

Table of Contents

- BIDMC Financial Assistance Policy 2
 - Applicable To..... 2
 - References..... 2
 - Purpose..... 2
 - Definitions..... 3
 - Services Eligible for Financial Assistance..... 7
 - Services Not Eligible for Financial Assistance..... 7
 - Community Health Needs Assessment..... 7
 - Public Assistance Programs..... 9
 - Hospital Financial Assistance through Health Safety Net..... 9
 - Role of the Financial Assistance Counselor 12
 - Patient Obligations..... 13
 - Eligibility Criteria for Hospital Financial Assistance..... 14
 - Financial Assistance Discounts..... 17
 - Financial Assistance Policy 17
 - Reasons for Denial..... 19
 - Presumptive Eligibility 19
 - Emergency Medical Services..... 20
 - Amount Generally Billed..... 20
 - Credit and Collections..... 20
 - Regulatory Requirements..... 20
- Appendix 1 21
 - Financial Assistance Application Form 21
- Appendix 2..... 24
 - Medical Hardship Application..... 24
- Appendix 3..... 27
 - Discount Chart Based on Income 27
- Appendix 4..... 28
 - Covered Providers and Clinics..... 28
- Appendix 5..... 29
 - Amount Generally Billed (AGB)..... 29
- Appendix 6..... 30
 - Public Access to Documents..... 30
 - Policy History 31

BIDMC Financial Assistance Policy

Applicable To This policy applies to Beth Israel Deaconess Medical Center (BIDMC) and Providers employed by or affiliated with BIDMC (see Appendix Four (4) for the complete list of providers covered under this policy).

References EMTALA: Collection of Financial Information
Credit & Collections Policy
Federal Poverty Guidelines, US Dept. of Health and Human Services
IRS Notice 2015-46 and 29 CFR §§1.501(r) (4)-(6)
Appendix 1: Financial Assistance Application Form
Appendix 2: Medical Hardship Application
Appendix 3: Discount chart based on income and asset thresholds
Appendix 4: Covered providers and departments
Appendix 5: Amounts Generally Billed (AGB) Percentage
Appendix 6: Public Access to Documents

Purpose Our mission is to distinguish ourselves through excellence in patient care, education, research and through improved health in the communities we serve.

BIDMC is dedicated to providing financial assistance to patients who have health care needs and are uninsured, underinsured ineligible for a government program, or otherwise unable to pay for medically necessary care based on their individual financial situation. This financial assistance policy is intended to be in compliance with applicable federal and state laws for our service area. Patients eligible for financial assistance will receive discounted care received from qualifying BIDMC providers.

Financial assistance provided under this policy is done so with the expectation that patients will cooperate with the policy's application process and those of public benefit or coverage programs that may be available to cover the cost of care.

We will not discriminate based on the patient's age, gender, race, creed, religion, disability, sexual orientation, gender identity, national origin or immigration status when determining eligibility.

Definitions

The following definitions are applicable to all sections of this policy.

Classification of emergency and nonemergency services is based on the following general definitions, as well as the treating clinician's medical determination. The definitions of emergency or urgent care services provided below are further used by the Hospital for purposes of determining allowable emergency and urgent bad debt coverage under the hospital's financial assistance program, including the Health Safety Net.

Amount Generally Billed (AGB): the amount generally billed is the expected payment for emergency or medically necessary services from patients and/or patient's guarantor. For patients who qualify, this amount will not exceed a rate that will be determined using the Look Back Method described in section 1.501(r)-5(b)(3) of the Internal Revenue Code. The Look Back Method was based on actual past claims paid to BIDMC by Medicare Fee For Service together with all private health insurers paying claims.

The claims to be included in the AGB calculation will be claims allowed during the prior calendar year. The amounts for coinsurance, copays and deductibles will be included in the numerator along with the Medicare Fee For Service together with all allowed claims from private health insurers. The gross charges for said claims will be the denominator. The AGB will be calculated annually by the 45th day following the close of the prior calendar year, and implemented by the 120th day following the close of the calendar year.

Amount Generally Billed Percentage: The AGB Percentage will be calculated each year by the 45th day of the year and is described in Appendix Five (5) of this policy.

Application Period: The period in which applications will be accepted and processed for financial assistance. The application period begins on the date that the first post-discharge billing statement is provided and ends on the 240th after that date.

Assets: Consists of:

- Savings accounts
- Checking accounts
- Health savings accounts (HSA)*
- Health reimbursement arrangements (HRA)*
- Flexible spending accounts (FSA)*

*Discounts may not apply if a patient/guarantor has an HSA, HRA, FSA or similar fund designated for family medical expenses. Payment from either fund is due before any discount can apply.

Emergency Medical Condition: As defined in Section 1867 of the Social Security Act (42 U.S.C. 1395dd), the term “Emergency Medical Condition” means a medical condition manifesting itself by acute symptoms of sufficient severity such that the absence of medical care could be reasonably expected to result in:

1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
2. Serious impairment to bodily functions
3. Serious dysfunction of any bodily organ or part
4. With respect to a pregnant woman who is having contractions:
 - a. There is inadequate time to effect a safe transfer to another hospital for delivery
 - b. That transfer may pose a threat to the health or safety of the woman or unborn child

Elective Admission: A hospital admission that is neither considered an Emergency Medical Condition or Medically Necessary is not covered under this policy.

Family: as defined by the U.S. Census Bureau, a group of two or more people who reside together and who are related by birth, marriage, or adoption. If a patient claims someone as a dependent on their income tax return, according to the Internal Revenue Service rules, they may be considered a dependent for the purpose of determining eligibility for this policy.

Family Income: an applicant’s family income is the combined gross income of all adult members of the family living in the same household and included on the most recent federal tax return. For patients under 18 years of age, family income includes that of the parent or parents and/or step-parents, or caretaker relatives. Family income is determined using the Census Bureau definition, which including the following income when computing Federal Poverty Guidelines:

1. Includes earnings, unemployment compensation, worker’s compensation, Social Security, Supplemental Security Income, public assistance, veteran’s payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational stipends, alimony and child support
2. Noncash benefits (such as food stamps and housing subsidies) do not count
3. Determined on a before tax (gross) basis
4. Excludes capital gains and losses

Federal Poverty Level: The Federal Poverty Level (FPL) uses the income thresholds that vary by family size and composition to determine who is in

poverty in the United States. It is updated periodically in the Federal Register by the United States Department of Health and Human Services under authority of the subsection (2) of Section 9902 of Title 42 of the United States Code. Current FPL guidelines can be referenced at <https://aspe.hhs.gov/poverty-guidelines>.

Financial Assistance: assistance provided to eligible patients, who would otherwise experience financial hardship, to relieve them of all or part of their financial obligation for emergency or medically necessary care provided by BIDMC.

Full Assistance: For patients, or their guarantors, with annualized family income at or below 200% of the FPL will receive a 100% waiver of patient financial obligation for eligible medical services provided by BIDMC.

Guarantor: A person other than the patient who is responsible for the patient's bill.

Gross Charges: Total charges at the full established rate for the provision of patient care services before deductions from revenue are applied.

Homeless: as defined by the Federal government, and published in the Federal Register by HUD:
An individual or family who lacks a fixed, regular and adequate nighttime residence, meaning the individual or family has a primary nighttime residence that is a public or private place not meant for human habitation or is living in a publicly or privately run shelter designed to provide temporary living arrangements. This category also includes individuals who are exiting an institution where he or she resided for 90 days or less who resided in an emergency shelter or place not meant for human habitation immediately prior to entry into the institution.

Medical Hardship: Financial assistance provided to eligible patients whose medical bills are greater than or equal to 25% of their gross income.

Medically Necessary Care: Medically necessary services, such as inpatient or outpatient health care services provided for the purpose of evaluation, diagnosis, and/or treatment of an injury or illness, as well as services typically defined by Medicare or other health insurance coverage as "covered items or services".

Medicare Fee for Service: Health insurance offered under Medicare Part A and Part B of Title XVIII of the Social security Act (42 USC 1395c-1395w-5).

Partial Assistance: Financial assistance that provides a discount, for eligible medical services provided by BIDMC, for eligible patients, or patient guarantors, with annualized family incomes between 201% and 400% of the Federal Poverty Level.

Payment Plan: a payment plan that is agreed to by either BIDMC, or a third party vendor representing BIDMC and the patient/guarantor for out of pocket fees. The payment plan will take into account the patient's financial circumstances, the amount owed and any prior payments.

Presumptive Eligibility: Under certain circumstances, uninsured patients may be presumed or deemed eligible for financial assistance based on their enrollment in other means-tested programs or other sources of information, not provided directly by the patient, to make an individual assessment of financial need.

Private Health Insurer: Any organization that is not a government unit that offers health insurance, including nongovernmental organizations administering a health insurance plan under Medicare Advantage.

Qualification Period: Applicants determined to be eligible for financial assistance will be granted assistance for a period of six months. Patients who qualify for financial assistance may attest that there have been no changes to their financial situation at the end of the six (6) month qualification period to extend eligibility for another six (6) months.

Uninsured Discount: Patients with no third party coverage will be provided an uninsured discount, for eligible services provided by BIDMC under this policy, at the time the undiscounted charges are rendered.

Uninsured Patient: A patient with no third party coverage provided by a commercial third party insurer, an ERISA, a Federal Healthcare Program (including without limitation Medicare, Medicaid, SCHIP, and CHAMPUS), Worker's Compensation, or other third party assistance available to cover the cost of a patient's healthcare expenses.

Underinsured Patients: Any individual with private or government coverage for whom it would be a financial hardship to fully pay the expected out-of-pocket expenses for medical services provided by BIDMC.

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

organ or part. Urgent Care Services are provided for conditions that are not life threatening and do not pose a high risk of serious damage to an individual's health. Urgent Care Services do not include Primary or Elective Care.

Services Eligible for Financial Assistance

Services eligible under the BIDMC financial assistance policy must be clinically appropriate and within acceptable medical practice standards. They include the following:

1. Emergency medical services, as well as care provided in a non-emergency setting for the purpose of stabilizing the patient's condition.
 2. Non-elective services provided in response to life-threatening circumstances in a non-emergency setting.
 3. Medically necessary services, such as inpatient or outpatient health care services provided for the purpose of evaluation, diagnosis, and/or treatment of an injury or illness, as well as services typically defined by Medicare or other health insurance coverage as "covered items or services".
 4. Services of providers employed by BIDMC and who are covered under this policy. See Appendix Four (4) for a full list of providers covered under this policy.
-

Services Not Eligible for Financial Assistance

Services not eligible for financial assistance include the following:

1. Elective procedures not medically necessary, as well as services not typically covered by Medicare or other health insurance coverage as not medically necessary.
 2. Services received from care providers not employed by BIDMC (e.g. private or non-BIDMC medical or physician professionals, ambulance transport, etc.). Patients are encouraged to contact these providers directly to see if they offer and assistance and to make payment arrangements. See Appendix Four (4) for a full listing of providers covered under this policy.
 3. Deductibles and coinsurance associated with medically necessary services provided to patients out-of-network as defined by their insurer.
-

Community Health Needs Assessment

A Community Health Needs Assessment was performed and was approved by the Board of Directors on September 18, 2013 in order to identify and address community health needs across BIDMC's community benefits service area. The following categorizes the health related issues and populations that have been identified as priorities as a result of this assessment.

Health Related Issues and Targeted Populations

1. Disease Management and Prevention including:

- Diabetes, heart disease, cancer and asthma
 - Health education, screening and disease management
- Targeted populations:
- Low income
 - Racial/ethnic minorities
 - Residents of Boston, in particular Allston/Brighton, North Dorchester, Roxbury, Fenway/Kenmore; the Outer Cape towns of Harwich, Wellfleet and Provincetown, as well as Quincy.
2. Access to Care includes:
- Primary medical care
 - Medical specialty care
 - Behavioral health care
 - Dental care
- Targeted populations:
- Low income
 - Racial/ethnic minorities
 - Medicaid insured, uninsured and under-insured
3. Healthy Living-Obesity, Fitness and Nutrition includes:
- Adequate exercise
 - Nutrition
 - Food security
 - Safe neighborhoods
- Targeted populations:
- All
4. Behavioral Health includes:
- Depression/anxiety/stress
 - Substance abuse
 - Access to care
 - Homicide/Domestic Violence
- Targeted population:
- Residents of Roxbury and Dorchester
 - Adults with opioid addiction

It should be noted that BIDMC will also invest in and support a handful of other issues that fall outside of these priority areas as special opportunities and health issues/crises arise or based on historical commitments. BIDMC's community benefits efforts will always be focused where there is need and opportunity for impact.

A copy of the full report can be obtained on our public website:

<http://www.bidmc.org/~media/Files/Centers%20and%20Departments/Community%20Initiatives/FinalCHNAReport92313.pdf>

Public Assistance Programs

For those individuals who are uninsured or underinsured, the hospital will work with patients to assist them in applying for public assistance and/or hospital financial assistance programs that may cover some or all of their unpaid hospital bills. In order to help uninsured and underinsured individuals find available and appropriate options, the hospital will provide all individuals with a general notice of the availability of public assistance and financial assistance programs during the patient's initial in-person registration at a hospital location for a service, in all billing invoices that are sent to a patient or guarantor, and when the provider is notified or through its own due diligence becomes aware of a change in the patient's eligibility status for public or private insurance coverage.

Hospital patients may be eligible for free or reduced cost of health care services through various state public assistance programs as well as the hospital financial assistance programs (including but not limited to MassHealth, the premium assistance payment program operated by the Health Connector, the Children's Medical Security Program, the Health Safety Net, and Medical Hardship). Such programs are intended to assist low-income patients taking into account each individual's ability to contribute to the cost of his or her care. For those individuals that are uninsured or underinsured, the hospital will, when requested, help them with applying for either coverage through public assistance programs or hospital financial assistance programs that may cover all or some of their unpaid hospital bills.

The Hospital is available to assist patients in enrolling into state health coverage programs. These include MassHealth, the premium assistance payment program operated by the state's Health Connector, and the Children's Medical Security Plan. For these programs, applicants can submit an application through an online website (which is centrally located on the state's Health Connector Website), a paper application, or over the phone with a customer service representative located at either MassHealth or the Connector. Individuals may also ask for assistance from hospital financial counselors (also called certified application counselors) with submitting the application either on the website or through a paper application.

Hospital Financial Assistance through Health Safety Net

Through its participation in the Massachusetts Health Safety Net, the Hospital provides financial assistance to low-income uninsured and underinsured patients who are Massachusetts residents and who meet income qualifications. The Health Safety Net was created to more equitably distribute the cost of providing uncompensated care to low income uninsured and underinsured patients through free or discounted care across acute hospitals in Massachusetts. The Health Safety Net pooling of uncompensated care is accomplished through an assessment on each hospital to cover the cost of care for uninsured and underinsured patients with incomes under 300% of the

federal poverty level. It is the hospital's policy that all patients who receive financial assistance under the hospital's financial assistance policy includes the health safety net services as part of the uncompensated care provided to low income patients.

Through its participation in the Health Safety Net, low-income patients receiving services at the Hospital may be eligible for financial assistance, including free or partially free care for Health Safety Net eligible services defined in 101 CMR 613:00.

(a) Health Safety Net - Primary

Uninsured patients who are Massachusetts residents with verified MassHealth MAGI household Income or Medical Hardship Family income, as described in 101 CMR 613.04(1), between 0-300% of the Federal Poverty Level (FPL) may be determined eligible for Health Safety Net Eligible Services.

The eligibility period and type of services for *Health Safety Net - Primary* is limited for patients eligible for enrollment in the Premium Assistance Payment Program operated by the Health Connector as described in 101 CMR 613.04(5)(a) and (b). Patients subject to the Student Health Program requirements of M.G.L. c. 15A, § 18 are not eligible for *Health Safety Net - Primary*.

(b) Health Safety Net - Secondary

Patients that are Massachusetts residents with primary health insurance and MassHealth MAGI Household income or Medical Hardship Family Countable Income, as described in 101 CMR 613.04(1), between 0 and 300% of the FPL may be determined eligible for Health Safety Net Eligible Services. The eligibility period and type of services for *Health Safety Net - Secondary* is limited for patients eligible for enrollment in the Premium Assistance Payment Program operated by the Health Connector as described in 101 CMR 613.04(5)(a) and (b). Patients subject to the Student Health Program requirements of M.G.L. c. 15A, § 18 are not eligible for *Health Safety Net - Primary*.

(c) Health Safety Net - Partial Deductibles

Patients that qualify for *Health Safety Net Primary* or *Health Safety Net - Secondary* with MassHealth MAGI Household income or Medical Hardship Family Countable Income between 150.1% and 300% of the FPL may be subject to an annual deductible if all members of the Premium Billing Family Group (PBF) have an income that is above 150.1% of the FPL. This group is defined in 130 CMR 501.0001.

If any member of the PBF has an FPL below 150.1% there is no deductible for any member of the PBF. The annual deductible is equal

to the greater of:

1. the lowest cost Premium Assistance Payment Program Operated by the Health Connector premium, adjusted for the size of the PBFPG proportionally to the MassHealth FPL income standards, as of the beginning of the calendar year; or
2. 40% of the difference between the lowest MassHealth MAGI Household income or Medical Hardship Family Countable Income, as described in 101 CMR 613.04(1), in the applicant's Premium Billing Family Group (PBFPG) and 200% of the FPL.

(d) Health Safety Net - Medical Hardship

A Massachusetts resident of any income may qualify for *Medical Hardship* through the Health Safety Net if allowable medical expenses have so depleted his or her countable income that he or she is unable to pay for health services. To qualify for *Medical Hardship*, the applicant's allowable medical expenses must exceed a specified percentage of the applicant's Countable Income defined in 101 CMR 613 as follows:

Income Level	Percentage of Countable Income
0 - 205% FPL	10%
205.1 - 305% FPL	15%
305.1 - 405%	20%
405.1 - 605% FPL	30%
>605.1% FPL	40%

The applicant's required contribution is calculated as the specified percentage of Countable Income in 101 CMR 613.05(1)(b) based on the *Medical Hardship* Family's FPL multiplied by the actual Countable Income less bills not eligible for Health Safety Net payment, for which the applicant will remain responsible. Further requirements for *Medical Hardship* are specified 101 CMR 613.05.

A hospital may request a deposit from patients eligible for Medical Hardship. Deposits will be limited to 20% of the Medical Hardship contribution up to \$1,000. All remaining balances will be subject to the payment plan conditions established in 101 CMR 613.08(1)(g).

For Medical Hardship, the hospital will work with the patient to determine if a program like Medical Hardship would be appropriate and submit a Medical Hardship application to the Health Safety Net. It is the patient's obligation to provide all necessary information as requested by the hospital in an appropriate timeframe to ensure that the hospital can submit a completed application. If the patient is able to provide all information in a timely manner, the hospital will endeavor to submit the total and completed application within five (5) business days of receiving all necessary and requested information. If the total and completed application is not submitted

within five business days of receiving all necessary information, collection actions may not be taken against the patient with respect to bills eligible for Medical Hardship.

**Role of the
Financial
Assistance
Counselor**

The hospital will help uninsured and underinsured individuals apply for health coverage through a public assistance program (including but not limited to MassHealth, the premium assistance payment program operated by the Health Connector, and the Children's Medical Security Program), and work with individuals to enroll them as appropriate. The hospital will also help patients that wish to apply for financial assistance from the hospital, which includes coverage through the Health Safety Net and Medical Hardship.

The hospital will:

- a) provide information about the full range of programs, including MassHealth, the premium assistance payment program operated by the Health Connector, the Children's Medical Security Program, Health Safety Net, and Medical Hardship;
- b) help individuals complete a new application for coverage or submit a renewal for existing coverage;
- c) work with the individual to obtain all required documentation;
- d) submit applications or renewals (along with all required documentation);
- e) interact, when applicable and as allowed under the current system limitations, with the Programs on the status of such applications and renewals;
- f) help to facilitate enrollment of applicants or beneficiaries in Insurance Programs; and
- g) offer and provide voter registration assistance.

The hospital will advise the patient of their obligation to provide the hospital and the applicable state agency with accurate and timely information regarding their full name, address, telephone number, date of birth, social security number (if available), current insurance coverage options (including home, motor vehicle, and other liability insurance) that can cover the cost of the care received, any other applicable financial resources, and citizenship and residency information. This information will be submitted to the state as part of the application for public program assistance to determine coverage for the services provided to the individual.

If the individual or guarantor is unable to provide the necessary information, the hospital may (at the individual's request) make reasonable efforts to obtain any additional information from other sources. Such efforts also include working with individuals, when requested by the individual, to determine if a bill for services should be sent to the individual to assist with

meeting the one-time deductible. This will occur when the individual is scheduling their services, during pre-registration, while the individual is admitted in the hospital, upon discharge, or for a reasonable time following discharge from the hospital. Information that the hospital obtains will be maintained in accordance with applicable federal and state privacy and security laws.

The hospital will also notify the patient during the application process of their responsibility to report to both the hospital and the state agency providing coverage of healthcare services any third party that may be responsible for paying claims, including a home, auto, or other insurance liability policy. If the patient has submitted a third party claim or filed a lawsuit against a third party, the hospital will notify the patient of the requirement to notify the provider and the state program within 10 days of such actions. The patient will also be informed that they must repay the appropriate state agency the amount of the healthcare covered by the state program if there is a recovery on the claim, or assign rights to the state to allow it to recover its applicable amount.

When the individual contacts the hospital, the hospital will attempt to identify if an individual qualifies for a public assistance program or through the hospital financial assistance program. An individual who is enrolled in a public assistance program may qualify for certain benefits. Individuals may also qualify for additional assistance based on the hospital's financial assistance program based on the individual's documented income and allowable medical expenses.

**Patient
Obligations**

Prior to the delivery of any health care services (except for services that are provided to stabilize a patient determined to have an emergency medical condition or needing urgent care services), the patient is expected to provide timely and accurate information on their current insurance status, demographic information, changes to their family income or group policy coverage (if any), and, if known, information on deductibles or co-payments that are required by their applicable insurance or financial program. The detailed information for each item should include, but not be limited to:

- Full name, address, telephone number, date of birth, social security number (if available), current health insurance coverage options, citizenship and residency information, and the patient's applicable financial resources that may be used to pay their bill;
- If applicable, the full name of the patient's guarantor, their address, telephone number, date of birth, social security number (if available), current health insurance coverage options, and their applicable financial resources that may be used to pay for the patient's bill; and
- Other resources that may be used to pay their bill, including other insurance

programs, motor vehicle or homeowners insurance policies if the treatment was due to an accident, worker's compensation programs, student insurance policies, and any other family income such as an inheritances, gifts, or distributions from an available trust, among others.

The patient is responsible for keeping track of their unpaid hospital bill, including any existing co-payments, co-insurance, and deductibles, and contacting the hospital should they need assistance in paying for some or their entire bill. The patient is further required to inform either their current health insurer (if they have one) or the state agency that determined the patient's eligibility status in a public program of any changes in family income or insurance status. The hospital may also assist the patient with updating their eligibility in a public program when there are any changes in family income or insurance status provided that the patient informs the hospital of any such changes in the patient's eligibility status.

Patients are also required to notify the hospital and the applicable program in which they are receiving assistance (e.g., MassHealth, Connector, Health Safety Net, or Medical Hardship), of any information related to a change in family income, or if they are part of an insurance claim that may cover the cost of the services provided by the hospital. If there is a third party (such as, but not limited to, home or auto insurance) that is responsible to cover the cost of care due to an accident or other incident, the patient will work with the hospital or applicable program (including, but not limited to, MassHealth, Connector, or Health Safety Net) to assign the right to recover the paid or unpaid amount for such services.

**Eligibility
Criteria for
Hospital
Financial
Assistance**

Financial assistance will be extended to uninsured and underinsured patients/guarantors who meet specific criteria as defined below. These criteria will assure that this financial assistance policy is applied consistently across BIDMC. BIDMC reserves the right to revise, modify or change this policy as necessary or appropriate.

BIDMC will make diligent efforts to collect the patient's insurance status and other information in order to verify coverage for the emergency, inpatient or outpatient health care services to be provided by the Hospital. All information will be obtained prior to the delivery of any non-emergent and non-urgent health care services (i.e., elective procedures as defined in this credit and collection policy). The Hospital will delay any attempt to obtain this information during the delivery of any EMTALA level emergency level or urgent care services, if the process to obtain this information will delay or interfere with either the medical screening examination or the services undertaken to stabilize an emergency medical condition.

The hospital's reasonable due diligence efforts to investigate whether a third

party insurance or other resource may be responsible for the cost of services provided by the hospital shall include, but not be limited to, determining from the patient if there is an applicable policy to cover the cost of the claims, including: (1) motor vehicle or home owner's liability policy, (2) general accident or personal injury protection policy, (3) worker's compensation programs, and (4) student insurance policies, among others. If the hospital is able to identify a liable third party or has received a payment from a third party or another resource (including from a private insurer or another public program), the hospital will report the payment to the applicable program and offset it, if applicable per the program's claims processing requirements, against any claim that may have been paid by the third party or other resource. For state public assistance programs that have actually paid for the cost of services, the hospital is not required to secure assignment on a patient's right to third party coverage of services. In these cases, the patient should be aware that the applicable state program may attempt to seek assignment on the costs of the services provided to the patient.

Payment resources (insurance available through employment, Medicaid, Indigent Funds, Victims of Violent Crime, etc.) must be reviewed and evaluated before a patient is considered for financial assistance. If it appears that a patient may be eligible for other assistance, BIDMC will refer the patient to the appropriate agency for assistance in completing the applications and forms. Applicants for assistance are required to exhaust all other payment options as a condition of their approval for financial assistance.

Financial assistance applicants are responsible for applying to public programs and pursuing private health insurance coverage. Patients/guarantors choosing not to cooperate in applying for programs identified by BIDMC as possible sources of payment may be denied financial assistance. Applicants are expected to contribute to the cost of their care based on their ability to pay as outlined in this policy.

BIDMC will check the Massachusetts Eligibility Verification System (EVS) to ensure that the patient is not a Low Income Patient and has not submitted an application for coverage for either MassHealth, the premium assistance payment program operated by the Health Connector, the Children's Medical Security Program, Health Safety Net, or Medical Hardship, prior to submitting claims to the Health Safety Net Office for bad debt coverage.

If there is no specific coverage for the services provided, the hospital will work with the patient to determine if a different state program option, such as applying for Medical Hardship through the Health Safety Net, would be available following the Health Safety Net regulations. It is the patient's obligation to provide all necessary information as requested by the hospital in an appropriate timeframe to ensure that the hospital can submit a completed application. The hospital will endeavor to submit the total and completed

application within five (5) business days of receiving all necessary information from the patient. If the total and completed application is not submitted within five business days of receiving all necessary information in the timeframe requested by the hospital, collection actions may not be taken against the patient with respect to bills eligible for Medical Hardship.

Patients/guarantors that may qualify for Medicaid or other health insurance must apply for Medicaid coverage or show proof that he or she has applied for Medicaid or other health insurance through the Federal Health Insurance Marketplace within the previous six (6) months of applying for BIDMC financial assistance. Patients/guarantors must cooperate with the application process outlined in this policy in order to qualify for financial assistance.

The criteria to be considered by BIDMC when evaluating a patient's eligibility for financial assistance include:

- Family income
- Assets
- Medical obligations

BIDMC financial assistance program is available to all patients meeting the eligibility requirements set forth in this policy, regardless of geographic location or residency status. Financial assistance will be granted to patients/guarantors based on financial need and in compliance with state and federal law.

Financial assistance will be offered to eligible underinsured patients, providing such assistance is in accordance with the insurer's contractual agreement. Financial assistance is generally not available for patient copayment or balances in the event the patient fails to comply with the insurance requirements.

Patients with a Health Savings Account (HSA), Health Reimbursement Account (HRA), or a Flexible Spending Account (FSA) will be expected to utilize account funds prior to being granted financial assistance. BIDMC reserves the right to reverse the discounts described in this policy in the event that it reasonably determines that such terms violate any legal or contractual obligation of BIDMC.

Financial Assistance Discounts

Based on an assessment of an applicant's family income, assets and medical obligations, patients may receive one of the following assistances:

Prompt Pay Discount: Patients with no third party coverage that do not qualify for Public Assistance or Financial Assistance will be provided a discount of 30%. Payment must be made prior to services being rendered. This discount would also apply to patients paying for non-medically necessary services.

This does not preclude patients/guarantors from applying and qualifying for additional financial assistance.

Insured patients who chose to become voluntary self pay patients do not qualify for financial assistance for the amount owed on any account registered as voluntary self pay.

Full Assistance: BIDMC will provide care at 100% discount under this policy for patients/guarantors whose gross family income is at or below 200% of the current Federal Poverty Guideline.

Partial Assistance: A 50% discount will be provided on BIDMC charges for services covered under the financial assistance policy for any uninsured or underinsured patient/guarantor whose family gross income is 201% but less than or equal to 400% of the FPL.

Medical Hardship: A 65% discount will be provided for eligible patients whose medical debt is greater than or equal to 25% of their gross income.

Financial Assistance Policy

Information for the BIDMC financial assistance policy, plain language summary and financial assistance application are available, free of charge, on all affiliate public websites, posted in hospital and clinic locations and will be translated in any language that is the primary language spoken by the lessor of 1,000 or 5% of the residents in the service area.

In addition, BIDMC references payment policies and financial assistance on all printed monthly patient statements and collection letters. Information on the financial assistance policy is available, at any time, upon request.

1. Patients/guarantors may apply for financial assistance at any time up to two hundred and forty (240) days after the first post-discharge billing statement is available.
2. In order to be considered for financial assistance, patients/guarantors are required to cooperate and supply financial, personal or other documentation relevant to making a determination of financial need. A financial assistance application form can be obtained in any of the

following ways:

- a. On the BIDMC public websites
 - b. In person at the Financial Counseling Unit
330 Brookline Ave
East Campus/Rabb Building
Room 111
Boston, MA 02215
(617) 667-5661
 - c. Call the number above to request a copy to be mailed
 - d. Call the number above to request an electronic copy
3. Patients/guarantors are required to provide an accounting of financial resources readily available to the patient/guarantor.
Household income may be verified using any or all of the following:
- a. Current W2s
 - b. Current state or federal tax returns
 - c. Four (4) most recent payroll stubs
 - d. Four (4) most recent checking and/or savings statements
 - e. Health savings accounts
 - f. Health reimbursement arrangements
 - g. Flexible spending accounts
4. Prior to evaluating eligibility for financial assistance, the patient/guarantor must show proof the he or she has applied for Medicaid or other health insurance through the Federal Health Insurance Marketplace.
- a. BIDMC Financial Counselors will assist patient/guarantors for applying for Medicaid and will subsequently assist those same individuals with applying for financial assistance.
 - b. If an individual applies for financial assistance during the Federal Health Insurance Marketplace open enrollment, such individual is required to seek coverage prior to BIDMC & Affiliate's evaluation of any financial assistance application.
5. BIDMC may *not* deny financial assistance under this Policy based on an individual's failure to provide information or documentation that is *not* clearly described in this policy or the financial assistance application.
6. BIDMC will determine final eligibility for financial assistance within thirty (30) business days upon receipt of a completed application.
7. Documentation of the final eligibility determination will be made on all current (open balance) patient accounts retroactive to 6 months from the application where no patient payment has been received. A determination letter will be sent to the patient/guarantor.
8. If a patient/guarantor submits an incomplete application, a notification will be sent to the patient/guarantor explaining what information is missing. The patient/guarantor will have thirty (30) days to comply and provide the requested information. Failure to complete the application will result in the financial assistance being denied.

9. A determination of eligibility for financial assistance based on the submission of a financial assistance application will remain valid for a period of six (6) months for all necessary BIDMC & Affiliate services provided, based on the date of the determination letter and will include all outstanding receivables for the previous six (6) months including those at bad debt agencies unless a patient payment has been applied to the account. Patients who are currently receiving financial assistance from one BID affiliate will not be required to reapply for financial assistance from another affiliate. It is the patient/guarantors responsibility to notify BIDMC of any financial change during the six (6) month eligibility period. Failure to do so may result in the loss of eligibility.

Reasons for Denial

BIDMC may deny a request for financial assistance for a variety of reasons including, but not limited to:

- Sufficient income
- Sufficient asset level
- Patient uncooperative or unresponsive to reasonable efforts to work with the patient/guarantor
- Incomplete financial assistance application despite reasonable efforts to work with the patient/guarantor
- Pending insurance or liability claim
- Withholding insurance payment and/or insurance settlement funds, including payments sent to the patient/guarantor to cover services provided by BIDMC, and personal injury and/or accident related claims

Presumptive Eligibility

BIDMC understands that not all patients are able to complete a financial assistance application or comply with requests for documentation. There may be instances under which a patient/guarantor's qualification for financial assistance is established without completing the application form. Other information may be used by BIDMC to determine whether a patient/guarantor's account is uncollectible and this information will be used to determine presumptive eligibility.

Presumptive eligibility may be granted to patients based on their eligibility for other programs or life circumstances such as:

- Patients/guarantors who have declared bankruptcy. In cases involving bankruptcy, only the account balance as of the date the bankruptcy is discharged will be written off.
- Patients/guarantors who are deceased with no estate in probate.
- Patients/guarantors determined to be homeless
- Accounts returned by the collection agency as uncollectible due to any of the reasons above and no payment has been received.

- Patients/guarantors who qualify for state Medicaid programs will be eligible for financial assistance for any cost sharing obligations associated with the program or non-covered services.

Patient accounts granted presumptive eligibility will be reclassified under the financial assistance policy. They will not be sent to collection nor will they be subject to further collection actions.

**Emergency
Medical
Services**

In accordance with Federal Emergency Medical Treatment and Labor Act (EMTALA) regulations, no patient is to be screened for financial assistance or payment information prior to the rendering of services in an emergency situation. BIDMC may request that patient cost sharing payments (i.e. co-payments) be made at the time of service, provided such requests do not cause delay in the screening examination or necessary treatment to stabilize the patient in an emergency situation.

**Amount
Generally
Billed**

The amount generally billed (AGB) is the expected payment from patients/guarantors eligible for financial assistance. For qualifying patients/guarantors this amount will not exceed a rate determined by using the Look Back Method. BIDMC calculated the AGB by dividing the total payments received from all Commercial plans and Medicare by the total charges sent to those same payers for the previous fiscal year. For more information, see Appendix Five (5).

**Credit and
Collections**

The actions that may be taken by BIDMC in the event of non-payment are described in a separate Credit and Collections Policy. Members of the public may obtain a free copy by calling (617) 667-5661 or by going to the BIDMC public website:
<http://www.bidmc.org/patient-and-visitor-information.aspx>

**Regulatory
Requirements**

BIDMC will comply with all federal, state and local laws, rules and regulations, and reporting requirements that may apply to activities pursuant to this policy. This policy requires that BIDMC track financial assistance provided to ensure accurate reporting. Information on the financial assistance provided under this policy will be reported annually on the IRS form 990 Schedule H.

BIDMC will document all financial assistance in order to maintain proper controls and meet all internal and external compliance requirements.

Appendix 1

Financial Assistance Application Form

Application for Financial Assistance

Please Print

Today's Date: _____ Social Security # _____

Medical Record Number: _____

Patient Name: _____

Address: _____
 _____ Street _____ Apt. Number
 _____ City _____ State _____ Zip Code

Date of Hospital Services: _____

Patient Date of Birth _____

Did the patient have health insurance or Medicaid** at the time of hospital service?
 Yes No

If "Yes", attach a copy of the insurance card (front and back) and complete the following:

Name of Insurance Company: _____

Policy Number: _____

Effective Date: _____

Insurance Phone Number: _____

**Prior to applying for financial assistance, you must have applied for Medicaid in the past 6 months and will need to show proof of denial.

Note: *Financial assistance may not apply if a Health Savings Account (HSA), Health Reimbursement Account (HRA), Flexible Spending Account (FSA) or similar fund designated for family medical expenses has been established. Payment from any established fund is due before assistance can be provided.*

To apply for financial assistance complete the following:

List all family members including the patient, parents, children and/or siblings, natural or adopted, under the age 18 living at home.

Family Member	Age	Relationship to Patient	Source of Income or Employer Name	Monthly Gross Income
1.				
2.				
3.				
4.				

In addition to the Financial Assistance Application we also need the following documentation attached to this application:

- Current state or federal income tax returns
- Current W2
- Four most recent payroll stubs
- Four most recent checking and/or savings account statements

If these are not available, please call the Financial Counseling Unit to discuss other documentation they may provide.

By my signature below, I certify that I have carefully read the Financial Assistance Policy and Application and that everything I have stated or any documentation I have attached is true and correct to the best of my knowledge. I understand that it is unlawful to knowingly submit false information to obtain financial assistance.

Applicant's Signature: _____

Relationship to Patient: _____

Date Completed: _____

If your income is supplemented in any way or you reported \$0.00 income on this application, have the Support Statement below completed by the person(s) providing help to you and your family.

Support Statement

I have been identified by the patient/responsible party as providing financial support. Below is a list of services and support that I provide.

I hereby certify and verify that all of the information given is true and correct to the best of my knowledge. I understand that my signature will not make me financially responsible for the patient's medical expenses.

Signature: _____

Date Completed: _____

Please allow 30 days from the date the completed application is received for eligibility determination.

If eligible, financial assistance is granted for six months from the date of approval and is valid for all Beth Israel Deaconess affiliates:

- Beth Israel Deaconess Medical Center-Boston
- Beth Israel Deaconess Milton
- Beth Israel Deaconess Needham
- Beth Israel Deaconess Plymouth

Staff Only.	
Application Received by:	
BIDMC	<input type="checkbox"/>
BID Milton	<input type="checkbox"/>
BID Needham	<input type="checkbox"/>
BID Plymouth	<input type="checkbox"/>

Appendix 2

Medical Hardship Application

Medical Hardship Application

Please Print

Today's Date: _____

Social Security# _____

Medical Record Number: _____

Patient Name: _____

Patient Date of Birth _____

Address: _____

Street	Apt. Number	
City	State	Zip Code

Did the patient have health insurance or Medicaid at the time of hospital service(s)?

Yes No

If "Yes", attach a copy of the insurance card (front and back) and complete the following:

Name of Insurance Company: _____

Policy Number: _____

Effective Date: _____

Insurance Phone Number: _____

Note: Financial assistance may not apply if a Health Savings Account (HSA), Health Reimbursement Account (HRA), Flexible Spending Account (FSA) or similar fund designated for family medical expenses has been established. Payment from any established fund is due before assistance can be provided.

To apply for medical hardship assistance, complete the following:

List all family members including the patient, parents, children and/or siblings, natural or adopted, under the age 18 living at home.

Family Member	Age	Relationship to Patient	Source of Income or Employer Name	Monthly Gross Income
1.				
2.				
3.				
4.				

In addition to the Medical Hardship Application we also need the following documentation

attached to this application:

- Current state or federal income tax returns
- Current W2
- Four most recent payroll stubs
- Four most recent checking and/or savings account statements
- Copies of all medical bills

If these are not available, please call the Financial Counseling Unit to discuss other documentation they may provide.

List all medical debt and provide copies of bills incurred in the previous twelve months:

Date of service	Place of Service	Amount owed
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please provide a brief explanation of why paying these medical bills will be a hardship:

By my signature below, I certify all of the information submitted in the application is true to the best of my knowledge, information and belief.

Applicant's Signature:

Relationship to Patient: _____

Date Completed: _____

Please allow 30 days from the date the completed application is received for eligibility determination.

If eligible, assistance is granted for six months from the date of approval and is valid for all Beth Israel Deaconess affiliates:

- Beth Israel Deaconess Medical Center-Boston
- Beth Israel Deaconess Milton
- Beth Israel Deaconess Needham
- Beth Israel Deaconess Plymouth

Staff Only.	
Application Received by:	
BIDMC	<input type="checkbox"/>
BID Milton	<input type="checkbox"/>
BID Needham	<input type="checkbox"/>
BID Plymouth	<input type="checkbox"/>

Appendix 3

Discount Chart Based on Income

Prompt Pay Discount: Patients with no third party coverage that do not qualify for Public Assistance or Financial Assistance will be provided a discount of 30%. Payment must be made prior to services being rendered. This discount would also apply to patients paying for non-medically necessary services.

2016 Federal Poverty Level (FPL)

Household Size	100%	133%	150%	200%	250%	300%	400%
1	\$11,880	\$15,800	\$17,820	\$23,760	\$29,700	\$35,640	\$47,520
2	16,020	21,307	24,030	32,040	40,050	48,060	64,080
3	20,160	26,813	30,240	40,320	50,400	60,480	80,640
4	24,300	32,319	36,450	48,600	60,750	72,900	97,200
5	28,440	37,825	42,660	56,880	71,100	85,320	113,760
6	32,580	43,331	48,870	65,160	81,450	97,740	130,320
7	36,730	48,851	55,095	73,460	91,825	110,190	146,920
8	40,890	54,384	61,335	81,780	102,225	122,670	163,560

For each additional family member add \$4,164.00 per year.

Financial Assistance Discounts for eligible patients:

Income Level	Discount
Less than or equal to 200% FPL	100% - Full Assistance
201%-400% FPL	50% - Partial Assistance

Medical Hardship Discount for eligible patients

Patients will be determined as eligible for Medical Hardship if the medical bills are greater than or equal to 25% of the gross income and will receive a 65% discount.

Appendix 4

Covered Providers and Clinics

This policy covers all Hospital (Facility) charges as well as the following:

Nurse Practitioners in the following clinics:

- Urology
- Breast Surgery
- Health Care Associates (HCA)
- Prostate Cancer Care
- OB/GYN
- Cardiology Device Clinic

Hospital Billed Clinics:

- Multidisciplinary Breast Clinic
- Hematology/Oncology-SC and 7F
- Cognitive Neurology
- Multi-Specialty Thoracic Unit
- Optometry
- Cutaneous Oncology
- Voice and Speech Clinic
- Musculoskeletal Medicine
- Bowdoin Community Health Center
- Lexington Optometry
- Rectal Clinic –Multidisciplinary
- Chelsea Podiatry
- BID Cancer Center Global Services
- Brain Tumor Nursing

The following Physician groups are *not* covered under this policy:

- Harvard Medical Faculty Physicians (HMFP)
- Health Care Associates (HCA)
- Beth Israel Deaconess Health Care (APG)
- Atrius Health Medical Group
- BIDMC Emergency Department Physicians
- Chestnut Hill Urgent Care Physicians
- Any other physician or medical group not specified under “Covered Providers and Clinics” above

Patients should inquire with their physicians directly for financial assistance information.

Appendix 5

**Amount
Generally
Billed (AGB)**

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 Insurance carriers and Medicare when using the Look Back Method. BIDMC determines the AGB by dividing the total payments received by total charges for all Commercial and Medicare plans in aggregate for the previous fiscal year. The calculation includes patient copays, coinsurance and deductibles.

For example:

<u>Total Payments</u>	<u>\$510,000,000</u>	
		= 51%
Total Charges	\$1,000,000,000	

Total payments from Commercial and Medicare plans equal	\$510,000,000
Total charges sent to Commercial and Medicare plans equal	\$1,000,000,000
AGB	51%

The AGB is subject to change at any time due to the following reasons:

- Commercial and Medicare contract changes
- Settlements received by Commercial plans and Medicare

BIDMC will publish any change to the AGB prior to its implementation.

Appendix 6

Public Access to Documents

Information on the BIDMC Financial Assistance Policy, Plain Language Summary, Financial Assistance Application, Medical Hardship Application and the BIDMC Credit and Collection Policy will be made available to patients and the community served by BIDMC through a variety of sources, free of charge.

1. Patients and guarantors may request copies of all documents pertaining to Financial Assistance and Credit and Collections via mail or in person at:

BIDMC
Financial Counseling Unit
East Campus/Rabb
Room 111
Boston, MA 02215

The Financial Counseling Unit is also available to assist patients and guarantors in completing both the Financial Application and Medical Hardship Application.

2. Patients and guarantors may request copies of all documents pertaining to Financial Assistance and Credit and Collections Policy via phone at (617) 667-5661

3. Patients and guarantors may download copies of all documents pertaining to Financial Assistance and Credit and Collection Policy via the BIDMC public website:

<http://www.bidmc.org/patient-and-visitor-information.aspx>

The Financial Assistance Policy, Plain Language Summary, Financial Assistance Application, Medical Hardship Application and Credit and Collection Policy are available to the public in the following languages:

- English
- Simplified Chinese
- Traditional Chinese
- Spanish
- Russian
- Portuguese

BIDMC has posted notices (signs) of availability of financial assistance as outlined in this credit and collection policy in the following locations:

1. Inpatient, clinics, and the emergency department's admission and/or waiting/registration areas;
2. Patient financial counselor areas; and
3. Business office areas open to patients

Posted signs are clearly visible (8.5" x 11") and legible to patients visiting these areas and are translated into Spanish. The signs read:

FINANCIAL ASSISTANCE NOTICE

The Medical Center offers a variety of financial assistance programs to patients who qualify.

To find out if you're eligible for assistance with your hospital bills, please visit our Financial Counseling office in the 1st floor of the Rabb building or call 617-667-5661 for information about the various programs and their availability.

Policy History

Date	Action
	Policy approved by the Board of Directors
