

Facility: Walla Walla General Hospital

System-wide Corporate Policy

Standard Policy

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Department: Patient Financial Svs

Category/Section:

Manual:

POLICY/PROCEDURE: LOW INCOME PATIENT BILLING: CHARITY CARE

POLICY SUMMARY/INTENT:

To ensure quality healthcare for all patients regardless of their ability to pay

To define Charity Care, eligibility of patients and the services covered as well as provides income levels, based on a sliding scale, eligible for assistance.

To comply with Adventist Health corporate policy, all federal, state, and local regulations

If any regulation, current or future, conflicts with this policy, the regulation supersedes this policy.

AFFECTED DEPARTMENTS/SERVICES:

Administration, Admitting, Patient Business Office

POLICY: COMPLIANCE – KEY ELEMENTS:

A. General Considerations

1. Communication of Financial Assistance Policies with Patients and the Public:
 - a. Notices regarding the availability of financial assistance to low-income patients are posted in all patient registration areas and patient business office in both English and Spanish.
 - b. Notices regarding financial assistance policies contain brief instructions on how to apply for Charity Care or a discounted payment. The notices also include a contact telephone number that a patient or family member can call to obtain more information.
 - c. Hospital staff and volunteers are knowledgeable regarding the existence of the hospital's financial assistance policies. Training is provided to staff members (i.e., billing office, financial department, etc.) who directly interact with patients regarding their hospital bills.
 - d. When communicating to patients regarding their financial assistance policies, WWGH attempts to do so in the primary language of the patient, or family, if reasonably possible, and in a manner consistent with all applicable federal and state laws and regulations.

B. Charity Care

1. Any self-pay, uninsured patient who indicates an inability to pay is screened for Charity Care. Additionally, any insured patient who indicates an inability to pay their liability after their insurance has paid may also be screened for Charity Care.
2. At a minimum Charity Care is granted to qualified patients for appropriate hospital based services for urgent, emergent and labor and delivery.
 - a. Urgent is defined as: Requiring prompt medical action or intervention because of potential for deterioration of patient condition.
 - b. Emergent is defined as: Requiring immediate medical action or intervention because of imminent threat to patient life or limb.
 - c. Labor & Delivery is defined as: Patient is in active labor and delivery is imminent.

3. Any services outside of these definitions may be screened and charity determination made by Charity Board.
4. Any elective and/or non-medically necessary services are not eligible for Charity Care.
5. Screening for Charity Care occurs only after all other potential resources have been exhausted. The screening process optimally occurs at the time of service but may occur anytime during the collection process including post assignment to an outside collection agency.
6. Patients are required to complete a financial statement and application. Patients must provide income and debt verification as detailed in the application. Currently Medicaid programs may be available for patients that are over 65 years of age, under 19 years of age, disabled for more than 90 days, or pregnant. These patients and their households must apply for state Medicaid and provide a letter of determination as part of their charity application. A Trans Union credit report will be secured when possible for each application.
7. Charity Care is granted based upon the following income levels:

<u>Income Level</u>	<u>Discount Amount</u>
Less than 200% of the Federal Poverty Level	100% Discount
200% to 300% of the Federal Poverty Level	75% Discount
301% to 350% of the Federal Poverty Level	50% Discount
350% to 400% of the Federal Poverty Level	25% Discount
Greater than 400% of Federal Poverty Level	Patient Pays Full charges

C. Duration

1. Approved charity adjustments are considered valid for all existing accounts and for an additional 90 days after approval for appropriate medical services as noted above. Any accounts that have gone to collections will be canceled and written off to charity

D. Catastrophic Charity Care

1. Based upon the patients' complete financial situation, when the patient liability amount exceeds 50% of the total annual family income, amounts greater than 50% of the income may be written off to Charity Care.

C. Medicaid Denials

1. Patients who qualify for Medicaid is also presumed to qualify for full charity write off. Any charges for days or services written off (excluding billing timeliness, medical records, missing invoices, or eligibility issues) as a result of a Medicaid denial should be written off to a specific code and booked as charity.

D. Restricted Medicaid Coverage

1. Some Medicaid plans offer coverage for a limited or restricted list of services. If a patient is eligible for Medicaid, any charges for days or services not covered by the patient's coverage may be written off to charity without a completed Confidential Financial Statement. This does not include any Share of Cost (SOC) amounts, as SOC's are determined by the state to be an amount that the patient must pay before the patient is eligible for Medicaid. DSHS uses the term "Spend Down" instead of Share of Cost.

E. Documentation Requirements

1. Application
 - a. Unless otherwise noted, a Confidential Financial Statement is completed. The Confidential Financial Statement allows for the collection of information. Income

and documentation requirements are defined below. Pending the completion of such application, the patient is treated as a pending Charity Care patient in accordance with the hospital's policies and the appropriate financial class recorded to reflect this status. The patient will have at least fourteen days to provide the required documentation.

- b. Every effort is made to secure a signed application, but this may not be possible in all cases. Patients stating that they are homeless and without income, at the discretion of the PFS Director, do not need to complete a Confidential Financial Statement.
 - c. Family Members:
 - (1) Patients are required to provide the number of family members in their household.
 - (2) Adults:
 - (a) In calculating the number of family members in an adult patient's household, include the patient, the patient's spouse and/or legal guardian, and all dependents.
 - (3) Minors:
 - (a) In calculating the number of family members in a minor patient's household, include the patient, the patient's mother and/or father and/or legal guardian and any other dependents.
 - e. Income Calculation:
 - (1) Patients are required to provide their household's yearly gross income.
 - (2) Adults:
 - (a) The term "yearly income" on the Confidential Financial Statement means the sum of the total yearly gross income of the patient and patient's spouse. Income means total cash receipts before taxes derived from wages and salaries, welfare payments, Social Security payments, strike benefits, unemployment or disability benefits, child support, alimony, and net earnings from business and investment activities paid to the individual.
 - (3) Minors:
 - (a) If the patient is a minor, the term "yearly income" on the Confidential Financial Statement means income from the patient, the patient's mother and/or father and/or legal guardian and any other dependents.
2. Income Verification:
- a. Patients are required to verify the income set forth in the Confidential Financial Statement in accordance with the documentation requirements identified below in cases where documentation is available. Any of the following documents is appropriate for verifying income:
 - b. Income Documentation:
 - (1) Income documentation may include most recent IRS Form W-2, wage and earnings statement, recent paycheck stub, most recent tax returns, telephone verification by employer of the patient's income, bank statements, or other appropriate indicators of income.
 - c. Participation in a Public Benefit Program:
 - (1) Documentation showing current participation in a public benefit program including Social Security, Workers' Compensation, Unemployment Insurance Benefits, Medicaid, County Indigent Health, AFDC, Food Stamps, WIC, or other similar indigence related programs.

3. Documentation Unavailable:
 - a. In cases where the patient is unable to provide documentation verifying income, the following procedures is followed:
 - b. Obtain Patient's Written Attestation:
 - (1) Have the patient sign the Financial Assistance Application attesting to the accuracy of the income information provided; or
 - c. Obtain Patient's Verbal Attestation:
 - (1) The Financial Counselor who is completing the Confidential Financial Statement may provide written attestation that the patient verbally verified the income calculation. In all cases, at least two attempts must be made and documented to attempt to obtain the appropriate income verification.
 - d. Expired Patients:
 - (1) Expired patients may be deemed to have no income for purposes of the financial calculation. Although no documentation of income is required for expired patients, an asset verification process should be completed to ensure that a Charity Care adjustment is appropriate.
4. Uncooperative Patients:
 - a. Uncooperative patients are defined as unwilling to disclose any financial information as requested for Medicaid and/or Charity Care determination during the screening process. In these cases, the account is not processed as Charity Care. The patient is advised that unless they comply and provide the information, no further consideration will be given for Charity Care processing, and standard A/R follow-up will begin. Non-Compliant patients are defined as not meeting all required documentation for Medicaid screening, but qualifying for Charity Care. In these cases, the Financial Counselor may process the account for Charity Care, and the account remains in the charity-pending financial class until the facility processes a charity write-off adjustment.
5. Collection Accounts:
 - a. Any accounts that are already in collection are placed on hold. The collection agency is notified to hold all collection efforts until such time a determination is made. Once made, the agency is notified of the amount of charity granted. The account is then released and any amount still owed is collected. The failure of the patient to complete the charity application process results in continued collection action.
6. Communication
 - a. Adventist Health facilities are required to post signs in their admitting and registration areas that inform patients about their financial assistance policies. Additionally, patient statements have standard language informing patients that they may request financial screening to determine eligibility for Charity Care. To the extent possible, these communications are in the primary language of the patient.
 - b. Once a charity determination has been made, the outcome must be communicated to the patient of their final determination within fourteen calendar days of receiving information. Such notification must include a determination of the amount, if any, for which the responsible party is held financially accountable. That communication may be accomplished by sending the patient Exhibit B.

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7. Denials:
- a. All patients denied Charity Care due to not meeting the income guidelines or not supplying necessary documentation will be notified and given the option of an appeal. The appeals procedure will enable them to correct any deficiencies in documentation or request review of the denial and results in review of the determination by the hospital's chief financial officer or equivalent.
 - b. Patients shall be notified that they have thirty calendar days within which to request an appeal of the final determination of Charity Care. Within the first fourteen days of this period, the hospital may not refer the account at issue to an external collection agency. After the fourteen-day period, if no appeal has been filed, the hospital may initiate collection activities if appropriate.
 - c. If the hospital has initiated collection activities and discovers an appeal has been filed, they shall cease collection efforts until the appeal is finalized.

REFERENCES: PFS-112, WAC 246-453
AUTHOR: Patient Financial Services Director
APPROVED: Chief Financial Officer
ACCEPTED: 01/06/09
EFFECTIVE DATE: 02/10/2005
DISTRIBUTION: Administration, Admitting, Patient Business Office
REVIEWED EVERY THREE YEARS:
REVISION: 01/09
POLICY HISTORY:
ATTACHMENTS: A – Applications