NMHS CORPORATE
POLICIES AND PROCEDURES

SUBJECT:	**FINANCIAL ASSISTANCE**
APPLICABLE:	**Nebraska Methodist Hospital, Methodist Women's Hospital, Methodist Jennie Edmundson and Methodist Physicians Clinic**
EFFECTIVE DATE:	**04/04**
REVIEWED/REVISED:	**06/05, 05/10, 12/10, 03/11, 11/11, 03/12, 10/13, 09/14, 08/15**
PURPOSE:	**TO DEFINE ELIGIBILITY CRITERIA FOR FINANCIAL ASSISTANCE**

I. PURPOSE:

The purpose of this policy is to outline the circumstances under which financial assistance may be provided to qualifying low income patients for medically necessary healthcare services provided at facilities or by providers that are a part of the Nebraska Methodist Health System D/B/A Methodist Health System (MHS).

II. POLICY:

Methodist Health System is a not for profit healthcare organization guided by a commitment to its mission and core values through compassionate service. It is both the philosophy and practice of each MHS facility and provider that medically necessary healthcare services are available to patients, and those in emergent medical need, without delay and regardless of their ability to pay.

Patients qualifying for MHS financial assistance will receive care provided at a discounted fee. The MHS financial assistance policy is intended to be compliant with applicable federal and state laws. Financial assistance provided under this policy is done so with the expectation that patients will cooperate with the policy's application procedures and those of public benefit or coverage programs that may be available to cover the cost of care. Methodist Health System will not discriminate on the basis of age, sex, race, creed, color, disability, sexual orientation, national origin, or immigration status when making financial assistance determinations.

III. DEFINITIONS:

The following definitions are applicable to all sections of this policy.

Amount Generally Billed: The amount generally billed is the expected payment from patients, or a patient's guarantor, eligible for financial assistance. For uninsured patients this amount will not exceed the rate of average payment received retrospectively from Medicare and private health insurers, including all patient responsibility. For patients with third party coverage, the payer will determine allowable amount and patient's financial responsibility.

Assets: Certain assets will be considered in making a determination of eligibility for financial assistance.

Discounted Care: Financial assistance that provides a percentage discount, based on a sliding scale, for eligible patients, or patient guarantors, with annualized family incomes between 200-400% of the Federal Poverty Level.

Emergency Medical Condition: As defined in Section 1867 of the Social Security Act (42 U.S.C. 1395dd), the term "emergency medical condition" means:

(1) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—

- placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
- serious impairment to bodily functions, or
- serious dysfunction of any bodily organ or part; or
  with respect to a pregnant woman who is having contractions—
- that there is inadequate time to effect a safe transfer to another hospital before delivery, or
- that transfer may pose a threat to the health or safety of the woman or the unborn child.

Family: As defined by the U.S. Census Bureau, a group of two or more people who reside together and who are related by birth, marriage, or adoption. If a patient claims someone as a dependent on their income tax return, according to the Internal Revenue

Service rules, they may be considered a dependent for the purpose of determining eligibility for this policy.

Family Assets: An applicant's family assets are the combined assets (as follows) of all adult members of the family living in the household. Assets include bank accounts, CD's, investment accounts, real estate (excluding primary residence) and miscellaneous other assets. Retirement fund assets are not considered to be part of family assets.

Family Income: An applicant's family income is the combined gross income of all adult members of the family living in the household and included on the most recent federal tax return. For patients under 18 years of age, family income includes that of the parents and/or step-parents, or caretaker relatives.

Federal Poverty Level: The Federal Poverty Level (FPL) uses income thresholds that vary by family size and composition to determine who is in poverty in the United States. It is updated periodically in the Federal Register by the United States Department of Health and Human Services under authority of subsection (2) of Section 9902 of Title 42 of the United States Code. Current FPL guidelines can be referenced at http://aspe.hhs.gov/POVERTY/

Financial Assistance: Assistance provided to eligible patients, who would otherwise experience financial hardship, to relieve them of all or part of their financial obligation for medically necessary care provided by MHS.

Free Care: A 100% waiver of patient financial obligation resulting from eligible medical services provided by MHS for eligible uninsured and underinsured patients, or their guarantors, with annualized family incomes at or below 200% of the Federal Poverty Level.

Guarantor: An individual other than the patient who is responsible for payment of the patient's bill.

Gross charges: Total charges at the full established rate for the provision of patient care services before deductions from revenue are applied.

Medical Hardship: Financial assistance provided to eligible patients with annualized family incomes in excess of 400% of the Federal Poverty Level and financial obligations resulting from medical services provided by MHS, and other healthcare providers, in excess of 25% of the family income.

Medically Necessary: As defined by the State Medicaid programs in Nebraska and Iowa, as services or supplies which are medically appropriate and necessary to meet basic health needs consistent with the diagnosis of the patient's condition. Treatment should be in accordance with standards of good medical practice with demonstrated value and consistent in type, frequency and duration with scientifically based guidelines of national medical research or healthcare coverage organizations or governmental agencies. Treatment to be required to meet the medical need of the patient for reasons other than convenience of the patient or the patient's practitioner or caregiver. Treatment is to be rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the covered service within a proper balance of safety, effectiveness and efficiency.

Payment Plan: An extended payment plan that is agreed to by both MHS and a patient, or patient's guarantor, for out-of-pocket fees. The payment plan shall take into account the patient's financial circumstances, the amount owed, and any prior payments.

***Qualification Period*:** Applicants determined eligible for financial assistance will be granted assistance for a period of six months. Assistance will also be applied retroactively to unpaid bills incurred for eligible services that are active within MHS accounts receivable.

Uninsured Discount: Patients ineligible for financial assistance and having no third-party coverage for emergency or medically necessary services provided by MHS will be granted a discount equal to that of the average amount generally billed.

***Underinsured Patient*:** An individual, with private or public insurance coverage, for whom it would be a financial hardship to fully pay the expected out-of-pocket expenses for medical services provided by MHS.

Uninsured Patient: A patient with no third-party coverage provided through a commercial third-party insurer, an ERISA plan, a Federal Health Care Program (including without limitation Medicare, Medicaid, SCHIP, and Tricare,) Worker's Compensation, or other third party assistance to assist with meeting a patient's payment obligations.

IV. <u>ELIGIBLE SERVICES:</u>

Services eligible under this financial assistance policy must be clinically appropriate and within generally accepted medical practice standards. They include the following.

1. Emergency medical services provided in an emergency setting. Care provided in an emergency setting will continue until the patient's condition has been stabilized prior to any determination of payment arrangements.
2. Services for a condition that, if not treated promptly, would lead to an adverse change in the health status of a patient.
3. Non-elective services provided in response to life-threatening circumstances in a non-emergency room setting.
4. Other medically necessary services, for example, inpatient or outpatient health care services provided for the purpose of evaluation, diagnosis and/or treatment of an injury, illness, disease or its symptoms. Also, services typically defined by Medicare or other health insurance coverage as "covered items or services."
5. Services of healthcare providers employed by MHS and delivered in MHS facilities.

Services not eligible for financial support include the following:

1. Elective procedures not medically necessary.
2. Cosmetic surgery, services or products offered through the Skin Renewal Clinic, reproductive services, bariatric procedures not covered by insurance, experimental care, or services provided under a clinical research program.
3. Services of healthcare providers employed by MHS but delivered in private offices, not in MHS facilities.
4. Those services received from care providers not billed by MHS. Care providers not billed by MHS may include: radiologists, anesthesiologist, surgeons, hospitalist, wound clinic physicians, neonatologist, pulmonologists, plus various physician specialists as well as ambulance transport. Patients must contact the service providers directly to inquire into assistance and make payment arrangements directly with these practitioners.

    See attached appendix A Methodist Health System maintains a list of providers available upon request (free of charge).

V. ELIGIBILITY CRITERIA:

Financial assistance will be extended to uninsured and underinsured patients, or a patient's guarantor, in accordance with MHS policy. Eligibility will be considered for those individuals who are unable to pay for their care; it will be based on a combination of family income, assets, and medical obligations.

Financial assistance will be extended to patients, or a patient's guarantor, based on financial need and in compliance with federal and state laws. Financial assistance applicants will be responsible for applying to public programs and pursuing private health insurance coverage. Patients, or patient's guarantors, choosing not to cooperate in applying for programs identified by MHS as possible sources of payment for care, may be denied financial assistance.

In accordance with FEDERAL EMERGENCY MEDICAL TREATMENT AND LABOR ACT (EMTALA) regulations, no patient is to be screened for financial assistance or payment information prior to the rendering of services in emergency situations.

Patients, or patient's guarantors, must cooperate with the application process outlined in this policy to obtain financial assistance. They are expected to contribute to the cost of their care based on their ability to pay, as outlined in this policy.

Financial assistance is typically not available for patient co-payment or balances after insurance when a patient fails to comply reasonably with insurance requirements such as obtaining proper referrals or authorizations. Financial assistance will be offered to underinsured patients providing such assistance is in accordance with insurer's contractual obligations.

VI. FINANCIAL ASSISTANCE:

The type of assistance to be provided will be based on a combination of family income, family assets, and medical obligations. The federal poverty level will be used to determine an applicant's eligibility for financial assistance. Eligible applicants will receive the following assistance.

Uninsured Discount*:* Patients with no third-party coverage will be granted a discount on MHS bills equal to that of the amount generally billed.

Full Free Care: The full amount of MHS charges will be determined covered under this financial assistance policy for any uninsured or underinsured patient, or patient guarantor, whose gross family income is at or below 200% of the current federal poverty level and assets are not available to pay the amount due.

Discounted Care: The MHS sliding fee scale will be used to determine the amount eligible for financial assistance for any uninsured or underinsured patient, or patient guarantor, with gross family incomes greater than 200% but at or below 400% of the current federal poverty level after all third party payment possibilities available to the applicant have been exhausted or denied and personal financial resources have been reviewed and assets are not available to pay for billed charges.

Discounts will be provided based on the family income of the patient, or the guarantor, according to the following schedule.

Family income above 200% FPL but equal to or less than 250% FPL are eligible to receive 80% discount on the patient balance due.

Family income above 250% FPL but equal to or less than 300% FPL are eligible to receive 60% discount on the patient balance due.

Family income above 300% FPL but equal to or less than 350% FPL are eligible to receive 40% discount on the patient balance due.

Family income above 350% FPL but equal to or less than 400% FPL are eligible to receive 20% discount on the patient balance due.

NOTE: If the family assets are in excess of 600% FPL, the above discounts will be reduced to 60%, 40%, 20% and 0, respectively.

Medical Hardship: Methodist Health System charges may be eligible for financial assistance for patients or guarantors with family income greater than 400% of the federal poverty level when circumstances indicate severe financial hardship. Patients, or their guarantors, may be eligible for medical hardship assistance if they have incurred out-of-pocket obligations resulting from medical services provided by MHS, as well as other healthcare providers, that exceed 25% of family income and sufficient family assets are not available to meet the obligation.

Patients, or their guarantors, meeting eligibility criteria for medical hardship will have their MHS charges discounted to an amount equal to 25% of family income.

Payment Plans: Payment in full is expected, for balances due, within 30 days of the initial invoice. If unfeasible for a patient or guarantor to pay in full within this timeframe, a payment plan may be extended for up to three months. Arrangements for payment plans must be made with MHS Customer Service or MHS Patient Financial Counselor. If approved, the plan will be interest-free. Payment plans are developed only after Financial Assistance eligibility is determined.

Patients are responsible for communicating with customer service anytime an agreed upon payment plan cannot be fulfilled. Lack of communication from the patient may result in the account being assigned to a collection agency.

VII. EMERGENCY MEDICAL SERVICES:

Methodist Health System will provide individuals requesting emergency care, or those for whom a representative has made a request if the patient is unable, a medical screening examination to determine whether an emergency medical condition exists. Examination and treatment will not be delayed in order to inquire about methods of payment or insurance coverage, or a patient's citizenship or legal status.

Methodist Health System will treat an individual with an emergency medical condition until the condition is resolved or stabilized and the patient is able to provide self-care following discharge, or if unable, can receive needed continual care. Inpatient care will be provided at an equal level for all patients, regardless of ability to pay. No patient with an emergency medical condition will be discharged prior to stabilization if the patient's insurance is canceled or otherwise discontinues payment during course of stay.

If MHS does not have the capability to treat the emergency medical condition, it will make an appropriate transfer of the patient to another hospital with such capability.

VIII. AMOUNTS BILLED TO PATIENTS ELIGIBLE FOR FINANCIAL ASSISTANCE:

Methodist Health System has elected to use the look-back method in determining the amount generally billed (AGB). Under this method the Health System calculates the percentage discount annually on allowed claims for emergency and other medically necessary care provided to patients covered by Medicare and private health insurers including all patient responsibility over a twelve month period. Patients determined eligible for financial assistance will not be expected to pay gross charges for eligible services while covered under MHS financial assistance policy. Questions concerning amount generally billed should be directed to the Methodist Health System Customer Service department at 402-354-4230 or 888-485-4494. Questions can also be directed to www.bestcare.org.\FinancialAssistance.

For more information on the amount generally billed (AGB) percentages, please contact, Methodist Health System, Financial Assistance, 8511 West Dodge Road, PO Box 2797 Omaha, NE 68103-2797.

Example:

Gross Charges incurred from visit to Emergency Department:	$200.00
Amount generally billed (AGB) discount	($100.00)
Net amount due from patient, for patient obligation	$100.00
40% financial assistance discount (income @ 300% of FPL)	($ 40.00)
Due from patient	$ 60.00

IX. APPLYING FOR FINANCIAL ASSISTANCE:

Eligibility determinations for financial assistance will be based on the MHS policy and an assessment of the applicant's financial circumstances and need. Patients will be informed of the financial assistance policy and the process for submitting an application. Applications for financial assistance may be submitted up to 240 days after the date of the first post-discharge statement. Patients, or patient's guarantor, have a responsibility to cooperate in applying for financial assistance by providing information on family size and documentation of income and assets.

Methodist Health System will make reasonable effort to explain the benefits of Medicaid and other available public and private coverage programs to patients, or a patient's guarantors. The MHS will take steps to help patients, or a patient's guarantor, apply for programs that may assist them in obtaining and paying for healthcare services. Patients identified as potentially eligible will be expected to apply for such programs; those patients choosing not to cooperate in applying for programs may be denied financial assistance.

In the case of incomplete applications, the applicant will be notified in writing of all required information or documentation to complete the application. The applicant will be informed that this information must be received within 30 days of the date the notification was postmarked. If the applicant does not respond with the information needed to complete the application within the 30 day timeframe, the request for assistance will be denied.

Information on the MHS financial assistance policy will be communicated to patients in easy-to-understand, culturally appropriate language, and in the primary language spoken by the lessor of 1,000 or 5% of the residents in communities comprising the MHS service area.

Documentation:
Eligibility for financial assistance shall be based on financial need at the time of application. In general, documentation is required to support an application for financial assistance. If adequate documentation is not provided, MHS may seek additional information.

Income Documentation Includes:

1.) Copy of the tax return from the most recent tax year including all schedules, W-2s, and 1099s.

2.) A copy of the most recent pay stub.

3.) If social security income: a copy of check or a copy of bank statement showing the most recent social security deposit.

4.) If unemployed: verification of any compensation received. Example: unemployment compensation, workers compensation

Asset Information: Applicants will also be asked to provide information on monetary assets such as checking accounts, savings or money market accounts, certificates of deposits, non-retirement investment accounts as well as real estate other than the primary residence and other assets.

Certain income documentation requirements may not be required for encounter balances under $2,000.

A financial assistance application form must be completed and documentation provided in order to make an eligibility determination. If an application is incomplete, or there has been a request for additional information, the application will remain active for 30 days from the date the letter was mailed to the applicant requesting this information. If the applicant has not responded within the 30 day timeframe, the application will be denied.

Financial assistance applications are to be submitted to the following office:

Methodist Health System
Financial Assistance
8511 West Dodge Road
P.O. Box 2797
Omaha, NE 68103-2797
402-354-4230 or 888-485-4494

www.bestcare.org/FinancialAssistance

X. QUALIFICATION PERIOD:

Completed requests for financial assistance shall be promptly processed and applicants will be notified within 30 days of receipt of a completed application. If eligibility is approved, MHS will grant financial assistance for a period of six months. Financial assistance shall also be applied to unpaid bills incurred for eligible services that are within 240 days of the first post-discharge statement. No patient shall be denied assistance based on failure to provide information or documentation not required in the application.

If denied financial assistance, the patient or patient's guarantor, may re-apply at any time there has been a change of income or status.

XI. PRESUMPTIVE ELIGIBILITY:

Methodist Health System understands that not all patients are able to complete a financial assistance application or comply with requests for documentation. There may be instances under which a patient's qualification for financial assistance is established without completing the formal financial assistance application. Other information may be utilized by MHS to determine whether a patient's account is uncollectible and this information will be used to determine presumptive eligibility.

Presumptive eligibility may be granted to patients based on their eligibility for other programs or life circumstances such as:

1. homelessness or receipt of care from a homeless clinic or shelter;
2. patient deceased with no known estate;
3. Women, Infants and Children (WIC) program;
4. SNAP benefits (Supplemental Nutritional Assistance Program, (formerly known as Food Stamps) as proof of need, and are therefore presumptively eligible).

For patients who are non-responsive to the MHS application process, information from other sources may be used to make an informed decision on the financial need of non-responsive patients. The purpose of using this information is to make the best estimate available in the absence of information provided directly by the patient.

The MHS utilizes a presumptive eligibility analytics solution that examines historical data combined with household economic information. It evaluates accounts based on the following standards: available household income, household size, capacity to make payment, and over-extension compared to federal poverty guidelines. The analytics solution uses socioeconomic data from numerous sources including Census data. Using this presumptive eligibility approach, a score is assigned at the individual patient level. The score enables Patient Financial Services to meet internal processing requirements while providing a community benefit through forgiving account balances for those in need.

This approach enables MHS to evaluate accounts for financial assistance equally, regardless of the patient's ability to complete an application for assistance.

When the presumptive eligibility solution is the basis for determining eligibility, a full free care discount will be granted for eligible services for retrospective dates of service only. These accounts will not be sent to collection and will not be included in bad debt expense.

In the event a patient does not qualify under the presumptive rule set, the patient may still be considered under the traditional financial assistance application process.

XII. APPEALS AND DISPUTE RESOLUTION:

Applicants denied financial assistance may appeal the determination in writing by providing information on the reason for the appeal and any relevant information. An appeal letter must be received within 30 days of the date of the determination letter.

Disputes and appeals may be filed by contacting:

Methodist Health System
Financial Assistance
8511 West Dodge Road
P.O. Box 2797
Omaha, NE 68103-2797
402-354-4230 or 888-485-4494

www.bestcare.org/FinancialAssistance

The appeal will be reviewed and a written decision provided to the patient within 30 days of receiving a completed, written appeal.

XIII. NOTIFICATION OF FINANCIAL ASSISTANCE:

Information on financial assistance will be available to patients and the community served by MHS. The MHS financial assistance policy, application and a plain language summary of the policy will be available on the system's website.
Financial assistance information will also be provided in the patient admission information package. Information on the MHS financial assistance policy and instructions on how to contact MHS for assistance and further information will be posted in hospital and physician clinic admitting and registration locations, as well as the hospital(s) emergency departments. Financial assistance information will also be included in patient statements.

Information on financial assistance, and the notice posted in hospital and physician clinic locations will be in English, Spanish and in any other language that is the primary language spoken by the lessor of 1,000 or 5% of the residents in the service area.

A request for financial assistance may be made by the patient, a patient's guarantor, a family member, close friend, or associate of the patient, subject to applicable privacy laws. The MHS will respond to oral or written requests for more information on the financial assistance policy made by a patient or any interested party. Any MHS staff member may make a referral of a patient to a financial counselor to examine eligibility for financial assistance.

The MHS will distribute informational materials on the financial assistance policy to agencies and non-profit organizations serving the low-income population in the particular hospital or clinic service area.

XIV. REGULATORY REQUIREMENTS:

Methodist Health System will comply with all federal, state and local laws, rules and regulations and reporting requirements that may apply to activities conducted pursuant to this policy. This policy requires that MHS track financial assistance provided to ensure accurate reporting. Information on financial assistance provided under this policy will be reported annually on the IRS Form 990 Schedule H.

XV. RECORD KEEPING:

Methodist Health System will document all financial assistance in order to maintain proper controls and meet all internal and external compliance requirements.

XVI. POLICY APPROVAL:

This policy was approved by the MHS Audit Committee on August 25, 2015 and the MHS Board of Directors on August 27, 2015. The MHS financial assistance policy is subject to periodic review. Significant changes to the policy must be approved by the MHS Board of Directors (or designated committee).