Header Information

Policy		Deployment	
Policy Name:	VGH Charity Care VGH Charity Care	Institution:	Valley General Hospital
Supercedes:	Charity Care	Division:	Hospital
Policy Level:	Hospital wide	Department:	Business Services
Owner(s):	Zachary Gongaware/VGH Nancy Worley/VGH	Contributing Departments:	
Priority:		Manual Name:	Financial
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		Policy Review Date:	10/02/2014

Policy

SCOPE

The charity policy is limited to treatment for patients who receive medically necessary "appropriate hospital-based medical services" at Valley General Hospital, Snohomish County Public Hospital District 1.

PURPOSE

Valley General Hospital is committed to providing medically necessary health care services to all persons in need of medical attention regardless of the ability to pay. In order to protect the integrity of operations and fulfill this commitment, the following criteria for the provision of charity care, consistent with the requirements of the Washington Administrative Code, Chapter 246-453, are established, as set forth in Resolution No. 2004-04.

Charity Care is made available to patients residing within Snohomish County Public Hospital District No. 1 with limited financial resources. The program provides an evaluation of the financial need of the patient to qualify for charity care sponsorship.

COMMUNICATIONS TO THE PUBLIC

Valley General Hospital's charity care policy shall be made publicly available through the following elements:

A. A notice advising patients that the hospital provides charity care is posted in key areas of the hospital, including Admitting, the Emergency Department and Business Services financial counseling area.

B. When admitting for emergency, observation or inpatient care, patients receive a copy of the *Important Information About Your Bill*, which provides information about the financial assistance program. Patient statements also have a notation stating that if a patient is unable to pay their bill due to a financial hardship, to contact the hospital to discuss financial

assistance programs. If for some reason the patient is not notified of the existence of charity care before receiving treatment, he/she is notified as soon as possible thereafter.

C. Both the written information and the verbal explanation are available in any language 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 patients and for other patients who cannot understand the writing and/or explanation. The hospital finds that the following non-English translation(s) of this document is made available: Spanish.

D. Admissions staff will direct inquiries about DSHS application or about our Charity Care program to the hospital's financial counselors or to the Medicaid enrollment facilitator.

E. Written information about the hospital's Charity Care Policy is available to any person, who requests the information, either by mail, by telephone or in person. The hospital's sliding fee schedule, if applicable, is available upon request.

ELIGIBILITY CRITERIA

For all references as applicable in this policy and the charity program, the "patient" shall refer to and include the responsible party for the patient (guarantor).

Charity care is available to the residents of Snohomish County Public Hospital District No. 1 meeting income and eligibility guidelines. Charity care for patients who are not residents of the District shall be evaluated on a case-by-case basis and require the approval of the Chief Financial Officer and/or Chief Executive Officer.

Charity care is always secondary to all other financial resources available to pay for the patient's care and treatment at the hospital or physician practices. Primary sources of payment include group or individual medical plans, worker's compensation, Medicare, Medicaid or medical assistance programs, Crime Victims, other state, federal, or military programs, personal injury protection (PIP) coverage for auto accidents or personal injuries, or any other situation in which another person or entity may have a legal responsibility to pay for the costs of medical services. If a patient is eligible for coverage through third party insurance, for Medicaid, Crime Victims or other available source of payment for services, and does not cooperate, comply, or follow-through with the application for the available coverage; the patient will not be eligible to receive a charity care adjustment to their hospital bill.

Under this policy, qualifying patients will be granted charity care regardless of race, color, sex, religion, age, national origin, or immigration status.

In those situations where appropriate primary payment sources are not available, patients will be considered for charity care under this hospital policy based on the requirements of WAC 246-453-040 and WAC 246-453-050, and the following criteria:

The full amount of hospital charges will be determined to be charity care for a patient whose gross family income is at or below 100% of the current federal poverty level, (consistent with WAC 246-453-050 (2) (b).

The following sliding fee schedule is used to determine the amount that shall be written off for patients with family incomes between 101% and 300% of the current federal poverty level (FPL).

101% to 150% of FPL	75% Charity reduction
151% to 175% of FPL	50% Charity reduction
176% to 200% of FPL	35% Charity reduction

Patients with family income between 201% and 300% of the Federal Poverty Level, adjusted for their family size may receive a 35% adjustment.

Patients that are between 201 and 300% of the poverty level may be asked to provide additional financial information depending upon the patient's individual financial circumstances. The additional information may include family assets, future income earning capacity, and the ability to make payments on an installment basis consistent with hospital payment practices.

Financial assistance and charity care shall be limited to "appropriate hospital-based medical services" as defined in WAC 246-453-010 (7). Such "appropriate services" do not include:

a) Elective surgery, including elective costmetic surgery;
b) Services that are not generally covered by third party payers;
c) Services not paid by a third party payer due to patient's failure to follow payer guidelines or requirements.
d) Recovery Center elective services

The above exclusions are examples and do not represent an all-encompassing list.

Catastrophic Charity. The hospital may provide a discretionary reduction as charity care amount for patients with family income in excess of 300% of the federal poverty level when circumstances indicate severe financial hardship or personal loss. Severe hardship is measured by the amount of medical expenses in relation to family income, among other factors. Eligibility for catastrophic charity care will be evaluated on a case-by-case basis, and must be approved by the Chief Financial Officer or Chief Executive Officer.

As noted above, the responsible party's financial obligation which remains after the application of any sliding fee schedule charity adjustment is payable in monthly installments over a reasonable period of time, without interest or late fees, as negotiated between the hospital and the responsible party. The responsible party's account will not be turned over to a collection agency unless two payments in a row are missed or there is some period of inactivity on the account, and there is no satisfactory contact with the patient.

Valley General Hospital shall not require a disclosure of resources from charity care applicants whose income is clearly less than 100% of the current Federal Poverty Level, but will require a disclosure of resources from charity care applicants whose income is at or above 100% of the current Federal Poverty Level. When a patient reports income at or above 100% of the FPL and the hospital is not able to ascertain an estimated income via a credit report or other outside reporting agency due to no reported social security number or available scoring information; the patient will be billed for services. It is the patient's responsibility to notify the hospital if a financial hardship exists.

PROCESS FOR ELIGIBILITY DETERMINATION

A. Initial Determination:

1. The hospital Business Services Department uses information from a formal Charity Care application to determine eligibility for charity care. Requests to provide charity care will be accepted from sources such as physicians, community or religious groups, social services, financial services personnel, and the patient.

   Valley General Hospital will accept and act upon information provided within the Patient Profile query when:

   a) The patient's estimated income is clearly below 100% of the current Federal Poverty Guideline for the patients family size, and;
   b) The patient is underinsured (catastrophic coverage or high deductible) or uninsured; and
   c) The patient's face sheet information indicates that the patient (guarantor) is unemployed.

   If the indicators listed above are not clearly present, but the estimated income indicates probability of charity care eligibility, the patient (guarantor) is sent a charity care

application and letter indicating evidence of current income is required for consideration under the hospital's charity care program.

2. During the patient registration process, or at any time prior to the final payment of the bill and after the patient has been notified of the existence and availability of charity care, the hospital will make an initial determination of eligibility based on verbal, written application or the Patient Profile income estimator query for charity care.

3. Pending final eligibility determination, the hospital will not initiate collection efforts or request deposits, provided that the responsible party is cooperative with the hospital's efforts to reach a final determination of eligibility for charity care.

B. Final Determination:

1. Prima Facie Write-Offs. In the event that the responsible party's identification as an indigent person is obvious to hospital personnel, and the hospital can establish that the applicant's income is clearly within the range of eligibility, the hospital will grant charity care based solely on this initial determination. In these cases, the hospital is not required to complete full verification or documentation [in accordance with WAC 246-453-030 (3)]. This process referred to as "Presumptive Charity Care".

2. Charity care forms, instructions, and written applications are furnished to patients when charity care is requested, when need is indicated, or when the initial Patient Profile financial screening indicates a possible eligibility for Charity Care. All applications, whether initiated by the patient or the hospital staff, should be accompanied by documentation to verify income amounts indicated on the application form. Any one of the following documents is considered sufficient evidence upon which to base the final determination of charity care eligibility:

   a) A "W-2" withholding statement;
   b) Pay stubs from all employment during the relevant time period;
   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 DSHS employees;
   g) A letter or written statement from a third party providing room and board or other financial support to a low income patient;

3. During the initial request period, Charity Care will be approved only when all other sources of payment are exhausted. Valley General Hospital requires patients to pursue Medicaid enrollment, when appropriate, prior to Charity Care approval. Valley General Hospital will also work with patients who seek treatment for accident related injury to pursue PIP (Personal Injury Protection) coverage where appropriate. The Hospital may not require that a patient applying for a determination of indigent status seek bank or other loan source funding.

4. Usually, the relevant time period for which documentation will be requested will be three months prior to the date of application. However, if such documentation does not accurately reflect the applicant's current financial situation, documentation will only be requested for the period of time after the patient's financial situation changed. The hospital reserves the right to ask for additional documentation supporting the patient's current financial situation, when it deems this is needed for accurate determination of charity care eligibility.

5. In the event that the responsible party is not able to provide any of the documentation described above, the hospital will rely upon written and signed statements from the responsible party for making a final determination of eligibility for classification as an indigent person. (WAC 246-453-030 (4))

C. Time frame for final determination and appeals.

1. Each charity care applicant who has been initially determined eligible for charity care is provided with at least thirty (30) calendar days, or such time as may reasonably be necessary, to secure and present documentation in support of his or her charity care application prior to receiving a final determination of sponsorship status.

2. The hospital will notify the applicant of its final determination of charity eligibility within fourteen (14) days of receipt of all application and documentation material.

3. The patient/guarantor may appeal the determination of eligibility for charity care by providing additional verification of income or family size to the Business Services Director within thirty (30) days of receipt of notification.

4. The timing of reaching a final determination of charity care status will have no bearing on the identification of charity care deductions from revenue as distinct from bad debts, in accordance with WAC 246-453-020 (10).

D. If the patient has paid some, or all, of the bill for medical services, and is later found to have been eligible for charity care at the time services were provided, he/she will be reimbursed for any amounts in excess of what is determined to be owed based on the sliding fee schedule. The patient will be reimbursed within sixty (60) days of receiving the charity care designation.

E. Generally, the patient (and/or their dependents) will be deemed eligible for charity care, for the next 30 days following the initial date of service for which the eligibility determination was made.

Patients who are charity care eligible, and are referred from the VGH Emergency Department, will be seen for one ED follow-up visit as required under the hospitals medical staff policies. The hospital will assist patients without a primary care provider to identify services within the community to meet their care needs in the appropriate setting.

Patients are required to notify the hospital during the charity care eligibility period if their financial situation changes such that their income status improves, and/or they become eligible for employer provided insurance coverage, DSHS, or other source of third party payment.

Similarly, if a patient's financial situation changes due to loss of employment or other income reduction, during the time they are in the process of paying an account balance, the patient/guarantor may notify the hospital of the change in income status and receive a consideration for a new charity care eligibility determination or for a revised charity care sliding fee discount level. If an existing account balance exists, the new charity discount level will be applied to the remaining balance(s). If the account(s) with an open balance did not previously have charity applied and there is a remaining balance after the charity care determination, the account will be placed in the post charity care contract payment financial class and a new payment arrangement notification will be sent to the patient/guarantor.

F. Adequate notice of denial:

1. When a patient's application for charity care is denied, the patient will receive a written notice of denial which includes:

   a) The reason or reasons for the denial and the rules to support the hospital's decision;
   b) The date of the decision; and
   c) Instructions for appeal or reconsideration.

2. When the applicant does not provide requested information and there is not enough information available for the hospital to determine eligibility, the denial notice also includes:

a) A description of the information that was requested and not provided, including the date the information was requested;
b) A statement that eligibility for charity care cannot be established based on information available to the hospital; and
c) That eligibility will be determined if, within thirty days from the date of the denial notice, the applicant provides all specified information previously requested but not provided.

3. The Director of Business Services and/or Chief Financial Officer will review all appeals. If this review affirms the previous denial of charity care, written notification will be sent to the patient/guarantor and the Department of Health in accordance with state law.

DOCUMENTATION AND RECORDS

A. Confidentiality: All information relating to the application will be kept confidential. Copies of documents that support the application will be kept with the application form.

B. Documents pertaining to charity care will be retained for a minimum of five (5) years for audit purposes, as required under state law.

Attachments List:

Name	Size
Approval Levels.doc	83 KB