Policy and Procedure Manual

Policy # 13.5 Approved: October 2016 Reviewed: Revised: Section: 13.0 – Billing and Collections

South Boston Community Health Center
Financial Assistance Policy

Introduction

The mission of South Boston Community Health Center ("The Center"), in partnership with Boston Medical Center and its licensed community health centers, is to provide consistently excellent and accessible services to all in need of care, regardless of status or ability to pay. Its vision is to meet the health needs of the people of South Boston and its surrounding communities by providing high quality, comprehensive care to all, particularly mindful of the needs of vulnerable populations, through its integrated delivery system, in an ethically and financially responsible manner.

This policy applies to The Center and its providers, as identified in this policy.

The Center is the frontline caregiver in providing medically necessary care for ***all*** people who present to its facility, regardless of ability to pay. The Center offers this care for all patients that come to our facility during our business hours. As a result, the Center is committed to provide all of our patients with high-quality care and services. As part of this commitment, the Center works with individuals with limited incomes and resources to find available options to cover the cost of their care.

The Center will help uninsured and underinsured individuals apply for and enroll in health coverage through a public assistance program (including but not limited to MassHealth, the premium assistance payment program operated by the Health Connector, the Children's Medical Security Program, the Health Safety Net, and Medical Hardship), and/or the Center's Financial Assistance Program, the "Sliding Fee Discount Program" as appropriate. Assistance for these programs is determined by reviewing, among other items, an individual's household income, assets, family size, expenses, and medical needs. All patients who are un- or under-insured are eligible to apply for the Center's Sliding Fee Discount Program which is based on HRSA regulation.

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

In working with patients to find available public assistance or coverage through the Center's financial assistance, the Center does not discriminate on the basis of race, color, national origin, citizenship, alienage, religion, creed, sex, sexual orientation, gender identity, age, or disability in its policies or in its

application of policies, concerning the acquisition and verification of financial information, preadmission or pretreatment deposits, payment plans, deferred or rejected admissions, determination that an individual qualifies for Low Income Patient status as determined by the Massachusetts Mass Health/Connector eligibility system, or attestation of information to determine Low Income patient status. As such, this policy was reviewed and approved by the Finance Committee of the Board of Directors of the Center.

While we understand that each individual has a unique financial situation, information and assistance regarding eligibility for public assistance programs and/or coverage through the Center's Sliding Fee Discount Program may be obtained by contacting: Financial Counseling, South Boston Community Health Center, 409 West Broadway, South Boston, MA 02127; Monday through Friday, 9AM to 5PM; to speak with one of the South Boston Community Health Center's Financial Counselors.

More information about this policy and the Center's Sliding Fee Discount Program, including the application form and a plain language summary of the financial assistance policy, is available on the Center's website: www. sbchc.org.

A copy of the financial assistance policy is also available:

(1) In the Financial Counseling Department on the first floor of our 409 West Broadway site.
(2) By requesting that a copy be mailed to the individual. This request may be made by calling the Financial Counseling Department at 617-464-6124 or by making a written request to the Financial Counseling Department at the address noted above.

The actions that the Center may take in the event of nonpayment are described in the Center's separate "Patient Payment and Collections" policy. Members of the public may obtain a free copy of the billings and collections policy:

(1) In the Billing Department located at 386 West Broadway
(2) By downloading the policy from the Center website, www.sbchc.org
(3) By requesting that a copy be mailed to the individual. This request may be made by calling the Billing Department at 617-464-5891 or by making a written request to the address below:
South Boston Community Health Center
Attention: Billing Department
386 West Broadway
South Boston, MA 02127

I. Coverage for Medically Necessary Health Care Services

The Center provides medically necessary medical, dental, eyecare and behavioral health care services for all patients who present at the Center regardless of their ability to pay. Medically necessary services includes those 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 aggravate a disability, or result in illness or infirmity. Medically necessary services at The Center include outpatient services as authorized under Title XIX of the Social Security Act.

The treating medical professional will determine the type and level of care and treatment that is necessary for each patient based on the patient's presenting clinical symptoms and the applicable standards of practice.

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 urgent care services provided below are further used by the Center for the purposes of determining allowable urgent bad debt coverage under the Center's financial assistance program, including the Health Safety Net.

A. Emergency and Urgent Care Services

Any patient who presents at the Center requesting emergency level or urgent care services will be evaluated based on the presenting clinical symptoms without regard to the patient's identification, insurance coverage, or ability to pay. The Center will not engage in actions that discourage individuals from seeking emergency or urgent medical care, such as demanding that patients pay before receiving treatment for emergency medical conditions, or interfering with the screening for and providing of emergency medical care by first discussing the Center financial assistance program or eligibility for public assistance programs.

a. Emergency Level Services include treatment for:
    i. A medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, such *that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in placing the health of the person or another person in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part,* or, with respect to a pregnant woman, as further defined in 42 U.S.C. § 1395dd(e)(1)(B).

b. Urgent Care Services include treatment for:
    i. Medically Necessary Services provided in the Center 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.

B. Non-Emergent, Non-Urgent Services:

For patients who (1) the treating clinician determines require non-emergent or non-urgent level care or (2) seek care and treatment following stabilization of an emergency medical condition, the Center may deem that such care constitutes primary or elective services.

a. Primary or Elective Services include medical care that is not an Urgent or Emergency level of care and is required by individuals or families for the maintenance of health and the prevention of illness. Typically, these services are medical or behavioral health procedures and visits scheduled in advance or on the same day by the patient or by the health care provider at the Center. Primary Care consists of health care services customarily provided by general practitioners, family practitioners, general internists, general pediatricians, and primary care nurse practitioners or physician assistants in a primary care service. .Primary Care does not require the specialized resources of an Acute Hospital emergency department and excludes Ancillary Services and maternity care services.
b. Non-emergent or non-urgent health care services (i.e., primary or elective care) may be delayed or deferred based on the consultation with the Center's clinical staff, as well as the patient's primary care or treating provider, if available and as appropriate. Coverage for healthcare services, including medical and behavioral health, is determined and outlined in a public and private health insurer's medical necessity and coverage manuals. While the Center will attempt to determine

coverage based on the patient's known and available insurance coverage, it may bill the patient if the services are not a reimbursable service and the patient has agreed to be billed.

c. Coverage from a public, private, or Center based financial assistance program may not apply to certain primary or elective procedures that are not reimbursable by such coverage options. If the patient is unsure whether a service is covered, the patient should contact the Center's staff in the Financial Counseling Department, located at 409 West Broadway, South Boston, MA 02127, to determine what coverage options are available.

Public Assistance Programs and Center Financial Assistance

A. General Overview of Health Coverage and Financial Assistance Programs

The Center's patients may be eligible for free or reduced cost of health care services through various state public 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 Medical Hardship) as well as the Center's Sliding Fee Discount Program. Such programs are intended to assist low-income patients by taking into account each patient's ability to contribute to the cost of the patient's care. For those individuals that are uninsured or underinsured, the Center will, when requested, help them with applying for either coverage through public assistance programs or Center financial assistance programs that may cover all or some of their unpaid Center bills.

B. State Public Assistance Programs

The Center is available to assist patients in enrolling in 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 online application (located on the state's Health Connector Website), a paper application, or over the phone with a customer service representative from either MassHealth or the Connector. Individuals may also ask for assistance from the Center's financial counselors (also called certified application counselors) with submitting online and paper applications.

C. Center Financial Assistance

The Center also provides financial assistance to patients whose income demonstrates an inability to pay for all or a portion of services provided. Qualifying patients are eligible for the Center's Financial Assistance Policy based on the below criteria:

C.1 Center Financial Assistance through the Health Safety Net

Through its participation in the Massachusetts Health Safety Net, the Center 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 hospital and community health centers in Massachusetts. The Health Safety Net pooling of uncompensated care is accomplished through an assessment of each hospital to cover the cost of care for uninsured and underinsured patients with incomes under 300% the federal poverty level. The Center'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 Center 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* are 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 (PBFG) 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 PBFG has an FPL below 150.1%, there is no deductible for any member of the PBFG. 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 PBFG 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 (PBFG) 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.

C2. Charitable Care provided for HSN Eligible Individuals

Individuals that meet the eligibility requirements to qualify for financial assistance under an HSN program outlined in I.C1 of the policy may have existing billing for services rendered prior to the 10 days that precede the application for HSN coverage. Under HSN regulations, certain primary and elective services will not be eligible for coverage under HSN prior to the 10 day period, and the individual remains liable for such invoice amounts. At the time HSN eligibility is determined, the Center will provide for 100% charitable care coverage of these invoices for services rendered prior to the 10 day period and will not engage in further collection on these invoices.

C3. Center Financial Assistance Sliding Fee Discount Program:

Individuals that met the eligibility requirements to qualify for the Center's Sliding Fee Discount Program may be eligible for additional discounts, based upon income and family size. Individuals with income levels at or below 200% FPL may qualify.

D. Limitations on Charges

The Center will not charge any individual who is eligible for assistance under its financial assistance policy for emergency, urgent, and medically necessary care more than the "amount generally billed" to individuals who have insurance for such care. For this purpose, the "amount generally billed" is determined using the Medicare reimbursement rate.

Center

The Center will charge any individual who is eligible for assistance under its financial assistance policy for all other care an amount that is less than gross charges for such care.

E. Notices & Application for Center Financial Assistance and Public Assistance Programs

E.1 Notices of Available Center Financial Assistance & Public Assistance Options

For those individuals who are uninsured or underinsured, the Center will work with patients to assist them in applying for public assistance and/or Center financial assistance programs that may cover some or all of their unpaid Center bills. In order to help uninsured and underinsured individuals find available and appropriate options, the Center 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 Center 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.

In addition, the Center also posts general notices at service delivery areas where there is a registration or check-in area, in Financial Counselor's offices, and in general business office areas that are customarily used by Patients (e.g., registration areas, or patient financial services offices that are actively open to the public). The general notice will inform the patient about the availability of public assistance and the Center's financial assistance (including MassHealth, the premium assistance payment program operated by the Health Connector, the Children's Medical Security Program, the Health Safety Net, Medical Hardship and Sliding Fee Discount program) as well as the location(s) within the Center and/or

the phone numbers to schedule an appointment with a Financial Counselor. The goal of these notices is to assist individuals in applying for coverage within one or more of these programs.

E.2. Application for Center Financial Assistance and Public Assistance Programs

The Center is able to assist patients in enrolling in a state public assistance program. These include MassHealth, the premium assistance payment program operated by the state's Health Connector, and the Children's Medical Security Plan. Based on information provided by the patient, the Center will also identify available coverage options though it's financial assistance program, including the Health Safety Net, Medical Hardship programs and the Center's own Sliding Fee Discount Program.

For programs other than Medical Hardship, applicants can submit an online application (located on the state's Health Connector Website), a paper application, or over the phone with a customer service representative from either MassHealth or the Connector. Individuals may also ask for assistance from the Center's Financial Counselors with submitting online or paper applications.

For Medical Hardship, Center will work with the patient to determine if a program such as Medical Hardship would be appropriate and submit a Medical Hardship application to the Health Safety Net. It is the patient's obligation to timely provide all necessary information as requested by the Center to ensure that the Center can submit a completed application. If the patient is able to provide all information in a timely manner, the Center 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.

The Center may also assist patients with enrolling in the Health Safety Net using a presumptive determination process, which provides a limited period of eligibility. This process is conducted by Center staff, who, on the basis of self-attestation of financial information from the patient, will deem a patient as meeting the low income patient definition and will be covered for Health Safety Net services only. Coverage will begin on the date that the provider makes the determination through the end of the following month in which the presumptive determination is made. However, coverage may be terminated sooner if the patient submits a full application as described above.

E.3 Role of the Center Financial Counselor

The Center 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 Center will also help patients that wish to apply for financial assistance from the Center, which includes coverage through the Health Safety Net and Medical Hardship.

The Center 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, Medical Hardship and our Sliding Fee Discount Program;
b) Help individuals complete a new application for coverage or submit a renewal for existing coverage;
c) Work with individuals 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 facilitate enrollment of applicants or beneficiaries in Insurance Programs; and
g) Offer and provide voter registration assistance.

The Center will advise patients of their obligation to timely provide the Center and the applicable state agency with accurate 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 Center may (at the individual's request) make reasonable efforts to obtain any additional information from other sources. Such efforts 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 schedules services, during pre-registration, upon discharge checkout, or for a reasonable time following check out from the Center. Information that patient services obtains will be maintained in accordance with applicable federal and state privacy and security laws.

The Center will also notify the patient during the application process of the patient's responsibility to report to both the Center 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 patient accounting department 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 the patient must repay the appropriate state agency for the amount of the healthcare covered by the state program if there is a recovery on the claim, or the patient must assign rights to the state to allow the state to recover its applicable amount.

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