Outer Cape Health Services

Credit & Collection Policy 2016
101 CMR 613.00

Table of Contents

1. General Filing Requirement
- 1.1 Electronic Filing with Table of Contents

2. General Definitions
- *2.1 Emergency Care - NA*
- 2.2 Urgent Care Definition to be used in determining allowable Bad Debt Under 613.06

3. General Collection Policies & Procedures
- 3.1 Standard Collection Policies & Procedures for Patients
- 3.2 Policies & Procedures for Collecting Financial Information
- *3.3 Emergency Care Classification - NA*
- 3.4 Policy for Deposits and Payment Plans
- 3.5 Copies of Billing Invoices and Notices of Assistance
- 3.6 Discount/Charity Programs for Uninsured Patients
- *3.7 Hospital deductible payment option at HLHC - NA*
- *3.8 Full or 20% deductible payment option for all partial HSN patients at HLHC, satellite and/or student health center-NA*
- *3.9* Community Health Center (CHC) charge of 20% of deductible per visit to all partial HSN patients
- 3.10 Direct Website(s) or URL(s) where the Provider's Credit and Collection Policy, Provider Affiliate List (if applicable) and other financial assistance policies are posted
- 3.11 *Provider Affiliate List effective the first day of the Acute Hospital's fiscal year beginning after December 31, 2016 – N/A*

4. Collection of Financial Information
- 4.1 Emergency, Inpatient, Outpatient & CHC Services
- *4.2 Inpatient Verification - NA*
- 4.3 Outpatient/CHC Verification

5. Deposits and Payment Plans
- 5.1 Deposits Requirement for Emergency Services & Low Income Patients
- 5.2 Deposits Requirement for Partial-HSN Low Income Patients
- 5.3 Deposits Requirement for Medical Hardship Patients
- 5.4 Payment Plan on Balance less than, and greater than $1000

6. Populations Exempt from Collection Action

6.1 MassHealth and EAEDC enrollees
6.2 Participants in CMSP with MAGI income equal or less than 300% FPL
6.3 Low Income Patients except Dental Only low income patients
6.4 Low Income Patients – Partial HSN
6.5 Low Income Patient Consent to billing for non-eligible services
6.6 Low Income Patient Consent Exclusion – Medical Errors (SRE)
6.7 Low Income Patient Consent Exclusion – Admin/Billing Errors
6.8 Low Income Patient CommonHealth one time deductible billing
6.9 Medical Hardship Patient & Emergency Bad Debt Eligible for Medical Hardship
6.10 Provider fails to timely submit Medical Hardship application

7. Minimum Collection Action on Hospital Emergency Bad Debt & CHC Bad Debt

7.1 Initial Bill
7.2 Collection action subsequent to Initial Bill
7.3 Documentation of alternative collection action efforts
7.4 Final Notice by Certified Mail
7.5 Continuous Collection Action – no gap exceeding 120 days
7.6 Collection Action File
7.7 *Emergency Bad Debt claim and EVS check - NA*
7.8 HLHC Bad Debt claim and EVS check - NA
7.9 CHC Bad Debt claim and EVS check

8. Available Third Party Resources

8.1 Diligent efforts to identify & obtain payment from all liable parties
8.2 Determining the existence of insurance, including motor vehicle liability
8.3 Verification of patient's other health insurance coverage
8.4 Submission of claims to all insurers
8.5 Compliance with insurer's billing and authorization requirements
8.6 Appeal of denied claim
8.7 Return of HSN payments upon availability of 3rd-party resource

9. Serious Reportable Events (SRE)

9.1 Billing & collection for services provided as a result of SRE
9.2 Billing & collection for services that cause or remedy SRE
9.3 Billing & collection by provider not associated with SRE for SRE related services
9.4 Billing & collection for readmission or follow-up on SRE associated with a provider

10. Provider responsibilities

10.1 Non-discrimination

10.2 Board approval for legal execution against patient home or motor vehicle
10.3 Advise patient on TPL duties and responsibilities

11. Patient Rights and Responsibilities

11.1 Provider responsibility to advise patient on right to apply for MassHealth, Health Connector Programs, HSN and Medical Hardship
11.2 Provider responsibility to provide individual notice of Eligible Services and programs of public assistance during the Patient's initial registration with the Provider
11.3 Provider responsibility to provide individual notice of Eligible Services and programs of public assistance when a Provider becomes aware of a change in the Patient's eligibility or health insurance coverage
11.4 Provider responsibility to advise patient of the right to a payment plan
11.5 Provider responsibility to advise patient on duty to provide all required documentation
11.6 Provider responsibility to advise patient on duty to inform of change in eligibility status & available Third Party Liability (TPL)
11.7 Provider responsibility to advise patient on duty to track patient deductible
11.8 Provider responsibility to advise patient on duty to inform HSN/MassHealth of any TPL claim/lawsuit
11.9 Provider responsibility to advise patient on duty to file TPL claim on accident, injury or loss
11.10 Provider responsibility to advise patient on assigning right to recover HSN payments from TPL claim proceeds
11.11 Provider responsibility to advise patient on duty to provide TPL claim or proceeding information.
11.12 Provider responsibility to advise patient on duty to notify HSN/ MassHealth within ten days of filing TPL claim/lawsuit
11.13 Provider responsibility to advise patient on duty to repay HSN for Eligible Services from TPL proceeds
11.14 Provider responsibility to provide individual notice of financial assistance during the Patient's initial registration with the Provider
11.15 Provider responsibility to provide individual notice of financial assistance when a Provider becomes aware of a change in the Patient's eligibility or health insurance coverage
11.16 Provider responsibility to advise patient of HSN limit on recovery of TPL claim proceeds

12. Signs

12.1 Location of the signs
12.2 Size of the signs
12.3 Multi-lingual signs when applicable
12.4 Wording in signs
12.5 Providers must make their Credit and Collection Policy and Provider Affiliate List (if applicable) available on the Provider's website

13. Sample Documents & Notices on Availability of Assistance

13.1 Sample on assistance notice on billing invoice

13.2 Sample of Eligible Services and programs of assistance notice on billing invoice

13.3 Sample of assistance notice in collection actions (billing invoices)

13.4 Sample of payment plan notice to Low Income or Medical Hardship patients

13.5 Posted Signs

*Sections in Italics are not applicable to CHCs

1. General Filing Requirement

1.1 Outer Cape Health Services will electronically file its Credit & Collection Policy with the Health Safety Net (HSN) Office within 90 days of adoption of amendments to this regulation that would require a change in the Credit & Collection Policy; when Outer Cape Health Services changes its Credit & Collection Policy; or when two Providers merge and request to be paid as a single merged entity or when requested by the HSN Office.

2. General Definitions

2.1 Emergency Care – N/A

2.2 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 elective or primary care.

3. General Collection Policies & Procedures

3.1 Standard Collection Policies and Procedures for patients

(a) Outer Cape Health Services will make reasonable efforts prior to or during treatment to obtain the financial information necessary to determine responsibility for payment of the bill from the patient or guarantor. The center's staff provides all first-time patients with a registration form which includes questions on the patient's insurance status, residency status, and financial status, and provides assistance, as needed, to the patient in completing the form. A patient who states that they are insured will be requested to provide evidence of insurance sufficient to enable the center to bill the insurer. Health center staff will ask returning patients, at the time of visit, whether there have been any changes in their insurance coverage status. If there has been a change, the new information is recorded in electronic management system, eClinical Works, a manual entry to insurance file on the Patient's demographics, and a scanned copy attached to patient file. The patient will be advised or assisted in informing MassHealth of the change in Insurance status.

(b) Outer Cape Health Services undertakes the following reasonable collection efforts for patients who have not provided complete eligibility documentation, or for whom insurance payment may be available:

(1) an initial bill/statement will be sent to the party responsible for the patient's financial obligations, guarantor or patient;

(2) subsequent billings, telephone calls, and any subsequent notification method that constitute a genuine effort to contact the party which is consistent with patient confidentiality are sent;

(3) efforts to locate the patient or the correct address on mail returned as an incorrect address are documented, and

(4) a final notice is sent by certified mail for balances over $1000, where notices have not been returned as an incorrect address or as undeliverable.

(c) Cost Sharing Requirements. Outer Cape Health Services staff must inform patients who are responsible for paying co-payments in accordance with 101 CMR 613.04(6)(b) and deductibles in accordance with 101 CMR 613.04(6)(c), that they will be responsible for these co-payments at the time of visit.
(d) Low Income Patient Responsibilities.1. Outer Cape Health Services requests co-payments of $1 for each generic drug in the following drug classes: antihyperglycemics, antihypertensives, and antihyperlipidemics; and $3.65 for each generic and brand-name drugs from all patients over the age of 18, with the exception of pregnant or postpartum women, up to a maximum pharmacy co-payment of $250 per year.
(e) Health Safety Net - Partial Deductibles/Sliding Fees: For Health Safety Net-Partial patients with MassHealth MAGI Household income or Medical Hardship Family Countable Income between 150.0% and 300% of the FPL, Outer Cape Health Services will collect the 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(l) in the applicant's Premium Billing Family Group and 200% of the FPL. If any member of the PBFG has an FPL below 150.1% there is no deductible for any member of the PBFG. The Patient is responsible for 20% of the HSN payment for all services, with the exception of pharmacy services provided, up to this Deductible amount. Once the Patient has incurred the Deductible, the patient is no longer required to pay 20% of the payment. Only one deductible is allowed per PBFG approval period.

3.2 Policies & Procedures for Collection Financial Information

All patients who wish to apply for HSN or other public coverage are required to complete and submit a MassHealth Application using the eligibility procedures and requirements applicable to MassHealth applications under 130 CMR 502.000 or 130 CMR 515.000.

(a) Determination Notice. The Office of Medicaid or the Commonwealth Health Insurance Connector will notify the individual of his or her eligibility determination for health care coverage, or if the individual is a Low Income Patient status.

(b) The Division's Electronic Free Care Application issued under 101 CMR 613.04(2)(b)(3) may be used for the following special application types:
a. Minors receiving Services may apply to be determined a Low Income Patient using their own income information and using the Division's Electronic Free Care Application. If a minor is determined to be a Low Income Patient, the health center will submit claims for confidential Services when no other source of funding is available to pay for the services confidentially. For all other services, minors are subject to the standard Low Income Patient Determination process.
b. An individual seeking eligible services who has been battered or abused, or who has a reasonable fear of abuse or continued abuse, may apply for Low Income Patient status using his or her own income information. Said individual is not required to report his or her primary address.
Presumptive Determination. Outer Cape Health Services Inc. does not do Presumptive Determinations. If a patient is not eligible for Health Safety Net, they meet with a Certified Application Counselor to determine if they are eligible for the Sliding Fee Discount.

3.3 Emergency Care Classification - NA

3.4 Policy for Deposits and Payment Plans

Outer Cape Health Services' billing department provides and monitors Deposits and Payment Plans as described in **Section 5** of this policy for qualified patients as described in 101 CMR 613.08) Each payment plan must be authorized by the Billing Manager or other health center authorized person as designated by the billing manager.

3.5 Copies of Billing Invoices and Notices of Assistance

(a) Billing Invoices: The following language is used in billing statements sent to low income patients: "If you are unable to pay this bill, please call 508 905 2821. Financial counseling is available upon request."

(b) Notices: Outer Cape Health Services provides all applicants with notices of the availability of financial assistance programs, including MassHealth, subsidized Health Connector Programs, HSN and Medical Hardship, for coverage of services exclusive of personal convenience items or services, which may not be paid in full by third party coverage. The center also includes a notice about Eligible Services and programs of public assistance to Low Income Patients in its initial invoices, and in all written Collection Actions. All applicants will be provided with written notice of approval for Health Safety Net or denial of Health Safety Net once this has been determined. The following language is used on billing statements sent to low income patients: "If you are unable to pay this bill, please call 508-905-2821. Financial counseling is available upon request." Outer Cape Health Services will notify the patient that the Provider offers a payment plan if the patient is determined to be a Low Income Patient or qualifies for Medical Hardship.

(c) Signs: Outer Cape Health Services posts signs in the clinic and registration areas and in business office areas that are customarily used by patients that conspicuously inform patients of the availability of financial assistance and programs of public assistance and who to speak with to apply for such programs. Signs will be large enough to be clearly visible and legible by patients visiting these areas. All signs and notices will be in English.

3.6 Discount/Charity Programs for Uninsured Patients

Outer Cape Health Services offers Sliding Fee Discounts to patients who are ineligible for the Health Safety Net. For these patients, Outer Cape Health Services offers full discount to patients under 100% of the Federal Poverty Income Guidelines (FPIG) and Sliding Fee Discounts to patients with incomes between 100% and 200% of the FPIG.

3.7 Hospital deductible payment option at HLHC - NA

3.8 Full or 20% Deductible Payment Option for all Partial HSN Payments at HLCH Satellite or Student Health Center – NA

3.9 CHC charge of 20% of deductible per visit to all partial HSN patients

Outer Cape Health Services charges HSN-Partial Low Income Patients 20% of the HSN payment for each visit, to be applied to the amount of the Patient's annual Deductible until the patient meets the Deductible.

3.10 Direct Website(s) (or URL(s)) where the provider's Credit & Collection Policy, Provider Affiliate List (if applicable) and other financial assistance Policies are posted

outercape.org

3.11 Provider Affiliate List effective the first day of the acute hospital's fiscal year beginning after December 31, 2016 - NA

4. Collection of Financial Information

4.1 Emergency, Inpatient, Outpatient & CHC Services: Outer Cape Health Services makes reasonable efforts, as soon as reasonably possible, to obtain the financial information necessary to determine responsibility for payment of the bill from the patient or guarantor.

4.2 Inpatient Verification - NA

4.3 Outpatient/CHC Financial Verification

Outer Cape Health Services makes reasonable efforts to verify patient-supplied information at the time the patient receives the services. The verification of patient-supplied information may occur at the time the patient receives the services or during the collection process as defined below:

1. Verification of gross monthly-earned income is mandatory. When possible this is done through electronic data matching using the eligibility procedures and requirements under 130 CMR 502 or 516. If the information received is not compatible or is unavailable, the following are required:,

a. Two recent pay stubs;

b. A signed statement from the employer; or

c. The most recent U.S. tax return.

2. Verification of gross monthly-unearned income is mandatory and shall include, but not be limited to, the following:

a. A copy of a recent check or pay stub showing gross income from the source;

b. A statement from the income source, where matching is not available;

c. The most recent U.S. Tax Return.

3. Verification of gross monthly income may also include any other reliable evidence of the patient's earned or unearned income.

5. Deposits and Payment Plans

5.1 Outer Cape Health Services does not require pre-treatment deposit from individuals that require Emergency Services or Low Income patients.

5.2 Deposit Requirement for Partial-HSN Low Income Patients: Outer Cape Health Services does not require a deposit from individuals determined to be Low Income Patients pursuant 101 CMR 613.08(1)(f)2.

5.3 Deposit Requirement for Medical Hardship Patients: Outer Cape Health Services does not require a deposit from patients eligible for Medical Hardship.

5.4 Payment Plan on Balance less than $1000: Outer Cape Health Services will offer an individual with a balance of $1,000 or less an interest-free one year payment plan with a minimum monthly payment of no more $25. A patient that has a balance of more than

$1,000, will be offered an interest-free payment plan with duration of at least two years by the health center.

6. Populations Exempt from Collection Action

6.1 MassHealth and EAEDC: Outer Cape Health Services does not bill patients enrolled in MassHealth, patients receiving governmental benefits under the Emergency Aid to the Elderly, Disabled and Children program, except that Outer Cape Health Services may bill patients for any required co-payments and deductibles. Outer Cape Health Services 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, Outer Cape Health Services will cease its collection activities.

6.2 Participants in CMSP with MAGI income equal or less than 300% FPL: 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. Outer Cape Health Services 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, Outer Cape Health Services will cease all collection activities.

6.3 Low Income Patients except Dental – Full HSN: Low Income Patients with MassHealth MAGI Household income or Medical Hardship Family Countable Income equal or less than 150.1% of the FPL, are exempt from Collection Action for any Eligible Services rendered by the Health center during the period for which they have been determined Low Income Patients, except for co-payments and deductibles. Outer Cape Health Services 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.

6.4 Low Income Patients – Partial HSN: Low Income Patients with MassHealth MAGI Household income or Medical Hardship Family Countable Income, as described in 101 CMR 613.04(l) between 200.1 to 300.1% of the FPL are exempt from Collection Action for the portion of their bill that exceeds the Deductible and may be billed for co-payments and deductibles as set forth in 101 CMR 613.04(6)(b) and (c). Outer Cape Health Services 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.

6.5 Low Income Patient Consent on billing for non-reimbursable services: Outer Cape Health Services may bill Low Income Patients for services other than Eligible Services provided at the request of the Patient and for which the patient has agreed in writing to be responsible.

6.6 Low Income Patient Consent Exclusion – Medical Errors: Outer Cape Health Services will not bill low income patients for claims related to medical errors occurring on Outer Cape Health Services' premises.

6.7 Low Income Patient Consent Exclusion – Admin/Billing Errors: Outer Cape Health Services will not bill Low Income Patients for claims denied by the patient's primary insurer due to an administrative or billing error.

6.8 At the request of the Patient, Outer Cape Health Services may bill a Low Income Patient in order to allow the Patient to meet required CommonHealth One-Time Deductible as described in 130 CMR 506.009.
6.9 Medical Hardship Patient & Emergency Bad Debt eligible for Medical Hardship: Outer Cape Health Services will not undertake a Collection Action against an individual who has qualified for Medical Hardship with respect to the amount of the bill that exceeds the Medical Hardship contribution. If a claim already submitted as Emergency Bad Debt becomes eligible for Medical Hardship payment from Health Safety Net, Outer Cape Health Services will cease collection activity on the Patient for the services.
6.10 Outer Cape Health Services will not undertake a collection action against any individual, who has qualified for Medical Hardship with respect to any bills that would have been eligible for HSN payment in the event that Outer Cape Health Services has not submitted the patient's Medical Hardship documentation within the 5 days.

7. Minimum Collection Action on Hospital Emergency Bad Debt & CHC Bad Debt

The Outer Cape Health Services and any collection agency used by Outer Cape Health Services is required to conform to the above policies and will make the same effort to collect accounts for Uninsured Patients as it does to collect accounts from any other patient classifications.

The minimum requirements before writing off an account to the Health Safety Net include:
7.1 Initial Bill: Outer Cape Health Services sends an initial bill to the patient or to the party responsible for the patient's personal financial obligations.
7.2 Collection action subsequent to Initial Bill: Outer Cape Health Services will use subsequent bills, phone calls, collection letters, personal contact notices, and any other notification method that constitutes a genuine effort to contact the party responsible for the bill.
7.3 Documentation of alternative collection action efforts: Outer Cape Health Services will document alternative efforts to locate the party responsible or the correct address on any bills returned by the USPS as "incorrect address" or "undeliverable."
7.4 Final Notice by Certified Mail: Outer Cape Health Services will send a final notice by certified mail for balances over $1,000 where notices have not been returned as "incorrect address" or "undeliverable"
7.5 Continuous Collection Action: Outer Cape Health Services documents that the required collection action has been undertaken on a regular basis and, to the extent possible, does not allow a gap in this action greater than 120 days. days If, after reasonable attempts to collect a bill, the debt for an Uninsured Patient remains unpaid for more than 120 days, Outer Cape Health Services may deem the bill to be uncollectible and bill it to the Health Safety Net Office.

7.6 *Collection Action File* The health center maintains a patient file which includes documentation of the collection effort including copies of the bill(s), follow-up letters, reports of telephone and personal contact, and any other effort made.
7.7 *Emergency Bad Debt Claim and EVS Check – NA*
7.8 HLHC Bad Debt Claim and EVS Check – NA

7.09 CHC Bad Debt claim and EVS check. Outer Cape Health Services may submit a claim for Urgent Care Bad Debt for Urgent Care Services if:

(a) The services were provided to:

1. An uninsured individual who is not a Low Income Patient. Outer Cape Health Services will not submit a claim for a deductible or the coinsurance portion of a claim for which an insured patient is responsible. Outer Cape Health Services will not submit a claim unless it has checked the REVS system to determine if the patient has filed an application for MassHealth; or

2. An uninsured individual whom Outer Cape Health Services assists in completing a MassHealth application and who is subsequently determined into a category exempt from collection action. In this case, the above collection actions will not be required in order to file.

(b) Outer Cape Health Services provided Urgent Services as defined in 101 CMR 613.02 to the Patient. Outer Cape Health Services may submit a claim for all Eligible Services provided during the Urgent Care visit, including ancillary services provided on site.

(c) The responsible provider determined that the patient required Urgent Services. Outer Cape Health Services will submit a claim only for Urgent Care Services provided during the visit.

(d) Outer Cape Health Services undertook the required Collection Action as defined in 101 CMR 613.06(1)(a) and submitted the information required in 101 CMR 613.06(1)(b) for the account; and

(e) The bill remains unpaid after a period of 120 days.

8. Available Third Party Resources

8.1 Diligent efforts to identify & obtain payment from all liable parties: Outer Cape Health Services will make diligent efforts to identify and obtain payment from all liable parties.

8.2 Determining the existence of insurance, including motor vehicle liability:
In the event that a patient seeks care for an injury, Outer Cape Health Services will inquire as to whether the injury was the result of a motor vehicle accident; and if so, whether the patient or the owner of the other motor vehicle had a liability policy. Outer Cape Health Services will retain evidence of efforts to obtain third policy payer information

8.3 Verification of patient's other health insurance coverage: At the time of application, and when presenting for visits, patients will be asked whether they have private insurance. Outer Cape Health Services will verify, through EVS, or any other health insurance resource available to Outer Cape Health Services, on each date of service and at the time of billing.

8.4 Submission of claims to all insurers: In the event that a patient has identified that they have private insurance, Outer Cape Health Services will make reasonable efforts to obtain sufficient information to file claims with that insurer; and file such claims.

8.5 Compliance with insurer's billing and authorization requirements: Outer Cape Health Services will comply with the insurer's billing and authorization requirements.

8.6 Appeal of denied claim. Outer Cape Health Services will appeal denied claims when the stated purpose of the denial does not appear to support the denial.

8.7 Return of HSN payments upon availability of 3rd-party resource: For motor vehicle accidents and all other recoveries on claims previously billed to the Health Safety Net, Outer Cape Health Services will promptly report the recovery to the HSN.

9. Serious Reportable Events (SRE)

9.1 Billing & collection for services provided as a result of SRE: Outer Cape Health Services shall not charge, bill, or otherwise seek payment from the HSN, a patient, or any other payer as required by 105 CMR 120.332 for services provided as a result of aSRE occurring on the premises covered by a provider's license, if the provider determines that the SRE was: a. Preventable; b. Within the provider's control; and c. Unambiguously the result of a system failure as required by 105 CMR 130.332 (B) and (c).

9.2 Billing & collection for services that cause or remedy SRE: Outer Cape Health Services shall not charge, bill, or otherwise seek payment from the HSN, a patient, or any other payer as required by 105 CMR 120.332 for services directly related to: a. The occurrence of the SRE;

b. The correction or remediation of the event; or c. Subsequent complications arising from the event as determined by the Health Safety Net office on a case-by-case basis.

9.3 Billing and collection by provider not associated with SRE: Outer Cape Health Services will submit claims for services it provides that result from an SRE that did not occur on its premises

9.4 Billing & collection for readmission or follow-up on SRE associated with provider: Follow-up Care provided by Outer Cape Health Services is not billable if the services are associated with the SRE as described in 101 CMR 613.03(1)(d)2.

10. Provider responsibilities

10.1 Non-discrimination: Outer Cape Health Services shall not discriminate on the basis of race, color, national origin, citizenship, alienage, religion, creed, sex, sexual orientation, age, or disability, in its policies, or in its application of policies, concerning the acquisition and verification of financial information, pre-admission or pretreatment deposits, payment plans, deferred or rejected admissions, or Low Income Patient status.

10.2 Before seeking legal execution against the personal residence or motor vehicle of a Low Income Patient, Outer Cape Health Services requires its Board of Directors to approve such action on an individual basis.

10.3 Advise patient on TPL duties and responsibilities: Outer Cape Health Services will advise patients of the responsibilities described in 101 CMR 613.08(2)(b) at the time of application and at subsequent visits

11. Patient Rights and Responsibilities

11.1 Provider responsibility to advise patient on right to apply for MassHealth, Health Connector Programs, HSN and Medical Hardship:

Outer Cape Health Services informs all patients of their right to apply or MassHealth, Premium Assistance Payment Program, HSN, and Medical Hardship.

11.2 Provider responsibility to provide individual notice of eligible services and programs of public assistance during the patient's initial registration with the provider. The health center informs all Low Income Patients and patients

determined eligible for Medical Hardship of their right to a payment plan as described in 101 CMR 613.08(1)(f).

11.3 Provider to provide individual notice of eligible services and programs of public assistance when a provider becomes aware of a change in the patient's eligibility for health insurance coverage: The health center provides patients with individual notices of eligible services and programs of public assistance when we become aware of a change in the patient's eligibility for health insurance coverage.

11.4 Provider responsibility to advise patient of the right to a payment plan: The health center advises patients of their right to an payment plan.

11.5 Provider responsibility to advise patient on duty to provide all required documentation: The health center advises patients of their duty to provide all required documentation.

11.6 Provider responsibility to advise patient of duty to inform of change in eligibility status and available third party liability (TPL): The health center informs all patients that they have a responsibility to inform the health center and/or MassHealth when there has been a change in their MassHealth MAGI Household income or Medical Hardship Family Countable Income as described in 101 CMR 613.04(1), insurance coverage, insurance recoveries, and/or TPL status

11.7 Provider responsibility to advise patient on duty to track patient deductible: At the time of application, Low Income Partial patients are advised that it is their responsibility to track expenses toward their deductible and provide documentation to the health center that the deductible has been reached when more than one family member has been determined to be a Low Income Patient or if the patient or family members receive Eligible Services from more than one provider.

11.8 Provider responsibility to inform the HSN Office or MassHealth of a TPL claim/lawsuit: In the event that a patient is identified as having been involved in an accident or suffers from an illness or injury that has or may result in a lawsuit or insurance claim, the health center advises the patient of his/her duty to inform the HSN Office or MassHealth of a TPL claim/lawsuit as well.

11.9 Provider responsibility to advise patient on duty to file TPL claims on accident, injury of loss: In the event that a patient is identified as having been involved in an accident or suffers from an illness or injury that has or may result in a lawsuit or insurance claim, the health center advises the patient of his/her duty to file TPL claims

11.10 Provider responsibility to inform patient on Assigning the right to recover HSN payments from TPL claim proceeds: In the event that a patient is identified as having been involved in an accident or suffers from an illness or injury that has or may result in a lawsuit or insurance claim, the health center informs the patient that they are required to assign the right to recover HSN payments from the TPL proceeds.

11.11 Provider responsibility to inform patient to provide TPL claim or legal proceedings information: In the event that a patient is identified as having been involved in an accident or suffers from an illness or injury that has or may result in a lawsuit or insurance claim, the health center informs the patient that they are required to provide TPL claims or legal proceedings information.

11.12 Provider responsibility advise patient to notify HSN/MassHealth within 10 days of filing a TPL claim/lawsuit: In the event that a patient is identified as having been involved in an accident or suffers from an illness or injury that has or may result in a lawsuit or insurance claim, the health center advises the patient that they are responsible to notify HSN/MassHealth of it within 10 days.

11.13 Provider responsibility to advise patient of duty to repay the HSN for applicable services from TPL Proceeds: In the event that a patient is identified as having been involved in an accident or suffers from an illness or injury that has or may result in a lawsuit or insurance claim, the health center advises the patient that they are responsible for repaying the HSN for applicable services from TPL proceeds.

11.14 Provider responsibility to provide individual notice of financial assistance during the patient's initial registration with the provider: The health center provides individual notice of financial assistance during the patient's initial registration.

11.15 Provider's responsibility to provide individual notice of financial assistance when the provider becomes aware of a change in a patient's eligibility or health insurance coverage: The health center provides individual notice of financial assistance when the provider becomes aware of a change in a patient's eligibility or health insurance coverage.

11.16 11.16 Provider responsibility to advise patient of HSN limit on recovery of TPL claim proceeds: In the event that a patient is identified as having been involved in an accident or suffers from an illness or injury that has or may result in a lawsuit or insurance claim, the health center advises the patient that recovery from TPL payments is limited to the HSN expenditures for eligible services.

12. Signs

12.1 Location of the signs Outer Cape Health Services has posted signs in the clinic and registration areas and in business office areas that are customarily used by patients that conspicuously inform patients of the availability of financial assistance programs and Outer Cape Health Services location at which to apply for such programs.

12.2 Size of the Signs: The signs are large enough to be clearly visible and legible by Patients visiting these areas.

12.3 Multi-lingual signs when applicable: All signs and notices have been translated into the languages spoken by 10% or more of the residents in our health center's service area. These are: English

12.4 Wording in Signs: Outer Cape Health Services signs notify patients of the availability of financial assistance and of programs of financial assistance. Copies of Signs can be found in the Section 13 of this Policy.

12.5 Providers must make their Credit & Collection Policy and provider affiliate list, if applicable, available on the provider's website. Outercape.org

13. Sample Documents & Notices on Availability of Assistance

13.1 Sample of Assistance Notice on Billing Invoice Attached

13.2 Sample of Eligible Services and programs of assistance – notice on billing invoice.– Attached

13.3 Sample of Assistance notice in collection actions (billing invoices)

13.4 Payment plan notice to Low Income or Medical Hardship patients –

Attached

13.5 Posted Signs – Sample(s) attached

Approved by the Board of Directors of **Outer Cape Health Services:**

Date:_____

Authorized Signature:_____

Title:_____

Outer Cape Health Services, Inc.

Financial Assistance for Medical Appointments is Available

Outer Cape Health Services offers a Sliding Fee Scale that discounts the cost of medical appointments.

For program details, please see one of our Healthcare Access Specialists or call (508) 349-3131 Ext. 2107