

Document Title: Financial Assistance – Hospital Based Services

Scope:

This policy applies to patients who qualify for Charity Care or Financial Assistance for the services received within the Hospital facilities of MultiCare Health System (“MHS”) as provided by MHS.

Locations include Tacoma General/Allenmore Hospital, Mary Bridge Children’s Hospital, Good Samaritan Hospital, Auburn Medical Center, Covington Medical Center, Deaconess Hospital, Valley Hospital, Home Health and Hospice, Navos Behavioral Health Center and Capital Medical Center.

Policy Statement:

MHS is guided by a mission to provide high quality, patient-centered care. We are committed to serving all patients, including those who lack health insurance coverage or who cannot pay for all or part of the essential care they receive. We are committed to treating all patients with compassion. We are committed to maintaining Financial Assistance policies that are consistent with our mission and values and that take into account an individual’s ability to pay for medically necessary health care services.

Definitions:

1. **Collection Efforts** and **Extraordinary Collections Actions** (ECA) are defined by the MHS Collection Guidelines policy.
2. **Charity Care** and/or **Financial Assistance** means medically necessary hospital health care rendered to Eligible Persons when Third-Party Coverage, if any, has been exhausted, to the extent that the persons are unable to pay for the care or to pay deductible or coinsurance amounts required by a third-party payer based on the criteria in this policy. When communicating with patients, the phrase “Financial Assistance” will be used in lieu of “Charity Care.” Both terms are synonymous with one another for the purposes of this policy and MHS billing statements.
3. **Eligible Person(s)** is defined as those patients who have exhausted any third-party sources and whose income is equal to or below 500% the federal poverty standards adjusted for family size.
4. **Emergency Medical Conditions** (EMC) are defined by the MHS Emergency Medical Treatment and Active Labor Act (EMTALA), Compliance With policy, which is consistent with WAC 246-453-010.
5. **Family** is defined per WAC 246-453-010 (18) as a group of two or more persons related by birth, marriage or adoption that live together; all such related persons are considered as members of one family.
6. **Income** is defined per WAC 246-453-010(17) as 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.

	<p>7. Medically Necessary is defined per WAC 246-453-010 (7) as appropriate hospital-based medical services.</p> <p>8. Responsible Party means that individual who is responsible for the payment of any hospital charges not otherwise covered by a funding source as described below.</p>
	<p>Policy Guidelines:</p> <p>This policy provides a guideline for making consistent and objective decisions regarding eligibility for Financial Assistance. Financial Assistance is available for medically necessary hospital-based health care services (to include emergency care) provided by MultiCare Health System.</p> <p>Emergency care will be provided to patients with Emergent Medical Conditions regardless of their ability to pay. MHS shall allocate resources to identify charity cases and provide uncompensated care per RCW 70.170 and WAC 246- 453. See MHS Policy: Emergency Medical Treatment and Active Labor (EMTALA), Compliance With.</p> <p>MHS supports the state-wide voluntary pledge of hospitals to provide Financial Assistance to Eligible Persons in accordance with the methodology provided and updated annually by the Washington State Hospital Association.</p> <p>Consideration for Financial Assistance will be given equally to all Eligible Persons, regardless of race, color, sex, religion, age, national origin, veteran’s status, marital status, sexual orientation, immigration status or other legally protected status. See MHS Policy: Patient Nondiscrimination</p> <p>All information relating to the Financial Assistance application is confidential and protected by HIPAA guidelines. See HIPAA Privacy Compliance – Administrative policy.</p> <p>Lists of providers accepting and not accepting Financial Assistance are available at https://www.multicare.org/financial-assistance/ .</p> <p>This policy describes the processes for evaluating applications and awarding Financial Assistance for free and discounted care at the following levels based on the Federal Poverty Limit (FPL) adjusted for family size:</p> <ol style="list-style-type: none"> 1. 100% Financial Assistance - Income levels at or below 300% of the (FPL); or 2. Sliding Scale Financial Assistance - Income levels between 300.5% and 500% of the FPL.
	<p>Procedure:</p> <p>I. Eligibility Criteria</p> <p>In order for a Responsible Party to be considered eligible for Financial Assistance, the following criteria must be met:</p> <p>A. Exhaustion of All Funding Sources</p> <ol style="list-style-type: none"> 1. Any of the following sources must first be exhausted before a Responsible Party will be considered for Financial Assistance: <ol style="list-style-type: none"> a. Group or individual medical plans b. Workers’ compensation programs

- c. Medicaid programs
- d. Other state, federal or military programs
- e. Third party liability situations (e.g., auto accidents or personal injuries)
- f. Tribal health benefit programs
- g. Health care sharing ministry programs
- h. Any other persons or entities having a legal responsibility to pay
- i. Health saving account (HSA) funds. MHS may require a Responsible Party to fully utilize any available funds from HSA to satisfy outstanding balances.
- j. MHS will pursue payment from any available Funding Source. The remaining patient liability will be eligible for Financial Assistance based on the criteria in this policy.

B. *Accurate Completion of Financial Assistance application.*

- 1. Incomplete applications will be denied. Patients may appeal the denial and provide the missing information per the guidelines set forth below.
- 2. If the application places an unreasonable burden, 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 on the Responsible Party, then the application process will not be imposed.

C. *Medicaid Eligibility Within 90 Days of Services in Lieu of Application*

- 1. A determination of Medicaid eligibility within (90) days of date of services may replace the Financial Assistance application and may be used to qualify the Responsible Party for 100% Financial Assistance except for spend down amounts. Proof of eligibility will be the presence of Medicaid coverage during the applicable timeframe in the patient's coverage record in Epic.

D. *Presumptive determination or Extraordinary Circumstances*

- 1. The Responsible Party may qualify for Financial Assistance based on a presumptive determination or extraordinary life circumstances, as outlined below.

E. *Medically Necessary Health Care Services Rendered*

- 1. The services provided to the patient must be medically necessary and not elective.
- 2. Scheduled services that appear to not be medically necessary will be reviewed by Utilization Management prior to the date of service to determine medical necessity.

F. *International Patients*

- 1. Eligibility determinations for International Patients for non-emergent services will be considered on a case-by-case basis by a committee representing Physician Leadership, Revenue Cycle and Finance.

II. Proof of Income: Income will be evaluated based on the following criteria:

A. Income Verification

1. Any of the following types of documentation will be acceptable for purposes of verifying income:
 - a. W2 withholding statements
 - b. Payroll check stubs
 - c. Most recent filed IRS tax returns
 - d. Determination of Medicaid and/or state-funded medical assistance
 - e. Determination of eligibility for unemployment compensation
 - f. Written statements from employers or welfare agencies
2. For Social Security and Pension benefits, bank statements may be used to demonstrate the consistent monthly deposit.
3. In the event the Responsible Party is unable to provide the documentation described above, MHS must rely upon the written and signed statements from the Responsible Party for making a final determination of eligibility.
4. MHS may also use third party verification of ability to make a presumptive determination and apply a charity discount without receiving a financial assistance application.

B. Calculation of Income

1. MHS will use the following guidelines to calculate income:
 - a. All Family income will be included in the calculation.
 - b. Based on the type of documentation provided, the income will be calculated to represent a twelve (12) month period.

C. Timing of Determination

1. Income will be determined as of the time the services were provided.
2. Income at the time of application for Financial Assistance will be considered if the application is made within two years of the time the services were provided and the Responsible Party has been making good faith efforts towards payment for the services.

III. Process for Determination of Eligibility

- A. At the time of registration or as soon as possible following the initiation of services, MultiCare will make an initial determination of eligibility following the patient's review of the FPL grid. If a patient is determined to likely fall below 300% of the FPL, they will not be asked for payment and will be referred to a Patient Financial Navigator (PFN), who will provide additional information about Financial Assistance and other programs that may be available to the patient.
- B. Collection activity will cease for 30 calendar days for patients believed to be under 300% of the FPL and the Responsible Party will be asked to complete a Financial Assistance application. If no application is received within 30 days, collection activity will resume.

- C. When an application is received, a PFN will review the application to determine eligibility.
- D. Incomplete applications will be denied. The Responsible Party will be provided a letter specifying missing information and may Appeal the decision per the requirements below.
- E. A written notice of determination will be sent to the applicant within fourteen (14) calendar days from receipt of the complete application.
- F. If approved, this notice will include the amount for which the Responsible Party is financially responsible, if any.
- G. Approvals will be valid for 180 days and a new application will be required after such time. Awards to Eligible Persons on fixed incomes like Social Security shall be approved for one (1) year, at the discretion of the PFN reviewing the application.

IV. Appeals

- A. The Responsible Party may appeal the determination by providing additional verification of income or family size within thirty (30) calendar days of receipt of the determination.
- B. MultiCare will respond to the appeal within fourteen (14) calendar days from receipt of the appeal.
- C. All appeals will be reviewed and approved or denied by the Manager or Director, Patient Financial Navigation.
- D. If an appeal is denied, it will be presented to the AVP, Financial Clearance, Vice President of Revenue Cycle or Chief Financial Officer (CFO) for final determination. If this determination affirms the previous denial of Financial Assistance, written notification will be sent to the Responsible Party and the Department of Health in accordance with state law.
- E. Collection efforts will be suspended during the thirty (30) calendar day appeal period and the fourteen (14) calendar day appeal review period.

V. Application of Financial Assistance Discount Levels

- A. Financial Assistance applies to combined balances for all open accounts for the Responsible Party at time of application submission. The amount owed by an Eligible Person qualifying under this Financial Assistance policy will not exceed amounts generally billed to a Responsible Party not receiving assistance. The method used to calculate the discount to an Eligible Person's balance will be based on an annual retrospective analysis. A rate will be determined for each hospital. This will be calculated using a Look-Back Method pulling a year of claims that have paid in full for Medicare and private/commercial health insurance Responsible Party to determine the "Amount Generally Billed". Patients may obtain information about the Amounts Generally Billed calculations free of charge by calling 800-919-1936.
 - 1. Balances will be considered for Financial Assistance based on the FPL guidelines in Appendix A.
 - 2. If an Eligible Person's residence is in Hawaii or Alaska, the associated FPL guidelines for those states will be utilized to make the determination of assistance.

- B. Financial Assistance adjustments will be considered on an individual account balance basis. Approvals on adjustments will be authorized as follows:
1. Patient Financial Navigators: \$0.01 - \$4,999
 2. Supervisor: \$5,000 - \$49,999
 3. Manager/Director: \$50,000 - \$99,999
 4. AVP: \$100,000 - \$499,999
 5. Vice President: \$500,000 - \$999,999
 6. SVP, CFO: \$1,000,000 - \$2,999,999
- C. The volume of applications and adherence to this policy will be tracked and audited on a monthly basis. This report will be reviewed and signed by the Vice President of Revenue Cycle or AVP, Financial Clearance.

VI. Presumptive Eligibility

- A. Eligibility may be determined presumptively.
1. MHS may utilize third party vendor software or software applications to determine an account's collectability. This is a "soft" credit check and will not impact the Responsible Party's credit standing.
 2. If these reviews determine the patient may be at 300% or below of the FPL, an adjustment will be taken automatically assuming the account otherwise qualifies for Financial Assistance.

VII. Extraordinary Life Circumstances

- A. Extraordinary Life Circumstances may also warrant Financial Assistance. Examples of such circumstances may include:
1. **Homeless Persons:** A Homeless person is an individual who has no home or place of residence and depends on charity or public assistance. Such individuals will be eligible for Financial Assistance, even if they are unable to provide the documentation required for the Financial Assistance application.
 2. **Deceased Patients:** The charges incurred by a patient who expires may still be considered eligible for Financial Assistance. For the Financial Assistance application, the deceased patient will count as a family member. Accounts in an "Estate" status or situations where the estate has not been opened are not eligible for Financial Assistance until the Estate is settled.
 3. **Inmates:** Responsible Party who is incarcerated may be considered eligible in the event the State or County has made a determination that the State or County is not responsible for charges and the inmate/patient is responsible for the bill. Charges incurred while in custody are usually paid through the Law Enforcement Agency and would not qualify for Financial Assistance.
 4. **Catastrophic Determinations:** Responsible Party may qualify for a Catastrophic Discount. Only medically necessary services are eligible for a Catastrophic Discount. A Catastrophic event will be determined on a case-by-case basis. Catastrophic cases may include extraordinary medical expenses or hardship situations. All income and non-income resources are considered in the determination, to include the Responsible Party's future income earning

potential, especially where his or her ability to work may be limited as a result of illness and/or their ability to make payments over an extended period of time. All of the debt or a portion of the debt may qualify for Financial Assistance. The Director or Manager of Patient Financial Navigation will assist in making a catastrophic event application determination.

- B. Requests for Financial Assistance may originate from other sources including a physician, community or religious groups, social services, financial services personnel, and/or the Responsible Party.

VIII. Individuals that Qualify for Medical Assistance Programs

- A. MHS takes the following steps to identify patients or guarantors that may qualify for medical assistance programs under RCW 74.09:

1. Patient Financial Navigators review completed financial assistance applications and will follow up with patients or guarantors that appear to qualify for medical assistance programs.
2. Navigators are available on site at MHS hospital facilities, including our off-campus emergency departments, to identify and screen patients and their guarantors.
3. All self-pay patients admitted to an MHS hospital facility are screened to determine if they qualify for any medical assistance programs.
4. Patients may be referred for screening for coverage or medical assistance programs by Care Managers, Registration staff, and providers.
5. Certified Navigators are located throughout MHS and are available at no cost to help customers sign up for coverage through Washington Healthplanfinder. This service is available to anyone searching for a health plan—not only MHS patients.

- B. Once a patient or guarantor is identified as potentially being eligible for a medical assistance program:

1. The patient is screened by a Navigator, who helps determine eligibility for public health care coverage based on household size and income.
2. If the patient's eligibility is confirmed, then a Navigator will partner with the patient and assist the patient in applying for the appropriate health plan.
3. The patient account is flagged to ensure no billing occurs while the application is pending.

- C. MHS is not obligated to provide financial assistance if a patient or their guarantor qualifies for retroactive health care coverage under RCW 74.09 and the patient or their guarantor fails to make reasonable efforts to cooperate with a Navigator's attempts to assist them in applying for such coverage. (RCW 70.170.060(5)).

IX. Collection Efforts for Outstanding Patient Accounts

- A. MHS will not initiate collection efforts or requests for deposits, provided that the Responsible Party within a reasonable time is cooperative with the system's efforts to reach a determination of Financial Assistance eligibility status. ECA may only be initiated after the Notification Period, in accordance with the MHS Policy: Collection

Guidelines, Patient Accounts.

- B. The Responsible Party's financial obligation remaining after application of the sliding fee schedule will follow regular collection procedures to obtain payment, pursuant to Policy.
- C. In the event that a Responsible Party pays a portion or all of the charges related to medically necessary health care services, and is subsequently found to have met the Financial Assistance criteria, any payments for services above the qualified amount will be refunded to the Responsible Party within 30 days of the eligibility determination.

X. Staff Training

- A. All relevant and appropriate staff supporting Hospital based locations who perform registration, admission, billing, or other related functions shall participate in standardized training based on this Financial Assistance Policy and the use of interpreter services to assist persons with limited English proficiency and non-English-speaking persons in understanding information about the availability of Financial Assistance.
- B. The training shall help ensure staff can answer Financial Assistance questions effectively, obtain any necessary interpreter services, and direct inquiries to the appropriate department in a timely manner.

XI. Dissemination of MHS Financial Assistance Policy

- A. All patients are provided with information about the availability of Financial Assistance upon registration. Additional copies can be requested from the Hospital Financial Navigators or Patient Access Techs within the hospital facilities.
- B. Notices in all languages spoken by more than 10 percent of the population advising patients of the availability of Financial Assistance will be posted in key public areas of the hospital, including Admissions and/or Registration, the Emergency Department, Billing and Financial Services.
- C. This policy, the application, and a plain language summary are available to patients free of charge by contacting 800-919-1936.
- D. Financial counselors are available to discuss Financial Assistance options in person at all hospital locations or over the phone for other areas of the health system.
- E. Billing Statements sent to Responsible Parties will contain information regarding the availability of Financial Assistance in both English and Spanish.
- F. Written materials are available in English, Spanish, Russian and Vietnamese. .
- G. Wide-reaching community notifications will occur in the following ways:
 - 1. Available at registration areas of all hospital facilities,
 - 2. On MHS website www.multicare.org
 - 3. Communications provided to our community partners for distribution, and
 - 4. Upon request, by calling 800-919-1936

Related Forms:

Proof of Income for Financial Assistance Instruction Sheet Financial Assistance Application Financial Assistance Letter to Patients Patient Brochure Containing Plain Language Summary	
Appendix A: Financial Assistance	
References: RCW 70.170 WAC 246-453 Federal Register Vol 79, December 31, 2014 Final Rule	
Point of Contact: AVP, Financial Clearance, rcardenas@multicare.org	
Approval By: Finance Leadership Corporate Compliance Leadership System Policy Council MHS Quality Safety Steering Council	Date of Approval: 12/18, 4/21, 10/21, 4/22 12/18, 4/21, 10/21, 4/22 4/22 7/12, 8/13, 7/14, 4/15, 9/19, 5/21, 12/21, 5/22
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Reviewed with no Changes Dates:	X/XX; X/XX

Previously Titled: Charity Care and Financial Assistance (prior to 9/14)

Financial Assistance
Appendix A
2022

FAMILY SIZE	Gross Annual Income	300%	350%	400%	450%	500%
1	\$13,590	\$40,770	\$47,565	\$54,360	\$61,155	\$67,950
2	\$18,310	\$54,930	\$64,085	\$73,240	\$82,395	\$91,550
3	\$23,030	\$69,090	\$80,605	\$92,120	\$103,635	\$115,150
4	\$27,750	\$83,250	\$97,125	\$111,000	\$124,875	\$138,750
5	\$32,470	\$97,410	\$113,645	\$129,880	\$146,115	\$162,350
6	\$37,190	\$111,570	\$130,165	\$148,760	\$167,355	\$185,950
7	\$41,910	\$125,730	\$146,685	\$167,640	\$188,595	\$209,550
8	\$46,630	\$139,890	\$163,205	\$186,520	\$209,835	\$233,150
9	\$51,350	\$154,050	\$179,725	\$205,400	\$231,075	\$256,750
10	\$56,070	\$168,210	\$196,245	\$224,280	\$252,315	\$280,350
EACH ADD'L	\$4,720					

Poverty Level, Up To					
	300%	350%	400%	450%	500%
Charity Discount, %					
	100%	95%	90%	80%	70%
Patient Responsibility, %					
	0%	5%	10%	20%	30%