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 References:

Hospital Price Transparency

SUBJECT:

Hospital Price Transparency

POLICY:

It is the policy of Riverside Medical Center to allow the public access to the hospital's standard charges for services in compliance with the Affordable Care Act, Section 2718(e) of the Public Health Service Act. Our staff will ensure timely responses to patient requests for the list of standard charges for services rendered, patient payment estimates for ordered services or the complete listing of the hospital charge description master. Patient's may also access a machine readable version of Riverside's hospital charge description master and average charges by MS-DRG on our website.

Riverside Medical Center will assist our patients in the understanding of their potential financial liability for services ordered by the patient's treating physician(s) that are performed by the hospital staff. These estimates will allow patients to compare prices with other hospitals that provide the same or similar services.

PROCEDURE:

Definitions used in this policy:

- **Standard charges** - means the charge amount set before any discounts. Hospitals are required by the federal government to use standard charges as the starting point for all bills.
- **Total charges** - means the sum of all charges based on the services provided and may vary from patient to patient, depending on the physician's treatment plan due to individualized patient health needs.

Riverside Medical Center allows public access to standard charges for health care services. Sharing charge information is one way to help patients and their families make informed decisions regarding their health care treatment and expenses.

The public may obtain our standard charges by,

- Calling Riverside Medical Center's Customer Service at 1.815.935.7539, Monday through Friday from 8:30 a.m. to 5:00 p.m. Callers may leave a voice-mail message for Customer Service if calling outside of these hours. If dialing within the hospital, dial extension 3652;
- Email the request to CustomerService@RiversideHealthcare.net. A response will be returned by encrypted email;

- In person, Monday through Friday from 8:30 a.m. to 4:30 p.m. in the Cashier's office, located in the Schneider Outpatient Center, 375 North Wall Street, Kankakee, IL 60901;
- Requesting an estimate when scheduling an appointment for an outpatient or inpatient procedure;
- At the time of service during check-in (a.k.a. registration);
- or on our hospital website at <https://www.riversidehealthcare.org/patients-and-visitors/for-patients/hospital-charge-description-master-disclaimer>

We will make every effort to respond at the time of your request or within 5 business days, depending on the complexity of the request.

Total charges are based on the type of care provided to a specific patient. Total charges may be different for specific patients due to the patient's:

- medical condition;
- length of time spent in surgery, recovery or observation;
- implants;
- medication;
- individualized physician treatment plan

Riverside Medical Center's standard charges do not include the professional services provided by a physician, surgeon, radiologist, anesthesiologist, pathologist, hospitalist, advanced practice nurse or other independent practitioners. Patients will likely receive separate bills for the physicians and other professionals who provided treatment. These physicians may not be participating providers in the same insurance plans and networks as the hospital. There may be greater patient financial responsibility for services which are not under contract with the patient's health insurance plan.

Estimates and Financial Assistance:

- For patients with health insurance, patients are responsible to pay the deductible, copay and/or coinsurance set by their health insurance plan. Riverside Medical Center recommends contacting the health plan directly for specific financial obligations. Riverside may also provide estimates based on the ordered services, using the hospital standard charges and the contracted reimbursement the patient's health insurance plan has negotiated.
- For patients without health insurance, Riverside provides care at a reduced rate or without charge to eligible persons demonstrating financial need and the inability to pay. We have Assisters available in person or by telephone that provide help in determining if a patient may qualify for health care coverage provided by the State of Illinois Marketplace or Illinois Medicaid. Patients may contact either the Customer Service Department at 1.815.935.7539 or the Assister Hot-line at 1.800.560.9106.
- Both insured and uninsured patients may apply for Riverside Medical Center's financial assistance program.

Frequently Asked Questions:

1. How much will I actually have to pay out of my pocket?

A patient with health insurance needs to pay the deductible, copay and/or coinsurance set by their health plan.

The financial obligations could differ depending on whether the hospital or physicians are "out-of-network", meaning the health plan does not have a contract with them. Contact your insurance company to understand what your financial obligations will be.

A patient without health insurance will discuss financial assistance options available that could include either a complete write-off or a substantial reduction of the charges in accordance with the Illinois Hospital Uninsured

Patient Discount Act and the hospital's financial assistance program.

Please contact Customer Service at 1.815.935.7539 or CustomerService@RiversideHealthcare.net to obtain further information about the discounts available.

Health insurance plans such as Medicare, Medicaid, workers' compensation, commercial health insurance, etc., do not pay charges. Instead, they pay a set price that has been predetermined or negotiated in advance. The patient only pays the out-of-pocket amounts set by the health plan.

If you need help understanding your health care bill, please contact Customer Service at 1.815.935.7539 or CustomerService@RiversideHealthcare.net.

2. What do the following health insurance terms mean?

- *Deductible* means the amount the patient needs to pay for health care services before the health plan begins to pay. The deductible may not apply to all services.
- *Copay* means a fixed amount (for example, \$20) the patient pays for a covered health care service, such as a physician office visit or prescription.
- *Coinsurance* means the percentage the patient pays for a covered health service (for example, 20% of the bill). This is based on the allowed amount for the service. You pay coinsurance plus any deductibles you owe.

A patient's specific health care plan coverage, including the deductible, copay and coinsurance, varies depending on what plan the patient has. Health plans also have differing networks of hospitals, physicians and other providers that the plan has contracted with. Patients need to contact their health plan for this specific information.

3. What is the difference between charges, cost and price?

Total Charge is the amount set before any discounts. Hospitals are required by the federal government to utilize uniform charges as the starting point for all bills.

The charges are based on what type of care was provided and can differ from patient to patient for similar services, depending on any complications or different treatment provided due to the patient's health.

Cost - For a hospital, it is the total expense incurred to provide the health care. Hospitals have higher costs to provide care than freestanding or retail providers, even for the same type of service. This is because a hospital is open 24 hours a day, 7 days a week and needs to have everything necessary available to cover any and all emergencies. Non-hospital health care providers can choose when to be available and typically would not provide services that would result in losses. A hospital's cost of services can vary depending on additional factors such as:

- Types of services it provides since many vital services are provided at a loss such as trauma, burn, neonatal, psychiatric, ambulance transports and others;
- Providing medical education programs to train physicians, nurses and other health care professionals, again provided at a loss;
- More patients with significantly higher levels of illness, yet payment doesn't cover;
- A disproportionately high number of patients who are on public assistance or uninsured and unable to pay much if anything toward the cost of their care.

Total Price is the amount actually paid to a hospital. Hospitals are paid by health plans and/or patients, but the total amount paid is significantly less than the starting charges.

- On average in 2013, Medicare paid Illinois hospitals only 91% of a hospital's cost to provide that care and Medicaid even less.
- Medicare and Medicaid pay hospitals according to a set fee schedule depending on the service provided, much less than the hospital charge and actually less than their costs.
- Commercial insurers negotiate discounts with hospitals on behalf of their enrollees and pay hospitals at varying discount levels, but much less than starting charges.
- Illinois hospitals provide free care to uninsured patients with incomes up to 200% (\$47,700 for family of 4 in 2014) of the federal poverty level (FPL).
- Illinois hospitals provide discounts to 135% of the hospital's costs to uninsured patients with incomes up to 600% (\$143,100 family of 4 in 2014) FPL in urban areas.
- Illinois hospitals provided \$1.07 billion in free and discounted care measured at cost in 2012. In addition, they wrote off about \$780 million in bad debt cost.

4. How can I use this hospital charge information for comparing prices?

Charge information is not necessarily useful for consumers who are "comparison shopping" between hospitals because the descriptions for a particular service could vary from hospital to hospital and what is included in that description. It is difficult to try to independently compare the charges for a procedure at one facility versus another. An actual procedure is comprised of numerous components from several different departments - room and board, laboratory, other diagnostics, pharmaceuticals, therapies, etc.

A patient who has the specific insurance codes for services requested, available from their physician, can better gauge charge estimates across hospitals. Ask your physician to provide the technical name of the procedure that has been recommended as well as the specific ICD and CPT codes for service.

5. How can I get an estimate for a specific procedure?

If you need an estimate for a specific procedure or operation, please contact Customer Service at 1.815.935.7539 or CustomerService@RiversideHealthcare.net, ask at time of scheduling your appointment or at time of check-in.

Such estimates will be an average charge for the procedure without complications. A physician or physicians make the determination regarding specific care needed based on considerations using the patient's diagnosis, general health condition and many other factors. For example, one individual may require only a one-day hospital stay for a particular procedure, while another may require a two-day stay for the same procedure due to underlying medical condition.

The patient with health insurance will only pay the specified deductible, copay and coinsurance amounts established by their health plan. A patient without health insurance or sufficient financial resources may be eligible for significant discounts from charges. Please contact Customer Service for further information.

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Attachments: No Attachments

Approval Signatures

Approver	Date
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Kay Senesac: Director Revenue Integrity	12/2018