

**BAYSTATE HEALTH  
 BAYSTATE MEDICAL CENTER  
 BAYSTATE FRANKLIN MEDICAL CENTER  
 BAYSTATE MARY LANE HOSPITAL  
 PATIENT CREDIT AND COLLECTION POLICY**

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## **I. PATIENT COMMITMENT**

Baystate Health, Inc. (“BH”) is committed to ensuring that patients in its community have access to health care services and that such patients are treated with fairness and respect in all dealings with BH hospitals and other health care providers.

BH recognizes that the cost of necessary health care services can impose a significant financial burden on patients who are uninsured or underinsured and BH has chosen to act affirmatively to lessen that burden for patients. BH promotes patient access to health care services by offering patients the opportunity to obtain free or reduced cost services from BH hospitals and other health care providers under discount and financial assistance programs. BH not only offers free and reduced cost care to the financially needy as required by law, but has also chosen voluntarily to establish discount and financial assistance programs that provide more free and reduced cost care to more patients residing within the community served by BH.

BH recognizes that the billing and collection process itself can be bewildering and burdensome for patients and BH has implemented procedures to make the process understandable for patients; to inform patients about discount and financial assistance options; and to ensure that patients are not subject to aggressive collection activities.

Consistent with its patient commitment BH requires that each BH affiliate maintain a credit and collection policy that reflects its patient billing and collection procedures and complies with applicable state and federal laws and regulations. This policy describes the financial assistance and discount programs as well as the billing, payment and collection processes applicable to services provided to patients by BH hospitals and other health care providers. The policy addresses only those programs and processes applicable to patients (and patient guarantors) and not third party payors. The policy is developed to ensure compliance with applicable criteria required under (1) the Health Safety Net Eligible Services Regulation (114.6 CMR 13.00), (2) the Centers for Medicare & Medicaid Services Medicare Bad Debt Requirements (42 CFR § 413.89), (3) the Medicare Provider Reimbursement Manual (Part 1, Chapter 3), and (4) the Internal Revenue Code Section 501(r).

## **II. SUMMARY OF POLICY**

This policy applies to hospital services provided by Baystate Medical Center, Baystate Franklin Medical Center and Baystate Mary Lane Hospital (“BH Hospitals”) and other health care services provided by separately licensed providers operating within the hospital corporations such as Infusion and Respiratory Services (“I&RS”) and Baystate Reference Laboratory (“BRL”). (The BH Hospitals and these other providers are referred to as “BH Providers”) Each BH Provider applies the policy to its own operations.

BH Providers seek to allocate available financial resources effectively to reduce the cost of health care services for those patients within the community served by BH who are most in need consistent with their respective legal obligations. This policy recognizes that the financial resources of BH Providers are limited; and that BH Providers have a fiduciary responsibility to bill and collect appropriately for patient services. BH Providers do not discriminate on the basis of race, color, national origin, citizenship, alienage, religion, creed, sex, sexual preference, age,

or disability, in their policies, in the application of their policies, including the acquisition and verification of financial information, pre-admission or pretreatment deposits, payment plans, deferred or rejected admissions, eligibility status determinations, Low Income Patient status as determined by the Massachusetts Office of Medicaid or in their billing and collection practices.

BH Providers generally expect patients or their third party payors to pay in full for services provided. BH Providers will bill third party payors in accordance with the requirements of applicable law, contracts with third party payors (if any) or applicable billing guidelines. Patients are also responsible for charges that are not paid by a third party payor within a reasonable time frame or for any balances that exist after payment by the third party payor. Patients who seek services (other than emergency services) may be requested to pay in advance some or all charges for services that will not be covered by third party payors, including co-payments and deductibles related to covered services. Notice of amounts due from patients are issued on a regular basis. The patient's failure to pay or make satisfactory financial arrangements will render the account delinquent. BH Providers will take necessary steps to collect delinquent accounts, including referral to outside collection agencies and/or attorneys, subject to the limitations stated in this policy.

BH Providers' patients with self-pay obligations may have the opportunity to reduce the cost of their health care services through participation in general state programs, BH financial assistance programs available to some patients based on their financial circumstances, and BH discounts available to all patients based on prompt payment. Current discount and financial assistance programs available to BH Provider patients include:

**Financial Counseling.** BH Hospitals have financial counselors and specialized on-site staff to assist patients to apply and qualify for Federal Supplemental Security Income Program, State Programs, the Massachusetts Health Safety Net program and/or the Hospital Supplemental Financial Assistance Program. Patient Accounting Customer Services staff will help patients identify, determine eligibility for, and compare available State Programs as well as other financial assistance and discount programs. Staff and other agents will assist with the applicable process. The staff is also available to address concerns and provide payment assistance before and after services are provided. Patients have a responsibility to provide all necessary information and documentation to determine eligibility for government programs, the Health Safety Net program, Hospital Supplemental Financial Assistance Program, or payment plans.

**Health Safety Net Program.** BH Hospitals participate in the Health Safety Net program. Hospitals that participate in the program have an obligation to provide free care to Massachusetts residents who meet financial criteria demonstrating an inability to pay for services. Full free care is available for certain medically necessary services provided to patients whose family income is 200% or less than the Federal Poverty Income Guidelines and who are ineligible for MassHealth, Commonwealth Care or do not have access to affordable employer sponsored insurance. Partial free care is available for certain medically necessary services provided to patients whose family income is between 201% and 400% of the Federal Poverty Income Guidelines. Patients who qualify for partial free care are required to meet an annual family deductible based on their family's income. Patients may also qualify for free care on a "medical hardship" basis if their medical expenses exceed a specified percentage of their family income. Coverage of emergency

services bad debts is available to BH Hospitals for services provided to Massachusetts residents and other patients. Only hospital services provided by the BH Hospitals under their hospital licenses are subject to the Health Safety Net and its policies and procedures.

**Hospital Supplemental Financial Assistance Program.** BH Providers offer their own Financial Assistance Program that provides financial assistance to certain qualifying patients residing in the BH community who meet financial criteria demonstrating an inability to pay for services. The patients, or the services received by the patients, must be ineligible for coverage under MassHealth, Commonwealth Care, Health Safety Net or an affordable employer sponsored insurance. The Hospital Supplemental Financial Assistance Program is meant to supplement – and not replace - other coverage for services in order to ensure the financial assistance is provided when most needed. Financial Assistance from this program is not Health Safety Net eligible. Services provided by all BH Providers are eligible for coverage under the Hospital Supplemental Financial Assistance Program.

**Prompt Pay Discounts.** BH Providers offer limited prompt pay discounts to patients who promptly pay outstanding charges (and thereby reduce collection costs for BH Providers). The discounts are available to all patients regardless of financial status.

**Payment Plans.** BH Providers will work with patients who have outstanding charges to establish a payment plan that permits payment in installments over a specific time period consistent with a patient's financial circumstances.

Patients are advised that physician services (whether or not provided in a hospital setting) are generally not subject to the Health Safety Net or the Hospital Supplemental Financial Assistance Program. Physicians or physician groups may have their own policies for offering discounts or providing free care. BH Providers encourage patients to discuss the availability of discounts or free care directly with their physicians or with a billing representative.

All personnel at BH Providers must comply with this policy. The Patient Accounting Department is responsible for implementation and ensuring on-going compliance and inquiries about the policy should be directed to the department at (413) 794-9999.

### **III. CODE OF CONDUCT**

BH Providers must adhere to a specific code of conduct with respect to patient billing and collection activities. Any agents, including collection agencies, engaged by the providers to assist with collection are expected to adhere to the same guidelines. These guidelines affirm the providers' commitment to treating patients with fairness and respect. The guidelines are as follows:

- Maintain a high standard of fairness, honesty, and courtesy in the conduct of business and avoid any activity which may bring reproach to BH;
- Inform patients of available options for payment or settlement of outstanding charges;

- Apply billing and collection practices uniformly to all patients and do not discriminate on the basis of race, color, national origin, citizenship, alienage, religion, creed, sex, sexual preference, age, or disability;
- Show understanding and offer due consideration for patients' financial problems and assist patients with payment obligations according to the merits of each case individually;
- Make every effort to negotiate reasonable arrangements with patients who request to settle outstanding debts through partial payment;
- Do not seek to collect payment from patients exempt from collection action by law;
- Comply with all state and federal laws governing the collection of debt including, but not limited to, the United States Fair Collection Practices Act and the Massachusetts Debt Collection Regulations;
- Ensure the confidentiality of patient information is appropriately protected and that BH agents and contractors adhere to contractual obligations concerning confidentiality (including any HIPAA Business Associate Agreement);
- Do not add interest to BH accounts (nor threaten to do so);
- Do not seek to garnish wages of a patient or guarantor (nor threaten to do so);
- Do not report nor threaten to report any patient debt to a credit reporting bureau for BH patients;
- Do not take any legal action against a patient related to unpaid debt without the approval of the BH Senior Vice President of Finance or his designee (nor threaten to do so);
- Do not place liens on the personal property (which does not include real estate) or motor vehicle of a patient (nor threaten to do so);
- Do not place liens on any real estate owned by a patient (including the personal residence of the patient) without the approval of the applicable Board of Trustees based on consideration of such factors as the market value of the real estate, the patient's income, assets of the patient (nor threaten to do so);
- Do not seek legal execution against the personal residence or motor vehicle of the patient or guarantor without the express approval of the Board of Trustees of BH which approvals by the Board will be made on an individual basis;
- Do not foreclose on any property of a patient (or otherwise seek legal execution against real property) without the approval of the Board of Trustees of BH (nor threaten to do so); and

- Ensure all agents, contractors or subcontractors are aware of, and agree to abide by, these guidelines.

#### **IV. DELIVERY OF HEALTH CARE SERVICES**

BH Providers evaluate the delivery of health care services for all patients who present for services regardless of their ability to pay. 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 policies and procedures. It is important to note that classification of patients' medical condition is for clinical management 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 medical evaluation of the patient's medical condition reflected in final diagnosis. BH Hospitals also comply with the federal Emergency Medical Treatment and Active Labor Act (EMTALA) by conducting a medical screening examination to determine whether an emergency medical condition exists when required by that law.

Clinical and financial considerations as well as the benefits offered by private insurance or government programs may affect the timing of, or access to, non-emergent or non-urgent health care services (*i.e.*, elective services). Such 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. BH Providers may decline to provide a patient with non-emergent, non-urgent services in those cases when the providers are unable to identify a payment source or eligibility under a Financial Assistance Program. For patients covered by private insurance or government programs, patient choices related to the delivery of, and access to, care are often defined in the insurance plan's or the government program's coverage guidelines.

For those patients who are uninsured or underinsured, BH Providers will work with patients to assist with finding a Financial Assistance Program that may cover some or all of their unpaid hospital bill(s). For those patients with private insurance, BH Providers must work through the patient and the insurer to try to identify what services may be covered under the patient's insurance policy. As BH Providers are often not able to get this information from the insurer in a timely manner, the patient has an obligation to know personally what services will be covered prior to seeking non-emergent and non-urgent services.

##### **A. Emergency and Urgent Care Services**

Any patient who comes to BH Hospitals will be evaluated as to the level of emergency or urgent care services without regard to the patient's identification, insurance coverage, or ability to pay. The evaluation of emergency level or urgent care services as defined below is further used by BH Hospitals for purposes of determining allowable emergency and urgent bad debt coverage under the Health Safety Net Fund.

### **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. § 1295dd(e)(1)(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. Urgent Care Services include:**

Medically Necessary services 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: placing the 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, but prompt medical services are needed.

### **3. EMTALA Level Requirements:**

In accordance with federal requirements, EMTALA is triggered for anyone who comes to the hospital property requesting examination or treatment of an emergency level service (emergency medical condition), or who enters the emergency department requesting examination or treatment for a medical condition. Most commonly, unscheduled persons present themselves at the emergency department. However, 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 to the extent required under EMTALA, will be provided to the patient and will qualify as emergency care. The determination that there is an emergency medical condition is made by the examining physician or other qualified medical personnel of the hospital as documented in the medical record. The determination that there is an urgent or primary medical condition is also made by the examining physician or other qualified medical personnel of the hospital as documented in the medical record.

**B. Non-Emergent, Non-Urgent Services:**

For patient's who either (1) arrive to BH Hospitals seeking non-emergent or non-urgent level care or (2) seek additional care following stabilization of an emergency medical condition, BH Hospitals may provide elective services after consulting with BH Hospitals' clinical staff and reviewing the patient's coverage options. Elective Services: Medically Necessary services that do not meet the definition of Emergency Level Services or Urgent Care Services above. 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, other).

**C. Locations Where Patients May Present:**

All patients are able to seek Emergency Level Services and Urgent Care Services when they come to BH Hospitals emergency departments or designated urgent care areas. However, patients with emergent and urgent conditions may also present in a variety of other locations, including but not limited to Labor and Delivery, ancillary departments, hospital clinics and other areas. BH Hospitals also provide other elective services at the main hospital, clinics and other outpatient locations.

**V. FINANCIAL ASSISTANCE PROGRAMS**

BH Providers' patients may be eligible for free or reduced cost of health care services through various State Programs, Health Safety Net or the Hospital Supplemental Financial Assistance Program based on the patient's financial circumstances. Eligibility for one program may depend on eligibility for another program in addition to other eligibility criteria. Patients may be eligible for assistance through the Hospital Supplemental Financial Assistance Program only to the extent that patients do not qualify for State Programs or the Health Safety Net.

**A. Role of Hospital Patient Financial Counselors and Other Finance Staff**

BH Hospitals will try to identify available coverage options for patients who may be uninsured or underinsured with their current insurance program when the patient is scheduling their services, while the patient is in the hospital, upon discharge, and for a reasonable time following discharge from the hospital. BH Hospitals will direct all patients seeking available coverage options, or those they determine may be eligible, to the hospital's patient financial counseling to screen for eligibility in an appropriate coverage option. BH Hospitals will then assist the patient in applying for the appropriate coverage options that are available or notify them of the availability of financial assistance through the Hospital Supplemental Financial Assistance Program.

BH Hospitals 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 the hospital bill or seeking to dispute certain charges.

**B. State Financial Assistance Programs**

Patients with self-pay obligations may be eligible for financial assistance through participation in Massachusetts and other states' health care programs including: Medicaid, Mass Health, Commonwealth Care, Children's Medical Security Plan, Healthy Start, Common Health, Center Care, Emergency Aid to the Elderly, Disabled and Children. Eligibility criteria vary for each State Program and are determined and applied by the state. Not all health care services provided by BH Hospitals may be covered by such State Programs. BH Hospitals will assist potentially eligible patients with the application process and may offer patients the option of having an agent complete the application and assist with the submission process on their behalf.

**C. Health Safety Net**

Patients who are Massachusetts residents and who receive certain hospital services from BH Hospitals may be eligible for financial assistance through the Health Safety Net. The Health Safety Net has published regulations that include eligibility criteria.

**D. Hospital Supplemental Financial Assistance Program**

BH Providers offer financial assistance to qualifying patients residing in the community served by BH to assist with certain self-pay obligations for medically necessary services not covered by third party payors and for co-payments, deductibles or coinsurance on covered services. The Hospital Supplemental Financial Assistance Program is meant to supplement – and not replace - other coverage for services in order to ensure the financial assistance is provided where most needed. Patients eligible for health coverage through their (or a family member's) employer or State Programs will not be eligible for the Hospital Supplemental Financial Assistance Program. Financial assistance from the Hospital Supplemental Financial Assistance Program cannot be combined with Prompt Payment Discounts.

**1. Hospital Supplemental Financial Assistance Program Eligible Patients**

The Hospital Supplemental Financial Assistance Program is available to certain patients who reside in the BH Hospitals service area.

The following patients residing in the BH community will be considered qualifying patients and will be eligible for this financial assistance to the extent described below:

- (a) Self pay patients with no insurance, that do not qualify for State Programs or Health Safety Net; or
- (b) Patient who qualify for State Programs or Health Safety Net but have received Medically Necessary services prior to effective coverage date or have received Medically Necessary services ineligible for coverage; or

- (c) Patients who qualify for Health Safety Net Partial coverage but seek assistance with a partial deductible; or
- (d) Patients who qualify for Health Safety Net coverage but have received Medically Necessary services ineligible for State Programs, Health Safety Net, other governmental programs or private insurance (including services from BH Providers other than hospitals); or
- (e) Patients who are enrolled in State Programs in which BH Providers are not enrolled as a provider and therefore cannot obtain payment; or
- (f) Patients who are deceased and have no estate will be given individual consideration; or
- (g) Patients who are bankrupt will be given individual consideration; or
- (h) Patients who meet Health Safety Net income criteria for Medical Hardship and have balances (after free care) of \$10,000 or more. Specifically, these patients may (1) be eligible for Medical Hardship assistance under the Health Safety Net but have patient contribution requirements greater than \$10,000 or (2) meet the Medical Hardship income criteria, but be ineligible for Health Safety Net coverage because the services received are not hospital-licensed services. In such circumstances:
  - (i) Financial assistance will be determined after a review of all financial information and circumstances.
  - (ii) Financial assistance will generally reduce an outstanding balance to 15% of annual income absent significant assets.
  - (iii) Financial assistance up to 100% will be considered based on the patient's particular medical and financial circumstances and must be approved by the BH Senior Vice President of Finance or his designee.

## **2. Level of Financial Assistance**

Patients who qualify for the Hospital Supplemental Financial Assistance Program will be eligible for financial assistance to the extent described below.

Financial assistance is available to qualifying patients for outstanding charges for medically necessary services not covered by the State Programs or other third parties based on income levels.

Financial assistance is available to patients for outstanding deductibles, co-payments or co-insurance based on income levels.

**Supplemental Financial Assistance Program**

Income as a percentage of FPIG	BH Financial Assistance for “Non-covered” medically necessary service	BH Financial Assistance for co-pays or deductibles*
0%-200%	100%	100%
201%-400%	Payments due after application of financial assistance will not exceed amounts equal to Medicare rates	0%

\* per inpatient admission or outpatient episode of care

**VI. PROMPT PAYMENT DISCOUNTS**

All patients with account balances in excess of \$500 (other than balances resulting from co-payments or deductibles on insured services) are eligible to receive a prompt pay discount of 20% of the balance for claims paid in full within 60 days of the date of the initial bill. Patients must request the discount. The discount cannot be combined with Hospital Supplemental Financial Assistance Program.

**VII. COLLECTION OF INFORMATION ON PATIENT COVERAGE AND FINANCIAL RESOURCES**

**A. Patient Obligations:**

Prior to the delivery of any health care services (except for cases that require Emergency Level Services or Urgent Care services), the patient is expected to provide timely and accurate information on their insurance status, demographic information, changes to their family income or insurance status, and information on any deductibles or co-payments that are owed based on their existing insurance or financial program’s payment obligations. The detailed information will include:

1. Full name, address, telephone number, date of birth, social security number (if available), current health insurance coverage options, citizenship, residency information, and the patient’s applicable financial resources that may be used to pay their bill;
2. Full name of the patient’s guarantor, their address, telephone number, date of birth, social security number (if available), current health insurance coverage options, and their applicable financial resources that may be used to pay for the patient’s bill; and
3. Other resources that may be used to pay their bill, including other insurance programs, motor vehicle or homeowners insurance policies if the treatment was due to an accident, worker’s compensation programs, and student insurance policies, among others.

It is ultimately the patient's obligation to keep track of and timely pay their unpaid hospital bill, including any existing co-payments and deductibles. The patient is further required to inform either his/her current health insurer (if insured) or the government agency that determined the patient's eligibility status in a government program (if participating) of any changes in family income or insurance status.

Patients are required to notify the state public program (e.g., Office of Medicaid and the Health Safety Net), information related to any lawsuit or insurance claim that will cover the cost of the services provided by BH Hospitals. Patients are required to notify the Health Safety Net Office or MassHealth in writing within 10 days of filing any claim, civil action or other proceeding. A patient is further required to assign the right to a third party payment that will cover the costs of the services paid by the Office of Medicaid or the Health Safety Net.

**B. Hospital Obligations:**

BH Hospitals will make all reasonable and diligent efforts to collect the patient's insurance and other information to verify coverage for the health care services to be provided by BH Hospitals. These efforts may occur when the patient is scheduling their services, during pre-registration, while the patient is admitted in the hospital, upon discharge, or during the collection process which may occur for a reasonable time following discharge from BH Hospitals. This 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). BH Hospitals will delay any attempt to obtain this information during the delivery of any EMTALA level emergency 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.

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

BH Hospitals maintain all information in accordance with applicable federal and state privacy and security laws.

**VIII. 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, BH Providers will work with them to assist with applying for available Financial Assistance Programs that may cover all or some of their unpaid hospital bills. BH Providers provide this assistance for both Massachusetts residents and

other patients; however, there may not be coverage for a Massachusetts hospital's services through an out-of state program. In order for BH Providers to assist uninsured and underinsured patients to find the most appropriate coverage options, patients must actively work with the BH Providers to verify the patient's documented financial status and other information that could be used in determining eligibility.

**B. Hospital Screening and Eligibility Approval Process**

BH Hospitals provide patients with information about the availability of State Programs, Health Safety Net, or the Hospital Supplemental Financial Assistance Program which may cover all or some of their unpaid BH Hospitals bill. For those patients who request such assistance, the hospital assists patients by screening them for eligibility in available State Program and assisting them in applying for such programs. When applicable, BH Hospitals may also assist patients in applying for coverage of services as a Medical Hardship based on the patient's documented income and allowable medical expenses.

It is the patient's obligation to provide BH Hospitals 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 (including residency in Massachusetts or the BH community). 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, BH Hospitals 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, BH Hospitals will use this information to discuss eligibility for certain health insurance programs. If the patient or guarantor is unable to provide the necessary information, BH Hospitals 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 BH Hospitals, upon discharge, or for a reasonable time following discharge from BH Hospitals. Information that BH Hospitals obtain will be maintained in accordance with applicable federal and state privacy and security laws.

The screening and application process for a public health insurance programs is done 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. The Virtual Gateway manages the application process for the programs listed above, which is available for children, adults, seniors, veterans, homeless, and disabled individuals.

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

BH Hospitals specifically assist the patient in completing the Massachusetts Executive Office of Health and Human Services standard 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, and a letter from the employer, tax returns, or bank statements), (2) citizenship and identity, and (3) immigration status for non-citizens (if applicable). BH Hospitals will then submit this documentation to the Massachusetts Office of Medicaid and assist the patient in securing any additional documentation if such is requested by the state after completing the application. Massachusetts places a three day time limitation on submitting all necessary documentation following the submission of the application for a program. Following this three day period, the patient and the provider must work with the MassHealth Enrollment Centers to secure the additional documentation needed for enrollment in the applicable financial assistance program.

All Virtual Gateway applications are reviewed and processed by the Massachusetts Office of Medicaid, which uses the Federal Poverty Guidelines as well as the necessary documentation listed above as the basis for determining 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.

BH Hospitals have no role in the determination of program eligibility made by the state, but at the patient's request may take a direct role in appealing or seeking information related to the coverage decisions. It is still the patient's responsibility to inform BH Hospitals of all coverage decisions made by the state to ensure accurate and timely adjudication of BH Hospitals bills.

If patients are not eligible for State Programs or Health Safety Net services or receive services not covered by such programs, patients may request assistance under the Hospital Supplemental Financial Assistance Program. BH Hospitals will determine eligibility based on the Office of Medicaid determination or, if no determination is possible, completion of a standard application (to be used internally and not submitted to the Office of Medicaid) as well as on any additional information submitted by the patient to demonstrate residency in the BH community.

1. Office of Medicaid Determination. The Office of Medicaid determination may be used if the patient has been determined eligible for partial free care or determined eligible for full free care but the services received by the patient are not eligible for coverage (e.g., services are outside the eligibility period).
2. Separate Application. A separate application completed and submitted to the hospital may be necessary in certain cases (e.g., a non-Massachusetts resident is applying for financial assistance). A Medical Hardship patient will already have completed an application.

**C. Future State or Federal Programs**

As new Financial Assistance Programs are developed by Massachusetts or the federal government, BH Providers will evaluate their availability for patients and also include the new programs in the list of programs that are discussed with patients.

**D. Process for Patients of Other BH Providers**

Patients who do not receive hospital services are not eligible for free care under the Health Safety Net. Patients may, however, request assistance under the Hospital Supplemental Financial Assistance Program for services provided by BH Providers that are not hospital-licensed services. BH Providers may use various methods to determine eligibility for financial assistance by the patient:

- If patient has applied for MassHealth, Commonwealth Care or Health Safety Net in connection with hospital services, request a copy of any application submitted to the Office of Medicaid or the determination letter received by the patient.
- If patient has not applied for MassHealth, Commonwealth Care or Health Safety Net in connection with hospital services, submit an application (if permitted by the state) or request completion of a standard application (to be used internally but not submitted to Office of Medicaid).
- Other BH Providers may rely on current determinations of a patient's financial condition that are made by a BH Provider in accordance with this policy.

**IX. ELIGIBILITY PERIOD**

**A. Health Safety Net**

The determination that a patient is eligible under the Health Safety Net will be effective for the specific period set forth in the Health Safety Net regulations.

**B. Hospital Supplemental Financial Assistance**

If a patient is determined to be eligible for financial assistance under the Hospital Supplemental Financial Assistance Program, the determination will apply to all outstanding balances due BH Providers (including accounts referred to collection agencies) for Medically Necessary services covered by the financial assistance.

The determination that a patient is eligible for financial assistance under the Hospital Supplemental Financial Assistance Program will be effective for one year from the date of determination, unless over the course of that year the patient's family income or insurance status changes to such an extent that the patient becomes ineligible. Patients will be expected to update their financial information in the event of a change.

## **X. PATIENT NOTICE OF AVAILABILITY OF FINANCIAL ASSISTANCE**

### **A. General Principles**

BH Providers are committed to ensuring that patients or prospective patients in the community are aware of the availability of Financial Assistance Programs. A copy of this credit and collection policy is posted on the BH website.

BH Hospitals provide additional notices. For those patients that are uninsured or underinsured, BH Hospitals 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 to find 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 that are posted throughout the hospital.

The goal of these notices is to assist patients in applying for coverage within a Financial Assistance Program, such as MassHealth, Commonwealth Care, Children's Medical Security Plan, Healthy Start, and Health Safety Net. When applicable, BH Hospitals may also assist patients in applying for coverage of services as a Medical Hardship based on the patient's documented income and allowable medical expenses. BH Hospitals will provide, upon request, specific information about the eligibility process to be a Low Income Patient under either the Massachusetts Health Safety Net Program or additional assistance for patients who are low income through BH Hospitals' own internal financial assistance program. BH Hospitals will also notify the patient about available payment plans that may be available to them based on their family size and income.

### **B. Signs**

Signs will notify patients of the availability of Financial Assistance Programs.

Signs at Baystate Medical Center will be translated into Spanish, because Spanish is primarily spoken by 10% or more of the residents in the hospital's service area.

Signs will be large enough to be clearly visible and legible by patients in the hospital's service area. The signs at Baystate Franklin Medical Center and Baystate Mary Lane Hospital are 8 ½ x 11 inches and the Header print font is 32pts. Baystate Medical Center's sign is 8 ½ x 11 inches and the header print font is 24pts. See Exhibit 1.

### **C. Location of Signs**

Notice of availability of Financial Assistance Programs are posted in the following locations:

- Inpatient, clinic, emergency department admissions and/or registration areas

- Central admission/registration area
- Patient financial counselor areas
- Business office areas that are open to patients

**D. Notification Practices**

1. BH Providers will provide individual notice of the availability of Financial Assistance Programs to a patient expected to incur charges, exclusive of personal convenience item or services that may not be paid in full by third party coverage.
2. BH Providers will include a notice about the availability of financial assistance in all initial bills.
3. BH Providers will include a brief notice about the availability of financial assistance in all written collection actions.
4. All notices about the availability of financial assistance will be translated into Spanish at Baystate Medical Center.
5. BH Providers will notify patients that the providers offer a payment plan if the patient is determined to be eligible for a Financial Assistance Program.
6. BH Providers will provide notice of determinations under the Hospital Supplemental Financial Assistance Program within forty-five (45) days of receipt of all necessary information and documentation.

**XI. COLLECTION PROCESS**

**A. General**

BH Providers use the same reasonable efforts and follow the same reasonable process for collecting amounts due for services provided all patients, including insured, underinsured or uninsured patients. (Collection will not, however, be pursued against patients who fall within populations exempt from collection action by law.)

BH Providers will identify any current unpaid patient balance that is related to services provided to the patient and not covered by a private insurer, government program or other Financial Assistance Program (including the Hospital Supplemental Financial Assistance Program).

BH Providers will undertake a continuous collection process from the date of service to collection, a determination of uncollectibility or determination of eligibility for financial assistance. The collection process may include the use of deposits, the implementation of payment plans or discretionary settlements. The collection process may involve the use

of outside collection agencies. The collection process is documented in the patient's files of the hospital and its business associates.

BH Hospitals will also make reasonable and diligent 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, among others. In accordance with applicable state regulations or the insurance contract, for any claim where BH Hospitals' reasonable and diligent efforts resulted in a recovery on the health care claim billed to a private insurer or public program, BH Hospitals will report the recovery and offset it against the claim paid by the private insurer or public program. If BH Hospitals have prior knowledge and are legally able, they will attempt to secure assignment on a patient's right to a third party coverage on services provided due to an accident.

BH Hospitals maintain 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 Event (SRE). SREs that do not occur at a BH Hospital are excluded from this determination of non-payment. BH Hospitals also do 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. BH Hospitals further maintain all information in accordance with applicable federal and state privacy, security and ID theft laws.

## **B. Collection Notices**

### **1. Initial Notice (Exhibit 2)**

- (a) Patients without third party coverage will normally receive a bill for services within one month of discharge as an inpatient or treatment as an outpatient (excluding recurring visits). 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.

If third party coverage exists, patients will be advised of the balance due following third party payment or denial.

Payment is expected for any amounts known to be non-covered (by insurance).

- (b) Recurring visit patients without third party coverage will normally receive a bill for services posted for the prior month within one month.

Recurring visit patients with third party coverage will be advised of the balance due following third party payment or denial.

Payment is expected for any amounts known to be non-covered (by insurance).

## **2. Subsequent Notices**

- (a) Small balances under \$20.00 will be written off as Small Balance Bad Debt. These amounts are not eligible for submission to the Health Safety Net.
- (b) For balances \$20.00 - \$49.99, patients will receive minimum of four (4) notices and the collection process will extend a minimum of 120 days (with exception of mail returns that may be shorter than 120 days) from discharge.
- (c) For balances \$50.00 and over the account may be referred to outside collection agencies after at least four (4) notices and 120 days.
- (d) This process may be supplemented by other notification methods that constitute a genuine effort to contact the party responsible for the obligation, including, for example, telephone calls, collection letters, personal contact notices, and computer notifications.
- (e) 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.”
- (f) For statements that have been returned as undeliverable, reasonable efforts will be made to determine an accurate mailing address using internal and external tools and resources. These efforts will be documented on each patient account. The detailed policy is available within Patient Accounting Policy #PA-5 Returned Mail Processing.
- (g) 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.

## **C. Documentation of Collection Effort**

Patient financial records will be maintained by BH Providers as required by applicable law and in accordance with BH Providers’ policies. These records will include claims for

eligible services to Low Income Patients, emergency bad debt services and Medical Hardship services.

Documentation will support continuous billing or collection action undertaken on a regular, frequent basis. The patient's file will include all documentation of the hospital's collection effort including the bills, codes and letter templates, reports of telephone and personal contact, and any other efforts made. Such documentation is maintained until audit review by a federal and/or state agency of the fiscal year cost report in which the bill or account is reported or longer if required by law or internal policy.

**D. Populations Exempt from Collection Activities**

1. Patients who are enrolled in a public health insurance program including but not limited to, MassHealth, Emergency Aid to the Elderly, Disabled and Children program, Healthy Start program, Children's Medical Security Plan and Low Income Patients as determined by the Office of Medicaid are exempt from billing or collection action after the initial bill pursuant to state regulations subject to the following exceptions:
  - (a) BH Providers 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.
  - (b) BH Providers may initiate billing or collection for a patient who alleges that he or she is a participant in a State Program that covers the costs of the services, but fails to provide proof of such participation. Upon receipt of satisfactory proof that a patient is a participant in a State Program, (including receipt or verification of signed application), BH Providers shall cease their billing or collection activities.
  - (c) BH Providers may continue collection action on any Low Income Patient for services rendered prior to the Low Income Patient determination, provided that the current Low Income Patient status has been terminated or expired or not otherwise identified on the state Virtual Gateway or Eligibility Verification System. However, once a patient is determined eligible and enrolled in the Health Safety Net, MassHealth, or certain Commonwealth Care programs, BH Providers will cease collection activity for services provided prior to the beginning of their eligibility.
  - (d) BH Providers 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 BH Providers obtained the patient's prior written consent to be billed for the service.
  - (e) BH Providers 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. The hospital will further cease any collection efforts against an emergency bad debt claim that is approved for Medical Hardship under the Health Safety Net program.

2. Under the Hospital Supplemental Financial Assistance Program, BH Providers may cease any collection or billing actions against a patient who is unable to pay a bill at any time during the billing process. BH Providers will keep any and all documentation that shows that the patient met the Hospital Supplemental Financial Assistance Program.
3. BH Providers and their agents shall not continue collection or billing on a patient who is a member of a bankruptcy proceeding except to secure its rights as a creditor in the appropriate order.
4. BH Providers and their agents will not charge interest on a Low Income Patient's overdue balance.

**E. Deposits and Payment Plans**

1. Patients or their responsible parties are expected to pay their full liability for services rendered within thirty (30) days of receipt of their first bill or in accordance with a mutually agreed upon installment payment plan. See Exhibits 4 and 5 for notices.
2. BH Providers will, to the extent permitted by law, require "pre-admission" or "pre-treatment" deposits equal to 50% of the estimated charges for the services to be provided if the services are: (1) not covered by insurance; (2) elective services (i.e., not Emergency Level Services or Urgent Care Services; and (3) provided to patient other than Low Income Patients. BH Providers may require "pre-admission" or "pre-treatment" deposits for other services to the extent permitted by law.
3. BH Providers may request a deposit from individuals determined to be Low Income Patients. Such deposits will be limited to 20% of the deductible amount up to \$500.
4. BH Providers 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. BH Providers, at a minimum, will offer the following installment plans but may, based on the circumstances, permit repayment with a longer period:

- (a) A patient with a balance of \$1,000 or less, after initial deposit, will be offered a one-year interest free payment plan with a recommended monthly payment of \$25.
- (b) A patient with a balance greater than \$1,000, after initial deposit, will be offered a two-year interest free payment plan.

**F. Discretionary Settlements**

BH Providers may settle outstanding accounts based upon extenuating circumstances.

**G. Outside Collection Agencies**

BH Providers contract 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. BH Providers may assign, however, such debt as bad debt or charity care (otherwise deemed as uncollectible) prior to 120 days if BH Providers are able to determine that the patient was unable to pay under the Hospital Supplemental Financial Assistance Program.

BH Providers have a specific authorization or contract with the outside collection agency and require such agencies to abide by the BH Provider's credit and collection policies for those debts that the agency is pursuing. All outside collection agencies hired by BH Providers will provide the patient with an opportunity to file a grievance and will forward to the hospital the results of such patient grievances. BH Providers require that any outside collection agency that they use is licensed by the Commonwealth of Massachusetts and that the outside collection agency complies with the Massachusetts Attorney General's Debt Collection Regulations at 940 C.M.R. 7.00.

**XII. 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 programs.

**Low Income Patient.** A patient meets the financial criteria for free or partial care under the Health Safety Net based on their income and assets.

**Massachusetts Resident.** A person living in Massachusetts with the intention to remain permanently or for an indefinite period. A Massachusetts 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 Massachusetts residence.

**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.

**Non-Covered Services.** Non-medical services, such as social, educational, and vocational services; cosmetic surgery; canceled or missed appointments; telephone conversations or consultations; court testimony; research or the provision of experimental, unproven, or otherwise medically unnecessary procedures or treatments, specifically including, but not limited to, sex-reassignment surgery, thyroid cartilage reduction and any other related surgeries and treatments, including pre- and post-sex-reassignment surgery hormone therapy; the provision of whole blood except for the administrative and processing costs associate with the provision of blood and its derivatives; the treatment of male or female infertility (including, but not limited to, laboratory tests, drugs, and procedures associated with such treatment); vocational rehabilitation services; sheltered workshops; recreational services; life-enrichment services; alcohol or drug drop-in centers; drugs used for the treatment of obesity; cough and cold preparations; hormone therapy related to sex-reassignment surgery; drugs related to the treatment of male or female infertility; absorptive lenses of greater than 25 percent absorption; photochromatic lenses, sunglasses, or fashion tints; treatment of congenital dyslexia; extended-wear contact lenses, invisible bi-focals; and the Welsh 4-Drop Lens.

**Primary Care.** 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, for purposes of prevention, diagnosis, or treatment of acute or chronic disease or injury, but excludes ancillary services and maternity care services.

**Resident.** A person living in an area (such as a state, city or county) with the intention to remain permanently or for an indefinite period. A resident is not required to maintain a fixed address. Enrollment in an institution of higher learning or confinement in a medical institution, other than a nursing facility, is not sufficient to establish residence.

**State Programs.** Health care programs operated and/or funded by a state that pay for health care for certain low-income people. The programs include Medicaid (for patients eligible for Medicaid in other states), MassHealth, Commonwealth Care, Children's Medical Security Plan, Healthy Start, Common Health and Emergency Aid to the Elderly, Disabled and Children.

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Effective: April 12, 2011

### **XIII. EXHIBITS**

1. Financial Assistance Posted Sign
2. Collection Letter and Statements
3. Final Notice
4. Installment Payments
5. Final Notice - Payment Plan