

Southcoast Hospitals Group

*Charlton Memorial Hospital
Saint Luke's Hospital
Tobey Hospital*

Financial Assistance Policy (FAP)

*Based on Mass. EOHHS Regulation 101 CMR 613.00
&
Internal Revenue Code Section 501(r)*

Effective: October 1, 2016

Southcoast Hospitals Group

Policy: FINANCIAL ASSISTANCE POLICY

Date Effective: OCTOBER 1, 2016

GENERAL POLICY

The mission of Southcoast is to care for and improve the health, and to promote the wellness, of the individuals and communities we serve. Southcoast will render medical care to all those seeking service at this facility in accordance with 613.08(1)(a). Southcoast does not discriminate on the basis of race, color, national origin, citizenship, alien age, religion, creed, sex, sexual orientation, gender identity, age, or disability in its policies or in its application of policies, concerning the acquisition and verification of financial information, preadmission or pretreatment deposits, payment plans, deferred or rejected admissions, or Low Income Patient status. The hospital will not defer or refuse emergent/urgent treatment to any patient.

The hospital reserves the right to refuse or defer treatment in a case where a patient is scheduled to receive services that are considered non-emergent or non-urgent by the patient's physician.

Prompt payment of all hospital bills is necessary in order to maintain the high quality of services and continue to provide them. The hospital will assist and advise the patients and their families of all health care assistance programs and financial benefits for which they may be eligible.

This credit and collection policy is based upon industry standards for patient accounting and is intended to comply with the criteria set forth by the Executive Office of Health and Human Services regulations 101 CMR 613.00 (regulations governing criteria for credit and collection policies of acute care hospitals) and the Internal Revenue Code Section 501(r) as required under the Section 9007(a) of the federal Patient Protection and Affordable Care Act (PPACA) (Pub. L.No 111-148).

Our Credit and Collection Policies are filed in accordance with 101 CMR 613.08(1)(c)1 and Provider Affiliate lists (if applicable), as described in 101 CMR 613.08(1)(d), available on the Southcoast Health website <http://www.southcoast.org>.

Table of Contents

General Policy

SECTION 1: CRITERIA FOR SERVICES ELIGIBLE FOR FINANCIAL ASSISTANCE

- A. Eligibility for Financial Assistance – Mass. Only
 - 1. Eligibility Approval Process
 - 2. Income Criteria for Low Income - Full
 - 3. Income Criteria for Low Income – Partial
 - 4. Medical Hardship
 - 5. Eligibility Period
 - 6. Medical Coverage Dates
 - 7. Charity Care

- B. Eligibility for Financial Assistance – Mass. Only
 - 1. Eligibility Approval Process
 - 2. Income Criteria for Low Income - Full
 - 3. Income Criteria for Low Income – Partial
 - 4. Eligibility Period
 - 5. Medical Coverage Date
 - 6. Charity Care

- C. Exempt from Collection Actions

- D. Extraordinary Collection Actions

SECTION 2: SIGNS AND NOTICES –SIGNS NOTIFICATION PRACTICES

- A. Language

- B. Signs

- C. Notification Practices

SECTION 3: EMERGENCY CARE CLASSIFICATION

- A. Determination of Emergency Care

- B. Emergency and Other Medically Necessary Care Provider Affiliation List

SECTION 1: CRITERIA FOR SERVICES ELIGIBLE FOR FINANCIAL ASSISTANCE

A. Eligibility for Financial Assistance – Mass. Only

1. Eligibility Approval Process

- a) Patient must be a resident of the Commonwealth of Massachusetts, provide verification of identity, and document that the Modified Adjusted Gross Income of his or her MassHealth MAGI Household is equal to or 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 and documents that the Countable Income of his or her Medical Hardship Family is equal to or less than 300% of the FPL.
- b) SHG will check MassHealth Eligibility Verification System (EVS) to determine if a patient is enrolled in MassHealth, Health Safety Net or is eligible for, Emergency Aid to the Elderly, Disabled and Children (EAEDC); or Children’s Medical Security Plan (CMSP) programs.
- c) SHG will verify reported family income. SHG will compare reported family income to the latest Federal Poverty Income Guidelines.
- d) Verification of gross monthly earned income shall include, but not be limited to, the following:
 - recent pay stubs;
 - a signed statement from the employer; or
 - the most recent U.S. tax return.
- e) Verification of gross monthly unearned income shall include, but not be limited to, the following:
 - copy of a recent check or pay stub showing gross income from the source
 - a statement from the income source, where matching is not available;
 - the most recent U.S. tax return
- f) Verification of gross monthly income may also include any other reliable evidence of the applicant’s earned or unearned income.
- g) Minors receiving confidential services under M.G.L. c.112, Section 12 F may apply to be determined a Low Income Patient using their own income information. For all other services, minors are subject to the standard Low Income Patient Determination process.
- h) Patient must be uninsured or under insured for services provided.
- i) SHG will attempt to investigate whether a third party payer may be responsible for services provided by SHG, including but not limited to: (1) a motor vehicle or home owner’s liability policy, (2) general accident policies, (3) worker’s compensation programs, (4) student insurance policies, among others. In accordance with applicable state laws or the insurance contract, for any claims where SHG was able to seek a recovery on the health care claims billed to a private or public insurer, SHG will report the recovery and offset it against the claim paid by the private or public insurer. For state public assistance programs, the hospital is not required to secure assignment on a patient’s right to a third party coverage on service provided due to an auto accident. In these cases the State of Massachusetts will attempt to seek assignment on the costs

of the services provided to the patient and which was paid for by either the Office of Medicaid or the Health Safety Net.

- j) In the event SHG admissions staff become aware services provided to a Low Income Patient were related to an accident or injury that may result in a TPL claim or lawsuit, they will notify the patient of their responsibilities to notify the appropriate public assistance program.
- k) SHG shall use the Virtual Gateway system for Low Income Patient determinations for applicants under. A paper application will be completed for patients over 65 years of age based on the FACA Senior Affordable Care Act.
- l) The application will be completed through the HIX Verification System, a request for health benefits that is received by the MassHealth agency and includes all required information and a signature by the applicant or his or her authorized representative. The application may be submitted online at www.MAHealthConnector.org, or the applicant may complete a paper application, complete a telephone application, or apply in person at a MassHealth Enrollment Center (MEC). The date of application for an online, telephonic or in person application is the date the application is submitted to the MassHealth agency. The date of application for a paper application that is either mailed or faxed is the date the application is received by the MassHealth agency.
- m) MassHealth Family Assistance - Children. Minors enrolled in Family Assistance/Premium Assistance whose MassHealth MAGI Household income or Medical Hardship Family Countable Income, as described in 101 CMR 613.04(1), is between 150% and 300% of the FPL and who reported to MassHealth that they are enrolled in health insurance.
- n) The MassHealth Agency of the Commonwealth Health Insurance Connector notifies the individual of his or her eligibility determination for health care coverage or in the individual is Low Income Patient.
- o) In Special Circumstances, SHG may apply for the patient using a specific form designed by the Health Safety Net. Special Circumstances include confidential individuals age 19 and under, abused and battered individuals, incarcerated individuals or applications for Medical Hardship.
- p) SHG will notify the applicant of eligibility determination for Confidential Services

2. Income Criteria for Low Income – Full/Primary/Secondary

- a) Family Income equal to or less than 150% of the Federal Poverty Income Guidelines. A Low Income Patient is eligible for Health Safety Net – Primary or Secondary, if he or she is uninsured/insured and documents MassHealth MAGI Household income or Medical Hardship Family Income, as described in 101 CMR 613.04(1).

3. Income Criteria for Low Income – Partial

- a) Family Income from 150%-300% of the Federal Poverty Income Guidelines. A low income patient eligible for either Health Safety Net – Primary or Health Safety Net – Secondary who documents MassHealth MAGI Household income or Medical Hardship Family Countable Income, as described in 101 CMR 613.04(1), This includes those who participate in the Medical Security Plan.
- b) Annual Deductible - The Annual Deductible for Partial Payment equals 40% of the difference between the applicant's Family Income and 150%-300% of the Federal Poverty Income Guidelines.

The patient is responsible for payment for all services provided up to deductible under 101 CMR 613.04(6)(c).

- c) Annual Deductible per Family - There is only one Partial Payment Deductible per Family per approval period.
- d) Deductible Tracking - The annual Deductible is applied to all Eligible Services provided to a Low Income Patient or family member during the Eligibility Period. Each family member must be determined a Low Income Patient in order for their expenses for Eligible Services to be applied to the Deductible. SHG will track the patient's Eligible Service expenses until the patient meets the Deductible. If more than one Family member is determined to be a Low Income Patient, or if the patient or Family members are determined to be Low Income Patients by more than one Provider, it is the patient's responsibility to track the Deductible and provide documentation to the Provider that the Deductible has been reached.
- e) The patient must incur expenses for Eligible Services in excess of the Annual Deductible before SHG can submit a claim for Eligible Services.

4. Medical Hardship

- a) A Massachusetts resident at any income level may qualify for Medical Hardship if allowable medical expenses have so depleted the family's income and resources that he or she is unable to pay for eligible services. A determination of Medical Hardship is a one-time determination and not an ongoing eligibility category. An applicant may submit only two Medical Hardship applications within a twelve-month period and provider must submit the completed application to Health Safety Net Office within five business days. In order to qualify for Medical Hardship, the patient must meet both the expense and the resource qualifications. An applicant for Medical Hardship must complete a Medical Hardship application and provide required documentation of Countable Income, documentation of Massachusetts residency, verification of identity, and detailed itemized documentation of the medical expenses.
- b) Allowable Medical Expenses - The patient's allowable medical expenses are based on review of the submitted documentation. Allowable Medical Expenses may include only Medical Hardship Family medical bills from any health care Provider that, if paid, would qualify as deductible medical expenses for federal income tax purposes. Patient is responsible up to twelve months prior to the date of the Medical Hardship application. Allowable Medical Expenses do not include bills for services incurred while the applicant was a Low Income Patient or enrolled in MassHealth or the Premium Assistance Payment Program operated by the Health Connector. Bills included in a Medical Hardship determination are not included in a subsequent Medical Hardship application.
- c) Medical Hardship Contribution - The applicant's required contribution is calculated as the specified percentage of Income in 101 CMR 613.05(1) based on the Medical Hardship Family's FPL multiplied by the actual Income less bills not eligible for Health Safety Net payment, for which the applicant will remain responsible. There is one Medical Hardship contribution for each Medical Hardship determination. If the applicant is determined a Low Income Patient or eligible for MassHealth, the applicant's required contribution will be deferred until the applicant's Low Income Patient status or MassHealth eligibility is ended. If the Health Safety Net Office approves two Medical Hardship applications during a 12-month period, it will prorate the required contribution amounts.

5. Eligibility Period

- a) For individuals determined to be Low Income Patients, the patient may be eligible for services beginning 10 days prior to the date of determination.
- b) The determination that an individual is a Low Income Patient will be effective for a maximum of one year from the date of determination, subject to periodic redetermination and verification that the patient's Mass Health MAGI Household income or Medical Hardship family income, as described in 101 CMR 613.04(1), or insurance status has not changed to such an extent that the patient no longer meets eligibility requirements.

6. Medical Coverage Date

- a) The medical coverage date begins on the 10th day before the date the Application is received as described in 130 CMR 502.003(D).
- b) If these required verifications listed on the Request for Information are received after the 90-day period referenced in 101 CMR 613.02: *Medical Coverage Date(a)*, the begin date of medical coverage is 10 days before the date on which the verifications were received, if such verification are received within one year of receive of the application.
- c) For children younger than 21 years old and pregnant women receiving Provisional Eligibility as described in 130 CMR 502.003: *Verification of Eligibility Factors*, the medical coverage date begins ten days prior to the date of the application. For all other applicants receiving Provisional Eligibility as described in 130 CMR 502.003: *Verification of Eligibility Factors*, the medical coverage date begins on the date of the provisional eligibility determination. If all required verifications are received before the end of the provisional eligibility period, the medical coverage date of the verified coverage type will be ten days prior to the date of the Application.

7. Charity Care

- a) For individuals determined to be Low Income Patients, any services that are prior to the determination date and not covered under the Health Safety Net, will be written off as Charity Care.
- b) Services denied by HSN for not medically necessary will be considered charity care by SHG
- c) For patients under the age of 65, Co-insurance and deductibles for MassHealth and MassHealth Managed Care recipients will be considered Charity Care if unresolved at the conclusion of the SHG collection process.

B. Eligibility for Financial Assistance: Non-Mass. Only

1. Eligibility Approval Process

- a) Patient must provide verification of identity, and document that the Modified Adjusted Gross Income of his or her household is equal to or less than 300% of the FPL.
- b) SHG will check state's eligibility System to determine if a patient is enrolled in Medicaid or other state assistance programs.

- c) SHG will verify reported family income. SHG will compare reported family income to the latest Federal Poverty Income Guidelines.
- d) Verification of gross monthly earned income shall include, but not be limited to, the following:
 - recent pay stubs;
 - a signed statement from the employer; or
 - the most recent U.S. tax return.
- e) Verification of gross monthly unearned income shall include, but not be limited to, the following:
 - copy of a recent check or pay stub showing gross income from the source
 - a statement from the income source, where matching is not available;
 - the most recent U.S. tax return
- f) Verification of gross monthly income may also include any other reliable evidence of the applicant's earned or unearned income.
- g) Patient must be uninsured or under insured for services provided.
- h) SHG will attempt to investigate whether a third party payer may be responsible for services provided by SHG, including but not limited to: (1) a motor vehicle or home owner's liability policy, (2) general accident policies, (3) worker's compensation programs, (4) student insurance policies, among others. In accordance with applicable state laws or the insurance contract, for any claims where SHG was able to seek a recovery on the health care claims billed to a private or public insurer, SHG will report the recovery and offset it against the claim paid by the private or public insurer. For state public assistance programs, the hospital is not required to secure assignment on a patient's right to a third party coverage on service provided due to an auto accident.
- i) In the event SHG admissions staff become aware services provided to a Low Income Patient were related to an accident or injury that may result in a TPL claim or lawsuit, they will notify the patient of their responsibilities to notify the appropriate public assistance program.

2. Income Criteria for Low Income – Full/Primary/Secondary

- a) Family Income equal to or less than 150% of the Federal Poverty Income Guidelines.

3. Income Criteria for Low Income – Partial

- a) Family Income from 150%-300% of the Federal Poverty Income Guidelines.
- b) Annual Deductible - The Annual Deductible for Partial Payment equals 40% of the difference between the applicant's Family Income and 150%-300% of the Federal Poverty Income Guidelines. The patient is responsible for payment for all services provided up to deductible. Annual Deductible per family - The total amount of an individual's co-payments is capped in any given year by the Annual Deductible. There is only one Partial Payment Deductible per Family per approval period.
- c) The patient must incur expenses for Eligible Services in excess of the Annual Deductible before SHG can submit a claim for Eligible Services.

4. Eligibility Period

- a) The determination that an individual is a Low Income Patient will be effective for a maximum of one year from the date of determination, subject to periodic redetermination and verification that the patient's household income or insurance status has not changed to such an extent that the patient no longer meets eligibility requirements.

5. Medical Coverage Date

- a) If these required verifications listed on the Request for Information are received after the 90-day period referenced in 101 CMR 613.02: *Medical Coverage Date*(a), the begin date of medical coverage is 10 days before the date on which the verifications were received, if such verification are received within one year of receive of the application.
- b) For children younger than 21 years old and pregnant women receiving Provisional Eligibility as described in 130 CMR 502.003: *Verification of Eligibility Factors*, the medical coverage date begins ten days prior to the date of the application. For all other applicants receiving Provisional Eligibility as described in 130 CMR 502.003: *Verification of Eligibility Factors*, the medical coverage date begins on the date of the provisional eligibility determination. If all required verifications are received before the end of the provisional eligibility period, the medical coverage date of the verified coverage type will be ten days prior to the date of the Application.

6. Charity Care

- a) For individuals determined to be Low Income Patients, services will be considered Charity Care for one year from date of application.
- b) Services denied prior to date of application will also be considered charity care.

C. Exempt from Collection Action

1. The following individuals and patient populations are exempt from any collection or billing procedures beyond the initial bill pursuant to state regulation. Patients enrolled in a public health insurance program, including but not limited to, MassHealth, Health Safety Net, Emergency Aid to the Elderly, Disabled and Children, Children's Medical Security Plan, as determined by the Office of Medicaid – subject to the following:
 - a) SHG may seek collection action against any patient enrolled in the above mentioned programs for their required co-payments, co-insurance and deductibles that are set forth by each specific program.
 - b) SHG may also initiate billing or collection for a patient who alleges that he or she is a participant in a financial assistance program that covers the costs of SHG services, but fails to provide proof of such participation. Upon receipt of satisfactory proof that a patient is a participant in a financial assistance program, (including receipt or verification of signed application) SHG shall cease its billing or collection activities.
 - c) SHG may continue collection action on any Low Income Patient for services rendered prior to the Low Income Patient determination, provided that the current Low Income Patient status has been terminated or expired. However, once a patient is determined eligible and enrolled in the Health Safety Net, MassHealth, or certain Commonwealth Care programs, SHG will cease collection activity for services provided prior to the beginning of their eligibility.

- d) SHG will not undertake collection action against an individual that has been approved for Medical Hardship under the Massachusetts Health Safety Net program with respect to the amount of the bill that exceeds the Medical Hardship contribution.
- e) 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*.
- f) Participants in the Children 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.
- g) SHG will not garnish a Low Income Patient's (as determined by the Office of Medicaid) or their guarantor's wages or execute a lien on the Low Income Patient's or their guarantor's personal residence or motor vehicle unless:
 - (1) SHG can show the patient or their guarantor has the ability to pay.
 - (2) The patient/guarantor did not respond to hospital requests for information or the patient/guarantor refused to cooperate with SHG to seek an available financial assistance program or for purposes of the lien, it was approved by the SHG Board of Trustees on an individual case by case basis.
- h) SHG and its agents shall not continue collection or billing on a patient who is a member of a bankruptcy proceedings except to secure its rights as a creditor in the appropriate order.
- i) SHG and its agents will not charge interest on an overdue balance for a Low Income Patient.
- j) SHG will submit the completed application to the Health Safety Net Office within five business days. If they fail to submit the completed application to Health Safety Net Office with that time frame, SHG will not undertake a Collection Action against the applicant with respect to any bills that would have been eligible for Medical Hardship payment had the application been submitted and approved.
- k) SHG uses Medicare fees to determine the amounts generally billed (AGB) to individuals who have insurance covering emergency or other medically necessary care. Following a determination of FAP eligibility, a FAP eligible individual may not be charged more than the (AGB) for emergency or other medically necessary care.

D. Extraordinary Collection Actions (ECA)

1. ECA will not be taken before SHG has made reasonable efforts to determine whether the individual is eligible for financial assistance. SHG will provide a 120 day waiting period prior to pursuing collections. During this time, the patients will be able to apply for financial assistance and begin the application process. SHG will make reasonable efforts to determine FAP-eligibility including the following:
 - a) SHG will notify the individual about the FAP;
 - b) In the case of an individual who submits an incomplete FAP application, SHG must provide the individual with information relevant to completing the FAP application; and
 - c) In the case of an individual who submits a complete FAP application, SHG will make and document a determination as to whether the individual is FAP eligible.

2. Legal actions that require a legal or judicial process, including:
 - a) Placing a lien on an individual's property;
 - b) Foreclosing on real property;
 - c) Attaching or seizing bank account or any other personal property;
 - d) Commencing a civil action against an individual;
 - e) Causing an individual's arrest;
 - f) Causing an individual to be subject to a writ of body attachment; and garnishing an individual's wages.

SECTION 2: SIGNS AND NOTICES –SIGNS NOTIFICATION PRACTICES

A. Language

1. SHG will provide translated FAP applications and plain summary into any language spoken by a limited English proficiency language group that constitutes the lesser of 1000 people or 5% of the patient population served by SHG.

B. Signs

1. SHG will post signs at all registration locations (i.e., inpatient clinic, emergency, etc.).
2. Signs will inform patients of the availability of financial assistance programs and the locations at which to apply for such programs.
3. Signs will be large enough to be clearly visible and legible by patients visiting these areas. Signs will be compliant with regulation 13.08(1)(e).
4. Signs will be available in English, Spanish and Portuguese.

C. Notification Practices

1. SHG will provide individual notice of the availability of financial assistance programs, including Medical Hardship to a patient expected to incur charges, exclusive of personal convenience item or services that may not be paid in full by third party coverage. Notices will be available in English, Spanish and Portuguese. **(Exhibits A1, A2, A3)**
2. SHG will include a notice about Eligible Services to Low Income Patients and programs of public assistance in our initial bill. **(Exhibit B)**
3. SHG will include a brief notice about Eligible Services to Low Income Patients in all of our written collection actions. **(Sample Letter - Exhibit C)**
4. SHG will notify the patient that payment plans are available when the patient qualifies for Low Income Partial or Medical Hardship.
5. SHG shall advise the patient of their responsibility to notify MassHealth or SHG of any changes in Family Income or insurance status when SHG registration/admission staff interacts with the patient.
6. SHG shall advise patients of their responsibility to track the patient deductible and provide documentation to SHG that the deductible has been reached when more than one Family member is determined to be a Low Income Patient or if the patient or Family members receive Eligible Services from more than one Provider.
7. The Health Safety Net Office notifies both the Provider and the applicant of the Medical Hardship determination.

SECTION 3: Emergency Care Classification

A. Determination of Emergency Care

1. The urgency of treatment associated with each patient's presenting clinical symptoms will be determined by a medical professional responsible for triage. Classification of patients' medical condition is for clinical management (or triage) purposes only, and such classifications are intended for addressing the order in which physicians should see patients based on their presenting clinical symptoms. These classifications do not reflect medical evaluation of the patient's medical condition reflected in final diagnosis. The classifications are as defined in SHG's Emergency Department Triage Policies and Procedures.
2. Pursuant to EMTALA (The Federal Emergency Medical Treatment and Active Labor Act) under 42 U.S.C, SHG classifies as emergency care any person who enters the hospital requesting emergency treatment or who enters the emergency department requesting medical treatment. Most commonly, unscheduled persons present themselves at the SHG emergency rooms. However, unscheduled persons requesting emergency services while presenting at another inpatient unit, clinic, or other ancillary area 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).

B. Emergency and Other Medically Necessary Care Provider Affiliation List

1. SHG established an Affiliated Provider list for emergency and other medical necessary care. This list will indicate which Provider Affiliates are covered and which are not eligible by the FAP. This

list will be maintained on a quarterly basis and available on the Southcoast Health website <http://www.southcoast.org>.

Glossary:

Financial Assistance Programs

A Financial Assistance program is one that is intended to assist low-income patients, who do not otherwise have the ability to pay for their health care services. Such assistance should take into account each individual's ability to contribute to the cost of his or her care. Consideration is also given to patients who have exhausted their insurance benefits and/or who exceed financial eligibility criteria but face extraordinary medical cost. A financial assistance program is not a substitute for employer-sponsored, public financial assistance, or individually purchased insurance program.

Resident

A person living in Massachusetts with the intention to remain permanently or for an indefinite period. A resident is not required to maintain a fixed address. Enrollment in a Massachusetts institution of higher learning or confinement in a Massachusetts medical institution, other than a nursing facility, is not sufficient to establish residency.

Third Party

Any individual, entity or program that is or may be responsible to pay all or part of the cost for medical services.

EXHIBITS

- A.** Notification for Low Income Patients
 - 1.** English
 - 2.** Spanish
 - 3.** Portuguese
- B.** Letter for Approval for Low Income, Partial
- C.** Sample of Signage