POLICY

Category:	Children's Health System of Texas Administrative Departmental and Corporate Services Financial Services and Revenue Integrity Accounting, Finance and Tax	Origination Date:	05/01/1990
Title:	PS 2.17 Patient Financial Assistance	Effective Date:	07/21/2023
Approver(s):	CHST Board of Directors		
Author(s):	James Nicholson (Sr Dir Patient Access Services), John Buerkert (VP Assoc. General Counsel)	Page	**1** of **14**

I. Policy

Children's Health System of Texas ("Children's Health") and Children's Health Providers (as defined in Section III) are committed to providing access to quality health care for the communities they serve, including patients and their families in difficult financial circumstances. Children's Health and Children's Health Providers offer Financial Assistance (as defined in Section III) in the form of free and discounted Emergency Medical Care (as defined in Section III) and Medically Necessary Care (as defined in Section III) in certain cases in which patients and their families are unable to pay due to their financial circumstances.

II. Purpose

This Policy serves to establish and ensure a fair and consistent method for uninsured and underinsured patients and their families to apply and be considered for Financial Assistance for Emergency Medical Care and other Medically Necessary Care. Please note that not all medical services provided by Children's Health Providers qualify for Financial Assistance under this Policy. In general, Financial Assistance involves free or discounted care based on household income and assets that are required to be disclosed in the application process if an application is required. As explained further in Section V, Financial Assistance is based on a discount off the Gross Charges (as defined in Section III) for Emergency Medical Care and Medically Necessary Care with a minimum discount of 70% for those determined to be eligible for Financial Assistance under this Policy.

III. Definitions

AGB: Amount generally billed as more fully described in Section V.A. below.

Application Period: Begins on the date Emergency Medical Care or Medically Necessary Care is provided and ends 240 days after the first post-discharge billing statement.

Children's Health Providers: Defined in Section IX below.

Domestic Partner: a partner of the patient who is of the same sex, sharing a long-term committed relationship of indefinite duration with all of the following characteristics: (1) a mutual and exclusive commitment to each other's well-being; (2) financial interdependence through sharing common assets and common debts (e.g., joint home ownership, joint bank

accounts, joint loans); (3) not related by blood closer than would bar opposite sex marriage in the state of their residence; (4) joint responsibility for each other's common welfare including basic living expenses; and (5) neither is married to each other or to someone else or has another partner who meets the foregoing criteria.

Eligible Applicant: Patient under the age of 26 who is present in the United States without a permanent residence in another country or the guarantor (i.e., person responsible for payment for services) for such patient and who meet the Family Income requirements set forth in this Policy.

Emergency Medical Care: Medically Necessary Care provided in an emergency room setting.

Family: (a) for a patient 18 years of age and older, the patient and the patient's spouse, Domestic Partner, and dependent children under 26 years of age, whether living at home or not and (b) for a patient under 18 years of age, that patient's parent, caretaker, relatives and other children of the parent, patient caretaker, relative who are under 26 years of age.

Family Income: the annual earnings and cash benefits from all Family sources before taxes and minus payments made for alimony and child support. Proof of such earnings may be determined by annualizing year-to-date the Family's income.

Financial Assistance: The cost of providing free or discounted Emergency Medical Care or Medically Necessary to patients and their families who cannot afford to pay all or a portion of the cost of care based on the eligibility rules described in this Policy.

FPG: The Federal Poverty Guidelines found at https://aspe.hhs.gov/poverty-guidelines.
Gross Charges: The full established price for medical care provided to patients.
Medically Necessary Care: Health care services or supplies that a prudent physician would provide to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease, or its symptoms in a manner that is:

- In accordance with generally accepted standards of medical practice;
- Clinically appropriate in terms of type, frequency, extent, site and duration; and
- Not primarily for the economic benefit of the health plans and purchasers or for the convenience of the patient, treating physician, or other healthcare provider.

For purposes of this Policy, the following medical care is not considered Medically Necessary Care:

- Services not covered by or not considered medically necessary by the Medicare or Medicaid programs;
- Transplantation or cell or gene therapy services;
- Supplements;
- Outpatient prescription medications and treatments considered experimental; and
- Cosmetic procedures or elective procedures, even if otherwise covered by the Medicare or Medicaid programs.

Self-pay Balance: The amount due to the Children's Health Provider after Emergency Medical Care or Medically Necessary Care is rendered and all other payment options or reimbursement methods are exhausted.

IV. Eligibility Criteria for Financial Assistance

A. General Eligibility Requirements. Except as otherwise provided in this Policy, eligibility for Financial Assistance is based on a demonstrated inability to pay for services determined when comparing the level of annual Family Income and Family size for the previous tax year to the FPG. Children's Health may determine inability to pay before or after Emergency Medical Care or other Medically Necessary Care is provided. Free and discounted care is, except as otherwise provided in this Policy, available based on the following income levels and Self-pay Balances:

- 70% adjustment of the Self-pay Balance (as defined in Section III) for Eligible Applicants with Family Income between 301-400% of the FPG
- 85% adjustment of the Self-pay Balance for Eligible Applicants with Family Income between 201-300% of the FPG
- 100% adjustment of the Self-pay Balance for Eligible Applicants with Family Income equal to or less than 200% of the FPG
- An Eligible Applicant with a Self-pay Balance over the past 12 months exceeding 10% of the Eligible Applicant's Family Income, who has exhausted all third-party payment sources, whose Family Income exceeds 400% of the FPG, and who is unable to pay the Self-pay Balance is eligible for a write-off of 85% of the Self-pay Balance if the Family Income is greater than 400% but less than 500% of FPG and 70% of the Self-pay Balance if the Family Income is in excess of 500%.

B. Emergency Department Care. Children's Health Providers with emergency departments provide medical screening examinations and Emergency Medical Care to stabilize patients, regardless of the patient's ability to pay and in compliance with the Emergency Medical Treatment and Labor Act ("EMTALA"). Children's Health prohibits any actions that would discourage individuals from seeking Emergency Medical Care and does not perform debt collection activity in the specific Children's Health Provider's emergency department. Financial Assistance will be available to all individuals seen in a Children's Health Provider's emergency department and who do not have the resources to pay for the services, regardless of residency or citizenship status, including patients who have no permanent address or insurance coverage and those without access to the required application documentation.

C. Presumptive Eligibility. The following may automatically qualify the Eligible Applicant for Financial Assistance under this Policy:

i. Charges for services not covered by Medicaid will be automatically written off to charity if the patient was a Medicaid beneficiary at the time of the uncovered service;
ii. When a patient has applied for private health insurance, Medicare, Medicaid, Children's Health Insurance Program ("CHIP"), The Children with Special Healthcare Needs ("CSHCN"), or other state-funded programs designed to provide health coverage but such coverage is not expected to begin until after treatment is expected to start, then Financial Assistance will be automatically approved for Emergency Medical Care and Medically Necessary Care provided within 60 days prior to the effective date of coverage;
iii. Patients eligible for other governmental means-tested programs such as food stamps, as determined by Children's Health from time-to-time; and
iv. An internal assessment of eligibility to receive Financial Assistance may be conducted in lieu of requiring the individual to complete the application process set forth in this Policy. The assessment process screens uninsured patients using independent third-party sources and takes into account estimated annual income, Family size, and employment status. Those individuals who qualify under the internal assessment process will be eligible for Financial Assistance as set forth in this Policy. Those individuals who do not satisfy the internal assessment process may nonetheless apply for Financial Assistance pursuant to Section VI below.

D. Circumstances in Which Financial Assistance May Not Be Available. Eligible Applicants are not generally eligible for Financial Assistance if they:

- Refuse to be screened to determine whether third-party coverage, including without limitation Medicaid, is available;
- Have third-party coverage from a health insurer, health care service plan, Medicare, Medicaid, CHIP or CSHCN and there is no Self-Pay Balance;
- Have access to resources for payment through a health care sharing ministry or other third-party resources and there is no Self-Pay Balance
- Have access to in-network care from other providers where the Children's Health Providers are out-of-network;
- Have coverage for an injury that is compensable for the purposes of workers' compensation, automobile insurance, or other insurance or third-party resources and there is no Self-Pay balance; or
- Have any of the foregoing or any other coverage for Emergency Medical Care or Medically Necessary Care and refuse to apply for or use such coverage.

E. Denial Based on Failure to Apply for Other Coverage or False Information.

i. Children's Health reserves the right to deny Financial Assistance to Eligible Applicants who are required to obtain health insurance coverage but choose not to do so or Eligible Applicants who decline insurance coverage, including government assistance plans, due to, for example, religious reasons.

ii. Children's Health reserves the right to reject an application for Financial Assistance that contains false or misleading information.

F. Reversing Grant of Financial Assistance. Children's Health reserves the right to reevaluate an Eligible Applicant's eligibility for Financial Assistance during the period of eligibility if it is determined that the Eligible Applicant's financial status has changed. Children's Health reserves the right to reverse Financial Assistance and pursue appropriate reimbursement or collections as a result of newly discovered information, including insurance coverage or payment to the Eligible Applicant pursuit to a personal injury claim related to the services in question.

G. Provision of Continuing Care. Eligible Applicants eligible for pre-service Financial Assistance may be required to demonstrate an ability to provide or sustain any continuing care necessary for the patient's health and well-being as the patient's initial condition dictates or the patient's care team directs. Providing Financial Assistance does not obligate Children's Health Providers to provide continuing care; however, in the applicable

Children's Health Provider's sole discretion, services and support that are medically necessary and unavailable elsewhere may be provided on a continuing basis.

H. Reapplication for Financial Assistance. Patients may be required to re-apply for financial assistance at least every twelve (12) months.

I. No Discrimination. Children's Health is committed to upholding the multiple federal and state laws that preclude discrimination based on race, sex, age, religion, national origin, marital status, sexual orientation, disabilities, military service, or any other classification protected by federal, state, or local laws.

V. Basis for Calculating Amounts Charged to Patients

A. Gross Charges and AGB. All patients are billed Gross Charges; however, the Self-pay Balance for Eligible Applicants is limited to the AGB. AGB is determined by multiplying Gross Charges for the specific care by the AGB percentage for such care. The AGB percentage is determined using the "look-back method" and is based on all allowed claims where the primary payer is Medicaid fee-for-service, Medicare fee-for-service, and all private health insurers for the previous fiscal year's encounters. The total amount of such allowed claims is divided by the associated charges from those claims to identify the AGB percentage.

AGB is calculated annually and applied on a calendar year basis.

The AGB percentage is then multiplied by the Gross Charges of the Emergency Medical Care or other Medical Necessary Care received by the patient to determine the AGB.

B. Limitation of Payment Amount to AGB. The amount that an Eligible Applicant is expected to pay out-of-pocket is limited to the AGB percentage of the Gross Charge if that Eligible Applicant is deemed eligible for Financial Assistance. The combination of insurance payments and Eligible Applicant payments may exceed the AGB.

C. More Information About AGB. Individuals may obtain more information, in writing and without charge, about the Children's Health AGB by either:

- Contacting the Admitting Office
  - In Dallas: **214-456-8640** – Monday – Friday: 7:30 a.m. – 5:30 p.m. or
  - In Plano: **469-303-8640** – Monday – Friday: 6:30 a.m. – 3:30 p.m. or

- Obtaining the Children's Health AGB and information on the AGB calculation on the Children's Health website at https://www.childrens.com/patient-families/billing-and-insurance/financial-assistance-and-support.

VI. Method for Applying for Financial Assistance

A. Application. Financial Assistance is offered through either an application process or automatically in the situations described above in Section IV.C. To be start the Financial Assistance application process:

i. The Eligible Applicant must complete the Financial Assistance application, if required and provide the documentation required in the application that is reasonably available.
ii. Income verification can be performed over the telephone with the employer and account documented with the verification, title, date, and phone number.
iii. If it appears that the Eligible Applicant is eligible for government programs, the Eligible Applicant is assisted with that application process, which must be completed as part of the process for qualifying for Financial Assistance under this Policy.
iv. Applications may be made by the patient, patient's parent, patient's guarantor, or authorized representative of the patient, subject to applicable privacy laws. The determination of the patient's citizenship and residency status will generally be based on the patient's, not a parent's, residency, and citizenship status while any income or asset evaluation will be based on the Family's Income.
v. 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 Care. However, the determination may be done at any point in the collection cycle. The need for Financial Assistance shall be re-evaluated at each subsequent time of services if the last financial evaluation was completed more than twelve (12) months prior, or at any time additional information relevant to the eligibility of the patient becomes known.
vi. If an application and required documentation is not received, the Financial Counseling Services team will attempt to contact the Family via phone to obtain the missing document(s). The determinations required under this Policy will be made only after receipt of the information required by this Policy, unless the requirements for automatic Financial Assistance are met.

vii. The Admissions Department and Financial Counseling Services shall seek to obtain from the Eligible Applicant information about whether private or public health insurance or sponsorship may fully or partially cover the charges for care rendered by the Children's Health Provider to the patient, including, but not limited to, private health insurance, Medicare, Medicaid, Children's Health Insurance Program ("CHIP"), The Children with Special Healthcare Needs ("CSHCN"), or other state-funded programs designed to provide health coverage.

viii. If it is determined the applicant submitted false information, the application will be automatically denied.

ix. The Eligible Applicant must provide a signed authorization and service terms form allowing Children's Health to submit claims.

B. Cooperation. Children's Health requires the complete cooperation of the Eligible Applicant during the Financial Assistance application and determination process.

C. Incomplete Applications. Children's Health will notify Eligible Applicants of incomplete applications and specify the documents or information needed to complete the application process, which should be provided within 30 days. Children's Health reserves the right to deny Financial Assistance if the application is not received within the Application Period as defined in Section III above.

D. Application Review. Children's Health staff will review the application and make a determination of what Financial Assistance, if any, may be offered. The application review process takes approximately 30 days. Once a decision has been made for Financial Assistance, a letter will be sent to the Eligible Applicant advising of the decision.

E. If Financial Counseling Services determines that the Eligible Applicant does not meet the required factors for Financial Assistance, the Eligible Applicant or service area director/senior director (or designee) may request consideration for an exception from the Charity Review Committee ("CRC"). The Eligible Applicant or service area director/senior director (or designee) may request a consideration for exception from the applicable executive. The respective executive or designee will promptly submit the request to the Children's Health Senior Vice President, Managed Care or designee who will initiate review by the CRC. The CRC will review the Eligible Applicant's information and determine the final disposition of Financial Assistance under this Policy.

F. Copies of Policy, Copies of Financial Assistance Application, and Help with Application Process.

i. **Applications for Financial Assistance, copies of this Policy, and information on help completing the application are available at no charge at the following website:**
https://www.childrens.com/patient-families/billing-and-insurance/financial-assistance-and-support

ii. **Applications for Financial Assistance, copies of this Policy, and help completing the application are available at no charge by calling:**
- Dallas: **214-456-8640** – Monday – Friday: 7:30 a.m. – 5:30 p.m.
- Plano: **469-303-8640** – Monday – Friday: 6:30 a.m. – 3:30 p.m.

iii. **Applications for Financial Assistance, copies of this Policy, and information on help completing the application are available at no charge by written request or in person at:**

Children's Medical Center Dallas
Admitting Office
1935 Medical District Drive
Dallas, TX 75235

Children's Medical Center Plano
Admitting Office
7601 Preston Road
Plano, Texas 75024

G. Confidentiality and Sharing of Financial Assistance Information.

i. Confidentiality of Financial Assistance Information. Children's Health will uphold the confidentiality and individual dignity of each patient and Eligible Applicant. Children's Health and the Children's Health Providers will adhere to applicable laws for handling personal medical, health, and financial information. Children's Health will maintain all information received from Eligible Applicants requesting Financial Assistance under this Policy as confidential information and will not share such information outside of Children's Health unless required by law.

ii. No Provision of Information to Collection Agencies. Information concerning monetary assets obtained as part of the Financial Assistance application and approval process will be maintained in a file that is separate from information that may be used to collect

amounts owed to Children's Health Providers. All information in such file will not be available to the personnel involved in debt collection.

iii. Information Obtained Outside of Financial Assistance Application Process. Nothing in this Policy shall prohibit the use of information obtained by Children's Health, its collection agencies or assignees independently of the Financial Assistance eligibility process.

iv. Sharing Information Between Children's Health Providers. Children's Health and its affiliates, including Children's Health Providers may share patient Financial Assistance information for the benefit and ease of administering Financial Assistance for Emergency Medical Care and Medically Necessary Care provided to a patient at different Children's Health Providers.

VII. Actions that May be Taken in the Event of Nonpayment

A. Placement of Self-pay Balances with Collection Agencies. Children's Health takes all reasonable efforts to collection outstanding amounts owed by third parties. Unpaid Self-pay Balances are initially worked in-house at Children's Health for a period of time. If the Self-pay Balance remains unpaid and suitable payment arrangements are not made, accounts will be placed with an initial external collection agency. This initial external agency acts more of as an extension of Children's Health's Business Office.

B. No Extraordinary Collection Actions. Children's Health and Children's Health Providers will not engage in extraordinary collection actions (such as reports to consumer credit reporting agencies or credit bureaus, sale of an individual's debt to another party, etc.) against patients to obtain payment of care. Accordingly, Children's Health, Children's Health Providers, Children's Health Provider's collections agents, and any Children's Health Provider's assignees that are subsidiaries or affiliates shall not file legal or court claims, use wage garnishments or body attachments, cause arrests, place liens on primary residences, refuse or defer the delivery of Emergency Medical Care and Medically Necessary Care, or undertake similar extraordinary actions as a means of collecting unpaid bills. This requirement does not preclude these parties from pursuing reimbursement from third-party liability settlements, tortfeasors, or other legally responsible parties.

C. Good Faith Settlement. If an individual is attempting to qualify for assistance under this Policy and is attempting in good faith to settle an outstanding bill with the Children's Health Provider by negotiating a reasonable payment plan or by making regular partial payments of a reasonable amount, the Children's Health Provider will not send the unpaid bill to any collection agency or other assignee.

D. Return of Overpayment. If an Eligible Applicant pays in excess of total amount of the Eligible Applicant's responsibility, the Children's Health Provider will, within 60 days from the date the overpayment is identified, refund the overpayment.

E. Further Information About Billing and Insurance. Information about billing and insurance:

- Is set out at https://www.childrens.com/patient-families/billing-and-insurance
- Can be obtained by calling **800-467-7404** or **214-456-2455**, Monday through Friday, 8:00 am to 5:00 pm Central Time or
- Can be obtained by emailing **patientbilling@childrens.com**

VIII. Information Obtained from Outside Sources and Use of Prior Financial Assistance Eligibility Determinations

A. Information from Outside Sources. Children's Health looks to the Eligible Applicant to provide the information reasonably necessary to process the application for Financial Assistance but does consider information collected by third-party vendors often in cases of presumptive eligibility under Section IV.C. above.

B. Prior Eligibility for Financial Assistance. Prior eligibility for Financial Assistance may be taken into account for purposes of determining eligibility for Financial Assistance and generally indicates eligibility for Financial Assistance if there have not been material changes in the Eligible Applicant's financial condition or access to other types of coverage for Emergency Medical Care or Medically Necessary Care.

IX. Providers Covered by this Policy

This Policy applies to all "**Children's Health Providers**," which means all hospitals, Section 162.001(b) non-profit health organization physician practices, and other providers wholly owned or wholly controlled, directly or indirectly, by Children's Health. A list of the Children's Health Provider organizations covered by this Policy is as follows:

- Anesthesiologists for Children
- Children's Health Imaging
- Children's Medical Center of Dallas
- Children's Medical Center Plano
- Complex Care Medical Services Corporation
- Dallas Physician Medical Services for Children, Inc. doing business as

- Children's Health Medical Group
- Children's Health Andrews Institute for Orthopaedics & Sports Medicine

The Policy ***does not*** apply to any other hospitals, physicians or other health care providers or provider entities, including independent providers whose relationship with Children's Health is only through medical staff membership or a contract for services or who are not wholly owned and controlled directly or indirectly by Children's Health.

X. Uncompensated Care

Notwithstanding anything in this Policy to the contrary, for purposes of reporting uncompensated and indigent care costs, the **Children's Health Provider** shall include charges for non-covered services rendered by the **Children's Health Provider** to Medicaid patients or patients covered under other indigent care programs as uncompensated care. Non-covered services include services to Medicaid and other indigent care program patients who have exhausted their benefit coverage, services denied (in whole or in part) by Medicaid and other indigent care programs, and services exceeding a spell of illness or length of stay limit. The uncompensated care amount is the amount of the charges written off or denied. In addition, for purposes of reporting uncompensated and indigent care costs, the **Children's Health Provider** shall include the difference between gross charges and the payment received by the **Children's Health Provider** for insured patients who meet the eligibility requirements under this Policy where the **Children's Health Provider** does not have a contractual agreement with the payer that covers the patient's service date(s).

SOURCES:

1. **Related Policies**
   AD 2.29.01 Emergency Medical Treatment (EMTALA) and Patient Transfer - Dallas
   AD 2.29.02 Emergency Medical Treatment (EMTALA) and Patient Transfer - Plano

2. **Joint Commission Manual**
   None

3. **Medicare Conditions of Participation**
   None

4. **State or Federal Statute(s) or Regulation(s)**
   Patient Protection and Affordable Care Act of 2010 – Internal Revenue Code Section 501(r)

5. References
None

6. Keywords
Financial Assistance, Emergency Medical Care, Medically Necessary Care, Billing and Collection

7. Quick Reference Guide links, Flowcharts, and Job Aids
None

Attachment A:

Calculation of Amounts Generally Billed

Following a determination of financial assistance eligibility, an individual will not be charged more than the amounts generally billed (AGB) to individuals with insurance for emergency or other medical necessary care. The Children's Health Provider use the "look-back method" to calculate the AGB using the previous year's closed encounters. This method bases AGB on fully paid hospital claims where the primary payer is Medicaid fee-for-service, Medicare fee-for-service, Medicaid, and commercial health insurers. The Children's Health Provider divides the sum of total payments made by those payers by the sum of total hospital charges for those claims to calculate the AGB. Closed claims during the prior fiscal year (12 months) are included in the calculation. The AGB is calculated annually and applied on a calendar basis.

Children's Health Provider Fiscal Year 2023

Gross Charges: $4,638,259,499
Discounts/ Contractual: $2,576,973,514
Payments: $2,061,285,984
Discount Rate: 56%

AGB Rate for Calendar Year 2024: 44%