Community Care

POLICY PATIENT FINANCIAL SERVICES

Purpose
At times, guarantors indicate that they do not have the monetary funds available to pay their hospital bills. Jamestown Regional Medical Center (JRMC) offers a Community Care program which aids these patients in resolving their financial obligations.

Policy
The Financial Counselor in Patient Access Management, is responsible for monitoring Community Care potential applicants from the initial distribution of the Community Care application. The Patient Accounts Coordinator in Patient Financial Services, is responsible for follow up and final notification to the guarantor of the amounts approved for Community Care.

At time of registration, Patient Access staff will offer Community Care to all patients insured or not insured. Community Care is available for all patients.

The Community Care application consists of a return date, contact number, an instructional checklist, a monthly financial income summary request and obligations of the partial community care agreement. The guarantor is requested to submit copies of the previous two years' income tax forms, along with other financial documentation proving need such as W2's, child support, pay stubs, bank statements etc. A credit check on the guarantor and spouse, if determined needed by the Patient Accounts Coordinator to further validate income and debt validation. If income tax forms have not been filed, the guarantor is asked to initial a statement noting as such.

Availability of the Community Care application and Plain Language Summary in English are available in all registration areas, in all waiting areas, by mail and on the JRMC website to patients at no charge. Applications can also be obtained at Central Valley Health.

All patients, upon registration, will be asked about their coverage for healthcare services. A patient with limited or no insurance will be offered the immediate assistance of financial counseling, who will review the Community Care application and process with the patient.

Qualifying Community Care discounts will be applied to the patient's gross charge balance at the time of receipt of application. A patient that qualifies for the community care program partially with income guideline provided in table 1; the partial discount will apply to the amount generally billed to JRMC patients. Please contact the business office for more details at (701) 952-4823.

Once the Community Care application has been completed and signed, the Community Care committee will meet and review the pending applications. Members of the Community Care committee are the Chief Financial Officer, the Fiscal Services Manager and the Patient Accounts Coordinator.

The Community Care committee will require that Medicaid or other social service applications (such as enrolling the guarantor's children in the 'Healthy Steps' insurance program) are completed, unless special circumstances are applicable.

A guarantor may be asked to pay a small percentage of the outstanding amount. They are set up on a payment plan within 15 days of the approval letter and offered an additional 5% discount for an auto-withdrawal plan with remaining balances covered by the Community Care Program. If a guarantor fails to pay the non-qualifying balance owed, this balance may be eligible for Extraordinary Collection Actions. The amount written off to Community Care will remain Community Care.

Once the application has been reviewed, notes put on the accounts, and amounts written off, they are sent to the Scanning Department to be scanned into the patient's file. The Patient Accounts Coordinator will notify all applicants of determination via letter. A detailed statement will be mailed to recipients.

Once Community Care has been applied those accounts are no longer eligible for any further Community Care. If Community Care has been denied, the patient may re-apply if their financial circumstances change.

Definitions

Community Care

100% free medical care for services provided by JRMC. Patients who are uninsured for the relevant, medically necessary service, who are ineligible for governmental or other insurance coverage, and who have family incomes not in excess of 100% of the Federal Poverty Guidelines will be able to receive Community Care. However, patients at this level of family income who have sufficient assets to pay for care without becoming medically indigent will not be eligible for Community Care but may nevertheless be eligible to receive up to a 90% discount off gross charges.

Partial Community Care

Care at a discounted rate for services provided by JRMC. Patients who are uninsured or underinsured for the relevant medically necessary service, who are ineligible for governmental or other insurance coverage, and who have family incomes in excess of 100%, but not exceeding 300% of the Federal Poverty Guidelines, will be eligible to receive Partial Community Care in the form of a discount off inpatient and/or outpatient charges. Patients at this level of family income who have sufficient assets to pay for care without becoming medically indigent are not eligible for discounts.

Uninsured Patient

An individual who does not have any third-party health care coverage from either: (a) a third-party insurer, (b) an ERISA plan, (c) a Federal or State Health Care Program that JRMC accepts, (d) Workers' Compensation, (e) Medical Savings Accounts, or (f) other coverage, for all or any part of the bill.

Amount Generally Billed (AGB)

AGB as defined in the Federal Registry in 26 CFR, Part 1 is the amount generally billed for emergency or other medically necessary care to individuals who have insurance covering such care. JRMC utilizes the look-back method as defined by the IRS in Section 501(r)(5) when calculating its AGB. The calculation looks at the prior fiscal year for all payors (excluding Self-Pay).

Medically Necessary Services

Clinical and rehabilitative physical, mental or behavioral health services that:

- are essential to prevent, diagnose or treat medical conditions (e.g., illnesses, injuries, physical, mental and behavioral disorders, impairments or disabilities) and enable the enrollee to attain, maintain or regain functional capacity; and
- are delivered in the amount, duration, scope and setting that is appropriate to the specific physical, mental and behavioral health care needs of the individual; and
- are provided within professionally accepted standards of practice and national guidelines; and
- are required to meet the physical, mental and/or behavioral health needs of the individual and are not primarily for the convenience of the individual, the provider or the payer.
- when a service is denied by Medicaid or Expansion Plan to patient responsibility due to a non-covered service, the patient may apply for the Community Care program and presumptive eligibility may apply. The Patient Accounts Coordinator will review this on a case-by-case situation.

Eligibility

This policy shall cover the provision of Community Care and Partial Community Care to individuals who are US citizens or are legally working and paying taxes, which have or intend to receive medically necessary services from JRMC. Patients who have received services at JRMC as a result of criminal activity are not eligible for Community Care or partial Community Care.

Applicants for Community Care must agree to complete the Community Care application process in a timely manner. Fraudulent or incomplete applications will not be processed.

Community Care is used after all other pay sources have been utilized towards service at JRMC, as a condition of approval for Community Care or Partial Community Care.

JRMC does not recognize Medicaid Expansion Plans as a presumptive eligibility. JRMC does recognize the income limitations to qualify for these plans. If a patient has a patient responsibility for services, this may be eligible for the Community Care plan with an application with signature.

If a patient notifies the JRMC Business Office or registration of an out of state Medicaid (medical assistance program) eligibility, it will be the responsibility of the Patient Accounts Coordinator and Patient Access team to verify out of state medical assistance coverage. This would qualify the patient for Community Care under 501c as presumption status of coverage to our charity care program. JRMC will make all attempts to have patient complete the Community Care application.

If JRMC is unable to verify the eligibility of out of state medical program the patient is on, it will be the patient or the patient's guarantor to provide verification. Under the circumstances that JRMC is unable to verify or confirm out of state medical assistance and the patient does not provide this verification, the balance will be moved to self-pay.

The patient must complete and sign the Community Care application.

To verify eligibility for Community Care the patient will be asked to provide the following documents to help the Patient Accounts Coordinator with financial eligibility determination:

- Medical Assistance eligibility/denial notice if applicable.
- Income tax returns for the 2 most recently filed years.
- If income taxes have not been filed, the patient will need to initial the statement on application form.
- Proof of income and Adjusted Gross Income such as:
  - Pay stubs from the past 6 pay periods
  - W-2 withholding statement
  - Social Security checks, receipts or deposits
  - Bank statements
- Notification of Benefit Decision from the ND Department of Human Services
- Any other documentation that the Community Care Committee thinks may serve as proof of eligibility for Community Care or Partial Community Care

Community Care patients will receive up to 100% discount off charges. Patients extended Partial Community Care in the form of a discount must sign (as part of application) a written agreement to pay the amount of the hospital bill remaining after deducting the discount. The patient will receive a letter explaining discount, detailed bill with the amount due and payment plan they are set up on.

An individual eligible for financial assistance through Community Care will not be charged more than the average amount generally billed. For more information, please contact the JRMC Business Office.

Upon receipt of an incomplete application, the guarantor will have 30 days from notification of the incomplete application to complete the application thoroughly or the application will be void.

Determination of eligibility is communicated from the Patient Accounts Coordinator. This will explain the financial assistance that the program may provide. The program is supported to retro date of services back to 6 months with going forward until the end of month eligibility. The Patient Accounts Coordinator may extend the eligibility period with approval from the Community Care Committee.

Dual Eligibility
In coordination with North Dakota Medicaid benefits, JRMC agrees to accept Medicaid's reimbursement as payment in full for the services rendered to persons eligible for such services under the North Dakota Medical Assistance Program.

In order to qualify for the North Dakota Medical Assistance Program a patient must prove indigence. As such, JRMC will consider all patients who qualify for North Dakota Medicaid as indigent to the extent that JRMC will not attempt to collect the non-allowed portion but will continue to attempt to collect co-pays and recipient liabilities as determined applicable by the North Dakota Medicaid Program.

Medicare co-insurance and deductibles for patients who qualify for dual eligibility are billed to the North Dakota Medicaid Program. Beginning October 1, 2002, Medicaid started processing these claims according to their regular DRG rate. As a result, Medicaid is no longer paying for the Medicare co-insurance and deductible amounts in most cases. JRMC will not be billing the dual eligibility patients the Medicare co-insurance and deductible amount unless a portion is designated as a Medicaid co-pay or recipient liability. As stated in paragraph 2, JRMC considers the patient indigent by North Dakota standards.

Presumptive Eligibility
It is recognized that not all patients will be willing or able to provide complete financial and/or social information. Therefore, some community care cases may be determined based on available resources:

- Patient is deceased with no known estate
- Family/friend provides undocumented information establishing the patient's inability to pay
- Members of religious organizations who have taken the vow of poverty
- Patients with current dual eligibility under county or state **and** federal medical indigent services for balances due to cost saving measures. (Co-pays and recipient liabilities do not apply).
- Patients with current dual eligibility under county or state **and** federal medical indigent services for balance due to medications that may be eligible for Medicare Part D.
- Patients eligible for Women's Way services for balances remaining or associated with an approved procedure.
- Patients who have established eligibility for out of state Medicaid which JRMC does not file. Presumptive eligibility towards out-of-state Medicaid will only be applied once coverage is verified. If verification is unable it will be the responsibility of the patient to provide this.
- Presumptive will be used on non-covered services for Medicaid and Expansion Plans by insurance company or deemed not medically necessary

Provider's Responsibilities
JRMC is committed to treating patients who have financial needs with the same dignity and consideration that is extended to all its patients. JRMC considers each patient's ability to pay for his or her medical care and extends Community Care or Partial Community Care to eligible patients who are unable to pay for their care, complete and submit an application, and meet all of the guidelines. This policy reinforces the eligibility procedures for Community Care and Partial Community Care that comply with applicable federal, state and local law.

JRMC will make every effort to make it known that Community Care is available in their organization. Information will be available with inpatient and outpatient admission packets, available on the hospital website, and publicly displayed at all registration areas.

All JRMC personnel in financial services, registration and those who come into direct contact with the patient will understand the Community Care program and be able to direct questions regarding the policy to the proper hospital representative.

The Patient Accounts Coordinators will process completed JRMC Community Care applications. The patient accounts coordinators will also perform a credit check on the patient. When the Community Care application has been received, the patient accounts coordinators will review and determine whether the application is complete and whether the documentation supports eligibility for Community Care or Partial Community Care.

Applications that do not meet all of the required guidelines may be approved based upon extraordinary circumstances with the documented approval of the Community Care Committee.

Collection Timeline and Eligibility:
The date of service plus 5 days with no communication and efforts of patients to find coverage or work on plan of coverage moves account to self-pay and patient responsibility. Patient Accounts Coordinator will send a self-pay letter, discount voucher and financial counseling contact information.

1st billing statement will be sent from the date of release to patient responsibility as self-pay or patient responsibility based off the insurance remit or postings with billing cycle equaling 30 days.

2nd statement is cycled off the first statement plus 30 days with no payment including a past due notice on the statement.

3rd statement plus 30 days starts aggressive efforts to resolve patient's financial responsibilities. These efforts will pertain to phone calls, letters and contact to patient demographic information on file.

4th statement is the final notice informing the guarantor of Extraordinary Collections Efforts. This will equal the date of the first statement plus 120 days.

Extraordinary Collection Actions will not be taken by JRMC against an individual related to obtaining payment of a bill for care covered under the hospital's Community Care Program that requires a legal or judicial process or involve selling an individual's debt to another party or reporting adverse information about the individual to consumer credit reporting agencies or credit bureaus.

INCOME GUIDELINES:

Community Care and Partial Community Care Table *

To apply for Community Care or Partial Community Care, the patient must complete the Jamestown Regional Medical Center Community Care application process. Applications will be processed in accordance with Patient Financial Services policies.

Size of Family	FPG** 100% Community Care	1.2 x FPG 90% Discount	1.4 x FPG 80% Discount	1.6 x FPG 70% Discount	1.8 x FPG 60% Discount	2 x FPG 50% Discount	2.2 x FPG 40% Discount	2.4 x FPG 30% Discount	2.6 x FPG 20% Discount	2.8 x FPG 10% Discount
1	15,650	18,780	21,910	25,040	28,170	31,300	34,430	37,560	40,690	43,820
2	21,150	25,380	29,610	33,840	38,070	42,300	46,530	50,760	54,990	59,220
3	26,650	31,980	37,310	42,640	47,970	53,300	58,630	63,960	69,290	74,620
4	32,150	38,580	45,010	51,440	57,870	64,300	70,730	77,160	83,590	90,020
5	37,650	45,180	52,710	60,240	67,770	75,300	82,830	90,360	97,890	105,420
6	43,150	51,780	60,410	69,040	77,670	86,300	94,930	103,560	112,190	120,820
7	48,650	58,380	68,110	77,840	87,570	97,300	107,030	116,760	126,490	136,220
8	54,150	64,980	75,810	86,640	97,470	108,300	119,130	129,960	140,790	151,620

Add $5,500 for each additional person.

* This table currently uses the current 2025 FPG. This table shall be adjusted in accordance with annually released changes to the Federal Poverty Guidelines.

**FPG = Federal Poverty Guidelines