assistance program or through the hospital financial assistance program. An individual who is enrolled in a public assistance program may qualify for certain benefits. Individuals may also qualify for additional assistance based on the hospital's financial assistance program based on the individual's documented income and allowable medical expenses.

**Hospital Billing and Collection Practices**

**A. Hospital Obligations:**

The hospital will make all reasonable efforts to collect the patient insurance status and other information to verify coverage for the health care services to be provided by the hospital. For many patients coverage determinations is made by either asking for a copy of the patient’s insurance card or checking the Recipient Eligibility Verification (EVS) system for coverage under an applicable public program. 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 level 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 is not limited to requesting information about the patient’s insurance status, checking any available public or private insurance databases, and following the billings rules of a known third party payer. Furthermore, upon registering a patient for healthcare services, the hospital will notify the patient of their responsibility and also the patient has a duty to inform the appropriate public program of any changes in their eligibility status when the provider is made aware by the patient of any such material changes.

If the patient or guarantor/guardian is unable to provide the information needed, and the patient consents, the hospital/department will make reasonable efforts to contact relatives, friends, guarantor/guardian, and the third party for additional information. This may 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.

**B. Reasonable Collection Efforts**
The Provider makes the same reasonable effort and follows the same reasonable process for collecting on bills owed by an individual as it does for all other patients. The Provider will first show that it has a current unpaid balance that is related to services provided to the patient and not covered by a private insurer or a financial assistance program. The Provider follows reasonable collection/billing procedures, which include:

1. An initial bill sent to the patient or the party responsible for the patient’s personal financial obligations, the initial bill will include information about the availability of a financial assistance program that might be able to cover the cost of the hospital’s bill;
2. Subsequent billings, telephone calls, collection letters, personal contact notices, computer notifications, or any other notification method that constitutes a genuine effort to contact the party responsible for the obligation and informs the patient of the availability of financial assistance;
3. If possible, documentation of alternative efforts to locate the party responsible for the obligation or the correct address on billings returned by the postal service such as “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.” And also notifying the patients of the availability of financial assistance in the communication;
5. Documentation of continuous billing or collection action undertaken on a regular, frequent basis. The Health Safety Net Office may use a gap in collection action of greater than 120 days as a guideline for noncompliance but may use discretion when determining whether a hospital has made a reasonable effort to meet the standard. If after reasonable attempts to collect a bill the debt for emergency services after 120 days of continuous collection action may be billed to Health Safety Office.
6. The file must include all documentation of the hospitals collection effort including copies of bills, follow up letters, phone contact and all other efforts.
7. Checking the MassHealth Eligibility Verification System to ensure an uninsured individual low income Patient has not submitted an application for MassHealth for coverage of the services under a public program prior to submitting claims to the Health Safety net for emergency bad debt coverage of an emergency level or urgent care service.

C. Populations Exempt from Collection Activities
The following individuals and patient populations are exempt from any collection or billing procedures beyond the initial bill.

a. A provider must not bill Patients enrolled in a public health insurance program, including but not limited to, MassHealth, Emergency Aid to the Elderly, Disabled and Children, Children’s Medical Security Plan, “Low Income Patients” as determined by the Office of Medicaid – subject to the following:
The Provider may seek collection action against any patient enrolled in the above-mentioned programs for their required co-payments and deductibles that are set forth by each specific program.

The Provider may also initiate billing or collection for a patient who alleges that he or she is a participant in a financial assistance program that covers the costs of the hospital services, but fails to provide proof of such participation. Upon receipt of satisfactory proof that a patient is a participant in a financial assistance program, (including receipt or verification of signed application) the Provider shall cease its billing or collection activities.

b) Participants in the Childrens Medical Security Plan whose MAGI income is equal to or less than 300% of the FPL are also exempt from collection actions. The provider may initiate billing for a patient who alleges that he or she is a participant in Childrens Medical Security plan but fails to provide proof of such participation. Upon receipt of proof that the patient is a participant the hospital will cease all collection activities. Low income patients with MAGI household income or Medical Hardship family countable income between 150.1% to 300% of the FPL are exempt from collection action. 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.

c) The Provider may seek collection action against any of the patients participating in the programs listed above for non-covered services that the patient has agreed to be responsible for, provided that the Provider obtained the patient’s prior written consent to be billed for the service.

The Provider will not undertake collection action against an individual that has been approved for Medical Hardship under the Massachusetts Health Safety Net program with respect to the amount of the bill that exceeds the Medical Hardship contribution

D. Standard Collection Action

a) The Provider will not undertake any “extraordinary collection activities” until such time as the hospital has made a reasonable effort and followed a reasonable review of the patient’s financial status, which will determine that an individual is entitled to financial assistance or exemption from any collection or billing activities under this credit and collection policy. The hospital will keep any and all documentation that was used in this determination pursuant to the hospital’s applicable record retention policy. Extraordinary collection activities may include lawsuits, liens on residences, arrests, body attachments, or as otherwise described below in compliance with state requirements.

b)
The Provider will not undertake collection action against an individual that has been approved for Medical Hardship under the Massachusetts Health Safety Net program with respect to the amount of the bill that exceeds the Medical Hardship contribution.

c) The Provider will not garnish a Low Income Patient’s (as determined by the Office of Medicaid) or their guarantor’s wages or execute a lien on the Low Income Patient’s or their guarantor’s personal residence or motor vehicle unless: (1) the hospital can show the patient or their guarantor has the ability to pay, (2) the patient/guarantor did not respond to hospital requests for information or the patient/guarantor refused to cooperate with the hospital to seek an available financial assistance program, or (3) for purposes of the lien, it was approved by the hospital’s Board of Trustees on an individual case by case basis.

d) The Provider and its agents shall not continue collection or billing on a patient who is a member of a bankruptcy proceedings except to secure its rights as a creditor in the appropriate order. Finally, the hospital and its agents will not charge interest on an overdue balance for a low income patient or for patients who are low income based on the hospital’s own internal financial assistance program.

e) The Provider maintains compliance with applicable billing requirements, including the Department of Public Health regulations (105 CMR 130.332) for non-payment of specific services or readmissions that the hospital determines was the result of a Serious Reportable Events (SRE). 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 also does not bill low income patients for claims related to medical errors including those described in 101CMR613.03).

E. Outside Collection Agencies

The Provider contracts with an outside collection agency to assist in the collection of certain accounts, including patient responsible amounts not resolved after issuance of hospital bills or final notices. However, as determined through this credit and collection policy, the hospital may assign such debt as bad debt or charity care (otherwise deemed as uncollectible) prior to 120 days if it is able to determine that the patient was unable to pay following the hospital’s own internal financial assistance program.

The hospital has a specific authorization or contract with the outside collection agency and requires such agencies to abide by the hospital’s credit and collection policies for those debts that
the agency is pursuing, including the obligation to refrain from “extraordinary collection activities” until such time as the hospital has made a reasonable effort and followed a reasonable process for determining that a patient is entitled to assistance or exemption from any collection or billing procedures under this credit and collection policy. All outside collection agencies hired by the hospital will provide the patient with an opportunity to file a grievance and will forward to the hospital the results of such patient grievances. The hospital requires that any outside collection agency that it uses is licensed by the Commonwealth of Massachusetts and that the outside collection agency also is in compliance with the Massachusetts Attorney General’s Debt Collection Regulations at 940 C.M.R. 7.00.

**Medicare Bad Debt**

For purposes of clarification, the Medicare Program’s criteria for allowable Bad Debt are as follows:

a) The debt must be related to covered services and derived from deductible and coinsurance amounts.

b) The provider must be able to establish that reasonable collection efforts were made.

c) The debt was actually un-collectible when claimed as worthless.

d) Sound business judgment established that there was no likelihood of recovery at any time in the future.

e) Claim as Medicare Bad debt only after reasonable collection actions were completed by a Collection Agency.

**Motor Vehicle Accidents**

A Provider may submit a claim for a Low Income Patient injured in a motor vehicle accident only if (1) it 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 hospital must offset the income from its claim for eligible services.
Grievance Process

An individual may request that the office conduct a review of the determination of low income patient status, or of provider compliance with the provisions of 101CMR613.00. The Health Safety Net office will conduct a review using the following process.

A. In order to request a review, the individual must send a written complaint to the office with supporting documentation. To request of the review of determination the individual must send the request within 30 days from the date the applicant received the official notification of the determination. The office may request additional information as necessary. Additional information requested by the Office must be submitted within 30 days.

B. The Office issues a written decision to the grievant and all other relevant parties within 30 days of the receipt of all necessary information.
Deposits and Installment Plans

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 provides the following deposits and installment plans. Any other plan will be based on the Provider’s own internal financial assistance program, and will not apply to patients who have the ability to pay.

A. Emergency Services
A Provider 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.

B. Low Income Patient Deposit

A Provider may request a deposit from individuals determined to be Low Income Patients. Such deposits must be limited to 20% of the deductible amount, up to $500. All remaining balances are subject to the payment plan conditions established in 101 CMR 613.08.

C. Deposits for Medical Hardship Patients
A Provider 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 interest free. All remaining balances will be subject to the payment plan conditions established in 101 CMR 613.08.

D. Payment Plans for Low Income Patients pursuant to the Massachusetts Health Safety Net Program
An individual with a balance of $1,000 or less, after initial deposit, must be offered at least one-year interest free payment plan with a minimum monthly payment of no more than $25. An individual with a balance of more than $1,000, after initial deposit, must be offered at least a two-year interest free payment plan.
. Payment Plans for HSN Partial Low Income Patients pursuant to the Massachusetts Health Safety Net Program, for services rendered in a Hospital Licensed Health Center this includes satellites in Auburn, Sterling, Worcester sites or Student Health Center. The hospital also offers the Health Safety Net Partial Low Income Patient a co-insurance plan that allows the individual to pay 20% of the Health Safety Net payment for each visit until the patient meets their annual deductible. The remaining balance will be written off to the Health Safety Net.

**Discount Policy**

The hospital will offer discounts to individuals who do not qualify for Mass Health, Health Safety Net Program or any other government programs. Discounts will be offered on a case-by-case basis from 3 to 50%. Staff, Supervisors, Managers, Central Business office Director or any Administrator (CFO, CEO, COO) according to hospital policy and procedure can authorize discounting.
VI. Glossary

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 program.

Low Income Patient
An individual who meets the criteria under 101CMR613.04 equal to or less than 300% of the Federal Poverty Level.

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.

Resident
A person living in Massachusetts with the intention to remain as defined by 130CMR 503.002A through D. 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.

State Public Assistance Programs include:

Mass Health:

Health Connector including Connectorcare.
Children’s Medical Security

Medical Hardship
Health Safety Net

V11. Attachments/Exhibits

Copies of Patient Financial Notices contained within
a. First, second, third, and/or final billing invoices
b. Copies of the general notices from Hospitals and/or agents on the availability of financial assistance.
c. Copies of posted signs as well as general flyers and other handouts (if any) regarding the availability of financial assistance