TITLE: Financial Assistance Policy	
LEVEL ☐ Department ☒ Organization	CATEGORY ☒ Administrative ☐ Clinical ☒ Regulatory
REVIEW CYCLE ☒ 1 YEAR ☐ 3 YEARS LAST REVIEW DATE: [11/25/2025]	EFFECTIVE DATE: [01/01/2026]

PURPOSE:

The purpose of this policy is to provide guidelines for financial assistance to eligible self-pay individual patients and eligible individual patients with balances after insurance receiving emergent or other medically necessary services based on financial need. This financial assistance policy also provides guidelines for discounted amounts that may be charged to all patients who receive medically necessary services.

Mile Bluff Medical Center will provide, without discrimination, emergency medical care to individuals regardless of their eligibility for financial assistance or for government assistance. Mile Bluff Medical Center provides financial assistance to people who have health care needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay, for non-emergent medically necessary care.

SCOPE:

This policy is to be used by all Mile Bluff Medical Center (MBMC) entities except MBMC's nursing homes, retail pharmacy, DME, transportation services, and Terrace Heights.

DEFINITIONS:

1. **Amount Generally Billed (AGB) Percentage:** The amount generally billed is the expected payment for emergency or medically necessary services from patients, and/or a patients' guarantor. For patients that qualify for financial assistance, 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 is based on actual past claims paid to MBMC by Medicare Fee-for-Service together with all Private Health Insurers paying claims. The claims included in the AGB calculation are claims allowed during the prior calendar year. The amounts for co-insurance, co- payments and deductibles are included in the numerator along with the Medicare Fee-for-Service together with all claims allowed from private health insurers. The Gross Charges for said claims are included in the denominator. The AGB is calculated annually by the 60th day following the close of the prior calendar year and implemented by the first day of the calendar year.

2. **Application Period:** The period during which applications are accepted and processed for Financial Assistance. The Application Period begins on the date the care is provided and ends on the 240th day after the date that the first post-service billing statement is provided.

3. **Eligible Services:** Services eligible under this Financial Assistance Policy are clinically appropriate and within generally accepted medical practice standards. They include the following services provided and/or billed by MBMC:

    a. Emergency medical services provided in an emergency setting, as well as care provided in an emergency setting for the purpose of stabilizing a Patients' condition.

    b. Non-elective services provided in response to life-threatening circumstances in a non-emergency setting.

    c. Medically Necessary services as defined by Medicare.

4. **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:

    a. 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,

    b. Serious impairment to bodily functions, or

    c. Serious dysfunction of any bodily organ or part; or

    d. With respect to a pregnant woman who is having contractions:

        i. That there is inadequate time to affect safe transfer to another hospital before delivery, or

        ii. That transfer may pose a threat to the health or safety of the woman or the unborn child.

5. **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.

6. **Family Income:** An applicant's Family Income is the sum of annual earnings and cash benefits from all sources before taxes, less payments made for child support, for all adult family members living in the household and included on the most recent federal tax return. Federal Poverty Level (FPL) - The 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 https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines.

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

8. **Gross Charges:** MBMC full established price for medical services that is consistently and uniformly charged to all patients before applying any contractual allowances, discounts, or financial assistance.

9. **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.

10. **Ineligible Services**:

    a. Elective procedures are 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 or cosmetic in nature. In addition, these specific services are excluded from this policy:

        1. Long-term care provided at MBMC Nursing Homes
        2. Retail Pharmacy and DME services
        3. Transportation services
        4. Any services provided at Terrace Heights Assisted Living

    b. Services received from providers not billed by MBMC (e.g., private and/or non – MBMC medical or physician professionals, ambulance transport, etc.) Patients are encouraged to contact these providers directly to inquire about any available assistance and to make payment arrangements.

    c. Services provided to insured patients, including under-insured patients, who are out-of-network (meaning the provider or facility providing care is not an in-network provider or have a negotiated contract with the patients' health insurance plan).

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

12. **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).

13. **Patient Balance Due:** The amount a patient or the patients' guarantor is personally responsible for paying, after all deductions, insurance reimbursements, and uninsured discount have been applied.

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

15. **Presumptive:** 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.

16. **Qualification Period:** Applicants determined eligible for financial assistance will be granted assistance for a period of twelve months. Assistance will also be applied retroactively to all eligible accounts incurred for services received during the application period.

17. **Uninsured Patient:** A Patient who is not covered in whole or in part under a policy of health insurance, including high deductible policies, and is not a beneficiary under a public or private health insurance, health benefit, or other health coverage program (including, without limitation, private health insurance, an ERISA plan, Medicare, Medicaid, or CHIP, or CHAMPUS), and whose injury, illness or treatment is not compensable for purposes of workers' compensation, automobile insurance, liability or other third party insurance, as determined by MBMC based on documents and information provided by the patient or obtained from other sources, for the payment of health care services provided by MBMC.

18. **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 MBMC.

POLICY:

1. Mile Bluff Medical Center is committed to providing emergency and medically necessary health care services to patients regardless of their insurance status or ability to pay.

2. MBMC shall provide financial assistance at all locations providing eligible health care services to patients.

3. This financial assistance policy is intended to follow 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 MBMC providers.

4. 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 other public benefit or coverage programs that may be available to cover the cost of care.

5. MBMC will not discriminate on the basis of age, sex, race, religion, color, disability, sexual orientation, national origin, or immigration status when making financial assistance determinations.

PROCESS:

1. Financial Assistance will be extended to uninsured and underinsured patients, or such patients' guarantors, who receive eligible services and meet specified criteria, as defined below. These criteria will ensure that this Financial Assistance Policy is consistently applied across MBMC and complies with any federal and state requirements. MBMC reserves the right to revise, modify or change this policy as necessary or appropriate.

2. Financial assistance applicants seeking services at MBMC facilities except designated ineligible services, will be responsible for applying to public programs and pursuing private health insurance coverage. Patients, or patients' guarantors, choosing not to cooperate in applying for programs identified by MBMC 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.

3. Patients, or patients' guarantors, seeking services at MBMC facilities except designated ineligible services, 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 MBMC financial assistance. Patients, or patients' guarantors, must cooperate with the application process outlined in this policy to obtain financial assistance.

4. MBMC may utilize a third party to determine whether uninsured patients receiving care in its hospitals are eligible for Medicaid and assist in the application for Medicaid. If the vendor review finds that the patient or patients' guarantors are not eligible for Medicaid and documents same in the medical record, neither the patient nor the patients' guarantor will be required to apply for Medicaid coverage.

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

6. Financial Assistance will be offered to eligible underinsured patients, providing such assistance is in accordance with MBMC's contractual agreement with insurers. Financial assistance is typically not available for patient co-payment or balances after insurance if a patient fails to comply with insurance requirements such as obtaining proper referrals or authorizations. Out of network balances are reviewed on a case-by-case basis. Patients with tax-advantaged, personal health accounts such as a Health Savings

Account, a Health Reimbursement Arrangement or a Flexible Spending Account, are expected to utilize account funds prior to being granted financial assistance. MBMC reserves the right to reverse the discounts described herein in the event that it reasonably determines that such terms violate any legal or contractual obligations of MBMC.

7. MBMC will collect and report statistical information regarding financial assistance applications in compliance with any federal or state laws or insurance program requirements.

FINANCIAL ASSISTANCE:

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

2. **Uninsured Discount:** Uninsured patients will be provided with an uninsured discount, at the time that the undiscounted charges are rendered, and prior to when a patient or patient guarantor is billed. In the event that insurance or other coverage, identified in the definition of uninsured patient, is subsequently discovered, the uninsured discount will be removed and full charges billed to that coverage as appropriate. Patient, or patients' guarantor, granted the uninsured discount, is not precluded from applying and qualifying for additional financial assistance provided herein.

3. **Free and discounted care at MBMC facilities except designated ineligible services:** The full amount of MBMC charges is determined covered under this financial assistance policy for any uninsured or underinsured patient, or such patients' guarantor, whose gross family income is at or below 200% of the current Federal Poverty Level. A sliding scale discount will be provided for MBMC charges for services covered under this Financial Assistance Policy for any uninsured or underinsured patient, or patients' guarantor, whose gross family income is greater than 200% but less than or equal to 300% of the current Federal Poverty Level. Free or discounted care will be provided based on the family income of the patient, or the patients' guarantor in accordance with the following schedule:

    a. Family Income up to 200% FPL are eligible to receive a 100% discount on the patient balance due.

    b. Family Income of above 200% FPL but equal to or less than 250% FPL are eligible to receive a 75% discount on the patient balance due.

    c. Family Income of above 250% FPL but equal to or less than 275% FPL are eligible to receive a 50% discount on the patient balance due.

    d. Family Income of above 275% FPL but equal to or less than 300% FPL are eligible to receive a 25% discount on the patient balance due.

PAYMENT PLANS:

1. Payment in full is expected for balances due upon receipt of initial patient statement. If a patient, or guarantor cannot pay in full, a payment plan may be extended for any balance remaining after discounts have been granted to applicants eligible for financial assistance.

2. A reasonable payment plan will be established between MBMC 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.

3. The initial term of the payment plan should be based on a $50/month minimum payment, not to exceed a 24-month repayment period. Based on the applicant's circumstances, a repayment period up to 36 months is allowable with proper approval. Refer to the Patient Billing and Collections Policy for specific requirements. In the advent the applicant requires more than 2 years they should be referred to MBMC's third party patient financing company.

4. Patients are responsible for communicating with MBMC 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.

5. MBMC reserves the right to reverse the financial assistance described herein in the event that it reasonably determines that such terms violate any legal or contractual obligations of MBMC.

PRESUMPTIVE ELIGIBILITY:

1. MBMC 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 patients' qualification for financial assistance is established without completing the formal financial assistance application. Other information may be utilized by MBMC to determine whether a patients' account is uncollectible, and this information is used to determine presumptive eligibility.

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

    a. 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.

    b. Patients or guarantors who are deceased with no estate in probate.

    c. Patients or guarantors are determined to be homeless.

    d. Patients or guarantors who qualify for State Medicaid programs (including but not limited to WIC, SNAP) are eligible for assistance for any cost-sharing obligations associated with the program.

e. Accounts returned by the collection agency as uncollectible due to any of the above reasons.

f. Incarceration, when eligible services are provided but payment is not the responsibility of the jail or prison in which patient is incarcerated.

g. Mental incapacitation with no one to act on the patients' behalf.

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

4. MBMC may utilize a third-party to conduct an electronic review of patient information to assess financial needs. This review will utilize a health care 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 MBMC financial assistance under the traditional application process.

5. 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 MBMC to screen all patients with charges for financial assistance prior to pursuing any bad debt collection actions. The data returned from this electronic review will constitute adequate documentation of financial need under this policy.

6. When electronic enrollment is used as the basis for presumptive eligibility, the highest discount level 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. MBMC will provide patients who do not qualify for financial assistance through this process with a written notice informing them that financial assistance is available. This notice will include a plain language summary of the financial assistance policy and actions to be taken if an application is not submitted or the outstanding balance paid.

7. Patient accounts granted presumptive eligibility will be reclassified under the financial assistance policy. They will not be sent to collection, will not be subject to further collection actions, will not be sent a written notification of their electronic qualification, and will not be included in the hospital's bad debt expense.

EMERGENCY MEDICAL SERVICES:

1. In accordance with the FEDERAL EMERGENCY MEDICAL TREATMENT AND LABOR ACT (EMTALA) regulations, MBMC shall provide, without discrimination, care for emergency medical conditions to individuals regardless of whether they can pay for the care or are eligible for financial assistance. MBMC shall not engage in actions that discourage

individuals from seeking care for emergency medical conditions, including, but not limited to, demanding payment or screening for financial assistance eligibility or payment information prior to receiving care for emergency medical conditions. MBMC 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 or otherwise interfere with the provision, without discrimination, of care for emergency medical conditions.

AMOUNTS BILLED TO PATIENTS ELIGIBLE FOR FINANCIAL ASSISTANCE:

1. The amount generally billed (AGB) is the expected payment from patients, or a patients' guarantor, eligible for financial assistance. For qualifying underinsured and uninsured patients, this amount will not exceed a rate that will be determined utilizing a Look Back Method. Financial assistance for eligible patients may not be charged more than AGB for emergency or other eligible services.

2. Patients determined to be eligible for financial assistance will not be expected to pay gross charges for eligible services while covered under the MBMC Financial Assistance Policy. Patients, or a patients' guarantor, may request to make a payment of any amount if covered by financial assistance, but MBMC will not require them to do so and will make clear to the patient, or patients' guarantor, payment is not required. Documentation in the patient's medical record is required for this circumstance.

APPLYING FOR FINANCIAL ASSISTANCE:

1. 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, MBMC may seek additional information.

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

3. One of the following is required from patients, or their guarantor, to determine eligibility based on Family Income:

    a. Copy of the Federal tax return, and all attached Schedules, from the most recent tax year.

    b. Most recent W2 or 1099.

    c. Current Proof of Income (copy of two most recent pay stubs) or written income verification from an employer if paid in cash.

    d. Proof of other income, including unemployment, workers' compensation, alimony, trust income, veteran's benefits.

    e. Current bank statements.

4. If a patient cannot provide any of the documents listed above, MBMC will work with the patient to determine if there is another acceptable means of documenting family income.

5. Applications for financial assistance may be submitted up to 240 days after the date of the first statement. If an application is incomplete, or there has been a request for additional information, the application remains active for 30 days from the date the letter was mailed to the applicant requesting this information. If the applicant has not responded within the 30-day time frame, the application will be denied unless the applicant satisfies one of the non-responsive categories identified above.

6. During the period in which the fully completed financial assistance application is being reviewed, there will be a stay of all collection proceedings. The normal billing process will continue while the application is reviewed and considered. If a properly completed application is approved, this will be noted in the patients' file, and the account balance is adjusted off to the appropriate code.

7. If initially denied financial assistance, the patient or patients' guarantor may re-apply at any time if there has been a change in income or status.

8. Patients applying for financial assistance are required to certify that all information provided by the patient to MBMC is true. If any of the information provided by the patient is found to be untrue, any financial assistance granted to the patient may be forfeited and the patient may be responsible for payment of MBMC's gross charges.

9. In addition, patients shall communicate to MBMC any material change in the patients' financial situation that occurs during the qualification period that may affect financial assistance determination within thirty (30) days of the change. Patients' failure to disclose a material improvement in family income may void any provision of financial assistance by MBMC after the material improvement occurs.

DETERMINATIONS, APPEALS, AND DISPUTE RESOLUTION:

1. Patients must be notified of the decision in writing regarding their application within thirty (30) days of submitting a completed application. An applicant determined eligible for financial assistance will be refunded payments more than the amount determined owed by the patient or guarantor on the accounts for which they are granted assistance under this Financial Assistance Policy. Refunds apply to excess payments of $5 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.

2. Patients may appeal this decision in writing within 30 days of receiving notification to:
   Mile Bluff Medical Center
   Attn: Financial Counselors
   1050 Division St
   Mauston, WI 53948

3. Appeals must be filed within 30 days of the date of the original decision. The Vice President – CFO or designee of Revenue Cycle will review the appeal for further consideration. Decisions of the Vice President - CFO or designee will be final.

QUALIFICATION PERIOD:

If an applicant is determined eligible for assistance, MBMC will grant financial assistance for a period of 12 months from application date. Financial assistance will also be applied retroactively to all unpaid bills for eligible accounts incurred for services received during the application period. No patient shall be denied assistance based on failure to provide information or documentation not required in the application.

NOTIFICATION OF FINANCIAL ASSISTANCE:

1. Information on the MBMC Financial Assistance Policy and instructions on how to contact MBMC 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.

2. The MBMC Financial Assistance Policy, application, and a plain language summary of the policy will be available on the system's website, https://www.milebluff.com/patients-visitors/billing-information/financial-assistance/. This information is also available, free of charge, by calling (608) 847-6161. If you need help in completing the Financial Assistance application, you may call (608) 847-6161 to speak with a financial counselor.

3. Information on the MBMC 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 as determined by MBMC policy.

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

REGULATORY REQUIREMENTS:

1. MBMC 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 MBMC tracks financial assistance provided to ensure accurate reporting. Information on financial assistance provided under this policy will be reported as required annually on the IRS Form 990 Schedule H, and the Community Benefits Report.