

Rush Copley Medical Center
Policy & Procedure

Title: Financial Assistance Policy

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Purpose

Rush Copley Medical Center (**RCMC**) is committed to caring for the entire community. In order to serve those who may not have health insurance, sufficient health insurance or other means to pay for their care. RCMC offers a comprehensive program of Financial Assistance/Charity Care (“**Assistance**”) for eligible patients. This Financial Assistance Policy (“**Policy**”) was developed to assist patients/Guarantors who are financially unable to meet the minimum payment required for Medically Necessary services provided at RCMC and to provide guidelines for the Application and balance adjustment processes.

RCMC provides health care services without discrimination to individuals regardless of ability to pay when requested and deemed medically necessary. Assistance is available for those individuals who meet the eligibility requirements under this policy and who have submitted a completed Application. RCMC Patient representatives are available to work closely with Patients to review payment options and determine eligibility.

The provisions of this Policy apply to Copley Memorial Hospital, Inc. Rush Copley Medical Group NFP, and all subsidiary corporations providing health care services collectively known as “**RCMC**”. As part of RCMC’s mission to provide comprehensive, coordinated health care to our patients, we offer several Assistance programs to help patients with their health care costs for medically necessary or emergent services. At RCMC, all patients are treated with dignity regardless of their ability to pay. Emergency services will never be denied or delayed on the basis of a patient’s ability to pay. This policy defines the guidelines and criteria to qualify for all components of RCMC’s Assistance Programs. Any Assistance awarded will be applied to the patient’s responsibility for emergency or other Medically Necessary services only.

Assistance, as noted below, may cover a Patient’s deductibles, copay and coinsurances remaining after insurance. Similarly, Assistance is not available to Patients receiving care at RCMC as out of network except for emergent services. Assistance is only available to Patients whose services are deemed either Medically Necessary or are Emergency Services.

This Policy is intended to comply with Section 501(r) of the Internal Revenue Code, the Illinois Hospital Uninsured Patient Discount Act (“**Discount Act**”) and the Illinois Fair Patient Billing Act (“**Billing Act**”) and the regulations promulgated thereunder and must be interpreted and applied in accordance with those laws and regulations. This policy will be separately adopted and reviewed annually by the governing bodies of RCMC.

This Policy describes: (i) the eligibility criteria for Assistance, and whether such Assistance includes free or discounted services; (ii) the basis for calculating amounts charged to patients; (iii) the financial assistance application method; (iv) the collection actions RCMC may take in the event of non-payment,

including civil collection actions, reporting to consumer credit reporting agencies, and potentially deferring non-emergent or urgent care; and (v) RCMC's approach to presumptive eligibility determinations and the types of information that it will use to assess presumptive eligibility.

RCMC will comply with all federal, state and local laws, rules and regulations applicable to the conduct described in this Policy. If the provisions of this Policy become subject to additional federal, state or local law requirements, and those laws impose more stringent requirements than are described in this Policy, then those laws will govern how RCMC administers its financial assistance program.

Please refer to the Definitions beginning on page 8.

Financial Assistance Programs and Eligibility Criteria

This Policy describes those circumstances under which RCMC may provide care without charge or at a discounted rate based on a Patient's financial need. Proof of Illinois residency may be required for qualification for any of the programs described in this Policy. Additionally, a Patient may be required to complete an Application and provide supporting documentation as outlined below to determine eligibility. In some cases, RCMC, in its sole discretion, may not require supporting documentation to determine presumptive charity care and Uninsured Patient discount programs, provided RCMC is able to verify eligibility through the use of available third-party information. If a Patient qualifies for more than one program, the program that provides the greatest benefit to the Patient will govern. Exceptions to this Policy will only be made in extraordinary circumstances and with the prior approval of the Senior Vice President of Finance, CFO or their designee.

- A. Any individual who receives Medically Necessary services at RCMC will be considered for Assistance upon meeting the eligibility requirements outlined in this Policy. The Policy and Application will be provided to any individual upon request without regard to race, ethnicity, color, religion, sex, gender identity, national origin, age, handicap or immigration status.
- B. Applicants who apply for Assistance should expect the following:
 - 1. To complete an Application by providing all of the required supporting documentation.
 - 2. Submit the completed Application within 240 days following receipt of Medically Necessary services.
 - 3. Once a completed Application has been received, receive a response approving or denying the Application no less than 60 days prior to any Extraordinary Collection Actions being initiated.
 - 4. Although Assistance discounts may vary depending upon the type of Assistance being offered, all charges for Medically Necessary and Emergency Services provided to eligible Patients for Assistance with income levels less than 600% of the Federal Poverty Level ("FPL") will not be billed more than the "Amounts Generally Billed."
 - 5. If, at any time during the review process, RCMC finds that an Application has been falsified or information is inaccurate, the Application will be denied and normal or Extraordinary Collection Actions, as applicable, will be initiated or resumed.
- C. Assistance is calculated based upon gross family income for the past twelve (12) months. The Application will remain valid for 12 months before a new Application would be required, as long as the Application has refreshed financial information every 4 months after the initial approval.

- D. A determination of the Applicant's eligibility will be made as early as possible once all required information is provided and verified.
- E. Not all healthcare services are covered by Assistance. For example, your physician or other non-hospital provider may not participate in the RCMC Assistance program.
- F. Applicants are required to advise RCMC of any material change in their financial condition within thirty (30) days of such change.

Overview of the Financial Assistance Application Process

1. The Assistance program may be initiated by the Patient, family member, physician and/or hospital department (i.e., Administration, Care Management, and Pastoral Care). Any Financial Counselor or Patient Financial Services staff member can initiate the initial Application and screen for eligibility.
 2. Applicants are asked to complete and return the Application with all required supporting documentation to a Financial Counselor or Patient Financial Services staff member within 240 days following receipt of Medically Necessary services.
 3. Applications are reviewed and evaluated to determine the eligible amount (if any) of Assistance by the Financial Counselors and then given to the Manager and Director of Patient Financial Services for final approval. RCMC reserves the right to verify credit records and any other sources to verify income and assets.
 4. After Patient Financial Services makes the final determination as to what extent Assistance is granted or not granted, the Applicant is notified via mail and any Assistance discount adjustments are applied to outstanding balances.
 5. Applicants may be approved for Assistance multiple times, as long as all of the required financial documentation has been verified for each new Application received and the original or updated financial documents are not older than four (4) months from the previous submission.
 6. If a determination is made that the Applicant has the ability to pay for Medically Necessary services, such determination does not prevent a future reassessment of the Applicant's ability to pay.
 7. A worksheet/report of all approved and denied Applications include, at a minimum, the amount of Assistance granted or denied and the rationale.
 8. Approved Assistance requests and supporting documentation are maintained for seven (7) years.
- G. Each Application will be reviewed based on individual circumstances at the time of Application and may require additional information. No information should be older than four (4) months and the Applicant must communicate to RCMC any material change in their financial condition within thirty (30) days of such change. The following documents, if applicable, will be used to verify income and assets:
1. Valid government issued photo ID: such as driver's license, passport, or government issued ID.

2. Last or most recent year income tax return (1040,1040EZ) with all W-2 forms and schedules attached.
 3. Two most recent paychecks or unemployment check stubs or a written statement of earnings from your employer for the previous two (2) months.
 4. Documents approving or denying Unemployment Compensation or Workman's Compensation (if applicable) or assistance from the Department of Public Aid.
 5. Statement of monthly benefits from Social Security or denial of benefits (if applicable).
 6. All checking, savings, and/or investment earnings statements and accounts for the previous two (2) month period.
 7. A current copy of an Illinois Department of Public Aid card or proof of enrollment in any of the assistance programs listed under the presumptive eligibility section of this Policy.
 8. For any missing documentation, room and board letters providing supporting documentation and/or a missing/incomplete status letter detailing the reason(s) why any documentation required was not provided, are required to be completed and signed by the Applicant or their designee.
 9. The Application must be signed by the Applicant or designee verifying that all information contained is accurate and truthful and that the Applicant is applying for Assistance under this Policy.
 10. For Patients who are deceased, without a surviving spouse and no open estate, any family member or hospital representative may complete the Application on behalf of the deceased Patient.
- H. The income guidelines for Assistance will be updated when changes to the Federal Poverty Guidelines are published in the Federal Register.
- I. The Applicant is required to apply for other public assistance programs prior to consideration for Assistance. Assistance discount adjustments are only available to those individuals who exhaust all other forms of third-party payment, which may include applications to Medicare, Health Insurance Exchange, other third-party liability, Workman's Compensation coverage, SCHIP, Illinois Public Aid, or any other public programs based on their eligibility requirements, and who provide documentation of their inability to pay.
- J. Assistance will not be approved until all applicable third-party payments have been received and will be applied only to open personal balances after all such payments have been posted. Approved amounts are not to exceed Patient's current balance.
- K. Assistance is not available or applied to any RCMC health care services that would not be covered under the Medicare program as Medically Necessary services for beneficiaries. Assistance also does not apply to non-Medically Necessary services such as elective, cosmetic or non-medical services such as social or vocational, except as noted below.
- L. Patient accounts that have proceeded through the collection process may be reviewed at any time, as long as there is an open balance outstanding. If it is determined that sufficient Applicant financial

information is available to meet the income guidelines, Assistance may be granted based on what information is known and verified.

- M. Prior to taking any Extraordinary Collection Actions, RCMC will make reasonable efforts to determine if an Applicant is eligible for Assistance. Applicants are given at least 120 days from the date of the first post discharge billing statements to submit an Application for review before any Extraordinary Collection Actions will occur.
- N. After receipt of a completed Application, a determination of the Applicant's eligibility will be made as early as possible, provided the Application is complete, allowing at least 60 days to provide the Applicant with written notice of determination and prior to initiation of any Extraordinary Collection Actions.
- O. RCMC will apply the applicable financial assistance discount to all open balances and refunds of any previous payments on accounts shall be reviewed and provided as required by law and based upon the approval of the Application for payments that were made prior to the completion of the Application.

Residency Requirements

- 1. Applicants who have received Medically Necessary services and are: a) legal Illinois residents or, b) who are not legal Illinois residents but reside in Illinois with the intent to remain and did not relocate for the sole purpose of receiving health care are eligible for Assistance. There is no residency requirement for any Patient who receives Emergency Services.
- 2. Except for Applicants receiving Emergency Services, Applicants who are not legal Illinois residents and are not residing in Illinois at the time of service with the intent to remain, or who have relocated for the sole purpose of receiving health care, are not eligible for Assistance.

Calculating Amounts Charged to Patients

Presumptive Charity Care

Any Applicant meeting the requirements and criteria below are presumed to be eligible for Assistance. Applicants presumed to be eligible do not need to complete an Application; provided, however, that they provide proof of the requirements below.

Eligibility Requirements for 100% Discount Adjustment When the Patient is:

- 1. Homeless;
- 2. Deceased with no estate;
- 3. Mental incapacitation with no one to act on Patient's behalf;
- 4. Medicaid eligible, but not on date of service or for non-covered services;
- 5. Incarcerated in a penal institution;
- 6. Family income of less than 200% of the Federal Poverty Guidelines.
- 7. Enrolled in one of the following assistance programs:
 - a. Women, Infants and Children Nutrition Program (WIC);
 - b. Supplemental Nutrition Assistance Program (SNAP);
 - c. Illinois Free Lunch and Breakfast Program;
 - d. Low Income Home Energy Assistance Program (LIHEAP);
 - e. Temporary Assistance for Needy Families (TANF); or

- f. 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.

Discount Application Process:

RCMC provides Assistance to Applicants under this Policy except as provided in the section below. Assistance to Applicants shall be available for all Medically Necessary services and Emergency Services not covered by insurance and for all open balances regardless of when the Application was approved.

Services Excluded from Financial Assistance

For purposes of this Policy, “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 with the same clinical presentation as the uninsured Patient. Accordingly, the following services are not considered to be Medically Necessary under this Policy:

- Services defined by Medicare as non-covered include:
 - Elective procedures
 - Gastric bypass surgery
 - Experimental, including non-FDA approved procedures and devices or implants
 - Elective cosmetic surgery (but not plastic surgery designed to correct disfigurement caused by injury, illness, or congenital defect or deformity)
 - Nonmedical services such as social and vocational services
 - Eating Disorder Program
 - Ophthalmology lens implants
 - Infertility
 - Orthodontic Care
 - Robotic Assisted Surgical Techniques, if there is other conventional treatment available
- Other exclusions:
 - Services intended to solely improve appearance (i.e. Cosmetic), elective services to treat a condition of convenience or a condition not requiring immediate attention, and/or non-medically necessary services.
 - Services or procedures for which there is a reasonable substitute or if there is an alternative service or procedure that is covered by the patient’s insurance company.
 - Services or procedures for which an insurer denies payment for lack of medical necessity.

Discount Calculation

RCMC provides Assistance to eligible Insured and Uninsured Patients using two calculation methods: (1) the insured sliding fee scale, or (2) Uninsured/catastrophic assistance. If the Patient qualifies under both methods, RCMC will apply the method that is most beneficial to the Applicant. For all Applications, the Applicant must provide asset information to determine if those assets will be in excess of 600% of the then current Federal Poverty Guidelines.

Insured Patient Discount

Discounts under the insured sliding fee scale are calculated as follows:

1. Legal Illinois Residents with Household Income of 300% or less of the current Federal Poverty Guidelines are eligible for a 100% discount. The discount shall be applied to coinsurance and deductibles as well as Medically Necessary services not covered by insurance.
2. Legal Illinois Residents with Household Income of more than 300%, but less than or equal to 600% of the current Federal Poverty Guidelines are eligible for an 80% discount or a discount amount equal to the Amount Generally Billed for Medically Necessary services not covered by insurance, whichever amount is more advantageous to the Patient.

Uninsured Patient Discount

RCMC will provide Assistance to Uninsured Patients in accordance with the Illinois Hospital Uninsured Patient Discount Act.

1. Legal Illinois Residents with Household Income of 300% or less of the current Federal Poverty Guidelines are eligible for a 100% discount.

Legal Illinois Residents with Household Income of more than 300%, but less than or equal to 600% of the current Federal Poverty Guidelines are eligible for an 80% discount or a discount which is calculated based on the cost to charge ratio received from the State of Illinois, derived from Worksheet C, Part I of the most recently filed Medicare Cost Report. The uninsured discount factor means and is calculated as 1.0 less the product of a hospital’s cost to charge ratio multiplied by 1.35, the discount amount applied would be whichever amount is more advantageous to the Patient.

Catastrophic Balance Program

1. For Applicants with Household Income more than 300%, but less than or equal to 600% of the current Federal Poverty Guidelines, the total payment shall not exceed 20% of the Applicant’s Household Income during any twelve-month period.
2. Catastrophic Needs Discount is calculated in the following example: To qualify, debt is higher than income in a 12-month period; the discount is equal to total charges, minus 20% of income level.

Applicant Billed Responsibility (12 months)	\$220,000
Annual Income (12 months)	\$200,000
20% Applicant Family Income/Responsibility	<u>\$ 44,000</u>
<u>Discount amount</u>	<u>\$176,000</u>

Other Discounts

All Uninsured Patients will receive a 30% discount amount applied to their charge balance, at the time of initial billing, based on the total charges for any Medically Necessary services provided by RCMC as long as all other sources of third-party payment has been exhausted.

All other discounts to Patient balances are detailed in the RCMC Administrative Adjustment/Discount to Charges policy.

Collections and Other Actions Taken In the Event of Non-Payment

RCMC has the right to pursue collections for unpaid and past due balances directly or through a third-party collection agency. If the Application is not timely completed and submitted, RCMC may pursue collections from the patient. RCMC may list a patient's account with a credit agency or credit bureau. RCMC reserves the right to seek to attach liens to insurance benefits/proceeds (auto, liability, life and health) in connection with its collection process to the extent third party liability insurance exists. No personal judgments or liens will be sought or filed against FAP-eligible individuals.

Before engaging in, or resuming, any of the extraordinary collection actions mentioned here (except the deferral or denial of care for non-payment of amounts for previous care), RCMC will issue a written notice to the Patient that (i) describes the specific collection activities it intends to initiate (or resume), (ii) provides a deadline after which such action(s) will be initiated (or resumed), and (iii) includes a plain-language summary of this Policy (the "**ECA Initiation Notice**"). RCMC will also make a reasonable effort to notify the Patient about this Policy.

RCMC may defer or deny (or require a payment before providing) Medically Necessary care, but not Emergency Services, due to a Patient's non-payment for prior care. RCMC does not need to provide the ECA Initiation Notice described above before deferring or denying (or requiring a payment before providing) care based on past non-payment. RCMC will, however, provide separate notices, described below, after which it may defer or deny (or request payment before providing) care immediately. The notification requirement specific to this collection action is satisfied if RCMC provides a copy of its Application to the Patient, notifies them that Assistance is available and provides a plain language summary of this Policy.

Publicizing the Policy

RCMC will take the following steps to ensure that members of the communities to be served are aware of the Assistance program and have access to this Policy and the related documents.

- ❖ RCMC will make a copy of this Policy available to the community by posting it online at www.rush.edu/financial-assistance along with downloadable copies of the Application (form and instructions), and a plain language summary of this Policy. There will be no fee for accessing these materials.
- ❖ RCMC will notify and inform visitors about the Assistance program through conspicuous public displays in places designed to attract visitors' attention.
- ❖ RCMC will make available, in both print and online, this Policy, the plain language summary, and the Application in English, Spanish, Tagalog and Polish.
- ❖ Each billing statement for self-pay accounts will include information about the Financial Assistance Program.
- ❖ RCMC will include information on the availability of financial assistance in Patient guides provided to Patients at registration.

Contact Us

To obtain a copy of the Application, please visit www.rush.edu/financial-assistance. Paper copies of the Application are also available at any registration locations.

Completed Applications should be returned or mailed to:

Rush Copley Medical Center
2000 Ogden Avenue
Aurora, IL 60504

(630) 978-4990, Monday through Friday, 8 am to 4:30 pm
Email us at: RC_Business_Office@rush.edu

The current year charity table which details the current year FPL sliding scale, the Amounts Generally Billed Discount amount and the Uninsured discount amount, is available by calling the phone number above.

For all billing questions please contact:

Customer Service
(630) 978-4990, Monday through Friday, 8 am to 4:30 pm
Email us at: RC_Business_Office@rush.edu

Attachments:

Federal Poverty Guidelines by Family Size
Cost to Charge Ratio Discount Rate
Amounts Generally Billed Discount Rate
List of Providers Who Do Not Follow the RCMC Financial Assistance Policy

Definitions

Amounts Generally Billed/Amounts Generally Billed Discount: The discount required to ensure that charges for care for Emergency Services or other Medically Necessary care provided during an outpatient visit or inpatient stay to individuals eligible for Assistance under this Policy are not more than amounts generally billed to individuals who have Medicare or commercial insurance covering such care. Calculation of the Amount Generally Billed Discount shall be in accordance with law based on the look-back method.

Applicant: An Applicant is the person submitting an Application , including the Patient and/or the Patient's Guarantor.

Application: An Assistance Application.

Application Period: The period during which RCMC must accept and process an Application in order to have made reasonable efforts to determine whether the Applicant is eligible for Assistance. The Application Period begins on the date the care was provided to the individual and ends on the 240th day after the date of the first post-discharge billing statement.

Billed Charge(s): The fees charged for a service based on the charge master in effect at the time of service prior to applying any contractual allowances, discounts, or deductions.

Cost-of-Care Discount (Uninsured): The discount equal to that amount calculated by multiplying the total cost-to-charge ratio from RCMC's Medicare cost report to the charges on accounts identified as qualifying for Assistance. Notwithstanding the foregoing, RCMC may, for administrative ease, establish a single Cost-of-Care Discount that is most advantageous to the Patient. The Cost-of-Care Discount shall be equal to or greater than the Amount Generally Billed Discount.

Discounted Care: Care provided at less than Billed Charges other than Assistance. Discounts include the Cost-of-Care Discount and the Amount Generally Billed Discount.

Emergency Services: Emergency Services include services received through the Emergency Department for Emergency Medical Conditions, or other services identified and set forth in an appendix to this policy.

Extraordinary Collection Action: Those actions that RCMC may take against an individual related to obtaining payment in full for a bill covered under the Assistance. These efforts may include requiring payment for previously-rendered care and/or placing a lien on a patient's property.

Federal Poverty Guideline(s): The Federal Poverty Guidelines updated periodically in the Federal Register by the United States Department of Health and Human Services under the authority of 42 USC 9902(2). The guidelines are attached in a separate table and will be adjusted annually following the release of the update poverty guidelines in the Federal Register and on the U.S. Department of Health and Human Services website.

Assistance: Amounts provided to Patients who meet the criteria for Assistance under the various programs, who are unable to pay for all or a portion of their health care services.

Guarantor: The individual who is financially responsible for services rendered to a patient.

Household Income: Income attributable to the Applicant's household based on definitions used by the U.S. Bureau of the Census. Household Income includes all pre-tax earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance payments, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, assistance from outside the household, and other miscellaneous sources. Non-cash benefits (such as SNAP and housing subsidies) are not considered Household Income.

If the Applicant indicates that the adjusted gross income listed on the Applicant's most recent tax return is not accurate (e.g., the Applicant is no longer employed or is being paid a different amount), the Household Income shall be calculated on the basis of other available documentation (e.g., pay stubs, unemployment statements, etc.). Household Income includes the income of all members of the household.

Illinois Resident: An Illinois Resident is a patient who lives in Illinois and who intends to remain living in Illinois indefinitely. Relocation to Illinois for the sole purpose of receiving health care benefits does not satisfy the residency requirement under the Illinois Hospital Uninsured Patient Discount Act ("HUPDA"). HUPDA requires that the Uninsured Patient be a resident of Illinois, but does *not* require that the Patient be legally residing in the United States. Patients may be required to provide evidence of Illinois residency as provided for under HUPDA. Relocation to Illinois for the sole purpose of receiving health care benefits does not satisfy the residency requirement under this definition.

Insured Patient: A patient covered under a policy of health insurance or a beneficiary under public or private health insurance, health benefit, or other health coverage program, including high deductible health insurance plans, worker's compensation, accident liability insurance, or other third-party liability.

Legal Illinois Resident: A Legal Illinois Resident is a patient legally residing within the United States and who has his or her principal residence within the state of Illinois. With respect to foreign nationals, "legally residing" shall include individuals who have current visas and who are permanent residents and temporary workers. "Legally residing" shall not include foreign nationals who have visitor or student visas. Relocation to Illinois for the sole purpose of receiving health care benefits does not satisfy the residency requirement under this definition.

Medically Necessary: Any inpatient or outpatient health care service, including pharmaceuticals or supplies, covered under Title XVIII of the federal Social Security Act for beneficiaries with the same clinical presentation as the patient. A "Medically Necessary" service does not include any of the following: (1) non-medical services such as social and vocational services; or (2) elective cosmetic

surgery, but not plastic surgery designed to correct disfigurement caused by injury, illness or congenital defect or deformity.

Non-Resident: A Non-Resident is a patient who is neither a Legal Illinois Resident nor an Illinois Resident.

Patient: The individual receiving services.

Plain Language Summary: A clear, concise, and easy-to-understand written statement that notifies an individual that RCMC offers Assistance and provides the following information: (i) brief description of the eligibility requirements and assistance offered under this Policy; (ii) a brief summary of how to apply for Assistance under this Policy; (iii) a direct listing of a website address or URL and physical locations where a copy of this Policy and the Applications may be obtained; (iv) instructions on how to obtain a free copy of the Policy and Application by mail; (v) contact information (including telephone numbers and physical location, if applicable) of the offices or departments who can provide an individual with the Application process; (vi) availability of translations; and (vii) a statement that no Assistance-eligible Patient will be charged more than the Amounts Generally Billed.

Self-Pay Package-Priced Services: Multiple services offered for a single price that is discounted such that the single price is less than the sum of the prices for all the individual services comprising the package of services.

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