Reedsburg AREA MEDICAL CENTER
Organization Focused

COMMUNITY CARE AND FINANCIAL ASSISTANCE POLICY

Effective_____, 2024

PURPOSE:

To assist those individuals who are unable or have limited ability to pay for emergency or medically necessary care provided by Reedsburg Area Medical Center (the "Hospital").

Emergency care is defined in the Hospital's EMTALA (Emergency Medical Treatment and Labor Act Policy. The Hospital will always provide emergency care regardless of the patient's ability to pay in compliance with Federal EMTALA regulations.

"Medically necessary" is defined as healthcare services that a provider, exercising prudent clinical judgment, would provide to a patient for the purpose of evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms, and that are in accordance with the generally accepted standards of medical practice and/or clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease.

The terms "Community Care Policy" and "Financial Assistance Policy" (or, "FAP") may be used interchangeably herein.

SUPPORTIVE DATA:

Refer to Organization Focused Manual:

- Authorization for Disclosure of Billing Information—(LD)
- Billing & Collection Policy —(LD)
- Eligibility Notification for Community Care—(LD)
- Patient Financial and Billing Guidelines Policy
- Financial Assistance Policy (Community Care) Plain Language Summary

POLICY STATEMENT:

To provide care to all persons regardless of their ability to pay for services.

CONTENT:

This program is for the benefit of our community. Community Care determination will be based upon an individual's financial need at the time of service and will not take into account gender, race, social status, sexual orientation, or religious affiliation. Individuals must reside or have a primary care physician in RAMC's service area. RAMC's service area includes the communities and surrounding areas of Reedsburg, Cazenovia, Hillpoint, LaValle, Loganville, Lyndon Station, Rock Springs, Wisconsin Dells, Wonewoc, Lake Delton, Lime Ridge and North Freedom. Exceptions to these areas will be made when the patient has a family physician at RAMC, or requires emergency room services.

- An applicant's ability to pay for some or all of the Hospital's charges will be determined on a case-by-case basis.

- RAMC will provide care for emergency medical conditions, without discrimination, to individuals regardless of their ability to pay or their eligibility for financial assistance.
- All RAMC Physicians Group Providers, Specialty Group Providers, Walk-In Clinic Providers, and Emergency Department Providers and Hospitalists are included in this policy.
- Apogee Hospitalist group claims fall under their Charity/Financial Assistance program.

Process By Which Patients Apply for Financial Assistance

1. The patient, patient's representative or Hospital representative may initiate an application. Patients may call Hospital Financial Counselors for assistance with the application process. All patients have 240 days from the first post-discharge bill date to apply for Community Care (the "Application Period").

2. In order to be considered for Community Care, all other sources of payment must have been applied for and denied (*i.e.*, third party liability, insurance, government programs or Medical Assistance). Any account pending liability determination by a third-party payor will be excluded from consideration until such determination is made. If an applicant appears likely to qualify for Medical Assistance but refuses to apply, RAMC may deny their application for Community Care.

3. Financial need will be determined using procedures that assess an individual's financial need consistently and equitably. These may include the following:
   a. A completed application to include personal, financial and other information needed to assist in determining financial need. The application is to be completed in its entirety. This includes the use of external publicly available data to determine a guarantor's ability to pay.
   b. Reasonable efforts by RAMC to seek alternative sources of coverage (public or private) and payment.
   c. Review of the patient's all financial resources available.
   d. A review of patient's payment history.

4. As verification of income, a copy of the applicant's most recent federal income tax return or W-2 form(s) and last 3 current paycheck stub(s) are required by the Hospital. Hospital personnel may require other verification of income as deemed necessary.

5. Some individuals who may otherwise qualify for community care may be referred to the Sauk County/RAMC voucher program for free services such as physician office visits, laboratory tests, radiology exams and discounted medications. Contact Sauk County Public Health or RAMC Physician's Group for more information.

6. If a patient does not initially qualify for financial assistance, the patient may reapply if there is a change in income or family responsibilities.

Collection Activity

Extraordinary Collection Action ("ECA") refers to any collection activity taken against an individual that requires a legal or judicial process, involves selling an individual's debt to another party, reporting adverse information to consumer credit reporting agencies/credit bureau, or deferring or denying medically necessary services due to insufficient payment or nonpayment of one or more bills for previously provided care.

The Hospital will not engage in any ECAs before it makes reasonable efforts to determine the patient's eligibility for financial assistance under this policy, including refraining from initiating ECAs for at least 120 days from the date the Hospital provides the first post-discharge billing statement for care. If a patient has multiple episodes of care, such 120-day period begins after the Hospital provides the first post-discharge billing statement for the most recent episode of care.

All patients have 30 days to make financial arrangements regarding their bill before an ECA will occur whether within the Application Period or outside the Application Period.

At least thirty (30) days before first initiating any ECAs, the Hospital will (1) provide the patient with a written notice, including a Plain Language Summary ("PLS") of the FAP, that indicates that Community Care is available for eligible individuals, identifies the ECAs that the Hospital (or an authorized party) intends to initiate to obtain payment for the care, and states a deadline after which such ECAs may be initiated, which deadline will thirty (30) days or more after the date such written notice is provided, and (2) attempt to contact the responsible party(ies) by telephone at the last known telephone number, if any, at least once during the series of mailed or emailed statements, if the account remains unpaid. During all conversations, the patient or responsible party(ies) will be informed about the financial assistance that may be available under the FAP.

If (i) our collection agency identifies a patient is meeting financial assistance eligibility criteria or (ii) the patient submits a completed financial assistance application during the Application Period and after initiation of an ECA, the patient's account may be considered for financial assistance. Collection activity will be suspended on the accounts and the financial assistance application will be reviewed. If the entire account balance is adjusted, the account will be returned. If a partial adjustment occurs, the patient fails to cooperate with the financial assistance process, or if the patient is not eligible for financial assistance, collection activity will resume.

Revenue Cycle Director/Chief Financial Officer have the final authority for determining that RAMC has the processes in place to make reasonable efforts to determine whether an individual is FAP-eligible and therefore the Hospital may engage in extraordinary collection actions.

Additional information on billing & collections can be found in the Patient Financial and Billing Guidelines Policy, available free of charge as described below.

Community Care Allowance Determination
As a general rule, to be eligible under Community Care, the applicant's income should not exceed 400% of the federal poverty level in existence at the time of application. Poverty guidelines used will be those published annually in the Federal Register.

The following table is a guide to amount of community care provided.

Community Care Thresholds	
% of Poverty	Community Care %
< 150%	100%
151-275%	75%
276-400%	51%

1. Community Care is not applied to elective procedures, including but not limited to Bariatrics, Vasectomies, Cosmetic procedures and any other service or procedure determined by a licensed physician to be not medically necessary.

2. Approved Community Care assistance will cover service dates for six (6) months after the initial approval date without requiring a re-application.

3. Upon application approval, outstanding patient balances for services provided up to one year prior to the approval date will be eligible for Community Care discounts.

4. Discounts will be applied to gross charges and/or patient responsibility after insurance.

5. Applications for Community Care will be processed promptly. Patients applying will be notified in writing within 15 business days of approval, denial or need for additional information and the basis for the determination.
    a. If a Community Care Application is submitted and is incomplete, a Hospital representative will inform the patient and explain what information is needed to complete the application.
    b. Requested information should be provided to the Hospital within 30 days of the initial application unless compelling circumstances are brought to the Hospital's attention.

Amounts Generally Billed to Patients
1. Patients whose family income qualify for discounts under this program, will receive services at amounts no greater than Amounts Generally Billed (AGB), for emergency or other medically necessary care, in accordance with the Internal Revenue Code Section 501(r) regulations.

2. To calculate the AGB, RAMC takes the total Medicare, Medicaid, Commercial, and Managed Care payments for the prior fiscal year and divides it by charges for those same payers (look back method). RAMC will

recalculate the AGB on an annual basis, based upon data from the prior 12 months. The AGB is calculated as of January 1 each year, [implemented not more than 120 days after such data] and applied to determinations made on or after such date regardless of the date of service or original date of application. Individuals may obtain a copy of the current AGB percentage calculation and accompanying description free of charge by calling 608-768-6255.

Presumptive Financial Assistance Eligibility

1. Patients who are unable to complete an application form may be eligible for Community Care if other evidence is available which may indicate financial hardship. This information may be obtained from a patient interview, credit report, or other available records. Consideration will be given on an individual basis. RAMC uses prior FAP-eligibility determinations to presumptively determine that a patient is FAP-eligible.

2. Other provisions under Presumptive Eligibility:
    a. Deceased No Assets – based on the conclusion that the decedent has no assets and therefore no ability to pay. No Community Care application needs to be filled out.
    b. Homeless patients with no ability to pay;
    c. If it has been determined that a patient has been approved for Medical Assistance, all accounts currently in AR with RAMC will be written off to Community Care after payment is received from the insurance – No Community Care application needs to be completed in this instance.

3. Community Care also applies to all charges incurred by RAMC employed physicians at RAMC Physician's Group and RAMC Specialty Center.

4. Accounts placed with an external collection agency will be eligible under this policy when an application for Community Care is received within the Application Period.

5. Any account returned by the collection agency that has been determined to be uncollectable will be considered Community Care.

6. If a patient is presumptively determined to be eligible for less than the most generous assistance available under this policy, the Hospital will notify the individual regarding the basis for such determination and the way to apply for more generous assistance under this policy, as well as providing a reasonable period of time to such an application.

Efforts to Widely Publicize the Community Care Policy

1. Community Care notifications are appropriately posted in public areas of the Hospital and clinics. Copies will be made available in the language of any population consisting of the lesser of 5% or 1,000 people in the community.

2. Notices of the Community Care and Financial Assistance Policy will be made available on every billing statement.

3. Notifications/Plain Language Summary of the Community Care Policy ("PLS") will be present within the Emergency Room and Walk-in Clinic.

4. Patients will be able to obtain a free copy of the policy/Plain Language Summary and application for Community Care at all points of admission as well as the Business Office.

5. The Community Care and Financial Assistance Policy and application, PLS, Billing and Collection Policy and Community Care Application, and list of providers covered and not covered under FAP will be publicized on the RAMC website at https://www.ramchealth.com/community- care, along with a link to the locations of the Patient Financial Counselors who are trained to assist with applications.

6. Questions regarding this policy or the Community Care application process can be directed to Financial Counselors, Reedsburg Area Medical Center, 2000 N Dewey Avenue, Reedsburg, WI 53959 or call 608-524-6487.

Approved by Governing Board: 1/2024

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tlb\ Community Care and Financial Assistance Policy