

# Advocate Aurora Health

## Financial Assistance Policy

Advocate Health and Aurora Health Care and affiliates, collectively Advocate Aurora Health, Inc (AAH) are committed to caring for the health and well-being of all patients regardless of their ability to pay. AAH is committed to assisting eligible patients in the communities we serve with obtaining coverage from various programs and extending financial assistance to those in need as outlined in this policy. This policy describes the procedure, requirements, and eligibility criteria related to AAH's financial assistance programs.

AAH offers coverage assistance and financial assistance to eligible individuals with the following five objectives:

- **To model AAH's core value of "Caring."**
- **To ensure the patient exhausts other applicable coverage opportunities prior to qualifying for financial assistance.**
- **To provide financial assistance based on the patient's ability to pay.**
- **To ensure AAH complies with applicable Federal and/or State regulations related to financial assistance.**
- **To establish a process that minimizes the burden on the patient and is cost efficient to administer.**

AAH will always provide emergency care regardless of the patient's ability to pay in compliance with Federal EMTALA regulations.

This policy applies to medical services billed by an Advocate Aurora Health, Inc. entity or Participating Provider that has been provided by a Wisconsin Aurora Health Care hospital, a Wisconsin Aurora Health Care employed medical professional, a Wisconsin Participating Provider, an Illinois Advocate Health hospital, an Illinois Advocate Health employed medical professional, or an Illinois Participating Provider.

### **Definitions**

The terms used within this policy are to be interpreted as follows:

- **Amounts Generally Billed (AGB):** amounts generally billed for emergency or other medically necessary care to individuals who have insurance covering such care. The AGB is calculated using the look-back method annually by averaging Medicare and all private third-party insurer allowed claims for medically necessary hospital services billed in a 12-month period. For Wisconsin Aurora Health Care facilities and providers, individuals may obtain information on the calculation of the AGB Percentage free of charge by calling 1-800-326-2250. For Illinois Advocate Health facilities and providers, individuals may obtain information on the calculation of the AGB percentage free of charge by calling 847-795-2300.
- **Elective:** services that, in the opinion of the ordering provider, are not needed, are cosmetic or can be safely postponed.

- Emergency Care: Immediate care that is necessary in the opinion of a provider to prevent putting the patient's health in serious jeopardy, serious impairment to bodily functions, serious dysfunction of organs or body parts or death.
- EMTALA: AAH shall provide, without discrimination, care for emergency medical conditions to individuals regardless of whether they can pay for the care, or their eligibility under this Policy. Such care will be provided in accordance with the Federal Emergency Medical Treatment and Labor Act (EMTALA), section 1867 of the Social Security Act (42 U.S.C. 1395dd).
- Extraordinary Collection Action (ECA): 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.
- Federal Poverty Guidance (FPG): The applicable household income thresholds established periodically in the Federal Register by the U.S. Department of Health and Human Services under authority of 42 U.S.C. §9902(2).
- Financial Advocates: AAH teammates that assist uninsured or insured patients by reviewing the patient's current financial situation to determine available coverage and financial assistance programs, assist those patients with enrollment in available programs, educate patients on the cost of care, and assist patients with overall management of patients' financial responsibility.
- Financial Assistance Score (FAS Score): a score developed with the assistance of a third-party vendor to provide a proactive, consistent, and automated mechanism to substantiate a patient's financial profile.
- Generally Accepted Standards of Medical Practice:
  - Standards that are based on credible scientific evidence published in peer-reviewed, medical literature generally recognized by the relevant medical community.
  - Physician Specialty Society recommendations.
  - Views of Physicians practicing in the relevant clinical area.
  - Any other relevant factors.
- Household: the patient and any individuals (such as a spouse, children, or other dependents) who could be included on a federal income tax return regardless of whether the patient files a tax return.
- Household Financial Income: monies received by the household which may require documentation and includes but is not limited to the following:
  - Annual household pre-tax job earnings.
  - Unemployment compensation.
  - Workers' Compensation.
  - Social Security and Supplemental Security Income.
  - Veteran's payments.
  - Pension or retirement income.
  - Other applicable income, including for example, rents, alimony, child support and any other miscellaneous income regardless of source.
- Ineligible services: Elective, preventive, screening and/or routine services and procedures are not considered eligible Services. Other medical services not considered Eligible Services include, but are not limited to, cosmetic procedures, complementary medicine, fertility services, Global and Executive Health, Occupational Health and retail type services, and other services that already

have a specific global/package pricing arrangement. The final determination of whether medical care is considered urgent and/or medically necessary shall be made by the examining provider.

- Insured: Patients who are insured and covered under a third-party insurer.
- Medical Group: professional medical services provided by providers who are employed by AAH.
- Medically Necessary: 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.
- Other Coverage Options: Options that would yield a third-party payment on account(s) under coverage assistance and financial assistance review including, but not limited to: Workers' Compensation, governmental plans such as Medicare and Medicaid, State/Federal Agency plans, Victim's Assistance, etc., or third-party liability resulting from automobile or other accidents.
- Participating Providers- Health care providers who have agreed to comply with this Policy with respect to billable services provided at AAH hospitals. Attached is a list of all Participating Providers. Any provider not listed in this document can be contacted directly to see if they are a Participating Provider.
- Plain Language Summary (PLS): A summary of this Policy that is simplified to understand the eligibility criteria and how to apply for financial assistance.
- Presumptive Eligibility: A Financial Assistance eligibility determination made in the Wisconsin and Illinois markets by reference to specific criteria which have been deemed to demonstrate financial need on the part of an uninsured patient without completion of a Financial Assistance application. In compliance with the Illinois Hospital Fair Patient Billing Act, Section 4500.40 Presumptive Eligibility Criteria.
- Third-party Insurers: Any party ensuring payment on behalf of a patient, including insurance companies, workers' compensation, governmental plans such as Medicare and Medicaid, State/Federal Agency plans, Victim's Assistance, or third-party liability resulting from automobile or other accidents. Health Cost Sharing plans such as MediShare, but not limited to, are not considered a third-party insurer.
- Self-Pay Balance: The portion of a patient's bill that the patient or the patient's guarantor is legally responsible for paying after any applicable discounts.
- Uninsured Patient: A patient who is not covered in whole or in part under a third-party insurer and is not a beneficiary under a public or private health insurance, or other health coverage program (including, without limitation, private insurance, Medicare, Medicaid or Crime Victims Assistance) and whose injury is not compensable for purposes of worker's compensation, automobile insurance, liability or other third party insurance, as determined by AAH based on documents and information provided by the patient or obtained from other sources, for the payment of health care services provided by AAH.

## Uninsured Patients:

Uninsured patients will be reviewed for assistance through the coverage assistance and financial assistance process by the AAH financial advocate teammates. The AAH advocates will review uninsured patients seeking assistance for other coverage opportunities prior to determining financial assistance eligibility.

- Uninsured patients will be interviewed by the AAH financial advocate team.
- Uninsured patients who are not proactively interviewed by the AAH team can call the AAH financial advocate call center or download an application and mail it to the AAH financial advocate team to initiate a review.
- The AAH financial advocate team will screen the patient for other coverage opportunities (i.e. Medicaid) and financial assistance.
- The interview and/or application gathers information needed to determine if the patient is eligible for any other coverage options as well as information for financial assistance.
- If the coverage assistance process indicates a high likelihood of other coverage opportunities, then the patient, with AAH assistance, will be required to pursue those opportunities before the patient will be considered for AAH financial assistance.
- **If the patient fully cooperates when seeking other coverage options**, but such coverage is unlikely or properly denied, AAH will then determine the patient's eligibility for financial assistance.
- **Uninsured patients who fail to fully cooperate with the coverage assistance process will be deemed ineligible for financial assistance.**
- *Patients found ineligible may appeal by contacting the financial advocate team.*

### Eligibility Criteria

- Uninsured patients who reside in Illinois or Wisconsin.
- Uninsured patients receiving non-elective, medically necessary services at an AAH facility or by an AAH Participating Provider.
- Uninsured patients who fully cooperate with the determination of other coverage options.
- Uninsured patients who are ineligible for all other coverage options for the account(s) under review.
- Uninsured patients meeting all the above criteria with a household income between 0% and 300% of the Federal Poverty Guidelines (FPG) are eligible for 100% financial assistance.
- **Illinois patients ONLY:** Uninsured patients meeting all the above criteria with a household income between 301% and 600% of the Federal Poverty Guidelines (FPG) are eligible for a financial assistance discount per HUPDA\* IL state regulatory requirements.

*\* In compliance with the Illinois Hospital Uninsured Patient Discount Act (210 ILCS 89/1) (HUPDA) effective 4/1/09, eligibility for Financial Assistance for patients with Family income of four to six (4-6) times FPG is restricted to patients with Illinois residency and medically necessary charges. AAH has compared the discounts for 135% of the hospital's cost to charge ratio to the AGB and have applied the more generous discounts for patients. Per HUPDA, the amount charged to a patient will be capped at 20% of the patient's gross annual income when the patient notifies AAH of previous Financial Assistance approval within the past 12 months.*

### **Ineligible Services**

- Preventative, Screening and Routine care.
- Elective and/or cosmetic services.
- Non-medically necessary services.
- Complementary medicine.
- Fertility services.
- Global & Executive Health services.
- Occupational Health services.
- Retail services.
- Services with specific global agreed upon packaged pricing.

### **Insured Patients**

Financial assistance for insured patients is available once a patient receives a bill. Patients can initiate the process by completing an application via mail or calling the AAH financial advocate team to be screened for financial assistance.

#### **Eligibility Criteria:**

- Insured patients who reside in Illinois or Wisconsin.
- Insured patients receiving non-elective, medically necessary services at an AAH facility or by an AAH provider or participating provider.
- Insured patients who are an in-network patient based on the patient's third-party insurer benefit plan at an AAH facility or by an AAH provider or participating provider except for out-of-network patients seen in the emergency department.
- Insured patients with fully adjudicated claims resulting in a self-pay balance.
- Insured patients who cooperated with the third-party insurer to resolve payment concerns if applicable. i.e. coordination of benefit questions, accident information etc.
- Insured patients who fully cooperate with the determination of other secondary coverage options.
- Insured patients who are ineligible for all other secondary coverage options for the account(s) under review.
- Insured patients meeting all the above criteria with a household income between 0% and 300% of the Federal Poverty Guidelines (FPG) will receive 100% financial assistance on the self-pay balance under review.

#### **Ineligible Services:**

- Services that are out-of-network based on the patient's third-party insurer benefit plan except for services received in an AAH emergency department.
- Services not covered by the patient's third-party insurer.
- Preventative, Screening and Routine care.
- Elective and/or cosmetic services.
- Non-medically necessary services.
- Complementary medicine.

- Fertility services.
- Global & Executive Health services.
- Occupational Health services.
- Retail services.
- Services with specific global agreed upon packaged pricing.

### **Determination of Financial Assistance Eligibility for Uninsured & Insured Patients:**

- Financial advocates strive to interview uninsured patients proactively to complete an application on their behalf prior to service. Those that are not interviewed may apply for assistance via an application prior to service or once receiving a bill by calling the AAH financial advocate call center.
- Insured patients may apply via a mailed application or by calling the AAH financial advocate call center to initiate a review after receiving a bill to be considered for financial assistance.
- In addition to information obtained from the patient, financial advocates may refer or rely on the following external sources when determining whether a patient is eligible for the Financial Assistance Program:
  - Experian Health Financial Assistance Screening.
  - Wisconsin Forward Health Portal for information about public assistance.
  - Illinois state's I.H.F.S. database to search for public aid coverage.
  - Eligibility tools to search for eligibility for health insurance coverage and public aid coverage.
- The financial advocate shall review information received from the patient and/or the written financial assistance application and determine whether the patient meets the financial assistance eligibility requirements provided in this policy.
- The patient will be notified of the financial assistance determination either in person or via mail, as applicable. This notification shall include a statement informing the patient that the determination was made after applying AAH's Financial Assistance Policy eligibility criteria to the patient's financial situation.
- If a patient is determined to be eligible for AAH's Financial Assistance Program, payments made on Eligible Services prior to application for Financial Assistance will be reviewed to determine if a refund should be processed.
- If a patient is determined to be eligible for AAH's Financial Assistance Program, the patient shall communicate to AAH any material change in their financial situation that occurs during the six-month period after approval that may affect their eligibility status. This communication must take place within thirty (30) days of the change. A patient's failure to do so may void any amount of Financial Assistance provided by AAH after the material change occurred.
- If a patient is determined to be ineligible for AAH's Financial Assistance Program, a financial advocate will work with the patient to create a payment plan to resolve the patient's remaining Self Pay Balance. These Self Pay Balances are subject to AAH Billing and Collections Policy.
- AAH may defer or deny elective, preventive, screening and/or routine services and procedures based on a financial assessment.

### **Presumptive Eligibility Determinations**

- A presumptive eligibility determination may be made for patients in Wisconsin and Illinois in accordance with the IL Fair Patient Billing Act. Uninsured patients who qualify under certain federal

and state assistance programs may be considered presumptively eligible for a 100% financial assistance adjustment and no application is necessary.

- If at least one criterion can be verified, no other proof of income will be requested.
- AAH may ask the patient to provide verification of eligibility if the financial advocate is unable to verify eligibility electronically.
- If the financial advocate can determine that a patient is presumptively eligible for Financial Assistance, a written application is not required.
- **Presumptive Eligibility Criteria is demonstrated by enrollment in one of the following programs:**
  - Women, Infants and Children Nutrition Program (WIC).
  - Supplemental Nutrition Assistance Program (SNAP).
  - Illinois Free Lunch and Breakfast Program.
  - Low Income Home Energy Assistance Program (LIHEAP).
  - Temporary Assistance for Needy Families (TANF).
  - Illinois Housing Development Authority's Rental Housing Support Program.
  - Organized community-based program or charitable health program providing medical care that assesses and documents low-income financial status as criteria.
  - Medicaid eligibility, but not eligible on date of service or for non-covered service (*IL patients only*)
- **Presumptive Eligibility Criteria can also be demonstrated by the following life circumstances:**
  - Receipt of grant assistance for medical services.
  - Homelessness.
  - Deceased with no estate.
  - Mental incapacitation with no one to act on patient's behalf.
  - Incarceration in a penal institution.
  - Affiliation with a religious order and vow of poverty.
  - Evidence from an independent third-party reporting agency indicating family income is less than two times FPL.
- **Ways to demonstrate Presumptive Eligibility include:**
  - Electronic Confirmation of program enrollment or other presumptive eligibility criteria.
  - Where independent electronic confirmation is not possible, proof of enrollment or other eligibility criteria will be requested. Any one of the following will be satisfactory proof:
    - WIC voucher.
    - SNAP card with proof of enrollment screen print, or copy of SNAP approval letter.
    - Letter from the school or Free/Reduced Price Meals & Fee Waiver Notification with signature.
    - LIHEAP award or approval letter.
    - TANF approval letter from Red Cross, DHS, or HFS.
    - Rent receipt in the case of state or federally subsidized housing program.
    - Rent adjustment letter from Lessor or HUD card or letter.
    - Card or Award statement showing current eligibility for State of Illinois program.
    - Statement from Grant Agency or Grant Letter.
    - Personal attestation or letter from church or shelter confirming homelessness.
    - Letter from attorney, group home, shelter, religious order or church.

## **Verification of Household Financial Resources and Eligibility Period**

AAH, where appropriate, may use external third-party data to validate information provided by the patient during the interview or on the financial assistance application. If there is a discrepancy between what is reported by third party vendors and the patient, the patient may be asked to provide further documentation of income and residency.

- **Documentation**

Patients may be asked to provide proof documents to verify the information provided to AAH:

- Financial information can be verified by using any/all of the following: the patient's most recent year tax returns, W-2s, the patient's income tax documentation, check stubs, banking statements, unemployment statements, or letters of financial support (if no income). If there is more than one employed person in the patient's family, each may verify his or her financial information using these same verification options.
- Proof of residency can be verified by the patient presenting any two (2) of the following valid forms of identification that indicate the same address: State issued driver's license (or other photo identification card such as a student or military ID), utility bills (gas, electric, water) bank statements, car registrations, or any other mail received from a government entity with the current date and address.
- Financial statements and verification of income and third-party vendor documentation will be retained by AAH for a period of 10 years or as required by law. Falsification of financial information, including withholding information, will be reason for denial of financial assistance.

- **Eligibility Period**

- **Uninsured**: Financial Assistance and presumptive eligibility determinations will be effective retrospectively for all eligible open self-pay balances, and prospectively for up to 180 days. Future services will be reviewed and assessed prior to or at the time of the service for continued eligibility. If any changes occur during the eligibility period, the patient is required to cooperate with the coverage assistance process to maintain financial assistance eligibility.
- **Insured**: For insured patients, Financial Assistance and presumptive eligibility determinations will be effective for current, open Self Pay Balances only and patient must re-apply for Financial Assistance for any emergent and medically necessary care occurring in the future.

- **Fraud**

AAH reserves the right to reverse financial assistance adjustments provided by this policy if the information provided by the patient during the information-gathering process is determined to be false or if AAH learns that the patient has received compensation for the medical services from other sources not disclosed to AAH.

## **Financial Assistance Applications**

Financial assistance applications are for:

- Uninsured patients who AAH financial advocates were unable to proactively review for assistance.
- Uninsured patients who were reviewed by financial advocates, but the advocate determined more information was needed and an application is necessary to complete the process.
- Insured patients wishing to be reviewed for financial assistance after receiving a bill.

### **How to Apply:**

Patients can apply by downloading a financial assistance application on the Advocate Health or Aurora Health Care websites and mailing it to the financial advocates. A patient may also request a review via phone or an application to be mailed to them by calling the financial advocates as well.

<b>Illinois – Advocate Health Patients</b>	<b>Wisconsin – Aurora Health Care Patients</b>
<ul style="list-style-type: none"><li>• <b>Visit:</b> <a href="http://www.advocatehealth.com/financialassistance">www.advocatehealth.com/financialassistance</a></li><li>• <b>Call:</b> (847) 795-2300</li><li>• <b>Mail:</b> Advocate Health Financial Advocates, P.O. Box 3039, Oak Brook, IL 60522-9908</li></ul>	<ul style="list-style-type: none"><li>• <b>Visit:</b> <a href="http://www.aurorahealthcare.org/patients-visitors/billing-payment/financial-assistance">www.aurorahealthcare.org/patients-visitors/billing-payment/financial-assistance</a></li><li>• <b>Call:</b> 1-800-326-2250</li><li>• <b>Mail:</b> Aurora Health Care Financial Advocates, PO Box 51116, New Berlin WI 53151</li></ul>

Patients have 240 days from the first post-discharge bill date to apply for financial assistance.

Only fully completed financial assistance applications will be reviewed for financial assistance. An application is considered complete if all fields on the application are complete, any requested documents are received, and a coverage assistance services representative has reviewed the information and deemed the patient ineligible for other coverage opportunities. The application is then processed for financial assistance and a determination is made within a timely manner.

**Incomplete Applications:** If a Financial Assistance Application is submitted and is incomplete, a Financial Advocate will inform the patient and explain what information is needed to complete the application. Requested information should be provided to AAH within 30 days of the initial application unless compelling circumstances are brought to AAH's attention.

**All paper applications should be mailed to the AAH financial advocate team.**

- Once an application is received, an AAH financial advocate team member will contact the patient if necessary.

## **Catastrophic Assistance**

Catastrophic assistance is an additional program designed to assist patients with very large balances in relation to their household income. Patients determined by AAH to be eligible for Catastrophic Assistance may receive a discount on Episodic Care equal to the amount of the Self-Pay Balance that exceeds 25% of the patient's Annual Adjusted Net Income. Eligible patients will undergo a Financial Assistance review to determine the applicable discount and payment plan. The remaining Self-Pay Balances after the Financial Assistance discount is applied will be subject to AAH's standard repayment guidelines. In the event the patient defaults on a payment plan, the remaining Self-Pay Balance shall become subject to the AAH Billing and Collection Policy. To be eligible for Catastrophic assistance, a patient must:

- Have a self-pay balance that exceeds \$25,000; and
- Have a self-pay balance that exceeds 25% of the patient's Annual Adjusted Net Income; and
- Undergo a Financial Assistance assessment and complete a Financial Assistance Application with appropriate financial documentation.

## **Communication of Policy**

To make AAH patients, families, and the broader community aware of the availability of Financial Assistance, AAH has taken measures to notify patients and visitors to its care locations of the availability of Financial Assistance, and to widely publicize this policy to members of the broader community served. These measures include:

- **Financial Counseling:** available to assist patients who anticipate difficulty paying their portion of their bill. Our Financial Advocates make every effort to assist patients who are uninsured, underinsured, or face other financial challenges associated with paying for the health care services we provide. Financial Advocates may screen patients for eligibility for a variety of government-funded programs, set up an extended time payment plan, or help patients apply for Financial Assistance.
- **Plain Language Summary:** AAH has a PLS of this Financial Assistance Policy. A paper copy of the PLS as well as a paper copy of the Financial Assistance Application will be offered to all patients at the earliest practical time of service. Free paper copies of these documents are also available upon request in the emergency department and hospital registration areas, from the sites Financial Advocate, as well as by mail.
- **Translated copies:** AAH offers its Financial Assistance Policy, Plain Language Summary and Financial Assistance Application in English and other languages if such translations are required under 26 C.F.R § 1.501(r)-4(a)(5)(ii). Free paper copies of these documents are available upon request in the emergency department and hospital registration areas, from the sites Financial Advocate, as well as by mail. These translated documents are also available on our website.
- **Signage:** Financial Assistance signage will be clearly and conspicuously posted in locations that are visible to the public, including, but not limited to AAH emergency departments and patient registration areas. Signage will indicate that Financial Assistance is available and the phone number to reach a Financial Advocate for more information.

- Website: AAH’s websites will prominently post notice that Financial Assistance is available with an explanation of the Financial Assistance application process. Also available on AAH’s website will be the financial assistance policy, the plain language summary (PLS), financial assistance application and the Billing and Collections Policy.
- Patient Bills and Statements: Patient statements include a conspicuous written notice that informs recipients of the availability of financial assistance under the FAP and includes the telephone number of the department that can provide information about the FAP and the FAP application process, and also the direct Web site address (or URL) where copies of the FAP documents may be obtained.

### **Actions in the Event of Non-Payment**

ECAs including credit reporting, ONLY occur after all reasonable efforts have been made to determine the patient’s eligibility for financial assistance. AAH provides all patients with 240 days from the first post-discharge bill date to apply for financial assistance prior to any extraordinary collection action for non-payment. All patients have 30 days to make financial arrangements regarding their bill before an ECA will occur whether within the 240-day window or outside the 240-day window.

More information on AAH’s billing and collection practices can be found in a separate billing and collections policy located on the AAH websites. A free copy of the policy can also be obtained by mail by calling the respective customer service department.

Illinois – Advocate Health Patients	Wisconsin – Aurora Health Care Patients
<ul style="list-style-type: none"> <li>• Visit: <a href="http://www.advocatehealth.com/financialassistance">www.advocatehealth.com/financialassistance</a></li> <li>• Call: (847) 795-2300</li> </ul>	<ul style="list-style-type: none"> <li>• Visit: <a href="http://www.aurorahealthcare.org/patients-visitors/billing-payment/financial-assistance">www.aurorahealthcare.org/patients-visitors/billing-payment/financial-assistance</a></li> <li>• Call: 1-800-326-2250</li> </ul>

### **Quality Assurance and Other Provisions**

**Quality Assurance:** AAH teammates are prohibited from making recommendations and/or processing financial assistance applications for family members, friends, acquaintances, and co-workers. The Patient Financial Services Quality Assurance Department will conduct periodic audits of accounts processed for financial assistance to ensure policy and processes are followed.

**Eligibility Criteria Adjustments:** AAH may adjust the eligibility criteria in this policy periodically based upon the community health needs assessments or improvement studies conducted for applicable organizations and/or as necessary to comply with applicable laws, regulations, and/or county agreements.

**Public Health Emergency Provision:** Alternative funding sources due to a public health emergency will NOT prevent uninsured patients from receiving financial assistance for remaining balances that qualify under this policy. As part of AAH’s dedication to our community, financial assistance may also be applied to any insured patient copays or responsibility that have been waived but not paid/reimbursed by payors or when conflicting billing guidance is issued during any public health emergency.