MIDWEST ORTHOPEDIC SPECIALTY HOSPITAL

FINANCIAL ASSISTANCE POLICY

06/30/2020

POLICY/PRINCIPLES

It is the policy of Midwest Orthopedic Specialty Hospital (the "Organization") to ensure a socially just practice for providing emergency and other medically necessary care at the Organization's facility. This policy is specifically designed to address the financial assistance eligibility for patients who are in need of financial assistance and receive care from the Organization.

1. All financial assistance will reflect our commitment to and reverence for individual human dignity and the common good, our special concern for and solidarity with persons living in poverty and other vulnerable persons, and our commitment to distributive justice and stewardship.

2. This policy applies to all emergency and other medically necessary care provided by the Organization, including employed physician services and behavioral health. This policy does not apply to charges for care that is not emergency and other medically necessary care.

3. The List of Providers Covered by the Financial Assistance Policy provides a list of any providers delivering care within the Organization's facilities that specifies which are covered by the financial assistance policy and which are not.

DEFINITIONS

For the purposes of this Policy, the following definitions apply:

- "**501(r)**" means Section 501(r) of the Internal Revenue Code and the regulations promulgated thereunder.
- "**Amount Generally Billed**" or "**AGB**" means, with respect to emergency and other medically necessary care, the amount generally billed to individuals who have insurance covering such care.
- "**Community**" means any county in Wisconsin that has an Ascension WI facility or clinic including but not limited to Outagamie, Winnebago, Calumet, Marathon, Portage, Lincoln, Oneida, Vilas, Clark, Milwaukee, Waukesha, Ozaukee, Washington, Racine, Kenosha and Jefferson Counties. A Patient will also be deemed to be a member of the Organization's Community if the emergency and medically necessary care the Patient requires is continuity of emergency and medically necessary care received at another Ascension Health facility where the Patient has qualified for financial assistance for such emergency and medically necessary care.
- "**Emergency care**" 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:
    1. Placing the health of the individual or, with respect to the pregnant woman, the health of the woman or her unborn child in serious jeopardy;
    2. Serious impairment of bodily functions; or
    3. Serious dysfunction of a bodily organ or part; or
    4. With respect to a pregnant woman who is having contractions;

a. That there is adequate time to affect a safe transfer to another hospital before delivery; or
b. That transfer may pose a threat to the health or safety of the woman or unborn child.

- "**Medically necessary care**" means care that is (1) appropriate and consistent with and essential for the prevention, diagnosis, or treatment of a Patient's condition; (2) the most appropriate supply or level of service for the Patient's condition that can be provided safely; (3) not provided primarily for the convenience of the Patient, the Patient's family, physician or caretaker; and (4) more likely to result in a benefit to the Patient rather than harm. For future scheduled care to be "medically necessary care," the care and the timing of care must be approved by the Organization's Chief Medical Officer (or designee). The determination of medically necessary care must be made by a licensed provider that is providing medical care to the Patient and, at the Organization's discretion, by the admitting physician, referring physician, and/or Chief Medical Officer or other reviewing physician (depending on the type of care being recommended). In the event that care requested by a Patient covered by this policy is determined not to be medically necessary by a reviewing physician, that determination also must be confirmed by the admitting or referring physician.
- "**Organization**" means Midwest Orthopedic Specialty Hospital.
- "**Patient**" means those persons who receive emergency and other medically necessary care at the Organization and the person who is financially responsible for the care of the patient.

Financial Assistance Provided

Financial assistance described in this section is limited to Patients that live in the Community:

1. Subject to the other provisions of this Financial Assistance Policy, Patients with income less than or equal to 250% of the Federal Poverty Level income ("FPL"), will be eligible for 100% charity care on that portion of the charges for services for which the Patient is responsible following payment by an insurer, if any, if such Patient determined to be eligible pursuant to presumptive scoring (described in Paragraph 5 below) or submits a financial assistance application (an "Application") on or prior to the 240th day after the Patient's first discharge bill and the Application is approved by the Organization. Patient will be eligible for up to 100% financial assistance if Patient submits the Application after the 240th day after the Patient's first discharge bill, but then the amount of financial assistance available to a Patient in this category is limited to Patient's unpaid balance after taking into account any payments made on Patient's account. A Patient eligible for this category of financial assistance will not be charged more than the calculated AGB charges.

2. Subject to the other provisions of this Financial Assistance Policy, Patients with incomes above 250% of the FPL but not exceeding 400% of the FPL, will receive a sliding scale discount on that portion of the charges for services provided for which the Patient is responsible following payment by an insurer, if any, if such Patient submits an Application on or prior to the 240th day after the Patient's first discharge bill and the Application is approved by the Organization. Patient will be eligible for the sliding scale discount financial assistance if Patient submits the Application after the 240th day after the Patient's first discharge bill, but then the amount of financial assistance available to a Patient in this category is limited to Patient's unpaid balance after taking into account any payments made on Patient's account. A Patient eligible for this category of financial assistance will not be charged more than the calculated AGB charges. The sliding scale discount is as follows:

Percent Shown is the % Reduction to Patient Responsibility

	Level of Charity Care Assistance & FPL %						
Family Size	**100%**	**95%**	**90%**	**85%**	**80%**	**75%**	**70%**
	250% FPL	**275% FPL**	**300% FPL**	**325% FPL**	**350% FPL**	**375% FPL**	**400% FPL**
	Income Level Not Exceeding						
1	$ 31,900	$ 35,090	$ 38,280	$ 41,470	$ 44,660	$ 47,850	$ 51,040
2	$ 43,100	$ 47,410	$ 51,720	$ 56,030	$ 60,340	$ 64,650	$ 68,960
3	$ 54,300	$ 59,730	$ 65,160	$ 70,590	$ 76,020	$ 81,450	$ 86,880
4	$ 65,500	$ 72,050	$ 78,600	$ 85,150	$ 91,700	$ 98,250	$ 104,800
5	$ 76,700	$ 84,370	$ 92,040	$ 99,710	$ 107,380	$ 115,050	$ 122,720
6	$ 87,900	$ 96,690	$ 105,480	$ 114,270	$ 123,060	$ 131,850	$ 140,640
7	$ 99,100	$ 109,010	$ 118,920	$ 128,830	$ 138,740	$ 148,650	$ 158,560
8	$ 110,300	$ 121,330	$ 132,360	$ 143,390	$ 154,420	$ 165,450	$ 176,480
9	$ 121,550	$ 133,705	$ 145,860	$ 158,015	$ 170,170	$ 182,325	$ 194,480
10	$ 132,750	$ 146,025	$ 159,300	$ 172,575	$ 185,850	$ 199,125	$ 212,400

3. Subject to the other provisions of this Financial Assistance Policy, a Patient with income greater than 400% of the FPL may be eligible for financial assistance under a "Means Test" for some discount of Patient's charges for services from the Organization based on a Patient's total medical debt. A Patient will be eligible for financial assistance pursuant to the Means Test if the Patient has excessive total medical debt, which includes medical debt to Ascension and any other health care provider, for emergency and other medically necessary care, that is equal to or greater than such Patient's household's gross income. The level of financial assistance provided pursuant to the Means Test is the same as is granted to a patient with income at 400% of the FPL under Paragraph 2 above, if such Patient submits an Application on or prior to the 240th day after the Patient's first discharge bill and the Application is approved by the Organization. Patient will be eligible for the means test discount financial assistance if such Patient submits the Application after the 240th day after the Patient's first discharge bill, but then the amount of financial assistance available to a Patient in this category is limited to Patient's unpaid balance after taking into account any payments made on Patient's account. A Patient eligible for this category of financial assistance will not be charged more than the calculated AGB charges.

4. A Patient may not be eligible for the financial assistance described in Paragraphs 1 through 3 above if such Patient is deemed to have sufficient assets to pay pursuant to an "Asset Test." The Asset Test involves a substantive assessment of a Patient's ability to pay based on the categories of assets measured in the FAP Application. A Patient with such assets that exceed that exceed 250% of such Patient's FPL amount may not be eligible for financial assistance.

5. Eligibility for financial assistance may be determined at any point in the revenue cycle and may include the use of presumptive scoring for a Patient with a sufficient unpaid balance within the first 240 days after the Patient's first discharge bill to determine eligibility for 100% charity care notwithstanding Patient's failure to complete a financial assistance application ("FAP Application"). If Patient is granted 100% charity care without submitting a completed FAP Application and via presumptive scoring only, the amount of financial assistance for which Patient is eligible is limited to Patient's unpaid balance after taking into account any payments made on Patient's account. A determination of eligibility based on presumptive scoring only applies to the episode of care for which the presumptive scoring is conducted.

6. For a Patient that participates in certain insurance plans that deem the Organization to be "out-of-network," the Organization may reduce or deny the financial assistance that would otherwise be available to Patient based upon a review of Patient's insurance information and other pertinent facts and circumstances.

7. The Patient may appeal any denial of eligibility for Financial Assistance by providing additional information to the Organization within fourteen (14) calendar days of receipt of notification of denial. All appeals will be reviewed by the Organization for a final determination. If the final determination affirms the previous denial of Financial Assistance, written notification will be sent to Patient. The process for Patients and families to appeal the Organization's decisions regarding eligibility for financial assistance is as follows:
   a. Patient or family should submit appeal directly to the Financial Counselor with whom they are working. Patient or family should include detailed letter/form indicating specific financial circumstances that warrant appeal, and all financial and legal documents supporting the letter.
   b. All appeals will be considered by the Organization's financial assistance appeals committee, and decisions of the committee will be sent in writing to the Patient or family that filed the appeal.

Other Assistance for Patients Not Eligible for Financial Assistance

Patients who are not eligible for financial assistance, as described above, still may qualify for other types of assistance offered by the Organization. In the interest of completeness, these other types of assistance are listed here, although they are not need-based and are not intended to be subject to 501(r) but are included here for the convenience of the community served by the Organization.

1. Uninsured Patients who are not eligible for financial assistance will be provided a discount based on the discount provided to the highest-paying payor for that Organization. The highest paying payor must account for at least 3% of the Organization's population as measured by volume or gross patient revenues. If a single payor does not account for this minimum level of volume, more than one payor contract should be averaged such that the payment terms that are used for averaging account for at least 3% of the volume of the Organization's business for that given year.
2. Uninsured and insured Patients who are not eligible for financial assistance may receive a prompt pay discount. The prompt pay discount may be offered in addition to the uninsured discount described in the immediately preceding paragraph.

Limitations on Charges for Patients Eligible for Financial Assistance

Patients eligible for Financial Assistance will not be charged individually more than AGB for emergency and other medically necessary care and not more than gross charges for all other medical care. The Organization calculates one or more AGB percentages using the "look-back" method and including Medicare fee-for-service and all private health insurers that pay claims to the Organization, all in accordance with 501(r). A free copy of the AGB calculation description and percentage(s) may be obtained on the Organization's website or by obtained by requesting a mailed copy from Ascension Wisconsin's Customer Service Department.

Applying for Financial Assistance and Other Assistance

A Patient may qualify for financial assistance through presumptive scoring eligibility or by applying for financial assistance by submitting a completed FAP Application. The FAP Application and FAP Application Instructions are available on the Organization's website, by contacting Ascension Wisconsin's Customer Service Department, request in person at all hospitals and clinic registration areas, or requesting from any Ascension Wisconsin financial counselor. The Organization will require the uninsured to work with a financial counselor to apply for Medicaid or other public assistance programs for which the patient is deemed to be potentially eligible in order to qualify for financial assistance (except where eligible and approved via presumptive scoring). A Patient may be denied financial assistance if the Patient provides false information on a FAP Application or in connection with the presumptive scoring eligibility process, if the patient refuses to assign insurance proceeds or the right to be paid directly by an insurance company that may be obligated to pay for the care provided, or if the patient refuses to work with a financial counselor to apply for Medicaid or other public assistance programs for which the patient is deemed to be potentially eligible in order to qualify for financial assistance (except where eligible and approved via presumptive scoring). The Organization may consider a FAP Application completed less than six months prior to any eligibility determination date in making a determination about eligibility for a current episode of care. The Organization will not consider a FAP Application completed more than six months prior to any eligibility determination date.

Billing and Collections

The actions that the Organization may take in the event of nonpayment are described in a separate billing and collections policy. A free copy of the billing and collections policy may be obtained on the Organization's website or by calling Ascension Wisconsin's Customer Service Department.

Interpretation

This policy, together with all applicable procedures, is intended to comply with and shall be interpreted and applied in accordance with 501(r) except where specifically indicated.

MIDWEST ORTHOPEDIC SPECIALTY HOSPITAL
AMOUNT GENERALLY BILLED CALCULATION
July 1, 2020

Midwest Orthopedic Specialty Hospital calculates AGB percentages annually.

Midwest Orthopedic Specialty Hospital LLC calculates one AGB percentage using the "look-back" method and including Medicare fee-for-service and all private health insurers that pay claims to the Organization, all in accordance with IRS Reg. Sec. 1.501(r)-5(b)(3), 1.501(r)-5(b)(3)(ii)(B) and 1.501(r)-5(b)(3)(iii). The details of that calculation and AGB percentage is described below.

The AGB percentages for Midwest Orthopedic Specialty Hospital, LLC – 43%

This AGB percentage is calculated by dividing the sum of the amounts of all of the hospital facility's claims for emergency and other medically necessary care that have been allowed by Medicare fee-for-service and all private health insurers that pay claims to the hospital facility by the sum of the associated gross charges for those claims. The only claims that are utilized for purposes of determining the AGB are those that were allowed by a health insurer during the 12-month period prior to the AGB calculation (rather than those claims that relate to care provided during the prior 12 months).

Notwithstanding the foregoing AGB calculation, Midwest Orthopedic Specialty Hospital has chosen to apply a lower AGB percentage as follows:

Midwest Orthopedic Specialty Hospital 30%