



Marshfield Clinic

HEALTH SYSTEM

SUBJECT: Financial Assistance Policy **Board Approval Date:** 06/21/19
EFFECTIVE 6/21/19
POLICY NUM: S XKPPKZ72WEZ-3-924
CONTACT: **Kari Weik, Director Patient Access**

I. Applies to

Marshfield Clinic Health System, Inc. (referred to as “MCHS” for purposes of this policy), MCHS Hospitals, Inc., and the affiliated entities owned and controlled by, including, but not limited to:

- All Marshfield Clinic locations and services

Hospital Facilities:

- Marshfield Medical Center, Marshfield, Wisconsin
- Marshfield Medical Center-Rice Lake, Rice Lake, Wisconsin
- Marshfield Medical Center-Eau Claire, Eau Claire, Wisconsin
- Marshfield Medical Center-Ladysmith, Ladysmith, Wisconsin
- Marshfield Medical Center-Neillsville, Neillsville, Wisconsin

- This policy *does not* apply to services provided by Family Health Center of Marshfield, Inc. (“FHC”). Financial assistance is available for FHC services through FHC’s financial assistance policy.

- See Exhibit 3 below for a list of providers (physicians) to which this policy applies or does not apply.

II. Purpose

MCHS’ mission is to enrich lives through providing accessible, affordable, compassionate health care. It is our vision to continue to innovate and define the future of health care for generations and be the consumer’s first choice for health care.

To foster its mission, the MCHS Board of Directors and the Boards of Directors of Lakeview Medical Center, Inc. of Rice Lake, and MCHS Hospitals, Inc., each establish this policy to ensure that the financial capacity of people who need health care services

does not prevent them from seeking or receiving care. Patients eligible for financial assistance under this policy will receive a discount toward their individual portion of the bill.

Patients are expected to adhere to this policy's procedures in order to demonstrate financial need and to contribute toward the cost of their care based on their ability to pay. MCHS will not discriminate on the basis of age, sex, race, religious affiliation, disability, national origin, sexual orientation, or immigration status when making financial assistance decisions.

III. Definitions

Amount Generally Billed: The amount generally billed for emergency or other medically necessary care to individuals who have insurance coverage. AGB refers to the total amount due after applicable insured discounts are applied. See Section XII for calculation of AGB.

Emergency Medical Condition: A medical condition (including labor and delivery) that shows acute symptoms of sufficient severity (including severe pain) such that the lack of immediate medical care could result in one or more of the following: (a) serious jeopardy to the patient's health; (b) serious impairment to bodily functions; (c) serious dysfunction of a bodily organ or part.

Evidence-Based Care: The conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients or in helping individual patients make decisions about their care in the light of their personal values and beliefs.

Extraordinary Collection Action (ECA): Actions taken against an individual to obtain payment of a bill for care that requires a legal or judicial process, involves selling an individual's debt to another party or involves reporting adverse information about an individual to consumer credit reporting agencies or credit bureaus.

FPL: Federal Poverty Level

Guarantor: Person(s) financially responsible for payment of medical services. The Guarantor may be the patient, a parent, legal guardian or other persons financially obligated by law. Any reference to "patient" in this policy shall mean the patient and/or the Guarantor.

Homeless: A homeless person is an individual without permanent housing who may live on the streets; stay in a shelter, mission, single room occupancy facilities, abandoned building or vehicle; or in any other unstable or non-permanent situation.

Household: For purposes of determining household size and household income under federal poverty guidelines, Household includes the applicant, the applicant's spouse (regardless of whether the spouse lives in the home), the applicant's unmarried partner if they are living together with a child in common, any minor children or dependents residing in the home and claimed on the patient's federal income tax return. If the applicant is claimed as a dependent on another's federal tax return, Household will

include all claimed members. Household will also include a third party or sponsor who has agreed to be financially responsible for the patient. Copies of legal or immigration documents may be requested to determine sponsorship.

Medically Necessary: Services or items reasonable and necessary for the purpose of evaluating, diagnosing, and/or treating an injury or illness under Evidence-Based standards of care.

Qualified Accounts: Tax-advantaged accounts designated for personal health care expenses, including Health Savings Accounts, Health Reimbursement Arrangements or Flexible Spending Accounts.

Service Area: Consists of MCHS' primary and secondary service areas; meaning the State of Wisconsin and the Upper Peninsula of Michigan.

- See Exhibit 5 below for map of Marshfield Clinic Service Areas.

Primary Residence: The IRS defines principal residence as a person's "main home." If a person owns or lives in more than one home, the test for determining which one is the main home is a "facts and circumstances" test. Facts that are relevant include where the person is a registered voter, the address on the borrower's driver's license and where the person pays local or state income tax.

Uninsured: An individual who has no health insurance coverage. Patients who have insurance coverage but have balances due to portions not paid by their health insurance (including but not limited to deductibles, coinsurance, copayments, benefit maximums or non-covered services) are not considered uninsured.

IV. Emergency Medical Services

MCHS will not engage in any actions that discourage individuals from seeking emergency medical care, such as by demanding that emergency department patients pay before receiving treatment or by permitting debt collection activities in the emergency department or other areas where such activities could interfere with the provision of emergency care on a non-discriminatory basis.

V. Eligible Services

Services eligible for financial assistance under this policy include:

- a. Emergency services, provided to treat an Emergency Medical Condition, including labor and delivery.
- b. Urgent services, provided to avoid the likely onset of an Emergency Medical Condition.
- c. Medically Necessary services.
- d. Preventive and screening services recommended under Evidence-Based standards of care.
- e. Prescription medications are eligible for financial assistance if the prescription resulted from a financial assistance eligible encounter, is medically necessary, follows the Wisconsin Medicaid formulary and is obtained from a MCHS pharmacy.
- f. Eyeglasses must follow Wisconsin Medicaid guidelines, limited to one pair per

calendar year, and be obtained from a MCHS optical department. Frames and other enhancements outside Wisconsin's Medicaid guidelines are patient responsibility.

Services Not eligible for financial assistance under this policy are:

- a. Cosmetic, aesthetic, or performance-enhancement services.
- b. Services offered at a discounted package or cash price.
- c. Experimental/investigational and research-related services, outside the Evidence-Based standard of care.
- d. Services requested or required by a third-party, including but not limited to: pre-employment services, occupational medicine services, court ordered services, school and sports physicals, cross-bow evaluations, travel exams.
- e. reproductive services including: sterilization, sterilization-reversal and fertility services.
- f. Over the counter supplies and items.
- g. Contact lenses.
- h. Services related to worker's compensation, accident or liability are not eligible for financial assistance while a claim is in progress. The injured patient is required to seek any available third-party reimbursement by making a report of injury and pursuing a claim with the appropriate party before seeking financial assistance.
- i. Any other not Medically Necessary service.

VI. Applicant Eligibility

Financial assistance is generally secondary to all other financial resources available to the patient including insurance, government programs, third party liability, any public or other charitable resources, Qualified Accounts and Excess Assets (as defined in "Asset Review" below). The determination of eligibility for financial assistance is based on an application, written and oral communication, and other documentation used to conduct an individualized assessment and to validate the patient or guarantor's circumstances, including these criteria:

Insurance review: Individuals with the financial capacity to purchase health insurance shall be encouraged to do so, as a means of assuring access to health care services, for their overall personal health, and for the protection of their individual assets. Insured patients are expected to follow their insurance carrier's prior authorization and provider network rules. Balances resulting from failure to follow an insurance carrier's requirements may be excluded from financial assistance.

Insured patients receive multiple benefits from their insurance carrier, including free preventive and wellness services and contract discounts. MCHS financial assistance discounts are available to insured patients (excluding Medicaid) when the patient responsible balance exceeds two thousand, five hundred dollars (\$2,500).

Third-party resources: Stewardship of MCHS financial assistance resources includes review of any public or other charitable resources available for payment of a patient's eligible services. A MCHS counselor will refer patients or their guarantor(s) to available third-party resources if it is determined the applicant may qualify, such as Medicaid,

pharmaceutical programs, tribal benefits, veteran's programs, disability benefit.

The financial assistance application may be denied if the patient does not follow through with the third-party screening within 30 days of referral or provide evidence of a denial from the third party dated within six (6) months of applying for MCHS financial assistance.

Qualified Account review: Patients with tax-advantaged personal health accounts will be expected to utilize available funds upon being granted financial assistance.

Service Area Review: Financial assistance is available for services required for an Emergency Medical Condition regardless of whether a patient resides within Marshfield Clinic Health System's service area. For non-emergent medically necessary services, financial assistance eligibility is based on the patient's primary residence in relation to the MCHS service area and the nature of the care required (see Exhibit 5 below for map of MCHS service areas). However, consideration is given for services unique to MCHS versus the potential of providers local to the patient's residence or within the patient's insurance network. The patient's primary care provider may be asked to verify availability of local health care services and financial assistance.

Income review: Applicants will be asked to provide reliable documentation of annual income for all adult Household members. Documentation requested may include: the most recently filed tax return(s) (including schedules and forms such as W-2, 1099, and self-employment) or 4506T Verification of Non-filing; paycheck stubs, or copies of checks; employer wage verification forms; checking, savings and investment account statements; affidavits or letters of support; and contracts or court documents related to income sources (such as divorce decree, pre-marital agreements, annuities, land contracts, or rental income).

- Income includes earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, alimony, child support, assistance from outside the household, and other miscellaneous sources;
- Noncash benefits (such as food stamps and housing subsidies) are not included;
- Determined on a before-tax basis, i.e. gross income;
- Excludes capital gains or losses.

Asset review: Assets considered in determining eligibility for financial assistance include real estate, automobiles, recreational vehicles, cash accounts and any other identifiable asset. The individualized assessment of assets may consider documentation publicly available or requested of the applicant, including: cash or investment account statements; property titles or vehicle registrations; property tax statements; insurance documents; and contracts, statements, or court documents related to assets (such as mortgages, installment loans, land contracts, estates and divorce decrees). Wisconsin Medicaid guidelines are followed to determine the status and value of any recently divested assets.

An asset's equity value is its fair market value (FMV) minus the remaining balance of any secured loan. MCHS recognizes that certain asset and equity values are difficult to convert to cash. For this reason, allowances and exemptions for certain assets are provided as follows:

- The first \$100,000 of home equity is excluded;
- Up to \$14,000 equity for a primary vehicle is excluded;
- Up to \$7,000 equity for a secondary vehicle is excluded for households with more than one driver;
- Retirement accounts are excluded.

Fifty percent (50%) of any asset or equity amount in excess of the allowances described above is added to income when calculating eligibility for financial assistance ("Excess Assets").

Pre-existing payment plans: Patients who established long-term payment plans (including "medical lines of credit") but are later unable to make payments due to a significant change in financial circumstances may apply for financial assistance for outstanding balances owed. In such cases, financial assistance may be granted with respect to balances currently outstanding without regard to amounts previously paid for the healthcare services either at the time of service or pursuant to the payment plan.

Approval period: A financial assistance approval for free care or discounted care will continue for six months from the approval date. Eligible future services received during the six-month approval period will be discounted on the same basis as the initial approval. If a patient's financial circumstances materially change during the six-month approval period, the patient may be asked to update their financial assistance application.

VII. **Financial Assistance Discounts**

Patients who are eligible for financial assistance under this policy will not be charged more than the amount generally billed (AGB) to patients with insurance for emergency or medically necessary care (calculation as described in Part XII below). Patients may receive the following assistance, based on an assessment of income, assets and health care obligations:

Free Care: The gross (undiscounted) charge amount for eligible services will be waived for applicants whose total Income plus Excess Asset amount is at or below 200% of the current federal poverty level, shown on Exhibit 1.

Discounted Care: Applicants whose total Income plus Excess Asset amount is greater than 200% but less than or equal to 400% of the current federal poverty level will be provided a sliding scale discount for eligible services, shown on Exhibit 1. Uninsured patients will receive discounts applied against the gross charges for care and services. Insured patients qualify for financial assistance when the patient responsible balance exceeds \$2,500, in which case, discounts are applied to the patient's balance remaining after insurance.

Catastrophic Cap: A patient who incurs catastrophic medical expenses is eligible for assistance where payment of the balance would require liquidation of assets critical to living or would cause undue financial hardship. Patients are eligible for a catastrophic discount when their calculated FPL is at or below 600% and their patient responsibility

portion of MCHS medical bills exceeds 20% of income (calculated without regard for Excess Assets). Balances exceeding 20% of income will be waived as catastrophic financial assistance.

Payment Expectations: Financial Assistance eligible patients are expected to comply with MCHS Billing and Collection Policy and payment terms on any balances remaining after financial assistance discounts are applied.

Refunds: A patient who is determined to be eligible for financial assistance will be refunded amounts they had paid for eligible care in excess of the calculated personal responsibility amount due under the financial assistance policy. Refunds are processed for excess payments of five dollars (\$5) or more.

VIII. Presumptive Eligibility

There are instances when a patient may be determined to be eligible for financial assistance even though a financial assistance application or supporting documentation is not provided by the patient. Information accessed through other sources may provide sufficient evidence for MCHS management to make a financial assistance eligibility determination ("Presumptive Eligibility"). Presumptive Eligibility decisions are based on socio-economic factors that indicate a low financial capacity, such as: eligibility for specific means-tested state and local assistance programs, homelessness, residency in low-income housing, inability to locate any estate for a deceased patient and other available demographic and analytic tools.

Presumptive Eligibility discounts are granted for free care (100% discount) only and are applied only to outstanding balances. If an account is qualified for Presumptive Eligibility, reasonable measures will be taken to reverse Extraordinary Collection Actions, if any, as described in the MCHS Billing and Collection Policy.

IX. Application Process

MCHS desires to identify a patient's need for financial assistance as quickly as possible. It is requested that patients identify a financial need upon registration at an appointment, admission or discharge, or as soon afterward as possible. MCHS will accept a financial assistance application for at least 240 days following the patient's first post-discharge billing statement. If an account older than 240 days from the first post-discharge billing statement has proceeded into a legal or judicial process, a financial assistance application will be accepted up until the date of final judgment or settlement upon patient request.

If a patient indicates an inability to pay, or a need for financial assistance, a counselor from the Patient Assistance Center will interview the patient and provide referrals to third-party resources if the patient may qualify. The patient will be offered a financial assistance application with instructions and a list of all documentation that may be required. The application and documentation will be used to make an individual determination of financial need based on income, household size and asset values.

Counselors are available via phone and in person to assist with completing a financial assistance application. Call 1-800-782-8581, ext. 94475 to schedule an appointment with a counselor. In person assistance is available at locations shown on Exhibit 4.

Applications are to be completed and returned within 15 days from the date the application was given or mailed to the patient. If additional time is needed to complete the application or provide the required documentation, the patient must communicate with the Patient Assistance Center. If an extension is granted, the counselor will put a temporary hold on phone calls and written notices intended to collect the outstanding account balance for the designated timeframe.

Mail or hand-deliver completed financial assistance applications and required documentation to:

Marshfield Clinic Health System

Patient Assistance Center, 3Q4

1000 North Oak Avenue

Marshfield, WI 54449

1-800-782-8581, ext. 94475

Upon receipt of a complete financial assistance application and until notification of a decision is made to the patient, as described in this paragraph, ECAs will not be initiated and further action will not be taken on existing ECAs. Within 30 days after submission of a complete application, MCHS will determine whether the patient qualifies for financial assistance and will notify the patient in writing of an approval and the discount amount. MCHS will take reasonable measures to reverse any ECA already in place, if any, related to the amounts approved for financial assistance.

Patients qualifying for discounted, but not free, care will be notified in writing regarding any remaining balance due, including how the amount was determined and how to obtain information regarding the AGB. The patient may be asked to discuss payment terms with a Patient Assistance Counselor. Any such remaining balances will be treated in accordance with the MCHS Billing and Collection Policy.

Upon receipt of an incomplete financial assistance application, a written notice will be sent to the patient describing the additional information required. A reasonable time for completion will be provided. ECAs will not be initiated and further action will not be taken on existing ECAs during this time period. At the expiration of the time period, if a complete application has not been received, normal account and collection activity will resume, as described in the MCHS Billing and Collection Policy and the application and supporting documents will be confidentially destroyed.

X. Appeals

If the application is denied for financial assistance, the Patient Assistance Center will notify the patient in writing and include the reason for the denial. Patients may appeal the financial assistance decision within 30 days of the date on the written approval or denial notification by calling 1-800-782-8581, ext. 94475 or by writing to the address listed above.

XI. Impact on Billing and Collection Process

While the application is pending review and approval, a regular monthly statement of

account activity will continue to be delivered.

In the event that a patient qualifies for financial assistance but fails to timely pay the remaining balance due (including, if applicable, the agreed-upon payment plan), MCHS may take any of the actions set forth in the Billing and Collection Policy, a free copy of which is available at www.marshfieldclinic.org/financial-assistance.

XII. Measures to Widely Publicize Financial Assistance Policy

Information on the MCHS Financial Assistance Policy will be posted in hospital registration and admitting locations and in hospital emergency departments. Financial assistance information is printed on monthly billing statements and incorporated into other communications in order to widely publicize the availability of financial assistance, as described in the MCHS Billing and Collection Policy. The MCHS Financial Assistance Policy (including the Plain Language Summary), the Financial Assistance Application, and the Billing and Collection Policy are available in English, Spanish, Hmong, and any other language that is the primary language spoken by the lesser of 1,000 individuals or 5% of the population of the Service Area.

- See Exhibit 5 below for map of Marshfield Clinic Service Areas.

The MCHS Financial Assistance Policy (including the Plain Language Summary), the Financial Assistance Application, and the Billing and Collection Policy may be obtained free of charge:

- On the website, at www.marshfieldclinic.org/financial-assistance;
- In person, from financial counselors at locations shown in Exhibit 4;
- By phone, at 715-389-4475 or 800-782-8581, ext. 94475;
- By mail, by writing to the address shown in Section IX Application Process.

XIII. Amounts Billed to Patients Eligible for Financial Assistance

Patients who are eligible for financial assistance under this policy will not be charged more than the amount generally billed (AGB) to patients with insurance for emergency or medically necessary care.

MCHS determines AGB for the clinics and each hospital facility with more than 12 months of claim history utilizing the Look Back Method. AGB is based on amounts allowed under Medicare Fee-For-Service and all private health insurers paying claims to the applicable hospital facility or the clinics, over a 12-month period, divided by the gross charges for those claims. The AGB will be calculated at least annually. The updated AGB will be applied by the 120th day after the end of the 12-month measurement period. Patients may obtain the current AGB percentage and accompanying description of the calculation in writing and without charge by calling 715-389-4475 or 800-782-8581, ext. 94475.

MCHS determines AGB for any hospital facility with less than 12 months of claim history using the Prospective Medicare method. Under the prospective method, MCHS will not charge patients who are eligible for financial assistance more than the Medicare allowable.

XIV. Confidentiality:

MCHS recognizes that the need for financial assistance may be a sensitive and deeply

personal issue for patients. Confidentiality of information and preservation of individual dignity will be maintained for all who seek financial assistance under this Policy. No information obtained in the patient's financial assistance application will be released except where authorized by the patient or otherwise required by law. Incomplete applications and supporting documents will be confidentially destroyed.

XV. Other Related Policies:

- A. MCHS Billing and Collection Policy
- B. Family Health Center of Marshfield, Inc. Financial Assistance Policy

Attachments:

- Exhibit 1 Financial Assistance Discounts
- Exhibit 2 Sample Financial Assistance Application
- Exhibit 3 Physicians and Providers Covered by Financial Assistance Policy
- Exhibit 4 Plain-Language Summary of Financial Assistance Policy
- Exhibit 5 Marshfield Clinic Health System Primary Service Area

EXHIBIT 1

Financial Assistance Discounts

Income Guideline: The 2020 federal poverty guidelines based on household size:
2020 Federal Poverty Guidelines

Household Size	100% FPL	200% FPL	250% FPL	300% FPL	350% FPL	400% FPL
1	\$12,760	\$25,520	\$31,900	\$38,280	\$44,660	\$51,040
2	17,240	34,480	43,100	51,720	60,340	68,960
3	21,720	43,440	54,300	65,160	76,020	86,880
4	26,200	52,400	65,500	78,600	91,700	104,800
5	30,680	61,360	76,700	92,040	107,380	122,720
6	35,160	70,320	87,900	105,480	123,060	140,640
7	39,640	79,280	99,100	118,920	138,740	158,560
8	44,120	88,240	110,300	132,360	154,420	176,480

Free or Discounted Care: Applicants whose total household income plus excess asset amount (as defined in the Financial Assistance Policy) is less than or equal to 400% of the current federal poverty level will be provided a discount for services. Insured patients may qualify for financial assistance when the patient responsible balance exceeds \$2,500 and if approved, the discounts below will apply to the entire patient responsible balance.

Discounts applicable to each location	Federal Poverty Level		
	a) Less than or equal to 200%	b) Above 200% and less than or equal to 300%	c) Above 300% and less than or equal to 400%
Clinics	100%	75%	52%
Marshfield Medical Center- Rice Lake	100%	75%	50%
Marshfield Medical Center	100%	75%	60%
Marshfield Medical Center - Ladysmith	100%	75%	50%
Marshfield Medical Center- Neillsville	100%	75%	50%
Marshfield Medical Center - Eau Claire	100%	Medicare Allowable	Medicare Allowable

“Clinics” = Marshfield Clinic, all clinic locations

EXHIBIT 2

Financial Assistance Application

EXHIBIT 3

Physicians and Other Providers Covered by Policy

Emergency and medically necessary services offered by Marshfield Clinic Health System providers, with the exception of services through Family Health Center of Marshfield, Inc., are eligible for coverage under this policy.

Other provider groups may offer emergency or medically necessary services at MCHS facilities. Below is a list of those provider groups and whether they are covered under this MCHS financial assistance policy.

Provider Group	Covered under MCHS Financial Assistance Policy	Notes
Marshfield Clinic Health System, Inc	Yes	https://www.marshfieldclinic.org/doctors
Family Health Center of Marshfield, Inc.	No	Assistance available under FHC's policy
Branham Healy Orthopedic Clinic S.C.	No*	
Chippewa Valley Eye Clinic	No*	
Any other providers offering emergency or medically necessary services at any MCHS hospital	No*	Ahmed, Aisha MD
		Akhtar, Muhammad MD
		Alfred Chiang, DO
		Kyle Dettbarn, MD
		Eichten, Jeffrey MD
		Katie Fassbinder, MD
		Foerster, Susan MD
		Godar, Dennis DMD
		Graham, Peter MD
		Gray, Roger JR MD
		Gudibanda, Swetha MD
		Michael Hirsh, MD
		Horton, William DDS
		Martha Karlstad, MD
Khan, Muhammad MD		

		Joel Kowski, DPM	
		Martin, Garry DPM	
		Mckee, David MD	
		Mitchell, Michael MD	
		Mueller, Rick DMD	
		Nathan, Katherine PA	
		Norelle, Alexis MD	
		Polomis, David MD	
		Redfield, Robert MD	
		Reding, Douglas MD	
		Courtney Whitney, DO	

**For non-Marshfield Clinic provider groups, contact the provider group directly to inquire if they have a financial assistance policy.*

EXHIBIT 4

Plain-Language Summary of Financial Assistance Policy

EXHIBIT 5
Marshfield Clinic Health System Service Area

MCHS Primary and Secondary Service Area

Primary Service Area counties are in grey and are bordered in blue.
All remaining counties make up the Secondary Service Area.

