Marianjoy
Rehabilitation Hospital

Now part of Northwestern Medicine®

Category: MJ- FIN

POLICY & PROCEDURE

Subject: Marianjoy- Payment for Services/ Community Care

Policy Owner: Financial Services

Approved by: Sr. VP- Finance/ CFO

Effective: September 1, 2016

POLICY:

It is the policy of Marianjoy Rehabilitation Hospital (MRH) 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, including emergency care. In order to continue its mission to serve the health care needs of the communities it serves, however, MRH understands that the level of financial assistance provided by MRH must be balanced to ensure MRH's on-going financial viability. Accordingly, MRH has created its MRH 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 MRH.

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 MRH facilities through a patient's participation in the MRH Community Care Program. All patients requesting financial assistance through the MRH 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 MRH's

Community Care Program.

Eligibility for Participation in the Community Care Program

Patients shall be eligible for financial assistance for medically necessary services (including emergency services) from MRH through their participation in the MRH Community Care Program. Marianjoy will provide written notice to its patients and guarantors of its Community Care Program and information as to how a patient may apply for financial assistance under such Program. This program will comply with all state and local rules and regulations regarding self-pay patients. Self-pay patients will be considered those without any type of insurance, patients with exhausted benefits and patients that receive non-covered but medically necessary procedures. Patients are eligible to participate in the MRH 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: MRH must determine that the financial assistance requested is for MRH services that are medically necessary (as determined by a physician). Financial assistance under the MRH 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 MRH 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 MRH's obligations under applicable law to provide emergency medical treatment as required by EMTALA, as applicable, regardless of the patient's eligibility for financial assistance. With regard to emergency services, MRH will never require payment for treatment before the patient receives emergency treatment.

ii. All uninsured patients should be evaluated for their ability to pay or otherwise receive reimbursement for their services during the scheduling, registration process, first point of access, or as soon as possible thereafter. Identification of a financial hardship, however, can take place at any time during the collection process.

iii. Uninsured or Underinsured: MRH 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 and shall be referred to other community health care sources for non-emergent services. Additionally, patient who fail to provide requested information to potential third-party payors that results in a denial 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 MRH medical services were rendered may qualify for retroactive participation in the MRH 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.

iv. Inability to Pay: The patient must demonstrate to MRH 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.

v. Cooperation of the Patient: MRH 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 MRH region's Revenue Operation Policy. Patients who, based on financial screening, appear to meet the eligibility criteria for the MRH 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.

vi. Ordinarily, a Community Care Program application must be completed within a year of the date of service, but preferably before being sent to the collection agency, except as determined by the senior vice president of finance. Approved applications for community care will be valid for one year from approval or the

duration of the course of treatment contemplated in the application, whichever is longer, provided that during such time frame Marianjoy has not received notice of any change in the patient's financial situation. The patient shall be informed as part of the application process that he or she is responsible for notifying the Marianjoy provider in the event that there is a change in his or her financial situation. Patients who require unrelated treatment during that year can attest to the accuracy and completeness of their Community Care Program application as adequate verification.

vii. Services that are medically necessary but not covered by Medicaid are considered to be community care by as income and asset limits for the Medicaid program are consistent with our community care program. These patients will not require a community care application.

Eligibility Determination Process

All patients requesting information regarding or identified as potentially eligible for participation in the MRH Community Care Program shall be referred to the appropriate MRH staff to assist them in processing their documentation.

Each patient requesting assistance through the MRH Community Care Program must complete the Eligibility Determination Process, outlined in each MRH region's Revenue Operations Policy [which consists of the Pricing Quotations and Transparency Policy 7.20, and payment for Services/Community Care Policy], which may be either a paper or electronic application process wherein a patient's financial information is provided, reviewed and validated by MRH in accordance with this policy. Some information may be obtained orally.

All patients identified as potentially eligible for community care are referred to the appropriate staff and must complete a Community Care Program application (**Appendix A**).

The Community Care Program application requires completion of the following information:

- Family size
- Monthly income
- Assets/liabilities
- Other sources of Income (i.e. alimony, child support, unemployment compensation, etc.)
- Equity value in

home

Latest tax returns Additionally, as part of the Community Care Program application process, individuals will be asked to attest to the accuracy and completeness of the application and to submit the following materials for verification:

Bank statement
Application to applicable state agencies for eligible governmental programs.

The designated program manager will be responsible for ensuring all documentation is obtained and forwarded to patient financial services for processing. If approval is made by anyone other than the program manager, It is the responsibility of the approver to inform the program leader of all determinations.

Approval of community care funds will be based on a tiered level of authority:

- $0 to $25,000- Program, Patient Financial Services or Admission leaders
- $25,001- $50,000- Program Vice President or Director of Finance
- $50,001- $100,000- Senior Vice President or CFO
- $100,001-$200,000- Presdient/ CEO
- $200,000+ Board

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:

a. Homeless

b. Deceased with no estate

c. Mentally incapacitated with no one to act on patient's behalf

d. Medicaid eligibility, but not on date of service or for non-covered service

e. Enrollment in an organized community-based program providing access to medical care that assesses and

documents limited low-income financial status as criteria:

- 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)

f. Receipt of grant assistance for medical services

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.

Applicable Discounts Under MRH Community Care Program

If a patient is determined to be eligible for participation in the MRH Community Care Program in accordance with the Eligibility Determination Process described above, MRH will assess their poverty level, using the Federal Poverty Income Guidelines and they will be classified as either uninsured or underinsured using definitions set forth herein. If a patient is found to be eligible for community care, the patient will never be charged to pay more than the amounts generally billed (AGB.) On an annual basis, the Controller's office will utilize the "lookback" method to calculate the amounts generally billed and collected from all Medicare, managed care and non-contracted commercial insurance companies. This will be calculated by dividing all receipts from fully paid accounts for the payers defined in #1 into the respective gross charges to determine the (AGB %,.) This look back period will consist of the

prior calendar years 12 months and be completed by February 1st of the subsequent year. This overall, average collection amounts will then be used to determine the maximum amount an eligible community care recipient will be charged. This amount will be distributed to all program managers and revenue cycle departments for disposition.

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

1. Uninsured patients whose income is at or below 600% of the Federal Poverty Income Guidelines - Based on the Federal Poverty Income Guidelines, a sliding scale fee discount on medically necessary MRH services will be provided. The amount that the patient will pay shall not be more than 135% of the cost-to-charge ratio as defined by the Office of the Attorney General specific to the regional hospital

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 MRH 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 MRH 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 (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 MRH 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 MRH 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. In all situations, Provider reserves the right to reverse the discounts described herein in the event that it reasonably determines that such terms violate any legal or contractual obligations of the Provider. Determinations concerning application of any self-payor discount may be appealed to and resolved by the regional vice president for revenue cycle.

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 MRH 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, MRH must make a determination that the MRH services are "medically necessary" as defined herein. In addition, MRH 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.

Payment for Services[1]

Communications Requirements
At the first point of contact, patients will receive from each Marianjoy provider a standard notice regarding the Marianjoy policy on payment for services and other potential financial assistance available to eligible individuals. Such notice shall be written in a clear manner that facilitates patient understanding and shall be posted in all Marianjoy provider registration areas and all ancillary departments.

Authorization Coordination
Eligibility and benefits will be verified for all services that require prior- authorization where possible. This preauthorization requirement will not apply to emergency services or otherwise be used to limit access to medically necessary urgent care. Patients shall not be illegally discriminated against based on source of payment or ability to pay.

Notification of Community Care Program Eligibility Determination Written notification of eligibility determination will be provided to each patient identifying the payment for services due and the amount to apply to community care, if any.

Discounting Guidelines

[1] Please see Inhouse Collection of Patient Accounts Policy No. 740 for details on MRH's collection process.

Except as provided above, the Marianjoy provider will not routinely offer, provide a discount or waive a copayment or deductible. Where necessary and appropriate and consistent with payor rules to the extent they apply, approval may be sought for non-routine discounts or waivers in the following limited circumstances.Periodic non-routine discounts off established fees may be authorized for risk management considerations after consultation with the regional director of risk management and after appropriate documentation is completed.

MRH Community Care Program Public Notification Requirements

All MRH entities shall provide public notice of the availability of financial assistance through its MRH 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, the Application for Community Assistance, and a plain language summary of the Community Care Program are posted on all MRH web sites.

6) A copy of the policy, the Application for Community Assistance, and a plain language summary of the Community Care Program is available upon request by any party, by mail and in public locations.

7) Notify and inform members of the community MRH serves about this policy and how or where to obtain more information about the policy and application process as well as copies of materials. The notification shall be in a manner reasonably calculated to reach those members of the community who are most likely to require financial assistance. “Reasonably calculated” shall take into consideration the primary language(s) spoken by the residents of the community served by the MRH, as well as other

attributes of the community and MRH.

8) Materials shall be in English and translated in any other language that is the primary language of the lesser of 1000 individuals or 5 percent of the community MRH serves or the populations likely to be affected or encountered by MRH.

List of Providers Participating in the Community Care Program

MRH shall maintain and provide upon request a list of health care providers, delivering emergency or other medically necessary care at MRH and whether or not such health care providers are covered by this policy. This list shall be maintained by the Patient Financial Services Department and shall be incorporated by reference herein.

Definitions**:**

Amounts Generally Billed- The average of all Medicare, Contracted and non contracted commercial insurance reimbursement based on a 12 month lookback.

Assets – may exclude a patient from the 25% maximum collectible amount who has substantial assets (defined as a value in excess of 600% FPL in urban areas). Certain assets are not considered: primary residence, personal property exempt from collections under Section 5/12-1001 of the Illinois Code of Civil Procedure (see Appendix A), and any amounts held in a pension or retirement plan.

Authorization – Activity completed to ensure payment of services for both the patient and the provider.

Benefit checking/availability – Determination of covered services and the level of payment.

Case Rate – A facility established rate for specified elective services such as cosmetics and bariatrics that are non-billable to insurance.

Community Care Application – Process by which patient provides full financial disclosure for eligibility determination within the terms of this policy.

Discount – An allowance or deduction made from the provider's standard charge.

Elective – Patient's condition permits adequate time to schedule the availability of a suitable accommodation.

Eligibility checking – Verification of an active insurance policy or payor source available.

Emergent – Patient requires immediate medical intervention as a result of severe, life threatening or potentially disabling conditions. Generally, the patient is admitted through the emergency room.

Family – The patient, his or her spouse, including a legal common-law spouse, and his/her legal dependents according to the federal internal revenue rules.

Financial Screening – Process used to determine ability of the patient to pay for services within the guidelines established by this policy.

Federal Poverty Guideline – Level of income determined annually by the
Department of Health and Human Services to indicate a threshold of poverty.

Income – Funds generated as a result of employment or ownership of assets.

Maximum Amount - Maximum amount collected in a 12-month period from an eligible Amount: patient is 25% of family's annual gross income. Time period begins as of the first date of service determined to be eligible for discount. For any subsequent services to be included in the maximum, the patient must inform the hospital that he/she had received prior services from that hospital which were determined to be eligible for discount.

Medical Group – Medical professional service providers employed by the organization.

Medical Necessity – Delay of treatment will cause further deterioration of illness or injury.

Medical Screening – Process used to determine health status to determine if emergent care is needed of if issue is non-emergent.

Non-emergent – Patient's condition does not require immediate medical
intervention.

Pre-authorization – Notification to a payor prior to providing service, resulting in an authorization for services and payment being issued by the carrier.

Private Pay – Patients who are subject to full charges, without the benefits of any third party payment sources.

Reasonable Collection Efforts – Consists of at least three (3) statements
including a final notice being mailed to the guarantor's home address and may also include up to two (2) phone contacts to the guarantor's home phone number.

Referral – The facilitation of authorization of services from one provider to
nother.

Self-pay Payor– The financial obligation of the individual receiving service or
that person's guarantor.

Servicing Department – Department that assists the patient with their health care needs at initial point of service.

Small Balance – Account balance due which is not subject to collection agency activity.

Payor or Third-party Payor -- Entity financially obligated for services rendered to an enrollee or assignee.

Urgent – Patient requires immediate attention for care and treatment of a physical or mental disorder. Generally the patient is admitted to the first available and suitable accommodation.

Uninsured patients – A patient for which there is no insurance coverage or payment from any third party payor, and patient is not aware of any other source of payment 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).

Marianjoy Provider – Any Marianjoy owned or operated entity furnishing health care services, but excluding retail pharmacy.

Financial Relationships with Physicians Policy Construction Management Policy Mission Integration Policy

Two (2) years February 25, 1999

December 16, 1999; September 17, 2001; August 27, 2004; December 2006; March 25, 2010; March 30, 2012 (effective July 1, 2011)

DEFINITIONS:

Replaces:	WFH Payment for Services Policy
Cross reference:	Financial Authorization for Admissions; Community Care Program
Review Period:	Two (2) years
Original Policy Date:	April 1, 2009
Dates Updated:	1/1/13, 7/1/15, 8/30/16