MILE BLUFF MEDICAL CENTER
Mauston, Wisconsin

ADMINISTRATIVE POLICY

DEPT: Patient Accounts **EFFECTIVE DATE:** October 2016

SUBJECT: Community Care/Financial Assistance Policy

PURPOSE: The purpose of this policy is to outline the guidelines for applying & qualifying for free or discounted hospital services which are emergent or medically necessary at Mile Bluff Medical Center (MBMC).

POLICY: MBMC is committed to providing compassionate and progressive care, improving the health and wellness of the community, and going beyond expectations in healthcare today and always. As part of this commitment, MBMC recognizes the financial needs of the patients within the communities we serve. Our Community Care program offers free or discounted care to qualified individuals who have healthcare needs and are uninsured, underinsured or otherwise unable to pay for medically necessary care.

MBMC will provide care for emergency medical conditions, without discrimination, to individuals regardless of their ability to pay.

GUIDELINES:

A. ELIGIBLE SERVICES
   i. Emergency care or urgent care services deemed medically necessary. Medically necessary is defined as care that is non-elective and vital in order to prevent death or adverse effects to a patient's health.
   ii. Hospital services for a medical condition that would lead to a serious adverse change in the health of a patient.
   Note: Medically necessary services are evaluated on an individual basis and covered under this program at MBMC's discretion.

B. INELIGIBLE SERVICES
   i. Services which are cosmetic or elective in nature
   ii. Services provided in a clinic setting (see Appendix C)
   iii. Services related to a pending settlement from a liability claim.
   iv. Services provided by professionals which are not billed through MBMC (see appendix A)

PROCEDURE:

A. APPLICATION PROCESS
   i. Patient will be considered for Community Care providing an application is requested within 240 days of the first billing statement for the eligible service.
   ii. Application must be completed and returned within 30 days of request for the application, noted in the account.
   iii. All required supporting documentation must accompany the completed application.
   iv. External, publicly available data may be used to determine guarantor's ability to pay (ex: credit score)
   v. Reasonable efforts by patient to seek alternative sources of coverage.
   vi. Falsification of the application, refusal to cooperate or refusal to provide information may result in denial of the application.

B. PRESUMPTIVE ELIGIBILITY
   Patients who are unable to complete an application may be eligible for Community Care if other evidence is available which may indicate financial hardship. Consideration will be on an individual basis and at the sole discretion of MBMC.
   i. Information may be obtained through patient interview, credit report or other available records.
   ii. Deceased patient, without a living spouse, no estate has been filed with the court system within 12 months of death, or it can be determined patient does not have assets requiring the filing of an estate.
   iii. Accounts uncollectible due to discharge of debtor by bankruptcy
   iv. Homelessness

C. ELIGIBILITY CRITERIA & DETERMINATION
   i. Patient must be uninsured, underinsured or able to demonstrate a true inability to pay for medically necessary services.
   ii. Patient must return completed application and all requested supporting documentation within the timeframe provided to be eligible for consideration.
   iii. Federal Poverty Guidelines are referenced in determining a patient's level of eligibility for the program. These guidelines are based on annual household income and the number of household dependents.
   iv. MBMC may also reference the federal registry for standard allowable living expenses & other publically available data.
   v. Applicants could receive up to a 100% discount of the patient responsible amounts. If an applicant qualifies for less than 100% discount, the discount awarded will be no greater than the amount generally billed. (see appendix B)

D. DETERMINIG DISCOUNT AMOUNTS
   i. Patients who can demonstrate a household income that is at or below 250% of the federal poverty guidelines are eligible for a 100% discount of patient balance.
   ii. Patients demonstrating household income of 251%-300% of the federal poverty guidelines are eligible for a 50% discount or discount to the current AGB, whichever is the greater discount. (see appendix B).

E. EFFORTS TO PUBLICIZE THE COMMUNITY CARE PROGRAM

i. A plain language pamphlet explaining the Community Care Program will be offered to inpatients who are uninsured or who express payment concerns.
ii. Plain language pamphlets will be on display and available at all registration areas.
iii. Written notification of the program availability will be on all billing statements.
iv. Community Care Program information will be posted to the MBMC public website, along with a link to a printable application and information on how to find assistance with the application or questions regarding the program.
v. Information about the program will be advertised in the MB Times.

F. COLLECTION POLICIES AS THEY RELATE TO COMMUNITY CARE

MBMC has policies and procedures in place for billing and collections. MBMC will not engage in extensive collection actions, such as wage garnishment, liens on property or other legal action without first making reasonable efforts to determine whether a patient is eligible for Community Care. Reasonable efforts include:

i. Efforts to obtain payment from insurance and programs available to the patient and verify the patient balance owed. It is the patient's responsibility to provide MBMC with accurate insurance & program information in a timely manner.
ii. Documentation that MBMC has attempted to offer the patient opportunity to apply for Community Care.
iii. Documentation that the patient does not qualify for Community Care.
iv. Documentation that the patient has been offered a payment plan but has not honored the terms of the agreement.
v. Documented effort to provide at least three billing statements before facing extraordinary collection actions. 'Provide' is considered to be the date it was mailed, emailed or delivered by hand. It is the patient's responsibility to provide MBMC with accurate address and email information in a timely manner.

APPENDIX A
COVERED & NON-COVERED PROVIDERS

Charges for services provided by the following professionals are billed by Mile Bluff Medical Center or MBMC Clinics and are eligible for consideration under the Community Care Program.

- Emergency medicine physicians providing services in the Mile Bluff Medical Center, Inc emergency room.
- Urgent care providers providing services in the Mile Bluff Medical Center, Inc urgent care center
- Certified Registered Nurse Anesthetists
- Mile Bluff Medical Center, Inc employed professionals providing hospital services at Mile Bluff Medical Center, Moundview Memorial Hospital & Tomah Memorial Hospital
- Pinnacle LLC Orthopedic Group providing hospital services at Mile Bluff Medical Center

Charges for services provided by the following professionals are not billed by Mile Bluff Medical Center or MBMC Clinics and are not eligible for consideration under the Community Care Program.

- Pinnacle LLC Orthopedic Group providing services outside Mile Bluff Medical Center
- University of Wisconsin visiting providers
- Gundersen Health visiting providers
- WI Heart visiting providers
- Marshfield Clinics visiting providers
- UW Radiology services
- Innervisions Counseling services
- Air or ambulance transportation
- Any amounts billed by Moundview Memorial Hospital or Tomah Memorial Hosptial

APPENDIX B
AMOUNT GENERALLY BILLED (AGB)

Mile Bluff Medical Center limits charges for emergency and other medically necessary care provided to individuals eligible for financial assistance to amounts generally billed to insured individuals.

Mile Bluff Medical Center establishes its AGB rate annually based on its all payors past collection rate. The rate is equal to the total of Medicare, Medicaid, Commercial and Managed Care allowable for one year divided by the total Medicare, Medicaid, Commercial and Managed Care charges for the same time period.

APPENDIX C
CLINIC SETTING BALANCES

Patients who are eligible for community care for medically necessary services incurred in the Mile Bluff Medical Center hospital setting will also be considered for the same discount rates for medically necessary services incurred in one of our clinic settings and billed by MBMC Clinics. Our clinic settings include Mile Bluff Clinic, Delton Family Medical Center, Elroy Family Medical Center, Necedah Family Medical Center and New Lisbon Family Medical Center.

Qualifications, discounts, and restriction information for clinic services are defined in our Sliding Fee Scale Program Policy.

Clinic services are not subject to the required timelines of the application process set forth in the community care policy.