Lifespan Corporation and Affiliate Hospitals

Subject:
Financial Assistance Policy

File Under:

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Approved By:

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I. Purpose of the Financial Assistance Policy

1. To ensure, uninsured patients, who are residents in the state of Rhode Island, as defined in Section 1.30 of the *Rhode Island Rules and Regulations Pertaining to Hospital Conversions (R23-17.14 HCA)* receive the essential medical services needed at a reduced rate (partial or full financial assistance) referred to herein as Community Free Service ("CFS"). Non-Rhode Island residents and foreign nationals who are visiting the state or country are eligible for emergent and care (ED/Admission only) outpatient follow-up care excluded. They are not eligible for a discount for elective services.

2. The Lifespan Affiliate Hospitals, through this Lifespan Corporation ("Lifespan") Financial Assistance Policy ("FAP"), will provide any patient necessary medical care and treatment, regardless of the individual's citizenship or immigration status. If a patient is unable to pay for health care services, he/she may be eligible for free healthcare or healthcare at a reduced rate. This policy is subject to the rules and regulations promulgated, from time to time, by the Affiliate Hospital's Board of Trustees.

3. Patients are responsible for certain Physicians' fees, (Non-Lifespan Physicians), example: charges for the interpretation of certain tests/x-rays and all other services delivered by other providers. Patients are also responsible for non-covered services such as private room differentials that are not essential medical services. The designated Financial Medical Advisor at each affiliate site will provide guidance as needed to determine essential medical services of specific services or programs. Some services are not covered:

Rhode Island Hospital - Cosmetic Services, Contact Lenses, Sports Rehabilitation self referrals, Hearing Aids, Children's Rehabilitation Constraint Therapy Program and some Dental procedures - Occlusal Guards for bruxism, Laboratory fabricated veneers, Fixed bridgework of 4

or more units, Dental Implants, and Bleaching of teeth, Orthodontic Treatment, Posterior composite fillings. The following Dental procedures would qualify for a 50% CFS reduction only: Full mouth series of x-rays for comprehensive treatment planning, Full upper and lower dentures, Partial upper and lower dentures, Root canals, Porcelain fused to metal crowns and post & core, Periodontal scaling and root planing, Periodontal surgery, Prophylaxis (cleaning), Restorations (amalgam and composite) exception: if referred from Oncology, Transplant, and Craniofacial Clinics the procedure qualifies up to 100% deduction.

The Miriam Hospital Cosmetic Surgery and Women's Medicine Collaborative Self Pay Programs/Classes (Healthy Exercise and Lifestyle Planning, Massage, Yoga, Mindfulness Based Stress, etc.) and Acupuncture and Chiropractor services do not qualify for a reduction in fee. Cardiac Rehabilitation Maintenance and Weight Management services may be determined to be essential medical services if established medical criteria/guidelines are met with required documentation specific to the program.

Newport Hospital Cardiac Rehabilitation Maintenance Program is eligible for a reduction in fee when established medical criteria/guidelines are met. Cosmetic Surgery does not qualify for a reduction in fee.

Lifespan Physician Group - OB GYN Associates - services for surrogate pregnancy, laser treatments, skin care products, cord blood retrieval, and education classes do not qualify for a reduction in fee.

Lifespan Physician Group – Ophthalmology – "contact lens fitting" does not qualify for a discount.

4. In the event a patient refuses a medically safe and appropriate discharge plan and agreement cannot be reached, the hospital will hold the patient financially responsible for the continued hospital stay and will not qualify for LCS Financial Assistance Program.

5. Financial Assistance Policy:

- Lifespan FAP is available based upon immediate family's estimated gross income from all sources before taxes:

- The amount that is charged to any FAP eligible patient cannot exceed amounts generally billed (AGB) for insured individuals. The AGB is defined in the final regulations as the amount the individual is personally responsible for paying after all deductions and discounts have been satisfied, less any amount paid by insurance.

- Uninsured patients receive an automatic partial Community Benefit/Charity Care deduction as a commitment by Lifespan to the uninsured patients: RIH an automatic deduction of 80% on the outpatient charges with the exception of Samuels Sinclair Dental Center will be an automatic reduction of 50% and the inpatient reduction would equal the Medicare Reimbursement Rates, TMH an automatic reduction of 80% on the outpatient

charges and the inpatient reduction would equal the Medicare Reimbursement Rates, Newport Hospital an automatic reduction of 80% on the outpatient charges and the inpatient reduction would equal the Medicare Reimbursement Rates, Bradley Hospital an automatic reduction of 25% of charges for both inpatient and outpatient, and LPG an automatic reduction of 69% of outpatient charges.
The discount applies to all uninsured patients provided, however, that the Charity Care Benefit does not block an individual patient's ability to qualify for the State's Medicaid program. Massachusetts' residents only qualify for the hospital's automatic percentage discount.

- (Exception – Massachusetts' patients transferred to RIH/TMH Emergency Department or to an Inpatient Nursing Unit via the Express Care Center can apply for CFS for both services in addition to outpatient follow up related to the transfer diagnosis. Patients who may qualify for Mass Health must apply for that first, and if they are denied can apply for CFS.)

- Children over 18 years of age claimed as a dependent on their parents'/guardian's taxes the parents'/guardian's income are included to determine CFS eligibility.

- Insured Patients – Medicare Patients including Senior Products Waivers of cost-sharing amounts for financially needy Medicare Beneficiaries:
A discount offered to a Medicare beneficiary generally takes the form of a waiver of all or a portion of the Medicare program co-payment or deductible, that is, the portion of the bill that the beneficiary owes. While generally banning routine cost-sharing waivers of such "insurance" billing and the like, Congress recognized that some beneficiaries might not be able to afford coverage without these cost-sharing efforts. Lifespan makes an exception for waivers on the basis of financial need. While waivers may be granted, the following three conditions remain true:

    i. waivers are not routine
    ii. waivers are not offered as part of any advertisement or solicitation
    iii. waivers may only be made in good faith as evidenced by the completion of a Charity Free Care Application

- The affiliate hospital will waive payments, in part or in full, for necessary medical services provided for eligible applicants.

- The Patient Advocates (PFA'S)/Patient Financial Counselors (PFC'S) at Lifespan Hospitals will explore sources of funds from special programs that may be available on an individual patient need basis.

- Eligibility for CFS above the automatic discount is provided for those applicants whose family gross income is at or below the Income Guidelines (see attachment) effective on the date the patient applies for financial assistance. For patients who qualify

for less than 100% of the financial assistance program, the patient may be offered a payment plan – refer to *Lifespan Affiliate Hospital's Patient Payment Policy*.

- Patient's with insurance that opt not to use it **do not** qualify for a discount.
- Non-covered services do not qualify for a discount.

II. Procedure for Financial Assistance:

1. **Applications**: Applications for the Financial Assistance program are available in the Admitting Office, Emergency Departments, Business Office, Patient Financial Advocate's Office, Patient Financial Counselor's Office, Patient Financial Services and all Outsource Agencies offices. Assistance to complete the form is available with the Patient Financial Advocates/Patient Financial Counselors. The patient/patient's family may either schedule an appointment with, or walk-in to see a Patient Financial Advocate/Patient Financial Counselor. Patients can also receive assistance by calling the Patient Financial Services Customer Service Department when they have received a bill for charges previously incurred. In filling out the application, we ask that all patients provide us with as much information as possible. The list of items in the following sections will help us to better gauge the need for assistance. We understand not all patients will have all items listed, however we ask that patients/patients' families provide us with as many of those as are available or applicable.

2. **Rhode Island Residents**: We ask that patients provide us with proof of in-state residence. If a government-issued photo ID is not available, a rental agreement, a recent utility or telephone bill, or similar document with a Rhode Island address may be submitted. Applicants are asked to provide family income or "proof of income" information through as many of the following documents as may be applicable or available: W-2 forms, most recent annual tax forms (federal), most recent pay stubs (at least two (2) consecutive), copy of any savings and/or checking account statement, copy of government-issued photo identification, and any other income documentation such as a copy of a check for Veteran's Benefits. We also ask for any denial letters that may have been issued by Medical Assistance or Rhode Island's Rite Care Program. As part of our process we will have patients apply for Medical Assistance if they are eligible and have not done so before. Note that non-eligibility may be pre-determined by the Patient Financial Advocate/Patient Financial Counselor for those patients who clearly do not meet the Medical Assistance requirements. (Exceptions: in situations where there is no income, a self-declaration, signed letter from the patient, or person supporting the patient may be accepted.)

3. **Non-Rhode Island Residents**: Applicants are asked to provide family income or "proof of income" information through as many of the following documents as may be applicable or available: W-2 forms, most recent annual tax forms (federal), most recent pay stubs (at least two (2) consecutive), copy of any savings and/or checking account statement, copy of government-issued photo identification. If the patient has a Social Security number/Tax identification number (TIN) and the patient does not file taxes, we may request permission to obtain a credit report. Patients without a Social Security number or TIN number should provide a letter explaining their

living situation and a letter from the person who is supporting them, including evidence of domicile. Such letters should be signed under the penalties of perjury.

4. **Visiting Foreign Nationals**: Applicants are asked to provide family income or "proof of income" information through as many of the following documents as may be applicable or available: a copy of their passport and visa (as may be applicable) and a self-declaration letter explaining their income from their country of origin and a self-declaration letter explaining any arrangements for financial support they may have while staying in the U.S. Such letters should be signed under the penalties of perjury.

5. **Homeless Patients**: Homeless patients who are provided Emergency Room care will need to complete and sign a Financial Assistance application. Documentation is not necessary at the time care is provided. The application is valid for the ED Visit only. If an Inpatient or an Outpatient is homeless, the Patient Financial Advocate/Patient Financial Counselor will explore sources of funds from special programs that may be available on an individual patient basis. If the patient does not qualify for any program, the Financial Assistance application will be completed, and the following will be attached: a copy of a photo ID if available (may be government or shelter-issued); a letter from the shelter, if any; a self declaration letter from the patient explaining how he/she supports himself/herself; a credit report, if any; a copy of their most recently completed federal tax form(s), if any; and the most recent two consecutive pay stubs, if any.

6. **Self-Employed**: Applicants are asked to provide family income or "proof of income" information through as many of the following documents as may be applicable or available: the most current year tax return, credit report, a self-declaration letter with monthly expenses and proof of expenses, (copy of monthly bills) signed under the penalties or perjury.

7. **Processing**:

a) All completed applications, along with supporting documentation will be forwarded to the Patient Financial Services (PFS)-Customer Service Department to be filed away UNLESS the affiliate hospital has scanning capabilities, then the applications will be scanned by that affiliates designated staff and NO hard copy will be sent to PFS Customer Service Department.

b) All approved or denied applications should be documented in LifeChart Account Notes section. If the application is approved for full, additional partial or, denied the FPL table is updated to reflect the CFS outcome and the effective dates added for CFS approved coverage duration. A "history" comment will be added by the PFS-Customer Service Staff on all accounts indicating the effective dates of the CFS and listing the qualified percentage allowed for that duration of time. Patient Financial Advocates, Patient Financial Counselors and Patient Financial Services-Customer Service staffs are responsible for notifying all of the Lifespan Corporate Services Pre-Collection and Collection Agencies of the CFS approval for full or partial coverage.

8. **Inpatients:** Inpatients with Medicaid pending, the PFA/PFC will complete the Financial Assistance application and staff will provide this to the Medicaid Specialist. If Medicaid is denied and the patient qualifies for Financial Assistance, the account is revised with the appropriate LifeChart Federal Poverty Level ("FPL") table. Exception: Bradley Hospital – pending Medicaid, the CFS application is mailed to the patient by PFS if the patient is denied Medicaid.

9. **Time Limit for Applications:** Applications will not be accepted that are dated over 90 days ago from the first patient statement generated. The exception is accounts classified under the "pre-collection agency" accounts. These applications will not be accepted that are dated 90 days from the pre-collect transfer status, unless there is a problem with the applicant's third party coverage, pending third party coverage and liability, or if the applicant's financial circumstances have changed. (Patients that have been non-compliant with documentation and after the 90 days they decided to provide the documentation the original date of the application will be accepted.)

10. **Time Limit for Approvals:** Approved applications are valid for a period of ***twelve*** months going forward from the date of the application and six (6) months prior to the approved dates. Exceptions: applications that have balances after Medicare and Medical Assistance and the Immunology Clinic at TMH, special circumstances cases e.g. chronic homelessness, approvals for these exceptions are valid for one year from the date of application. **Non-Rhode Island residents: application is valid for one ED Visit; one ED Admission; and for follow-up care related to the ED visit or ED Admission.**

11. **Asset Guidelines:** Checking accounts, saving accounts, insurance policies (cash value), stocks, CD's and mutual fund accounts will need to be within the established saving guidelines for the affiliate hospital. If the saving accounts exceed the established guidelines, the patient needs to spend down the savings towards the affiliate hospital's bill until their savings are within the guidelines.

12. **Bad Debts:** Accounts assigned to bad debt and are found eligible for CFS the accounts will be reactivated from the bad debt status and written off to the CFS appropriate percentage.

13. **Special CFS with Limited Documentation:**

Approval of applications with extenuating circumstances:

a) Patient admitted but unable to provide documents due to their health issues i.e.: severe substance abuse and housing issues who are not associated with a homeless shelter;

b) Massachusetts Resident admitted but expires prior to the Mass Health application being filed (Mass Health will not consider these applications);

c) patients found eligible for Medicaid or GPA have CFS go retro 6 months from date of eligibility if patient does not comply with CFS documentation;

d) RI resident patient expires and family will not apply for RI Medicaid;

e) Patient admitted as self- pay but taken into State custody during their admission; State (ACI) will pay from date of custody, prior 6 months accounts to be adjusted to CFS

14. **Modified Application Process:** Patients who are receiving food stamps will qualify for a modified application process if they have a Food Stamp Letter and their income/assets are within the financial guidelines.

15. **Appeals Process:** Patients have the right to appeal a denial of an application for CFS. The patient/guarantor must submit their request in writing as to why the patient/guarantor wants to appeal the decision. The completed application and the supporting documentation with the patient's request to appeal the decision will be forwarded to the Manager or Director of the Patient Financial Advocates. The Manager/Director will review the appeal letter, original application and supporting documentation for adherence to Lifespan's guidelines. If the patient's financial information has changed from the original application a new application will be completed with the supporting documentation. The Manager/Director will notify the patient of their decision within ten days of receiving the appeal letter. If the appeal is denied, the patient/guarantor can request a second appeal to the Vice President of Finance. The patient/guarantor will be notified in writing of the Vice President's decision within ten days of receiving the second appeal letter. If additional documentation is required, the patient will receive a decision of the appeal within ten days after receipt of the documentation.

16. **Scope of Application:** Patient Financial Advocates, Patient Financial Counselors, PFS-Customer Service Department and Administration as deemed necessary. All registration personnel at affiliate hospitals and outsourced agencies are responsible to distribute the applications and to refer patients to the PFA, PFS and Customer Service Staff for assistance with applications for financial assistance.

17. **Communication of the Financial Assistance Program to patients and the Public:** Lifespan makes this policy, application form, and plain language summary of the policy available on its website and in various public locations throughout its facilities (such as emergency rooms and admission areas). A copy of the plain language summary of this policy is offered to patients as part of the intake or discharge process, and Lifespan also includes a written notice on billing statements to notify recipients about the availability of financial assistance.

Lifespan accommodates all significant populations that have limited English proficiency by translating this Financial Assistance Policy, application form, and plain language summary of the policy into primary language(s) spoken by such populations.