

## Financial Assistance Policy

### Purpose

This Financial Assistance Policy describes the financial assistance and financial counseling services that may be available to eligible patients of The Children's Hospital Corporation d/b/a Boston Children's Hospital (the "Hospital") and its related Physician Foundations (the "Foundations") who receive services at Hospital sites or Foundation sites where administrative support systems and personnel are provided through the Hospital, as well as the process for seeking financial assistance and financial counseling services. A list of the Hospital and Foundation practices, locations and other sites that provide Emergency Services and Medically Necessary Services for which financial assistance is available under this Financial Assistance Policy is available as described in this Financial Assistance Policy. This Policy does not apply to Boston Children's Health Solutions, Rx, LLC d/b/a Boston Children's Pharmacy or any items provided by Boston Children's Health Solutions, Rx, LLC d/b/a Boston Children's Pharmacy.

### Policy Statements

1. The Hospital and the Foundations are committed to being resources for children in need of care, regardless of ability to pay.
2. This policy applies to all Emergency Services and other Medically Necessary Services (as defined below) provided by the Hospital and the Foundations. Emergency Services and other Medically Necessary Services do not include elective cosmetic procedures.
3. The Hospital will provide Emergency Services to all patients, without discrimination and without regard to whether a patient may be eligible for assistance under this Financial Assistance Policy. The Hospital prohibits any actions that would discourage individuals from seeking emergency medical care, such as by demanding that Emergency Department patients pay before receiving treatment for Emergency Medical Conditions or permitting debt collection activities that interfere with the provision, without discrimination, of Emergency Services.
4. The Hospital and the Foundations, through the Hospital's Financial Counseling unit, will assist patients/Guarantors (defined below) with the process for completing applications for available public or Hospital programs, including MassHealth and other Medicaid programs, ConnectorCare and Health Safety Net, whenever possible.
5. The Hospital and the Foundations may provide financial assistance to patients who meet the eligibility criteria, as defined in this Financial Assistance Policy below.
6. The Hospital and the Foundations will (a) refrain from efforts to collect payment for Emergency Services and Medically Necessary Services (defined below) from

patients who are exempt from collection action under the Hospital's Credit and Collection Policy (b) refund any collections received from such patients for Emergency Services and Medically Necessary Services; and (c) share information with one another about patients' insurance and eligibility for public or Hospital programs.

7. The Hospital may, in accordance with the Credit and Collection Policy, extend discounts beyond those in this Financial Assistance Policy, on a case-by-case basis, in order to recognize unique cases of financial hardship.
8. The Foundations may maintain additional financial assistance policies that pertain to patients who receive services from a Foundation at a site unaffiliated with the Hospital (e.g., patients whose services are not scheduled in Hospital information systems).
9. Failure to follow the procedures outlined in this document may result in a delay or denial by the Hospital or Foundations for Financial Assistance.

## Definitions

**Amounts Generally Billed (AGB):** The amounts generally billed for Emergency Services or Medically Necessary Services provided to individuals who have Private Health Plan (as defined below) coverage or are covered under the Medicaid or Medicare programs. AGB will be calculated using the "Look-Back Method", in accordance with the provisions of 26 CFR Section 1.50(r)-5(b)(3)(ii)(C), and as more fully described in this Financial Assistance Policy, in the Section entitled "Limitation on Charges".

**Emergency Services:** Medically Necessary Services provided after the onset of a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses 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 function or serious dysfunction of any body organ or part or, with respect to a pregnant woman, as further defined in 42 USC Section 1395dd(e)(1)(B).

**Federal Poverty Guidelines (FPG):** Income thresholds issued annually by the United States Department of Health and Human Services.

**Guarantor:** A person or group of person, including, without limitation, a patient's parents, legal guardians and other family members, who/that assume(s) the responsibility of payment for all or part of the Hospital's or Foundations' charges for services.

**Insured Patient Financial Responsibility:** All copayments, coinsurance and deductibles required to be paid by the patient/Guarantor under the terms of the Private Health Plan or Public Health Care Assistance Program (defined below) in which the patient is enrolled or qualified.

**MassHealth MAGI:** Modified Adjusted Gross Income used for determining eligibility for MassHealth, including, without limitation, the time periods applicable for measuring MAGI Income to determine MassHealth eligibility.

**Medically Necessary Services:** Services that are reasonably expected to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a disability, or result in illness or infirmity.

**Non-Covered Services:** Non-Covered Services includes services (a) not included as covered benefits/eligible services under the patient's Private Health Plan coverage or Public Health Care Assistance Program, and for which the patient is financially responsible for payment to the provider(s) of such services; (b) included as covered benefits/eligible services, but are provided after the patient has exhausted all benefits under his/her Private Health Plan coverage or Public Health Care Assistance Program; and (c) that are rendered by a provider that is not included in the health plan's/program's network. Non-Covered Services does not include Emergency Services.

**Other Funding:** Includes other resources and sources of funding held by, available to, or for the benefit of, the patient/Guarantor, which can be used to pay for the patient's care, including, without limitation, through charitable organizations, from relatives, friends and other third parties, and trust funds (including funds available under crowd funding and other similar methods for fundraising).

**Primary Service Area:** Massachusetts, Connecticut, Maine, New Hampshire, Rhode Island, Vermont and New York, excluding the New York metropolitan area.

**Private Health Plan:** Coverage for health care services provided under health insurance, health plan or other coverage or under any other health, welfare or other plan, fund or trust established for the purpose of paying for, or otherwise addressing payment for, health care services provided to those enrolled in or under or qualified for such insurance, plan or program.

**Public Health Care Assistance Programs:** Programs established by a state or federal government to pay or otherwise address the cost of covered/eligible health care services provided to individuals who meet the program's eligibility criteria. Public Health Care Assistance Programs include, but are not limited to, MassHealth, Health Safety Net, subsidized plans offered under the Affordable Care Act, such as ConnectorCare plans, the Children's Health Insurance Program (CHIP), other Medicaid programs and Medicare.

## Eligibility Criteria for Financial Assistance

To be eligible for financial assistance under this Financial Assistance Policy, generally, patients must meet the following eligibility criteria:

1. The services to be rendered to the patient must be Medically Necessary;
2. The patient must reside in the Hospital's Primary Service Area;
3. The patient's MassHealth MAGI Income may not exceed 400% of FPG for the size of the patient's household;
4. The patient/Guarantor does not have Other Funding available to pay for Medically Necessary Services;

5. The patient/Guarantor must meet with the Hospital's Financial Counselors to determine whether the patient is eligible to enroll in or qualifies for any Private Health Plan coverage or for any Public Health Care Assistance Programs;
6. If determined by the Hospital's Financial Counselors to be eligible for financial assistance, the patient/Guarantor must apply for such coverage or program and provide the documentation required to qualify for such coverage or program, or submit documentation to Hospital Financial Counselors that verifies that enrollment applications and qualifying documents have been submitted to the appropriate Private Health Plans, government agencies, and other applicable entities;
7. The patient is not enrolled in/qualified for, has been determined not to be eligible or for any such coverage, and/or has not terminated such coverage/enrollment/qualification during the previous sixty (60) day period; and
8. The patient/Guarantor must complete and submit the Hospital's Financial Assistance Application and provide to Hospital Financial Counselors all documentation required under such application.

If the patient is enrolled in or qualifies for Private Health Plan coverage or any Public Health Care Assistance Program, financial assistance is not available to reduce amounts owing with respect to any Non-Covered Services provided to a patient; provided that, financial assistance may be available for services for which the Hospital or the Foundations are deemed to be out-of-network under the patient's Private Health Plan coverage or under any Public Health Care Assistance Program, but only if the Hospital and/or Foundation, as applicable, determine(s) that there are no providers in-network for the patient's health plan/program capable of providing the specialized care needed to treat the patient's medical condition.

Financial assistance is also not available to reduce the amount of a patient's Insured Patient Financial Responsibility. However, if the patient would otherwise qualify for financial assistance under the terms of this Financial Assistance Policy, the provisions below related to Amounts Generally Billed (AGB) will be applied to the patient's Insured Patient Financial Responsibility.

## Financial Assistance Available

If a patient is determined to have met the eligibility criteria for financial assistance under the terms of this Financial Assistance Policy, financial assistance may be available to reduce the cost of Emergency Services and other Medically Necessary Services, based on the patient's MassHealth MAGI Income. The following discount will be applied to the cost of Emergency Services and other Medically Necessary Services, based on the patient's MassHealth MAGI Income; provided that financial assistance and this discount does not apply to: (a) any Private Health Plan or other payments from third party payers, including, without limitation, under Public Health Care Assistance Programs; (b) the total amount of any and all Insured Patient Financial Responsibility; (c) government assistance; (d) liability claims payments; and (e) any and all Other Funding available to patient/Guarantor, such as payments by charitable organizations, crowd funding sources, contributions by family, friends or other third parties, etc.:

**MassHealth MAGI  
Income**

**Discount on  
Gross Charges**

|                    |      |
|--------------------|------|
| 0%-400% of the FPG | 100% |
| >400% of the FPG   | 0%*  |

\*An Uninsured Patient Discount may be available, under the Hospitals' and Foundations' Uninsured Patient Discount Policy, if the patient is uninsured.

## Financial Counseling

1. The Hospital, through its Financial Counselors, will assist patients of the Hospital and Foundations, and their Guarantors, with the process for completing applications for Hospital financial assistance programs; for Private Health Plan coverage; and/or for Public Health Care Assistance Programs.
2. The following patients will be offered Financial Counseling services: any patient who is (a) recorded in the Hospital's scheduling and registration system as uninsured; and (b) any patient who seeks financial assistance.
  - Hospital and Foundation personnel responsible for scheduling, registration, and billing will inform such patients and/or their Guarantors of how they may obtain Financial Counseling Services.
  - Signs announcing the availability of Financial Counseling services and how to obtain those services will be posted in patient care registration settings and other locations, including, without limitation, at inpatient, outpatient and emergency department admission/registration locations.
  - Patient bills for the Hospital and Foundations will include notice about the availability of Financial Counseling services and how to access those services.
3. Financial Counseling staff will assist patients and/or Guarantors with:
  - Applying or reapplying for Private Health Plan coverage, Public Health Care Assistance Programs, and/ or other available financial assistance programs.
  - Identify and refer patients to other sources and resources for coverage/ financial assistance.
  - Understanding the Hospital's and Foundations' Uninsured Patient Discount Policy and how to request those discounts.
  - Contact information for Hospital and Foundation Billing Departments.

The Hospital's Financial Counselors are also available to assist individuals who are not patients of the Hospital or the Foundations with applications for public assistance.

## Financial Assistance Procedures

1. A Patient/Guarantor who is uninsured or who seeks financial assistance will be referred to a Hospital Financial Counselor for determination of availability of/eligibility for Private Health Plan coverage; for Public Health Care Assistance Programs; or for Hospital financial assistance programs.

2. Patients who do not qualify for Public Health Care Assistance Programs or Private Health Plan coverage, may apply for financial assistance by completing the Hospital's Financial Assistance Application and providing all information, documentation, and verification described in the Financial Assistance Application. The Financial Assistance Application is available for download on the Hospital's website and is also available by mail or in person. Details on how to access a copy of the Financial Assistance Application are found in the section of this Financial Assistance Policy entitled "Publication/Availability of the Financial Assistance Policy, the Uninsured Patient Discount Policy, the Credit and Collection Policy, and Amounts Generally Billed Calculation." The Financial Assistance Application includes accompanying instructions for completion.
3. Under certain circumstances, the Hospital may deem a patient's enrollment in a means tested Public Health Care Assistance Program to presumptively confirm the patient's eligibility for financial assistance for any services for which financial assistance may be available under this Financial Assistance Policy.
4. Information collected will be provided to a designated Director in Patient Financial Services for determination of availability of/eligibility for financial assistance under the terms of this Financial Assistance Policy.
5. Patients/Guarantors who are approved to receive financial assistance will be notified in writing by Patient Financial Services staff.
6. Eligibility determinations will remain in effect for a period of 12 months following the date of the determination, and will apply to all additional services for which financial assistance may be available under this Financial Assistance Policy, unless the Hospital determines that the patient has become enrolled in/qualified for Private Health Plan or coverage, or for a Public Health Care Assistance Program.
7. Accounts will be adjusted with the financial assistance discount for both the applicable Foundation and Hospital. The discount will be applied against gross charges.
8. Patients/Guarantors can receive help with understanding the Financial Assistance Policy and completing the Financial Assistance Application by calling the Financial Counselors at (617) 355-7201 and/or by asking for help in person or by mail through the Financial Counseling Division of the Patient Financial Services Department at Boston Children's Hospital, 300 Longwood Avenue, Boston, MA, 02115, Farley Building rooms 160.

## **Limitation on Charges**

1. Any patient who is eligible for financial assistance under this Financial Assistance Policy will not be billed greater than the AGB to insured patients for Emergency Services and other Medically Necessary Services provided by the Hospital. For all other services, the Hospital's Uninsured Patient Discount Policy may apply.
2. The Hospital will calculate AGB using the "Look-Back" Method. Each fiscal year, the Hospital will determine a single AGB percentage, calculated as set forth in Amounts Generally Billed Calculation ("AGB Calculation"), in accordance with the provisions of 26 CFR Section 1.501(r)-5(b)(3)(ii)(C).

## **Patients Exempt from Collection Action**

In accordance with their Credit and Collection Policy, the Hospital and the Foundations exempt certain patients from collection actions. The patients exempt from collection actions, and the actions the Hospital may take in the event of nonpayment, are described in the Credit and Collections Policy.

## **Publication/Availability of the Financial Assistance Policy the Uninsured Patient Discount Policy, the Credit and Collection Policy, and Amounts Generally Billed Calculation**

1. Patients, Guarantors and other members of the public may obtain a copy of this Financial Assistance Policy, the Uninsured Patient Discount Policy, the Credit and Collection Policy, and the Amounts General Billed Calculation free of charge by any of the following methods:
  - a. Internet Posting: The Hospital's and Foundations' Financial Assistance Policy and a Plain Language Summary are available online at:  
[www.childrenshospital.org/financialassistance](http://www.childrenshospital.org/financialassistance).
  - b. In-Person: Paper copies of the Hospital's and Foundations' (i) Financial Assistance Policy and a Plain Language Summary, (ii) Amounts Generally Billed, (iii) Credit and Collection Policy, and (iv) Uninsured Patient Discount Policy, are available at the Hospital facility located at 300 Longwood Avenue, Boston, MA, Farley Building room 160.
  - c. By Mail: The public may request to receive a copy by mail by calling Patient Financial Services Customer Support at (617)-355-3397 and/or Patient Financial Counseling at 617-355-7201.
2. Foreign language translations of this Financial Assistance Policy, the Financial Assistance Plain Language Summary, the Financial Assistance Application, the Credit and Collection Policy, the Uninsured Patient Discount Policy and the Amounts Generally Billed Calculation are available in several languages to assist those with limited English proficiency.
3. On-site Communication: The Hospital will make efforts to communicate the availability of financial assistance through several methods.
  - a. Signage will be placed in admission areas regarding the availability of financial assistance.
  - b. Public displays or other measures reasonably calculated to attract visitors' attention will be conspicuously posted at various locations throughout the Hospital, including, without limitation, at inpatient, clinic and emergency admission/registration areas.
  - c. Copies of the Policy and/or the plain language summary will be offered to all patients either at time of admission or as part of the discharge process.

## Additional/Related Documents, Policies and Programs

1. Plain Language Summary for Financial Assistance Policy
2. Financial Assistance Application
3. List of Providers providing Emergency Services and Other Medically Necessary Services
4. Amounts Generally Billed Calculation
5. Credit and Collection Policy
6. Uninsured Patient Discount Policy
7. International Patient Financial Assistance Program

## Document Attributes

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|-----------------------------|---|---------------------------------|-----------------------------|
| <b>Title</b>                | Financial Assistance Policy   |                                 |                             |
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