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- Mercyhealth—All**
- Mercyhealth Hospital-Rockford
 - Rockton
 - Riverside
- Mercyhealth Hospital & Medical Center-Harvard
- Mercyhealth Hospital & Trauma Center-Janesville
- Mercyhealth Hospital & Medical Center-Walworth
- Mercyhealth Hospital & Medical Center-Crystal Lake
- MercyCare Health Plans
- Ambulatory Care Facilities
 - MHS
 - RPH
- Mercyhealth At Home-Janesville
- Mercyhealth At Home-Rockford
- Mercyhealth Transitional Care Center
- Mercyhealth Care Center-Harvard

Mercy Health Corporation (dba Mercyhealth) **POLICY** **PROCEDURE**

Subject: Hospital Financial Assistance Policy

Manual and Section: General Administration - 200

Approvals and Dates: Executive Council 1/18/2023

Original Date: 07/01/2016 Effective Date: 1/18/2023

Date of Last Revision: 7/27/23 Next Review Due: 1/1/2024

Reviewed Date: 1/18/2023 Page 1 of 7

Owner & Title: VP Revenue Cycle and Chief Financial Officer

I. OBJECTIVE

The objective of this policy is to provide written criteria for determining whether patients seeking medical care from Mercy Health Corporation (Mercyhealth) entities are eligible for various forms of Financial Assistance and also to provide guidelines for the provision of Financial Assistance to such patients. Mercyhealth entities include services provided at Javon Bea Hospital – Riverside, Javon Bea Hospital – Rockton, Mercyhealth Hospital and Medical Center – Harvard, Mercyhealth Hospital and Trauma Center – Janesville, Mercyhealth Hospital and Medical Center – Walworth, and Mercyhealth Hospital and Medical Center- Crystal Lake.

This policy is intended to comply with Section 501(r) of the Internal Revenue Code and other applicable law, which in Illinois includes the Illinois Community Benefits Act, Illinois Hospital Uninsured Patient Discount Act (HUPDA) and the Illinois Fair Patient Billing Act. If the provision of Financial Assistance becomes 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 Mercyhealth administers its Financial Assistance program.

II. POLICY OVERVIEW

44

45 At Mercyhealth, all patients are treated with dignity and respect regardless of their ability
46 to pay. Mercyhealth prioritizes the needs of communities; therefore, Mercyhealth will
47 generally limit the consideration of Financial Assistance to applicants who have proof of
48 residence with in Wisconsin or Illinois. Exceptions to residency requirements may be
49 made on a case-by-case basis at Mercyhealth’s sole discretion. Emergency stabilizing
50 services will never be denied or delayed on the basis of a patient’s ability to pay. Every
51 Mercyhealth hospital provides, without discrimination, Emergency Medical Care to
52 individuals regardless of ability to pay or eligibility for Financial Assistance. (For the
53 Javon Bea Hospitals the Emergency Medical Care policy is “**Emergency Medical**
54 **Treatment at Javon Bea Hospital / EMTALA Compliance**”. For all other
55 Mercyhealth hospitals, the Emergency Medical Care policy is “**EMTALA Screening,**
56 **Treatment & Transfer of Patients**”.)

57

58 **Any patient eligible for Financial Assistance under this policy will not be charged**
59 **more for Emergency Medical Care or Medically Necessary care provided by the**
60 **hospital (inpatient or outpatient departments) than the amount generally billed**
61 **(AGB) to insured patients.**

62

63 Financial Assistance will be provided only when care is deemed Medically Necessary
64 (including Emergency Medical Care) and after patients have been found to meet all
65 financial criteria. Patients seeking Financial Assistance may first be asked to apply for
66 external programs (such as Medicaid or insurance through the public marketplace) as
67 appropriate before eligibility under this policy is determined. Additionally, any uninsured
68 patients who are believed to have the financial ability to purchase health insurance may
69 be required to do so.

70

71 The Patient Financial Services Department leadership has final authority in determining
72 whether Mercyhealth has made reasonable efforts to determine eligibility for all Financial
73 Assistance programs.

74

75 **III. DEFINITIONS:**

76

The following terms are defined as follows for purposes of this policy:

77

A. **Financial Assistance:** The Presumptive Charity Care, Traditional Charity Care
78 and Illinois Hospital Patient Uninsured Discount Act (HUPDA) programs
79 described herein. Financial Assistance is available only for the providers or
80 groups specified as “COVERED” in the list of Providers Covered and Not
81 Covered under Mercyhealth’s Hospital Financial Assistance Supporting
82 Information document. That list is available on our website at
83 www.mercyhealthsystem.org or available free of charge as listed in Section VII.

84

B. **Medically Necessary:** Except in relation to the HUPDA program, “Medically
85 Necessary” means hospital services or supplies (inpatient or outpatient) needed to
86 diagnose or treat an illness, injury, condition, disease, or its symptoms and that
87 meet accepted standards of medicine, including Emergency Medical Care.

- 88 “Medically Necessary” does not include elective or cosmetic tests or procedures
89 or prescription drugs/supplies not administered in the hospital.
- 90 C. **Emergency Medical Care:** Care provided by the hospital for emergency medical
91 conditions as defined in Section 1867 of the Social Security Act (42 U.S.C.
92 1395dd).
- 93 D. **Uninsured:** A hospital patient without any health insurance or coverage.
- 94 E. **Amount Generally Billed (AGB):** The amount generally billed to insured
95 patients for Emergency Medical Care or Medically Necessary care. The AGB is
96 determined as described in Section IV below.
- 97 F. **Gross Charges:** The full amount charged by a Mercyhealth hospital for items and
98 services before any discounts, contractual allowances, or deductions are applied.
- 99 G. **Patient Responsibility Balance:** The balance for items and services after any
100 insurance, other third-party coverage, and other applicable deductions (except
101 Financial Assistance) have been applied.
- 102 H. **Presumptive Eligibility:** The process by which the hospital may use previous
103 eligibility determinations and/or information from sources other than the
104 individual to determine eligibility for Financial Assistance.

105 FINANCIAL ASSISTANCE PROGRAMS AND ELIGIBILITY CRITERIA

106
107 As part of Mercyhealth’s mission to provide comprehensive, compassionate coordinated
108 health care to our patients, we offer several Financial Assistance programs. Eligibility
109 for Financial Assistance is generally based on family size and gross income at or below
110 certain established federal poverty level guidelines. A patient failing to meet the criteria
111 related to financial income may be qualified for Presumptive Charity Care (see below).

112 If a patient is eligible for more than one program, Mercyhealth will approve the greatest
113 benefit amount available under the programs. On a case-by-case basis and consistent with
114 applicable law, other outstanding receivables, including bad debt, may be waived if it can
115 be documented that the patient met eligibility for Financial Assistance at the time of the
116 prior services.

117 All programs require proof of residency within the communities we serve. All programs
118 except the Presumptive Charity Care program require patients to submit all required
119 documentation to be considered for eligibility. An application may not be considered
120 complete unless it includes all documentation required by the application. Mercyhealth
121 may, from time to time, utilize outside third-party sources to help determine Financial
122 Assistance eligibility. For example, these third-party sources may provide information
123 about Medicaid eligibility, residency, or credit scores.

- 124
125 A. **Presumptive Charity Care** – Hospital bills for patients meeting certain
126 Mercyhealth requirements are categorically reduced by 100% on an episodic
127 basis for any patient liability. All third-party liability must be exhausted.
128 Based on information received from third party sources, Mercyhealth may

129 categorize an account as Presumptive Charity Care and reduce amounts up to
130 100%, if Mercyhealth determines one or more of the following criteria
131 applies; no other proof of income will be requested:

- 132 i. Patient is currently eligible for Medicaid for other dates of service or
133 services deemed non-covered by Medicaid; or,
- 134 ii. Homelessness;
- 135 iii. Deceased with no estate;
- 136 iv. Mental incapacitation with no one to act on the patient's behalf;
- 137 v. Confirmed bankruptcy;
- 138 vi. Patient is enrolled in or eligible for an assistance program for low
139 income individuals including but not limited to:
 - 140 (i) Women, Infant and Children Nutrition Program (WIC);
 - 141 (ii) Supplemental Nutrition Assistance Program (SNAP);
 - 142 (iii) Illinois Free Lunch and Breakfast Program;
 - 143 (iv) Community Based Medical Assistance;
 - 144 (v) Temporary Assistance for Needy Families (TANF);
 - 145 (vi) Low income/subsidized housing is provided as a valid
146 address;
 - 147 (vii) Receipt of grant assistance for medical services.

148

149 **B. Traditional Charity Care** – For patients meeting the criteria below and
150 submitting a complete application, patient liability exceeding \$300.00 is
151 reduced. All third-party payment sources must be exhausted.

- 152 • For patients who are otherwise qualified and have a gross family household
153 income equal to or less than 200% of the federal poverty guidelines, patient
154 liability will be reduced by 100%.
- 155 • For patients who are otherwise qualified and have a gross family household
156 income ranging from 201% to 300% of the federal poverty guidelines,
157 patient liability will be determined on a sliding fee scale. The scale is
158 available in the Financial Assistance Supporting Information on our website
159 at www.mercyhealthsystem.org or available free of charge as listed in
160 Section VII.
- 161 • A new completed application process will be required for further services
162 not included in the original approval notification. Traditional charity care is
163 not considered an insurance plan.

164

165 **C. Illinois Hospital Patient Uninsured Discount Act (HUPDA)** - Uninsured
166 patients residing in and receiving care in Illinois may qualify for scaled discounts
167 to medical fees under the following guidelines:

- 168
169 i. Patient must be an Illinois resident; and,
170
171 ii. Patient must have no other form of third-party insurance; and,
172
173 iii. Patient has a family income of 600% or less of the federal poverty level or
174 300% or less for Mercyhealth Harvard Hospital.
175

176 This discount applies only to “medically necessary” services, which are defined
177 differently for HUPDA than the other programs described in this policy. Under Illinois
178 law, “medically necessary” in relation to HUPDA means any inpatient or outpatient
179 hospital service, including pharmaceuticals or supplies provided by a hospital to a patient,
180 covered under Medicare for beneficiaries with the same clinical presentation as the
181 patient eligible for Financial Assistance. A “medically necessary” service does not
182 include any of the following: (1) non-medical services such as social and vocational
183 services; or (2) elective cosmetic surgery, but not plastic surgery designed to correct
184 disfigurement caused by injury, illness, or congenital defect or deformity.
185

186 Uninsured patients who are otherwise qualified and have a family household income
187 equal to or less than 200% of the federal poverty guidelines shall receive a 100%
188 discount on any bill for medically necessary services exceeding \$150 in any one
189 inpatient admission or outpatient encounter. The 100% discount applies to family
190 household income equal to or less than 125% of the federal poverty guideline for Mercy
191 Harvard Hospital.

192 For all other uninsured patients that qualify for HUPDA, charges for medically necessary
193 services exceeding \$150 in any one inpatient admission or outpatient encounter shall be
194 subject to an “Uninsured Discount”. The Uninsured Discount shall be calculated using
195 the following formula: $[1 - (1.35 \times \text{hospital ratio of cost to charges})] \times \text{charges}$.
196

197 Over a 12-month period, hospitals cannot collect more than 20% of family gross income
198 from a HUPDA-eligible patient. An uninsured patient may apply for a discount within 90
199 days of the date of discharge.
200

201 All uninsured patients not qualifying for one of the above Financial Assistance programs
202 will be granted an uninsured patient discount. There is no dollar limit to the uninsured
203 patient discount. No additional approval is required for the uninsured patient discount.
204 Because the uninsured patient discount is not based on financial need, the uninsured
205 patient discount is not subject to the Amount Generally Billed (AGB) limitation
206 described in Section IV.
207

208 **IV. CALCULATING AMOUNTS CHARGED TO PATIENTS**

209

210 Notwithstanding anything else in this policy, once eligibility for Financial Assistance has
211 been established, Mercyhealth will not charge patients who are eligible for Financial
212 Assistance under this policy more than the amounts generally billed (AGB) to insured
213 patients for Emergency Medical Care or Medically Necessary care.

214
215 To calculate the AGB, Mercyhealth uses the “look-back” method described in Section
216 4(b)(2) of the IRS and Treasury’s 501(r) final rule.

217
218 In this method, Mercyhealth uses data based on claims sent to Medicare’s fee-for-service
219 program and all private commercial insurers for Emergency Medical Care and Medically
220 Necessary care over the past year to determine the percentage of Gross Charges that is
221 typically allowed by these insurers. Mercyhealth uses data for a 12-month period
222 beginning April 1 through March 31 and will adjust the AGB percentage yearly, effective
223 each July 1. The current AGB for each hospital is listed in the Financial Assistance
224 Supporting Information on our website at www.mercyhealthsystem.org or available free
225 of charge as listed in Section VII.

226
227 Any discount is applied to the Patient Responsibility Balance for Emergency Medical
228 Care or Medically Necessary care. A discount may only be used to cover deductibles,
229 coinsurances, and copays for balances exceeding \$300.00 if permitted by law and the
230 hospital’s reimbursement contracts.

231

232 **V. CONFIDENTIALITY**

233

234 Mercyhealth respects the confidentiality and dignity of its patients and understands that
235 applying for Financial Assistance may be a sensitive issue. All application information is
236 subject to Mercyhealth privacy practices.

237

238 **VI. HOW TO APPLY AND FIND OTHER KEY DOCUMENTS**

239

240 The list of providers covered by this policy is maintained in a separate document,
241 Financial Assistance Supporting Information, which may be obtained free of charge
242 through the websites and contact points listed below.

243

244 There are multiple ways to obtain free copies of the Mercyhealth Financial Assistance
245 Policy, a Financial Assistance Application, the Billing and Collections Policy, the Plain
246 Language Summary and Spanish translations:

247

- 248 • Apply via MyChart: <https://mercyhealthsystem.org/mychart-login/>
- 249
- 250 • Visit our website at: <https://mercyhealthsystem.org/financial-policies/>
- 251
- 252 • Contact the Customer Service Department:

253

254 MercyCare Building
255 580 N. Washington Street
256 Janesville, WI 53547
257 (608) 741-7630 or (866) 269-7115

258 Monday through Friday, 8am to 4:30pm
259 Email: custserv@mhemail.org

260

261 • Pick up a paper copy at the following locations:

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263 Javon Bea Hospital – Riverside

264 Javon Bea Hospital – Rockton

265 Mercyhealth Hospital and Medical Center - Harvard

266 Mercyhealth Hospital and Trauma Center – Janesville

267 Mercyhealth Hospital and Medical Center – Walworth

268 Mercyhealth Hospital and Medical Center – Crystal Lake

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271 Paper copies of the application are available for free upon request in the
272 Emergency Departments and admissions areas at the following hospital locations:
273 Javon Bea Hospital – Riverside, Javon Bea Hospital – Rockton, Mercyhealth
274 Hospital and Medical Center – Harvard, Mercyhealth Hospital and Trauma Center
275 – Janesville, Mercyhealth Hospital and Medical Center – Walworth, and
276 Mercyhealth Hospital and Medical Center – Crystal Lake

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279 **Completed applications should be returned or mailed to the same address.**

280 This policy and its supporting documentation (i.e., Financial Assistance application) will
281 be made available on the websites listed above in a format that can be easily downloaded,
282 viewed and printed. The website may also include a plain language summary of the
283 policy. Paper copies of this policy, application, supporting information and plain
284 language summary of this policy will be made available upon request, without charge, at
285 locations in the hospital and by mail. Signage detailing the availability of Financial
286 Assistance will be visibly displayed and content concerning Financial Assistance will be
287 available on the websites listed above.

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