

Table of Contents

I. Purpose	2
A. Overview	2
B. Scope	2
II. Definitions	2
III. Financial Assistance Policy	5
A. Overview	5
B. Patient Eligibility	5
1. Generally	5
2. Financial Qualifications	6
3. Patient Responsibilities	7
C. Services Eligible for Financial Assistance	7
1. Urgent/Emergent	7
2. Elective Services at Acute Care Hospitals and Physician’s Organizations	7
3. Elective Services at Post-Acute and McLean Hospital	8
4. Excluded Services	8
D. Financial Assistance Discounts	9
1. Amounts Generally Billed	9
2. Financial Assistance Discount Rates	10
E. Application Process	11
F. Relationship between the Financial Assistance Policy and the Health Safety Net (HSN)	12
1. Health Safety Net Overview	12
2. Health Safety Net Full and Partial	12
3. HSN Medical Hardship & HSN Confidential	13
IV. Uninsured Patient Discounts	13
A. Overview	13
B. Uninsured Discounts and Exclusions	14
1. Available discounts	14
2. Exclusions	15
V. Individual Consideration	15
VI. Financial Counseling	16
A. Patient Financial Counseling Services	16
VII. Publication and Dissemination of Financial Assistance Policy	16
Appendix A: Affiliated Mass General Brigham Entities	17
Appendix B: Financial Assistance Application	18

I. Purpose

A. Overview

Mass General Brigham (MGB) entities are tax-exempt entities, whose underlying mission is to provide services to all in need of medical care. MGB strives to ensure patients requiring urgent, emergent, and medically necessary services shall not be denied those services based on their inability to pay, and that financial capacity does not prevent these individuals from seeking or receiving care. However, for Mass General Brigham entities to continue to provide high quality services and support community needs, each entity has a responsibility to seek prompt payment for services where collection is allowed and not in conflict with Commonwealth of Massachusetts (MA) regulations or Federal regulations including Emergency Medical Treatment and Labor Act (EMTALA).

Mass General Brigham entities recognize that some patients have limited means and may not have access to insurance coverage for all services. This policy has been developed to assist uninsured patients and underinsured patients with limited financial resources.

This document outlines the eligibility criteria, method, and circumstances for which patients can access the following discounts:

1. [Financial Assistance, Section III](#): discounts program based on a patient's financial status, if all other parameters of the discount are met
2. [Uninsured Patient Discount, Section IV](#): discount program for all uninsured patients that is available regardless of the patient's financial status if the other parameters for the discount are met.

B. Scope

This policy applies to Mass General Brigham entities outlined in [Appendix A](#).

Note: physicians associated with these entities, but who bill "privately" are encouraged, but not required, to follow this policy. Details may be found on the Mass General Brigham Provider Affiliate List.

II. Definitions

Behavioral Health Services: Medically necessary services that focus on the patient's psychological and mental health and may be provided in several care delivery settings.

Elective Services: Medically necessary services that do not meet the definition of Emergent or Urgent Services. The patient typically, but not exclusively, schedules these services in advance.

Emergent Services: Medically necessary services provided after the onset of a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in placing the health of the person or another person in serious jeopardy, serious impairment to body function or serious dysfunction of any body organ or part or, with respect to a pregnant woman, as further

defined in section 1867(e) (1) (B) of the Social Security Act, 42 U.S.C. § 1295dd(e)(1)(B). A medical screening examination and treatment for emergency medical conditions or any other such service rendered to the extent required pursuant to the **EMTALA** (42 USC 1395(dd)) qualifies as Emergency Care. Emergent services also include:

- Services determined to be an emergency by a licensed medical professional.
- Inpatient medical care which is associated with the outpatient emergency care; and,
- Inpatient transfers from another acute care hospital to a Mass General Brigham hospital for the provision of inpatient care that is not otherwise available.

Federal Income Poverty Guide (FPG): A measure of income issued each year by the Department of Health and Human Services (HHS). These guidelines are used to determine eligibility for certain programs and benefits (such as Medicaid).

Financial Assistance: A provision of healthcare services provided for free or discounted to eligible patients, with documented and verified financial need, who meet the criteria established within this policy.

Financial Assistance Discounts: Adjustments to patients' balances that are made based on the patient's financial status according to the Financial Assistance Policy. All discounts for Financial Assistance must be in accordance with state and federal regulations including IRS 501 (r).

Financial Counselor: Representatives responsible for assessing a patient's liability, identifying, and assisting with public funding options (Medicare, Medicaid, etc.), determining if patient is eligible for financial assistance, and establishing payment plans.

Financial Counseling: Services provided to patients without sufficient insurance coverage, unable to pay their estimated/actual liability prior to the treatment, or who have large past due balances.

Home Care: Any services provided by MGB Home Care

Medically Necessary Services: Services that are 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 Services include inpatient and outpatient services as authorized under Title XIX of the Social Security Act.

Medicare Bad Debt: The expense that CMS/Medicare allows hospitals to claim for most unpaid Medicare co-insurance and deductibles, provided the balance is completely processed per the established self-pay billing cycle or a determination is made that the patient is indigent for the purposes of the balance. The determination of indigence must be based on the patient's income level and a review of their available assets which typically excludes their vehicles and primary residence and a minimum bank/checking account.

Other Services: Services where medical necessity has not been demonstrated to the reviewing clinician or where the patient's qualifications for the service may not meet the general insurance plan definitions for meeting key medical necessity criteria for the service. Other Services also include services that many insurance plans do not consider to be Medically Necessary, including, but not limited to: Cosmetic Surgery, In-Vitro Fertilization (IVF) or other Advanced Reproductive

Therapy (ART), Gastric Bypass Services absent of a payer's determination of medical necessity, and Patient Convenience Items such as charges related to overnight services above and beyond those needed for medical care or patient overnight services (inpatient or partial hospitalization) where there isn't a clearly demonstrated medical necessity.

Patient Billing Solutions (PBS): The department at Mass General Brigham responsible for all self-pay revenue cycle processes including Customer Service, Collections, Financial Assistance determinations (other than WDH) and processing, Bad Debt processing, patient credits/refunds and associated processes.

Patient Liability: The financial responsibility that is due to the facility/provider as a result for receiving health care services; the amount is determined according to a patient's insurance benefits for the specific scheduled service; including deductibles, co-payments, co-insurance, and non-covered services.

Post-Acute Care: Medically necessary services, including rehabilitation services, provided at a hospital that is classified as post-acute.

Primary Service Area: MGB primary service area is considered to be Eastern Mass, east of Interstate 495 inclusive of the Cape Cod, Nantucket and Martha's Vineyard.

Self-pay: Patient identified as having no insurance coverage or opting out of their insurance coverage for specific services/events.

Serious Reportable Event (SRE): serious, largely preventable patient safety incident that should not occur if the available preventative measures have been implemented by healthcare providers

Underinsured Patient: A patient with some insurance or other third-party source of payment, whose out-of-pocket expenses exceed his/her ability to pay.

Uninsured Patient: A patient that does not have any health insurance in effect for a specific date of service or where their coverage is not effective for a specific service due to network limitations, insurance benefit exhaust or other non-covered services. Patients whose only coverage is MassHealth Limited and/or HSN are generally considered to be Uninsured since those programs do not function per standard insurance coverage rules.

Urgent Services: Medically necessary services provided after sudden onset of a medical condition, whether physical or mental, manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson would believe that the absence of medical attention within 24 hours could reasonably expect to result in: placing the patient's health in jeopardy, impairment to bodily function, or dysfunction of any bodily organ or part. Urgent 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.

III. Financial Assistance Policy

A. Overview

- Financial Assistance may be provided to patients with limited financial resources to make Medically Necessary healthcare services more affordable for those patients who do not qualify for government sponsored insurance programs (such as Medicaid or Medicare), cannot afford their Medicare premium, or are enrolled in Health Safety Net (HSN) or MassHealth Limited to provide more comprehensive coverage of services.
- Financial Assistance determinations may be made either pre or post service delivery based on the patient's financial status, the type & location of services provided, the patient's insurance status and the general classification of service provided.
- Emergent Services will always be rendered without a review of the patient's financial status up to the limits required by EMTALA.
- This policy addresses all Medically Necessary services. However, only some types of Medically Necessary Services will qualify for a Financial Assistance Discount, including:
 - Emergency Services and Urgent Services
 - Elective Services at an Acute Care Hospital as outlined in [Section III\(C\)\(2\)](#).
 - Elective Services at a Post-Acute Hospital and Behavioral Health Services as outlined in [Section III\(C\)\(3\)](#).
 - Dental Services at the Wentworth Health Partners (WHP) Community Dental Center with limitations as outlined in [Section III\(D\)\(2\)\(d\)](#)

B. Patient Eligibility

1. Generally

- Patients with demonstrated financial need, either due to limited income or because their medical bills are an excessive portion of their income, will be considered for discounts
- Patients must be a resident of MA, NH, or a non-resident who receives emergency treatment at an MGB facility
- Discounts based solely on income are generally limited to patients with family incomes less than or equal to 300% of the Federal Poverty Guidelines (FPG)
- Patients with a family income of more than 300% but less than or equal to 600% of the FPG may still qualify if they can demonstrate that their annual medical expenses exceeded 30% of their income in the most recent 12-month period. For families with an income of more than 600%, the threshold is medical bills exceeding 40% of their income. Expenses must have occurred within the prior 12 months and are limited to those expenses that could potentially qualify as a medical expense per the US Internal Revenue Service. Patients wishing to be considered for discounts under this policy must provide requested documentation of income, residence, assets and qualifying medical expenses in a timely manner.

2. Financial Qualifications

a. Income

The most recently published Federal Income Poverty Guidelines, using total household income, will be used as the primary determinant, though assets will be used as described in [Section III \(2\)\(b\)](#) below.

Federal Poverty Income Guide – 2022*			
Family Size	150% FPG	250% FPG	300% FPG
1	\$20,385	\$33,975	\$40,770
2	\$27,465	\$45,775	\$54,930
3	\$34,545	\$57,575	\$69,090
4	\$41,625	\$69,375	\$83,250
5	\$48,705	\$81,175	\$97,410
6	\$55,785	\$92,975	\$111,570
7	\$62,865	\$104,775	\$125,730
8	\$69,945	\$116,575	\$139,890

*The FPG noted above is for Fiscal Year 2022. Please view current year or additional family sizes of FPG level at the following link: [Poverty Guidelines | ASPE \(hhs.gov\)](#).

b. Assets

Assets will also be used when:

- Patient’s residency is outside the U.S. or Canada.
- Patient is deceased, determination must include review of the estate.
- Patient has been determined to be ineligible and is appealing for individual consideration due to unique circumstances.
- When a patient is covered by Medicare, excluding Medicare Advantage Plans, there is a goal to report any balances written off as Medicare Bad Debt. Balances can only be co-insurance or deductibles, the patient family must be less than 201% of the FPG, the patient must issue a declaration that they are unable to pay the balances including use of assets.

c. Medical Expenses

- Annual medical expenses may be used to determine eligibility for financial assistance when a patient’s household old income is >300% FPG, per [Section III\(B\)\(1\)](#).
- Expenses must have occurred within the prior 12 months and are limited to those expenses that could potentially qualify as a medical expense per the US Internal Revenue Service.
- Patients wishing to be considered for discounts under this policy must provide requested documentation of income, residence, assets and qualifying medical expenses in a timely manner.

3. Patient Responsibilities

Patients must meet the following conditions to qualify for financial assistance. Failure to meet these condition result in the patient being disqualified for consideration.

- a. Obtain and maintain insurance coverage if affordable coverage is available to the patient either from a government sponsored insurance program (Medicaid/Medicare), commercial insurance from their employer or from ConnectorCare or similar subsidized programs.
 - Patient may be asked to submit evidence of having applied for coverage.
 - Patient must make reasonable efforts to provide and submit all requested documentation that is needed to enroll in state coverage in a timely manner
- b. Except for the individuals that are presumptively eligible ([Section III\(F\)\(2\)](#)), patients must complete a Financial Assistance Application as outlined in [Section III\(E\)](#) and/or make reasonable efforts to provide and submit all requested documentation related to income, assets and residency to verify their qualifications for any Mass General Brigham financial assistance in a timely manner.
- c. Full disclosure of any Workers Compensation, Motor Vehicle or Third-Party Liability coverage and cooperate with requests to have claims processed by that coverage.
- d. Keep Mass General Brigham entities apprised of current demographic and insurance information.
- e. Pay all balances in accordance with agreed to timeframe.

C. Services Eligible for Financial Assistance

1. Urgent/Emergent

Medically Necessary Services that meet the definition of Emergent Services or Urgent Services will be considered for Financial Assistance except for some services covered by Third Party Liability coverage including Motor Vehicle coverage and Workers Compensation. Services will be billed first to any health insurance when applicable.

2. Elective Services at Acute Care Hospitals and Physician's Organizations

Elective services qualify for Financial Assistance when:

- a. Patient is a resident in Mass General Brigham Primary Service Area and has applied for all available government and non-government programs.

Note: For MA residents, this is typically demonstrated by their enrollment in MassHealth Limited and/or the Massachusetts Health Safety Net (HSN). This typically applies to services provided by Mass General Brigham Physicians Organizations, as described in [Section III\(F\)](#).

- b. Services that are directly proximate, within 60 days, to an Urgent/Emergent Service and are follow up care for the earlier service.
- c. Patient is screened for their financial status and determined to have diligently pursued all available options for coverage and has been determined to be ineligible for other coverage. Screening must occur at least every 12 months.
- d. Is not a service listed in Excluded Services, [Section III\(C\)\(4\)](#)

Please see [Appendix A](#) for covered Acute Care Hospitals and Physician Organizations.

3. Elective Services at Post-Acute and McLean Hospital

Elective services qualify for Financial Assistance when:

- a. Patient is a resident in Mass General Brigham Primary Service Area and has applied for all available government and non-government programs.
Note: For MA residents, this is typically demonstrated by their enrollment in MassHealth Limited and/or the Massachusetts Health Safety Net (HSN), since Post-Acute Hospitals, Behavioral Health and Home Care when the services do not qualify for billing to the HSN.
- b. Pre-screening of the services identifies that the specialized services are only available at the Mass General Brigham facility.
Note: Patients are typically screened for financial clearance at Post-Acute Care and McLean Hospital and may be deferred from admission after a clinical review if a more appropriate facility is available.
- c. The facility accepts the patient for care with the understanding that the patient has limited/no resources to pay for the care. These patients are typically from the Mass General Brigham primary service area and are enrolled with MassHealth Limited and/or HSN, demonstrating their limited financial resources.
- d. McLean Hospital: An established patient who incurs significant expenses for Medically Necessary Elective Care who becomes uninsured during therapy will be considered for Financial Assistance either until they are able to reestablish their health insurance or until their care can be transferred to an appropriate setting. The recommendation of the patient's provider regarding the clinical necessity is required in addition to the patient meeting the routine Financial Assistance process.
- e. Is not a service listed in Excluded Services, [Section III\(C\)\(4\)](#)

Please see [Appendix A](#) for covered Post-Acute Hospitals and Behavioral Health Providers

4. Excluded Services

a. Service Area Limitations

Patients who came to a Mass General Brigham facility from outside the primary service area for care, that a reasonable person could have anticipated would be needed, will

typically **not** be considered for a financial assistance or discounts. This includes presenting themselves as an Emergency when the underlying condition was known to the patient prior to their travel to a Mass General Brigham facility to receive care. Examples for exclusion include obstetrical care and specialties where the patient is already aware of a condition that they would reasonably expect needed care including oncology care, cardiac services, specialty rehabilitation services and psychiatric services. This does not exclude emergency services due to an accident or complications from a pre-existing condition when a reasonable person would not have anticipated that emergent care would be needed prior to traveling to our service area.

b. Insured Patient Network Coverage

Patients who know in advance that their health insurance plan will not cover services at a Mass General Brigham facility either due to contracting, network limitations or prior-authorization requirements and present themselves for service at a Mass General Brigham facility for a service that could have been delivered at a facility covered by their health plan or where other financial support was available, will typically not qualify for financial assistance. This includes balances due to a denial for no-referral, no authorization or out of network services.

c. Specific Service Exclusions

- Cosmetic Surgery
- In-Vitro Fertilization (IVF)
- Advanced Reproductive Therapy (ART)
- Gastric Bypass Services absent of a payer's determination of medical necessity
- Accounts linked to a research study
- Patient Convenience items inclusive of premium accommodations and overnight accommodations that are based on a patient request and typically not covered by a health insurance plan
- Other non-medically necessary services that are billed according to a pre-determined self-pay fee schedule
- All Residential All-Inclusive programs that do not submit claims to health insurer at McLean Hospital

D. Financial Assistance Discounts

1. Amounts Generally Billed

Per IRS 501(r), hospitals must limit charges to patients and services qualified under our Financial Assistance Policy (FAP) to the Amounts Generally Billed (AGB) to Commercial carriers and Medicare. Mass General Brigham determines the AGB by first dividing total payments by total charges for all Commercial and Medicare plans in aggregate for the prior fiscal year to determine the Payment on Account Factor (PAF) for the prior fiscal year. The minimum FAP discount for the current fiscal year is the inverse of the prior year PAF. This will reduce the charges billed to qualifying patients to no more than the AGB for the prior year.

Example:

Total Payments from Medicare and Commercial Plans	\$200,000,000
Total Charges from Medicare and Commercial Plans	\$500,000,000
PAF	40%
Net Minimum FAP Discount	60%

2. Financial Assistance Discount Rates

a. Acute Care Hospitals & Physicians Organizations

For services outlined in [Section III\(C\)\(2\)](#):

Family Income % FPG	Acute Care Hospitals listed in Appendix 1 EXCEPT WDH	Wentworth-Douglass Hospital (WDH)
0 to 150%	100% ¹	100%
150.1 to 250%	85% ²	100%
251 to 300%	70% ³	0%
300.1 – 600%	70% IF medical expenses exceed 30% of income per Section III(B)(1)	n/a
Over 600%	70% IF medical expenses exceed 40% of income per Section III(B)(1)	n/a

b. Post-Acute Hospitals & MGB Home Care

For services outlined in [Section III\(C\)\(3\)](#):

Family Income % FPG	Discount
0 to 150%	100%
150.1 to 250%	75%
251 to 300%	60%
300.1 – 600%	60% IF medical expenses exceed 30% of income per Section III(B)(1)
Over 600%	60% IF medical expenses exceed 40% of income per Section III(B)(1)

c. Behavioral Health Hospitals (McLean Hospital)

i. For services outlined in [Section III\(C\)\(3\)](#)

¹ For Physicians Organizations, patients with full HSN are presumptively eligible for this discount, per [Section III\(F\)\(2\)](#)

² For Physicians Organizations, patients with partial HSN are presumptively eligible for this discount, per [Section III\(F\)\(2\)](#)

³ For Physicians Organizations, patients with partial HSN are presumptively eligible for this discount, per [Section III\(F\)\(2\)](#)

Family Income % FPG	Discount
0 to 150%	100%
150.1 to 250%	80%
251 to 300%	60%
300.1 – 600%	60% <i>IF</i> medical expenses exceed 30% of income per Section III(B)(1)
Over 600%	60% <i>IF</i> medical expenses exceed 40% of income per Section III(B)(1)

ii. McLean Hospital Night Fee

This fee is associated with a Partial Hospitalization service and will be considered for a sliding scale using the Federal Poverty Guide (FPG) when not covered by insurance based on medical necessity.

Family Income % FPG	Discount
0 to 100%	90%
100.1 to 200%	75%
200.1 to 300%	50%
300.1 – 400%	25%

d. [Wentworth Health Partners \(WHP\) Community Dental Center](#)

Patients with a family income of equal to or less than 300% of the FPG may qualify for financial assistance discounts.

- \$35 flat fee per visit
- Some Services, including dentures and crowns will have a higher fee up to 50% cost the initial visit and 50% of cost at the fitting
- Limited to residents of Barrington, NH; Dover, NH; Durham, NH; Lee, NH; Madbury, NH; Rollinsford, NH; Somersworth, NH; Berwick, ME; South Berwick, ME.

E. Application Process

- Patients will be encouraged to apply for consideration of Financial Assistance in all cases whenever they meet the basic qualifications outlined in this policy. All applications will be reviewed including cases where all the qualifications have not been satisfied.
- Patients may request financial assistance at any time during pre-registration, registration, inpatient stay, outpatient service, or throughout the course of the billing and collections cycle.
- The application process can be initiated either directly with PBS Customer Service, PBS Collections or through contact with a Patient Financial Counselor at any Mass General Brigham hospital or health center. This policy and all application forms are also available from the Mass General Brigham home page from the drop-down menu under “For Patients.” [www.massgeneralbrigham.org/patient-information]
- Typically, only fully completed applications will be reviewed for consideration, with all applications being sent to PBS for final determination. All applications will be screened to

determine if the patient has met his/her obligations, including the obligation to obtain any available insurance coverage. The patient's status will also be reviewed to determine if he/she might be eligible for any state or federal programs. Designated staff at PBS will review all applications, contact the applicant for follow up information and communicate outcomes to the applicant. Applications will generally be effective for one year from the date of application.

Discounts approved under this policy will be applied when a patient is deemed qualified. Interest free payment plans will be offered to patients per existing guidelines in the Mass General Brigham [Credit and Collection Policy](#). All other collection practices, including those actions that may be taken for non-payment of balances are specified in the Mass General Brigham [Credit and Collection Policy](#).

- Per [Section III\(F\)\(2\)](#) below, patients with Health Safety Net Full and Health Safety Net Partial will be presumptively eligible for Financial Assistance- patients will be able to seek care for eligible services (per [Section III\(C\)](#)) without a Financial Assistance Application.

F. Relationship between the Financial Assistance Policy and the Health Safety Net (HSN)

1. Health Safety Net Overview

- The Commonwealth of Massachusetts maintains a safety net program that provides some coverage for healthcare services at a MA Acute Care Hospital for Massachusetts residents with family incomes up through 300% of the FPG who do not qualify for MassHealth (Medicaid).
 - Full HSN coverage is available through 150% of the FPG
 - Partial HSN is available from 150% through 300% of the FPG
- HSN coverage may be secondary to other insurance (Medicare, Medicaid or Commercial) and functions as a safety net for patients designated as Low Income per Massachusetts regulations. Coverage generally excludes copayment amounts determined by a primary insurance coverage, with the exception of copayments for Medicare or Medicare replacement plans which are included.
- All Medically Necessary services are available to these patients at either no charge (Full HSN) or after they meet an annual deductible (Partial HSN).

2. Health Safety Net Full and Partial

- All Massachusetts-based Mass General Brigham Acute Care Hospitals (see [Appendix A](#)), including hospital licensed health centers and designated hospital-based physician practices, participate in this coverage and comply with all aspects of the HSN regulations.
- Other Mass General Brigham entities, that are excluded by statute from participation in HSN, will use the patient's HSN approved status as presumptive qualification for Mass General Brigham Financial Assistance for eligible services, per [Section III\(C\)](#).

Presumptive Discounts

	HSN Full	HSN Partial
Physician's Organizations	100%	70%
Post-Acute Hospitals	May be available with the determination to be made during the patient's financial pre-screening for these scheduled services.	
Behavioral Health Hospitals		

- Patients whose only coverage is MassHealth Limited and/or HSN are generally considered to be Uninsured since those programs do not function per standard insurance coverage rules. Balances due to Acute Care Hospitals as part of a Partial HSN deductible are eligible for the Uninsured Patient Discount, as described in Section IV.

3. HSN Medical Hardship & HSN Confidential

- The HSN includes three additional programs (Confidential Services to Adults, Confidential Services to Minors, and Medical Hardship) which are available to patients. Participation in these programs is typically facilitated by a [Patient Financial Counselor](#) at one of the Acute Care hospitals.
- HSN's Medical Hardship program is available to Massachusetts residents at higher income levels. Patients should be encouraged to apply for this program when their out-of-pocket costs for medical care are a major portion of their income, generally more than 30% of their household income.
 - Applications must be initiated by a Patient Financial Counselor at an acute care hospital. Each application can include medical expenses incurred within the prior 12 months of filing an application with a limit of 3 applications in any year.
 - All balances continue to be considered a valid self-pay balance until HSN approves the application. This does not convey general coverage in the HSN program.
 - Patients will typically be informed of the program when they call PBS Customer Services or a Patient Financial Counselor when they have large balances and are concerned about paying their bills. Some limited proactive outreach is done by both Patient Financial Counselors, for large inpatient balances, and Collections Representatives, for large guarantor balances. Patient Financial Counselors counsel all patients who either contact them or are referred to them regarding the applicability of the program and work with the patient to complete the application and submit it to HSN.

IV. Uninsured Patient Discounts

A. Overview

- All Mass General Brigham entities generally provide Uninsured Patients a discount from charges, for most services. This program is inclusive of patients at all income levels with no financial qualifications or application required.

- The primary reasons for discounting patient balances, including balances after insurance (co-payments, co-insurance or deductibles) include:
 - To provide patients who have no effective insurance coverage a basic discount for most services.
 - Demonstrated financial hardship generally based on applicable patient income and asset information as detailed in [Section III\(B\)\(2\)](#).
 - The occurrence of a Serious Reportable Event (SRE) as detailed in the Mass General Brigham Non-Payment Policy for Quality and Safety Events which is available by request.
 - Other clinical process issues that do not rise to the level of a SRE but still negatively impact the patient as approved by the designated committee at the hospital.
- Discounts will not be based upon any relationship that the patient or his/her family may have with any Hospital employee or member of the governing body. Discounts will not be extended based upon any consideration of “professional courtesy” for a clinician or his/her family.
- Discounts will not be offered to patients to induce the patient to receive services or otherwise be linked in any manner to the generation of business payable by a federal healthcare program nor will they be redeemable for cash for items or services provided by the Hospital, or any other Mass General Brigham entity (this includes discounts to the gift shop, cafeteria, etc.).
- Patients are encouraged to apply for consideration of Uninsured Discounts if they meet basic qualifications outlined above. All applications will be reviewed including cases where all the qualifications have not been satisfied. Patients may apply for Uninsured Discounts at any time during pre-registration, registration, inpatient stay, outpatient service, or throughout the course of the billing and collections cycle. For more information, see [Section III\(E\)](#).

B. Uninsured Discounts and Exclusions

1. Available discounts

The following discount are available at the following entities, exclusions in [Section IV\(B\)](#):

MGB Provider	Discount
Acute Care Hospitals EXCEPT Wentworth-Douglass	25%
Wentworth-Douglass Hospital (WDH)	40%
Physicians Organizations EXCEPT Wentworth Health MGB (WHP)	25%, exclusions below
Wentworth Health MGB (WHP)	15%
Behavioral Health Hospitals (McLean)	25%, with exclusions below
Post-Acute Hospitals	25%, with exclusions below
MGB Urgent Care	Self-Pay services are billed on a fixed self-pay only fee schedule.

2. Exclusions

a. Mass General Physicians Organization (MGPO) exclusions

- There is no uninsured patient discount for MGPO Dental Services, Voice Center and Travel Clinic Services in addition to what is in the specific service exclusions.

b. Spaulding Rehabilitation Network exclusions

- There is no uninsured patient discount for the following:
 - Services at Spaulding Rehabilitation - Brighton
 - Outpatient therapy including Physical, Occupational, Speech Therapy or SRH Behavioral Health
 - Specialty Evaluations (ATEC, AAC, Lokomat)
 - Specialty Treatments (Lokomat, interpreter services, complex treatment, feeding treatment)
 - Physician Office Visit Technical Fee
 - Other office procedures or diagnostic testing

c. McLean Hospital exclusions

- There is no uninsured patient discount for the following:
 - Night Fee associated with a Partial Hospitalization when not covered by insurance based on medical necessity. A fee reduction schedule for this program is included with the Financial Assistance Policy.
 - Per-Diem based All-Inclusive Residential Programs and All-Inclusive Partial Programs
 - CATS Program (Psychological Testing, Neurobehavioral Status, Neuropsychological Testing)

V. Individual Consideration

Patients are encouraged to bring their unique financial situations to the attention of Patient Financial Counselor at any Mass General Brigham hospital, or to Patient Billing Solutions. Mass General Brigham affiliated entities may, in accordance with the Credit and Collections Policy, extend discounts beyond the other provisions in this policy on a case-by-case basis to recognize unique cases of financial hardship. MGB will apply financial assistance policies consistently and fairly, without regard to race, ethnicity, gender, religion, etc.

In certain situations, financial assistance may be denied. These specific instances may be due to, but not limited to:

- Sufficient family income
- Sufficient asset level
- Incomplete application, etc.

If financial assistance is denied, a patient may appeal the decision within 30 days with a letter to be reviewed by MGB. A final decision will be provided within 30 days of receipt of request for appeal.

VI. Financial Counseling

A. Patient Financial Counseling Services

- Acute Care Hospitals and other MGB providers with financial counseling services will seek to identify patients who may be uninsured or inadequately insured to provide counseling and assistance.
- These MGB providers will provide financial counseling to these patients and their families, through Financial Counselors, including screening for eligibility for other sources of coverage, such as State Programs and other government programs (including to the extent possible, Medicaid programs in states other than Massachusetts or New Hampshire), and providing information regarding all acceptable methods of payment of the Hospital bill.
- Financial Counselors will encourage patients who are potentially eligible for coverage from State Programs or other government programs to apply for coverage and shall assist the patient in applying for benefits. MA Residents may also apply for and be approved for coverage by the HSN for co-insurance or deductibles not covered by their primary insurance plan.
- If patients have any further questions related to the financial assistance program, program eligibility, or a bill received, the patient should reach out to a financial counselor. A Financial Counselor will respond as promptly as possible to patients' inquiries related to financial assistance or connect patient with correct department to handle request.

VII. Publication and Dissemination of Financial Assistance Policy

The Mass General Brigham Financial Assistance policy, application forms, and plain language summary are available at www.massgeneralbrigham.org. This webpage may be accessed from the Mass General Brigham home page from the drop-down menu under "For Patients." The website includes various ways in which patients can apply for assistance, including a list of hospital and health center patient financial counseling locations; a central phone number; and an email address. The website also informs patients that the application forms and assistance are free.

Information on the policy and how to apply is available at all applicable Mass General Brigham entities with public communication accomplished in several ways:

- Posted notices (signs) of the availability of financial assistance programs and describe where to go for assistance in the following locations:
 - Inpatient, clinic, emergency department, and community health center admission and/or registration areas
 - Financial Counseling waiting areas
 - Central admission/registration areas that are open to patients
 - Business office waiting areas that are open to patients
- Plain language brochures that advertise the availability of Mass General Brigham financial assistance options displayed in practices and Emergency Departments
- Standard notices will be provided to all patients at the time of their initial registration with Mass General Brigham. These notices will also be made widely available throughout all

hospitals and health centers and routinely offered to existing patients whenever they are expected to have an out-of-pocket liability.

- General information regarding availability of financial assistance is included on all patient statements
- Patient financial counseling resources available for any patient who requests assistance, has specific questions, or wants a paper application.
- All materials, including the policy, signage, application form, and plain language summary are available in English and will be translated into other languages to the extent that the language is the primary language of more than 10% of residents in the Hospital's service. Signs will generally be posted in English and Spanish. Signage will also include instructions on access to translation services for patients who have other language needs.

Appendix A: Affiliated Mass General Brigham Entities

This policy applies to the following Mass General Brigham entities:

Acute Care Hospitals

Massachusetts General Hospital (MGH)
Brigham and Women's Hospital (BWH)
North Shore Medical Center (NSMC)
Newton-Wellesley Hospital (NWH)
Brigham and Women's Faulkner Hospital (BWFH)
Martha's Vineyard Hospital (MVH)
Nantucket Cottage Hospital (NCH)
Cooley Dickinson Hospital (CDH)
Wentworth Douglass Hospital (WDH)
Massachusetts Eye and Ear (MEE)

Behavioral Health Hospitals

McLean Hospital (MCL)

Post-Acute Hospitals

Spaulding Rehabilitation Hospital Boston (SRH)
Spaulding Hospital for Continuing Medical Care Cambridge (SHC)
Spaulding Rehabilitation Hospital Cape Cod (SCC)

Physicians Organizations

Massachusetts General Physicians Organization (MGPO)
Brigham and Women's Physicians Organization (BWPO)
North Shore Physicians Group (NSPG)
Newton Wellesley Medical Group (NWMG)
Cooley Dickinson Medical Group (CDMG)
Nantucket Medical Group (NMG)
Mass Eye and Ear Associates
Wentworth Health Mass General Brigham (WHP)

Mass General Brigham Community Physicians - wholly owned groups

Pentucket Medical Associates (PMA)

Mystic Health Care

Home Care

Mass General Brigham Home Care

Mass General Brigham Ambulatory Care

Mass General Brigham Urgent Care


Note that physicians associated with these entities, but who bill “privately” are encouraged, but not required, to follow this policy. Details may be found on the [Mass General Brigham Provider Affiliate List](#)

Appendix B: Financial Assistance Application

The Mass General Brigham Financial Assistance application can be found here:

<https://www.massgeneralbrigham.org/content/dam/mgb-global/en/patient-care/patient-and-visitor-information/financial-assistance/documents/assistance-information/english/financial-assistance-application-english.pdf>

The application is available in 10 languages on www.massgeneralbrigham.org: English, Arabic, Chinese, Haitian Creole, Indonesian, Khmer, Portuguese, Russian, Spanish, and Vietnamese.



Mass General Brigham Financial Assistance Application

Please print out and complete all sections of the application that apply to you. **This application cannot be completed electronically.** Please read all instructions before completing application.

This application is used to evaluate your eligibility for financial assistance on medical bills from Mass General Brigham providers. You can use this application to apply for help with health care bills from any of the following Mass General Brigham entities:

Massachusetts General Hospital	Massachusetts General Physicians Organization
Brigham and Women's Hospital	Brigham and Women's Physicians Organization
Salem Hospital	North Shore Physicians Group
Newton-Wellesley Hospital	Newton-Wellesley Medical Group
Brigham and Women's Faulkner Hospital	Martha's Vineyard Hospital
Mass Eye and Ear	Mass Eye and Ear Associates
Nantucket Cottage Hospital	Nantucket Cottage Medical Group
Coolley-Dickinson Hospital	Coolley-Dickinson Medical Group
Spaulding Rehabilitation	McLean Hospital
Wentworth-Douglass Hospital	Wentworth Health Associates

Mass General Brigham Financial Assistance is not considered a substitute for enrolling in any available health insurance program or assistance plan. While the program covers all Medically Necessary Services, discounts vary based on the type of services provided and the location that the care was provided. Please refer to the complete policy on our website for the details on what is covered. A partial list of services that are typically excluded follows.

- Out of Network Denials
- Cosmetic Surgery
- Infertility Services (ART & IVF)
- Most non-medically necessary care including Gastric Bypass Services
- Patient Convenience Items including premium accommodations
- Services that are designated as "Self-Pay Only"

Failure to apply for a government assistance program that you potentially qualify for could result in a delay or denial of your application. If you need help applying for government assistance programs, one of our Mass General Brigham Financial Counselors can help.

You must fully disclose any other coverage, third-party liability claim, motor vehicle coverage or workers compensation coverage to be considered.

If you have any questions on this application, please contact [Patient Financial Services](#) at your hospital or call (617) 726-3884.

Rev. 11/21 Page 1 of 7