

Status **Pending** PolicyStat ID **15475102**



Origination 04/2021
Last Approved N/A
Effective Upon Approval
Last Revised 03/2024
Next Review 1 year after approval

Owner Tioni Tamling:
Manager,
Revenue Cycle
Area Revenue Cycle
Applicability Boscobel
References Policy

Financial Assistance, GB-16007

Document Configuration

Section

Revenue Cycle

Subsection

Business Office

Category

Corporate

References

- GB-3001, EMTALA: Collection of Financial Information
- Rev-006 Self-Pay Billing & Collection Policy
- Federal Poverty Guidelines, US Department of Health and Human Services
- IRS Notice 2015-46 and 29 CFR §§1.501(r) (4) - (6)
- 26 CFR 250 (31 Dec 2014) p78954-79016
- GL-3034 Reporting of Medicare Bad Debt
- Appendix 1: Financial Assistance Application Form
- Appendix 2: Discount chart based on income and asset thresholds, and the uninsured discount rate
- Appendix 3: Covered providers and departments

Appendix 4: Amounts Generally Billed (AGB) Percentage

Appendix 5: Public Access to documents

Applicable To

All patients and contracted staff of Memorial Hospital of Boscobel, Inc. d/b/a Gundersen Boscobel Area Hospital and Clinics (hereinafter, collectively referred to as "GBAHC") receiving healthcare services at Gundersen Boscobel Area Hospital and Clinics.

Purpose Statement

Together with our Billing & Collection policy and Gundersen's Mission and Vision we have outlined the process to ensure the community has availability to financial assistance while adhering to state, federal, and regulatory guidelines.

Definitions

The following definitions are applicable to all sections of this policy.

Amount Generally Billed (AGB): The amount generally billed is the expected payment for emergency or medically necessary services from patients, and/or a patient's guarantor. For qualifying patients, this amount will not exceed a rate that will be determined utilizing a Look Back Method described in §1.501(r)-5(b) (3) of the Internal Revenue Code. The Look Back Method will be based on actual past claims paid by Medicare Fee-for-Service together with all private health insurers paying claims. The AGB will be calculated annually by the 45th day following the close of the prior calendar year and implemented by the 120th day following the close of the calendar year.

Amount Generally Billed Percentage: The AGB percentage will be calculated each year by the 45th day of the year and is described in Appendix 4 of this policy.

Application Period: The period during which applications will be accepted and processed for financial assistance. The application period begins on the date of the first post-service billing statement and ends on the 240th day after the date that the first post-service billing statement is provided.

Catastrophic Care Assistance: Financial assistance provided to eligible patients with annualized family incomes in excess of 400% of the Federal Poverty Level, and assets at or below six times the Federal Poverty Level, and financial obligations resulting from medical services provided by GBAHC in excess of 25% of the family income.

Discounted Care: Financial assistance that provides a discount, for eligible medical services provided by GBAHC, based on a sliding scale, for eligible patients, or patient guarantors, with annualized family incomes between 201-400% of the Federal Poverty Level and assets at or below six times the Federal Poverty Level. Not applicable to families with annual income at or below 201% of the most current FPG for those service areas that participate in the NHSC.

Emergency Medical Condition: As defined in Section 1867 of the Social Security Act (42 U.S.C. 1395dd). The term "emergency medical condition" means a medical condition manifesting itself by acute

symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in serious impairment of organs or bodily functions, serious threat to life, and placing the health of a pregnant patient or the unborn child in serious jeopardy.

Family: As defined by the U.S. Census Bureau, a group of two or more people who reside together and who are related by birth, marriage, or adoption. If a patient claims someone as a dependent on their income tax return, according to the Internal Revenue Service rules, they may be considered a dependent for the purpose of determining eligibility for this policy.

Family Income: An applicant's family income is the combined gross income of all adult members of the family living in the household and included on the most recent federal tax return.

Federal Poverty Level: The Federal Poverty Level (FPL) uses income thresholds that vary by family size and composition to determine who is in poverty in the United States (<https://aspe.hhs.gov/topics/poverty-economic-mobility/povertyguidelines>).

Financial Assistance: Assistance provided to eligible patients, who would otherwise experience financial hardship, to relieve them of all or part of their financial obligation for emergency or medically necessary care provided by GBAHC.

Guarantor: An individual other than the patient who is responsible for payment of the patient's bill.

Gross Charges: Total charges at the full established rate for the provision of patient care services before deductions from revenue are applied.

Homeless: As defined by the Federal government, and published in the Federal Register on December 5, 2011, by HUD: An individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning the individual or family has a primary nighttime residence that is a public or private place not meant for human habitation or is living in a publicly or privately operated shelter designed to provide temporary living arrangements.

Medically Necessary: As defined by Medicare as services or items reasonable and necessary for the diagnosis or treatment of illness or injury.

Payment Plan: A payment plan that is agreed to by both GBAHC and a patient, or patient's guarantor, for out-of-pocket fees. The payment plan shall consider the patient's financial circumstances, the amount owed, and any prior payments.

Presumptive Eligibility: Under certain circumstances, uninsured patients may be presumed or deemed eligible for financial assistance based on their enrollment in other means-tested programs or other sources of information, not provided directly by the patient, to make an individual assessment of financial need. If a patient has made a payment, they will no longer qualify presumptive eligibility.

Qualification Period: Applicants determined eligible for financial assistance will be granted assistance for a period of six months. Assistance will also be applied retroactively to all eligible accounts incurred for services received six months prior to application date.

Uninsured Discount: Patients with no third-party coverage will be provided an uninsured discount, for eligible services provided by GBAHC under this policy, at the time that the undiscounted charges are

rendered. GBAHC applies a courtesy discount based on the Amounts Generally billed to uninsured patients for more hospital services. certain services are excluded, and the applicable discount is automatically applied to the patient's billing statement. This discount is removed if insurance coverage is subsequently identified and cannot be combined with other discounts except for the Prompt Pay Discount.

Uninsured Patient: A patient with no third-party coverage provided through a commercial third-party insurer, an ERISA plan, a Federal Health Care Program (including without limitation Medicare, Medicaid, SCHIP, and CHAMPUS), Worker's Compensation, or other third party assistance available to cover the cost of a patient's healthcare expenses.

Underinsured Patient: An individual, with private or public insurance coverage, for whom it would be a financial hardship to fully pay the expected out-of-pocket expenses for medical services provided by GBAHC.

Implementation

ELIGIBLE SERVICES

Services eligible for the uninsured discount under the GBAHC financial assistance policy must be clinically appropriate and within generally accepted medical practice standards. They include the following:

1. Emergency medical services provided in an emergency setting, as well as care provided in an emergency setting for the purpose of stabilizing a patient's condition.
2. Non-elective services provided in response to life-threatening circumstances in a nonemergency setting.
3. Medically necessary services, such as inpatient or outpatient health care services provided for the purpose of evaluation, diagnosis, and/or treatment of an injury or illness, as well as services typically defined by Medicare or other health insurance coverage as "covered items or services."
4. Unity House residential chemical dependency treatment program for adults
5. Services of providers employed by GBAHC are covered under this policy. Please see Appendix 3 for a full listing of providers included.

Services not eligible for financial assistance include the following:

1. Elective procedures not medically necessary, as well as services typically not covered by Medicare or defined by Medicare or other health insurance coverage as not medically necessary.
2. Lasik Surgery, Contacts/Glasses, Non-Standard Lenses, Chiropractic Care, Fertility Services, Cosmetic Surgery/Plastic Services, Hearing Aides, Orthodontics, and Dental Services
3. Services received from care providers not employed by GBAHC (e.g. private and/or non-GBAHC medical or physician professionals, ambulance transport, etc.). Patients are encouraged to contact these providers directly to inquire into any available assistance and to

make payment arrangements. See Appendix 3 for full listing of providers not covered under this policy.

4. Deductibles and coinsurance associated with medically necessary services provided to patients out-of-network as defined by their insurers. (Not applicable to families with annual income at or below 200% of the most current FPG).
5. Third-party requested exams (e.g., DOT physicals).

COORDINATION WITH COMMUNITY HEALTH NEEDS ASSESSMENT

A community health needs assessment (CHNA) was conducted for the area served by GBAHC. Obesity, mental health and substance abuse were identified as significant health issues. The community health implementation plan identifies substance abuse treatment as one of the effective medical interventions for mental health. The full range of residential treatment of substance abuse will therefore be eligible for financial assistance, and subject to AGB limitations for financial assistance eligible patients or guarantors at GBAHC.

ELIGIBILITY CRITERIA

Financial assistance will be extended to uninsured and underinsured patients, or a patient's guarantor, who meet specified criteria, as defined below. These criteria will assure that this financial assistance policy is consistently applied across GBAHC. GBAHC reserves the right to revise, modify or change this policy as necessary or appropriate.

Payment resources (insurance available through employment, Medical Assistance, Indigent Funds, Victims of Violent Crimes, etc.) must be reviewed and evaluated before an account is considered for financial assistance to assure that GBAHC resources are prudently managed in providing financial assistance. If a patient appears to be eligible for other assistance, GBAHC will refer the patient to the appropriate agency for assistance with completing the necessary applications and forms. Applicants for assistance are required to exhaust all other payment options as a condition of their approval for financial assistance. (Not applicable to families with annual income at or below 201% of the most current FPG).

The criteria to be considered by GBAHC when evaluating a patient's eligibility for financial assistance include family income, assets, and medical obligations. GBAHC's financial assistance program is available to all patients meeting the eligibility requirements set forth in this policy, regardless of geographic location or residency status. Financial assistance will be extended to patients, or a patient's guarantor, based on financial need and in compliance with federal and state laws.

Financial assistance is typically not available for patient co-payment or balances after insurance if a patient fails to comply reasonably with insurance requirements such as obtaining proper referrals or authorizations. Patients with tax advantaged, personal health accounts such as a Health Savings Account, a Health Reimbursement Arrangement, or a Flexible Spending Account, will be expected to utilize account funds prior to being granted financial assistance. (Not applicable to families with annual income at or below 201% the most current FPG).

GBAHC reserves the right to reverse the discounts described herein if it reasonably determines that such terms violate any legal or contractual obligations of GBAHC.

PRESUMPTIVE ELIGIBILITY

GBAHC understands that not all patients are able to complete a financial assistance application or comply with requests for documentation. There may be instances under which a patient's qualification for financial assistance is established without completing the formal financial assistance application. Other information may be utilized by GBAHC to determine whether a patient's account is uncollectible, and this information will be used to determine presumptive eligibility.

Presumptive eligibility may be granted to patients based on their eligibility for other programs or life circumstances such as:

1. Patients or guarantors who have declared bankruptcy. In cases involving bankruptcy, only the account balance as of the date the bankruptcy is discharged will be written off.
2. Patients or guarantors who are deceased with no estate in probate.
3. Patients or guarantors determined to be homeless.
4. Accounts returned by the collection agency as uncollectible due to any of the above reasons.
5. Patients or guarantors who qualify for State Medicaid programs, will be eligible for assistance for any cost-sharing obligations associated with the program or uncovered services.

GBAHC understands that certain patients may be non-responsive to GBAHC's application process. Under these circumstances, GBAHC may utilize other sources of information to make an individual assessment of financial need. This information will enable GBAHC to make an informed decision on the financial need of non-responsive patients utilizing the best estimates available in the absence of information provided directly by the patient. An asset test is not applicable to families with annual income at or below 201% of the most current FPG for those service areas that participate in the national health Service Corps Program (NHSC).

GBAHC may utilize a third-party to conduct an electronic review of patient information to assess financial need. This review utilizes a healthcare industry-recognized model that is based on public record databases. This predictive model incorporates public record data to calculate a socio-economic and financial capacity score that includes estimates for income, assets and liquidity. Not applicable to families with annual income at or below 200% of the most current FPG for those service areas that participate in the NHSC.

The electronic technology is designed to assess each patient to the same standards and is calibrated against historical approvals for GBAHC financial assistance under the traditional application process.

The electronic technology, when utilized, will be deployed prior to bad debt assignment after all other eligibility and payment sources have been exhausted. This allows GBAHC to screen all patients for financial assistance prior to pursuing any extraordinary collection actions. The data returned from this electronic eligibility review will constitute adequate documentation of financial need under this policy.

EMERGENCY MEDICAL SERVICES

In accordance with FEDERAL EMERGENCY MEDICAL TREATMENT AND LABOR ACT (EMTALA) regulations, no patient is to be screened for financial assistance or payment information prior to the rendering of services in emergency situations. GBAHC may request that patient cost-sharing payments (i.e. copayments) be made at the time of service, provided such requests do not cause a delay in a medical screening examination or necessary stabilizing care for an identified emergency medical condition (See Policy GL-3001).

AMOUNTS BILLED TO PATIENTS ELIGIBLE FOR FINANCIAL ASSISTANCE

The amount generally billed is the expected payment from patients, or a patient's guarantor, eligible for financial assistance. For qualifying uninsured patients, this amount will not exceed a rate that will be determined utilizing a Look Back Method.

The Look Back Method will be based on amounts allowed under Medicare Fee-For-Services together with all private health insurers paying claims to GBAHC. The claims to be included in the AGB calculation will be claims allowed during the prior calendar year. The amounts for co-insurance, co-payments and deductibles will be included in the numerator along with the Medicare Fee-For-Service together with all private health insurers paying claims. The gross charges for said claims will be included in the denominator. The AGB will be calculated annually. The percentages will be applied by the 120th day after the end of the calendar year used by GBAHC to calculate the AGB percentage(s).

APPLYING FOR FINANCIAL ASSISTANCE

Eligibility for financial assistance will be based on financial need at the time of application. In general, documentation is required to support an application for financial assistance. If adequate documentation is not provided, GBAHC may seek additional information.

Reliable evidence to support the need for financial assistance is required.

The following income documentation is required from patients, or their guarantors, to determine eligibility:

1. Copy of the Federal tax return, and all attached Schedules, from the most recent tax year
2. Current Proof of Income (copy of most recent pay stubs or other documentation)
3. Proof of other income, including unemployment, workers' compensation, child support, alimony, trust income, veteran's benefits
4. Current Bank Statements (Only used to verify direct deposit income for applicants with income at or below 201% of the most current FPG).

The following asset documentation is required from patients, or their guarantors, that have annual income above 201% of the current FPG, to determine eligibility (Not applicable to families with annual income at or below 200% of the most current FPG for those service areas that participate in the NHSC):

1. Checking accounts
2. Savings accounts
3. Money market accounts
4. Certificates of deposit
5. Annuities
6. Non-retirement investment accounts
7. Retirement accounts, including pensions
8. Real estate
9. Other assets

Applications for financial assistance may be submitted up to 240 days after the date of the first post-discharge statement.

If an application is incomplete, or there has been a request for additional information, the application will remain active for thirty (30) days from the date the letter was mailed to the applicant requesting this information. If the applicant has not responded within the thirty (30) day timeframe, the application will be denied.

During the period in which the fully completed Financial Assistance Application (FAA) is being reviewed, there will be a stay of all collection proceedings. The FAA will be documented in the patient record or scanned, and the account will be noted. The normal billing process is to continue while the FAA is reviewed and considered. If a complete, conforming FAA is approved by the appropriate GBAHC representative, this will be noted in the patient's file and the account balance will be written-off to the appropriate code. Financial assistance applications are to be submitted to the following office:

Gundersen Boscobel Area Hospital and Clinics
ATTN: Patient Financial Services
205 Parker St
Boscobel, WI 53805
~~(608) 375-4112~~ or (866) 662-2242

If denied financial assistance, the patient or patient's guarantor may re-apply any time there has been a change of income or status.

ELIGIBILITY DETERMINATIONS, APPEALS AND DISPUTE RESOLUTION

Patients must be notified of the decision in writing regarding their FAA within thirty (30) days of submitting a completed application. An applicant determined eligible for 100% financial assistance will be refunded payments in excess of the amount determined owed by the patient or guarantor on the accounts for which they have been granted assistance under the GBAHC financial assistance policy. Refunds apply to excess payments of \$5.00 or more. In accordance with this policy, financial assistance is generally not extended for co-payments or balances after insurance when a patient fails to obtain

proper referrals or authorizations, or if such assistance is not in accordance with insurer's contractual agreement, therefore such payments received will not be refunded. (Not applicable to families with annual income at or below 201% of the most current FPG).

Patients may appeal this decision in writing within thirty (30) days of receiving notification to:

Gundersen Health System
Attn: Customer Financial Service Manager
1900 South Avenue
La Crosse, WI 54601

Appeals must be filed within thirty (30) days of the date of the original decision. A designated committee from Revenue Cycle will review the appeal for further consideration. Decisions of the designated committee will be final.

QUALIFICATION PERIOD

If an applicant is determined eligible for assistance, GBAHC will grant financial assistance for a period of six (6) months. Financial assistance will also be applied retroactively to all unpaid bills for eligible accounts incurred for services received six (6) months prior to application date. No patient shall be denied assistance based on failure to provide information or documentation not required in the application.

NOTIFICATION OF FINANCIAL ASSISTANCE

Information on the GBAHC financial assistance policy and instructions on how to contact GBAHC for assistance and further information, as well as information on payment options, will be posted in hospital and clinic registration and admitting locations, and in the hospital emergency department. This information may also be obtained from financial counselors throughout the organization.

The GBAHC financial assistance policy, application and a plain language summary of the policy will be available on the system's website at www.gundersenhealth.org/FAA. This information is also available, free of charge, by contacting (608) 375-4112. If you need help in completing the financial assistance application, you may call (608) 375-4112 to talk with a financial counselor.

Information on the GBAHC financial assistance policy will be communicated to patients in culturally appropriate language. Information on financial assistance, and the notice posted in hospital and clinic locations will be translated and in any language that is the primary language spoken by the lessor 1,000 or 5% of the residents in the service area.

In addition, GBAHC includes reference to payment policies and financial assistance on all printed GBAHC monthly patient statements and collection letters. Information on the GBAHC financial assistance policy is available, at any time, upon patient request.

REGULATORY REQUIREMENTS

GBAHC will comply with all federal, state and local laws, rules and regulations and reporting

requirements that may apply to activities conducted pursuant to this policy. This policy requires that GBAHC track financial assistance provided to ensure accurate reporting. Information on financial assistance provided under this policy will be reported annually on the IRS Form 990 Schedule H.

RECORD KEEPING

GBAHC will document all financial assistance in order to maintain proper controls and meet all internal and external compliance requirements.

POLICY APPROVAL

The GBAHC financial assistance policy has been provided to and approved by the GBAHC Board of Directors on February 22, 2022. This policy is subject to periodic review. Any substantive changes to the policy must be approved by the GBAHC Board of Directors.

Responsibilities

GBAHC will document all financial assistance in order to maintain proper controls and meet all internal and external compliance requirements.

COPY

Attachments

[Appendix 1: Financial Assistance Application](#)

[Appendix 2: Discount Level](#)

[Appendix 3: Covered Providers and Departments](#)

[Appendix 4: Amounts Generally Billed \(AGB\) Percentage](#)

[Appendix 5: Public Access to Policy](#)

[Self-Pay Billing & Collection Policy](#)

[Summary of Financial Assistance Policy](#)

Approval Signatures

Step Description	Approver	Date
Finance Administrator	Jennifer Boigenzahn: Finance Administrator	Pending

Applicability

Boscobel

COPY