Title:	FINANCIAL ASSISTANCE POLICY		
Policy Type:	Administrative	Effective Date:	6/7/2019
Entities Affected:	Waukesha Memorial Hospital, Oconomowoc Memorial Hospital Mukwonago Ambulatory Care Center Rehabilitation Hospital of Wisconsin Pewaukee Ambulatory Care Center	Review Date:	6/7/2019

Purpose Statement:
This policy outlines the eligibility criteria for financial assistance, the basis for calculating amounts charged to patients, the method of applying for financial assistance, and publicizing of the financial assistance policy.

Definitions:

Amounts generally billed (AGB): the amounts generally billed for Medically Necessary Care, including Emergency Medical Care, to individuals who have insurance covering such care, as determined in accordance with this policy.

AGB Percentage; the percentage of gross charges that a Hospital Facility uses to determine the AGB for any Medically Necessary Care it provides to an individual who is eligible for assistance under this policy.

Authorized Body: the Board of Directors of each Hospital Facility.

Charged: the only the amount patient is personally responsible for paying, after all deductions, discounts (including discounts available under this FAP), and insurance reimbursements have been applied.

Emergency medical care: care provided by a hospital facility for emergency medical conditions, as defined in section 1867 of the Social Security Act (42 U.S.C. 1395dd).

Financial Assistance Policy (FAP): means this policy.

FAP Application: the information and accompanying documentation that an individual submits to apply for financial assistance under this FAP. An individual is considered to have submitted a complete FAP application if he or she provides information and documentation sufficient for a Hospital Facility to determine whether the individual is FAP–eligible and an incomplete FAP application if he or she provides some, but not sufficient, information and documentation to determine FAP–eligibility.

FAP Application Form: the application form (and any accompanying instructions) that a Hospital Facility makes available for individuals to submit as part of a FAP Application.

FAP-eligible: means that a patient is eligible for financial assistance under this FAP for care covered by the FAP.

FAP-eligibility Determination: A determination by a Hospital Facility that a patient is eligible or ineligible for financial assistance under this FAP.

Gross Charges or chargemaster rate: means a Hospital Facility's full, established price for medical care that the Hospital Facility consistently and uniformly charges patients before applying any contractual allowances, discounts, or deductions.

Hospital Facility: Waukesha Memorial Hospital, Oconomowoc Memorial Hospital, and Rehabilitation Hospital of Wisconsin.

Household: The total number of all adults and minors of a common residence, including spouse or domestic partner (domestic partner is defined as either one of an unmarried heterosexual or homosexual cohabiting couple especially when considered as to eligibility for spousal benefits), subject to the following conditions:

- Parents are included as household members for patients less than 27 years of age if the patient is claimed as a dependent on the parent's income tax returns.
- The income or assets of a minor, un-emancipated minor sibling of a patient are not included as household income and assets of the patient.
- A minor, un-emancipated child's income and assets are not included as household income and assets on an application for parents.
- If reasonable, the size of the patient's family will be determined by the number of dependents claimed on the applicant's tax returns or identified as part of the household

Household Assets: Any tangible or intangible asset owned by a member of a Household, including:

- Equity in a personal residence;
- cash on hand;
- savings;
- Stocks, bonds, annuities;
- IRAs, TSAs, 401(k)s, 403(b)s, health savings accounts, deferred compensation accounts;
- cash value of life insurance;
- the market value of non-homestead real estate (i.e.; second home; vacation home) and personal property;
- Tangible assets, such as household and personal possessions; and,
- Any property transferred by the Household or a member of the Household for less than fair market value within two years of the date the FAP Application is submitted is an the asset. In such instances, the difference between the fair market value of the asset and the amount for which the asset was transferred is included in the calculation of the patient's Household Assets.

Household Assets do not include:

- Personal property of reasonable value used in the production of income, such as farm equipment and livestock;
- Reasonable routine household and personal possessions; and,
- One automobile or one truck, unless additional vehicles are necessary to produce income.

Household Income: Household income includes all income from any source including the following;

- wage and salaries;

- all pensions from state, federal or private sources;
- income from annuities, IRAs, TSAs, 401(k)s;
- stocks, or bonds;
- veterans benefits;
- social security payments;
- regularly received insurance checks such as unemployment benefits and workers compensation;
- alimony; child support; and,
- returns on investments; net rents and net profits from business.

Income Cap: an amount equal to 15% of the patient's Household's gross yearly income.

Medicaid: any medical assistance program administered by the Wisconsin.

Medically Necessary Care: A health service or treatment that is mandatory to protect and enhance the health status of a patient, and could adversely affect the patient's condition if omitted, in accordance with accepted standards of medical practice. Medically Necessary Care includes Emergency Medical Care. The following are not Medically Necessary Care: cosmetic surgery that is not usually reimbursed by a health insurer, in vitro fertilization (IVF), any infertility programs, elective sterilization procedures or the reversal thereof, retail services, hearing aids, vision services, and services routinely denied as not medically necessary by health insurers.

Medicare Fee-for-Service: health insurance available under Medicare Part A and Part B of Title XVIII of the Social Security Act (42 U.S.C. 1395c through 1395w–5).

Patient: means the person receiving Medically Necessary Care and any person responsible for payment of the Medically Necessary Care.

Plain Language Summary of the FAP: a written statement that notifies an individual that the Hospital Facility offers financial assistance under this FAP and provides the following additional information in language that is clear, concise, and easy to understand: a brief description of the eligibility requirements and assistance offered under this FAP; a brief summary of how to apply for assistance under the FAP; a direct Web site address (or URL) and physical locations where the individual can obtain copies of this FAP and FAP application form; instructions on how the individual can obtain a free copy of the FAP and FAP application form by mail; and, the contact information, including telephone number and physical location, of the hospital facility office or department that can provide information about the FAP and assistance with the FAP application process.

Presumptive FAP-eligibility Determination: a determination that an individual is FAP–eligible based on information other than that provided by the individual or based on a prior FAP– eligibility determination, as described in § 1.501(r)–6(c)(2).

Private Health Insurer: any organization that is not a governmental unit that offers health insurance.

Residual Balances: Balances due from patients that hold insurance coverage (deductibles, co-insurance, copayments, non-covered services) and all sums due from patients without insurance.

Policy:

Hospital Facilities will provide eligible patients with discounts under this policy. FAP-eligible patients will pay no more than Amounts Generally Billed. Hospital Facilities will take certain actions to ensure that patients are aware of this policy. This FAP applies to all Medically Necessary Care, including Emergency Medical Care, provided by a Hospital Facility.

This policy is intended to comply with Section 501(r) of the Internal Revenue Code, and all Hospital Facilities shall interpret this policy in a manner consistent with Section 501(r).

Procedure:

Hospital Facilities will:

1) Widely Publicize this FAP;
2) Provide eligibility criteria for financial assistance under this FAP and whether such assistance includes free or discounted care;
3) Outline the basis for calculating amounts charged to patients;
4) Provide the method for applying for financial assistance;
5) Establish a list of providers delivering Medically Necessary Care in a Hospital Facility who are covered by this FAP and who are not covered by this FAP.

WIDELY PUBLICIZING THE FAP

In order to widely publicize the FAP, each Hospital Facility will

1) Make the FAP, FAP application form, and plain language summary of the FAP widely available and easily locatable at prohealthcare.org;

2) Make paper copies of the FAP, FAP application form, and plain language summary of the FAP available upon request and without charge, both by mail and in public locations in the Hospital Facility, including, at a minimum, in the emergency room and admissions areas;

3) Notify and inform members of the community served by the Hospital Facility about the FAP in a manner reasonably calculated to reach those members who are most likely to require financial assistance from the hospital facility;

4) Notify and inform individuals who receive care from the hospital facility about the FAP by

   a) Offering a paper copy of the plain language summary of the FAP to patients as part of the intake or discharge process;

   b) Including a conspicuous written notice on billing statements that notifies and informs recipients about the availability of financial assistance under the hospital facility's FAP and includes the telephone number of the hospital facility office or department that can provide information about the FAP and FAP application process and the direct Web site address (or URL) where copies of the FAP,

FAP application form, and plain language summary of the FAP may be obtained;

c) Setting up conspicuous public displays (or other measures reasonably calculated to attract patients' attention) that notify and inform patients about the FAP in public locations in the hospital facility, including, at a minimum, the emergency room (if any) and admissions areas; and

d) Making available translations of this FAP, FAP application form, and plain language summary of the FAP in the language spoken by each LEP language group that constitutes the lesser of 1,000 individuals or 5 percent of the community served by the hospital facility, as listed in Appendix A or the population likely to be affected or encountered by the Hospital Facility.

Signage identifying the availability of Financial Assistance will be posted in English and Spanish. Pamphlets in English and Spanish that briefly describe the Financial Assistance program will be available at intake and discharge points. Billings statements sent to patients will include a notification on the statement asking patients to contact the Central Business Office at 1-866-432-7855 if they wish to apply for financial assistance. Financial Assistance applications are also available via mail if requested.

Copies of ProHealth Care's Financial Assistance application are provided to other non-profit entities in Waukesha County that provide services to uninsured and under-insured patients who are referred to the Hospital Facilities for services.

FAP ELIGIBILITY CRITERIA

A patient is eligible for financial assistance under this policy if:

1. The patient meets the residence requirements;
2. The patient meets the income and asset limitations listed in this section;
3. The patient received Emergency Medical Services or Medically Necessary Services at a Hospital Facility;
4. If the patient is eligible for insurance from a government payer, employer or Private Health Insurer, the patient has applied for and paid for all premiums due to the government payer, employer or Private Health Insurer, and,
5. The patient complies with all procedural requirements in this FAP.

Requirement 1: Residence Requirement

The patient must reside in the ProHealth Care service area (see Appendix A) at the time of service and for a period of at least six of the prior eight months immediately prior to the date of service.

Requirement 2: Asset and Income Limitations

The patient's (1) total value of Household Assets must not exceed $100,000 and (2) Household Income must not exceed 400% of the federal poverty guidelines for the patient's Household size.

Requirement 3: The Patient Received Emergency Medical Services or Medically Necessary Services at a Hospital Facility.

All Medically Necessary Care provided by a Hospital Facility is eligible for financial assistance. Physician fees related to independent physicians providing care within Hospital Facilities is not eligible for financial assistance unless such physician or physician's group is listed in Appendix B.

Requirement 4: Applied For and Paid Premiums for Available Health Care Insurance

If the patient is eligible for insurance from a government payer, employer or Private Health Insurer, the patient have applied for and paid for all premiums due to the government payer, employer or Private Health Insurer.

If approved by the Vice President – Revenue Cycle, the Hospital Facility may waive this requirement for the following patients:

1) Patients who cannot apply for health coverage through the ACA Exchange System or other insurance. These patients must otherwise qualify for financial assistance under the FAP, and

2) Patients who can apply for health coverage through the ACA Exchange System or other insurance but did not apply for coverage who did not pay for coverage. These patients are given a one-time exception from Requirement 4. The one-time exception lasts until the patient is eligible for health insurance. These patients are tracked via a PHC exception tracker by the PHC Customer relations staff and, in addition, their accounts are noted accordingly.

Requirement 5: The Patient Complies with All Procedural Requirements in this FAP.

The patient must comply with all procedural requirements (such as submitting a completed FAP Application) under this FAP.

METHOD OF APPLYING FOR FINANCIAL ASSISTANCE

Whenever possible, arrangements for financial assistance should be made in advance of service. The patient or his/her physician should contact the Central Business Office at 1-866-432-7855 to request a financial assistance application or to receive assistance in completing the application for financial assistance. The financial assistance application is also available on-line at www.prohealthcare.org. Information provided will be used to assess the patient's eligibility. The Central Business Office and/or Department of Social Work may contact the patient as part of the determination process if additional information is needed. If additional information is needed, a final determination of eligibility will not be completed until all information is received. Financial assistance eligibility is based upon the financial status of the applicant and members of the applicant's household as of the date of the financial assistance application.

Applicants requesting FAP-eligibility Determinations prior to receiving services will be informed of their eligibility within five working days after the patient submits a complete FAP Application. A complete application includes providing required supporting

information, including pay stubs, bank statements, income tax returns, real estate assessments, and mortgage statements. Applicants requesting FAP-eligibility Determinations after service has been rendered will be informed of their eligibility within ten working days after the patient submits a complete FAP Application.

The Central Business Office will make the FAP-eligibility Determination. Patients eligible for financial assistance will receive free or discounted care, as detailed in this FAP. This benefit will be applied to any Residual Balances for Emergency Medical Care and Medically Necessary Care provided at the Hospital Facilities.

The patient's FAP-eligibility Determination is valid for a period of three months from the date of service If services continue for a period greater than three months or new service are provided after this three month period, the patient must re-apply for financial assistance by (1) re-affirming that the information supplied in the initial FAP Application is still valid or (2) submitting a new FAP Application.

In cases where a patient cannot provide documentation in order for PHC Patient Accounting to validate income or asset criteria, a written attestation furnished by the patient or patient's employer may be sufficient to qualify for financial assistance.

A Hospital Facility may reverse a FAP-eligibility Determination if the patient did not provide accurate and complete information during the application process.

BASIS FOR CALCULATING AMOUNTS CHARGED TO PATIENTS

To calculate the AGB, the Hospital Facilities uses the "look-back" method described in 26 C.F.R. 501(r)-4(b)(2). In this method, the Hospital Facilities use data based on claims sent to Medicare fee-for-service and all private commercial insurers for all medical care over the past year to determine the percentage of gross charges that is typically paid by these insurers.

The AGB percentage is then multiplied by gross charges for emergency and medically necessary care to determine the AGB. The Hospital Facilities re-calculate the percentage each year.

For fiscal year 2019, the AGB percentage for Waukesha Memorial Hospital is 32.37% and for Oconomowoc Memorial Hospital is 33.67%. Each year, the Hospital Facilities will update these amounts.

The patient's Residual Balance will be reduced according to the following sliding scale:

Income as a Percentage of the Federal Poverty Level for Household Size	Amount of Patient Responsibility for Residual Balance for Emergency Medical Care and Medically Necessary Care at a Hospital Facility
Below 200%	0% (free care)
200% to 210%	Lesser of 5% or Income Cap (discounted care)
211% to 220%	Lesser of 10% or Income Cap (discounted care)

221% to 230%	Lesser of 15% or Income Cap (discounted care)
231% to 240%	Lesser of 20% or Income Cap (discounted care)
241% to 250%	Lesser of 25% or Income Cap (discounted care)
251% to 400%	Lesser of 30% or Income Cap (discounted care)

"Income Cap" is 15% of the patient's Household's gross yearly income.

PROVIDERS SUBJECT TO THIS FAP

Appendix B is a list of ProHealth Care facilities where ProHealth Care providers deliver Medically Necessary Care who are covered by this FAP, or who are not covered by this FAP.

References:

Owned By:
Curtis Glaunert VP Revenue Cycle

Committees:
Administrative Policy Committee
Board Audit and Compliance Committee

Appendix A
Service Area

Zip Code	City/Town/Village	Zip Code	City/Town/Village
53003	Ashippun	53118	Dousman
53005	Brookfield	53119	Eagle
53018	Delafield	53120	East Troy
53029	Hartland	53122	Elm Grove
53036	Ixonia	53127	Genesee Depot
53038	Johnson Creek	53137	Helenville
53045	Brookfield	53146	New Berlin
53056	Merton	53149	Mukwonago
53058	Chenequa	53150	Muskego
53059	Neosho	53151	New Berlin
53064	North Lake	53153	North Prairie
53066	Oconomowoc	53156	Palmyra
53069	Okauchee	53167	Rochester
53072	Pewaukee	53178	Sullivan
53089	Sussex	53183	Wales
53094	Watertown	53185	Waterford
53098	Watertown	53186, 53188, 53189	Waukesha
53103	Big Bend	53549	Jefferson

Appendix B

Providers other than Waukesha Memorial Hospital, Oconomowoc Memorial Hospital, and Rehabilitation Hospital of Wisconsin who provide Medically Necessary Care in a Hospital Facility, or who do not fall under this policy. None