Wheaton Franciscan Healthcare

Category: ADMN-FIN

POLICY & PROCEDURE

Subject: Patient Financial Assistance/Community Care Program

Classification: Board Approved

Policy Owner: Vice President, Strategic Planning and Government Relations

Approved By: Sponsor Member Board **Effective:** July 1, 2012

POLICY: It is the policy of Wheaton Franciscan Healthcare (WFH) to provide access to medically necessary health care services to people in the communities it serves, including individuals without means or with limited ability to pay for medically necessary health care services. In order to continue its mission to serve the health care needs of the communities it serves, however, WFH understands that the level of financial assistance provided by WFH must be balanced to ensure WFH's on-going financial viability. Accordingly, WFH has created its WFH Community Care Program to ensure a fair and consistent process for financially eligible patents to request and obtain financial assistance for medically necessary health care services from WFH.

RATIONALE: Faithfulness to our Mission calls us to provide health care services with a special regard for the underserved. Our Values of Respect and Integrity compel us to treat all individuals with compassion and dignity in all our interactions with them, including matters involving payment. Our Value of Stewardship obliges us to provide access to health care services for all individuals in a manner that considers the financial viability of the organization.

SCOPE: This policy applies to patients receiving services at all Wheaton Franciscan Healthcare owned and operated hospitals; physician clinics; and outpatient centers.

PROCEDURE:

Financial Assistance

Financial assistance, in the form of a discount (meaning an allowance or deduction made from the provider's standard charge), is available for medically necessary health care services at WFH facilities through a patient's participation in the WFH Community Care Program. All patients requesting financial assistance through the WFH Community Care Program are required to participate in the Eligibility Determination Process described below. All patients requesting financial assistance will be treated fairly, with dignity, compassion and respect.

Residency Status Not Required

Residency status is not a consideration for eligibility in WFH's Community Care Program.

Eligibility for Participation in the Community Care Program

Patients shall be eligible for financial assistance for medically necessary services from WFH through their participation in the WFH Community Care Program. Patients are eligible to participate in the WFH Community Care Program to the extent that each of the following requirements is satisfied as determined through the "Eligibility Determination Process":

(i) **Medical Necessity of Services:** WFH must determine that the financial assistance requested is for WFH services that are medically necessary.

Financial assistance under the WFH Community Care Program is not available for non medically necessary or otherwise elective services (i.e., services where the patient's condition permits adequate time to schedule the availability of a suitable accommodation).

Medical necessity for WFH hospital and related services is determined by a committee comprised of Operational Leaders and/or Vice President of Medical Affairs, using established utilization review criteria.

The individuals noted above will be responsible for ensuring that the provisions of this policy are properly documented and administered.

Nothing in this policy shall be interpreted as reducing or limiting WFH's obligations under applicable law to provide emergency medical treatment as required by EMTALA, as applicable.

(ii) **Uninsured or Underinsured:** WFH must verify that the patient is uninsured or under insured and does not have access to other governmental or other third party coverage.

Note: patients determined to have potential eligibility in government programs who fail to comply with completing the appropriate paperwork associated with those programs will not be eligible for the Community Care Program.

Patients without insurance coverage will first be screened for eligibility into an existing governmental program and appropriate network (Medicare, Medicaid, etc.). If the patient qualifies for a governmental program, a staff member will assist in the enrollment process.

Patients eligible for government programs whose eligibility status is not established for the period during which the medically necessary WFH medical services were rendered may qualify for retroactive participation in the WFH Community Care Program for those services.

Similarly, patients who meet the Federal Poverty Level (FPL) but fail to provide requested information to potential non-governmental third-party payers or elect coverage that result in payment ineligibility by such third-party payer may not be eligible for the Community Care Program.

(iii) **Inability to Pay:** The patient must demonstrate to WFH an inability to pay in accordance with the income criteria as established by the current Federal Poverty Income Guideline sliding scale, as described further below.

(iv) **Cooperation of the Patient:** WFH must determine that the patient is cooperating in good faith in the process including accurately and timely completing the documentation required by the Eligibility Determination Process, as outlined in each WFH region's Revenue Operation Policy. Patients who, based on financial screening, appear to meet the eligibility criteria for the WFH Community Care Program but fail to cooperate with the Eligibility Determination Process may be denied future non-emergent and/or non medically necessary health care services and will be referred to community health care resources until a reasonable process for payment can be secured or their cooperation with respect to the standard process is obtained.

Eligibility Determination Process

All patients requesting information regarding or identified as potentially eligible for participation in the WFH Community Care Program shall be referred to the appropriate

WFH staff to assist them in processing their documentation.

Each patient requesting assistance through the WFH Community Care Program must complete the Eligibility Determination Process, outlined in each WFH region's Revenue Operations Policy, which may be either a paper or electronic application process wherein a patient's financial information is provided, reviewed and validated by WFH in accordance with this policy.

If extenuating circumstances prevent a patient from completing a Community Care application as part of the Eligibility Determination Process, the patient may still qualify for charity through a Presumptive Eligibility process. The criteria used for presuming eligibility for charity:

- Accounts returned by collection agencies – Accounts that are sent to a professional collection agency are written off as a bad debt. If the collection agency returns any accounts as uncollectible because the patient is unable to pay, these accounts can be reclassified as charity. Each professional agency has an established scoring methodology that determines the patient's ability to pay. If the likelihood regarding the ability to pay is so small that the agency does not want to expend their resources, the accounts will be closed and returned, and reclassified as charity. If presumptive eligibility is established using this method, it will be account specific and will not apply to previous or future accounts.
- Bankruptcy – if an account is discharged through bankruptcy, the account can be reclassified as charity care.

Certain medically necessary physician services which are not covered by Illinois Medicaid will be classified as community care. These patients will not require a community care application.

Applicable Discounts Under WFH Community Care Program
If a patient is determined to be eligible for participation in the WFH Community Care Program in accordance with the Eligibility Determination Process described above, WFH will assess their poverty level, using the Federal Poverty Income Guidelines and they will be classified as either uninsured or underinsured using the following definitions.

- Uninsured Patient – A patient for whom there is no insurance coverage or payment from any third party payer, and patient is not aware of any other source of payment available for the procedure.

- Underinsured Patient – A patient who has a form of insurance that does not satisfy coverage for the entire cost of the medically necessary care (i.e., a high-deductible plan).

Based on the above determinations, a corresponding discount on the WFH medically necessary services will be extended to the patient as follows:

1. Uninsured patients whose income is at or below 400% of the Federal Poverty Income Guidelines (600% in Illinois) - Based on the Federal Poverty Income Guidelines, a sliding scale fee discount on medically necessary WFH services will be provided. Because the total discount available to patients in this category includes the self-pay discount described below, no additional self-pay discount is extended. In addition, for patients in this category, the maximum out of pocket liability for medically necessary services shall not exceed 15% of gross household income.

2. Underinsured patients whose income is at or below 300% of the Federal Poverty Income Guidelines – Based on the Federal Poverty Income Guidelines, a sliding scale fee discount on medically necessary WFH services will be provided to offset the patient's balance outstanding after insurance coverage is applied.

Patients in this category will be required to satisfy the requirements of their existing insurance plan to ensure that maximum coverage is extended by the plan prior to receiving financial assistance through the WFH Community Care Program.

Any applicable discount for underinsured patients in this category is applied only to the patient/member liability portion of the patient's bill. Discounts in this category have been modified from the discounts extended to an uninsured person to reflect that, by virtue of insurance coverage, a discount off of charges has already been applied to the patient's bill. Any remaining balance due reflects the discount extended to the patient's insurance carrier.

If the patient's insurance plan deems a medically necessary service to be non-covered by the plan, the patient will be considered uninsured for that service and a discount consistent with category 1 above will apply. Persons in this category are eligible for the 15% out of pocket maximum liability described above.

In addition, for patients in this category, the maximum out of pocket liability for medically necessary services shall not exceed 15% of gross household income.

3. Uninsured patients whose income exceeds 400% of the Federal Poverty Income Guidelines (600% in Illinois) (Self-Pay Discount) - A discount that is annually calculated and consistent with the discounts allowed to the weighted average of the three largest managed care payers in a particular WFH geographic area (or such other similar criteria as established by the CFO) will be provided to patients who have no insurance coverage for a medically necessary service from WFH and whose income exceeds 400% of the Federal Poverty Income Guidelines.

The four geographic areas are defined as: 1) Milwaukee and surrounding counties; 2) Racine and surrounding counties; 3) Illinois; and 4) Iowa. The discount shall be recalculated on an annual basis to reflect the most current managed care payer discount.

The discount will apply if payment is received within 120 days of the first statement or contact made with the patient or an acceptable payment arrangement has been made within 120 days after an account is considered a self-pay account. If sufficient payment arrangements have not been made within the timeframe established above, the account may be referred to collection and/or the discount may be reduced or eliminated.

Persons in this category are not eligible for the 15% out of pocket maximum liability described above.

4. Underinsured patients whose income exceeds 300% of the Federal Poverty Income Guidelines. Patients who have a form of insurance that does not satisfy coverage for the entire cost of medically necessary care and whose income exceeds 300% of the Federal Poverty Income Guidelines will not be extended any further discount as patients in this category have already been extended a discount off of charges through their insurance carrier.

If the patient's insurance plan deems a medically necessary service to be non-covered by the plan, the patient will be considered uninsured for that service and the regional self-pay discount described above or a discount consistent with either categories 1 or 3 detailed above will apply. Persons in this category are not eligible for the 15% out of pocket maximum liability described above.

5. Medically Indigent. A patient will be recognized as "Medically Indigent,". if their income does not exceed 600% of the Federal Poverty Income Guidelines and their patient responsibility payments specific to medical care at Wheaton Franciscan Healthcare providers for a 120 day period retroactive from the date of request exceeds

20% of their gross household income, even after payment by third-party payers and/or the application of the Self-Pay Discount as provided herein, Any patient determined to be Medically Indigent will not be responsible for the amount that exceeds 20% of his/her gross household income ("Medically Indigent Discount"). This Medically Indigent Discount will be classified as Community Care. In order to qualify for a discount under this section, WFH must make a determination that the WFH services are "medically necessary" as defined herein. In addition, WFH must determine that the patient is cooperating in good faith with the process including but not limited to: accurately and timely completing the documentation as may be requested.

WFH Community Care Program Public Notification Requirements

All WFH entities shall provide public notice of the availability of financial assistance through its WFH Community Care Program as follows:

1) Notices are displayed in highly visible locations where there is a significant volume of inpatient or outpatient traffic such as: patient admitting and registration areas in both inpatient and outpatient settings; physician offices; and emergency departments.

2) A brochure describing the policy is available upon request in the same locations described above.

3) A financial counselor is provided to assist patients who have a demonstrated inability to pay.

4) Language referring to financial assistance programs is included in a prominent location on all billing statements.

5) A description and a copy of the policy are posted on all WFH web sites.

6) A copy of the policy is available upon request by any party.

Replaces:	Inter-company Loan Policy (December 1988) ADMN-FIN Payment for Services Policy
Cross reference:	Financial Relationships with Physicians Policy Construction Management Policy Mission Integration Policy Severance and Outplacement Benefits Policy Contract Management Policy
Review Period:	Two (2) years
Original Policy Date:	February 25, 1999
Dates Updated:	December 16, 1999; September 17, 2001; August 27, 2004; December 2006; March 25, 2010; March 30, 2012 (effective July 1, 2011)