

Title: Patient Financial Assistance/Charity Care	Page 1 of 15
Policy #: MA1023	
Type: Business Office	
Standard: N/A	

PURPOSE:

The purpose of this policy is to ensure a fair, non-discriminatory, effective, and uniform method for the Provision of Financial Assistance (charity care) to eligible individuals who are unable to pay in full or part for medically necessary emergency and other hospital services provided by Methodist Hospital of Southern California (MHSC). It is the intent of this policy to comply with all federal, state, and local laws. In keeping with its social mission and responsibility to the community, MHSC will assist patients without insurance coverage in obtaining coverage through government means-tested programs such as Medi-Cal, Covered California (Affordable Care Act/ Medi-Cal HMOs) and other programs that may exist from time to time.

POLICY:

MHSC will provide free or discounted hospital services to qualified low income, uninsured and underinsured and patient with high medical costs as who are at or below 400% of the Federal Poverty Level (FPL), when the ability to pay for services is a barrier to accessing medically necessary emergency and other hospital care and no alternative source of coverage has been identified. Patients must meet the eligibility requirements described in this policy to qualify.

MHSC will provide, without discrimination, care for emergency medical conditions (within the meaning of the Emergency Medical Treatment and Labor Act) consistent with available capabilities, regardless of whether an individual is eligible for financial assistance.

MHSC will not discriminate on the basis of age, race, color, creed, ethnicity, religion, national origin, marital status, sex, sexual orientation, gender identity or expression, disability, veteran or military status, or any other basis prohibited by federal, state, or local law when making financial assistance determinations.

MHSC will provide emergency medical screening examinations and stabilizing treatment or refer and transfer an individual if such transfer is appropriate in accordance with 42 C.F.R 482.55. MHSC prohibits any actions, admission practices, or policies that would discourage individuals from seeking emergency medical care, such as permitting debt collection activities that interfere with the provision of emergency medical care.

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Accordingly, this written policy:

1. Includes eligibility reasons for Financial Assistance – Charity Care (free) and Discounted Care (partial Charity Care);
2. Describes how MHSC decides how much patients who qualify for Financial Assistance will pay under this policy;
3. Describes how patients apply for Financial Assistance;
4. Describes how the facility will publicize this policy in the community served; and
5. Describes how the facility limits the amount billed to patients who qualify for Financial Assistance.

Financial Assistance is not to be considered a substitute for personal responsibility and patients are expected to cooperate with the Hospital's procedure for applying for Financial Assistance, and to contribute to the cost of their care based on their individual ability to pay.

1.0 DEFINITIONS

For the purposes of this policy the following definitions and requirements apply:

1.1. Allowable Medical Expenses: All family members' medical expenses that are deductible for federal income tax purposes even if the expenses are more than the medical expense deduction allowed by the IRS. Paid and unpaid bills may be included.

1.2. Allowance for financially qualified patient: with respect to services rendered to a financially qualified patient, an allowance that is applied after the hospital's charges are imposed on the patient, due to the patient's determined financial inability to pay the charges.

1.3. Amounts Generally Billed (AGB): The amounts generally billed for emergency and other medically necessary care to patients who have health insurance is referred to in the policy as AGB. MHSC uses the look-back AGB which is determined by multiplying the hospital's gross charges for any emergency or medically necessary care by a fixed percentage which is based on claims allowed under Medicare. See Appendix A for information detailing the AGB percentages used by MHSC and how they are calculated.

1.4. Application Period: The period during which MHSC must accept and process an application for financial assistance under its FAP submitted by an individual in order to have made reasonable efforts to determine whether the individual is eligible for financial assistance under the policy. The Application Period begins on the date that the first post-discharge billing statement for the care is provided and ends after 240 days.

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1.5. **Billed Charges:** Charges for services by MHSC as published in the Charge Description Master (CDM) and available at <http://www.methodisthospital.org> website under Patient Resources.

1.6. **Charity Care:** Free or Discounted Care provided when the patient is not expected to pay a bill or is expected to pay only a small amount of the Billed Charges. Charity Care is based on financial need.

1.7. **Discounted Care:** A deduction from the price of services, tests, or procedures that is given for cash, prompt, or advanced payment, or to certain categories of patients, e.g. self-pay patient or uninsured patient. A discount is usually described as a percentage of gross charges.

1.8. **Extraordinary Collection Action (ECA):** defined as those actions requiring a legal or judicial process, involve selling a debt to another party or reporting adverse information to credit agencies or bureaus. The actions that require legal or judicial process for this purpose include a lien; foreclosure on real property; attachment or seizure of a bank account or other personal property; commencement of a civil action against an individual; actions that cause an individual's arrest; actions that cause an individual to be subject to body attachment; and wage garnishment.

1.9. **Essential Living Expenses:** expenses for any of the following: rent or house payment and maintenance, food and household supplies, utilities and telephone, clothing, medical and dental payments, insurance, school or child care, child or spousal support, transportation and auto expenses, including insurance, gas, and repairs, installment payments, laundry and cleaning, and other extraordinary expenses

1.10. **FAP:** The Financial Assistance Policy of Methodist Hospital of Southern California

1.11. **Federal Poverty Level (FPL):** the poverty guidelines 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.

1.12. **Financially qualified patient:** a patient who is both of the following: (1) A patient who is a Self-Pay Patient, or a patient with High Medical Costs; and (2) A patient who has a family income that does not exceed 400% of the federal poverty level.

1.13. **High Medical Costs:** defined by the Hospital Fair Pricing Policies – California Health and Safety Code (Sections 127400-127446), being: (1) Not Self-Pay (has third party coverage); (2) Patient's Family income at or below

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400% of the Federal Poverty Level (FPL); (3) annual out-of-pocket medical costs (whether incurred in or out of any hospital) incurred by all Patient's Family that exceed 10% of the Patient's Family income in the prior 12 months.

1.14. Household income: Income of all Patient's Family who live in the same household as the patient, or at the home address the patient uses on tax returns, or on other government documents.

1.15. Means-Tested: the method by which external data sources or information provided by the patient are used to determine eligibility for a public coverage program or MFA based on whether the individual's income is greater than a specified percentage of the Federal Poverty Guidelines.

1.16. Medically Necessary Service: A service or treatment that is absolutely necessary to treat or diagnose a patient and could materially adversely affect the patient's condition, illness or injury if it were omitted, and is not considered an elective or cosmetic surgery or treatment.

1.17. Patient's Family: For patients 18 years of age and older, Patient's Family is defined as their spouse, domestic partner, as defined in Section 297 of the Family Code, and dependent children under 21 years of age, whether living at home or not. For persons under 18 years of age, Patient's Family means a parent, caretaker relatives, and other children under 21 years of age of the parent or caretaker relative.

1.18. Qualifying Assets: Monetary assets that are counted toward the patient's income when deciding if the patient meets income eligibility for the financial assistance. Qualifying assets include: (1) Fifty percent of the patient's monetary assets above \$10,000, including cash, stocks, bonds, savings accounts, or other bank accounts; (2) Certain real property or tangible assets, i.e., additional residences in excess of a single primary residence, recreational vehicles, etc.; and (3) Assets not included when deciding a patient's income include: IRS qualified retirement plans, such as IRAs, 401(k) or 403(b) retirement accounts, or deferred compensation plans, primary residents, and primary automobile.

1.19. Reasonable payment plan: Monthly payments that are not more than 10% of a Patient's Family income for a month, excluding deductions for Essential Living Expenses. If after a payment plan is established and there is a period of 90 days of no payment, the payment plan will be deemed to be no longer operative.

1.20. Self-Pay Patient: A financially eligible Self-Pay patient is defined as follows: (1) No third party coverage; (2) No Medi-Cal/Medicaid coverage or patients who qualify but who do not receive coverage for all services or for the entire stay; (3) No compensable injury for purposes of government programs, workers' compensation, automobile insurance, other insurance, or third party

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liability as determined and documented by the hospital; and (4) Patient's Family income is at or below 400% of the FPL.

2.0 COVERED ENTITIES

- 2.1 Only the Hospital, which includes all services and areas listed on our license from the state of California including but not limited to inpatient and outpatient services, Colorectal Clinic and Gynecologic Oncology Clinic is covered under this financial assistance policy. Any ancillary physician billing that may be generated during a patient's stay, i.e. pathology, radiology, anesthesia services are not covered under this policy.
- 2.2 Emergency Room physicians as defined in Section 127450, who provides emergency medical services at MHSC are not covered under this financial assistance policy but have their own financial assistance policy per Health and Safety Code Sections 127450-127462. See appendix B for a list of providers that provide emergency and medically necessary services at Hospital.

3.0 COMMUNICATION OF FINANCIAL ASSISTANCE

- 3.1 MHSC gives patient's information about Financial Assistance in different ways, including , but not limited to:
 - a. Placing notices in Emergency Room, and all Registration offices;
 - b. Placing information in the MHSC Health Conditions of Registration Form;
 - c. Printing information in our Post-Discharge Billing Statement, including information in standard language about how patients can obtain more information about financial assistance;
 - d. Providing a written copy at time of registration;
 - e. Posting a plain language summary of the FAP on MHSC website;
- 3.2 Written notice about the hospital's discount payment and charity care policy includes: (1) contact information for an office from which the person may obtain further information about the policy; (2) the internet address for the Health Consumer Alliance (<https://healthconsumer.org>); (3) explanation that there are organizations that will help the patient understand the billing and payment process; and (4) information regarding Covered California and Medi-Cal presumptive eligibility.
- 3.3 All patients will be informed of the hospital's financial assistance program at the time of admission or registration and will be offered a copy of the plain language version of the policy as well as an application for

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assistance.

- 3.4 The hospital will provide the financial assistance policy and application translated into the language spoken by the patient consistent with section 12693.30 of the Insurance Code and Health and Safety Code Section 127410(a).
 - 3.5 All printed statements of accounts to the patient will include a summary of the financial assistance policy with contact information on how to obtain an application for assistance and the copy of the complete policy. A summary of the FAP, the application for assistance with instructions will be sent out with the first two statements of account to the guarantor.
 - 3.6 Individuals can get information about the FAP, a copy of our Plain Language Summary and an application in different languages, free of charge, by:
 - a. Going to the registration area;
 - b. Speaking with a MHSC admitting representative;
 - c. going to our website: [https:// www.methodisthospital.org/patient resources](https://www.methodisthospital.org/patient-resources);
 - d. Calling MHSC at 626-574-3594;
 - e. Writing to MHSC address: Methodist Hospital of Southern California, ATTN: Patient Financial Services, 300 W Huntington Dr., Arcadia, CA 91007.
 - 3.7 All patients without insurance coverage will be counseled as to the financial options for paying their medical care upon registration, or as soon after presentation to the hospital as allowed under EMTALA.
 - 3.8 MHSC will include charity care services to patients for which MHSC is unable to assess the patient's financial condition prior to rendering services as required by the Emergency Medical Treatment & Active Labor Act (EMTALA).
- 4.0 **ELIGIBILITY FOR FINANCIAL ASSISTANCE:**
- 4.1 Eligibility for financial assistance will be looked at for patients who are uninsured, or underinsured with High Medical Costs and are unable to pay for their care. The Facility applies financial assistance according to this policy. Decisions made under this policy, including granting or denying financial assistance, is based on a patient's financial need. The following will not be considered: race; color; national origin; citizenship; religion; creed; ender; sexual preference; gender identity and expression; age; or disability.

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- 4.2 Medicaid Share of Cost (SOC) amounts are not eligible for financial assistance. The SOC amounts are set by the State. States require patients to pay the SOC as a condition of receiving Medicaid/Medi-Cal coverage
- 4.3 A patient may qualify for Financial Assistance under this policy, if they meet one of the following criteria:
 - a. Income: Household income is at, or below, 400% of the FPL;
 - b. Expenses: Patients that do not meet the income criteria, may be eligible for financial assistance based on essential living expenses and resources. The following two qualifications must both apply:
 1. Essential Living Expenses: 50% of the Household Income; and
 2. Resources: The patient's excess medical expenses must be greater than available Qualifying Assets.
- 4.4 Patients who are eligible for FPL-qualified programs such as Medicaid, Medi-Cal, and other government-sponsored low-income assistance programs, are deemed to be indigent. Therefore, such patients are eligible for Financial Assistance when the programs deny payment and then deem the charges billable to the patient. Patient account balances resulting from non-reimbursed charges are eligible for full charity write-off. Including but not limited to medically necessary services related to the following:
 - a. Denied inpatient stays;
 - b. Denied inpatient days of care;
 - c. Non-covered services;
 - d. Treatment Authorization Request (TAR) denials;
 - e. Denials due to restricted coverage;
- 4.5 General Relief patients are considered financial assistance eligible patients as they usually do not qualify for Medi-Cal because they are normally single, have no children, are unemployed and homeless.
- 4.6 Victims of Crime (VOC): Patients who are a victim of a crime could be eligible for State of California funding from the VOC program. The patient can apply at the District Attorney's office at the courthouse in Pasadena. The patient will not qualify if:
 - a. There is insurance involved;
 - b. He/she initiated the crime;
 - c. He/she expires
- 4.7 Employment status will be considered along with the projected availability of future earnings sufficient to meet the obligation within a reasonable period of time.

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- 4.8 Family or household size will be considered. See definition of Patient's Family in Section 1.17.
- 4.9 Other financial obligations, including living expenses and other items of a reasonable and necessary nature will be analyzed.

5.0 FINANCIAL ASSISTANCE LEVEL

Basis for calculating amounts charged to patients

- 5.1 Charity Care and Discounted Care: Discounts are based on combined Household Income and Qualifying Assets. Documentation of Household income and Qualifying Assets include recent pay stubs, income tax returns, and other documents.
- 5.2 FAP-eligible individuals may not be charged more than the AGB for emergency or other medically necessary care. MHSC does not bill or expect payment of gross charges from individuals who qualify for financial assistance under this policy. The specific AGB methodology used to calculate the AGB percentage, as well as the current AGB percentage is set forth in Appendix A.
- 5.3 Patients without third party coverage or High Medical Cost patients with third party coverage and with Patient's Family income at or below 200% of the FPL will be extended a 100% charity care discount on Medically Necessary services rendered.
- 5.4 Patients without third party coverage or High Medical Cost patients with third party coverage whose Patient's Family incomes are between 201% and 400% of the FPL will be extended a partial charity care discount on Medically Necessary services rendered.
- 5.5 The partial charity care discount amount is based on a sliding scale of the federal poverty guidelines. See Appendix A for more details regarding the current federal poverty guidelines specific to MHSC.
- 5.6 The remaining balance, for patients qualifying for partial financial assistance, may be paid in interest-free installments as mutually agreed upon between the patient and Methodist Hospital. If a payment plan cannot be agreed upon mutually, the "Reasonable Payment Plan" as defined will be applied. Payment will not be considered delinquent, nor will further collection activity occur, as long as any payments made pursuant to a payment plan are not more than 90 days delinquent under the terms of that plan. If an outside collection agency is utilized to collect the unpaid debt, the agency agrees to abide by the requirements of this policy and will not garnish wages or place a lien on a principal residence

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6.0 ITEMIZED BILLS

- 6.1 The final bill will be produced within ten days after discharge. The Business Office will automatically send the itemized bill. If a bill is not received, one can be obtained by calling the Business Office Customer Service at (626) 574-3594.
- 6.2 If the patient wishes to request an itemized bill while still a patient in the hospital, they may do so by calling (626) 574-3594 or by asking a financial counselor. The patient should keep in mind that an itemized bill requested during their stay will be incomplete and only list charges that have been put in the system through midnight of the previous day.

7.0 APPLYING FOR FINANCIAL ASSISTANCE

- 7.1 Patients or guarantors may request and submit a Financial Assistance Application, which is free of charge and available by the following means: (1) advising patient financial services staff at or prior to the time of discharge that assistance is requested and submitted with completed documentation; (2) by mail; or (3) by visiting [http://www.methodisthospital.org/for patients, visitors & vendors](http://www.methodisthospital.org/for-patients-visitors-vendors), and downloading and submitting the completed application with documentation.
- 7.2 A person applying for financial assistance will be given a preliminary screening, which will include a review of whether the patient has exhausted or is not eligible for any third-party payment sources.
- 7.3 MHSC shall make designated personnel available to assist patients in completing the Financial Assistance Application and determining eligibility for MHSC financial assistance or financial assistance from government-funded insurance programs, if applicable.
- 7.4 Interpretation services are available to address any questions or concerns and to assist in the completion of the Financial Assistance Application.
- 7.5 A patient or guarantor who may be eligible to apply for financial assistance may provide sufficient documentation to MHSC to support eligibility determination at any time upon learning that a party's income falls below

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minimum FPL per the relevant Federal and State regulations.

7.6 The financial assistance application with instructions is located in Appendix C of this policy.

7.6.1 hand deliver or mail the forms, letter, and supporting documents to:
Methodist Hospital of Southern California
Attn: Business Office - Financial Assistance Program,
Customer Service
300 West Huntington Drive
P.O. Box 60016
Arcadia, CA 91066

7.6.2 For questions regarding the Financial Assistance Application, please call: (626) 574-3594 from 8:00am-4:30pm Monday - Friday.

7.6.3 Assistance completing the application, obtaining copies of this policy, or answering any related financial assistance questions can be obtained by calling (626) 574-3594 from 8:00am-4:30pm Monday - Friday.

a. If the electronic copies are not a viable option, this Charity Policy, Charity application form, Billing and Collection Policy and Plain Language Summary (PLS) of the Financial Assistance Program are available upon request and without charge both by mail and in public locations within the hospital facility, including, at a minimum, in the emergency room and admission areas.

7.6.4 The approved application and any discounts can be applied to any subsequent hospital visits in the same calendar year the application was first approved, pending it is within the valid for six months beginning on the first day of the month of the screening.

7.6.5 The application and accompanying documents must be returned to business office within 15 days. If an additional time is needed to complete the application please call the business office.

7.6.6 Copies of all the financial assistance policies and the application can be found on the Hospital's website at <https://www.methodisthospital.org/For-Patients-Visitors/Financial-Assistance-for-Patients.aspx>

7.6.7 This policy is also available translated into the following written languages: Spanish; and Mandarin.

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8.0 FINANCIAL ASSISTANCE APPLICATION REVIEW & APPROVAL PROCESS

- 8.1 Requirements above will be reviewed and consistently applied in making a determination on each patient case.
- 8.2 Information collected in the Patient Financial Information Form will be verified by MHSC. A waiver or release will be required authorizing the hospital to obtain account information from a financial or commercial institution or other entity that holds or maintains the monetary assets to verify their value. The patient's signature on the Patient Financial Information Form will certify that the information contained in the form is accurate and complete.
- 8.3 Information obtained pursuant to the Patient Financial Information Form shall not be used for collections activities. This does not prohibit the use of information obtained by the hospital, collection agency, or assignee independently of the eligibility process for charity care or discounted payment.
- 8.4 Any patient, or patient's legal representative, who requests a charity care discount under this policy shall make every reasonable effort to provide MHSC with documentation of income and all health benefits coverage. Failure to provide information would result in denial of charity care discount.
- 8.5 Eligibility will be determined based on Patient's Family income including monetary assets as outlined in AB 774 (Health & Safety Code Section 127400 et seq.).
- 8.6 Financial Assistance Applications will be reviewed and approved, denied or returned to the patient with a request for additional information within thirty (30) business days of receipt.
- 8.7 Collection agency requests for financial assistance or Financial Assistance Applications received from a collections agency shall be reviewed by a MHSC Financial Counselor. The counselor shall follow the review process described above in determining ability to pay and approving partial, total or no financial assistance. Standard transaction approval levels will apply,

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regardless of the application source.

- 8.8 An approved financial assistance determination is applicable to all services referenced in the application AND services provided up to the end of the calendar year within which the services were rendered, provided there is no change in the applications financial status that would warrant a reevaluation or the services were within the valid six month period beginning on the first day of the month of the screening, of the calendar year.
- 8.9 If financial assistance is approved at 100%, any patient deposits paid toward accounts approved for financial assistance must be refunded to the account guarantor. This does NOT apply to any third-party payments, including casualty insurance payments or settlements paid from attorney trust accounts. Those payments will be retained and financial assistance will be granted for the difference between gross charges and the sum of those excluded payments. Refunds under this provision will include interest at the rate prescribed in Section 685.010 of the Code of Civil Procedure. In the event the refund is \$5 or less, no monies will be refunded.
- 8.10 Patients requesting charity care, discounted care or other financial assistance must make every reasonable effort to provide MHSC with required documentation of insurance coverage and of financial status. Failure to provide information that is reasonable and necessary may be considered by the hospital in making its determination. Additionally, patients who are eligible for coverage through government insurance or programs that provide financial assistance to pay for coverage under the ACA but refuse to obtain such coverage may be excluded from MHSC's charity program.
- 8.11 For a patient deemed to be ineligible for charity care, MHSC provides a discount from charges to patients without insurance coverage (See Cash Discount Policy MA 1035). Insured patients with a co-pay and/or deductible are not eligible for a further cash discount, per contractual obligations, as the insurer has already negotiated a discounted rate with MHSC. However, financial assistance is available in accordance with this document and/or payment plans may be available.

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- 8.12 Patients will be notified in writing regarding MHSC's decision to approve or, deny charity care coverage or if there is a need for additional documentation to make a decision.
- 8.13 In cases where the patient is non-responsive and/or other sources of information are readily available to perform an individual assessment of financial need, i.e., existing eligibility for Medicaid this source of information can be used to support and/or validate the decision for qualifying a patient for full financial assistance.
- 8.14 Unless a patient is informed otherwise, Financial Assistance provided under this Policy shall be valid for six months beginning on the first day of the month of the screening. However, Hospital reserves the right to re-evaluate a patient's eligibility for Financial Assistance during that six-month time period if there is any change in the patient's financial status. Additionally, financial assistance provided to non-responsive patients based on other sources of information will not be valid for the full year, and will only be applicable for the eligible retroactive dates of service.
- 8.15 In instances where MHSC determines that only a portion of a patient's financial liability qualifies as charity care due after applying all other resources, the patient is expected pay the remaining portion. If the patient refuses to pay the amount determined to be his/her responsibility, the uncollectible remainder would become bad debt.
- 8.16 In the event of non-payment of a discounted amount due under this financial assistance policy the hospital may engage in further collection activity. The details of the further collection actions can be found in the Billing and Collection policy

9.0 DISPUTE RESOLUTION

- 9.1 The patient may appeal a determination of ineligibility for financial assistance by providing relevant additional documentation to MHSC within 30 days of receipt of the notice of denial. All appeals will be reviewed and if the review affirms the denial, written notification will be sent to the guarantor and State Department of Health, where required, and in accordance with the law. The final appeal process will conclude within 10 days of receipt of the denial by MHSC. An appeal may be sent to Methodist Hospital of Southern California, ATTN: Patient Financial Services, 300 W Huntington Dr., Arcadia, CA 91007.

10.0 CHARITY CARE WRITE-OFFS can include:

- 10.1 All amounts written off for self-Pay uninsured discounts.
- 10.2 Patients who qualify for Medi-Cal but do not receive payments that equal the full costs of service or do not receive approval for coverage for the entire stay are eligible for charity care write-off. These include charges for non-covered costs and non-covered services.
- 10.3 Medicare patients who have Medi-Cal coverage for their co-insurance/deductibles, for which Medi-Cal does not make a payment.
- 10.4 Insured patients that have an insurance carrier that is not contracted with the Hospital are eligible for Charity Care.
- 10.5 Patients with special circumstances under which the patient may be deemed eligible for Charity Care without submission of a financial assistance application:
 - a. Patient is deceased and without third-party insurance coverage or identifiable estate and without a living spouse
 - b. Patient is homeless and is not currently enrolled in Medicare, Medi-Cal or any government sponsored program and is without third-party insurance; or
 - c. Seen in ER (unable to pay) patient is treated in the Emergency Department but the Hospital is unable to issue a billing statement.

11. CASH DISCOUNT POLICY FOR UNINSURED PATIENTS

- 11.1 Discounted cash rates for all its uninsured patients
 - a. Outpatient services: MHSC will automatically extend a discount to all of its uninsured patients of 65% of total charges with the following exceptions:
 - Cosmetic Surgery – Fee schedule rates
 - Gastric Bypass Surgery – Gastric case rates
 - Emergency Department visits – Flat rates. See table below

ED Left Without Treatment	\$75.00 + 35% ancillary charges NLE \$2500
Level One	\$120.00 + 35% ancillary charges NLE \$2500
Level Two	\$175.00 + 35% ancillary charges NLE \$2500
Level Three	\$300.00 + 35% ancillary charges NLE \$2500
Level Four	\$450.00 + 35% ancillary charges NLE \$2500
Level Five	\$800.00 + 35% ancillary charges NLE \$2500
Level Six (Critical Care)	\$5949 - All inclusive

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- b.** Inpatient services: MHSC will automatically extend a discount to all of its uninsured patients with the following exceptions:

Cosmetic Surgery – Fee schedule rates
Gastric Bypass Surgery – Gastric case rates

SOURCES

Internal Revenue Code Section 501(r); 26 C.F.R. 1.501(r)(1) – 1.501(r)(7)
California Health and Safety Codes section 127000 -127446
Emergency Medical Treatment and Labor Act (EMTALA), 42 U.S.C. 1395dd42
C.F.R. 482.55 and 413.89

Attachments: [Office Use Form](#), [Appendix A-AGB and FPL88](#), [Appendix B-List of Providers](#), [Appendix C-Financial Assistance Application](#)

Approvals:

Board of Directors: 11/17, 4/18, 6/22
CFO: 11/17, 3/18, 6/22
Chief Financial Officer: 11/17, 8/14, 6/22
Director of Patient Financial Services: 8/14
Executive Dir Finance: 11/17, 3/18, 6/22
Governing Policy and Procedure Committee: 8/14, 11/17, 3/18, 5/22
MAPPS: 5/90, 7/97, 12/02, 2/06, 1/07, 1/08, 6/11, 6/11

Effective Date: 5/90

Reviewed Dates: 5/90, 7/97, 12/02, 2/06, 1/07, 1/08, 6/11, 6/11, 8/14, 11/17, 4/18

Revised Dates: 7/97, 12/02, 2/06, 1/07, 1/08, 6/11, 6/11, 8/14, 11/17, 6/22

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APPENDIX A

CALCULATION OF AMOUNT GENERALLY OWED BY INDIVIDUALS ELIGIBLE FOR FINANCIAL ASSISTANCE

Methodist Hospital of Southern California (MHSC) limits the amount owed by individuals eligible under this Financial Assistance Policy who received services except for cosmetic and elective procedures to an Amount Generally Billed (AGB) to patients covered by Medicare. In addition, the hospital also limits the eligible patient’s financial responsibility to less than total charges. The hospital shall periodically, at least once a year, update the AGB calculation and re-evaluate the method used. The AGB shall be based on all services provided to Medicare patients fully adjudicated as of the end of a recent 12-month look back period ending no more than 120 days prior to the effective date of the policy or every January 1st thereafter. The calculation of the current AGB is as follows:

1.0 Total Medicare Expected Reimbursement / Total Medicare Gross Charges = AGB Percentage
(AGB is 16% effective January 1, 2022)

2.0 The eligible individual’s financial responsibility is calculated as follows and applied to the patient liability only (excluding any portion assumed or paid by insurance or other entities on behalf of the patient):

2.1 Total Gross Charges for the Services Rendered * AGB % = Patient Financial Responsibility

3.0 Below is the FAP Eligibility Percentage and the latest published Federal Poverty Level (FPL) Guideline:

Annual Income is	FAP Eligibility %
Below 200% of FPL	100% or FREE
200% to 267% of FPL	75%
268% to 335% of FPL	50%
336% to 400% of FPL	25%
Greater than 400% of FPL	0%

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Federal Poverty Guideline 2022					
Percent Discount		100%	75%	50%	25%
Household/ Family Size	100%	200%	267%	335%	400%
	1	\$ 13,590	\$ 27,180	\$ 36,285	\$ 45,527
2	\$ 18,310	\$ 36,620	\$ 48,888	\$ 61,339	\$ 73,240
3	\$ 23,030	\$ 46,060	\$ 61,490	\$ 77,151	\$ 92,120
4	\$ 27,750	\$ 55,500	\$ 74,093	\$ 92,963	\$ 111,000
5	\$ 32,470	\$ 64,940	\$ 86,695	\$ 108,775	\$ 129,880
6	\$ 37,190	\$ 74,380	\$ 99,297	\$ 124,587	\$ 148,760
7	\$ 41,910	\$ 83,820	\$ 111,900	\$ 140,399	\$ 167,640
8	\$ 46,630	\$ 93,260	\$ 124,502	\$ 156,211	\$ 186,520

For Households/families with more than 8 persons, add \$4,720 for each additional person.

Note: The 2022 Federal Poverty Guideline is effective as of January 12, 2022

APPENDIX B

Hospital Emergency & Other Providers

- 1.0 Emergency Room physicians are not covered under this financial assistance policy but have their own financial assistance policy per Health and Safety Code Sections 127450-127462.
- 2.0 The following providers may be utilized in providing emergency or medically necessary care, but these are NOT covered by the hospital's financial assistance policy. This list is not all inclusive. Only services provided by Hospital, excluding any professional services, are covered by the financial assistance policy.

Anesthesiology

Pacific Valley Medical Group
ABC Billing Solutions
8905 SW Nimbus Ave, Suite 300
Beaverton, OR 97008
503 372-2740

Pathology – Professional Fees

Medical Billing Management, Inc.
2320 Cotner Ave
Los Angeles, CA 90064
310 696 -5400

Emergency Physicians

Emergency Group Office
180 Via Verde, Suite 100
San Dimas, CA 91773
626 821 5702

Radiology – Interpretation Fees

California Medical Business Services
223 N. First Avenue, Suite 201
Arcadia, CA 91006
626 821-1411

- 3.0 In accordance with the state regulations the following specialties of physicians have medical staff privileges at MHSC however, the physician-patient relationship is affiliated with the independent physician practice. These groups may offer financial assistance programs but are NOT covered by this policy. It is the patient's responsibility to contact the physician and or group to inquire about any financial assistance programs offered.
- 4.0 Physician Specialties NOT included in the policy:

Physician Specialties Types		
-----------------------------	--	--

Allergies	Hospitalist	Pathology
Anesthesiology	Infectious Disease	Pediatrics
Cardiology	Internal Medicine	Perinatology
Clinician	Med Neurology	Plastic Surgery
Colon/Rectal Surgery	Neonatology	Podiatry
Dermatology	Nephrology	Psychiatry
Emergency Medicine	Neurosurgery	Pulmonology

Endocrinology	Ob/Gyn	Radiology
Family Practice	Ophthalmology	Rheumatology
Gastroenterology	Oral Surgery	Thoracic Surgery
General Hospital Sta	Orthopedics	Urology
General Surgery	Other	Vascular Surgery
Gynecology	Otolaryngology	Vascular Surgery
Hematology/Oncology	Palliative Care	

- 5.0 As a normal act of the Hospital business, the physician specialties will be added or removed accordingly. As such the above listing is a reasonable representative sample of the physician / surgeons on staff that may vary at times.
- 6.0 In addition, MHSC owns and operates two clinics; these are the MHSC Colorectal Clinic and the MHSC Obstetrics/Gynecology Clinic. MHSC will bill for services provided at these clinics and ARE included in this financial assistance program. However, the physicians seeing the patient at these clinics are entitled to bill for their professional fees of which are NOT included under this financial assistance program. As such, this physician will bill for these professional fees under a separate billing and may have a separate financial assistance program for which the patient may inquire.



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APPENDIX C

FINANCIAL ASSISTANCE PROGRAM APPLICATION

The following is the Financial Assistance Program Application. This application, policy and other related information are also available translated into the following written languages: Mandarin (Standard Chinese); and Spanish.

Methodist Hospital of Southern California (MHSC) offers Financial Assistance to aid those that may qualify to reduce or eliminate their cost of care obligation. Attached you will find an application to enable an evaluation of your financial hardship. You must complete the application in order to be considered for the financial assistance program and you must apply within six months of when you received the services you are applying for.

Applying for the Financial Assistance Program

You must meet the following criteria to be eligible for the Financial Assistance Program:

Types of Care: You must be receiving medically necessary services.

Other Payer Sources: We recommend that you apply for any private or public sector sources of medical financial assistance for which you re eligible, such as Medi-Cal or Healthy Families. You may be required to submit documentation of your application (or of the approval or denial of your application) to those sources. For services received which are the result of an accident you must show proof that there was no settlement before financial assistance can be considered.

Income: Your household income must be at or below 400 percent of the Federal Poverty Guidelines (FPG). If your financial situation meets the eligibility criteria set forth by the MHSC’s Financial Assistance Program, you may be eligible for full or partial forgiveness of debt.

Federal Poverty Guideline 2022					
Percent Discount	100%	75%	50%	25%	
Household/ Family Size	100%	200%	267%	335%	400%
1	\$ 13,590	\$ 27,180	\$ 36,285	\$ 45,527	\$ 54,360
2	\$ 18,310	\$ 36,620	\$ 48,888	\$ 61,339	\$ 73,240
3	\$ 23,030	\$ 46,060	\$ 61,490	\$ 77,151	\$ 92,120
4	\$ 27,750	\$ 55,500	\$ 74,093	\$ 92,963	\$ 111,000
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6	\$ 37,190	\$ 74,380	\$ 99,297	\$ 124,587	\$ 148,760
7	\$ 41,910	\$ 83,820	\$ 111,900	\$ 140,399	\$ 167,640
8	\$ 46,630	\$ 93,260	\$ 124,502	\$ 156,211	\$ 186,520



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Special Circumstances: If you have unusually high medical costs or you've experienced a catastrophic event, you may be eligible for the Financial Assistance Program under special circumstances, regardless of whether you meet the household income requirements described above. To qualify, you'll need to provide income documentation and copies of your out-of-pocket medical expenses for the past 12 months indicating that these expenses equal 10 percent or more of your annual gross income. Please note: Not all medical expenses qualify for financial assistance. Exclusions include, but are not limited to, expenses for premiums and dues, optical and hearing aids, medical supplies, health education classes, transportation, over-the-counter drugs and lifestyle medications (fertility, cosmetic, etc.).

Documentation required: In order to process this application we require the following documents:

- The enclosed application completed in its entirety.
- You must sign and date the financial assistance application. If the patient/guarantor and/or spouse provide information, both must sign the application.
- Copy of your most recent cancelled rent check, lease agreement or mortgage payment.
- Copy of the last two pay stubs for any wage earned contributing to the household income.
- Copy of your two most current bank statements (checking/savings).
- Copy of your disability, social security payment statement, unemployment notice of eligible benefits and bank statement reflecting deposits.
- If you do not have a source of income or proof of income documents, please provide a letter explaining how you support yourself and your family. This is a written and signed statement from a family member or friend who is providing your room and board and/or income.
- Copy of your most recent tax return, including all applicable schedules and attachments submitted to the Internal Revenue Service. If your most recent tax return is not available, then we will need one of the following:
 - Social Security Awards Letter.
 - Proof of non-filing from the IRS (call 800-829-1040 to obtain a copy).
 - If you have not filed a current federal tax return and have requested an extension for taxes, please include the previous year's tax returns.

Be sure to send only photocopies as originals will not be returned to you. You'll have an opportunity to appeal the decision if your application is denied. Corrected and/or additional documentation will be required to support your appeal request. Upon finalization of your application, notification of your determination will be mailed to the address on file.

Please send your Financial Assistance Application and required documents:

- Mail: Methodist Hospital of Southern California Attention: Business Office – Financial Assistance Program, 300 West Huntington Drive, Arcadia, CA 91066-6016
- Secure Fax: 626-821-6917
- Email: Carol.Mcclary@methodisthospital.org

If you have any questions, please contact the Customer Service Representative at 626-574-3594. Once we have reviewed your application, we will notify you of our decision in writing as soon as possible. Our business hours are Monday – Friday, 8:00 am to 5:00 pm PST



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FINANCIAL ASSISTANCE APPLICATION

Patient Name: _____ Account # _____

Patient Guarantor (Responsible Party Information)

Name: _____ Relationship to Patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Marital Status: **M** (Married), **S** (Single), **D** (Divorced), **W** (Widowed): _____

	Self	Spouse
Social Security #		
Date of Birth		
Employed By		
Employer Address		
Occupation		

Please list ALL persons living in your household: including dependents (attach additional sheet if needed):

	Last Name	First Name	MI	Date of Birth	Relationship to Applicant
1.					
2.					
3.					
4.					
5.					

Please list all sources of annual income:

	Self	Spouse
Gross Income		
Social Security/SSI/SSDI		
Pension Income		
Public Assistance		
Rental Property Income		
Self Employed Income		
Unemployment Support		
Workers Compensation Payments		
Child Support		
Other		
Total		



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Please list all assets (market value of items you or your spouse own)

Checking Accounts	\$	Home Value	\$
Savings Accounts	\$	Other Real Estate Value	\$
Trust Accounts	\$	Business Owned	\$
Investment Accounts	\$	Franchise	\$
Other accounts	\$	Other Major Assets	\$

Medical Expenses

If your household income exceeds 400percent of the Federal Poverty Guidelines (FPG) or if you are applying for special circumstances, you must complete this section.

Please provide copies of receipts and/or itemized invoices for out-of-pocket medical expenses due or paid in the last 12 months

	Patient Responsibility after Insurance Payment		Patient Responsibility after Insurance Payment
Hospital Visits	\$	Other Expenses (Describe)	\$
Doctor Visits	\$		\$
Prescribed medications	\$		\$
Skilled Nursing Care	\$		\$

Medi-Cal Screening

Have you applied for Medi-Cal or other governmental Assistance? (yes or no) _____

If the answer to the above question is yes, please provide the approval, denial or pending letter from Medi-Cal or other governmental agency.

Financial Agreement and credit report authorization

I hereby declare under penalty of perjury that all information set forth above in this application is true and accurate in all respects, and that all attachments are accurate copies of the original documents. I authorize employees and agents of Methodist Hospital of Southern California (MHSC) to investigate and verify that the information I have provided to it, including employment and credit history for the purpose of determining my eligibility to participate in the Financial Assistance Program. I also acknowledge and agree that I am liable to MHSC for any and all amounts owing to MHSC for medical goods and services that are not covered by the Financial Assistance Program (the remaining amounts).

Signature of Applicant/Guardian _____ Date: _____

Signature of Spouse of Applicant: _____ Date: _____