Chapter HRSC 10

COMMUNITY CARE

HRSC 10.01 Definitions. In this chapter:

(1) "Bad debts" has the meaning specified in s. HRSC 1.01 (2).

(2) (a) "Community care" means a hospital health service provided, as part of a hospital's financial requirements that the commission has approved, to a person who is unable to pay all or part of normal billed charges and who meets any of the following conditions:

1. The person is ineligible for medicare, medical assistance, general relief or other governmental medical aid programs.

2. The person is a beneficiary of medicare, medical assistance, general relief or another governmental medical aid program, but the hospital health service provided is not a benefit prescribed by the program.

3. The person is a beneficiary of medicare and is liable for a copayment or deductible, but is unable to pay all or part of that charge.

4. The person is eligible for Hill-Burton benefits.

(b) "Community care" does not include:

1. Government allowances. In this subdivision, "government allowances" means the difference between government program payments and normal billed charges.

2. Contractual discounts in the provision of health care services below normal billed charges, except as provided in s. HRSC 10.03 (2) (i) 3.

3. Costs associated with health care services that a utilization review program under s. 54.23, Stats., determines are medically unnecessary or inappropriate.

4. Costs associated with cosmetic medical prodecures that do not lead to a direct medical benefit.

5. Reductions in a hospital's payments received for health care services provided to the hospital's employes, public employes or prisoners.

6. Costs associated with health care services for which a hospital reduces normal billed charges as a courtesy.

7. Bad debts.

8. Medical assistance copayments or deductible amounts.

(3) "Hill-Burton" means the federal Hill-Burton program under 42 USC 291 *et seq.*

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HRSC 10.03 Justification for community care financial requirements. (1) ANNUAL SUBMISSION. Each hospital shall annually submit to the commission its proposed financial requirements for community care and bad debts. The commission may accept or reject the reasonableness of these proposed financial requirements based on the hospital's community care policy, the hospital's compliance with commission definitions of bad debt and community care, and the information supplied by the hospital under sub. (2).

(2) SUPPORTING INFORMATION. In support of its proposed community care financial requirements, each hospital shall annually submit the following information to the commission:

(a) A general written statement, approved by the hospital's governing board, that outlines the facility's overall philosophy on providing care to persons who are unable to pay.

(b) A description of special programs the hospital has established to provide care to persons who are unable to pay.

(c) A written statement outlining the hospital's procedures for determining ability to pay, when the hospital determines a patient's community care eligibility and the effort it expends to collect patient accounts. This statement shall describe information the hospital requests from the patient, the hospital's willingness to accept installment or partial payments and the hospital's bill collection activities.

(d) A description of major forces contributing to the hospital's projected bad debt financial requirements.

(e) A general economic and sociological profile of residents likely to receive community care from the hospital.

(f) The hospital's written procedures for informing individuals about governmental medical aid programs and about its community care policy. The hospital shall publish this policy in pamphlet form and make these pamphlets readily available in its admissions office, registration areas and similar areas as needed to communicate to patients the availability of, eligibility requirements and application procedures for community care.

(g) The hospital's nondiscrimination policies with respect to providing community care based on race, creed, color, sex, national origin, sexual orientation, handicap, age and source of income, the hospital's written patient appeals process regarding refusal to provide community care and the level of community involvement in this process. In order to justify its financial requirements for community care, the hospital's patient appeals process shall involve a final decision maker who was not involved in making the initial decision under review and shall involve at least one person who represents the community and is not a hospital employee.

(h) A statement indicating whether the hospital is submitting medicare copayment and deductible requirements as claims for year-end reimbursement from medicare, in which case the amounts shall be considered bad debts, or is crediting these amounts as community care.

(i) The hospital's written criteria and procedures for determining eligibility for community care. The hospital shall apply its eligibility criteria consistently and equitably. The hospital shall justify its eligibility crite-

ria based upon the demand for community care within its acute care service area, and may include in its eligibility criteria:

1. An assets test or provision allowing patients whose family income exceeds a maximum level to be considered eligible for community care if they spend excess income on medical or remedial care.

2. A sliding scale of payment or provision for cash deductible or copayment amounts, based on the patient's ability to pay.

3. Special projects or contractual obligations that target medically indigent persons or other groups with particular health care problems.

4. Other hospital specified economic factors that reflect, when equitably applied on a case by case basis, a person's ability to pay all or a portion of the charge for hospital health services or reflect the hospital's budgeted financial requirements for community care.

(3) PROJECTING COMMUNITY CARE LEVELS. (a) Each hospital shall support any financial requirements it proposes for community care by showing its previous year's budgeted community care level and the actual amount provided, an explanation of any variance between budgeted and actual levels, an estimate of the hospital's capacity to provide community care and the hospital's outstanding Hill-Burton obligations under 42 USC 291 *et seq.*

(b) 1. The commission may reject a hospital's proposed community care financial requirements and determine the hospital to be ineligible for any incentive it requests under s. HRSC 10.05, if the hospital's proposed financial requirements are less than the standard amount calculated under subd. 2 and the hospital fails to justify why it is budgeting less than this amount. The commission shall accept community care financial requirements at a level different than this standard amount, if the hospital reasonably justifies those financial requirements, and shall use the accepted financial requirements when reviewing the hospital's rate request and when determining its eligibility for any incentive under s. HRSC 10.05.

2. For the purpose of determining incentive eligibility under this paragraph, the standard level of hospital community care financial requirements shall be calculated as follows:

a. The commission shall total the hospital's most recent fiscal year actual or projected actual expenses for both bad debt and community care, compute 36% of that total, and determine what percentage this amount is of the hospital's total private pay revenues for its most recent fiscal year.

b. The commission shall apply this percentage to the hospital's private pay revenue for the budget year in order to calculate the standard level of hospital community care financial requirements.

(4) POLICY NOT CONSTITUTING AN ENTITLEMENT PROGRAM. No hospital patient is entitled to receive health care services for free or below normal billed charges solely because the hospital has established a community care policy under this chapter, the patient meets any eligibility criteria for community care that are specified in the hospital's community care policy or the hospital has not incurred its accepted level of community care financial requirements.

(5) COMMUNITY CARE AS PAYER OF LAST RESORT. In order to be acceptable to the commission, a hospital's community care shall be the payer of last resort. Hospital health care provided to a person who is a beneficiary or is eligible to be a beneficiary of medicare, medical assistance, general relief or any other governmental medical aid program except Hill-Burton is not community care, if that program pays for the type of hospital health service received. Hospital health care provided to a person who receives or is eligible to receive Hill-Burton benefits is a part of community care. For the purposes of determining if a patient is a dependent person and eligible for general relief, the existence of a hospital community care policy does not give any person the funds or other means sufficient to provide hospital care and does not thereby make the person ineligible for general relief.

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HRSC 10.05 Community care incentives. The commission shall create incentives for the provision of reasonable levels of community care that are available to hospitals with accepted community care financial requirements under s. HRSC 10.03 (3) (b). These incentives shall include:

(1) EXCESS REVENUE INCENTIVES. (a) The commission may allow a hospital with accepted community care financial requirements that generates excess revenue under s. 54.13 (1) (b) or 54.17 (4) (bm) 4, Stats., to retain an amount of excess revenue, up to the amount that its actual community care financial requirements exceed the standard level calculated under s. HRSC 10.03 (3) (b) 2. If a hospital with accepted community care financial requirements under s. HRSC 10.03 generates excess revenue under s. 54.13 (1) (b) or 54.17 (4) (bm) 4, Stats., but its actual community care financial requirements do not exceed the standard level calculated under s. HRSC 10.03 (3) (b) 2, the commission may consider alternates uses of some or all of the excess revenue, including capital accumulation, early debt retirement or the provision of additional community care. In order to be eligible for this incentive, the hospital shall provide certification from its independent auditor that the hospital has followed its community care policy, as presented to the commission, and as to the hospital's actual level of allowance for community care provided during the budget year.

(b) 1. If a hospital fails to establish acceptable community care financial requirements under s. HRSC 10.03 and generates excess revenue under s. 54.13 (1) (b) or 54.17 (4) (bm) 4, Stats., the commission shall disallow the entire amount of excess revenue that may legally be removed from the hospital's financial requirements.

2. The disallowance of excess revenue under s. 54.13 (1) (b), Stats., that is specified in subd. 1 is subject to the limitation on rate reductions specified in s. 54.17 (4) (bm), Stats.

(2) CAPITAL EXPENDITURE REVIEW INCENTIVE. Subject to the concurrence of the department of health and social services, the commission shall adopt a memorandum of understanding with the department to evaluate hospital compliance with community care policies for the purpose of capital expenditure review under ch. 150, Stats. If a project is submitted by or on behalf of a hospital for capital expenditure review, the commission shall evaluate the hospital's community care policy and its compliance with that policy in order to indicate whether the hospital

has an acceptable indigent care plan under the review criterion specified in s. 150.69 (13), Stats.

(3) BANKING INCENTIVE. If the commission approves more community care financial requirements for a hospital than the standard level calculated under s. HRSC 10.03 (3) (b) 2 and the hospital's actual community care financial requirements for this budget year equal or exceed the approved level, the commission may include as an incentive in the hospital's budget for the next year an amount not to exceed the difference between these actual financial requirements and the standard level. In order to be eligible for this incentive:

(a) The hospital shall provide certification from its independent auditor that the hospital has followed its community care policy, as presented to the commission, and as to the hospital's actual level of allowance for community care provided during the budget year.

(b) The hospital shall agree that if its actual community care financial requirements are less than the amount approved for the budget year, the remainder shall offset the hospital's approved level of community care financial requirements in its next rate review.

(c) The hospital's budget year shall begin on or after the date this chapter takes effect.

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