

LAKE CHELAN COMMUNITY HOSPITAL

POLICIES AND PROCEDURES

TITLE: Charity Care

INDEX NO.: 35.31

SECTION: Business Office

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DATE INITIATED: April 1, 1985

DATE REVISED/REVIEWED: May 9, 1991 *Spurgeon*

DISTRIBUTION: Business Office

PURPOSE: The purpose of this policy on charity care accounting is to establish an accounting classification system to differentiate between bad debt and charity care, based upon the criteria established within this policy. Further, this policy and guideline is established to comply with the Department of Health Rules and the requirements of State Regulations WAC 261-14.

POLICIES: Lake Chelan Community Hospital is organized and operated under the laws of Washington State for Public Hospital Districts. As a public hospital, Lake Chelan Community Hospital does not deny care to any person in need, regardless of ability to pay. As a public institution, LCCH has historically provided charity services to persons unable to pay, treating all who pass through its doors.

Qualified uncompensated care does not include any elective or cosmetic procedures or any physician fees. Services that are eligible for payment from any other sources are not eligible for inclusion under qualified uncompensated care.

Lake Chelan Community Hospital recognizes a responsibility to carry its share of the burden of meeting the needs of medically indigent patients - those with no or inadequate means for paying for needed care under current methods of financing health care services in the United States. LCCH fulfills its legal responsibilities to provide services without charge or at reduced charges as prescribed by WAC 261-14. Also, within the limits of its means, LCCH makes other arrangements to provide highly specialized services to needy patients. Charity care will be granted to all persons regardless of race, color, sex, religion, age or national origin.

GUIDELINES & PROCEDURES:

At the time of initial admission or occasion of service the Admitting Clerk will determine the applicable payer category as follows:

- a. Group or individual medical plan.
- b. Worker's compensation.
- c. Medicare.
- d. Medicaid/Medical assistance program.
- e. Private pay.

For those patients covered by medicare or medicaid, charges incurred are exempt from any classifications of qualified uncompensated care except those portions which are the responsibility of the patient. Medicare and Medicaid contractual adjustments may not be classified uncompensated care as separate accountability is established for contractual adjustments.

Requests to provide charity care will be accepted from sources such as physician, community or religious groups, social services, financial services personnel, or the patient. If the hospital becomes aware of factors which might qualify the patient for charity care under this policy, it shall advise him or her of this potential and make an initial determination that such account is to be treated as charity care.

In those situations where appropriate primary payment sources are not available, patients shall be considered for charity care under this hospital policy based on the following criteria as calculated for the 6 months prior to the date of request and up until the determination of the charity care credit is made:

1. The full amount of hospital charges will be determined to be charity care for any patient whose gross family income is at or below 100% of the current federal poverty guidelines (consistent with WAC 261-14-027.)
2. For those patients whose incomes fall between the 100% and 200% of the current federal poverty guidelines a determination will be made using the sliding fees schedule adopted by the hospital. (See attached schedule).

Available assets are used to determine eligibility for charity care if family income is greater than 100% of the federal poverty guideline. This will also be done on a case by case basis.

LCCH may also write-off as charity care amounts for patients with family income in excess of 200% of the federal poverty standards when circumstances indicate severe financial hardship or personal loss. Again, this will be evaluated on a case by case basis.

ABILITY TO PAY:

In determining a patient's ability to pay, many factors are pertinent and once the account has been deemed uncollectible a review of that account will be undertaken to determine the appropriate classification (i.e., bad debt or qualified uncompensated care) to assign that account. In determining appropriate assignment the following factors will be used to determine ability to pay:

1. Gross income should fall within established or recognized standards for determination of poverty level, considering family size, geographic area, and other pertinent factors. (Some persons may exceed property income levels but still qualify for charity services when additional criteria are considered).
2. Net worth would be considered including all liquid and non-liquid assets owned, less liabilities and claims against assets.

3. Employment status along with future earnings capacity. The includes the likelihood of future earnings sufficient to meet the obligation within a reasonable period of time.
4. Family size.
5. Analysis of other financial obligations including living expenses and other items of a reasonable and necessary nature.
6. The amount (s) and frequency of the hospital bill (s) in relation to all of the factors outlined above.
7. Application of all other resources should first be applied, including Medicaid, Welfare, and other third party sources.

In those cases where write-off of only a portion of the account is indicated only that portion will be classed as qualified uncompensated care, with the balance still being owed to the hospital, being further subjected to collection activity or other appropriate action as outlined in the LCCH collections manual.

QUALIFIED UNCOMPENSATED CLASSIFICATIONS:

It must be reemphasized that because a person has an unpaid bill which may totally or partially qualify for classification under qualified uncompensated care, that collection activity will not automatically be terminated and the charges written off against qualified uncompensated care. In many cases, the size of the bill and the overall ability of the patient to pay that bill must be taken into consideration.

Persons with incomes below 200% of the federal poverty guideline level will not automatically be eligible for dismissal of their bill under qualified uncompensated care, or a portion of their bill. The amount of the charge is important in a determination of the overall ability to pay that charge in full. This must be determined first. All determinations in cases of failure to pay hospital bills must be made on an individual basis and a decision made as to the classification of the individual's ability to pay and whether to apply the criteria outlined within this policy.

All write-offs will be individually determined based upon each individual's particular circumstances and ability to pay. Guidelines will be established for review of certain accounts by dollar size, within the financial management structure of the hospital.

When an account is determined to be uncollectible or an obvious inability to pay exists (based upon financial data provided), it will be classified into bad debt or qualified uncompensated care, according to the guidelines contained within this policy. This is done after a final determination has been made that no further collection activity will be made.

In all cases, consideration will be given to referring individuals for bank loans, appropriate hospital loans, and one year hospital notes.

FINAL DETERMINATIONS:

Charity care forms, instructions, and written applications shall be furnished to patients when charity care is requested, when need is indicated, or when financial screening indicates potential need. All applications, whether initiated by the patient or the hospital should be accompanied by documentation to verify income amounts indicated on the application form. One or more of the following types of documentation may be acceptable for purposes of verifying income:

1. W-2 withholding statements for all employment during the relevant time period;
2. Pay stubs from all employment during the relevant time period;
3. An income tax return from the most recently-filed calendar year;
4. Forms approving or denying eligibility for Medicaid and/or state-funded Medical Assistance;
5. Forms approving or denying unemployment compensation; or
6. Written statements from employers or welfare agencies.

Patients will be asked to provide verification of ineligibility for Medicaid or Medical Assistance. During the initial request period, the hospital may pursue other sources of funding, including Medicaid.

Income shall be annualized from the date of application based upon documentation provided and upon verbal information provided by the patient. The annualization process will be determined by the hospital and will take into consideration seasonal employment and temporary increases and/or decreases of income.

The hospital shall provide final determination within fourteen days of receipt of all application documentation material.

Denials will be written and include instructions for appeal or reconsideration as follows. The patient/guarantor may appeal the determination of eligibility for charity care by providing additional verification of income or family size to the Director of Patient Accounts within fourteen days of receipt of notification. All appeals will be reviewed by the Director of Business Office Services. If this determination 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:

All information relating to the application will be kept confidential. Copies of documents that support the application will be kept with the application form. Documents pertaining to charity care shall be retained with the patient accounts folder for seven years.

NOTIFICATION:

The hospital's charity care policy shall be publicly available through the posting of a sign and the distribution of written materials indicating the policy to patients at the time that the hospital requests information pertaining to third party coverage. Copies of these documents shall also be made available (per WAC 261-14-020) in Spanish as it has been determined that more than 10% of the districts population speaks this language.

TABLE I
 PAYMENT SCHEDULE
 CHARITY CARE ELIGIBLE PATIENTS*

	0	15%	30%	45%	60%	75%	100%
FAMILY GROSS MONTHLY SIZE FAMILY INCOME:							
1 Less than \$552		\$552-634	\$634-718	\$718-800	\$800-883	\$883-966	\$966-Over
2 Less than \$740		\$740-851	\$851-962	\$962-1073	\$1073-1184	\$1184-1295	\$1295-Over
3 Less than \$928		\$928-1067	\$1067-1206	\$1206-1346	\$1346-1485	\$1485-1624	\$1624-Over
4 Less than \$1117		\$1117-1285	\$1285-1452	\$1452-1619	\$1619-1787	\$1787-1955	\$1955-Over
5 Less than \$1305		\$1305-1501	\$1501-1697	\$1697-1892	\$1892-2088	\$2088-2284	\$2284-Over
6 Less than \$1493		\$1492-1717	\$1717-1941	\$1941-2163	\$2163-2389	\$2389-2613	\$2613-Over
7 Less than \$1682		\$1682-1934	\$1934-2187	\$2187-2439	\$2439-2691	\$2691-2944	\$2944-Over
8 Less than \$1870		\$1870-2151	\$2151-2431	\$2431-2712	\$2712-2992	\$2992-3273	\$3273-Over

*Based on 1991 Federal Poverty Guidelines

TABLE 2 (UPDATED)

1991 POVERTY INCOME GUIDELINES FOR ALL STATES (EXCEPT ALASKA AND HAWAII) AND THE DISTRICT OF COLUMBIA

Size of family Unit	Poverty Guideline
1	\$6,620
2	8,880
3	11,140
4	13,400
5	15,660
6	17,920
7	20,180
8	22,440

For family units with more than 8 members, add \$2,260 for each additional member.

TABLE 3

1991 FEDERAL POVERTY GUIDELINES: GROSS ANNUAL INCOME

FAMILY SIZE	Federal Poverty Guidelines	
	100% \$*	200% \$*
1	\$6,620	\$13,240
2	8,880	17,760
3	11,140	22,280
4	13,400	26,800
5	15,660	31,320
6	17,920	35,840
7	20,180	40,360
8	22,440	44,880

* \$1,800.00 for each additional family member