Houston Methodist
Policy FI49

Subject:
Financial Assistance

Effective Date:
January 1, 2016

Applies to:
Houston Methodist Hospitals

Date Revised/Reviewed
January 1, 2016

Originating Area:
Revenue Cycle Council

Target Review Date:
January 1, 2019

I. POLICY

Houston Methodist (HM) is committed to providing financial assistance to persons who have healthcare needs and are uninsured or underinsured and are ineligible for a government program, or otherwise unable to pay, for medically necessary care including emergency care as defined herein, based on their individual financial situation. Consistent with HM's objective to deliver high quality, cost effective healthcare, and to advocate for those in need, HM strives to ensure that those in need are not prevented from receiving necessary health care services. HM will provide, without discrimination, care for emergency medical conditions regardless of a patient's ability to pay.

This policy covers how to apply for financial assistance; eligible services; eligibility criteria; the approval process; the basis for calculating amounts billed; notification and posting requirements; collection procedures for unpaid amounts; a list of providers that are/are not covered by this policy (Appendix C), and also provides a plain language summary of this policy (Appendix A).

Financial assistance is not considered to be a substitute for personal responsibility. Patients are expected to contribute to the cost of their care, based on ability to pay, and comply with HM's procedures for obtaining financial assistance. Individuals with the financial capacity to purchase health insurance will be encouraged to do so, as a means of providing access to health care services. Patients that would qualify as a Houston Methodist Global patient are excluded from this policy.

Consistent with good financial stewardship and to enable HM to provide healthcare services to the greatest number of persons in need, HM's Board of Directors has established the following guidelines for the provision of patient charity.

II. DEFINITIONS

- Financial Assistance: Healthcare services provided by HM hospitals without charge or at a discount to patients approved for Financial Assistance.

- Family: Using the Census Bureau definition, a group of two or more people who reside together and who are related by birth, marriage, or adoption. According to Internal Revenue Service rules, if a patient claims someone as a dependent on their income tax return, they may be considered a dependent for financial assistance determination purposes.

- Family income: Family Income, on a before tax basis, is determined using the Census Bureau definition, which uses the following income when computing federal poverty levels (FPL):

    - Earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest and dividends (excluding capital gains or losses), rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources;

    - Noncash benefits (such as food stamps and housing subsidies) do not count;

    - If a person lives with a family, includes the income of all family members. Non-relatives, such as a housemate, do not count.

- Uninsured: A patient with no insurance or third party assistance.

- Underinsured: A patient with some insurance or third-party assistance who has non-covered services and/or out-of-pocket expenses that exceed his/her financial abilities.

- Houston Methodist Global: A corporation of Houston Methodist that serves the following patients:

    - Citizenship in a foreign country;
    - Possess valid passports;
    - United States retirees that permanently reside abroad; or
    - United States citizens that work abroad greater than six months in the year.

- Gross charges: Patient charges before the application of contractual adjustments or discounts.

- Amounts Generally Billed (AGB) Percentage: The average payment percentage that a HM hospital receives for medically necessary or emergency services from Medicare and private insurance companies (see Appendix B). The AGB percentage is calculated annually for each HM hospital, within 120 days of December 31st, utilizing a look back method which includes claims processed for the previous calendar year.

- Emergency medical conditions: Defined within the meaning of section 1867 of the Social Security Act (42 U.S.C. 1395dd).

- Medically necessary: As defined by Medicare (services or items reasonable and necessary for the diagnosis or treatment of illness or injury).

III. PROCEDURE

A. <u>How to Apply for Financial Assistance</u>

1. To apply for Financial Assistance, a patient can obtain a Financial Assistance Application (FAA), free of charge, as follows:

    a. Speak with a Financial Counselor prior to or at time of service;

    b. Download from HM's website at www.HoustonMethodist.org/Billing;

    c. Call HM's Centralized Business Office, Monday through Friday, 7:00 a.m. through 7:00 p.m., Saturday 8:00 a.m. through 12:00 p.m. at 832-667-5900 or toll free at 877-493-3228; or

d. By Mail :

Houston Methodist
Centralized Business Office
Attn: Financial Assistance Unit
701 S. Fry Road
Katy, TX 77450

2. Once you have obtained the FAA, please fill out the form completely, gather and attach required supporting documents, and submit all documents by way of the following:

a. By Mail :

Houston Methodist
Centralized Business Office
Attn: Financial Assistance Unit
701 S. Fry Road
Katy, TX 77450

b. Walk up and/or drop off to a Patient Access team member; or

c. Fax to 832-667-5995.

3. It is preferred but not required that a request for financial assistance and a determination of financial need occur prior to rendering of non-emergent medically necessary services. However, the determination may be done at any point in the collection cycle. The need for financial assistance is evaluated at each subsequent time of services if the last financial evaluation was completed more than a year prior, or at any time additional information relevant to the eligibility of the patient for financial assistance becomes known.

4. HM's values of human dignity and stewardship will be reflected in the application and approval process. Requests for financial assistance will be processed promptly and HM will notify the patient or applicant in writing within 15 days of receipt of a FAA. Financial Assistance will be approved or denied based on the completed FAA and other provisions of this policy (e.g., see below).

B. **Eligible Services** The following healthcare services are eligible for financial assistance :

1. Emergency medical services provided in an emergency room setting;

2. Services for a condition which, if not promptly treated, would lead to an adverse change in the health status of an individual;

3. Non-elective services provided in response to life-threatening circumstances in a non-emergency room setting; and

4. Medically necessary services, evaluated on a case-by-case basis at HM's discretion.

C. **Eligibility Process** Financial need will be determined in accordance with an individual assessment process that may include the following:

1. An application process culminating in the completion of a FAA (FAA – Appendix D);

2. Use of publically available data sources that provide information on a patient's, or a patient's guarantor's ability to pay (such as credit scoring);

3. Reasonable efforts by HM to explore appropriate alternative sources of payment and coverage from public and private payment programs, including assistance to patients to apply for such programs; and

4. Evaluation of patient's available assets, and other financial resources.

D. **Presumptive Financial Assistance Eligibility** In certain cases, there may be adequate information to make a financial assistance determination without a completed FAA. Presumptive financial assistance will be evaluated and/or reevaluated for each date of service. Some examples that HM may use to determine presumptive financial assistance include:

1. Homeless or received care from a homeless clinic;

2. Participation in Women, Infants, and Children programs (WIC);

3. Food stamp eligibility;

4. Eligibility for other state or local assistance programs that are unfunded (e.g., Medicaid spend-down);

5. Low income/subsidized housing is provided as a valid address;

6. Patient is deceased with no known estate; and

7. Paid subscription-based charity advisor score.

E. **Amounts Billed** Once care is confirmed for eligibility under this policy, patient billing will be limited to an amount no greater than AGB. The amount billed will be based upon the applicable percentage of AGB, applied to gross charges, according to the patient's family income as a factor of the Federal Poverty Level (FPL) as listed below:

1. Patient's family income at or below 200% of the FPL – 0% of AGB;

2. Patient's family income above 200%, but not more than 300% - 50% of AGB; and

3. Patient's family income above 300%, but not more than 400% - 100% of AGB.

F. **Collection Steps in Case of Non-payment** In cases where a patient doesn't pay the amount billed (Section III, E. above), HM management will follow its established collection policies, which will include extended payment options. At no time will HM impose extraordinary collection actions such as wage garnishments, personal liens on primary residences, credit bureau notification or other legal actions. A copy of HM's collection policies can be obtained for free by following one of the steps listed in Section III, A., 1. a. – d.

G. **Financial Assistance Notification and Posting Requirements** Notification about financial assistance will be made available by various means, which may include, but not limited to: the publication of notices in patient bills; notices in emergency rooms and urgent care centers; the Conditions of Admission form; Admitting and Registration departments, and at other public places as HM may elect. HM may also publish and widely publicize a summary of this Financial Assistance policy on its hospital websites, in brochures available in patient access sites and at

other places within the community served by HM. Such notices and summary information will be provided in various primary languages spoken by the population served by HM. Referral of patients for financial assistance can be made by any member of HM's staff or medical staff. A request for financial assistance may be made by the patient or a family member, close friend, or associate of the patient, subject to applicable privacy laws.

H. **Regulatory Requirements** In implementing this Policy, HM will comply with federal, state, and local laws, rules, and regulations that apply to activities conducted pursuant to this Policy.

I. Authoritative References

1. Patient Protection and Affordable Care Act of 2010;
2. Internal Revenue Code Section 501(r)(4)-(r)(6);
3. Extended Payment Options Policy (FI86); and
4. Collections Policy (FI85).

Recommended by Revenue Cycle Council
Approved by Houston Methodist Board of Directors

Authorized by Chief Administrative Officer:

(Signed Original on File)

_____ _____

M. Boom
President
Chief Executive Officer
Houston Methodist

Date

Appendix A

Plain Language Summary

Houston Methodist's Financial Assistance Policy

Houston Methodist is committed to providing charity care to persons who are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay, for emergency and medically necessary care based on their individual financial situation.

Patients whose family income is at or below 200% of the Federal Poverty Level (FPL) are eligible to receive free services; and patients whose family income is above 200% but not more than 400% of the FPL are eligible to receive services at a discounted amount. This discounted amount is not to exceed the average amount Houston Methodist would get paid by private insurance, and Medicare, including any patient payments in the form of deductibles, co-payments, and co-insurance.

You will not be required to make advanced payments or payment arrangements for emergency and medically necessary services prior to the rendering of services. However, if you are required to pay a discounted amount, and you cannot pay the discounted amount in full after the services are provided, Houston Methodist will attempt to collect this discounted amount. Houston Methodist will provide monthly billing statements requesting payment from you. If you cannot pay the discounted amount in a single payment, Houston Methodist offers interest free extended payment options. Any discounted amounts remaining unpaid will be turned over to a third party collection agency for further collection attempts. Third party collection activity will not include personal liens, legal actions or credit bureau notification.

A free copy of Houston Methodist's Financial Assistance Policy, the Financial Assistance Application and Collection Policies are available on Houston Methodist's website at www.HoustonMethodist.org/Billing, are available in the Hospitals' Admitting and Registration areas, can be obtained by contacting the Centralized Business Office at (local) 832-667-5900, (toll free) 877-493-3228, and can be requested by mail:

Houston Methodist
Centralized Business Office
Attn: Financial Assistance Unit
701 S. Fry Road
Katy, TX 77450

This Plain Language Summary, Financial Assistance Policy, Financial Assistance Application and Collection Policies are available in various languages at the contacts listed above.

Houston Methodist's Financial Assistance Unit is available to answer questions and provide information about the Financial Assistance Policy and to assist you with the application process. You can reach a member of the Financial Assistance Unit Monday through Friday between the hours of 7:00 a.m. through 7:00 p.m. and Saturday between the hours of 8:00 a.m. through 12:00 p.m. at 877-493-3228.

Once you have completed the Financial Assistance Application, please attach all required supporting documents and mail to the Financial Assistance Unit, see address listed above, or fax to the attention of the Financial Assistance Unit at 832-667-5995.

Appendix B

SAMPLE

AMOUNT GENERALLY BILLED (AGB) CALCULATION WORKSHEET

Annual Calculation of Amounts Generally Billed Percentage
Houston Methodist Hospital

Relevant Measurement Period: January 1, 2015 – December 31, 2015

A	Medicare Fee-for-Service allowed amounts on claims paid during relevant period	$
B	Private Insurance allowed amounts on claims paid during relevant period	$
C	Co-pays, co-insurance, and deductibles paid by patients on claims listed in A and B during relevant period	$
D	Total insurance allowed amounts and patient payments (A+B+C above)	$
E	Hospital gross charges for services provided in D above	$
F	Hospital-specific Amount Generally Billed (AGB) Percentage (D/E)	%

For a list of current AGB percentages for each Houston Methodist hospital, please follow one of the steps in Section III, A., 1.a-d. This information will be provided to you free of charge.

Appendix C

List of Providers that are/are not covered by this Policy

Organization/Group/Practice	Covered Yes/No
Houston Methodist Hospital	Yes
Houston Methodist Sugar Land Hospital	Yes
Houston Methodist Willowbrook Hospital	Yes
Houston Methodist West Hospital	Yes
Houston Methodist San Jacinto Hospital	Yes
Houston Methodist St. John Hospital	Yes
Houston Methodist St. Catherine Hospital	Yes
Houston Methodist Hospital Imaging Center: Katy Freeway	Yes
Houston Methodist Hospital Imaging Center: Kirby	Yes
Houston Methodist West Hospital Imaging Center: Cinco Ranch	Yes
Houston Methodist Willowbrook Hospital Imaging Center: Cypress	Yes
Houston Methodist West Houston Emergency Center: Cinco Ranch	Yes
Houston Methodist Willowbrook Hospital Emergency Center: Cypress	Yes
Houston Methodist Hospital Emergency Center: Kirby	Yes
Houston Methodist Hospital Emergency Center: Pearland	Yes
Houston Methodist Sugarland Hospital Emergency Center: Sienna Plantation	Yes
Houston Methodist Hospital Emergency Center: Voss	Yes
Houston Methodist Primary Care Group	No
Houston Methodist Specialty Physician Group	No
Non-Houston Methodist Physician Groups (Private MDs)	No
Anesthesiology: US Anesthesia Partners	No
Anesthesiology: Baylor	No
Anesthesiology: Space City Anesthesia	No
Emergency Physicians: EmergiGroup Physician Associates	No
Emergency Physicians: Neptune Emergency Services	No
Emergency Physicians: The Schumacher Group	No
Emergency Physicians: Kirby Emergency Physicians	No
Hospitalist: IPC - The Hospitalist Company PA	No
Hospitalist: Neptune Hospitalist Services, dba: Triton Hospitalist	No
Hospitalist: OB Hospitalist Group	No
Hospitalist: Sound Hospitalist Group of Texas	No
Imaging: MASTOS Imaging Associates	No
Newborns: Texas Children's Physician Services	No
Pathology: Coastal Pathology	No
Pathology: Methodist Pathology Associates, PLLC	No
Radiology: Baytown Radiology	No
Radiology: Houston Radiology Associated	No

HOUSTON Methodist LEADING MEDICINE

Financial Assistance Application

Instructions: Please fill in all the blanks below. If an item is not applicable, please write N/A. Attach photocopies of the following that apply to your current situation: **1. Most recent paycheck stub(s) that reflects YTD income information; 2. Most recent income tax return, including all attachments; 3. Social Security check or entitlement letter or bank statement, if direct deposit; 4. Unemployment award letter; 5. Harris Health System gold card.** If unemployed and dependent on others for income and/or living expenses, please attach a letter of support and a copy of the tax return, if listed as a dependent on the tax return. **If you have questions or need additional assistance in filling out this application, please contact the Centralized Business Office at 877-493-3228 M-F 7a – 7p, Saturday 8a-12p.**

Please return completed application and supporting documents to any Patient Access team member, or fax to (832) 667-5995 or by mail to: Houston Methodist, Centralized Business Office; Attn: Financial Assistance Unit; 701 S. Fry Road; Katy, TX 77450.

_____ _____
PATIENT NAME (PLEASE PRINT) SOCIAL SECURITY NUMBER

_____ _____
SPOUSE/PARENT/GUARDIAN NAME (PLEASE PRINT) SOCIAL SECURITY NUMBER

HOME ADDRESS _____

PHONE NUMBER _____ DATE OF BIRTH _____ MARITAL STATUS _____

SERVICE(S) REQUESTED: _____

ACCOUNT NUMBER: _____ SERVICE DATES: _____

No. of children under 18 years living at home: _____ Names of Dependents

Directly related _____ _____

Step-children _____ _____

Not related _____ _____

Guardian of _____ _____

MONTHLY EXPENSES

Housing:
- ☐ Rent
- ☐ Own
- ☐ Paid

Monthly payment $_____

Utilities:
Electricity $_____
Water $_____
Gas $_____

Automobiles:
- ☐ Own/# _____
- ☐ Lease/# _____

Monthly payment $_____

Patient	**Spouse/Other**
Employer _____	Employer _____
☐ Employed Full-time	☐ Employed Full-time
☐ Employed Part Time	☐ Employed Part Time
☐ Unemployed/retired/disabled	☐ Unemployed/retired/disabled
☐ Unable to return to work	☐ Unable to return to work
☐ Housewife	☐ Housewife

TOTAL FAMILY INCOME* $_____/month **(SEND PROOF(S) OF INCOME WITH APPLICATION)**

** Includes all wages, farm or self-employment, public assistance, Social Security, unemployment/worker's compensation, retirement, strike benefits, alimony, child support, military allotments, pensions, incomes from dividends, interest, rental property and other miscellaneous income sources.*

BANK ACCOUNTS/OTHER ASSETS:

Checking Account	☐	**Yes**	☐	**No**	**Balance**	$ _____
Savings Account	☐	**Yes**	☐	**No**	**Balance**	$ _____
Stocks/Bonds, Etc.	☐	**Yes**	☐	**No**	**Balance**	$ _____
Additional Property	☐	**Yes**	☐	**No**	**Describe**	_____

I certify that the above information is true and accurate to the best of my knowledge. It is understood that failure to provide all of the information requested above may be considered as a disqualification from any financial relief under the Program. Further, if applicable, I will make application for governmental assistance, take appropriate action to obtain such assistance and advise HM of the outcome of my application. I (we) give HM consent to obtain information from any source to verify the statement(s) that I (we) have made.

_____ _____
(Patient/Applicant's Signature) **(Date)**

Please complete this side only. **Rev. 10/2015**