QUINCY VALLEY MEDICAL CENTER	Ref. #:	Original Date: May 25, 2004	Effective Date: July 1, 2022	Supercede Date May 4, 2018
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APPROVALS: Glenda L. Bishop Administrator		**SUBJECT:** "Financial Assistance" (Charity Care)		
		_ Policy	_ Procedure	_ Protocol
Manual Distribution Business Office	**Originating Departments:** Administration		**Affected Departments:** Business Office (Registration)	

Background
Under Washington law, each hospital must develop a charity care policy. The law requires hospitals to provide free inpatient and outpatient care to very low income patients who have been treated in the hospital. It also requires that hospitals provide discounts to other low income patients. Whether or not a person qualifies for financial assistance often depends on how the person's income compares to the federal poverty guidelines.

Washington State Department of Health (DOH) is responsible for rule-making and monitoring related to charity care and is required to report to the legislature and governor on an annual basis.

Washington's charity care law was established in 1989; the law can be found in the Revised Code of Washington, Chapter 70 Section 170: http://apps.leg.wa.gov/RCW/default.aspx?cite=70.170

The rules implementing the law can be found in the Washington Administrative Code at Chapter 246, Section 453: http://apps.leg.wa.gov/WAC/default.aspx?cite=246-453

Purpose of the Policy
To meet the requirements of State law in providing access to quality health care services to those classified as indigent persons, and in compliance with Substitute House Bill 1616 (SHB1616).

Definitions:
(1) "Indigent persons" means those patients or their guarantors who qualify for charity care based on the federal poverty level, adjusted for family size, and who have exhausted any third-party coverage.
(2) "Third-party coverage" and "third-party sponsorship" means an obligation on the part of an insurance company or governmental program which contracts with hospitals and patients 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 which have resulted in the medical condition for which the patient has received hospital services;
(3) "Responsible party" means that individual who is responsible for the payment of any hospital charges which are not subject to third-party sponsorship;
(4) "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;
(5) "Family" means a group of two or more persons related by birth, marriage or adoption who live together; all such related persons are considered as members of one family;
(6) "Hospital" shall refer to Grant County Public Hospital District #2 dba Quincy Valley Medical Center.

Policy:

(1) The initiation of collection efforts directed at the responsible party shall be precluded pending an initial determination of sponsorship status; collection efforts include demand for payment or transmission of account documents or information which is not clearly identified as being intended solely for the purpose of transmitting information to the responsible party;

(2) The initial determination of sponsorship status shall be completed at the time of admission or as soon as possible following the initiation of services to the patient;

(3) If the initial determination of sponsorship status indicates that the responsible party may meet the criteria for classification as an indigent person (as defined above), collection efforts directed at the responsible party will be precluded pending a final determination of that classification, provided that the responsible party is cooperative with the hospital's reasonable efforts to reach a final determination of sponsorship status;

(4) During the pendency of the initial determination of sponsorship status and/or the final determination of the applicability of indigent person criteria, hospitals may pursue reimbursement from any third-party coverage that may be identified to the hospital.

(5) Any responsible party who has been initially determined to meet the criteria identified within this policy shall be provided with at least fourteen calendar days or such time as the person's medical condition may require, or such time as may be reasonable be necessary to secure and to present documentation as described below prior to receiving a final determination of sponsorship status.

(6) Medicaid and Health Benefit Exchange Obligations: Identification of Patients Eligible for Certain Third Party Coverage: For services provided to patients on or after July 1, 2022, the following procedures will apply for identifying patients and/or their guarantors who may be eligible for health care coverage through Washington medical assistance programs (e.g., Apple Health) or the Washington Health Benefit Exchange:

1. As a part of the charity care application process for determining eligibility for financial assistance and charity care, QVMC will query as to whether a patient or their guarantor meets the criteria for health care coverage under medical assistance programs under chapter 74.09 RCW or the Washington Health Benefit Exchange.

2. As part of the Financial Assistance application process, QVMC staff also work with patients/families who do not have applicable Third-Party Coverage to assess whether such patients/families may be eligible for Medicaid and/or health care coverage through Washington's Health Benefit Exchange (RCW 43.71). Staff will provide assistance with Medicaid and Qualified Health Plan applications, and including but not limited to providing the patient/family with information about the application process, assisting patients through the application process, providing necessary forms that must be completed, and/or connecting the patient/family with other agencies or resources who can assist the patient/family in completing such applications.

a. In providing assistance to the application process, QVMC will take into account any physical, mental, intellectual, sensory deficiencies or language barriers which may hinder either the patient or their guarantor from complying with the application procedures and will not impose procedures on the patient or guarantor that would constitute an unreasonable burden.

3. If the patient or guarantor fails to make reasonable efforts to cooperate with QVMC in applying for coverage under chapter 74.09 RCW or the Washington Health Benefit Exchange, QVMC is not obligated to provide charity care to such patient.

4. If a patient or their guarantor is obviously or categorically ineligible or has been deemed ineligible for coverage through medical assistance programs under chapter 74.09 RCW or the Washington Health Benefit Exchange in the prior 12 months, QVMC will not require the patient or their guarantor to apply for such coverage.

(7) Potential indigent persons shall use the hospital's application process attesting to the accuracy of the information provided for purposes of determining the individual's qualification for financial assistance/charity care sponsorship. The hospital will not impose application procedures for financial assistance/charity care sponsorship which place an unreasonable burden upon the responsible party, taking into account any physical, mental, intellectual or sensory deficiencies or language barriers which may hinder the responsible party's capability of complying with the application procedures. The failure of a responsible party to reasonably complete appropriate application procedures shall be sufficient grounds for the hospital to initiate collection efforts directed at the patient.

(8) The hospital will not require deposits from those responsible parties meeting the criteria indicated through an initial determination of sponsorship status.

(9) The hospital will notify persons applying for financial assistance/charity care sponsorship of their final determination of sponsorship status within fourteen calendar days of receiving information in accordance with the application. This notification will include a determination of the amount for which the responsible party will be held financially accountable.

(10) In the event that the hospital denies the responsible party's application for financial assistance/charity care sponsorship, the hospital must notify the responsible party of the denial and the basis for that denial.

(11) Responsible parties shall be notified that they have thirty calendar days within which to request an appeal of the final determination of sponsorship status. 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 the hospital has initiated collection activities and discovers an appeal has been filed, they shall cease collection efforts until the appeal is finalized.

(12) In the event that the hospital's final decision upon appeal affirms the previous denial of financial assistance/charity care, 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. The Department will review the instances of denials of financial assistance/charity care. In the event of an inappropriate denial of financial assistance/charity care, the Department may seek penalties as provided in RCW 70.170.070.

(13) 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 financial assistance/charity care criteria at the time that services were provided, 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.

Requirements for the identification of indigent persons

(1) For purpose of reaching an initial determination of eligibility for financial assistance/charity care, the hospital shall rely upon information provided orally by the responsible party. The hospital will require the responsible party to sign a statement attesting to the accuracy of the information provided to the hospital for purposes of the initial determination of eligibility.

(2) Any one of the following documents shall be considered sufficient evidence upon which to base the final determination of financial assistance/charity care eligibility 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
(f) Written statements from employers or welfare agencies

(3) In the event that the responsible party's identification as an indigent person is obvious to hospital personnel, and the hospital personnel are able to establish the position of the income level within income ranges included in the hospital's Charity Care Policy, the hospital is not obligated to establish the exact income level or to request the aforementioned documentation from the responsible party, unless the responsible party requests further review.
(4) In the event that the responsible party is not able to provide any of the documentation described above, the hospital shall rely upon written and signed statements from the responsible party for making a final determination of eligibility for classification as an indigent person.
(5) Information requests from the hospital to the responsible party for the verification of income and family size shall be limited to that which is reasonably necessary and readily available to substantiate the responsible party's qualification for charity sponsorship and may not be used to discourage applications for such sponsorship. Only those facts relevant to eligibility may be verified, and duplicate forms of verification shall not be demanded.

How to Apply
Quincy Valley Medical Center will notify all patients of the organization's FAP (Financial Assistance Policy) and provide an application to all patients/guarantors that request consideration. Each patient will have an initial consultation to determine eligibility. At the time of the review, Quincy Valley Medical Center will determine if there are any other programs that the patient may be eligible for.

Write Off Approval
All write offs will be approved by the Patient Accounts Manager, the CFO, the Finance Committee and the Board of Commissioners.

On an annual basis, the Patient Accounts Manager will update the write off schedule based on the most recent approved poverty guidelines.

Write Off Calculations

1. The full amount of patient or guarantor responsibility for hospital charges will be determined to be charity care for a patient or their guarantor whose income is at or below 200% of the current federal poverty level, adjusted for family size.
   a. QVMC will not consider the value of assets to reduce charity care discounts for individuals in this category.
2. Seventy-five percent of patient or guarantor responsibility for hospital charges will be determined to be charity care for a patient or their guarantor whose income is between 201% and 250% of the current federal poverty level, adjusted for family size.
   a. QVMC will not consider the value of assets to reduce charity care discounts for individuals in this category.
3. Fifty percent of uncovered hospital charges will be determined to be charity care for a patient or their guarantor whose income is between 251% and 300% of the current federal poverty level, adjusted for family size.
   a. QVMC will not consider the value of assets to reduce charity care discounts for individuals in this category.

This Financial Assistance/Charity Care Policy shall be applicable to accounts generated by the hospital (inpatient and outpatient services) and those services provided by the hospital-based Rural Health Clinic referred to as SageView Family Care.

In the event of non-payment, Quincy Valley Medical Center's "*Collection of Self Pay Accounts*" will be applied. All information used to determine eligibility will be provided by patient/guarantor. Quincy Valley Medical Center uses no other information to presumptively determine an individual's eligibility for financial assistance.

All services provided by Quincy Valley Medical Center are considered eligible under the organization's Financial Assistance Policy.

References: 70.170 RCW and WAC 246-453