PURPOSE:

This Charity Care/Financial Assistance Policy (CC/FAP) describes Methodist Hospital of Chicago's (hereafter known as "MHC") eligibility-determination process for the awarding of free or discounted health-care services. It also establishes application guidelines for individuals (hereafter known as "the patient") seeking free or discounted health-care services at MHC. Finally, it details administrative and accounting guidelines for the identification, classification and reporting of patient accounts as Charity Care to regulatory agencies as required by the Internal Revenue Service (IRS).

POLICY:

MHC is committed to providing financial assistance to patients who may be uninsured, underinsured, medically indigent, ineligible for government programs, or are otherwise unable to pay for medically-necessary care based on their financial situation. Consistent with its mission to deliver compassionate, high quality, affordable healthcare services and to advocate for poor and/or disenfranchised patients, MHC strives to ensure that the financial status of patients who need healthcare services does not prevent them from seeking or receiving care. MHC will provide, without discrimination, care for patients' emergency medical conditions regardless of their eligibility for financial assistance from MHC, any government entity, or other entity.

Financial assistance – also called charity care within this Policy - is not considered a substitute for personal responsibility. Patients are expected to cooperate with MHC's procedures for financial assistance and to contribute to the cost of their care based on their individual ability to pay. Patients with the financial ability to purchase health insurance shall be encouraged to do so, as a means of assuring access to healthcare services for their overall health and protection of their individual assets.

This Policy includes applies to all emergency healthcare and medically-necessary inpatient and outpatient healthcare services provided and billed by MHC. It does not include services provided by physicians; e.g., radiologists, anesthesiologists and surgeons. It also does not include elective cosmetic procedures.

DEFINITIONS:

For the purpose of this FAP, the following definitions apply:

- Charity Care: Healthcare services that have been or will be provided but are not expected to result in cash inflows. Charity care results from MHC's policy to provide healthcare services free or at a discount to patients meeting established criteria.
- Family Size: Using the U.S. Census Bureau's definition, a family is a group of two or more people who reside together and are related by birth, marriage or adoption. According to IRS rules, if a patient is claimed by a family member as a dependent on an income tax return, the patient may be considered a dependent when MHC considers financial assistance.
- Family Income: All before-tax monies earned or received by members of the family as defined above. This includes earnings from salaries, wages, tips, trust funds, annuities, legal judgements, dividends, interest, rents, farm profits, land-bank benefits, workers' compensation, alimony, and child support.

For the purposes of this FAP, the following definitions provided by IRS Rule 501 apply:

- Amounts Generally Billed (ABG): The monetary sum generally billed for emergency or other medically-necessary care for patients who have insurance that covers such care.
- Extraordinary Collection Actions (ECA): The steps taken by a hospital to obtain payment of a bill for care covered under the FAP which require a legal or judicial process. ECAs include: wage garnishment, liens, lawsuits, levies, reporting adverse information to credit agencies or credit bureaus, and selling a debt to a third party. ECAs requiring a legal or judicial process include, but are not limited to: foreclosing on patient's real property, attaching or seizing a bank account or other personal property, taking civil action against a patient, causing a patient's arrest, or causing the patient to be subject to a writ-of-body attachment.
- FAP-eligible: A patient eligible for financial assistance for healthcare service as provided for by the FAP, without regard to FAP-application status.
- Plain-language Summary (PLS): A written statement which notifies patients that MHC offers financial assistance through its FAP. The Summary provides clear, concise and easy-to-understand information. That information includes, but is not limited to: a brief description of financial assistance and FAP eligibility requirements; the website address, mailing address, and physical location(s) from which patients can obtain at no charge MHC's FAP and FAP application form and instructions for completion; contact information of MHC staff whom patients can contact for FAP and FAP application information, including telephone numbers and physical locations; and contact information of other organizations and government agencies, if applicable, that MHC has

identified as sources of FAP application forms; information about translations of the FAP, FAP application form, and PLS in languages other English; and a statement that no FAP-eligible patient will be charged more for emergency or other medically-necessary healthcare than AGB.

- Notification Period: The time frame during which MHC must notify a patient about its FAP. It starts on the date that the first post-discharge billing statement is provided to the patient and ends on the 120th day.
- Application Period: The timeframe during which MHC must accept and process an FAP application. It starts on the date that the first post-discharge billing statement is provided to the patient and ends on the 240th day.
- Completion Deadline: The date after which MHC may initiate or resume ECAs against a patient who has submitted an incomplete FAP application. The deadline must be provided via written notice no earlier than 30 days after MHC provides a patient with a written notice and no later than the last day of the application period.
- Reasonable Efforts: Actions MHC must take to determine whether a patient is FAP-eligible before engaging in ECAs.
- Complete FAP Application: A patient has submitted all information and documentation required for MHC to determine if s/he is FAP-eligible.
- Incomplete FAP Application: A patient has not submitted all information and documentation required for MHC to determine if s/he is FAP-eligible.
- Financially Indigent: A patient for whom payment of MHC's bill may result in financial hardship.
- Medically Indigent: A patient who has accrued medical bills of such an amount that payment threatens his/her financial survival. Upon request, MHC's third party billing agency, MedAssist, with the assistance of MHC's COO/CFO or Controller will determine if a charity-care discount is appropriate.
- Catastrophic Illness: Any lengthy illness or course of healthcare that would deplete a family's financial resources, unless covered by special medical insurance policies. The patient is not eligible for any other assistance and is deemed unable to repay, in 24 months or less, the self-pay portion of an MHC bill assuming current income.
- Uninsured: A patient has no health insurance or third-party assistance to meet MHC payment obligations.
- Underinsured: A patient has some health insurance coverage and/or third-party assistance, but out-of-pocket expense(s) would exceed his/her financial ability for self-payment.
- Medically-necessary Services: As defined by the Centers for Medicare and Medicaid, these are healthcare services or associated care items which are reasonable and necessary for the diagnosis or treatment of an illness or injury.

- Gross Charges: The total charges at MHC's established rates for healthcare services before deductions from revenue are applied.
- Emergency Medical Condition: As defined within Section 1867 of the Social Security Act (42 U.S.C. 1395dd), this is the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity which may include, but are not limited to: severe pain in which a lack of immediate medical attention could reasonably be expected to result in a patient's health being seriously jeopardized; serious impairment to bodily functions: or the serious dysfunction of bodily organs.
- Federal Poverty Level Guidelines (FPLG): Financial eligibility criteria established by the U.S. Department of Health and Human Services (HHS). Guidelines are issued annually by HHS and published in the Federal Register.

PROCEDURES:

A. Services For Which Assistance May Be Considered Under This Policy:
- Emergency care provided in an emergency room setting.
- Services for a condition which, if not promptly treated, would lead to an adverse change in the patient's health status.
- Non-elective care provided in response to life-threatening circumstances in a non-emergency room setting.
- Medically- necessary services.
- Physician services billed by MHC.
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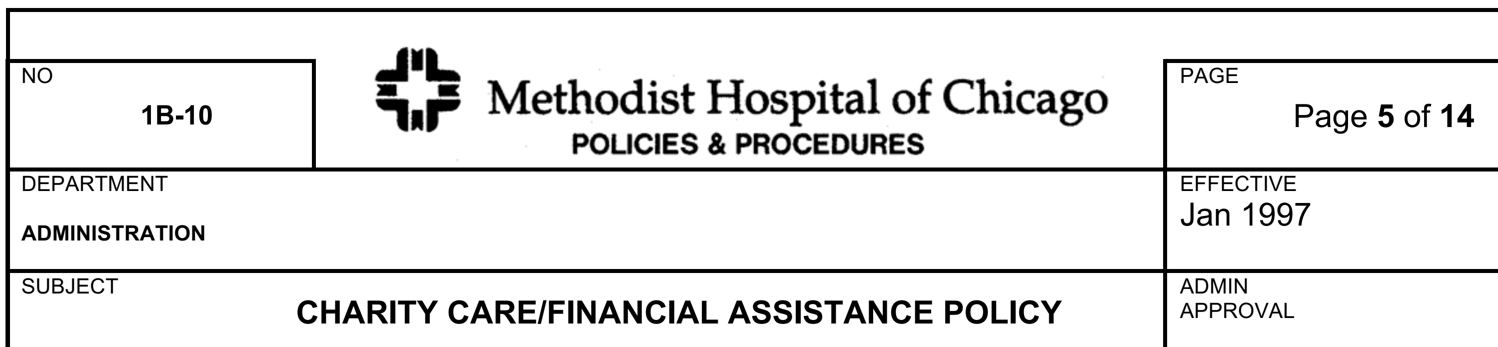
B. Services For Which Assistance May Not be Provided Under This Policy:
- Healthcare services not provided or billed by the hospital.
- Elective cosmetic surgery.
- Elective services or procedures which do not meet medically-necessary criteria, e.g., social, educational or vocational services.

C. Eligibility:
Eligible patients include those who are uninsured, underinsured, medically indigent, ineligible for any government healthcare benefit program, and who are unable to pay for their care based on a determination of financial need in accordance with this Policy. Assistance will be determined solely on the basis of financial need as described in this Policy, and shall not take into account as patient's or family member's age, race, social or immigrant status, sexual orientation, sexual or gender preference, or religious affiliation. MHC will determine a patient's eligibility for assistance with insurance deductibles,



co-insurance, or co-payment responsibilities.

D. Communication of Financial Assistance Availability:
MHC communicates the availability of financial assistance by: posting signage conspicuously throughout the facility, including, but not limited to: Emergency Department, Admitting Office, Registration areas, and Business Office. At points of service, patients will receive a Plain Language Summary and contact information for MHC staff who can provide additional information. Signs and written notices will be provided in English and Spanish, the primary languages used by persons in MHC's service area.

Each patient bill or statement will include a prominent notation about the availability of financial assistance for patients meeting the eligibility requirements described in this Policy, along with contact information for staff who can provide additional information.

The FAP, FAP application form, and PLS will be posted in MHC's public areas and on its website: www.methodistchicago.org. MHC will also provide, at no cost, hard copies of the FAP, FAP application form, and PLS upon request by mail, telephone or in person, as described above.

During the admission/registration process, staff will ask about the patient's health insurance. If a patient has no applicable insurance coverage, staff will refer the patient to MHC's contracted agency, **MedAssist** for help in applying for the State of Illinois' medical assistance program, MANG. MHC's Social Service Department staff will assist the patient in applying for other applicable governmental programs, e.g., Medicare. Admitting Department staff will also advise the patient about this Policy.

E. Application Process:
Patients who are uninsured, underinsured, medically indigent, or ineligible for any government healthcare benefit program and who are seeking financial assistance must complete a FAP application, so that MHC can determine eligibility. As noted above, the FAP Policy, application form, and PLS are available by contacting MHC, by mail (% of Business Office, 5025 N. Paulina St., Chicago, IL 60640), or via telephone at 773-989-1469 and at www.methodistchicago.org.

MHC expects applicants for financial assistance to cooperate with requests for information and/or documentation and affirm via signature that the form, information

and/or documentation are true. If any of these are determined to be untrue, any existing or potential financial assistance will be forfeited and the patient or his guarantor will be responsible for full payment of the patient's bill.

If an individual does not submit a FAP application by the Completion Deadline as defined above, MHC may engage in ECAs.

F. Incomplete FAP Applications:
If an individual submits an incomplete FAP application as defined above, and/or requested documentation is missing, MHC will:

- Provide the applicant with a written notice that describes the required missing and/or additional information/documentation.
- Suspend any ECAs until one of the following occurs: patient/guarantor completes the FAP application; MHC determines whether the individual is FAP-eligible; patient fails to respond to requests for missing and/or additional information within a reasonable period of time; or the Completion Deadline has passed without the FAP application being completed.
- Provide the patient with at least one written notice informing him/her of ECAs that MHC or another authorized party may initiate or resume if the FAP application is not completed the FAP application or pay the amount due by the Completion. If an incomplete FAP application is subsequently completed by the completion deadline, the individual will be considered to have submitted a completed application during the application period.
- If an incomplete application is submitted during the application period and the individual fails to complete the FAP application by the completion deadline the hospital may initiate or resume ECAs against the individual after the completion deadline.
- The hospital will initiated ECAs against an individual whose FAP-eligibility has not been determined as early are 120 days after the first post-discharge bill. However, if the hospital does initiate an ECA against an individual before the end of the 240th application period and the individual is subsequently determined FP-eligible, the hospital will reverse the ECA altogether and begin the collection process anew based on the discounted amount.

G. Complete FAP Applications:
If an individual submits a completed FAP application within the Application Period, MHC will not initiate or resume any ECAs until FAP-eligibility determination has been made. It will:

- Suspend any ECAs
- Determine and document the patient's FAP eligibility.
- Notify the patient in writing of the determination, including eligibility for free or discounted care, and the basis for the determination.
- Provide the FAP-eligible patient with a written notice or a billing statement (discounted gross charges) including the following: the amount of payment for which the patient is responsible; directions for obtaining information regarding the AGB for the care received; and how the amount for which the patient is responsible was determined.
- Refund any excess payments made by the patient for the care at issue.
- Take all reasonable measures to reverse any ECAs (with the exception of a sale of debt) taken against the patient including, but not limited to: measures to vacate any judgment; lift any liens or levies on the patient's property; and remove any adverse information that was reported to the credit agencies.

H. If a patient is determined to be FAP-eligible, MHC will:

- Provide the patient with a written notice of the determination and the basis for this determination.
- Provide the patient with a billing statement (discounted gross charges) that indicates the discounted amount he or she owes.
- Provide the patient an opportunity to establish a reasonable installment plan if s/he is unable to pay the full discounted amount owed upon receiving the first billing statement.
- Take all reasonable measures to vacate any judgement, lift any liens or levies on the patient's property; and, if applicable, remove reporting of adverse information to credit bureaus.

I. If a patient is determined not to be FAP-eligible, MHC will:

- Notify the patient in writing of the determination and the reason(s) for denial.
- Provide the patient with a billing statement for the amount he or she owes.
- Provide the patient an opportunity to establish a reasonable installment plan if s/he is unable to pay the full amount owed upon receiving the first billing statement.
- Provide the patient with a written notice of the ECAs action MHC may initiate in the event of non-payment.

J. Financial assistance may not be denied based on the omission of information and/or documentation if such information/documentation was not specifically requested or required by MHC. During the FAP application process, all collection activity will be suspended while the application is reviewed for eligibility determination.

K. MHC's mission and values will be reflected in its FAP application process, financial need determinations, granting of assistance, and interactions with patients seeking assistance.

L. All patients, regardless of FAP-eligibility, must cooperate with MHC to establish a reasonable payment plan if they are unable to pay the amount owed.

M. Presumptive Financial Assistance Eligibility:

There are instances in which a patient may appear eligible for financial assistance, but there is no FAP application on file due to a lack of supporting documentation and/or the patient's inability or refusal to complete an application because of his/her medical condition. There may be adequate information available from the patient or other sources which could provide sufficient evidence to determine the patient is eligible for assistance. Presumptive Eligibility may be determined on the basis of a patient's circumstances. These may include, but are not limited to:

- Patient is enrolled in a state-funded prescription-medication program.
- Patient is homeless or receives care from a homeless clinic.
- Patient is eligible for and/or receives food stamps.
- Patient is eligible for other state or local assistance programs that do not include hospital medical care; e.g., Medicaid-eligible 93 B DS category code or Medicaid spend-down is unmet.
- Patient is deceased with no known estate.
- Patient declared bankrupt by bankruptcy court.
- Patient who is currently Medicaid- eligible but not eligible at time of service.
- Patient who is mentally challenged and unable to complete or follow through on a FAP application or Medicaid application and unable to effectively deal with his/her healthcare finances.
- Patient who has been incarcerated and has no health insurance.
- Patient who is eligible for Illinois Link or SNAP.
- Patient treated in MHC's Emergency Department who lacks a payment source, job, residence, mailing address, or health insurance, Medicaid eligible HMO/PPO patients whose medical care was not paid because hospital was not a participating provider at the time of service;

- Patient who is Medicare-eligible with no secondary health insurance.
- Patient who participates in the Women's, Infants, Children Program (WIC).

N. Patients who meet at least one of the above Presumptive Eligibility criteria will be granted a 100% financial assistance discount without completing the FAP Application.

O. Eligibility Criteria and Amounts Charged to Patients:
Services eligible under this Policy will be made available on a sliding-fee scale in accordance to the patient's financial need, as determined in reference to the FPLG in effect at the time of determination. Determination of financial assistance will be based on the annual family income and family size. Once MHC/MedAssist determines that a patient is eligible for financial assistance, s/he will not receive any future bills based on discounted gross charges. Charity write offs that exceed $10,000 on a per case basis will need the approval of the COO/CFO and or Corporate Controller prior to write off.

The bases for the amounts MHC will charge FAP-eligible patients is as follows:

- Patients whose family income is at or below 200% of the FPLG are eligible for free care.
- For patients whose family income is between 201% and 600% of the FPLG; a sliding-fee scale will be used to determine the financial assistance percentage.
- Patients whose family income exceeds 601% of the FPLG may be eligible to received discounted rates on a case-by-case basis based on specific circumstances such as catastrophic illness or medical indigence, at the discretion/approval of the hospital's controller, COO and/or CFO.

2015 Federal Poverty Level Guidelines as published in the Federal Register.

Family Size	FPL Guideline
1	$11,770
2	15,930
3	20,090
4	24,250
5	28,410
6	32,570
7	36,730
8	40,890

For families with more than 8 persons, add $4,160 for each additional person.

Financial assistance and the discount of gross charges is based on:

FPLG	Discount On Gross Charges
At or below 200%	100%
Between 201% and 300%	75%
Between 301% and 400%	50%
Between 401% and 500%	25%
Between 501% and 600%	15%

Over 601% required approval from controller, COO or CFO on per case basis.

Patients eligible under this Policy will not be charged more for emergency or other medically-necessary healthcare services than the AGB for insured patients. The Prospective Method will be used by the hospital to determine AGB, which is based on Medicare's fee-for-service payment (including coinsurance and deductibles) for similar services. Total charity write off on a cumulative basis will be reviewed by the controller on a monthly basis

Financial-assistance approval is for one year from the approval date, unless changes have occurred in the family income and/or family size. In such cases, a new FAP application form must be submitted and processed for a new eligibility determination.

The patient must exhaust all other third-party payer options, including but not limited to, Medicare, Medicaid, and/or other state- or locally-funded programs.

P. Approval Levels and Authorization (on per case basis):

Value	Authority
$1.00 - $10,000	MedAssist Solutions
$10,000 - $20,000	
$20,000 and above	Corporate Controller and/or

Q. Verifications:

Patients may be required to provide proof of income, including but not limited to:

- Copy of the applicant's federal income tax return from the previous calendar year.
- Copy of the most recent W-2 or 1099 form.
- Copy of the two most recent paycheck stubs.
- Employer's written and signed income statement if paid in cash.
- Statement of earnings from Social Security.
- Unemployment or disability statements or checks.
- Letter of support from the individual(s) providing for the patient's basic living needs.
- Checking and/or savings account statement(s).

Patients may be required to provide legal proof of identification, including but not limited to:

- Copy of current Illinois Driver's License or state ID card.
- Copy of Social Security card.
- Photo ID that displays patient's current address.

Patients may be required to provide proof of family size:

- Copy of the previous year's Federal Income Tax Return; and/or
- Copy of the Birth Certificate for each family dependent.

R. Patient Responsibilities:

Patients determined to be FAP-eligible for a partial discount must cooperate with MHC to establish a reasonable installment payment plan which takes into account family income and size and the amount of the discounted bill and prior payments. Patients must make good-faith efforts to honor payment plans for discounted bills. They are responsible for communicating to MHC any change in their financial status that may impact their ability to pay MHC bills. If a patient's financial circumstances become more favorable while s/he receives financial assistance under this Policy, s/he must notify the MHC hospital of such a change.

S. Appeals Process:

A patient has the right to appeal if s/he disagrees with the denial of financial assistance. The patient must request an appeal within 60 days of the non-eligibility notification. S/he must provide any requested information that may assist in reviewing the determination. Appeals may only be requested if: incorrect information was originally submitted; the patient's financial status has changed; or if there are extenuating circumstances. MHC will notify the patient of the outcome within 30 days of receipt of the request for an appeal.

If the determination affirms the original denial, MHC will provide written notification indicating the reason(s) for denial of the appeal. Reasons may include, but are not limited to: patient/guarantor has sufficient income; applicant is uncooperative with or unresponsive to MHC's reasonable efforts to obtain pertinent data/documents; and/or The FAP application remains incomplete after MHC has made reasonable efforts to work with the patient to complete it.

T. Recording and Reporting Charity Care:

MHC's Finance Department is responsible for maintaining paper and electronic copies of all completed FAP applications, supportive documentation, and determination data in patients' financial files. Discounted-care amounts will be posted to each patient's accounts- receivable balance as a charity care write-off utilizing assigned adjustment codes. Applications are to be placed in a shared FTP site with our third-party biller, MedAssist.

MHC will report the amount of charity care provided each year to appropriate agencies in compliance federal, state and/or local statutes and regulations.

U. Nonpayment of a Bill:

MHC **(**or its authorized agent**)** will make reasonable efforts to determine if the patient is FAP-eligible before engaging in ECAs by:

- Advising the patient about the FAP
- Providing the patient with a FAP application form and PLS (upon request).
- Including a PLS in at least three billing statements and with all other written communications with the patient
- Informing the patient about the FAP in all oral communications

- Providing the patient with at least one written notice advising him/her about ECAs that MHC or its authorized agent may take if a FAP is not completed or a bill remains unpaid.

If an individual submits an incomplete FAP Application during the Application Period MHC will:

- Suspend any ECAs
- Provide the patient with a written notice describing the information and/or documentation required to make a FAP eligibility determination and include a PLS
- Provide the patient with at least one written notice.

After the above reasonable efforts have been made, MHC or its authorized agent may take ECAs as described above.

V. Regulatory Requirements

MHC management, staff and authorized agents will comply with all federal, state and local laws and regulations that may apply to activities conducted pursuant to this Policy.

W. Emergency Medical Care:

MHC will provide care for emergency medical conditions subject to the Emergency Medical Treatment and Labor Act (EMTALA) guidelines by providing medical screening, examinations and stabilization, and referring or transferring a patient to another facility when appropriate. MHC will provide emergency medical care to individuals without discrimination, and will not take into account a patient's or family member's age, race, social or immigrant status, sexual orientation, sexual or gender preference, or religious affiliation.

Individuals who may qualify for financial assistance will be identified as soon as possible, either before or after emergency medical services have been provided.

MHC and its authorized agent will not engage in medical debt collection activities in the Emergency Room or other areas where emergency medical conditions are being treated.

X. Extenuating Circumstances:

A patient's individual circumstances not specifically covered under this Policy may qualify the cost of services as a Charity Care write-off, with the approval of the COO/CFO, Administrator and or controller. Documentation related to this decision will

be maintained in the patient's financial file. Care for patients with Medicaid and Medicaid HMO coverage is eligible for Charity Care write-offs if related to denied days of care and non-covered services (except those excluded under this Policy). Treatment Authorization Number (TAN) denials and any lack of payment for services provided to Medicaid and Medicaid HMO patients may be classified as Charity Care.

Y. Catastrophic Charity Care:
Catastrophic Charity Care is available for patients who do not qualify for a full or partial discount when their allowable medical expenses are so significant that they are unable to pay for necessary medical care. Allowable medical expenses are defined as unpaid discounted charges for which the patient is responsible, incurred either before or after the financial assistance application date.

A catastrophic charity care discount will be offered to patients on a case-by-case basis when they:

- Have exhausted their health insurance coverage
- Are not eligible for Medical Assistance or state- or federally-funded programs
- Are unable to pay the self-pay portion amount owed in 24 months or less
- Have an income that exceeds 200% level of the current FPLG.

To be eligible, allowable medical expenses must exceed 30% of Family Income as described here:

- MHC will multiply Family Income by 30
- MHC will determine the patient's allowable medical expenses
- MHC will compare 30% of Family Income to the total allowable medical expense amount. If the total allowable medical expense is greater than 30% of Family Income, the patient meets the catastrophic charity care criteria
- MHC will subtract 30% of Family Income from the allowable medical expenses to determine the amount by which the allowable medical expenses exceed the available income. That amount is eligible for charity care write-off.

All catastrophic illness and financial hardship applications must be reviewed and approved by the CFO and/or corporate controller.

Reviewed: 10/05, 5/08, 8/11, 8/14, 6/17
Revised: 11/04, 5/08, 8/11, 5/15, 5/20