**POLICY & PROCEDURE MANUAL**
**EFFECTIVE DATE: 01/01/2024**

# Financial Assistance Policy

Methodist Rehabilitation Center (MRC) provides Financial Assistance at reduced or no cost to low income Mississippi residents who are uninsured or underinsured and do not have adequate financial resources to pay for the medically necessary healthcare services provided by MRC.

I. PURPOSE

The purpose of this policy is to provide a structured framework to allocate MRC's limited resources available to provide free or discounted rehabilitation services to patients in need, while maintaining the fiscal integrity of the organization and under the requirements of applicable laws including Section 501(r) of the Internal Revenue Code 1986, as amended, and the regulations thereunder.

II. OBJECTIVES

Accordingly, this policy establishes the following:

A. Eligibility Criteria for financial assistance
B. Basis for calculating amounts charged or billed to patients
C. Method by which patients may apply for financial assistance
D. Details financial assistance or other discounts available
E. Ensures the policy is widely publicized within the facility, referral sources and surrounding community

III. SCOPE

A. This policy applies to services provided by MRC. Because MRC is uniquely qualified to provide inpatient rehabilitation services, MRC will focus the limited provision for free care to Inpatient Rehabilitation services. Discounted care for uninsured or hardship waivers for large patient liability balances will apply to all services provided by MRC.
B. This policy excludes Methodist Specialty Care Center.

IV. Definitions

A. Amounts Generally Billed (AGB) – Amounts Generally Billed is determined by multiplying the gross charges for the medical care provided by the AGB percentage. MRC uses the "look-back" method to calculate this percentage based on an annual basis by service level. The percentages are determined by utilizing the sum of all claims paid by Medicare fee for service and all private health insurers divided by the sum of gross charges for these claims. See Exhibit A for the most current AGB percentages.

B. Extraordinary Collection Actions (ECA)- MRC does not typically apply or use ECA to resolve patient balances; however as a general rule, ECA is defined as actions taken by a hospital facility against an individual related to obtaining payment of a bill for covered care under the hospital facility's Financial Assistance Policy that may include but are not limited to the following:
   1. Selling an individual's debt to another party
   2. Reporting adverse information about an individual to consumer credit reporting agencies or bureaus.
   3. Defer or deny care unless payment made prior to medically necessary care because of an individual's non-payment of one or more bills for previously provided care under the hospital's FAP.
   4. Require a legal or judicial process.

C. Financial Assistance Policy (FAP)- This Financial Assistance Policy

D. Financial Assistance Referral – (FA patient) For purposes of this policy, a referral from an acute facility for a patient who has need of inpatient rehabilitation services but has no funding sources.

E. Inpatient Rehabilitation Admission Criteria- Patient must require intensive rehabilitation therapy in a resource intensive inpatient hospital environment due to the complexity of their nursing needs, medical management and rehabilitation needs. Patient must require and would benefit from an inpatient stay and an interdisciplinary team approach to the delivery of inpatient care. At time of prospective admission, the patient requires and must be able to participate in active and ongoing intensive therapeutic intervention of multiple disciplines of therapy. The patient must require supervision by a rehabilitation physician with specialized training in inpatient rehabilitation. The patient must be expected to benefit significantly from the intensive rehabilitation therapy program.

F. Federal Poverty Guidelines (FPG)- Poverty guidelines issued by the federal government at the beginning of each calendar year that are used to determine eligibility for poverty programs; the current FPG can be found on the US Department of Health and Human Services website at http://www.hhs.gov/.

G. Mississippi Resident- For purposes of this policy, a Mississippi resident is an individual who is of legal age or is an emancipated minor and shall have established a home in Mississippi, is habitually present for a period of at least one hundred eighty days, with the bona fide intention of making the state his or her permanent residence. An extension of this definition includes: 1) The parent/parents/guardian are/is habitually present for a period of at least one hundred eighty days with the bona fide intention of such parents, parent or guardian to make this state their permanent residence, supported by documentary proof; or 2) A non-resident of Mississippi prior to marriage and marries a person who has established a home in Mississippi where he or she is habitually present for a period of least one hundred eighty days, with the bona fide intention of making this state his or her permanent residence, supported by documentary proof.

H. Insured- Patients with any type of insurance coverage and/or third party payor program which reimburses for, compensates or discounts medical expenses. For purposes of this policy, patients are considered to be insured even if their benefits have been exhausted, they are out of network and/or their insurance does not cover a specific treatment.

I. Uninsured- Patients for who there is no third party responsible for any portion of their medical expenses.

J. Visit- For purposes of this policy, a "visit" is defined as a daily treatment session.

K. Discounted Care – For purposes of this policy, a fixed discount amount is applied to any services provided to patient with no other funding sources. Also referred to as self pay discount or private pay discount. Discount rate is calculated using the AGB lookback method. (See Section IV A.).

L. Financial Hardship Patient Liability Waiver – For purposes of this policy, a financial hardship waiver will be considered for patients who are insured but are unable to pay the patient liability portion of their bill.

V. Eligibility – FA Inpatient Rehabilitation, Full Waiver (Free Care)

Because of the unique specialty services provided by MRC and in an effort to meet the rehabilitation needs of more patients, MRC only offers full Financial Assistance Waiver (free care) to qualifying first-time inpatient referrals. Priority will be given to patients with first-time traumatic spinal cord injury and/or first-time traumatic brain injury, due to the limited availability of specialty rehabilitation services for these conditions.

A. Referral Criteria-

An appropriate FA referral would require the following:

1. Patient must meet the Inpatient Rehabilitation Admission Criteria requirements. See Section IV Definitions – E.
2. Patient must have the ability to make significant progress in a reasonable time-frame.
3. Patient must have a reasonable and established discharge plan for post-rehabilitation.
4. Patient presents as or is believed to be uninsured.
5. The patient's injury cannot have derived as the result of being involved in a criminal activity that would be a predictor for a poor patient outcome.
6. Patient may be required to have a designated representative/caregiver to be available to the MRC team as needed to be an active participant in patient's treatment to ensure adequate training for post discharge care.

B. Inpatient Financial Assistance Application Process

If above referral criteria is met, the application for financial assistance must be completed and approved prior to admission. All applicants will be screened for Medicaid coverage and must cooperate with Medicaid representatives to be considered for financial assistance. Financial counseling and eligibility screening is conducted by MRC Financial Counselor or other designated staff.

1. A representative of the patient must be present for an in-person interview/screening with MRC Financial Counselor prior to admission approval.
2. MRC Staff may initiate the Financial Assistance application on behalf of patient under circumstances where the patient may be unable to do so. It is ultimately the patient or patient representative's responsibility to provide complete and accurate information in order for the application to be completed and considered for review.
3. The patient or representative will be required to provide supporting documentation to substantiate income which may include the following: prior year tax return, pay stubs representing income for a period designated, bank statements for income verification.
4. Additional information may be needed from the patient to substantiate the following:
    a. Number of dependents or number in household unit
    b. Physical Address
    c. Employment Status
    d. Current Monthly Income
    e. Current Monthly Expenses
    f. Total Assets and Liabilities

5. When the application is completed, MRC Financial Counselor will review to determine if the application is complete, supporting documentation is appropriate, and provide an assessment of FA eligibility. Determination will be communicated to the referral source and/or patient prior to MRC acceptance or admission of patient. Determination would typically be communicated on same day as completed application received, but may be up to 3 days.

C. Financial Criteria
   1. Annual household income less than 250% of Federal Poverty Guidelines and inability to pay for care.
   2. Uninsured, with no other funding for care
   3. United States Citizen
   4. Mississippi Resident – See Section IV Definitions – G.
   5. All procedural requirements of application process are completed and approved by MRC Financial Counselor or other MRC designee.

VI. Financial Assistance Eligibility - Outpatient Services

A. Patients referred from MRC Inpatient Rehabilitation program that were approved under FAP may also be eligible for financial assistance for limited outpatient services to provide appropriate follow up and continuation of care. Patients must comply with their established treatment plan and MRC policies for continuation of this additional Financial Assistance. MRC Financial Counselor will monitor patient compliance and assess eligibility on an ongoing basis.

   Outpatient qualified benefits are as follows:
   a. Up to 8 outpatient rehabilitation visits
   b. 1 Follow up Clinic visit
   c. 1 Follow up Neuropsychology visit

B. Individuals referred for outpatient treatment from external referral sources are not covered or included under this FAP.

C. Exclusions: Services provided at the following MRC outpatient clinic will NOT be considered for FA (free care/full waiver) to uninsured patients.
   1. Methodist Orthotics and Prosthetics Clinics
   2. Methodist Pain Management Clinic
   3. Methodist Physical Medicine Clinic

VII. Discounted Care – Inpatient and Outpatient Services

A. Uninsured patients may be eligible for financial assistance in the form of reduced charges for services rendered if the FAP financial criteria (See Section V)) is not met and the patient is admitted or registered as "Self Pay"; or an insured/underinsured patient's coverage is inadequate to cover a catastrophically large medical bill. MRC typically refers to this type of discount as a "self pay discount".

1. An initial deposit will be requested from the patient prior to inpatient admission or outpatient visit. This deposit amount will be an estimate of payments due from patient or guarantor based on the AGB (See Section II Definitions – A) and expected length of stay or number of outpatient visits or services. If the full amount of estimate is not able to be collected, other arrangements may be made on a case-by-case basis with approval of MRC Financial Counselor. During the patient's inpatient stay or outpatient course of treatment, the case is monitored on an ongoing basis by MRC Financial Counselor or designated staff to determine when deposits are exhausted and additional funds are due.

B. Insured patients who are unable to meet the patient liability requirements of their own insurance coverage may be eligible for discounts/financial assistance in the form of full waiver of patient liability, including unmet deductible, coinsurance or copays or long-term interest free payment plans.

1. Insured patients must meet the following qualifications and requirements in order to qualify for full waiver of patient liability.
    a. Annual household income less than 150% of the Federal Poverty Guidelines and inability to pay for patient liability portion after Insurance has covered medical care.
    b. All procedural requirements of application process are completed and submitted to MRC Financial Counselor, including but not limited documentation needed to substantiate financial need.
2. Insured patients who do not meet the financial qualifications for full waiver of patient liability are eligible for an extended interest free payment plan. Each case is reviewed individually to determine monthly payment amount appropriate for patient.
3. MRC Financial Counselor will notify patient and MRC business office of review determination within 5 business days of receipt of completed application via phone call and written notification.
4. Insured patients who do meet criteria for waiver of patient liability because of financial hardship may qualify for this waiver up to 1 year following application approval date.

5. The patient may seek this waiver and/or request assistance up to 240 days after the first post-discharge statement.

VIII. Patient Billing and Collections

MRC strives to work with every patient that does not qualify for full financial assistance to resolve unpaid patient liability balances.

A. MRC staff will make every effort to determine an equitable payment schedule following established guidelines with consideration of the individual patient's financial and medical circumstances.
B. MRC will employ an outside collection agency only after giving the patient or guarantor multiple notices regarding the availability of financial assistance and adequate time in which to apply. Prior to accounts being submitted to outside collection agency, the billing and collection process will be completed, the patient's record reviewed to verify reasonable efforts were taken to ensure that financial assistance was offered if appropriate based upon established guidelines. The outside collection agency will be directed to follow MRC guidelines regarding collection.
C. MRC will not force the sale or foreclosure of a patient's primary residence to pay an outstanding medical bill.
D. MRC will not force garnishment of wages in order to resolve patient's outstanding medical bill.
E. MRC will not make it normal practice to take legal action against patient in order to resolve outstanding medical bill.
F. MRC will not report patient debts to Credit Reporting agencies.
G. MRC does reserve the right to make an exception to above routine practice and use ECA in an extreme circumstance. This exception may be requested by MRC Business Office Director and approved by members of MRC Executive Officers.

IX. FAP Exclusions

A. Non Participating Providers - MRC is contracted with University of Mississippi Medical Center and other specialized providers for physician and nurse practitioner services. These providers do not participate in this FAP and may bill the patient separately for their services.

B. This FAP does not apply to the following MRC facilities.
   1. Methodist Specialty Care Center

X. Exceptions

Exceptions to funding and/or hospital services covered within this policy are at the discretion of the Executive Vice President of Finance and Operations or delegated official.

## EXHIBIT A

AGB Percentages
Amounts Generally Billed (AGB) is equal to charges multiplied by the percentages below for each patient service area.

Inpatient Rehabilitation –66%
Outpatient Rehabilitation-35%
Hospital Clinics-43%
Orthotics and Prosthetics-58%
Physical Medicine Clinic-45%
Pain Management-53%

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