DEPARTMENT: Collections	**POLICY DESCRIPTION:** Discount Charity Policy for Patients for **Capital Medical Center**
	REPLACES POLICY DATED: 01/09/15
REVISED: 9/20/2010; 6/17/13; 1/9/15; 03/31/2015; 9/27/2018	
APPROVED: 12/06/2018	**RETIRED:**
EFFECTIVE DATE: 10.01.2008	**REFERENCE NUMBER:**

SCOPE:

For requesting and evaluating Financial Assistance Applications for the purposes of processing a Charity discount.

PURPOSE:

To define the policy, in compliance with State guidelines, for providing financial relief to patients who have received appropriate hospital-based medical services including those hospital services which are reasonably calculated to diagnose, correct, cure, alleviate, or prevent the worsening of conditions that endanger life, or cause suffering or pain, or result in illness of infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and there is no other equally effective more conservative or substantially less costly course of treatment available or suitable for the person requesting the service. To ensure the policy for financial assistance to patients is consistent with the income guidelines as defined in WAC 246-453-040(1) and WAC 246-453-040(2).

Also, to establish protocols for requesting and processing the Financial Assistance Application and defining the supporting income validation documentation requirements.

Charity Care and/or Financial Assistance means medically necessary hospital health care rendered to indigent persons when Third-Party Coverage, if any, has been exhausted, to the extent that the persons are unable to pay for the care or to pay deductible or coinsurance amounts required by a third-party payer based on the criteria in this Policy.

Third-Party Coverage means an obligation on the part of an insurance company, health care services contractor, health maintenance organization, group health plan, government program (Medicare, Medicaid or medical assistance programs, workers compensation , veteran benefits), tribal health benefits, or health care sharing ministry as defined in 26 USC Sec.5000A to pay for the care of covered patients and services, and may include settlements, judgments, or awards actually received related to the negligent acts of others (for example, auto accidents or personal injuries) which have resulted in the medical condition for which the patient has received hospital health care services.

POLICY:

Charity care or discounts may only be provided to patients receiving appropriate hospital-based medical services as defined in WAC 246-453-010(7). Patients meeting the income level requirements in WAC 246-453-040(1) and WAC 246-453-040(2) qualify for a charity discount based on the patient's annual total household income:

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- All responsible parties with annual household income equal to or below 250% of the federal poverty standard, adjusted for family size, shall be determined to be indigent persons qualifying for charity sponsorship for the full amount of hospital charge related to appropriate hospital-based medical services that are not covered by private or public Third-Party Coverage.
- Patients must cooperate and apply for any and all Third-Party Coverage that may be available to help pay their hospital bill. Non-compliance with this process may result in an initial denial of the application.
- Total annual household income of the responsible party will be determined based on the time the appropriate hospital-based medical services were provided, or based on the time of the Financial Assistance Application if the application is made within two years of the time the appropriate hospital-based medical services were provided, the responsible party has been making good faith efforts toward payment for the services, and the responsible party demonstrates eligibility for charity care or discount / financial assistance.
- A validation must be completed to ensure that if any portion of the patient's medical services can be paid by Third-Party Coverage, that the payment has been received and posted to the account. Charity discounts will be applied to the patient's account once Third-Party Coverage payments are posted.

Public Notification

Pursuant to WAC 246-453-020(2) and WAC 246-453-010(16), notice will be posted and prominently displayed in areas where patients are admitted or registered, in the emergency department, and any financial service of billing area accessible to patients advising that the hospital offers Financial Assistance and Charity Care (including free and reduced price care) to insured and uninsured persons meeting the specified income requirements and made available to patients in writing and personally explained at the time the hospital requests information regarding Third-Party Coverage.

Notice and a plain language summary of this Policy, the current version of this Policy and the Financial Assistance Application will be available on the hospital's website.

All hospital billing statements and other written communications involving billing or collection of a hospital bill by the hospital will include the following statement on the front / first page of the statement in both English and the second most spoken language in the hospital's service area:

You may qualify for free care or a discount on your hospital bill, whether or not you have

insurance. Please contact our financial assistance officer at [web site] and [phone number].

The written notices, verbal explanations, the summary of this Policy, this Policy, and the Financial Assistance Application will be available in all languages spoken by more than ten percent of the population in the hospital's service area and interpreted for other non-English speaking or limited-English speaking or other patients who cannot read or understand the writing and explanation.

Verbal Statement for Initial Determination of Eligibility

Patient Access staff will provide the patient/responsible party with a Financial Assistance Application with instructions and assign charity review based upon information provided orally by the patient/ responsible party or upon receiving a signed application and/or statement attesting to the accuracy of the information provided or based solely when upon initial determination of a guarantor's status as an indigent person is obvious. The patient or responsible party will have 14 days, or such time that is medically and reasonably feasible, for patients to secure and present the required documentation. Collection efforts will not be initiated during the determination process for charity care provided the responsible party is cooperative with the hospital's efforts to reach an initial determination of sponsorship status.

Income and Asset Verification

- Medicare requires independent income and resource verification for a charity care determination with respect to Medicare beneficiaries (PRM-I § 312).
- For Medicare beneficiaries, in addition to thorough completion of the Financial Assistance Application, the preferred income documentation will be the most current year's Federal Tax Return. Any patient/responsible party unable to provide his/her most recent Federal Tax Return may provide one piece*** of supporting documentation from the following list to meet this income verification requirement:
    - Supporting W-2
    - Supporting 1099's
    - Most recent bank and broker statements listed in the Federal Tax Return
    - Current credit report
    - Qualified Medicare Benefits (QMB for inpatients only)

    ***A Medicare beneficiary who also qualifies for Medicaid (dual-eligible beneficiary) will be presumed indigent automatically as long as the "Must Bill" requirements are met which is supported by a State Medicaid remittance advice.

- Additional documentation acceptable for Non-Medicare patients:
    - Most Recent Employer Pay Stubs
    - Copies of all bank statements for last 3 months
    - Written documentation from income sources

- Any one of the following documents shall be considered sufficient evidence upon which to base the final determination of charity care sponsorship status, when the income information is annualized as may be appropriate:
    (a) A "W-2" withholding statement;
    (b) Pay stubs;
    (c) An income tax return from the most recently filed calendar year;
    (d) Forms approving or denying eligibility for Medicaid and/or state-funded medical assistance;
    (e) Forms approving or denying unemployment compensation; or
    (f) Written statements from employers or welfare agencies.

- In the event that the responsible party is not able to provide any of the documentation described above, the hospital may rely upon written and signed statements from the responsible party for making a final determination of eligibility for classification as an indigent person.

- Supplemental information may also be gathered using external database information as available through national credit reporting agencies such as Experian, Equifax, or Transunion. Such information will be used for the purposes of defining qualification for "presumptive" financial assistance / presumptive qualification for charity care or discount. Under no circumstances will such information be used to exclude anyone from qualification for charity care or discount.

- After thorough review of the Financial Assistance Application and documented research through Medicaid Eligibility processing or other means, a manager may waive supporting documentation on non-Medicare, non-Champus, non-Medicaid, and non-Medicare Secondary Payer accounts when it is apparent that the patient/responsible party is unable to meet the supporting documentation requirement but clearly meets the Charity guidelines.

- Under no circumstances will liens be considered on properties.

- Registrars, Financial Counselors, Support Services, and Collectors (Patient Access Staff) should utilize all relevant on-line systems available to gather correct information for review of charity. All efforts should be documented in a clear, concise, and consistent manner in the Collections/Artiva System. Staff should demonstrate respect and integrity in all internal and external dealings. Confidentiality is considered of utmost importance and should be adhered to by all staff. All guidelines set forth by this policy should be adhered to without exception.

Pending Medicaid Effect on Charity Discount

The Pending Medicaid and Pending Charity processes should not be concurrent processes. Determination of Pending Medicaid should be resolved prior to evaluating for potential Pending Charity.

Charity Processing based on Federal Poverty Guidelines

Patients that fall within 0-250% of the Federal Poverty Guideline will have a 100% Charity Discount processed. Patients that fall within 251%-400% of the Federal Poverty Guideline will receive a 60% charity discount. This process will be managed by establishing IPLANS with a Financial Class of 15 for Charity Pending, Charity 0%– 250%, and Charity 251% - 400%. When an account qualifies for FPG 0%-250%, the charity tool will assign 099-51 to post the discount of 100%. When an account qualifies for FPG 251%-400%, the charity tool will assign the 099-53 Iplan and auto-post the discount of 60% (log C300, model C300), auto-posted discount. These IPLANS will be attached to standard LOGIDS with the appropriate models to calculate the applicable discount and auto post to the account at final bill and should be prorated at the appropriate percentage of patient charges. These logs will not be worked for discrepancies or any other purposes since self-pay underpayments or overpayments would be identified as they are normally identified today through our collection pools and credit balance reports. On accounts where the charity IPLAN is placed in the secondary or tertiary position, the applicable manual discount will need to be applied. Standard procedure codes will be established to use in those instances where the discount must be manually applied.

Charity Processing based on Extenuating Circumstances

There may be occurrences of extenuating circumstances where the patient/responsible party is not able to complete the Financial Assistance Application and/or provide supporting documentation and resource testing cannot be completed or where the medical indigence of

the patient is determined as outlined by state requirement/policy. In those circumstances, a CFO, PAD, or designee may make the decision to waive the required documentation provided that all attempts to obtain additional information are documented clearly or may perform additional resource testing to validate the need for charity. Some of the following could be considered extenuating circumstances:

- Undocumented Residents or Homeless - Patients identified as undocumented residents or homeless through
  - Medicaid Eligibility screening
  - Registration process
  - Discharge to a shelter
  - Clinical or Case Management documentation

- Patient Expiration - Patients that expire and research determined through family contact and/or courthouse records that an estate does not exist and was documented, may be considered for a charity discount with the manager's review and approval for a policy exception. Patients that expire prior to or during the charity review process will be reviewed for estate if not already completed. If review for estate is not documented, the account will be forwarded to a Sr. Correspondence Representative for review and the charity process will be suspended pending results of the review.

- Medically Indigent – Based upon state guidelines or requirements if the patient/responsible party meets the medically indigent status, a charity discount may be applied after completion of the resource testing process for the patient/responsible party according to state guidelines:

- Per WAC 246-453-040, patients will be considered indigent if the annual family income falls below 200% of the FPG adjusted for family size (for Capital Medical Center, patients will be considered indigent if the annual family income falls below 250% of the FPG adjusted for family size) or in cases where the patient/responsible party's income exceeds two hundred percent of the federal poverty standard, adjusted for family size, the hospital may determine to classify as indigent based upon that responsible party's individual financial circumstances.

Approval of Extenuating Circumstances

- Charity write-off for extenuating circumstances must be submitted on the "Charity-Request for Write-Off Approval" form. Request must be approved based on ETRAN (ref. NSH.PP.PAS.003) approval levels.

- Signed form should be batched and forwarded to scanning into Charity folder.

State Programs and Future Coverage

Several county and local government based programs pre-screen patient under the federal poverty guideline for participation in Medicaid. Patient participation in these programs or future participation also satisfies the income attestation requirements of the Uninsured Charity Policy. Zero income and one dependent will be entered in the web tool to have the 100% adjustment applied; completion of the Financial Assistance Application is not required. The account will be noted, "MCD 100% approved" or Future coverage, for "program or MCO".

Out of State Medicaid-No Provider Number

Patients who actively participate in Out of State Medicaid programs where a provider number is not available and whose prorated charges are less than twenty-five hundred dollars ($2,500) also satisfy the income attestation requirements of the Uninsured Charity Policy. For these accounts, the OOS Medicaid Iplan will be replaced with the charity pending IPLAN (099-50). A list of these accounts will be sent each week to the Correspondence Manager. The accounts will be reviewed and approved in the Charity Web Tool.

Insurance Denials

When an account is denied by Third-Party Coverage for non-covered services or date of service not covered, etc., the payor Iplan will be deleted and the Uninsured Iplan will be assigned as primary payor. The uninsured discount will auto-post and a statement will be sent to the patient. Per policy, an attempt must be made to collect the patient liability. If the patient is unable to pay and contacts the hospital, Customer Service, Agency or other SSC agent, a Financial Application will be provided. Upon receipt of the Financial Application by the SSC, the charity pending Iplan (099-50) will be added to the account.

Refunds on Charity accounts

The general expectation is that all patients pay for services rendered if they are not fully covered by Third-Party Coverage. In the event that a responsible party pays a portion or all of the charges related to appropriate hospital-based medical services, and is subsequently found to have met the charity care criteria at the time that services were provided or if Financial Assistance Application is made within two years of the time the appropriate hospital-based medical services were provided, the Applicant has been making good faith efforts towards payment of the services, and the Applicant demonstrates eligibility for Charity Care and/or Financial Assistance, any payments in excess of the amount determined to be appropriate in accordance with WAC 246-453-040 shall be refunded to the patient within thirty days of achieving the charity care

designation.

Collection Efforts

Collection efforts will not be directed at the responsible party during an initial determination of sponsorship status. If the initial determination indicates that the responsible party may meet the criteria for classification as an indigent person, collection efforts will be precluded until a final determination provided the responsible party is cooperative with the hospital's reasonable efforts to reach a final determination of sponsorship status.

Notice of Final Determination

Charity care applicants will be notified of the final determination of sponsorship status within fourteen calendar days of receipt of requested information. In the case of approvals, parties should be notified of the amount that will be covered. In the case of a denial, parties will be notified in writing of the denial and the basis for denial.

Patient Dispute Process

- All parties denied charity care coverage will be notified that they have thirty days within which to request an appeal of the final determination. All parties denied charity care coverage will also be provided with an appeals procedure that enables them to correct any deficiencies in documentation or request review of the denial.
- In the event a patient wishes to file a dispute and appeal their eligibility for this policy, patient may seek review from the Patient Access Director, Hospital Chief Financial Officer or an SSC Executive. Any such dispute / appeal will be forwarded to the Chief Financial Officer upon receipt of such dispute / appeal.
- If a patient appeals their denial and is denied a second time on the same account for the same reason, a copy of that appealed denial and the basis for that denial will be sent to the responsible party, with a copy to the Chief Financial Officer,and sent to the office of Hospital and Patient Data Systems, Washington State Department of Health with copies of documentation upon which the decision was made.
- Any collection efforts will be ceased if an appeal has been filed for charity care coverage until the appeal is finalized.

Approval Responsibility

The business office administers the policy based on above policy guidelines with final approval, denials or exceptions being made by Capital Medical Center PAD and/or CFO.

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Training

The hospital has established a standardized training program on this Policy and the use of interpreter services to assist persons with limited English proficiency and non-English-speaking persons in understanding information about this Policy. The hospital will provide regular training to front-line staff who work in registration, admissions and billing and any other appropriate staff to effectively answer questions about Financial Assistance / Charity Care availability at the hospital, to obtain any necessary interpreter services, and direct inquiries to the appropriate department in a timely manner.