



# **South Shore Hospital**

55 Fogg Road  
South Weymouth, MA 02190

## ***Hospital Credit, Collection & Financial Assistance Policy***

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## **I. INTRODUCTION**

South Shore Hospital, Inc. (“SSH” or the “Hospital”) exists to benefit the people of our region by promoting good health, healing, caring and comforting. SSH is proud of its not-for-profit public mission to provide quality care to all in need 24 hours a day, 365 days a year. SSH seeks ways of fulfilling our moral, ethical, and legal obligations to ensure that everyone gets the care they need regardless of ability to pay. To successfully provide this assistance, SSH asks patients to actively participate in their healthcare.

SSH is a frontline caregiver providing medically necessary care for all people regardless of ability to pay. SSH offers this care for **all** patients that come into our facility.

SSH assists patients in obtaining financial assistance from public programs and other sources, including South Shore Hospital’s Financial Assistance Program whenever appropriate. To remain viable as it fulfills its mission, SSH must meet its fiduciary responsibility to appropriately bill and collect for medical services provided to patients. This Credit, Collection and Financial Assistance Policy is designed to comply with state and federal law and regulations.

SSH’s Credit, Collection and Financial Assistance Policy (“CC&FAP”) is concerned with preserving assets and maintaining a sound financial basis for operations while balancing the needs of our community and the patients that we serve. The CC&FAP is intended to provide management with general guidelines for classifying patients according to their ability to pay, and for acquiring and verifying information and collecting payment from patients, their guarantors, third party insurance companies, and others financially responsible for payment of health care services. This CC&FAP applies to Emergent, Urgent, and Primary care services provided by the Hospital at its main campus and all satellite and inpatient clinics listed on the Hospital’s license (see Exhibit I, South Shore Hospital Facility locations). Non-Hospital employed physicians practicing at the Hospital’s main campus, satellite, and inpatient clinics, but who bill for their own services are encouraged, but not required, to follow this policy. A list of providers/groups, other than the Hospital facility itself, delivering emergency, urgent or medically necessary care at SSH, including the SSH facility locations listed in Exhibit I, is available on the South Shore Hospital website <http://www.southshorehospital.org/financial-counselingassistance> and a paper copy of the list is available upon request from a SSH Financial Counselor. The list indicates which providers/groups follow SSH’s Credit, Collection and Financial Assistance Policy.

The Hospital’s policy is intended to comply with state and federal law and regulations in performing the functions outlined in the policy. SSH updates its CC&FAP whenever there are significant changes in state and federal regulations and will present those changes to its Board of Directors or to an entity/individual authorized by the Board to review/approve the CC&FAP policy. When future coverage options are developed, as a result of federal and state healthcare reform proposals, the Hospital will make appropriate changes to this credit, collection and financial assistance policy.

The Hospital shall not discriminate on the basis of race, color, national origin, religion, sex, identity, sexual orientation, age, or disability in providing its services. This applies to the substance and application of Hospital policies concerning the acquisition and verification of

financial information, pre-admission or pre-treatment deposits, payment plans, deferred or rejected admissions, Low Income Patient Status determinations, and billing and collection practices.

This policy was developed to ensure compliance with the Massachusetts Health Safety Net Eligible Services Regulation (101 CMR 613.000) and to meet the IRS regulations (Internal Revenue Code Section 501(r)) which are effective with the Hospital's taxable year beginning after December 29, 2015.

This Credit, Collection and Financial Assistance Policy is in compliance with applicable criteria required under (1) the Health Safety Net Eligibility Regulation (101 CMR 613.00), (2) the Centers for Medicare and Medicaid Services Medicare Bad Debt Requirements (42 CFR 413.89), and (3) The Medicare Provider Reimbursement Manual (Part 1, Chapter 3). The information contained and referenced in this policy applies solely to Hospital based services provided at SSH or at any facility that is part of the Hospital's license or tax ID number. It does not extend to affiliates or other physician practice groups that may routinely do business with SSH.

#### **A. Definitions**

Meaning of Terms. As used in 101 CMR 613.00, unless the context otherwise requires, the following terms shall have the following meanings and be used as a reference point for this policy and the requirements thereof.

Administrative Day

A day of inpatient hospitalization on which a patient's care needs can be provided in a setting other than an acute inpatient hospital in accordance with the standards in 130 CMR 415.000 and on which a patient is clinically ready for discharge.

Ancillary Services

Non-routine services for which charges are customarily made in addition to routine charges, that include, but are not limited to, laboratory, diagnostic, and therapeutic radiology services, surgical services and physical, occupational, and speech and language therapy. Generally ancillary services are billed as separate items when the patient receives these services.

Bad Debt

An account receivable based on services furnished to a patient that: (a) is regarded as uncollectable, following reasonable collection efforts, consistent with 101 CMR 613 and the Hospital's established Credit, Collection and Financial Assistance Policy; (b) is charged as a credit loss; (c) is not the obligation of a governmental unit or the federal or state government or any agency thereof; (d) is not a Reimbursable Health Care Service and (e) is not a Low Income Patient as defined in this Policy.

Charge

The uniform price set for a specific service charged by a Provider.

<u>Collection Action</u>	Any activity by which a Provider or designated agent requests payment for services from a patient, a patient's guarantor or a third party responsible for payment. Collection Actions include activities such as pre-admission or pre-treatment deposits, billing statements, collection follow-up letters, telephone contacts, personal contacts, and activities of collection agencies and attorneys.
<u>Confidential Services</u>	Services for the treatment of sexually transmitted diseases provided under M.G.L. c. 112, §12F and family planning services provided under M.G.L. C. 111, §24E.
<u>Credit, Collection and Financial Assistance Policy</u>	A policy statement in compliance with 101 CMR 613.00 and IRS Code 501(r) , outlining the Hospital's billing, collections and financial assistance principles that guides its billing, collections and financial assistance practices and procedures.
<u>Countable Income</u>	Income as defined in 101 CMR 613.05(1)(b).
<u>Elective Services</u>	Medically necessary services that do not meet the definition of emergency or urgent. 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).
<u>Eligible Services</u>	Services eligible for Health Safety Net payment pursuant to 101 CMR 613.03 Eligible Services include: <ol style="list-style-type: none"><li>1. Reimbursable Health Services to Low Income Patients;</li><li>2. Medical Hardship; and</li><li>3. Bad Debts as further specified in 101 CMR 613.00 and 614.00. <i>Health Safety Net Payments and Funding.</i></li></ol>
<u>Emergency Aid to the Elderly, Disabled and Children (EAEDC)</u>	A program of governmental benefits under M.G.L. c. 117A.
<u>Emergency Bad Debt</u>	The amount of uncollectible debt for emergency services that meets the criteria set forth in 114.6 CMR 13.05.
<u>EVS</u>	The MassHealth Eligibility Verification System.
<u>Emergency Medical Condition</u>	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 pregnant woman, as further defined in 42 U.S.C. § 1395 dd(e)(1)(B).

EMTALA

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

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 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.

Federal Poverty Limit (FPL)

The federal poverty income guidelines issued annually in the Federal Register.

Hospital

An acute hospital licensed under M.G.L. c. 111, §51 that contains a majority of medical-surgical, pediatric, obstetric, and maternity beds as defined by the Department of Public Health.

Hospital Services

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

Hospital Visit

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

<u>Low Income Patients</u>	An individual who meets the criteria under 101 CMR 613.04(1).
<u>MassHealth MAGI Household</u>	A household as defined in 130CMR 506.002(B): <i>MassHealth MAGI Household Composition</i> .
<u>Medically Necessary Care or Service</u>	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 disability, or result in illness or infirmity. Medically Necessary Care or Services shall include inpatient and outpatient services as authorized under Title XIX of the Federal Social Security Act.
<u>Primary or Elective Care</u>	Medical care required by individuals or families that is appropriate for the maintenance of health and the prevention of illness. Primary care consists of health care services customarily provided by general practitioners, family practitioners, general internists, general pediatricians, and primary care nurse practitioners or physician assistants. Primary Care does not require the specialized resources of a hospital emergency department and excludes Ancillary Services and maternity care services.
<u>Provider</u>	A Hospital or Community Health Center that provides Eligible Services.
<u>Reimbursable Health Services</u>	Eligible Services provided to uninsured and underinsured patients who are determined to be financially unable to pay for their care, in whole or in part, and who meet the criteria for Low Income Patient status; provided that such services shall not be eligible for reimbursement by any other public or third party payer.
<u>Resident</u>	<p>A person living in the Commonwealth of Massachusetts with the intention to remain as defined by 130CMR 503.002(A) through (D). Persons who are not considered residents are:</p> <ol style="list-style-type: none"><li>1. Individuals who came to Massachusetts for the purpose of receiving medical care in a setting other than a nursing facility, and who maintain a residence outside of Massachusetts;</li><li>2. Persons whose whereabouts are unknown; or</li><li>3. Inmates of penal institutions except in the following circumstances;<ol style="list-style-type: none"><li>a. They are inpatients of a medical facility; or</li></ol></li></ol>



- b. They are living outside of the penal institution, are on parole, probation, or home release, and are not returning to the institution for overnight stays.

<u>Satellite Clinic</u>	A facility that operates under an acute Hospital's license, is subject to the fiscal, administrative and clinical management of the acute Hospital, provides services solely on an outpatient basis, is not located at the same site as the acute Hospital's inpatient facility, and has CMS Provider-based status in accordance with 42 CFR 413.65.
<u>Third Party</u>	Any individual, entity or program that is or may be responsible to pay all or part of the cost for medical services.
<u>Underinsured Patient</u>	A patient whose health insurance plan or self-insurance plan does not pay, in whole or in part, for health services that are eligible for payment from the Health Safety Net, provided that the patient meets income eligibility standards set forth in 101 CMR 613.04.
<u>Uninsured Patient</u>	A patient who is a resident of the Commonwealth, who is not covered by a health insurance plan or a self-insurance plan and is not eligible for a medical assistance program. A patient who has a policy of health insurance or is a member of a health insurance or benefit program which requires such patient to make payment of deductibles, or co-payments, or fails to cover certain medical services or procedures is not uninsured.
<u>Urgent Care Services</u>	Medically Necessary Care or 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 patients' 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.

## **B. General Principles**

Fear of a hospital bill should never get in the way of patients receiving essential health services. Hospital personnel should develop and communicate messages to patients regarding their ability to access medically necessary care and the availability of financial assistance.

Financial assistance is intended to assist low-income patients who do not otherwise have the ability to pay for their healthcare services.

The Hospital's financial assistance policies set forth herein are consistent with its charitable mission and values and take into account each individual's ability to contribute to the cost of his or her care and the Hospital's ability to provide this care.

These policies should be communicated in a clear and easy to understand manner.

Financial assistance policies do not eliminate personal responsibility. Patients may or may not qualify for financial assistance from public programs, so they may be expected to contribute to the cost of their care based on their individual ability to pay. In addition, it is the patient's responsibility to provide the Hospital with the necessary financial and personal documentation that is required in determining eligibility for applicable financial assistance programs.

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

### **A. Care for Emergency Medical Conditions**

SSH will provide, without exception, care for emergency medical conditions to all individuals seeking such care, regardless of 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's 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). The Hospital will not engage in actions that discourage individuals from seeking emergency medical care, such as demanding that patients pay before receiving treatment for emergency medical conditions, or interfering with the screening for and providing of emergency medical care by first discussing the Hospital's financial assistance program or eligibility for public assistance programs.

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 with the individual and 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 bodily function or serious dysfunction of any bodily organ or part or, with respect to a pregnant woman, as further defined in 42 U.S.C. § 1395 dd (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 U.S. C. §1395dd 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 the 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. Elective or scheduled services are either primary care services or medical procedures scheduled in advance by the individual or by the health care provider (hospital, physician office, other).

**B. Documenting Eligibility for Enrollment in a Massachusetts Public Assistance Program and/or SSH's Financial Assistance Program**

**1. 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 the Hospital to verify family income, other insurance coverage, and any other information that could be used in determining eligibility.

## **2. Enrollment in a Public Assistance Program**

Hospitals have no role in specifically determining the eligibility for enrollment with a public assistance program. In Massachusetts, individuals applying 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.

### **3. 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 this individual's financial and other demographic information to a federal data site as well as conducting 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 the MAHealthConnector website or by 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, and (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).

**C. Assisting Individuals Seeking Coverage Through a Massachusetts Public Assistance Program and/or SSH 's Financial Assistance Program**

**1. 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, the premium assistance payment program offered through the Health Connector (including ConnectorCare), Health Safety Net, the Children's Medical Security Program, Medical Hardship and South Shore Hospital's (SSH) Financial Assistance Program.

**2. 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 train personnel in the eligibility and benefit rules and regulations and be certified as Certified Application Counselors (CAC) to assist individuals with enrollment in MassHealth, premium assistance payment program offered by the Health Connector (including ConnectorCare), Health Safety Net, the Children's Medical Security Program, Medical Hardship and SSH's Financial Assistance Program. Certified Application Counselors (CAC) 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 in finding 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, Medical Hardship and SSH's Financial Assistance Program;

- 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; and
- g. offer and provide voter registration assistance.

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.

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 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 (5) 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. 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 homeowner's liability policy, (2) general accident or personal injury protection policies, (3) workers' compensation programs, or (4) student insurance policies, among others. 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.

### **Notification Practices**

The Hospital will post a notice (signs) of availability of financial assistance as outlined in this Credit, Collection and Financial Assistance policy in the following locations:

1. Service Delivery Areas (e.g., Inpatient, Emergency, and Outpatient, areas);
2. Certified Application Counselor offices;
3. Admission/Registration areas; and
4. Financial office 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.

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 SSH 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 from the Hospital's financial assistance program based on the individual's documented income and allowable medical expenses.

### **III. COLLECTING PATIENT INFORMATION ON HEALTH COVERAGE AND FINANCIAL RESOURCES**

#### **A. General**

The Hospital will work with patients to advise them of their duty to provide the Hospital with accurate information regarding health insurance (including primary and secondary carriers), address, and applicable financial resources to determine whether the patient is eligible for coverage through private insurance or through available public assistance programs. SSH informs patients of their duty to work cooperatively with Hospital personnel on these items to facilitate the consistent application of its policies.

In most cases, the Scheduling Department, Patient Access Department or other Hospital designee will obtain and verify the financial information necessary to determine the responsibility for payment of the Hospital bill from the patient or guarantor at the time the patient service is scheduled, or at the time of patient registration.

Financial information for emergency visits and outpatient visits will only be verified if SSH has an electronic solution that allows verification. The Hospital will delay any attempt to obtain this information during the delivery of any EMTALA 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. If the patient or guarantor is unable to provide the information needed, and the patient consents, the Hospital will make reasonable efforts to contact relatives and friends for additional information while the patient is in the Hospital and at the time of the patient's discharge. All information gathered pursuant to this policy will be treated confidentially in accordance with applicable federal and state privacy laws.

The Hospital will make reasonable and diligent efforts, including following billing and authorization rules, and as appropriate, appealing any denied claim when the service is payable in whole or in part by known third party insurance, to investigate whether a third party resource may be responsible for the services provided, such as : (1) a motor vehicle or home owners liability policy, (2) general accident or personal injury protection policies, (3) workers' compensation programs, or (4) student insurance policies, among others. In accordance with applicable state regulations or the insurance contract, for any claim where the Hospital's reasonable and diligent efforts resulted in a recovery on the health care claim billed to a private insurer or public program, the Hospital will report the recovery and offset it against the claim paid by the private insurer or public program. If the Hospital has prior knowledge and is legally able, it will attempt to secure assignment on a patient's right to a third party coverage on services provided.

While the Hospital will generally complete insurance verification and other requirements as set forth by individual third party payers, the patient has the ultimate responsibility in understanding their specific insurance benefits and requirements and needs to remain actively involved in notifying or obtaining the proper prior authorization(s) and referral(s) or other requirements of the health insurance source as required by the patient's policy



of insurance. SSH uses industry-wide and generally acceptable means of insurance verification via electronic media and web based applications such as Passport.

Outlined below are specific instructions by major type of service provided at the Hospital.

**B. Pre-Admission Activity for Elective Services Including Inpatient Surgery and Surgical Day Care Procedures**

1. On elective admissions, a valid payment source must be identified and in place before the booking is complete. Self-pay patients must show a payment source before the booking is done. This may be facilitated by working with a Financial Counselor and/or a patient accounts representative who will help the patient seek alternative funding sources, advise the patient of available programs, explain SSH policies, or set up a payment plan as appropriate. In the event that appropriate payment options have not been identified, SSH reserves the right to defer the service to a later time so long as such deferral does not jeopardize the patient's health. This includes services determined to be cosmetic in nature or not medically necessary.
2. Upon receipt of an advance booking, the Scheduling or Patient Access Department will review the insurance information provided and complete the pre-certification process. A follow-up call is placed to the patient as needed when information is missing or inaccurate.
3. SSH will verify insurance for most major payers' public assistance programs insurance, preferred provider organizations, and health maintenance organizations and will obtain, whenever possible, the prior authorization and/or second opinion requirements as dictated by the third party payer. SSH utilizes tools such as Passport software to help facilitate the identification, confirmation, and eligibility status of the information provided by the patient.
4. Workers' compensation patients are requested to provide evidence of prior approval from their employer's worker's compensation insurer or self-insurer or the utilization review agent. If available, full disclosure is requested regarding accident or injury date, utilization review agent, insurance carrier, claim number, status of claim, and attorney.
5. Non-standard third party plans and foreign insurance will be addressed on a case-by-case basis with the expectation that requirements are met and in place prior to the booking of the elective service.
6. Elective cosmetic surgery patients must either pay the estimated charges for the requested surgery or provide proof of third party coverage in effect prior to admission. The definition used to determine this type of admission can be found in the Medicare Benefit Policy Manual Ch. 16, Sect. 120. *"Cosmetic surgery includes any surgical procedure directed at improving appearance, except when required for the prompt (i.e., as soon as medically feasible) repair of accidental injury or for*

*improvement of functioning of malformed body member.”* Due to the requirement of medical necessity, the free care or Uncompensated Care Program does not apply to elective cosmetic surgery.

### **C. Preparation of Estimates**

In accordance with Massachusetts Chapter 224 of the Acts of 2012, the Hospital’s Patient Access/Financial Counseling staff or other Hospital designee is responsible for providing all estimates to patients upon request. They are also responsible for collecting appropriate payments prior to the date of service for those patients considered self-pay.

The estimate information is gathered and then calculated using internal inpatient and outpatient estimate calculators. These internal estimate calculators will be updated once a year.

SSH has 2 business days from the date of request to finalize the estimate and respond to the patient. The final estimate is provided to the patient, along with an acknowledgement letter, and payment options. For those patients without insurance, the patient is required to pay the estimate or a deposit prior to the date of service. If the patient indicates he/she cannot pay the estimate, Financial Counseling will evaluate the patient’s financial status and assist the patient in applying for public health benefits such as Medicaid.

### **D. Emergency and Urgent Inpatient Admissions or Observation Services**

1. The Hospital shall obtain the financial information necessary to determine responsibility for payment of the bill from the patient or guarantor.
2. Upon admission, a Hospital Representative will obtain from the patient, guarantor or family member, with the patient’s permission, demographic and insurance information including specific details as to the types of insurance coverage available.
3. A Hospital representative will perform third party eligibility verification and insurance notifications, if necessary. As outlined in Section III B, this will vary depending on the type of insurance. SSH will use electronic verification means whenever possible. This includes the use of Passport to complete verifications and individual payer websites (i.e., HPCconnect for Harvard Pilgrim Healthcare patients).
4. Financial Counselors will be available or may seek to speak with the patient or family member once they are medically stable and it is appropriate to do so to complete the financial and insurance review process.
5. If a patient does not have insurance, a Financial Counselor will be notified. The patient or guarantor will be given a patient notice – *“Availability of Financial Assistance”* information sheet. This information sheet will help communicate the options available to the patient and how to access further assistance through SSH.

6. For these patient classifications, SSH may attempt to contact the patient's employer to see if patients are covered by insurance as a consequence of employment. This will be done only if other avenues have not identified an appropriate payment source.

**E. During Hospitalization**

1. The Hospital will make reasonable efforts to verify the information supplied by the patient early on in the admission process and prior to the patient discharge. Many third party payers require that the information be verified and that they are notified prior to or at the time the admission occurs, or within a defined period of time. For scheduled and planned admissions, the Hospital prefers to complete this verification prior to the actual hospitalization, or at minimum as early on in the inpatient hospitalization process as possible, so as to avoid any delay in approval or payment from a third party payer. The verification process may, however, occur at any time during the provision of services or at the time of patient discharge as necessary and will be amended during the collection process as necessary.
2. The Hospital will review and verify all insurance information, including foreign health insurance coverage and foreign government health care plans for foreign residents and motor vehicle coverage for victims of automobile accidents. The Hospital will request that patients who are foreign residents provide the name and address of any foreign health plan, and/or the name and address of the appropriate consulate. For patients who are automobile accident victims, the Hospital requests they provide the name and address of the applicable automobile insurance carrier and other accident related information if needed. SSH also requires that these patients assign such benefits to the Hospital for direct payment.
3. A Financial Counselor will discuss insurance information and financial arrangements with the patient as appropriate or with a family member, and will evaluate the patient's ability to pay. The Hospital or its agent will assist patients in applying for MassHealth and other state sponsored health insurance and uncompensated care programs. Patients may be interviewed with prior approval from clinical personnel, or at the patient's request.
4. Automobile accident cases will be identified and details of the accident obtained from the police department if needed. Claims for payment will be submitted to the appropriate automobile insurance carriers and where appropriate Hospital liens will be filed with motor vehicle liability insurers (and in other types of accident cases). The liens are not filed against an individual's personal assets. These liens only relate to payment from motor vehicle liability insurers and are done to help ensure that the Hospital receives appropriate payment from the third party payers involved. A Hospital representative will provide forms to automobile accident/workers' compensation patients in order to obtain complete automobile and health insurance information, adhering to the regulations pertaining to the individual insurance. For patients also eligible for MassHealth or uncompensated care, the Hospital will investigate, document and submit to the automobile insurer in accordance with the requirements of 101 CMR 613.00.

5. Hospital liens may be placed on automobile, accident and other third party liability cases by the Hospital or its agent, with the exception of MassHealth patients, for which the Hospital also has the option of billing MassHealth.
6. In instances where the patient states workers' compensation is responsible for covering the service but where the name of the carrier is unknown, the Hospital will attempt to contact employers and request their workers' compensation insurance information.
7. The Hospital reserves the right to utilize outside agencies to help obtain information, verify eligibility for MassHealth, Health Safety Net or commercial health plans, or pursue claims for services related to workers' compensation or automobile cases.

**F. At Discharge**

1. All insurance verifications should be completed prior to discharge where possible.
2. The Financial Counselor may seek to establish payment options with the self-pay patient prior to or at the time of discharge. Hospital personnel should strongly encourage patients to see or make an appointment with the Financial Counselor at or shortly after discharge to ensure appropriate information is in place.
3. Payment or budget arrangements can be established in accordance with SSH payment and budget criteria and will also follow the guidelines set by 101 CMR 613.08(1).

**G. Outpatient Service**

1. The Hospital shall make reasonable efforts to verify patient supplied information when services are scheduled or at the time the patient receives services. This includes use of such things as Passport and/or proof of identification. This will be monitored or adjusted during the collection process if new information becomes available.
2. Registration staff will obtain all demographic and insurance information including specific details as to the types of insurance coverage available, prior to or at the time services are rendered. Patients may be requested to provide identification such as driver's license to insure accuracy of demographics and will also be required to provide proof of insurance coverage by presenting a valid insurance card. The Registration staff will review and verify all insurance information including foreign health insurance coverage, foreign government health care plans for foreign residents, and motor vehicle coverage for victims of automobile accidents. The Hospital will request that patients who are foreign residents provide the name and address of the foreign health plan, and/or the name and address of the appropriate consulate. For patients who are automobile accident victims, the Hospital requests that the patient provide the name and address of the applicable automobile insurance carrier and other accident related information if needed. SSH also requires that these patients assign such benefits to the Hospital for direct payment.
3. Automobile accident cases will be identified and details of the accident obtained from the police department if needed and claims for payment submitted to the appropriate

automobile insurance carriers and, where appropriate, hospital liens filed with motor vehicle liability insurers. A Hospital Representative will obtain complete automobile and health insurance information. For patients also eligible for uncompensated care, the Hospital will investigate, document and submit to the appropriate automobile insurer.

4. Hospital liens are placed on automobile, accident and other third party liability cases by the Hospital or its agent, with the exception of MassHealth patients, for which the Hospital also has the option of billing MassHealth. Such decisions will be made on a case by case basis by the Director of Patient Financial Services.
5. In workers compensation cases, where the name of the carrier is unknown, the Hospital will contact employers, if appropriate, and request their workers' compensation insurance information.
6. The Hospital reserves the right to utilize outside agencies to help obtain information, verify eligibility for MassHealth, Health Safety Net or commercial health plans or pursue claims for services related to workers' compensation or automobile cases.

#### **H. Other Information on Emergency Related Services**

1. Financial Counselors are available during regular business hours. During these hours of operation, Financial Counselors will work with all types of emergency related patients. This includes those patients that present in the Emergency Department, or those patients seen in other Hospital locations on an emergency basis. The patient can be classified as an outpatient, inpatient, or emergency room patient.
2. In all emergency related instances, the patient will be given a patient notice – “*Availability of Financial Assistance*” information sheet during the registration process. This is especially intended and helpful for those patients treated in the off hours when Financial Counselors are not available. If the patient does not have insurance, a Financial Counselor will be notified. The intent is for the Financial Counselor to contact the patient at the time of service and prior to discharge. If this does not occur, the Financial Counselor will make every effort to contact the patient the following business day regardless of whether the patient has been discharged or admitted. If the patient has been discharged, the Financial Counselor will check self-pay patients via EVS for existing MassHealth coverage or Passport for other potential coverage. The Financial Counselor will attempt to contact the patient directly. If the patient is not available by phone the next business day, a letter will be mailed to them outlining available programs of assistance.
3. Other communications and follow-up will occur if the patient cannot be contacted or has not responded. These items are outlined further in section VI.

## **IV. DEPOSITS, LIMITATIONS ON CHARGES AND INSTALLMENT/PAYMENT PLANS**

SSH expects patients to adhere to the following guidelines in paying their outstanding balances in a timely manner. There are many instances where payment will be required in advance or at the time of service, particularly for non-covered services, copayments, and other deductibles, or selected services such as cosmetic procedures. The general expectation is that payments for elective services will be secured in advance of the service delivery and that payment in full is due within 30 days of the initial patient billing statement. The Hospital realizes that there may be a number of instances where payment in full is not financially feasible and may necessitate an appropriate payment or budget plan. The items listed below provide additional guidelines and criteria for deposits and installment plans.

**A. Deposits – General**

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. SSH and its agents will not charge interest on co-payments or deductibles.
2. The Hospital requests “pre-admission” or “pretreatment” deposits for any identified out-of-pocket expense due from the patient for most elective services. Deposit amounts vary based on type of service and the estimated amount due from the patient (i.e. 100% of the estimated amount due is requested for cosmetic services; 50-100% is requested for the estimated amount due for elective services with acceptable payment terms for any remaining balance prior to the delivery of the service (i.e. subject to the balance being paid on an established installment/payment plan).
3. Routine copayments will be requested at the time of service. Copayments related to emergency care will be requested of the patient post assessment and after they are medically stable. This may occur prior to or at the time of discharge.

**B. Deposits – Emergency Services/Low Income Patients/Medical Hardship**

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

1. SSH does not require pre-admission and/or pretreatment deposits from individuals that require Emergency Services or that are determined to be Low Income Patients.
2. SSH may request a deposit from individuals determined to be Low Income. Such deposits are limited to 20% of the deductible amount, up to \$1,000. All remaining

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

3. SSH may request a deposit from patients eligible for Medical Hardship. Deposits are limited to 20% of the Medical Hardship contribution up to \$1,000. All remaining balances will be subject to the payment plan conditions established in CMR 613.08(1) (f).
4. An individual with a balance of \$1,000 or less, after the initial deposit, must be offered at least a 1 year payment plan interest free with a minimum monthly payment of no more than \$25. A patient that has a balance of more than \$1,000, after initial deposit, must be offered at a 2-year interest free payment plan.
5. Regarding CommonHealth One-Time Deductible, at the request of the patient, the Hospital may bill a Low Income Patient in order to allow the Patient to meet the required CommonHealth One-time Deductible.

#### **C. Limitations on Charges for Emergency Care**

1. South Shore Hospital will not charge any individual who is eligible for financial assistance under this CC&FAP for emergency and medically necessary care more than the Amount Generally Billed (“AGB”).
2. The AGB percentage is determined using the “look-back” method which is calculated as the Medicare Fee for Service fee schedule amount associated with the service for a 12-month period, divided by the gross charges for those claims. The resulting percentage is multiplied by gross charges for all emergency and medically necessary care to determine the AGB. The AGB percentage is recalculated annually. The specific timeframe for the look-back period and the Hospital’s current AGB percentage can be found at [southshorehospital.org/ccfap](http://southshorehospital.org/ccfap) or upon request from a SSH Financial Counselor.
3. No individual who is found to be eligible for financial assistance will be charged more than the AGB for emergency or medically necessary care.

**D. Installment or Payment Plans (Self-Pay/No Insurance/Balance After Insurance)**

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.
2. Patients will be informed of the right to payment plans and options to apply for public assistance programs.
3. Where alternate financial sources for payment have failed, budget arrangements may be extended by the Hospital ("installment or payment plan").
4. Patients who do not otherwise qualify for Low Income Status, Health Safety Net, or Medical Hardship and feel that they cannot reasonably make payment in full within thirty (30) days of the initial bill are required to contact the Business Office. The Business Office will work with individuals to determine if the patient is eligible for other financial assistance in accordance with this policy and/or in establishing a monthly payment plan until the balance has been paid in full. The payment plan or budget contract is based on the outstanding amount due and is requested to be resolved within 2 years or less. Individuals who do not enter into a formalized payment plan process with the Hospital and/or do not meet the minimum monthly payments are subject to referral to an external collection agency for additional collection activities.
5. Patients are expected to make payments on time based on the agreement that they have agreed upon with the Hospital.
6. If a patient is on an installment payment plan and he/she anticipates missing a payment, the patient should notify the Credit and Collection Department/Business Office in advance and the payment should be made-up no later than the following month.
7. The Credit and Collections Department may contact patients via mail or telephone if payment is not made or is less than the scheduled amount. Telephone contact is generally attempted on balances greater than \$25.
8. If payment is not made due to a change in the patient's financial position, the patient will be advised of available options and will be supported in completing a common intake form and advised of their rights to be screened for MassHealth and other financial assistance programs. This includes setting up an appointment to meet with a Financial Counselor.
9. If no satisfactory response is received, the account will be placed for referral to an outside collection agency for additional follow-up in accordance with the billing and notification guidelines of this policy. See Section VI D for standard referral, collection, procedures, and notification practices.



#### **E. Notice of Contract Payment Plan**

The following represents contract payment criteria/guidelines for patients with balances after insurance as well as self-pay patients.

1. Uninsured patients who qualify for any SSH discount policies will receive a discount and contract arrangements will be made on balances after the discount has been applied.
2. In order to give uninsured and underinsured patients the same opportunity for discounts as other payers, a discount will be applied to self-pay accounts. This discount will not be applied to deductibles, co-insurance or for elective cosmetic surgeries.

Note: The Hospital does not employ interest, penalties, or accruals on outstanding balances due from patients. There may, however, be associated filing and court fees applied by the state or parties collecting on behalf of the Hospital in instances where appropriate payment arrangements were not made in a timely fashion and the account had been transferred to an external collection agency by the Hospital. These fees, however, do not represent interest or penalties imposed by the Hospital.

At this time, the Hospital does not have an established relationship with a third party to extend credit for payment of healthcare debt. Use of personal loans, credit cards, and other payment sources are encouraged as means of paying for or financing the self-pay portion due to the Hospital.

#### **V. SERVICES ELIGIBLE FOR PAYMENT FROM HEALTH SAFETY NET**

Patients may or may not qualify for financial assistance in public programs and are expected to contribute to the costs of their care based on their individual ability to pay.

SSH policies are based upon industry standards for patient accounting and are intended to comply with the criteria set forth by Massachusetts law in 101 CMR 613.00 and IRS Code 501 (r). This section of the CC&FAP provides guidelines for patients who are deemed unable to pay for all or part of their own health care expenses due to extenuating circumstances surrounding their illness or financial situation. The following guidelines are also intended to ensure the Hospital's compliance with applicable state and federal regulations to provide for financial assistance and uncompensated care and cover the areas of, MassHealth, Low Income Status, the Health Safety Net or Medical Hardship as defined by Massachusetts law. It is the Hospital's policy that all patients who receive financial assistance under this policy are receiving uncompensated care provided to low income patients.

**A. Standards and General Procedures**

1. Any patient who feels that he/she may be eligible for free or low-cost healthcare shall be given the opportunity to apply for such an allowance.
2. All patients seeking uncompensated care are required to discuss the available options with a Financial Counselor or Business Office Representative and submit all required information needed to complete the screening or common intake process. Application for such available services must be completed by the patient or legal guardian of the patient. Full disclosure of all personal assets and financial resources is required for Medical Hardship Applications.
3. The Hospital reserves the right to defer or reject the elective admission of patients if it is determined that the services to be rendered are not medically necessary.
4. MassHealth or the Commonwealth Health Insurance Connector notifies the individual of his or her eligibility determination for health care coverage or if the individual is a Low Income Patient.

**B. Eligible Services to Low Income Patients**

1. Providers may submit claims for Eligible Services that:
  - a. are permissible Services as defined in 101 CMR 613.03;
  - b. are provided to a Low Income Patient as defined in 101 CMR 613.04(1); and
  - c. meet the billing criteria in 101 CMR 613.00.
2. Permissible Services
  - a. SSH may submit claims only for services that are Medically Necessary.
  - b. Site of Service:
    1. Hospitals – The Health Safety Net Office will pay hospitals only for the Hospital Services listed in 101 CMR 613.03(a) and subject to the limitations specified in 114.6 CMR 13.03 (3)(b).
    2. Reimbursable Services – The Health Safety Net will pay for services specified in 101 CMR 613.03(3)(a) through 34. The Health Safety Net Office will pay only for services provided by licensed professionals and will only pay in accordance with the specified codes.

**C. Criteria to Submit Claims for All Eligible Services to Low Income Patients**

1. Patients are eligible for Health Safety Net if the services are: (a) Medically Necessary, (b) meet the criteria listed under “Reimbursable Services” as defined in 101 CMR 613.04, (c) are provided to Low Income Patients as defined in 101 CMR 613.04(1), and (d) meet the billing criteria in 101 CMR 13.04(1).
2. A Low Income Patient must be a resident of the Commonwealth of Massachusetts and determined to be a Low Income Patient pursuant to 101 CMR 613.04(1). In order to be determined a Low Income Patient; an individual must be a resident of the Commonwealth and document Family Income equal to or less than 300% of the FPL, subject to the following conditions. The following individuals are not eligible for Low Income Patient status:
  - a. Individuals enrolled in MassHealth Standard and MassHealth Family Assistance/Direct Coverage programs;
  - b. Individuals who have been determined to be eligible for any MassHealth program including MassHealth Premium Assistance but who have failed to enroll; and
  - c. Individuals whose enrollment in MassHealth or ConnectorCare has been terminated due to failure to pay premiums.

Note: A Massachusetts resident is a person living in the Commonwealth of Massachusetts with the intention to remain as defined by 130CMR 503.002(A) through (D). Persons who are not considered residents are:

1. Individuals who came to Massachusetts for the purpose of receiving medical care in a setting other than a nursing facility, and who maintain a residence outside of Massachusetts;
2. Persons whose whereabouts are unknown; or
3. Inmates of penal institutions except in the following circumstances;
  - a. They are inpatients of a medical facility; or
  - b. They are living outside of the penal institution, are on parole, probation, or home release, and are not returning to the institution for overnight stays.

The Federal Poverty Level (FPL) is updated annually and is posted on the state’s website at <http://www.mass.gov>.

#### **D. Criteria to Submit Partial Claims for Eligible Services for Low Income Patients**

1. Definition and Eligibility: Low Income Patients may be determined to be eligible for Health Safety Net Primary, or Health Safety Net Secondary in accordance with 101 CMR 613.04(4) In order to be determined a Low Income Patient an individual must be a resident of the Commonwealth, provide verification of identity, and document that a Modified Adjusted Gross Income of his or her MassHealth MAGI Household is equal to less than 300% of the FPL, provided that an individual may be determined a Low Income Patient if such individual applied for Medicaid assistance by completing a Senior Application as defined in 130 CMR 515.001.
2. Low Income Patient Financial Responsibility: For Health Safety Net- Partial Low Income Patients with MassHealth MAGI Household income or Medical Hardship Family Countable Income between 150.1% and 300% of the FPL, there is an annual deductible equal to 40% of the difference between the lowest MassHealth MAGI Household income or Medical Hardship Family Countable Income as described in 101 CMR 613.04(1), in the applicants Premium Billing Family Group (PBFG) and 200% of the FPL. The patient is responsible for payment for all services provided up to this deductible amount.

#### **E. Criteria Exclusions**

An individual may not be determined to be a Low Income Patient if he or she:

1. has been terminated from MassHealth due to failure to pay a MassHealth premium or deductible; or
2. is eligible for Premium Assistance for Employer Sponsored Insurance, but fails to enroll or apply for ESI.

#### **F. Claims for Eligible Services**

Emergent Bad Debt: For those cases where an account is being considered by the Hospital for application to the HSN as Emergent Bad Debt, the Hospital will ensure the following conditions are met:

1. The account was subject to continuous collection action for a minimum of 120 days.
2. An eligibility inquiry was made to MMIS to screen for coverage.
3. The services provided qualify as Emergent per the definitions in this policy.
4. A final collection notice was sent by certified mail for balances of \$1,000 or more. Accounts that are properly documented as Bad Address accounts may be submitted to the HSN without the mailing of a final collection notice via certified mail provided

the 120 days have elapsed from initial billing and that after a reasonable effort, the Hospital was unable to obtain an updated address.

#### **G. Medical Hardship**

A Massachusetts resident at any income level may qualify for HSN Medical Hardship if allowable medical expenses exceeded the family's income beyond their ability to pay for eligible services. This retrospective program is per regulations, limited in scope, it is a one-time determination, and is not a coverage category 114.6 CMR 13.95 (1). This program may only be applied for after service delivery when the patient had incurred a financial liability.

1. **Expense Qualification:** The patients allowable medical expenses must exceed the percentage of the family income for the applicable income bracket as determined by the Health Safety Net (114.6 CMR 13.05 (1). Allowable medical expenses are the total of family medical bills that, if paid, would qualify as deductible medical expenses for Federal income tax purposes. Paid and unpaid bills with service dates up to 12 months prior to the date of application may be submitted. Per EOHHS regulations, the patient is limited to 2 applications within a 12 month period.
2. **Application Process:** The Hospital will assist the patient in the collection of all applicable information and will submit Medical Hardship applications to the Health Safety Net for review and approval.
3. **Determination:** Health Safety Net will determine the patient's qualification for the program and will notify the Hospital as to which bills are the patient's responsibilities and which bills may be submitted to the HSN. Determination of Medical Hardship is limited to those bills that were included with the application. There is no eligibility period and bills may only be used once to support an application.
4. **Protection from Collection:** All collection actions will be discontinued for all balances that are determined by EOHHS to be eligible for coverage under Medical Hardship. This includes balances that may have been assigned to an external agent or collection agency working on behalf of the Hospital.

#### **H. Special Circumstances**

Under some circumstances, additional information or procedures may be necessary to properly process a patient's accounts.

1. **Workers' Compensation:** Services related to industrial accidents should be appropriately labeled in the registration record. Additional information that is required includes the date and time of accident, employer name and phone number and employer's workers compensation carrier and phone number.

2. **Motor Vehicle Accidents (MVA) and Third Party Liability:** Services related to a motor vehicle accident or other third party liability should be appropriately labeled in the registration record. Diligent efforts will be made to collect additional information that is required for submission of MVA claims including the date and time of accident, the location for third party liability cases, and any known automobile insurer. The name of any attorney associated with the claim should be noted in the registration system if it is available.
3. **Victims of Violent Crimes:** Services related to victims of violent crimes should be appropriately labeled in the registration record, with the time and place of the incident. In some cases, limited funds are available from the Attorney General's office to offset medical expenses that are not otherwise covered by medical insurance or the Health Safety Net. When indicated, patients should be referred to Financial Counseling for completion of the appropriate documentation for compensation from the Victims of Violent Crimes Fund.
4. **Confidential Application:** Confidential applications may be submitted under two circumstances.
  - a. **Minors:** Confidential applications may be submitted for minors presenting for family planning services and services related to sexually transmitted diseases. These applications may be processed under the minor's income without any regard to the family income. These patients should be referred to Financial Counseling.
  - b. **Battered or Abused individuals:** These individuals may also apply for HSN coverage on the basis of their individual income. These patients may be approved for the full range of services covered by the Health Care Safety Net. These patients should be referred to Financial Counseling.
5. **Undocumented Persons.** Patients may be concerned about the immigration implications of applying for Low Income Patient status. Patients with limited means should be encouraged to apply for assistance via the [MAHealthConnector.org](http://MAHealthConnector.org) website or paper application. Patients refusing to apply for assistance through MAHealthConnector will continue to be treated as self-pay. Urgent and Emergent services (including up to two weeks of drugs required to respond to immediate threats to the patient's health) should continue to be provided. Non-urgent, non-emergent services may be deferred or canceled until such time as the patient is able to pay, make suitable financial arrangements, obtain insurance or become enrolled in a financial assistance program that will cover the service.
6. **Research Studies:** Services related to research studies should be noted at time of registration for that service and labeled to insure that charges for these services are submitted to the designated research fund.

**I. Grievance Process**

An individual may request that the Commonwealth of Massachusetts conduct a review of the determination of Low Income Patient Status, or of Provider compliance with the provisions of 101 CMR 613.00.

**J. Hospital Additional Financial Assistance**

In addition to the Health Safety Net, the Hospital provides financial assistance for those patients who meet its criteria as outlined below:

**Financial Assistance Discount for Patients with Limited Income:**

Patients who qualify for this discount will have their charges for applicable services discounted according to the following schedule. The discounts are based on the total charges and are not applied to balances that have already been discounted due to insurance coverage.

<i><b>Family Income as % of FPG</b></i>	<i><b>Discount for South Shore Hospital</b></i>
0 to 133%	100%
134 to 250%	85%
251 to 300%	70%

This financial assistance is meant to supplement and not replace other coverage for services in order to ensure that financial assistance is provided when needed. The Hospital will not deny financial assistance under its financial assistance policy based on the applicant's failure to provide information or documentation unless that information or documentation is described in and necessary for the determination of financial assistance through the application form.

**VI. HOSPITAL COLLECTION PRACTICES**

The Hospital has a fiduciary duty to seek reimbursement for services it has provided from individuals who are able to pay, from third party insurers who cover the cost of care, and from other programs of assistance for which the patient is eligible. The SSH Credit, Collection and Financial Assistance Policy (CC&FAP) is based upon industry standards for patient accounting and is intended to comply with the criteria set forth by the Commonwealth of Massachusetts (see 114.6 CMR 13.00) and the United States Internal Revenue Service (see Internal Revenue Code 501 (r)). The purpose of the CC&FAP is to provide general guidelines to assure reasonable collection of accounts from all available sources and to recognize as soon as possible when an individual requires assistance and/or that an account may qualify for MassHealth or Health Safety Net or as Bad Debt. It is also intended to ensure that the Hospital complies with applicable state and federal requirements as well as those set forth in the Fair Debt Collections Practices Act.

**A. Hospital Rights and Responsibilities**

1. Patients will be informed of the rights to payment plans, options to apply for MassHealth, Health Safety Net or commercial health plans and low income determination and options to file a grievance if so desired. This information will be communicated verbally when meeting with a SSH Financial Counselor, in discussions with Credit and Collection staff from the Business Office, and via various correspondences the Hospital uses to educate and communicate with patients regarding their rights. As outlined in the introduction of this CC&FAP, SSH will 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, pre-admission or pre-treatment deposits, payment plans, deferred or rejected admission, or Low Income Patient Status as defined in 613.08(1)(A).
2. SSH will advise patients about the availability of coverage options through an available public assistance or Hospital financial assistance program, including coverage through MassHealth, the premium assistance payment program operated by the Health Connector, the Children's Medical Security Program, Health Safety Net, or Medical Hardship, in billing invoices that are sent to the patient or the patient's guarantor following delivery of services.
3. SSH, or its agent, shall not garnish the wages or seek legal execution against the personal residence or motor vehicle of a Low Income Patient determined pursuant to 101 CMR 13.00 unless: (a) SSH can show the patient or their guarantor has the ability to pay, (b) 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 (c) for purposes of the lien, it was approved by the Board of Trustees. All approvals by the Board will be made on an individual case basis.
4. The Hospital also does not seek payment from a Low Income Patient determined eligible for the Health Safety Net program whose claims were initially denied by an insurance program due to an administrative billing error by the Hospital. The Hospital further maintains all information in accordance with applicable federal and state privacy, security, and ID theft laws.
5. The Hospital shall advise patients of the right to apply for MassHealth, the Premium Assistance Payment Program, operated by the Health Connector, a Qualified Health Plan, Low Income Patient determination, and Medical Hardship; and a payment plan, as described in 101 CMR 613.08(1) (f), if the patient is determined to be a Low Income Patient or qualifies for Medical Hardship.
6. The Hospital shall provide individual notice to patients of Eligible Services and programs of public assistance during the patient's initial registration and when the Hospital becomes aware of a change in the patient's eligibility or insurance coverage.



7. The Hospital shall advise patients of the responsibilities described in 101 CMR 613.08(2) (b) in all cases where the patient interacts with registration personnel.
8. The Hospital shall provide individual notice to patients of the Hospital's financial assistance policy during the patient's initial registration and when the Hospital becomes aware of a change in the patient's eligibility or insurance coverage.
9. Eligible Service Limitations-Serious Reportable Events. The Health Safety Net does not pay for services directly related to a Serious Reportable Event (SRE) as defined in 105 CMR 130.332(A). Definitions Applicable to 105 CMR 130.33
  - a. The Hospital must not charge, bill, or otherwise seek payment from the Health Safety Net, a Patient, or any other payer as required by 105 CMR 130.332: Serious Reportable Events (SREs), for services provided as a result of an SRE occurring on premises covered by a Provider's license, if the Provider determines that the SRE was:
    - i. preventable;
    - ii. within the Provider's control; and
    - iii. unambiguously the result of a system failure as required by 105 CMR 130.332: (B) Reporting of SREs and (C): Preventability Determination.
  - b. The Hospital must not charge, bill, or otherwise seek payment from Health Safety Net, a patient, or any other payer as required by 105 CMR 130.332: Serious Reportable Events (SRE's) for services directly related to:
    - i. the occurrence of the SRE;
    - ii. the correction or remediation of the event; or
    - iii. subsequent complications arising from the event as determined by the Health Safety Net Office on a case-by-case basis.
  - c. The Hospital may submit a claim for services it provide as a result of an SRE that did not occur on its premises only if the treating facility and the facility responsible for the SRE do not have common ownership or a corporate parent.
  - d. Readmissions to the same hospital or follow-up care provided by the same Provider or a Provider owned by the same parent organization are not billable if the services are associated with the SRE as described in 101 CMR 613.03(1)(d)2.

## **B. Patient Rights and Responsibilities**

Patient Rights and Responsibilities Include:

1. Providing complete and timely insurance and demographic information, and informing the Hospital, and the state if patient is on a state program, of any changes in their status including, but not limited to, changes in income or insurance status.
2. For Massachusetts residents, apply for and maintain coverage through any government sponsored programs for which they may qualify, including submission of all required documentation within the required timeframes. All patients should obtain and maintain insurance coverage if affordable coverage is available to them.
3. SSH, through this policy, advises patients that a patient who receives Reimbursable Health Services must:
  - a. Provide all required documentation;
  - b. Inform MassHealth of any changes in MassHealth MAGI Household income or Medical Hardship Family Countable Income, as described in 101 CMR 613.04(1), or insurance status, including but not limited to, income, inheritances, gifts, distributions from trusts, the availability of health insurance, and third party liability. The patient may, in the alternative, provide such notice to the Provider that determined the patient's eligibility status;
  - c. Track the patient deductible and provide documentation to the Provider that the deductible has been reached when more than one Premium Billing Family Group member is determined to be a Low Income Patient or if the patient or Premium Billing Family Group members receive Reimbursable Health Services from more than one Provider; and
  - d. Inform the Health Safety Net Office or the MassHealth Agency when the patient is involved in an accident, or suffers from an illness or injury, or other loss that has or may result in a lawsuit or insurance claim. In such a case the patient must:
    - i. file a claim for compensation, if available; and
    - ii. agree to comply with all requirements of M.G.L. c. 118E, including but not limited to:
      - i a. assigning to the Health Safety Net Office the right to recover an amount equal to the Health Safety Net payment provided from the proceeds of any claim or other proceeding against third party;
      - ii a. providing information about the claim or any other proceeding, and fully cooperating with the Health Safety Net Office or its designee, unless the Health Safety Net Office determines the cooperation would

not be in the best interests of, or would result in serious harm or emotional impairment to, the patient;

- iii a. notifying the Health Safety Net Office or the MassHealth Agency in writing within 10 days of filing any claim, civil action, or other proceeding; and
  - iv a. repaying the Health Safety Net from the money received from a third party for all Eligible Services provided on or after the date of the accident or other incident after becoming a Low Income Patient for purposes of Health Safety Net payment, provided that only Health Safety Net payments provided as a result of the accident or other incident will be repaid.
4. The Health Safety Net office recovers sums directly from the patient only to the extent that the patient has received payment from a third party for the medical care paid by the Health Safety Net or to the extent specified in 101 CMR 613.06(5).

At the request of the patient, a Provider may bill a Low Income Patient in order to allow the patient to meet the required CommonHealth One-time Deductible as described in 130 MCR 506.009; The One-time Deductible.

Notify the Hospital of any potential Motor Vehicle Accident coverage, Third Party Liability coverage, or Workers' Compensation coverage. For patients covered by a state program, file a claim for compensation, if available, with respect to any accident, injury or loss and notify the state program (e.g. Massachusetts State Medicaid Agency and the Health Safety Net) within ten days of information related to any lawsuit or insurance claim that will cover the cost of services provided by the Hospital. 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 Massachusetts State Medicaid Agency or the Health Safety Net.

- 1. Make reasonable efforts to understand the limits of their insurance coverage including network limitations, service coverage limitations and financial responsibilities due to limited coverage, co-payments, co-insurance and deductibles.
- 2. Conform with insurance referral, pre-authorization and other medical management policies.
- 3. Conform to other insurance requirements, including completion of coordination of benefits forms, updating membership information, updating physician information and other payer requirements.
- 4. Pay co-pays, deductibles and co-insurance amounts in a timely manner.
- 5. Provide timely updates of demographic, insurance and HSN eligibility and annual deductible data.

### **C. Documentation and Audit**

SSH will maintain records documenting claims for Eligible Service to Low Income Patients, Emergency Bad Debt services and Medical Hardship Services.

1. The SSH Patient Financial Services Department shall make reasonable efforts to maintain auditable patient accounting records or credit and collection activities made in compliance with Regulation 101 CMR 613.00.
2. Prior to sending an account to Bad Debt, SSH will make sure that EVS has been checked for potential eligibility.

### **D. Standard Collection Principles**

1. The Hospital will provide prompt and courteous financial counseling to all patients in need and will assist patients in obtaining available financial assistance from federal, state, private agencies or the Hospital's financial assistance program in order to meet their financial obligations to the Hospital. Various Hospital representatives, including Financial Counselors, Outreach Workers, Social Services, or Patient Account Representatives may handle this process and interactions with patients.
2. A collection agency will be used when the Patient Accounting Department has exhausted all reasonable collection efforts on the accounts, except for patients who are exempt from collection action pursuant to 101 CMR 613.04(1).
3. The Hospital will not force the sale or foreclosure of a patient's primary residence to pay an outstanding medical bill. The legal execution of real estate attachments on the patient's personal residence or on a patient's other assets (e.g., automobile) to secure the patient's debts is an extraordinary action that will only be used in truly exceptional circumstances. At a minimum, liens are permitted only where there is evidence that the patient or responsible party has income and/or assets to meet his or her obligations. Such action will require prior express authorization from the Hospital's Board of Trustees in each case, in accordance with Massachusetts regulations.
4. The Hospital will not use body attachment (i.e., a third-party that uses physical or legal means to compel an action) to require the patient or responsible party to appear in court.
5. All collection agents of South Shore Hospital are required by contract to comply with SSH's Credit Collection and Financial Assistance policy.
6. The Hospital will submit a universal billing form to insurers.
7. The Hospital shall comply with the insurer's billing and authorization requirements, appeal a denied claim when the service is payable in whole or part by an insurer and immediately return any payment received from the Office when any available third-party resource has been identified.

#### **E. Hospital Billing and Collection Procedures**

1. An initial bill will be sent to the responsible party for the patient's personal financial obligations.
2. The Hospital will issue subsequent billings at least every 30 days and for a minimum of 120 days after the initial bill before referring an account to an external collection agency. The patient will receive at least 3 billing statements and a "final notice" indicating that the account will be referred to an external collection agency when an acceptable payment has not been received or when an appropriate payment plan has not been established.
3. The statement or billing notices will be accompanied by telephone calls, collection letters, and any other notification method that constitutes a genuine and reasonable effort to contact the party responsible for the obligation.
4. The Hospital will document alternative efforts to locate the party responsible for the obligation or the correct address on billings returned by the postal office service as "incorrect address" or "undeliverable" that is otherwise considered a "bad address." Alternative efforts may include use of skip tracing methods, use of the internet, post office records or other purchased or widely available means of tracing a patient or guarantors residence or point of contact with the intent of collecting outstanding debt or notifying them of options and other programs of public assistance that may be available to them.
5. For Emergency Care services (services that could qualify as emergency bad debt) with balances over \$1,000 where notices have not been returned as "incorrect address" or "undeliverable," the Hospital will send a final collection notice by certified mail (see 101 CMR 613.06(1)(a)(3)(b)(iv)). In these instances where, after reasonable effort, an account has been deemed as undeliverable, the account shall be referred to an external collection agency for additional follow-up prior to the exhaustion of the 120 days from the attempt of the initial bill.
6. Documentation of continuous collection action undertaken on a regular, frequent basis will be maintained by paper or electronic media.
7. The patient's file will include documentation of collection effort including bills, follow-up letter, and telephone calls.

#### **F. Reasonable Collection Efforts**

1. The Hospital must make the same effort to collect accounts for Uninsured Patients as it does to collect accounts from any other patient classification.
2. The minimum requirements before writing off an account to the Health Safety Net include:

- a. An initial bill to the party responsible for the patient's personal financial obligations;
  - b. Subsequent billings, telephone calls, collection letters, and any other notification method that constitutes a genuine effort to contact the party responsible for the obligation;
  - c. Documentation of alternative efforts to locate the party responsible for the obligation or the correct address on billings returned by the postal office service as "incorrect address" or "undeliverable";
  - d. Sending a final notice by certified mail for balances over \$1,000 where notices have not been returned as "incorrect address" or "undeliverable";
  - e. Documentation of continuous Collection Action undertaken on a regular, frequent basis. When evaluating whether a Provider has engaged in continuous Collection Action, 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 its discretion when determining whether a Provider has made a reasonable effort to meet the standard; and
  - f. Checking EVS to ensure that the patient is not a Low Income Patient as determined by MassHealth and has not submitted an application to the Health Information Exchange 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.
3. If, after reasonable attempts to collect a bill, the debt for Emergency Care for an Uninsured Patient remains unpaid for more than 120 days, the bill may be deemed uncollectible and billed to the Health Safety Net Office.
  4. The patient's file must include all documentation of the Provider's collection effort including copies of the bill(s), follow-up letters, reports of telephone contact, and any other effort made.

#### **G. Emergency Care Classification for Bad Debt**

Pursuant to EMTALA, the Hospital classifies as emergency care any persons who enters the Hospital requesting emergency treatment or who enters the emergency department requesting medical treatment. These patients may be walk-ins or may arrive by ambulance. Most commonly, unscheduled persons present themselves at the Hospital's emergency room or urgent care center. However, unscheduled persons requesting emergency services while presenting at another inpatient unit, clinic, or other ancillary area such as laboratory of radiology may also be subject to an emergency medical screening examination pursuant to EMTALA. Examination and treatment for emergency medical conditions or any such other

service rendered to the extent required pursuant to EMTALA, will be provided to the patient and will qualify as emergency care for uncompensated care purposes.

1. Emergent (or Emergency) Care: Medically Necessary services provided after the onset of a medical condition, whether physical or mental, manifesting itself by acute symptoms of sufficient severity, including severe pain, which a prudent layperson would reasonably believe is an immediate threat to life or has a high risk of serious damage to the individual's health. Conditions include, but are not limited to those which may result in jeopardizing the patient's health, serious impairment to bodily functions, serious dysfunction of any bodily organ or part, or active labor in women. Examination or treatment for emergency medical conditions or any such other service rendered to the extent required pursuant to EMTALA qualifies as Emergency Care.
2. Urgent Care: Medically Necessary services provided in a hospital or community health center after the sudden onset of a medical condition, whether physical or mental, manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent 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.
3. Elective or Scheduled Services: represent a condition that requires evaluation and/or treatment but time is not a critical factor; does not include patients with complaints of severe pain or loss of function. Elective care is generally a scheduled service. Scheduled services include appointments made over the phone by calling the Hospital or departments within the Hospital, are scheduled as a follow-up visit from a previous service, and can result from a referral by an outside clinician or other healthcare entity. Examples of this include services of diagnostic labs, elective surgical day services, cosmetic procedures, diagnostic imaging and other outpatient therapeutic services.

#### **H. Population Exempt from Routine Collection Action**

The following individuals and patient populations are exempt from any collection or billing procedures pursuant to state regulations and policies:

1. A provider must not bill patients enrolled in MassHealth and patients receiving governmental benefits under the Emergency Aid to the Elderly, Disabled and Children program except that the Provider may bill patients for any required copayments and deductibles. The Provider may initiate billing for a patient who alleges that he or she is a participant in any of these programs but fails to provide proof of such participation. Upon receipt of satisfactory proof that a patient is a participant in any of the above listed programs, and receipt of the signed application, the Provider must cease its collection activities.

2. Participants in the Children's Medical Security Plan whose MAGI income is equal to or less than 300% of the FPL are also exempt from Collection Action. The Provider may initiate billing for a patient who alleges that he or she is a participant in the Children's Medical Security Plan, but fails to provide proof of such participation. Upon receipt of satisfactory proof that a patient is a participant in the Children's Medical Security Plan, the Provider must cease all collection activities.
3. Low Income Patients, except Dental-Only Low Income Patients, are exempt from Collection Action for any Reimbursable Health Services rendered by a Provider receiving payments from the Health Safety Net for services received during the period for which they have been determined Low Income Patients, except for copayments and deductibles. Providers may continue to bill Low Income Patients for Eligible Services rendered prior to their determination as Low Income Patients after their Low Income Patient status has expired or otherwise been terminated.
4. Low Income Patients with MassHealth MAGI Household income or Medical Hardship Family Countable Income, as described in 101 CMR 613.04(1), between 150.1 to 300% of the FPL are exempt from Collection Action for the portion of his/her Provider bill that exceeds the deductible and may be billed for copayments and deductible as set forth in 101 CMR 613.04(6)(b) and (c). Providers may continue to bill Low Income Patients for services rendered prior to their determination as Low Income Patients after their Low Income Patient status has expired or otherwise been terminated.
5. Providers may bill Low Income Patients for services other than Reimbursable Health Services provided at the request of the patient for which the patient has agreed to be responsible, with the exception of those services described in 101 CMR 613.08(3)(d) 1. and 2., Providers must obtain the patient's written consent to be billed for services.
  - a. Providers may not bill Low Income Patients for claims related to medical errors including those described in 101 CMR 613.08(3)(1)(e).
  - b. Providers may not bill Low Income Patients for claims denied by the patient's primary insurer due to an administrative or billing error.
6. At the request of the patient, a Provider may bill a Low Income Patient in order to allow the patient to meet the required CommonHealth One-time Deductible as described in 130 CMR 506.009: *The One-Time Deductible*.
7. A Provider may not undertake a Collection Action against an individual that has qualified for Medical Hardship with respect to the amount of the bill that exceeds the Medical Hardship contribution. If a claim already submitted as Emergency Bad Debt becomes eligible for Medical Hardship payment from the Health Safety Net, the Provider must cease collection activity on the patient for the services.



The Hospital or its agent will not garnish the wages or seek legal execution against the personal residence or automobile of patients or guarantors except as outlined in Section VI D (3) of the CC&FAP.

Notwithstanding anything in this section to the contrary, the Hospital will bill patients who allege that they are a participant in one of the above-named programs who fail to provide proof of such participation or who, upon the Hospital's verification, fail to actually participate in such program.

#### **I. Extraordinary Collection Actions**

1. The Hospital will not undertake any "extraordinary collection actions" until such time as the Hospital has made reasonable efforts and followed a reasonable review of the patient's financial status and other information necessary to determine eligibility for financial assistance, which will determine that a patient 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.
2. The Hospital will accept and process an application for financial assistance under its Credit Collection and Financial Assistance Policy submitted by a patient for the entire "application period." The total period during which Hospital must accept and process FAP applications is 240 days from the date of the first billing statement. If Hospital receives an FAP application during the application period, it must suspend any ECAs it has started until it has processed the application. The application period does not end before 30 days after the Hospital has provided the patient with the 30-day notice described below. In the case of a patient who the Hospital has presumptively determined to be eligible for less than the most generous assistance under the Credit Collection and Financial Assistance policy, the application does not end before the end of a reasonable period for the patient to apply for more generous financial assistance, as further described below.
3. Extraordinary collection actions include:
  - a. Selling a patient's debt to another party (except if the special requirements set forth below are met);
  - b. Reporting to credit reporting agencies or credit bureaus;
  - c. Deferring, denying, or requiring a payment before providing, Medically Necessary Care because of nonpayment of one or more bills for previously covered care under the Hospital's financial assistance policy (which is considered an extraordinary collection action for the previously provided care)

- d. Actions that require legal or judicial process, including
    - i. Placing a lien on a patient's property;
    - ii. Foreclosing on real property;
    - iii. Attaching or seizing bank account or any other personal property;
    - iv. Commencing a civil action against a patient;
    - v. Causing a patient's arrest;
    - vi. Causing a patient to be subject to a writ of body attachment; and
    - vii. Garnishing a patient's wages.
  - e. The Hospital will treat the sale of a patient's debt to another party as an extraordinary collection action unless the Hospital enters into a binding written agreement with the purchaser of the debt pursuant to which (i) the purchaser is prohibited from engaging in any extraordinary collection actions to obtain payment for care; (ii) the purchaser is prohibited from charging interest on the debt at a rate higher than the applicable IRS underpayment rate; (iii) the debt is returnable to or recallable by the Hospital upon a determination that the patient is eligible for financial assistance; and (iv) if the patient is determined to be eligible for financial assistance and the debt is not returned to or recalled by the Hospital, the purchaser is required to adhere procedures that ensure that the patient does not pay the purchaser more than the patient is personally responsible to pay under the financial assistance policy.
  - f. Extraordinary collection actions include actions taken to obtain payment for care against any other patient who has accepted or is required to accept responsibility for the patient's Hospital bill for the care.
4. The Hospital will refrain from initiating any extraordinary collection actions against a patient for a period of at least 120 days from the date the Hospital provides the first post-discharge billing statement for the care; except that special requirements apply to deferring or denying medically necessary care because of nonpayment as described below.
5. In addition to refraining from initiating any extraordinary collection actions for the 120-day period described above, the Hospital will refrain from initiating any extraordinary collection actions for a period of at least 30 days after it has notified the patient of its financial assistance policy in the following manner: the Hospital (i) provides the patient with a written notice that indicates that financial assistance is available for eligible patients, that identifies the extraordinary collection actions that the Hospital (or other authorized party) intends to initiate to obtain payment for the care, and that states a deadline after which extraordinary collection actions may be initiated that is no earlier than 30 days after the date that written notice is provided: (ii) provides the patient with a plain

language summary of the financial assistance policy; and (iii) makes a reasonable effort to orally notice the patient about the financial assistance policy and how the patient may obtain assistance with the financial assistance policy application process; except that special requirements apply to deferring or denying Medically Necessary Care as described below.

6. The Hospital will meet the following special requirements in the event that it defers or denies care due to nonpayment for prior care that was eligible for financial assistance. The Hospital may provide less than the 30 days' notice described above if it provides the patient with a financial assistance application form and a written notice indicating financial assistance is available for eligible patients. The written notice will state a deadline after which the Hospital will no longer accept and process an application for financial assistance, which will be no earlier than the end of the application period or 30 days after the date the written notice is first provided. If the patient submits an application before the deadline, the Hospital will process the application on an expedited basis.
7. If a patient submits a complete or incomplete application for financial assistance under the Hospital's financial assistance policy during the application period, the Hospital will suspend any extraordinary collection actions to obtain payment for care. In such event, the Hospital will not initiate, or take further action on any previously initiated extraordinary collection actions until either (i) the Hospital has determined whether the patient is eligible for financial assistance under the financial assistance policy or (ii) in the case of an incomplete application for financial assistance, the patient has failed to respond for requests for additional information and/or documentation within a reasonable period of time. The Hospital will also take further action, depending on whether the application is complete or incomplete, as described below.
8. In the event that a patient submits a complete application for financial assistance during the application period, the Hospital will in addition make a determination as to whether the patient is eligible for financial assistance. If the Hospital determines that the patient is eligible for assistance other than free care, the Hospital will (i) provide the patient with a billing statement that indicates the amount the patient owes for the care as a patient eligible for financial assistance and states, or describes how the patient can get information regarding the Amount Generally Billed for the care, (ii) refund to the patient any amount that the patient paid for the care that exceeds the amount the patient is determined to be personally responsible for paying and (iii) take all reasonable measures to reverse any extraordinary collection action (with the exceptions of a sale of debt and deferring or denying, or requiring a payment before providing, Medically Necessary Care because of a patient's nonpayment of prior bills for previously provided care for which the patient was eligible for financial assistance) taken

against the patient to obtain payment for care. Reasonable measures to reverse such an extraordinary collection action will include measures to vacate any judgment, lift any levy or lien, and removing from the patient's credit report any adverse information that was reported to a consumer reporting agency or credit bureau.

9. In the event that a patient submits an incomplete application for financial assistance during the application period, the Hospital will provide the patient with written notice that describes the additional information and/or documentation required under the financial assistance policy and that includes contact information.
10. The Hospital may make presumptive determinations that a patient is eligible for financial assistance under the financial assistance policy based on information other than that provided by the patient or based on a prior determination of eligibility. In the event that a patient is determined to be eligible for less than the most generous assistance available under the financial assistance policy, the Hospital will: (i) notify the patient regarding the basis for the presumptive eligibility determination and the way to apply for more generous assistance available under the financial assistance policy; (ii) give the patient a reasonable period of time to apply for more generous assistance before initiating extraordinary collection actions to obtain the discounted amount owed; and (iii) if the patient submits a complete application seeking more generous financial assistance during the application period, determine whether the patient is eligible for the more generous discount.
11. The Hospital and its agents shall not continue collection or billing efforts related to a patient who is a member of a bankruptcy proceeding except to secure its rights as a creditor in the appropriate order (similar actions may also be taken by the applicable public assistance program that has paid for services). The Hospital and its agents will also not charge interest on an overdue balance for a Low Income Patient or for patients who meet the criteria for coverage through the Hospital's own internal financial assistance program.

## **J. Outside Collection Agencies**

The Hospital contracts with outside collection agencies to assist in the collection of certain accounts, including patient responsible amounts not resolved after issuance of Hospital bills or final notices.

The Hospital has a specific authorization or contract with the outside collection agencies and requires such agencies to abide by the Hospital's Credit Collection and Financial Assistance policy for those debts that the agency is pursuing. 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.

## **K. Signs**

South Shore Hospital shall post signs, in the inpatient, clinic, and emergency admissions/registration areas and in the business office areas that are customarily used by Patients that conspicuously inform Patients of the availability of financial assistance programs and the Hospital location at which to apply for such programs. Signs shall be large enough to be clearly visible and legible by Patients visiting these areas. All signs and notices must be translated into languages other than English if such languages are the primary language of the lesser of 1,000 individuals or 5% of the residents in the Hospital's service area.

Signs shall notify Patients of the availability of financial assistance and of other programs of public assistance.

Wording on signage:

"If you are unable to pay your hospital bill you and other family members may be eligible for financial assistance through a public assistance program or the Hospital's financial assistance program. Our Financial Counselors may be able to help you find a program that meets your needs and assist you in enrolling in that program. For more information please contact a Financial Counselor at 781-624-4329. The Financial Counseling department is open Monday-Friday from 9am-5pm and Saturday from 8am-4pm and is located on the first floor of the Emerson building."

## **L. Website**

This Credit, Collection and Financial Assistance Policy is available online at the following website: <http://www.southshorehospital.org/financial-counselingassistance>

## **VII. NOTICES, FORMS AND OTHER EXHIBITS**

- A. Exhibit I:** South Shore Hospital Facility Locations
- B. Exhibit II:** Sample Patient Letters
- C. Exhibit III:** South Shore Hospital Financial Assistance Application
- D. Exhibit IV:** Sample of Patient Statement (invoice) with Notice of Financial Assistance, Eligible Services and programs of assistance
- E. Exhibit V:** Sample of Patient Notice - Availability of Financial Assistance

## **Exhibit 1**

### **List of South Shore Hospital Satellites/Substantially-related Entities**

1. South Shore Hospital's Center for Wound Care & Hyperbaric Medicine
2. South Shore Hospital Breast Care Center /Multispecialty Care
3. South Shore Hospital Outpatient Pre-testing Suite
4. Center for Orthopedics, Spine and Sports Medicine
5. South Shore Hospital Center for Physical Wellness



## **Exhibit 2**



John Smith  
123 Main St.  
Boston, MA 02127

Patient Name: John Smith

Patient Account #:123456

Dear Mr. Smith:

Our records indicate that you did not have health insurance at the time of your care. In order to assist you with your medical expenses you may be eligible for free or low-cost health care under Mass Health or other Financial Assistance programs.

Our financial counselors are available to assist you in this process. Please contact our financial counselors at 781-624-4329 for more information or to set up an appointment. We will need information regarding your current income and health insurance status so please have this information readily available. Eligibility is determined by your family size and income in accordance with federal poverty guidelines. The federal poverty guidelines can be viewed on our website at [www.southshorehospital.org](http://www.southshorehospital.org)

Please be advised it is very important that you call us as soon as possible. Enrollment in assistance plans is time sensitive. Please contact the Financial Counseling Department upon receipt of this letter.

For information regarding payment plans please contact our Business Office at 800-486-1915  
Monday through Friday 8:00 a.m.-5:00 p.m.

Sincerely,

South Shore Hospital

Financial Counseling Department



John Smith  
123 Main St  
Boston, MA 02127

Re: John Smith  
Acct Number: 123456  
Date of Service: 06/01/16

Dear Mr. Smith:

Thank you for choosing South Shore Hospital for your healthcare needs.

Our records indicate that you submitted an application requesting financial assistance.

We are informing you that your Financial Assistance application has been denied.  
The reason for the denial is:  
(sample text)

Incomplete Application  
Income exceeds 300% Federal Poverty Limit

If you have any questions or concerns, please call South Shore Hospital Financial Counseling Department at 781-624-4329.

Sincerely,

South Shore Hospital  
Financial Counseling Department



**South Shore  
Hospital**

55 Fogg Road  
South Weymouth  
Massachusetts  
02190-2455  
southshorehospital.org

(781) 624-8000

John Smith  
123 Main St  
Boston, MA 02127

Re: John Smith  
Acct Number: 123456  
Date of Service: 06/01/16

Dear Mr. Smith:

Thank you for choosing South Shore Hospital for your healthcare needs.

Our records indicate that you submitted an application requesting financial assistance.

This is notification that your Financial Assistance application has been approved.  
Your enclosed outstanding South Shore Hospital bills have been adjusted accordingly.

If you have any questions or concerns, please call South Shore Hospital Financial Counseling Department at 781-624-4329.

Sincerely,

South Shore Hospital  
Financial Counseling Department

## **Exhibit 3**



**South Shore Hospital Financial Assistance Application**

**1. BASIC INFORMATION**

Please complete this section about the applicant. The applicant is either the patient or the person who is financially responsible for the patient.

**DOCUMENTATION REQUIRED:** Please include documentation that verifies residency: driver's license, other photo identification or documents that prove your current residence. Anything submitted must include your name.

Last name	First name	MI
Date of birth		Gender Male <input type="checkbox"/> Female <input type="checkbox"/>
Telephone numbers Home: (    ) Work: (    ) Cell: (    )		Mailing address (include city, state and zip code)
Patient's name (if different from applicant)		Patient's dates of service (include location where the services were provided)
Patient's date of birth (if different from applicant)		
Patient's Medical Record Number (MRN)		



**South Shore Hospital Financial Assistance Application**

**2. FAMILY INFORMATION**

If applicable, please list the applicant's spouse and children under 19 who live with the applicant. This section can be left blank if the applicant does not live with a spouse or children.

Name of family member	Relationship	Date of birth

**3. EARNED INCOME**

Please complete this section about earned income for applicant and each household member listed in Section 2 who works. **Please list gross income, which is income before taxes and deductions.** Please document this section "no working income" if the applicant and his/her household members do not have any earned income.

Name of working family member	Employer name and address	Gross amount earned	How often check one	Facility use only
			<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly	
			<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly	
			<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly	
			<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Yearly	



**South Shore Hospital Financial Assistance Application**

**4. OTHER INCOME**

Please complete this section about other income for the applicant and each household member listed in Section 2 who receives other income. Other income is money you receive that does not come from an employer. **Please list gross income, which is income before taxes and deductions.** This section can be left blank if the applicant and his/her household members do not have any other income.

**DOCUMENTATION REQUIRED:** Please include documentation that verifies this income: pay stubs, income taxes, W2 statements, bank statements or other proof.

Type of Income	Family member (s) receiving income	Gross amount received	How often <i>circle one</i>	Facility use only
Unemployment			Weekly, Monthly Yearly	
Social Security			Weekly, Monthly Yearly	
Veteran's Benefits			Weekly, Monthly Yearly	
Annuities and Pensions			Weekly, Monthly Yearly	
Child Support & Alimony			Weekly, Monthly Yearly	
Rental Income			Weekly, Monthly Yearly	
Workers Compensation			Weekly, Monthly Yearly	
Dividend & Interest Income			Weekly, Monthly Yearly	
Other			Weekly, Monthly Yearly	

**5. OTHER HEALTH CARE EXPENSES**

Please attach copies of outstanding health care expenses

Medical Expenses	Total Amount	How often does this occur?	Facility use only <i>Total Cost</i>
Medical Bills			
Pharmacy Bills			
Dental			





**South Shore Hospital Financial Assistance Application**

**6. AUTHORIZATION**

**Please read this section carefully and sign at the bottom.**

All information in this application is true to the best of my knowledge. I agree to provide additional documentation upon request. **I understand that this confidential information cannot be disclosed to any party outside of South Shore Health System without my prior approval.**

\_\_\_\_\_  
**Signature of applicant**

\_\_\_\_\_  
**Date**

*If signing on behalf of the applicant: All information in this application is true to the best of my knowledge.*

\_\_\_\_\_  
**Signature of authorized representative**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Name of authorized representative**

\_\_\_\_\_  
**Relationship to applicant**

\_\_\_\_\_  
**Contact phone number**

**Before submitting, please make sure that you have completed all applicable sections of this application and have included all requested documents to verify your financial status. Incomplete applications will not be approved.**

**If you have any question please contact the Financial Counseling department at**

**781-624-4329**

## **Exhibit 4**



South Shore Hospital - Business Office  
P.O. Box 1021  
Pembroke, MA 02359-1021



ADDRESS SERVICE REQUESTED

0101

#BWNCYSP  
#015597448#

STATEMENT DATE 08/10/2016	ACCOUNT #
AMOUNT DUE \$176.99	AMOUNT PAID \$ _____

Please see reverse side for credit card payments.  
Please write your account number on your check and make  
checks payable to: **South Shore Hospital**.



P.O. Box 1021  
Pembroke, MA 02359-1021



PLEASE DETACH AND RETURN THIS PORTION WITH YOUR PAYMENT

0700

656911 (PC1)



**South Shore  
Hospital**

Business Office Hours: Mon-Fri 8:30-5:00  
1-800-486-1915

PO Box 1021  
Pembroke, MA 02359-1021

### YOUR STATEMENT

Thank you for choosing **South Shore Hospital** for your healthcare needs. The below balance for hospital services is now due. Please take note that you may receive additional bills for physician services. Please make your check payable to **South Shore Hospital** and mail to:

**South Shore Hospital**  
Attn: Business Office  
P.O. Box 1021  
Pembroke, MA 02359-1021

If you have additional Insurance information or are unable to pay the amount due, please contact us immediately at 1-800-486-1915. You may be eligible for programs that can help you with this obligation. Please see reverse side for assistance.

Thank you for choosing **South Shore Hospital** for your healthcare needs.

#### ► SUMMARY OF CHARGES

Insurance Payments/Adjustments	-\$575.01
EMERGENCY ROOM	\$713.00
MED/SURG SUPPLY	\$39.00

#### ► INSURANCE INFORMATION

Insurance Name:	BC HMO BLU
Subscriber ID:	MTN

#### ► ACCOUNT SUMMARY

Statement Date:	08/10/2016
Patient Name:	
Date of Service:	05/10/2016
Account Number:	
Total Charges:	\$752.00
Ins. Payments/Adjustments:	-\$575.01
Patient Payments/Adjustments:	\$0.00
Total Due:	\$176.99

0700

**This is your balance** **\$176.99**



South Shore Hospital - Business Office  
P.O. Box 1021  
Pembroke, MA 02359-1021



ADDRESS SERVICE REQUESTED

0101

STATEMENT DATE 08/10/2016	ACCOUNT #
AMOUNT DUE \$75.00	AMOUNT PAID \$ _____

Please see reverse side for credit card payments.  
Please write your account number on your check and make  
checks payable to: **South Shore Hospital**

#BWNCYSP  
#014951235#

  
P.O. Box 1021  
Pembroke, MA 02359-1021  




PLEASE DETACH AND RETURN THIS PORTION WITH YOUR PAYMENT

0702

656911 (PC1)



**South Shore  
Hospital**

Business Office Hours: Mon-Fri 8:30-5:00  
1-800-486-1915

PO Box 1021  
Pembroke, MA 02359-1021

### YOUR STATEMENT

We recently sent you a statement summarizing healthcare services provided at **South Shore Hospital**. We request your cooperation in paying the current balance due of \$75.00.

If you have additional insurance information or are unable to pay the amount due, please contact us immediately at 1-800-486-1915. You may be eligible for programs that could help you with this obligation. Please see reverse side for assistance. Otherwise, we will assume this bill is your responsibility.

Prompt payment of the balance due will eliminate future collection activity. Please include the top portion of this letter with your payment and mail to:

**South Shore Hospital**  
Attn: Business Office  
P.O. Box 1021  
Pembroke, MA 02359-1021

Thank you for choosing **South Shore Hospital** for your healthcare needs.

#### ► SUMMARY OF CHARGES

<u>Date of Service</u>	<u>Account Number</u>	<u>Amount Due</u>
02/06/2016		\$75.00

#### ► INSURANCE INFORMATION

Insurance Name: R I I F CROSS  
Subscriber ID:

#### ► ACCOUNT SUMMARY

Statement Date: 08/10/2016  
Patient Name:  
Date of Service: 02/06/2016  
Account Number:  
Total Due: \$75.00

0702

This is your balance **\$75.00**



South Shore Hospital - Business Office  
P.O. Box 1021  
Pembroke, MA 02359-1021



ADDRESS SERVICE REQUESTED

0101

#BWNCYSP  
#014606882#

STATEMENT DATE 08/10/2016	ACCOUNT # .
AMOUNT DUE \$100.00	AMOUNT PAID \$ _____

Please see reverse side for credit card payments.  
Please write your account number on your check and make  
checks payable to: **South Shore Hospital**



P.O. Box 1021  
Pembroke, MA 02359-1021



PLEASE DETACH AND RETURN THIS PORTION WITH YOUR PAYMENT

0703

656911 (PC1)



**South Shore  
Hospital**

Business Office Hours: Mon-Fri 8:30-5:00  
1-800-486-1915

PO Box 1021  
Pembroke, MA 02359-1021

### YOUR STATEMENT

The balance of \$100.00 for services rendered at **South Shore Hospital** is now overdue.

This account may be forwarded to a collection agency if it remains unpaid. Call us immediately at 1-800-486-1915 to make payment arrangements. Otherwise, enclose your payment along with the top portion of this letter and mail to:

**South Shore Hospital**  
Attn: Business Office  
P.O. Box 1021  
Pembroke, MA 02359-1021

You may be eligible for programs that can help you with this obligation. Please see reverse side for assistance.

Thank you for choosing **South Shore Hospital** for your healthcare needs.

#### ► SUMMARY OF CHARGES

Date of Service	Account Number	Amount Due
11/01/2015		\$100.00

#### ► INSURANCE INFORMATION

Insurance Name:	HARVARD
Subscriber ID:	HF

#### ► ACCOUNT SUMMARY

Statement Date:	08/10/2016
Patient Name:	
Date of Service:	11/01/2015
Account Number:	
Total Due:	\$100.00

0703

**This is your balance \$100.00**



South Shore Hospital - Business Office  
P.O. Box 1021  
Pembroke, MA 02359-1021



ADDRESS SERVICE REQUESTED

STATEMENT DATE 08/02/2016	ACCOUNT #
AMOUNT DUE \$530.67	AMOUNT PAID \$ _____

Please see reverse side for credit card payments.  
Please write your account number on your check and make  
checks payable to: South Shore Hospital

#BWNCYSP  
#014755333#



P.O. Box 1021  
Pembroke, MA 02359-1021



PLEASE DETACH AND RETURN THIS PORTION WITH YOUR PAYMENT

0704

656911 (PC1)



**South Shore  
Hospital**

Business Office Hours: Mon-Fri 8:30-5:00  
1-800-486-1915

PO Box 1021  
Pembroke, MA 02359-1021

### YOUR STATEMENT

The below account with South Shore Hospital is seriously past due. Previously we sent you an invoice requesting payment. We offered alternative payment arrangements in each request but you have failed to respond.

This is your final notice, this account may be referred to a collection agency if it remains unpaid. You may be eligible for programs that can help you with this obligation. Please see reverse side for assistance.

To remit directly, include your account number on your check and make your check payable to:

**South Shore Hospital**  
Attn: Business Office  
P.O. Box 1021  
Pembroke, MA 02359-1021

Thank you for choosing South Shore Hospital for your healthcare needs.

#### ► SUMMARY OF CHARGES

Date of Service	Account Number	Amount Due
02/11/2016		\$530.67

#### ► INSURANCE INFORMATION

Insurance Name: BLUE CROSS  
Subscriber ID: CDQ

#### ► ACCOUNT SUMMARY

Statement Date: 08/02/2016  
Patient Name:  
Date of Service: 02/11/2016  
Account Number: V  
Total Due: \$530.67

0704

This is your balance \$530.67



South Shore Hospital - Business Office  
P.O. Box 1021  
Pembroke, MA 02359-1021



ADDRESS SERVICE REQUESTED

0101

#BWNCYSP  
#012674443#



STATEMENT DATE 08/12/2016	ACCOUNT #
AMOUNT DUE \$322.39	AMOUNT PAID \$ _____

Please see reverse side for credit card payments.  
Please write your account number on your check and make  
checks payable to: **South Shore Hospital**



P.O. Box 1021  
Pembroke, MA 02359-1021



PLEASE DETACH AND RETURN THIS PORTION WITH YOUR PAYMENT

0707

656911 (PC1)

Business Office Hours: Mon-Fri 8:30-5:00  
1-800-486-1915

PO Box 1021  
Pembroke, MA 02359-1021



**South Shore  
Hospital**

## YOUR STATEMENT

Your monthly payment is due for **South Shore Hospital**.

Please send your check or money order to:

**South Shore Hospital**  
Attn: Business Office  
P.O. Box 1021  
Pembroke, MA 02359-1021

If you would like to pay by credit card, please fill out the information on the back of the letter and mail to the address listed above. You may be eligible for programs that can help you with this obligation. Please see reverse side for assistance.

Failure to remit your agreed upon payment in a timely manner may result in additional collection activity.

Thank you for choosing **South Shore Hospital** for your healthcare needs.

### SUMMARY OF CHARGES

Date of Service	Account Number	Amount Due
01/28/2011		\$322.39

### INSURANCE INFORMATION

Insurance Name:	BC HMO BLU
Subscriber ID:	XXH




### ACCOUNT SUMMARY

Statement Date:	08/12/2016
Patient Name:	
Date of Service:	01/28/2011
Account Number:	VI
Total Due:	\$322.39

0707

This is your balance **\$322.39**

PLEASE COMPLETE THE APPROPRIATE SECTIONS AND RETURN IN THE ENCLOSED ENVELOPE AS SOON AS POSSIBLE

CREDIT CARD PAYMENT/ CHANCE ADDRESS	INSURANCE INFORMATION	SECONDARY INSURANCE INFORMATION
<input type="checkbox"/>  <input type="checkbox"/>  <input type="checkbox"/> 	<b>MASSHEALTH</b> MassHealth Subscriber Number <input type="text"/>	<b>OTHER INSURANCE</b> Insurance Company Name and Address <input type="text"/> <input type="text"/>
CREDIT CARD NO: <input type="text"/>	<b>MEDICARE</b> Medicare Number <input type="text"/>	Policy/ID Number <input type="text"/>
CARDHOLDER SIGNATURE _____ MY INFORMATION HAS CHANGED TO: NAME _____ ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____ TELEPHONE _____	Retirement Date _____ Medex Number _____ ACCIDENT/WORK RELATED INJURY Injury Date _____ Case No. _____ Insurance Carrier _____ Employer Name _____ Employer Phone _____ Employer Address _____ City _____ State _____ Zip Code _____	PI's Relationship to Subsc. _____ Subscriber Name _____ Subscriber Employer _____ Employer City & State _____

Statements are available to you in Spanish, Portuguese, Mandarin and Vietnamese.

**NOTICE OF AVAILABILITY OF FINANCIAL COUNSELING, DISCOUNTS AND PAYMENT PLANS**

We offer financial counseling on federal, state and South Shore Hospital financial assistance programs that might help you with your medical bills.

To see what programs you may qualify for please call our Financial Counseling Department at 781-624-4329.

These options are time sensitive, so please call Customer Service at the telephone numbers listed below as soon as possible.

**PLEASE CALL US IMMEDIATELY IF YOU THINK YOU WILL HAVE DIFFICULTY PAYING THIS BILL.**

Las declaraciones están disponibles para usted en español, Portugués, Mandarin y vietnamita.

**AVISO DE DISPONIBILIDAD DE: ASESORIA FINANCIERA, DESCUENTOS Y PLANES DE PAGO**

Ofrecemos asesoria financiera sobre programas federales y estatales para ayudarle con sus gastos médicos.

Para ver lo que otras inscripciones usted puede calificar para por favor llame 781-624-4329.

Los plazos para acogerse a estas opciones son limitados, por favor llame cuanto antes al telefono de Servicio al Cliente.

**POR FAVOR LLAMENOS DE INMEDIATO SI PIENSA QUE SE LE HARA DIFICIL PAGAR ESTA CUENTA.**

**CUSTOMER SERVICE - SERVICIO AL CLIENTE**  
**Questions About Your Bill?**  
**Preguntas Sobre Su Cuenta?**

**SOUTH SHORE HOSPITAL**

Please call: Por favor llame: 800-486-1915



Monday-Friday: Lunes-Viernes: 8:30 am - 5:00 pm

Fax 781-826-6367



Send Correspondence to: Envie Correspondencia a:

SOUTH SHORE HOSPITAL

P.O. Box 1021

Pembroke, MA 02359-1021



## **Exhibit 5**



## **Availability of Financial Assistance**

The hospital is the frontline caregiver providing medically necessary care for all people who present to its facility and locations regardless of ability to pay. The hospital offers this care for **all** patients that come to our facility 24 hours a day, seven days a week, and 365 days a year. As a result, the hospital is committed to providing all of our patients with high-quality care and services. As part of this commitment, the hospital works with individuals with limited incomes and resources to find available options to cover the cost of their care.

The hospital will help uninsured and underinsured individuals apply for health coverage through a public assistance program or the hospital's financial assistance program (including but not limited to MassHealth, the premium assistance payment program operated by the Health Connector, the Children's Medical Security Program, the Health Safety Net, and Medical Hardship), and work with individuals to enroll as appropriate. Assistance for these programs is determined by reviewing, among other items, an individual's household income, assets, family size, expenses, and medical needs.

The hospital will assist patients in obtaining health coverage through public programs and financial assistance through other sources, including the hospital, whenever appropriate. The hospital may also be required to appropriately bill for and collect specific payments, which may include but not be limited to, applicable co-payments, deductibles, coinsurances, and other amounts for which the patient is responsible. When registering for services or if receiving a bill, the hospital encourages patients to contact our staff to determine if they and/or a family member are in need of and eligible for financial assistance.

**While we understand that each individual has a unique financial situation, information and assistance regarding eligibility for public assistance programs and/or coverage through the hospital's financial assistance program may be obtained by contacting the Financial Counseling department. Our Financial Counselors are available Monday–Friday from 9am–6pm and every Saturday from 8am–4pm. Please contact the Financial Counseling Department at 781-624-4329 to make an appointment to meet with a certified application counselor. Please do not delay in speaking with a financial counselor to explore your options. Enrollment in programs is time sensitive.**

More information about this policy and the hospital's financial assistance program, including the application form and a plain language summary of the financial assistance policy, are available on the hospital's website: [www.southshorehospital.org](http://www.southshorehospital.org)

Thank you for choosing South Shore Hospital for your care.

## **Exhibit 6**

## **South Shore Hospital Credit, Collection & Financial Assistance Policy**

### **Amounts Generally Billed (AGB):**

To calculate Amounts Generally Billed (AGB), South Shore Hospital uses the “look-back” method. In this method, the Hospital derives an AGB percentage based on Medicare Fee for Service claims over a specified 12-month period, divided by the gross charges for those claims. The resulting percentage is multiplied by gross charges for all emergency and medically necessary care to determine the Amount Generally Billed. The AGB percentage is recalculated annually.

For the 12 month period ending September 30, 2015, the AGB percentage is 42.3% based on the following information:

Total Charges	Claims Allowed	AGB Percentage
\$ 364,897,510	\$ 154,280,568	42.3%

Patients will not be charged more than the Amount Generally Billed.

### **South Shore Hospital Financial Assistance Discount for Patients with Limited Income:**

Patients who qualify for this discount will have their charges for applicable services discounted according to the following schedule. The discounts are based on the total charges and are not applied to balances that have already been discounted due to insurance coverage

<b><i>Family Income as % of FPG</i></b>	<b><i>Discount for South Shore Hospital</i></b>
0 to 133%	100%
134 to 250%	85%
251 to 300%	70%