GUNDERSEN HEALTH SYSTEM®

Policy

Subject	Financial Assistance
Index Number	GL-2555
Section	Revenue Cycle
Subsection	Revenue Cycle Admin
Category	Corporate
Contact	Shannon Carey
Effective Date	04/01/2025
Next Revision Date	03/31/2026

References

EMTALA: Collection of Financial Information
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
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., Gundersen Boscobel Area Hospital and Clinics, Gundersen Moundview Hospital and Clinics, Gundersen Palmer Lutheran and Clinics, Inc., Gundersen St. Elizabeth's Hospital and Clinics, Gundersen St. Joseph's Hospital and Clinics, and Gundersen Tri-County 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 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. Service areas participating in NHSC will utilize annualized family incomes between 201-400% of the Federal Poverty level. For those eligible participants, or patient guarantors, with annualized family income at or below 200% of the poverty level, a full discount will be applied.

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/poverty-guidelines).

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.

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 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.

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. Applicants may reapply every six months.

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. 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 Gundersen 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.
2. Non-elective services provided in response to life-threatening circumstances in a non- emergency setting**.**
3. Medically necessary 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 Gundersen 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 Gundersen (e.g., private and/or non-Gundersen medical or physician professionals, ambulance transport, etc.). See Appendicies 3 and 6 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 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.

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. An asset test is not applicable to families with annual income at or below 200% of the most current FPG for those service areas that participate in the National Health Service Corps Program (NHSC).

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.

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 or other government-funded food assistance, 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. An asset test is not applicable to families with annual income at or below 200% of the most current FPG for those service areas that participate in the National Health Service Corps Program (NHSC).

Gundersen 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. (An asset test is 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, 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.

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).

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 (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 time frame, 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 Services; 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 Services 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, 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. Applicants may reapply every six months.

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 systems' website at or https://www.gundersenhealth.org/patients-visitors/financial-assistance. This information is also available, free of charge, by contacting GHS Health at (608) 775-8660 or (800) 362-9567, ext. 58660.

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

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

POLICY APPROVAL

The Gundersen Financial Assistance Policy has been provided to and approved by the Gundersen Finance Committee and Board on February, 2025. This policy is subject to periodic review. Any substantive changes to the policy must be approved by the Gundersen Board.