Financial Assistance Policy

Memorial HEALTH SYSTEM

SUBJECT: MHS Financial Assistance Policy
DEPARTMENT: PATIENT FINANCIAL SERVICES
PREPARED BY: Financial Assistance Committee
REVIEWED BY: Kathryn Keim
APPROVED BY: MHS Board of Directors

REFERENCE
EFFECTIVE DATE:
10/01/2016
LAST REVIEWED:
10/01/2020

MISSION:

The mission of Memorial Health System and its Affiliates (MHS or MHS Affiliate[s]) is to improve the health of the people and communities we serve.

In order to better serve the community and further our mission, MHS will accept a wide variety of payment methods and will offer resources to assist the patient in resolving any outstanding payments for hospital services. We will treat all patients equitably, with dignity, respect and compassion, and wherever possible, help patients who cannot pay for all or part of their care.

MHS recognizes there are occasions when a patient is not financially able to pay for their hospital care, and is not covered by any Payer. Since the provision of care is not dependent on the patient's ability to pay, MHS has established guidelines in which a patient may apply and qualify for financial assistance. MHS strives to balance needed patient financial assistance with the broader fiscal responsibilities to accomplish our mission.

PURPOSE:

The purpose of this policy is to define eligibility criteria for financial assistance and provide guidelines for the identification, evaluation and documentation of patients in need of financial assistance. We will ensure our policy is effectively communicated to those in need, that we assist patients in applying and qualifying for known programs of financial assistance and that all policies are accurately and consistently applied. We will define the standard and scope of services to be used by our outside agencies that are collecting on our behalf, and will obtain this agreement in writing to ensure that this policy is incorporated throughout the entire collection process. This policy is also intended by MHS to be compliant in all respects with the provisions of the Illinois Fair Patient Billing, Hospital Uninsured Patient Discount Acts, Illinois Medicaid statute and regulations and the Internal Revenue Service, Treasury Department 501(r) regulations. MHS's desire is to provide services to all persons as is appropriate, to reduce governmental burden and to use its facilities in furtherance of its mission for the benefit of all persons, regardless of ability to pay.

POLICY:

It is the policy of MHS to identify financial assistance that is provided to patients according to the guidelines described below.

- Financial assistance is defined as hospital services provided at no charge, or on a reduced charge, to patients.
- Financial assistance will be based solely on the criteria in this policy and will not be judged on the basis of any particular race, color, religion, national origin, ancestry, creed, sex, age, marital status, physical or mental disability, sexual orientation or citizenship status.
- Emergency admission, treatment, screening and/or stabilization services will not be delayed or denied due to coverage or payment ability.
- Classification of hospital services for financial assistance may occur up to 240 days from the first post-discharge billing statement.
- Financial assistance is applicable to all emergency or Medically Necessary Hospital Services, as defined herein.

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DEFINITIONS:

Amounts Generally Billed: Any patient eligible for financial assistance under MHS's FAP will not be charged more for emergency or Medically Necessary Hospital Services than the Amounts Generally Billed (AGB) to insured patients. MHS Affiliate facilities use the Lookback Method to calculate AGB. See Exhibit 4 (Explanation of the Amounts Generally Billed) for a detailed explanation of how the "amounts generally billed" is calculated. To request a free copy of the Explanation of the Amounts Generally Billed, including the AGB percentage, click the following link (MHS Affiliate Facility Directory) or see Exhibit 5 for each facility's contact information.

Extraordinary Collection Actions: A list of collection activities, as defined by the IRS and Treasury, that healthcare organizations may only take against an individual to obtain payment for care after reasonable efforts have been made to determine whether the individual is eligible for financial assistance. These actions are further defined in the Reasonable Efforts and Extraordinary Collection Actions (ECA) section of the MHS Billing and Collections policy, and may include actions such as reporting adverse information to credit bureaus/reporting agencies, along with legal/judicial actions such as garnishing wages.

Group Providers: A list of providers, other than the hospital itself, delivering emergency or other medically necessary care at the hospital. The Group Provider List indicates those providers participating under the MHS's FAP as identified in Exhibit 2 (Group Provider List).

Income: "Family income" means the sum of a family's annual earnings and cash benefits from all sources before taxes, less payments made for child support. When providing income information, the patient is limited to providing the following information:

- Whether patient or patient's spouse, as defined by Illinois law, is currently employed
- If patient is a minor, whether patient's parents or guardians are currently employed
- If patient or patient's spouse, as defined by Illinois law, is employed, name, address and telephone number of all employers
- If a minor patient's parents or guardians are employed, name, address and telephone number of all employers
- If patient is divorced or separated or was a party to a dissolution proceeding, whether the former spouse, as defined by Illinois law, is financially responsible for patient's medical care per the divorce, separation or dissolution agreement
- The patient is limited to the following gross monthly family income information, including cases in which a spouse, as defined by Illinois law, is guarantor for the patient or in which a parent or guardian is guarantor for a minor, from sources such as:
  - Wages
  - Self-employment
  - Unemployment Compensation
  - Social Security
  - Social Security disability
  - Veterans' pension
  - Veterans' disability
  - Private disability
  - Workers' Compensation
  - Retirement income
  - Child support, alimony or other spousal support
  - Other income

DEFINITIONS (cont'd):

Assets: Include, and are limited to, checking, savings, stocks, certificates of deposit, mutual funds and health savings/flexible spending accounts

Exemption to Assets: MHS will examine available assets as an indicator of income for comparison to poverty guidelines, but will exclude from consideration the following Assets:

- A minimum of $2,000 liquid assets for single household/applicants
- A minimum of $3,000 liquid assets for married household/applicants
- Plus $500 for each additional dependent in household
- Homestead or primary place of residence
- All personal property including, but not limited to, household goods, wedding/engagement rings and medical equipment
- All automobiles or other vehicles
- Assets held in pension plans
- Available business equity below $50,000
- Other assets at our discretion that should be exempt

MHS Affiliates: For the purpose of this policy MHS Affiliates refers to Abraham Lincoln Memorial Hospital, Lincoln, Illinois; Decatur Memorial Hospital, Decatur, Illinois; Memorial Medical Center, Springfield, Illinois; Passavant Area Hospital, Jacksonville, Illinois; and Taylorville Memorial Hospital, Taylorville, Illinois.

Medically Necessary Hospital Services: "Medically necessary" means any inpatient or outpatient hospital service, including pharmaceuticals or supplies provided by a hospital to a patient, covered under Title XVIII of the federal Social Security Act for beneficiaries. A "medically necessary" service does not include any of the following:

- Non-medical services such as social and vocational services
- Elective cosmetic surgery, but not plastic surgery designed to correct disfigurement caused by injury, illness or congenital defect or deformity
- Services which could have been safely performed in another facility free of charge, which were knowingly refused by the patient
- Services which could have been paid by a Payer if the patient complied with providing the information requested to the Payer
- Any procedure not covered by a Payer, despite being deemed to be medically necessary, due to the patient's failure to follow Payer guidelines and procedures. Examples include dental procedures, services provided in a non-contracted hospital, the patient's failure to receive precertification/ authorization or a physician's failure to submit proper documentation to obtain precertification/ authorization.

Payer: Entity other than the patient that finances or reimburses the cost of health services. In most cases, this term refers to an insurance carrier, other third-party payer or health plan sponsor (employer or union).

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DEFINITIONS (cont'd):

Presumptive Eligibility: Uninsured patients shall be deemed presumptively eligible for hospital financial assistance if the patient demonstrates one or more of the following:

- Homelessness
- Deceased with no estate
- Mental incapacitation with no one to act on patient's behalf
- Medicaid eligibility, but not on date of service or for non-covered service
- Recent personal bankruptcy
- Incarceration in a penal institution
- Affiliation with a religious order and vow of poverty
- Enrollment in Temporary Assistance for Needy Families (TANF)
- Enrollment in IHDA's Rental Housing Support Program

Enrollment in the following assistance programs for low-income individuals:

- Women, Infants and Children Nutrition Program (WIC)
- Supplemental Nutrition Assistance Program (SNAP)
- Illinois Free Lunch and Breakfast Program
- Low Income Home Energy Assistance Program (LIHEAP)
- Enrollment in an organized community-based program providing access to medical care that assesses and documents limited low income financial status as a criterion for membership
- Receipt of grant assistance for medical services

Uninsured: Patient of a hospital who is not covered under a policy of private health insurance, health benefit or other health coverage program, including high-deductible health insurance plans, workers' compensation, accident liability insurance or other third-party liability.

Uninsured Patient Discount: MHS will provide a discount from its charges to all Uninsured patients, regardless of income or cooperation for all emergency or Medically Necessary Hospital Services. See Exhibit 1 (Schedule of Income Guidelines and Discounts).

Schedule Income Guidelines and Discounts: A schedule included as Exhibit 1 that lists the family income at which an Uninsured patient would qualify for full or partial financial assistance.

PROCEDURES:

MEMORIAL HEALTH SYSTEM RESPONSIBILITY OF COMMUNICATION:

MHS will communicate the availability of the FAP, plain language summary and application forms to all patients at no charge. Forms of communication include, but are not limited to:

- Placing signage, plain language summaries, etc., in prominent patient locations throughout MHS facilities, including, but not limited to, Emergency Departments, Patient Financial Services, Admissions and on each MHS facility's website.

- Offer paper copies of MHS Plain Language Summary during patient intake or prior to the patient's discharge. See Exhibit 3 (Plain Language Summary).
- Using a language that is appropriate for patients who make up the lesser of 1,000 individuals, or 5% of those patients served by an MHS facility.
- Designating staff members in Patient Financial Services and Registration departments to explain the FAP to the patient. MHS staff in the Patient Financial Services and Registration departments will understand the FAP and will be able to answer or direct questions regarding the policy to the appropriate hospital representative.
- Using billing statements to notify patients of the availability of financial assistance, including contact information and website URL where FAP information and application forms are available.
- Providing itemized bills within seven (7) days from date of patient request.
- Making available to the public a copy of our FAP, application and eligibility criteria, upon request.

GENERAL APPLICATION GUIDELINES:

To apply for financial assistance, patients must submit a complete application (Financial Assistance Application Form) with supporting documents to each MHS Affiliate facility providing services. The required documents are listed in the Verification of Income and Assets section below. See Exhibit 5 (MHS Affiliate Facility Directory) for website, email, phone numbers and office locations to request a free copy of the financial assistance application and/or policies and for assistance in completing the application. Applications will be accepted by mail or in person at the Patient Financial Services offices.

- Verification of income, assets and medical expenses may be requested to accompany the application.
- Documentation showing a patient meets Presumptive Eligibility would be considered a complete application without other documentation required.
- Upon receipt of completed application and/or documentation, the Patient Financial Services representative will complete the Financial Assistance Worksheet and submit for appropriate approval(s). The Financial Assistance Worksheet determines the amount of financial assistance for which the patient is eligible. The MHS Schedule of Income Guidelines and Discounts (Exhibit 1) is used as a tool to aid in determining the amount of financial assistance applicable. The Patient Financial Service Representative is responsible to verify that all figures used to calculate eligibility are correct and, if needed, seek additional verification before submitting for approval. The Manager or Director will evaluate the recommendations, verify calculations and documentation and either approve, deny or forward to the appropriate person(s) as necessary.
- The patient may apply for financial assistance up to 240 days from the first post-discharge billing statement. However, the hospital may begin Extraordinary Collection Actions (ECAs) after 120 days from the first post-discharge billing statement or 30 days after a written notice, whichever is later. Patients may go to the website or request ECAs.
- An application, whenever possible, should be submitted and approved before the service is provided.

- No application for financial consideration will be required for emergency medical treatment or for services that are provided without advance notification from a physician or other referral area. The application should be completed as soon as possible, keeping the patient's medical needs as the primary focus. Application to cover the emergency treatment will be made after the service is provided.
- It is crucial that financial assistance applicants cooperate with MHS's need for accurate and detailed information within a reasonable time frame. If information is illegible or incomplete, the Patient Financial Assistance representative will provide the applicant with a written notice that describes the additional information and/or documentation required, gives the deadline for submission and includes the contact information. The Financial Assistance representative will ensure that all ECAs are suspended.
- Applications should contain applicant's signature or, where that is not possible, reasonable documentation demonstrating applicant's intent to apply for financial assistance.
- The absence of any requested application data, after notification, would subject that application to management discretion and possible denial.
- The documentation may be used for evaluation for services along with other updated pertinent, supplemental information for up to six months. Exceptions may be granted during this six-month period based on management discretion, in consideration of changing circumstances from the initial qualifying period.
- Once financial assistance status is determined, it will be applied to all patient accounts and will be valid for a period of six months from date of determination and retroactively. It is the responsibility of the patient or guarantor to notify the hospital that financial assistance was previously granted and should be applied to subsequent accounts.

VERIFICATION OF INCOME AND ASSETS:

For determining eligibility, it is the patient's responsibility to provide information for eligibility verification which may include, and is limited to, any of the following information:

- A completed federal income tax return for the previous calendar year(s) if required to file
- A copy of the patient's most recent W-2s and 1099 forms
- Paycheck stubs (two most recent), preferably with income listed for the month prior to the month the application is received and statements of all other income received, as defined as "Income" in the Definitions section of this policy and as indicated on the Financial Assistance application. An income statement is requested for all self-employed persons or patients paid in cash.
- Benefit statements
- Award letters
- Court orders
- Checking, savings and investment account statements (two most recent) as defined under "Assets" and "Exemption to Assets" in the Definitions section of this policy
- Other documentation that can be provided by the patient

- In the event that there is no income, a letter from the person who pays the living expenses of the patient or guarantor explaining the situation

Financial assistance levels of Income may be verified for either the previous twelve (12) months or annualization of partial year information. Qualification is valid under either method of calculation. In addition to historical information, future earning capacity, along with the ability to meet those obligations within a reasonable time, may be considered. Providing false information or excluding requested information may result in denial of application and eligibility. This financial information is considered confidential and is protected to ensure that such information will only be used to assist in enrollment or evaluating eligibility for financial assistance.

PATIENT QUALIFICATION & ELIGIBILITY FOR FINANCIAL ASSISTANCE:

MHS will automatically provide an Uninsured Patient Discount from its charges to all, regardless of income or cooperation for all emergency or Medically Necessary Hospital Services. See Exhibit 1 (Schedule of Income Guidelines and Discounts). Applying this discount will ensure that the patient will not be charged more than the Amounts Generally Billed.

Uninsured patients may qualify for 100% assistance if they have proof of Presumptive Eligibility as defined in the Definition section of this policy.

For any remaining monies owed by an Uninsured patient after the automatic discount is applied, an Uninsured patient is eligible for financial assistance based upon the Schedule of Income Guidelines and Discounts.

An Uninsured patient is eligible for 100% financial assistance with Income up to 300% of federal poverty guidelines.

An Uninsured patient who has Income greater than 301% of federal poverty guidelines will be eligible for partial financial assistance if what is owed is more than the maximum patient out-of-pocket responsibility as identified in the Schedule of Income Guidelines and Discounts.

Also, there are cases where a patient may be eligible for financial assistance, but has failed to cooperate by completing a financial assistance application or providing adequate supporting documentation. When there is adequate third-party collaborating information obtained through alternative sources, this information could provide sufficient evidence to provide the patient up to 100% financial assistance.

Insured patients may qualify for financial assistance if the patient has Income below 300% of federal poverty guidelines, notifies MHS that they qualify by submitting an application and supporting documentation which includes proof of one or more of the following Presumptive Eligibility categories:

- Homelessness (application can be waived if the address cannot be found using address verification tools)
- Deceased with no estate (financial assistance application not required)
- Current Medicaid eligibility, but not on date of service or for non-covered service
- Personal bankruptcy within the past 12 months (application only required for hospital admissions after the bankruptcy file date)
- Enrollment in Temporary Assistance for Needy Families (TANF)

- Enrollment in IHDA's Rental Housing Support Program
- Enrollment in Women, Infants and Children Nutrition Program (WIC)
- Enrollment in Supplemental Nutrition Assistance Program (SNAP)
- Enrollment in Low Income Home Energy Assistance Program (LIHEAP)
- Crime Victim (application can be waived with receipt of a Crime Victim letter)

In the event of an illness which is catastrophic and where proper documentation has been submitted, but the patient still owes monies that causes an undue hardship upon the household, the Patient Financial Services director along with senior leadership may review and determine if an additional financial assistance discount is merited. The definition of "catastrophic" and the amount of financial assistance will be determined on a case-by-case basis, considering all financial, family and health circumstances of the patient.

COMMITMENT TO THE FINANCIAL ASSISTANCE APPLICANTS:

MHS will seek no payment through administrative, third party or court proceedings from those patients that qualify for 100% financial assistance under the FAP.

MHS will not place a lien, force the sale or foreclosure of patient's primary residence to pay for an outstanding medical bill, or include the primary residence in the asset calculation unless the equity of the property clearly indicates an ability to assume the financial obligation; the patient has had the opportunity to assess the accuracy of the bill, apply for financial assistance or avail him or herself of a reasonable payment plan (or has failed to make payments in accordance with a reasonable payment plan); and senior leadership's prior approval has been obtained.

MHS will not pursue collection action in court against those patients that qualify for 100% financial assistance under the FAP.

MHS will not use forced court appearance to require the patient to appear in court for those patients that qualify for 100% financial assistance under the FAP.

MHS will not garnish wages of a patient that qualifies for 100% financial assistance under the FAP.

Once financial assistance is determined, it will be applied retroactively to all FAP qualifying accounts that are within 240 days from the first post-discharge billing statement.

Any payments made on accounts that qualified for 100% financial assistance under the FAP will be refunded to the appropriate party.

If an Uninsured patient has requested financial assistance and/or applied for other coverage and is cooperating with the hospital, the hospital will not pursue collection action until a decision has been made that there is no longer a reasonable basis to believe that the patient may qualify for financial assistance or other coverage.

For more information on MHS's collection activities, please see MHS's Billing and Collections Policy and Procedure (MHS Billing and Collections Policy).

ADDITIONAL RESPONSIBILITIES FOR PATIENTS WHO HAVE RECEIVED PARTIALLY DISCOUNTED FINANCIAL ASSISTANCE:

When the patient has been approved under the FAP for a partial discount, MHS will work with the patient or the responsible party to establish a reasonable payment option.

If a patient complies with a payment plan that has been agreed upon by the hospital, MHS will not pursue collection action.

If MHS has given the patient the opportunity to assess the accuracy of the bill and has sufficient reason to believe that the patient does not qualify for additional financial assistance under all terms of the FAP regarding his or her partial obligation, and the patient continues with non-payment, collection action may be taken by MHS to enforce the terms of any payment plan.

MAXIMUM OUT-OF-POCKET:

A maximum out-of-pocket payment will be required of Uninsured patients whose Income exceeds 300% of the federal poverty guidelines as outlined in Exhibit 1 (Schedule of Income Guidelines and Discounts). Charges for services in excess of such maximum will be discounted 100% as qualified financial assistance.

The maximum amount that may be collected in a 12-month period for Medically Necessary Health Care Services provided by MHS from a patient is 25% of the patient's family income, and is subject to the patient's continued eligibility under the FAP.

The 12-month period to which the maximum amount applies shall begin on the first date a patient receives healthcare services that are determined to be eligible under the FAP.

To be eligible to have this maximum amount applied to subsequent charges, the eligible patient must inform MHS in subsequent inpatient admissions or outpatient encounters that the patient has previously received healthcare services from MHS and was determined to be entitled under the FAP.

APPROVAL PROCESS:

Financial assistance must be approved as follows:

	MHS Facility:
$0 to $10,000	Service Provider representatives or above
$10,000 to $25,000	Patient Financial Services manager or above
$25,000 to $75,000	Director of Patient Financial Services or above
$75,000 to $100,000	CFO
$100,000 and greater	CEO or COO

These thresholds can be adjusted for price changes.

The above approval limits will be considered for all open accounts on an account-by-account basis, as opposed to aggregate, where a patient has multiple qualifying accounts.

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FINANCIAL ASSISTANCE FILINGS:

The financial assistance application and supporting documentation will be maintained on paper or digital image, with appropriate indexing, and cross-referenced to allow for subsequent retrieval and review.

The CEO or CFO at each facility may utilize their discretion to make exceptions to the above procedures based on specific extraordinary circumstances, to authorize additional qualifying financial assistance. The MHS CEO and CFO shall approve routine and administrative changes to this policy including but not limited to updates to the federal poverty guidelines and the MHS Group Provider List. All material changes will be approved by the MHS Board of Directors on behalf of MHS Affiliates.

REFERENCES:

IRS and Treasury's 501(r) final rule

Illinois Hospital Uninsured Patient Discount Act

Illinois Fair Patient Billing Act

OIG Third Party Billing Compliance Guidance, 1998, page 27

CCH-EXP, MED-GUIDE 5267, Comment—Hill-Burton Free Care Costs

HHS Poverty Guidelines