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Mid-Valley Hospital

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 Policy Area: *Business Office*
 References:

Healthcare Assistance Program

POLICY:

Mid Valley Hospital is committed to serve, without exclusion, and to provide appropriate hospital-based medical services to all persons in need of medical attention, regardless of ability to pay. Charges that exceed a patient's ability to pay and which are not covered by any third party payment sources, including Medicare and Medicaid, shall be considered eligible for application to the Healthcare Assistance Program (HAP).

In order to protect the integrity of the operations and fulfill this commitment, the following criteria for the provisions of HAP have been established. These criteria will assist the staff in making consistent and objective decisions regarding eligibility for HAP, while ensuring the maintenance of a sound financial base.

SCOPE:

Business Office Manager, Chief Financial Officer and Administrator

RESPONSIBILITIES:

Business Office Manager, Chief Financial Officer and Administrator

CONTROL:

Business Office Manager, Chief Financial Officer and Administrator

A. POLICY AND DEFINITIONS

- Policy and definitions shall conform to those described in WAC 246-453 & RCW 70.170
- Abbreviations used in this document: Healthcare Assistance Program Application (HAPA), Patient Account Representative (PAR), Business Office Manager (BOM).

B. NOTIFICATION

- Notice shall be made publicly available through the posting of signs in public areas of the hospital that charges for services provided to those persons meeting the criteria established within WAC 246-453-040 may be waived or reduced.
- The hospital will provide written notice to all patients informing them about the availability of HAP at the time of admission or during pre-authorization process. The notice will also be verbally explained. In the case of patients receiving emergency services, the notice will be provided as soon as possible after discharge.

- Information regarding HAP will be posted on every statement generated and made available on Mid Valley Hospital and Mid Valley Medical Groups websites.

C. ELIGIBILITY CRITERIA

- HAP is always secondary to any other financial resources available to the patient including a government subsidized program, third party liability carriers or any other situation in which another person or entity may have a legal responsibility to pay for the costs of medical service.
- In those situations where appropriate primary payment sources are not available, patients may be considered for HAP based on the following criteria:
 - a. All responsible parties with family income equal to or below one hundred percent of the federal poverty standard, adjusted for family size, shall be determined to be indigent persons qualifying for HAP sponsorship for the full amount of hospital charges related to appropriate hospital-based medical services that are not covered by private or public third-party sponsorship; (WAC 246-453-040[1]). Please refer to chart at the end of this Policy.
 - b. All responsible parties with family income between one hundred one and two hundred percent of the federal poverty standard, adjusted for family size, shall be determined to be indigent persons qualifying for discounts from charges related to appropriate hospital-based medical services in accordance with the hospital's sliding fee schedule and policies regarding individual financial circumstances; (WAC 246-453-040[2]). Attached at end of this policy.
 - c. All deceased patients will be verified by certificate of death or death notice in newspaper along with verification of no estate filed with county.
 - d. Financial screening to rule out potential eligibility for Medicare or Medicaid benefits or third party liability benefits will be done prior to processing HAP applications.
 - e. If a patient has qualified for HAP and continues to receive services for an extended period of time, the hospital may require the responsible person to reapply for assistance to ensure that their income status has not changed. Applications will be reviewed at the hospital's discretion.

D. CATASTROPHIC HEALTH ASSISTANCE

- a. The hospital may also assign HAP in those instances when families with income in excess of two hundred percent of the federal poverty guidelines are in circumstances which indicate severe personal hardship or personal loss, e.g. death of primary wage earner or extreme, catastrophic medical services subsequent to the date of service. Determination shall be made on a case-by-case basis and at the discretion of the BOM, in accordance with WAC 246-453-030(3) and WAC 246-453-030(4).

PROCEDURE:

A. IDENTIFICATION OF POTENTIAL HEALTHCARE ASSISTANCE PROGRAM (HAP) RECIPIENTS AT TIME OF ADMISSION

RESPONSIBILITY: Admitting Staff

1. At time of admission or registration, admitting staff will determine the patient's responsibility to pay if the patient is uninsured. A brief screening will be conducted in the course of the registration process
2. The admitting staff will provide patients with a Healthcare Assistance Program Application (HAPA) dependent on the results of the financial screening.
3. All HAPA's will be forwarded to the Patient Account Representative (PAR) on a daily basis.

4. In the event that a patient is unable or has not been screened during the course of the admission, the financial counselor is expected to review all potential uncompensated accounts and conduct a financial screening with the guarantor and initiate HAP when appropriate.

B. PROCESSING HEALTHCARE ASSISTANCE PROGRAM APPLICATIONS (HAPA)
RESPONSIBILITY: Patient Account Representative (PAR)

- C. 1. All applications, whether initiated by the patient or hospital, should be accompanied by documentation to verify income as indicated on the application form. Any one of the following documents shall be considered sufficient evidence upon which to base the final determination of charity care eligibility:
 - a. Payroll check stubs
 - b. Bank statements for the last six months
 - c. Income tax returns for recent year with W2 withholding statements
 - d. Medicaid denial
 - e. Unemployment benefits
 - f. List of family member in your household (family includes people related by birth, marriage, or adoptions who live together).
 - g. Proof of Social Security Benefits
2. The PAR will conduct a financial screening to determine if the patient is potentially eligible for State or Federal funding, example, Medicaid or SSI Medicare. If their medical history or personal status indicates potential benefits, the guarantor will be asked to apply for this funding before processing HAPA's. During the determination process for our HAP, all collection efforts will be ceased, in accordance with WAC 246-453-020(9)(b).
3. The guarantor will be asked to provide income verification documents within 30 days from the date the patient received the HAPA, or such time as the person's medical condition may require, or such time as may reasonably be necessary to secure and to present documentation prior to receiving a final determination of sponsorship status. The failure of a responsible party to reasonably complete the appropriate application procedures shall be sufficient grounds for the hospital to initiate collection efforts directed at the patient.
4. Using the above information, the PAR will evaluate the income information and, based on the patient's ability to pay at that time and with the Sliding Payment Scale, verify the amount of write-off or denial. Refer to last page of this Policy.
5. Upon receipt of all verification documentation from the patient, the PAR shall *review* and forward the HAPA with a *recommendation* of approval or denial to the Business Office Manager (BOM).
6. After review by the BOM the PAR will send written notice to the applicant of denial or approval within fourteen (14) days. If the application is denied, the PAR will notify the patient, in writing, advising guarantor of the reason for the denial and also advising them of the appeal process.
7. If the account is approved for HAP, the PAR will change the financial class to "PAM" (Patient Account Management) which will then be presented to the Board of Commissioners for approval. If approved, the recommended balance will then be written off the account with the transaction code that corresponds to HAP in the General Ledger.

8. After determination of the HAPA, any financial obligation that is owed shall be payable in monthly installments over a reasonable period of time. The responsible party will not be turned over to a collection agency unless payments are missed and no satisfactory contact has been made with the responsible party. WAC 246-453-050(1)(c).

D. IDENTIFICATION OF HEALTHCARE ASSISTANCE PROGRAM ACCOUNTS DURING PRE-COLLECTION ACTIVITY

RESPONSIBILITY: Patient Account Representative

1. The Patient Account Representative (PAR), in the course of pre-collection activity, may identify potential HAP accounts. The PAR will send a Notice of HAP in the pre-collect letter to the patient's guarantor.
2. Upon receipt of the completed HAPA, follow guidelines as outlined in B1-B7, above.

E. HEALTHCARE ASSISTANCE PROGRAM (HAP) APPROVAL AUTHORITY LEVELS

1. All balances will be tentatively approved on a daily basis by the Business Office Manager.
2. The Board will review and approve all write-offs during regularly scheduled Board Meetings.

F. APPEAL PROCESS

1. All applications will receive written notice of denial within fourteen (14) days of HAP application. WAC 246-453-030.
2. Patients/Guarantor may appeal by writing a letter explaining why they feel the denial is inappropriate and or by supplying additional information to support a favorable decision.
3. Upon denial, the patient shall be given thirty (30) days to appeal the decision.
4. Appeals should be directed to the BOM, who will invite a review committee to and shall be responded to within ten (10) business days from date of receipt.
5. If it is found that the denial stands, the responsible party and the department of health shall be notified in writing of the decision and the basis for the decision, and the department of health shall be provided with copies of documentation upon which the decision was based.
6. The hospital should make every reasonable effort to reach initial and final determinations of HAP designation in a timely manner; however, the hospital shall make those designations at any time upon learning of facts or receiving documentation, as described in WAC 246-453-030, indicating that the responsible party's income is equal to or below two hundred percent of the federal poverty standard as adjusted for family size. The timing of reaching a final determination of HAP status shall have no bearing on the identification of HAP deductions from revenue as distinct from bad debts.
7. In the event that a responsible party pays a portion or all of the charges related to appropriate hospital based medical care services, and is subsequently found to have met the HAP criteria at the time that services were provided, any payments in excess of the amount shall be refunded to the patient within thirty days of achieving the HAP designation.

All revision dates:

Attachments:

No Attachments



Mid-Valley Hospital
 Mid-Valley Medical Group
 Carillon Total Orthopedics
 500 Harrison Street - 4th Floor, WA 99041
 509.250.1700

Notice of Availability of Healthcare Assistance Program - Effective January 25, 2016

Patient eligibility for the Healthcare Assistance Program is determined by measuring family income against the federal poverty guidelines. The current income guidelines are as follows:

Sliding Payment Scale
 based on
 Monthly Income

Family Size	Patient Pays 0% Monthly Income	Patient Pays 9% Monthly Income	Patient Pays 17% Monthly Income	Patient Pays 26% Monthly Income	Patient Pays 34% Monthly Income	Patient Pays 43% Monthly Income	Patient Pays 51% Monthly Income	Patient Pays 60% Monthly Income	Patient Pays 69% Monthly Income	Patient Pays 77% Monthly Income	Patient Pays 100% Monthly Income Over
1	0 to 990	991 to 1,188	1,189 to 1,386	1,387 to 1,584	1,585 to 1,782	1,783 to 1,980	1,981 to 2,228	2,229 to 2,475	2,476 to 2,723	2,724 to 2,970	2,971
2	0 to 1,335	1,336 to 1,602	1,603 to 1,869	1,870 to 2,136	2,137 to 2,403	2,404 to 2,670	2,671 to 2,937	2,938 to 3,204	3,205 to 3,471	3,472 to 3,738	3,739
3	0 to 1,680	1,681 to 2,016	2,017 to 2,352	2,353 to 2,688	2,689 to 3,024	3,025 to 3,360	3,361 to 3,696	3,697 to 4,032	4,033 to 4,368	4,369 to 4,704	4,705
4	0 to 2,025	2,026 to 2,430	2,431 to 2,835	2,836 to 3,240	3,241 to 3,645	3,646 to 4,050	4,051 to 4,455	4,456 to 4,860	4,861 to 5,265	5,266 to 5,670	5,671
5	0 to 2,370	2,371 to 2,844	2,845 to 3,318	3,319 to 3,792	3,793 to 4,266	4,267 to 4,740	4,741 to 5,214	5,215 to 5,688	5,689 to 6,162	6,163 to 6,636	6,637
6	0 to 2,715	2,716 to 3,258	3,259 to 3,801	3,802 to 4,344	4,345 to 4,887	4,888 to 5,430	5,431 to 5,973	5,974 to 6,516	6,517 to 7,059	7,060 to 7,602	7,603
7	0 to 3,061	3,062 to 3,673	3,674 to 4,285	4,286 to 4,897	4,898 to 5,510	5,511 to 6,122	6,123 to 6,734	6,735 to 7,346	7,347 to 7,958	7,959 to 8,570	8,571
8	0 to 3,408	3,409 to 4,089	4,090 to 4,771	4,772 to 5,452	5,453 to 6,134	6,135 to 6,815	6,816 to 7,497	7,498 to 8,178	8,179 to 8,860	8,861 to 9,541	9,542

For family units with more than eight (8) members, add \$346.67 per month for each additional member.

If you think you are eligible for the Healthcare Assistance Program and wish to request it, please make a written request to the Business Office. The Business Office will make a written determination of eligibility within fourteen (14) business days of your request, provided you have supplied the proper documentation.

The federal poverty guidelines change each year and will be reflected in this schedule when we are notified by the Department of Health.