



I. POLICY:

Franciscan Children's ("FC") and Franciscan Pediatrics, Inc. ("FP") are charitable, tax-exempt corporations whose underlying mission is to provide services to all pediatric patients in need of healthcare. FC and FP will work with patients and families who have a demonstrated financial need in order to provide financial assistance to those patients seeking care. In order for FC and FP to continue to provide high quality services and support community needs, however, it must seek prompt payment for services provided. FC and FP have a fiduciary responsibility to appropriately bill and collect for patient services provided. All patients will be treated consistently, respectfully and with dignity. All information is treated confidentially in accordance with federal and state privacy laws.

FC and FP do not discriminate on the basis of race, religion, color, ancestry, national origin, age, gender, disability, veteran status, marital or family status, sexual orientation, or gender identity and expression, in their policies or in the application of their policies, concerning the acquisition and verification of financial information, pre-admission or pretreatment deposits, payment plans, low income patient status determinations, or in their billing and collection practices.

II. APPLICATION:

This policy applies to all hospital inpatient units for behavioral health (Unit 1) and medical (Units 2 &3), Community Based Acute Treatment (CBAT), Partial Hospital Program (PHP), and outpatient medical, behavioral health, operating room, and dental clinic. Franciscan Children's Hospital is a post-acute pediatric facility which does not include an Emergency Department or Urgent Care Clinic.

III. PROCEDURE:

A. All Patients

1. Patient Insurance & Payment Information: It is the responsibility of the scheduler or intake specialist to complete the Financial Clearance Request Form ("FCRF") (Copy attached) or a similar form approved for intake of Unit 1, CBAT, or PHP patients ("FCRF/BH") to obtain from the patient information necessary to determine whether the

patient has insurance that can cover the planned service or admission, including, but not limited to, requesting that the patient, or his or her parent/guardian or other responsible party, provide identification and insurance coverage card for copying if possible. The patient has the responsibility to provide accurate information for determination of coverage. All scheduling and registration of patients to receive services in the dental clinic shall be performed by the dental clinic staff. For all other patients, immediately after scheduling or intake have determined that the patient is appropriate for inpatient admission or outpatient services, scheduling or intake shall forward the completed FCRF or FCRF/BH to the Franciscan Children's Registration Department for completion of the registration process prior to inpatient admission or provision of services. Except for patients committed to Unit 1 unaccompanied by a parent or guardian, no patient shall be admitted for inpatient or outpatient services unless: (1) the patient is an adult or emancipated minor, (2) the patient is accompanied by a parent or guardian with legal authority to consent to healthcare services, **or** (3) the Registration Department obtains verbal consent by phone from a parent or guardian prior to transfer of a medical patient from an acute hospital to Unit 2 or 3 along with confirmation that the parent or guardian will stop at the Registration Department to complete necessary forms when they next visit Franciscan Children's. The scheduling or intake personnel shall direct any emancipated/adult patient or minor patient's parent or legal guardian to complete registration in the Registration Department before the patient can be admitted for inpatient or outpatient services, or as soon as practicable after commitment for any minor admitted to Unit 1 unaccompanied by a parent or guardian or at a time when the Registration Department is closed. The Registration Department shall meet with the emancipated/adult patient or the patient's parent or legal guardian to complete insurance verification and any required authorization, to collect copayments and deductibles or other out of pocket payments, and to complete necessary registration forms including a General Agreement form and a Financial Responsibility form.

2. Collection on Patient Accounts: Any required or estimated patient payments, such as co-payment, or amounts for services not covered by insurance, should be collected at or before the time of service or admission at Registration or the Dental Clinic for dental patients. Any outstanding patient costs or charges that are not paid after a service is rendered or a patient is discharged shall be issued bills by FC, or FP or an external company hired to process bills. The statement/data mailers are sent one time a month, one business day after the month-end close. After four or five bills have been

sent, the account will be sent to collection. The patient/guarantor can contact the Patient Accounts Department to request financial counseling, information about this financial assistance plan or a payment plan.

3. **Bad Debt:** Franciscan Children's will make reasonable efforts to collect any required copayment, deductible or coinsurance amount as required by a patient's health plan, and any outstanding balance not covered by insurance. After reasonable attempts are made to collect payment, Franciscan Children's may determine that the patient's bill shall be treated as Bad Debt and halt further collection efforts. In determining whether to treat an outstanding balance as Bad Debt, among other factors, Franciscan Children's may consider the patient's family income, assets beyond primary residence and automobile, level of medical expenses, and other information as may be reported on a Financial Assistance application. FC, FP, and its agents will make reasonable efforts to determine whether a financial assistance application is allowable and provide the patient/guarantor with notice of financial assistance within 120 days from the date of initial bill. FC, FP, and its agents will not seek to execute a lien against the personal residence or motor vehicle of a patient or parent/guarantor without the approval of the Chief Financial Officer (CFO).

B. Insured Patients

Network agreements: FC and FP shall comply with all legal obligations as network providers under and public or private health insurance plan. If the patient is covered by a health insurance plan, FC and FP will bill the insurance company in accordance with any applicable agreements with the insurance company. It is the Patient's obligation to provide complete and accurate information about insurance coverage.

1. **Referrals and prior authorizations:** If the insurance plan requires a physician referral or prior authorization, it is the patient's responsibility to obtain the referral or prior authorization. The Registration Department will work with the patient and service department to obtain or confirm any necessary referral or prior authorization prior to admission or provision of outpatient services; provided, however, if urgent and uncontrollable circumstances prevent initial insurance preauthorization for a necessary admission to Unit 1 or the CBAT, and failure to admit pending insurance authorization would likely expose the child to harm, the program director or administrator on call may

authorize admission subject to completion of any necessary prior authorization and registration documentation as soon as practicable after admission. The service departments are required to complete of the FCRF or FCRF/BH forms and to provide appropriate clinical documentation needed to obtain authorization. If a patient requires services beyond the scope of the initial prior authorization, the service department or unit shall take primary responsibility to obtain any necessary additional or continued authorization. Changes in insurance eligibility, insurance provider, or identification of secondary insurance provider after admission that are identified by the service departments shall be immediately reported to the registration department. All authorizations for testing or therapy services are the responsibility of the service departments. All authorizations for dental services will be obtained by the dental clinic. Please refer to the Registration Procedures for Surgical Clearances for obtaining authorizations for operating room services.

2. Co-pays and Deductibles: Co-pays are due at time of visit. If a patient does not know his/her private insurance co-pay or does not have an insurance card to establish a private insurance co-pay amount, an amount of \$15.00 will be requested, and FC or FP will refund or bill any differences when the actual amount is determined. Pre-registration staff will determine through the eligibility process the amount of any deductibles. FC and FP attempt to collect any co-payment, deductible, or co-insurance not paid or deposited at the time of the service or admission. FC and FP shall never waive co-payment, deductible or co-insurance required by the patient's health insurance plan; provided however that it may agree to enter a payment plan or determine that an unpaid amount is bad debt in accordance with this policy. FC or FP shall use reasonable efforts to collect any unpaid co-payment or deductible directly or through a collection agency including by mail, telephone calls, e-mails, or text messages.

3. Insurance Billing: The insurance information is collected from departments and registration. The Billing department will send the claim to the insurance company for payment. Secondary insurance will be billed when primary explanation of benefits has been received and tertiary billed when secondary explanation of benefits has been received.

Billing will research any denied or unpaid claims:

1. Determine what corrections need to be made and resubmit claim.

2. Resubmit a claim that has not been acknowledged on a remittance advice or other correspondence within 30 days.
3. Appeal claims that have been denied incorrectly.
4. Provide any and all information requested by the Insurance Company, as it pertains to claim payment.
5. Determine if claim is the responsibility of the patient.

C. Uninsured “Self-Pay” Patients

1. A self-pay patient, or his or her parent/guardian or other responsible party, shall be asked to complete a Self-pay Agreement as part of the scheduling or registration process when the service/admission will not be covered by the patient’s public or private health plan because the patient or personal representative acknowledges that the service/admission: (1) is not covered by a public or private health plan, (2) is not authorized or was denied by the patient’s public or private health plan, or (3) the patient or personal representative voluntarily elected not to seek coverage from the patient’s *private* health plan. A patient’s co-payment, co-insurance or deductible under his or her health plan is not a form of self-pay.

2. FC or FP shall provide the self-pay patient a good faith estimate for the anticipated charges for the service or admission based on the information available to it. Payment of the full estimated amount is expected prior to Service/Admission. Patients admitted as inpatients shall pay the estimate cost of inpatient care in advance of admission. If an admitted patient stays longer than the originally estimated duration, or if an insured patient loses coverage for continued admission, such patient shall be charged on a week to week basis in advance until discharge. Within thirty (30) days after completion of the service or admission, FC or FP will refund any amount of the payment amount that exceeds the final cost for the service/admission, or it will issue a bill for any amount the final cost exceeds the payment made based on the estimated amount.

3. Self-pay Discount: All residents of the United States are eligible for a discount of up to 10% on FC and FP medical bills for self-pay service or admission if payment is received, or a payment plan agreed to, within 30 days of service or admission. Certain outpatient and inpatient services that are not covered by insurance may require payment,

or a payment plan agreement, prior to the provision of the service or treatment. In order to take advantage of this discount, a patient must be current on all outstanding balances. Patient co-payments, co-insurance and insurance deductibles are specifically excluded from this discount. Discounts under this policy do not apply to motor vehicle claims, third party liability claims, or services where other discounts have already been applied to the charge.

D. Financial Assistance Plan

1. Eligibility and Application: The Financial Assistance Plan is intended to assist residents of the United States who require medically necessary care, but who do not have public or private health insurance, “exhausted” benefits under their insurance plan, or for costs for service/admission not covered by public or private insurance, including coverage denials due to the insurer’s network limitations. To be eligible the patient has a number of responsibilities to meet in order to qualify for this discount program, including: (1) to obtain and maintain insurance coverage if affordable coverage is available to them; (2) to apply for any government sponsored insurance programs that they may qualify for; (3) to submit all requested documentation of income, assets and residency that is needed to enroll in state coverage or to verify their qualifications for any Franciscan Children’s financial assistance in a timely manner; and (4) an obligation to pay all balances in accordance with agreements.

Eligibility for the Financial Assistance Plan only applies to medically-necessary healthcare services delivered and billed by Franciscan Children’s (“FC”) or Franciscan Pediatrics, Inc. (“FP”) at the Franciscan Children’s, 30 Washington Street, Brighton, MA 02135. The Financial Assistance Plan does not apply to professional healthcare services performed at Franciscan Children’s that are not delivered and billed by FC or FP, including Children’s Hospital physicians who may provide specialty medical services to patients in the medical units (Units 2 & 3), and independent medical and dental providers who may arrange to provide services to their patients at Franciscan Children’s outpatient medical, behavioral, surgical operating or dental clinics.

In order to determined eligibility and to apply for Financial Assistance a patient must:

- Apply for government medical assistance program if eligible.

- Complete, sign and date the Financial Assistance Application
- Provide verification of all household income and documentation as required by the Application.
- Return your completed application to Franciscan Children's Patient Financial Counseling by email to: mspeller@FranciscanChildrens.org or regular mail to Franciscan Children's Patient Accounts, 30 Warren Street, Brighton, MA 02135.

A copy of the Financial Assistance Application can be obtained from the Franciscan Children's Patient Registration or Patient Account Departments free of charge in paper format, or at <http://franciscanchildrens.org/financial-assistance-application/>. You can call the Patient Accounts Department for more information and assistance at 617-254-3800, Extension 1202. A patient must submit a properly completed Application within 240 days of the first bill to be eligible for Financial Assistance. Franciscan Children's shall review and respond to a properly submitted Application within thirty (30) days of submission. An Application submitted without necessary supporting documentation shall be rejected no later than 30 days after submission if the supporting documentation is not submitted. After a properly submitted Application has been submitted, FC, FP, and its agents shall suspend billing and collection efforts until an eligibility determination has been made.

2. Financial Assistance Due to Limited Income. Financial assistance on Franciscan Children's medical bills for services not covered by insurance is limited to US residents with demonstrated financial need either due to limited income or if their medical bills are an excessive portion of their family income. The most recently published Federal Income Poverty Level (FPL) will be used as the primary determinant. In all cases, the total income of the family will be used in this determination. Discounts based solely on income are generally limited to patients with family incomes that do not exceed 400% of the FPL.

2016 Federal Income Poverty Level (FPL)

| Household/ Family Size | 100% | 200% | 300% | 400% |
|---------------------------|----------|----------|----------|----------|
| 1 | \$11,880 | \$23,760 | \$35,640 | \$47,520 |
| 2 | \$16,020 | \$32,040 | \$48,060 | \$64,080 |

| | | | | |
|----------|----------|----------|----------|-----------|
| 3 | \$20,160 | \$40,320 | \$60,480 | \$80,640 |
| 4 | \$24,300 | \$48,600 | \$72,900 | \$97,200 |
| 5 | \$28,440 | \$56,880 | \$85,320 | \$113,760 |
| 6 | \$32,580 | \$65,160 | \$97,740 | \$130,320 |

3. **Financial Assistance Due to Excessive Medical Bills.** Patients who do not qualify under Section A may still qualify for financial assistance to the extent that they can demonstrate that their medical expenses exceed their available assets and their family ability to pay. To qualify, the patient's medical expenses must be greater than 30% of the family annual income and exceed available family assets. Expenses must have occurred within the prior 12 months and are limited to those expenses that could potentially qualify as a medical expense in accordance with Internal Revenue Service rules. Available assets do not include the family primary residence, one family motor vehicle, and other assets limited to \$6,000 for a family of two, and \$1,500 for each additional family member. Patients wishing to be considered for discounts under this policy must provide requested documentation of income, residence and qualifying medical expenses in a timely manner.

4. **Amounts Generally Billed.** Franciscan Children's will limit charges to patients whose families qualify for Financial Assistance to the Amounts Generally Billed (AGB) under the "Look-Back Method" as defined by federal regulations. Franciscan Children's determines the AGB by dividing total payments for all claims allowed by Medicare and private plans by the charges submitted for these claims in aggregate for the prior fiscal year to determine the Payment on Account Factor (PAF) for the prior fiscal year. This will reduce the charges billed to patients qualifying for Financial Assistance to no more than the AGB for the prior year.

5. **Financial Assistance Discounts.** Patients who qualify for this discount will have their charges for applicable services discounted according to the following schedule. The discounts are based on the total charges and are not applied to balances that have already been discounted due to insurance coverage.

| Family Income at % of FPL | 0 to 100% | 101 to 200% | 201 to 300% | 301 to 400% |
|----------------------------------|------------------|--------------------|--------------------|--------------------|
| Financial Assistance Rate | Free | AGB less 25% | AGB Rate | AGB Rate |

6. Publication and Dissemination. The Franciscan Children's Financial Assistance policy, application forms, and a plain language summary are available: (i) on the Franciscan Children's website at <https://franciscanchildrens.org/resources/insurance-billing/> and under the drop-down menu under "Resources" and (ii) at the Patient Registration and Patient Accounts departments. Materials, including the policy, application form, and plain language summary, will be disseminated in English and other languages. Information describing the program will be available on the Franciscan Children's website and post near Patient Registration.