

# Policies and Procedures

## THE MENNINGER CLINIC Finance & Admissions

### Policy MC-241      Financial Assistance Policy

**Effective Date:**      November 1, 2016

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#### **Mission Statement**

The Menninger Clinic (The Clinic) is a leading psychiatric center dedicated to treating individuals with psychiatric illness. In support of this mission, Menninger provides financial assistance for emergency and medically necessary care to individuals who are classified as “medically or financially indigent” and who meet The Clinic’s Financial Assistance policy. Patient notices about Menninger Financial Assistance will be available in applicable languages on the website, admissions offices, outpatient offices, finance offices, and the general waiting area.

#### **Purpose**

The Menninger Clinic is committed to providing emergency and medically necessary care to individuals without the ability to pay. The Board of Directors, or authorized body, has adopted the following policy according to rules adopted by Internal Revenue Code 501(r) and the Texas Department of State Health Services. This policy outlines how to apply for financial assistance, including the eligibility criteria for free medically necessary care.

#### **Policy**

All patients/guarantors seeking medically necessary care will be provided with a copy of the financial assistance policy as part of the admission process. The Clinic will make reasonable efforts to orally communicate an offering of financial assistance to those patients throughout the course of treatment and after discharge, or until a determination is made regarding the patient’s/guarantor’s eligibility for financial assistance. The Clinic encourages every patient who is receiving medically necessary care to apply for financial assistance prior to admission. An individual who has been classified as “medically indigent” or “financially indigent” and who requires medically necessary care at The Clinic shall be provided care in accordance with this policy.

#### **Emergency Medical Care**

An individual who presents themselves at The Menninger Clinic stating they are seeking treatment, admission, or evaluation will be triaged by the admissions department to ascertain services needed, if any. Individuals who evidence an emergency medical condition that is not within the scope of services for the Menninger Clinic will be transferred to the appropriate medical facility. Triage services are provided free of charge to all patients. MC 105 Patient Transfers addresses the process for assessment and transfer of individuals who exhibit an emergency medical condition. A copy of the policy can be obtained free of charge from the admissions department.

#### **Definitions**

1. **Clinic:** The Menninger Clinic
2. **Referral Source:** Licensed clinician, hospital or mental health affiliated agency indicating that the patient would benefit from and is able to cooperate with a comprehensive psychiatric assessment taking place on a milieu-based inpatient psychiatric unit.
3. **Emergency Medical Condition:** A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could be reasonably 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) or others in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

4. **Household:** Defined as the number of individuals listed on the federal tax return of the guarantor, which may include the patient, in accordance with Internal Revenue Service guidelines.
5. **Financial Contract:** Contract that every paying patient signs that outlines the services to be provided and financial responsibility of each patient/guarantor.
6. **Clinic Admission Criteria:** Pre-established criteria that all patients must meet in order to be accepted into any inpatient program. Examples of the criteria include, but are not limited to, presence of psychiatric or substance abuse diagnosis as principal diagnosis, voluntary status, the patient's level of aggression, ability to participate in their care, ability to provide activities of daily living with minimal assistance, and the level of general medical care needed.
7. **Inpatient Medically Necessary Criteria:** The patient has a diagnosed or suspected mental illness; There is a question as to the accuracy of the current diagnosis and/or uncertainty about the recommended treatment for the mental illness; The patient would benefit from and is able to cooperate with a comprehensive psychiatric assessment within a milieu-based inpatient psychiatric unit; The patient requires an individual plan of psychiatric staffing, including 24 hour services in a controlled environment; Without a comprehensive psychiatric assessment, the patient is at risk of continued deterioration or inadequate response to treatment; The patient is capable of and is willing to cooperate with a three week inpatient assessment that may include medical imaging, psychological or neuropsychological testing, diagnostic and laboratory studies, and diagnostic interviews; The patient is capable of giving informed consent for recommended medications for the purpose of controlling symptoms that interfere with the assessment process; The patient is not currently suffering from urges to harm themselves or others to a degree that would interfere with their ability to undergo and cooperate with an intensive evaluation.
8. **Outpatient Medically Necessary Criteria:** The patient has, or is being evaluated for, a diagnosed or suspected mental illness; the presenting behavioral, psychological, and/or biological dysfunctions and functional impairment are consistent with psychiatric/substance-related disorders. The patient does not require a higher level of care, the patient demonstrates motivation to manage symptoms or make behavioral change, and the patient is capable of developing skills to manage symptoms or make behavioral change. The patient must also demonstrate one of the following: symptomatic distress and impaired functioning due to psychiatric symptoms in at least one of the three spheres of functioning (occupational, academic, or social), that are description of the symptoms and specific measurable behavioral impairment in occupational, academic, or social areas, or the patient has persistent illness with a history of repeated admissions, or there is clinical evidence that a limited number of additional treatment sessions are required to support termination of therapy.
9. **Billing and Collection Policy:** The Menninger Clinic policy MC 1281 addresses how patient billings and collections are handled at the Clinic. All inpatient and Pathfinder patients not eligible for financial assistance under this policy are expected to make a deposit upon admission/start of the program. The amount of the deposit varies based on each Clinic program. The deposit will be applied to each day's charges. Charges are processed in accordance with each patient's financial contract. Charges include a daily rate, and some additional ancillary charges. When the deposit has been fully applied to all charges, another deposit is expected. This process continues throughout the course of treatment. Any funds remaining upon discharge will be refunded to the patient within 30 days of discharge. All refunds are processed in the form of a check. All outpatients are expected to make payment at the time the services are rendered. All patients will be sent a final bill within 10 days of discharge. Full payment is expected within 30 days of the post discharge bill. Any balances due, from the patient, after that time, will be subject to additional collection actions which may include requiring a deposit (from individuals not covered by the Clinic's Financial Assistance policy), obtaining external collection assistance, possible denial of non-medically necessary services if a previous balance is owed, and reporting to credit bureaus. Copies of this policy are available upon request, free of charge, by contacting the Admissions department at 713-275-5000.

### **Covered Services**

The Menninger Clinic provides financial assistance in the form of free medically necessary services for both inpatient and outpatient care to individuals who require medically necessary care and who meet the clinical and financial qualifications. Adult inpatient medically necessary care is defined as a comprehensive psychiatric assessment lasting up to three weeks on a milieu-based psychiatric unit, as well as a reasonable time to complete referrals to the appropriate level of follow up care. Adolescent inpatient medically necessary care is defined as psychiatric diagnostic and assessment services lasting approximately two weeks on a milieu-based psychiatric unit, as well as a reasonable time to complete referrals to the appropriate level of follow up care. Outpatient care is defined as an initial visit and medically necessary treatment through the Clinic's core outpatient providers.

### Excluded Services

The following named programs do not provide the medically necessary services stated above and are excluded from this policy: PIC, HOPE, COMPASS, Child & Adolescent Long Term Treatment, Outpatient Assessments, Pain, ECT, Pathfinder, and Readiness for Care.

### Financial Assistance Criteria

Once a patient meets the Clinic Admission Criteria and the required services are deemed medically necessary, as stated above, the patient must meet the financial or medically indigent criteria listed below. Once a favorable determination is made, the patient will be covered under this policy and will receive free medically necessary care, for the covered services, as stated above.

1. ***Inpatient Clinical Criteria:*** Patients meeting clinical criteria for admission into the Clinic must also meet medically necessary criteria and be appropriate for a comprehensive assessment taking place in a milieu-based inpatient unit. Every patient who applies for financial assistance must also have current medical insurance coverage. Current medical coverage is needed for any transfers outside of the Clinic for general medical emergency care, as well as post discharge psychiatric care for patients who may not wish to use the Clinic's outpatient clinic.
2. ***Outpatient Clinical Criteria:*** Patients who meet the financial qualifications may receive an initial evaluation by a core outpatient provider, free of charge. The outcome of the initial evaluation will determine if the recommended treatment plan includes ongoing medically necessary outpatient treatment eligible for financial assistance under this policy.
3. ***Referral and Resident Criteria:*** Patients being considered for financial assistance must meet all of the criteria outlined below. Resident criteria will enable the Clinic to use its resources to assist the patient with obtaining appropriate follow-up care.
  - a. Patients seeking inpatient care must be referred by a referral source (e.g. licensed clinician, hospital or mental health affiliated agency). A referral source is not required for patients seeking outpatient care. If no referral source is available, patient may receive an evaluation of medical necessity, through the Clinic's outpatient services. This evaluation of medical necessity will be in the form of a scheduled outpatient appointment and is subject to the financial criteria of this policy.
  - b. Patient must be a legal resident of the U.S.
  - c. Patient must reside in the Houston Metropolitan area. Defined as the following counties:
    - i. Harris
    - ii. Fort Bend
    - iii. Montgomery
    - iv. Brazoria
    - v. Galveston
    - vi. Liberty
    - vii. Waller
    - viii. Chambers
    - ix. Austin
4. ***Financial Criteria:*** Patients qualify as "financially indigent" based on their total household income on the date of admission.
  - a. Eligible patients must be legal residents of the U.S.
  - b. Household income is defined as Adjusted Gross Income from the most recently filed federal tax return.
    - i. If the patient/guarantor is not required to complete a federal tax return, income can be defined as 1) earnings from a job or self-employment and 2) alimony income.
  - c. Households with income more than \$130,000 may self-report their income on the financial assistance application. Households with less than \$130,000 must use their most recently filed tax return or documentation to support income, based on the Internal Revenue Service guidelines.

- d. Households with a significant change in income since their most recently filed tax return, may use appropriate documentation to support income, based on the definition stated above.
- e. Household income does not exceed 200% of the 2016 HHS Poverty Guidelines.

Persons in Household	Poverty guideline	200%*	300 %**
1	\$11,880	\$23,760	\$35,640
2	16,020	32,040	48,060
3	20,160	40,320	60,480
4	24,300	48,600	72,900
5	28,440	56,880	85,320
6	32,580	65,160	97,740
7	36,730	73,460	110,190
8	40,890	81,780	122,670
For families with more than 8 persons, add \$4,160 for each additional person		8,320	12,480
* Income must be less than 200% to meet section 4.e. Financial Criteria.			
** Income must be less than 300% to meet section 5.a. Medically Indigent Criteria.			

- 5. **Medically Indigent Criteria:** Previous payments to The Menninger Clinic and/or future payment plans to other medical providers, for previous healthcare services, may be used to reduce the household income of the patient/guarantor. To be considered for financial assistance under medically indigent criteria, all of the following criteria must be met:
  - a. Annual income between 201% - 300% of FPL.
  - b. Previous payments to The Menninger Clinic, within the last 12 months, or future payment plans to other medical providers, for previous healthcare services, that exceed 20% of the annual household income.
  - c. The verified payment amounts will reduce the reported income used to consider financial eligibility.
  - d. The revised household income does not exceed 200% FPL as stated in the financial criteria.
- 6. **Amounts Generally Billed (AGB):** Once a patient qualifies for financial assistance, at no time will the patient be charged more than the amounts generally billed for medically necessary care. AGB is determined by using the prospective Medicare or Medicaid method.
- 7. **Criteria Changes:** The financial assistance criteria will be reviewed periodically and may be adjusted, depending on the resources of the Clinic and/or as necessary to meet the needs of the community. If changes to the financial criteria of this policy are made and once approved by the governing body of the Clinic, patients who are receiving care at that time will be re-evaluated and the most beneficial criteria will apply to their current episode of care. Any patients who have discharged will be evaluated based on the policy at the time the application is completed. All other criteria will be based on the policy in place at the time of admission. If the patient was actively receiving services as of June 2016 and had qualified under the previous financial assistance policy, the patient will continue to be eligible for financial assistance until their level of care changes, or for six months, giving the patient an opportunity to attempt to qualify under the new guidelines.

**Inpatient Procedure**

Requests for inpatient services under this policy will follow the procedure listed below.

- a) The referral source will contact the Admissions office to refer a potential patient, indicating that the patient would benefit from and is able to cooperate with a comprehensive psychiatric assessment in an inpatient milieu-based setting.
- b) The admissions office will screen potential patient according to the following:
  - i. The acuity of the patient
  - ii. The clinical appropriateness

- iii. The level of care desired
  - iv. The medical necessity of the patient,
    - i. based on the definition above
    - ii. determination must be on file
  - v. The availability of services and acuity levels on the unit
  - vi. The Clinic's capacity to treat the patient.
- c) The admissions office will notify the referral source whether the applicant has been accepted by The Clinic within 2 business days of receipt of the medical necessity determination by the referral source.
  - d) After a determination is made regarding whether or not the Clinic can admit the patient for the requested medically necessary care, the patient will be provided with a financial assistance application.
  - e) If the patient/guarantor provides false or incomplete information that would have excluded them from financial assistance, the Clinic reserves the right to retroactively exclude the patient from financial assistance. This will result in the patient/guarantor being financially responsible for all charges.
  - f) The patient/guarantor is responsible for participating in the financial assistance determination process. If the patient/guarantor does not actively participate in the process, they will not be covered under this policy. They will be responsible for payment of their full bill and their account will be processed under the Clinic's Billing and Collection policy, starting 130 days after discharge.
  - g) It is recommended that the patient complete the financial assistance application, and receive a determination prior to admission, however, an admission date will not be delayed due to an incomplete financial assistance application, unless requested by the patient. Any patient who admits into the Clinic and is subsequently deemed to not meet the financial or clinic criteria will be responsible for payment of all charges incurred at a rate of 100% of billed charges. Normal billing and collections practices would apply.
  - h) If the applicant is denied admission to The Clinic, the referral source may appeal The Clinic's decision by submitting a written request for review of such decision with The Clinic's Review Committee within two (2) days of the receipt of notice of the initial rejection. The Clinic Review Committee shall be comprised of the Medical Director, the Chief Financial Officer and the Chief Nursing Officer. The Clinic Review Committee has full discretion as to when and how it shall act on an appeal.
  - i) The decision of the Clinic Review Committee is final.

### **Outpatient Procedure**

Requests for outpatient services under this policy will follow the procedure listed below.

- a) The patient or referral source will contact the Outpatient services office to request an appointment for an initial evaluation.
  - i. The initial evaluation will be used to determine what medically necessary services are needed.
    - i. Such services could include either inpatient or outpatient care.
    - ii. If inpatient services are needed, the outpatient provider may become the referral source.
- b) The patient will be provided with the financial assistance policy and an application to determine eligibility.
- c) An outpatient appointment will be scheduled.
- d) It is recommended that the patient complete the application prior to their first appointment.
- e) Inpatient Procedure sections e) – i) must also be followed.
- f) After the initial evaluation, the patient will be informed of the medically necessary services that are recommended, including the number of visits, the level of care, the type of provider, etc.
- g) Re-evaluation is required for ongoing outpatient services.
- h) Re-evaluation of financial criteria is required annually.

### **Application Process**

- a) The application, along with any documentation that is needed to substantiate the information in the application, will be submitted to the Admissions department.
- b) Presumptive qualification of financial criteria may be made, without requiring proof of income, if the patient/household meets any of the following conditions, and can provide documentation to support these conditions:

- i. Participation in a low income benefit program, such as WIC, CHIP, Medicaid, food stamps, local assistance programs, etc. Proof of participation in a low income benefit program presumptively qualifies a patient for financial assistance. No proof of income is required.
  - ii. Patient is deceased. If patient is deceased and has a past due bill, the past due balance will qualify under this policy and amounts due will be reduced to \$0.
- c) Documentation, to support income reported on the financial assistance application, may include any of the following:
- i. Tax returns
  - ii. Pay stubs, or other documentation to support earnings, for one month
  - iii. Documentation to support alimony income
  - iv. Medical insurance card or other proof of medical insurance coverage
  - v. Documentation to support medical payment plans (for medical indigence qualification)
  - vi. Death certificate, or documentation from a valid source
  - vii. Documentation to support participation in a low income benefit program
  - viii. An affidavit must be provided if there is no income or documentation to support no income.
- d) If the patient qualifies for financial assistance, based on the above mentioned criteria, the following will apply:
- i. Eligibility for financial assistance is determined for each admission, for medically necessary care, as defined above. Financial assistance determinations are reviewed at 1 year intervals in outpatient, or whenever the medically necessary care ends.
  - ii. The patient will not be billed more than Amounts Generally Billed, as defined above.
  - iii. Outpatients will be evaluated throughout the course of treatment to ensure that they continue to meet medical necessity criteria.
  - iv. Once the patient no longer meets medical necessity criteria, and a referral has been processed for after-care, the patient is no longer considered eligible under this policy and as such as is responsible for payment of all services rendered from that time forward. Normal billing and collections practices would apply.
- e) The clinic does not use prior financial assistance application determinations to determine eligibility under this policy. Each admission for each episode of care will require a new application and determination of eligibility under this policy.
- f) Patients not eligible for financial assistance are provided contact information to an appropriate provider or facility in the Houston metropolitan area or a national mental health agency.

### **Where and How to Obtain an Application or Further Information**

Admissions Office  
The Menninger Clinic  
12301 Main Street  
Houston, TX 77035  
Attn: Financial Assistance

Phone 713-275-5000

***<http://www.menningerclinic.com/patient-care/financial-information>***

In an effort to notify members of the community about the availability of financial assistance, the Clinic will publicize the policy as follows:

- Post the financial assistance policy, financial assistance application and plain language summary on the Clinic's website at: <http://www.menningerclinic.com/patient-care/financial-information>
- Provide information on how to access, download and print copies of the documents upon request at the admission desk and security kiosk.
- Offer a copy of the plain language summary without charge in English (and in languages listed below) as part of the admission process
  - a) English, Spanish, Vietnamese, Chinese and Tagalog,

- b) Additional translation is available upon request.
- Provide information on the availability of financial assistance for medically necessary care with the following community agencies
  - a) Texas Children's Pediatric Associates (TCPA) Project Medical Home practices
  - b) The Gathering Place
  - c) Meadows Mental Health Policy Institute
  - d) Baylor College of Medicine
  - e) National Alliance for Mental Illness - Houston
  - f) Mental Health America of Greater Houston
  - g) Depression Bipolar Support Alliance – Houston

### **Billing and Collection Activity**

Any covered services provided to individuals covered under this policy will be at no cost to the patient/guarantor. As such, no extra-ordinary collection actions will occur on the services and individuals covered under this policy.

If an application for assistance is not made prior to services being rendered, the Clinic will continue to communicate with the patient/guarantor in an attempt to complete the application process and make a determination while services are being rendered, and up to 250 days after the patient discharges. After 250 days post discharge, collection actions under the Clinic's separate billing and collection policy will commence.

Billing and Collections processes for any services provided outside of this policy, or any patients who are not covered by this policy, will be processed in accordance with the Clinic's Billing and Collection policy. Collection actions may include requiring a deposit (from individuals not covered by the Clinic's Financial Assistance policy), obtaining external collection assistance, possible denial of non-medically necessary services if a previous balance is owed, and reporting to credit bureaus.

Any services performed on patients who have incomplete applications will be treated as covered under this policy while the application is completed and a determination for financial assistance is finalized. Patients will be notified of any additional information needed to complete the application and will have no longer than 130 days after discharge to complete the application process. After 130 days post discharge, Billing and Collections will be processed in accordance with the Clinic's separate Billing and Collection policy. Once the application is completed and a favorable determination has been made, the patient's account, for this episode of care, will retroactively be treated as covered under this policy and any payments made by the patient for the episode of care will be refunded. Retroactive application of financial assistance based on presumptive qualification of the patient being deceased will only apply to past due charges, and not to the entire episode of care.

### **Non-Covered Providers**

Occasionally, outside medical providers may see patients on The Menninger Clinic's campus. These services are generally paid by the Clinic and may be billed to the patient, based on their financial contract. These services may include radiology, lab, physical therapy, or psychological testing. However, in some cases, the patient may be billed directly from the external provider. These providers may bill the patients separate from their Clinic bill and are not covered under the Clinic's financial assistance policy. The Clinic will pay for these services for patients covered under this policy, provided they are necessary to the core treatment. If the services are optional, patients may contact these providers separately for information regarding whether or not they have a financial assistance policy. Currently, the only non-covered provider who will have services performed on the Clinic's campus and will bill the patient directly is Genomind. Questions regarding Genomind's financial assistance policy can be obtained by calling Genomind directly at 877-895-8658.

Occasionally, the Clinic will refer a current inpatient to an outside medical provider, for general medical and dental services. These services may include physical therapy, lab, radiology, dental, etc. These providers will bill the patient directly. The patient is responsible for the financial arrangements for each external provider. The patient does have the option to select a different provider, or to decline services. If there is a substantial out-of-pocket cost to the patient, the Clinic will review the situation and may provide payment to the external provider, on the patient's behalf, on a case-by-case basis, for individuals qualifying under this policy.