
Subject	Financial Assistance
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Section	Revenue Cycle
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Category	Corporate
Contact	Shannon Carey
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References

GL-3001, EMTALA: Collection of Financial Information
RevCycle-1055 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 of Gundersen Lutheran Health System, Inc. (hereinafter, collectively referred to as "GHS") receiving healthcare services at Gundersen Lutheran Medical Center, Inc., or Gundersen Clinic, Ltd.

Purpose Statement

Gundersen Health System's mission is to distinguish ourselves through excellence in patient care, education, research and through improved health in the communities we serve. Its vision is to enhance the health and well-being of our communities while enriching every life we touch, including patients, families, and staff.

In service to this mission, GHS is committed to providing emergency and medically necessary healthcare services to patients regardless of their insurance status or ability to pay. This financial assistance policy is intended to be in compliance with applicable federal and state laws for our service area. Patients

qualifying for assistance under this policy will receive a discount for care received from qualifying GHS providers.

Financial assistance provided under this policy is done so with the expectation that patients will cooperate with the policy's application procedures and those of public benefit or coverage programs that may be available to cover the cost of care. GHS will not discriminate on the basis of age, sex, race, creed, color, disability, religion, sexual orientation, national origin, or immigration status when making financial assistance determinations.

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 to Gundersen by Medicare Fee-for-Service together with all private health insurers paying claims. 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 allowed claims from private health insurers. The gross charges for said claims will be included in the denominator. 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 of less than the equivalent of 600% of the Federal Poverty Level, and financial obligations resulting from medical services provided by GHS in excess of 25% of the family income.

Discounted Care: Financial assistance that provides a discount, for eligible medical services provided by GHS, based on a sliding scale, for eligible patients, or patient guarantors, with annualized family incomes between 200-400% of the Federal Poverty Level and assets at or below six times the Federal Poverty Level.

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:

1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
2. Serious impairment to bodily functions, or
3. Serious dysfunction of any bodily organ or part; or
4. With respect to a pregnant woman who is having contractions:
 - a. That there is inadequate time to affect a safe transfer to another hospital before delivery, or
 - b. That transfer may pose a threat to the health or safety of the woman or the unborn child.

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. For patients under 18 years of age, family income includes that of the parent or parents and/or stepparents, or caretaker relatives. Family income is determined using the Census Bureau definition, which include the following income when computing federal poverty guidelines:

1. Includes earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational stipends, alimony, child support,
2. Noncash benefits (such as food stamps and housing subsidies) do not count.
3. Determined on a before-tax basis.
4. Excludes capital gains or losses

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. It is updated periodically in the Federal Register by the United States Department of Health and Human Services under authority of subsection (2) of Section 9902 of Title 42 of the United States Code. Current FPL guidelines can be referenced at <http://aspe.hhs.gov/POVERTY/>.

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 GHS.

Free Care: A 100% waiver of patient financial obligation for eligible medical services provided by GHS for eligible patients, or their guarantors, with annualized family incomes at or below 200% of the FPL with assets below the equivalent of 600% of the FPL.

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. This category also includes individuals who are exiting an institution where he or she resided for 90 days or less who resided in an emergency shelter or place not meant for human habitation immediately prior to entry into the institution.

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

Medicare Fee-For-Service (FFS): Health insurance available under Medicare Part A and Part B of Title XVIII of the Social Security Act (42 USC 1395c – 1395w-5).

Payment Plan: A payment plan that is agreed to by both GHS 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.

Private Health Insurer: Any organization that is not a governmental unit that offers health insurance, including nongovernmental organizations administering a health insurance plan under Medicare Advantage.

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 GHS under this policy, at the time that the undiscounted charges are rendered. GHS applies a courtesy discount based on the Amounts Generally Billed to uninsured patients for most 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 GHS.

Implementation

ELIGIBLE SERVICES

Services eligible for the uninsured discount and under the GHS 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 non-emergency 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 GHS 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 GHS (e.g., private and/or non-GHS 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.
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 GHS. 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 GHS.

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 GHS. GHS 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 GHS resources are prudently managed in providing financial assistance. If a patient appears to be eligible for other assistance, GHS 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.

Financial assistance applicants will be responsible for applying to public programs and pursuing private health insurance coverage. Patients, or patient's guarantors, choosing not to cooperate in applying for programs identified by GHS as possible sources of payment for care, may be denied financial assistance. Applicants are expected to contribute to the cost of their care based on their ability to pay, as outlined in this policy.

Patients, or patient's guarantors, identified as likely to qualify for Medicaid, must apply for Medicaid coverage or produce a Medicaid denial that was received within the previous six (6) months of applying for GHS financial assistance. Patients, or patient's guarantors, must cooperate with the application process outlined in this policy to obtain financial assistance.

The criteria to be considered by GHS when evaluating a patient's eligibility for financial assistance include family income, assets, and medical obligations. GHS'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 will be offered to eligible underinsured patients, providing such assistance is in accordance with insurer's contractual agreement. 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.

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

FINANCIAL ASSISTANCE

Based on an assessment of an applicant's family income, assets, and medical obligations, eligible applicants may receive the following assistance.

Uninsured Discount: Patients with no third-party coverage will be provided an uninsured discount at the time that the undiscounted charges are rendered. This applies to patients with no coverage for payment from health care insurance and/or other third-party payors.

Patients, or patient guarantors, granted the uninsured discount, are not precluded from applying and qualifying for additional financial assistance provided herein.

Full Free Care: The full amount of Gundersen Lutheran Medical Center charges will be determined covered under this financial assistance policy for any uninsured or underinsured patient, or patient guarantor, whose gross family income is at or below 200% of the current federal poverty level with assets below the equivalent of 600% of the FPL threshold.

Discounted Care: A sliding scale discount will be provided for GHS charges for services covered under this financial assistance policy for any uninsured or underinsured patient, or patient guarantor, whose gross family income is greater than 200% but less than or equal to 400% of the current federal poverty level with assets below the equivalent of 600% of the FPL. Discounts will be provided, according to the following schedule, based on the family income of the patient, or the patient's guarantor:

1. Family income above 200% FPL but equal to or less than 225% FPL are eligible to receive a 80% discount on the patient balance due.
2. Family income above 225% FPL but equal to or less than 250% FPL are eligible to receive a 60% discount on the patient balance due.
3. Family income above 250% FPL but equal to or less than 275% FPL are eligible to receive a 40% discount on the patient balance due.
4. Family income above 275% FPL but equal to or less than 400% FPL are eligible to receive a 20% discount on the patient balance due.

Catastrophic Care: GHS patients not meeting financial assistance eligibility thresholds may be eligible for assistance under circumstances when GHS medical bills would result in severe financial hardship. Patients, or their guarantors, may be eligible for catastrophic care assistance if they have incurred out-of-pocket obligations resulting from medical services provided by GHS that exceed 25% of family income and have assets below the equivalent of 600% of the FPL threshold.

Patients, or patient guarantors, meeting eligibility criteria for catastrophic care will have their GHS charges discounted to an amount not to exceed 25% of family income.

Payment Plans: Payment in full is expected, for balances due, within 21 days of the initial patient statement. If unfeasible for a patient, or guarantor, to pay in full within this timeframe, a payment plan may be extended for up to 36 months or 3 years for any balance remaining after discounts have been granted to applicants eligible for financial assistance. A reasonable payment plan will be established between GHS and the patient. The term of the payment plan will be based on the applicant's

outstanding medical bills, family income and any extenuating circumstances. If approved, the plan will be interest-free.

Patients are responsible for communicating with GHS anytime an agreed upon payment plan cannot be fulfilled. Lack of communication from the patient may result in the account being assigned to a collection agency.

PRESUMPTIVE ELIGIBILITY

GHS 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 GHS 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.

GHS understands that certain patients may be non-responsive to GHS's application process. Under these circumstances, GHS may utilize other sources of information to make an individual assessment of financial need. This information will enable GHS 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.

GHS 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.

The electronic technology is designed to assess each patient to the same standards and is calibrated against historical approvals for GHS 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 GHS 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.

When electronic enrollment is used as the basis for presumptive eligibility, the highest discount levels will be granted for eligible services for retrospective dates of service only. If a patient does not qualify under the electronic enrollment process, the patient may still be considered under the traditional financial assistance application process.

Patient accounts granted presumptive eligibility will be reclassified under the financial assistance policy. They will not be sent to collection and will not be included in the hospital's bad debt expense.

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. GHS may request that patient cost-sharing payments (i.e., co-payments) 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 GHS. 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 GHS to calculate the AGB percentage(s).

If you have any questions regarding the AGB percentages, please contact the Customer Financial Services office at (608) 775-8660 or (800) 362-9567, ext. 58660. Information on AGB will be provided free of charge.

Patients determined eligible for financial assistance will not be expected to pay gross charges for eligible services while covered under GHS financial assistance policy.

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, GHS 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

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

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 GHS 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 Health System
Customer Financial Service; Mailstop NCA3-01
1900 South Avenue
La Crosse, WI 54601
(608)775-8660 or (800) 362-9567, ext. 58660

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 GHS 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.

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. The Director of Patient Access will review the appeal for further consideration. Decisions of the Director of Patient Access will be final.

QUALIFICATION PERIOD

If an applicant is determined eligible for assistance, GHS 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 GHS financial assistance policy and instructions on how to contact GHS 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 GHS 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) 775-8660 or (800) 362-9567, ext. 58660. If you need help in completing the financial assistance application, you may call (608) 775-8660 or (800) 362-9567, ext. 58660 to talk with a financial counselor.

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

REGULATORY REQUIREMENTS

Gundersen Health System 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 GHS 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

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

POLICY APPROVAL

The GHS financial assistance policy has been provided to and approved by the GHS Finance Committee and Board on February 17, 2023. This policy is subject to periodic review. Any substantive changes to the policy must be approved by the GHS Board.

Responsibilities

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