Status Active PolicyStat ID 17516310

Effective	11/2000
Approved	02/2025
Last Revised	10/2024
Due For Review	02/2026
Owner	Jana Symonds: Director of Revenue Cycle
Policy Area	Business Office

Health Care Assistance Policy and Procedure

Purpose

To provide guidelines for the determination of eligibility for Mid Valley Hospital and Mid Valley Medical Group's (MVH) Charity Care program also known as Health Care Assistance Program (HAP)

Definitions

Policy and definitions shall conform to those described in WAC 246-453 **& RCW 70.170**

Annual- Occurring once every year

Annual Income- A measure of a household's gross annual cash receipts before taxes derived from wages and salaries, welfare payments, social security payments, strike benefits, unemployment or disability payments, child support, alimony and net income from business and investment activities paid to the individual. the following income sources should also be factored into calculating total gross income: freelancing, side jobs, consulting, tips, self-employment, selling goods on on-line storefronts, selling items at a craft fair or similar venue, rental property income, interest/dividends or capital gains from investments, alimony, royalties, oil/gas/mineral rights, gambling or lottery winnings, etc.

Catastrophic Charity Care-Catastrophic Charity. MVH may write off debts as charity care for patients with family income in excess of 300 % of the federal poverty level when circumstances indicate severe financial hardship or personal loss.

Charity Care-Charity Care means medically necessary health care rendered to indigent 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.

DRC- Director of Revenue Cycle

Family-Family is define as a group of two or more persons related by birth, marriage or adoption, who

live together, all such persons are considered members of one family. Adult children living with their parents will be considered their own guarantor.

Federal Poverty Guideline- **(FPG)** is a poverty threshold issued by the Department of Health and Human Services (HHS) for administrative purposes, for example, determining financial eligibility for federal programs. FPG, like FPL, varies by family size. However, elderly status is not considered in FPG calculations. Additionally, FPG is not uniform nationally: The 48 contiguous states and D.C. use the same FPG, while Alaska and Hawaii each have their own FPG. Reflective of new administrative practices for the Office of Economic Opportunity (OEO) during the 1966-1970 period, separate guidelines were established for Alaska and Hawaii. Other U.S. territories, such as Puerto Rico and the U.S. Virgin Islands, for instance, do not have separate guidelines, and FPG determinations use either the rate for the 48 contiguous states or some other calculation made by local program officials.

Federal Poverty Level- (FPL) An economic measure established by the Department of Health and Human Services (HHS) that is used to decide whether the annual income level of an individual or family qualifies them for certain federal benefits and programs. HHS updates it's poverty guidelines annually, illustrating the set minimum amount of income that a family needs for food, clothing, transportation, shelter and other necessities, adjusting for inflation.

The poverty definition is based on money income before taxes and does not include capital gains or non-cash benefits. The official FPL is calculated annually in order to reflect inflation by the Census Bureau and is used primarily for statistical purposes, for example, to estimate the number of Americans in poverty each year. The Census Bureau assigns each person or family a singular threshold out of a possible 48, which can vary by family size (designated up to a nine-person family unit or more), number of children, and in the case of one-person and two-person households, elderly status. The FPL is the same, however, for all 50 states and the District of Columbia (D.C.).

Fiscal Year- The IRS defines a fiscal year as 12 consecutive months, ending on the last day of any month (except December**)** For our purposes we define it as a calendar year or the same as the income tax filing year.

HAPA-Health care Assistance Program Application/applications for consideration.

Income- Total cash receipts before taxes derived from wages, salaries, welfare/social security payments, strike payments, **u**nemployment, disability benefits, child support/alimony and net earnings from business and investment activities paid to the individual**.**

Indigent Person- the term "indigent person" is defines as a patient or the patients guarantor, who qualifies for Charity Care or Health care Assistance based on the FPL, adjusted for family size and who has exhausted any third party coverage in accordance with the law.

Liquid Assets-An asset in the form of money or cash in hand, or an asset which can be quickly converted into cash without losing much value. Real property is not considered a liquid asset.

MVH- Mid-Valley Hospital District

Nominal charges- unadjusted rate or change in value. In economics and finance, a nominal change is a change in value that is unadjusted for inflation, seasonality, interest compounding, or other

factors. Nominal values are expressed in terms of current prices or figures.

PAR- Patient Account Representative

Real Property- Fixed property, land, buildings or dwellings.

Third Party Coverage-An obligation on the part of an insurance company, health care services contractor, health maintenance organization, group health plan, government program(Medicare Law Medicaid or other assistance programs, workers compensation, veteran benefits or health sharing ministry as defined in 26 U.S.C. Sec 5000A., 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 (for example, auto accidents or personal injuries) which have resulted in the medical condition for which the patient has received health care services.

WSN- Washington State Navigator

Applicability

Policy is applicable to outpatient medical services provided on or after July 1, 2022 and inpatient services with a discharge date on or after July 1, 2022. Discounts listed in the policy also are effective for services received before the July 1, 2022 date as well and in accordance with Mid- Valley hospital's sliding fee schedule.

The policy applies to all patients, regardless of whether or not the patient is insured or uninsured.

Policy

This policy allows for partial or complete reduction of charges incurred for medical services.The amount owed is considered for Charity Care when all other means have been exhausted and all benefits have been applied against the debt. The only amounts that will be included in such a reduction must be considered to be the patient's balance.

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. Mid Valley Hospital's Health Care Assistance Program offers free or discounted care to individuals who meet the established criteria. Medically necessary 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 Health care 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.

Nominal fees are not charged to patients and patients at or below 200% of the FPG receive full discounts.

A sliding scale shall be used to determine the amount to be written off for the patient's obligation with

thresholds as follows:

Applicants up to 200% FPL shall be written off at 100%without requirement of an asset test.

Applicants from 201% to 250% FPL will have a reduction in the amount owed of 75% with an asset test requirement of liquid assets.

Applicants from 251% to 300% FPL will have a reduction in the amount of 50% with an asset test requirement of liquid assets.

A patient who exceeds 300% FPL but has medical debt in excess of 25% of annual income will be considered " Catastrophic Charity Care". The following sliding scale shall be used to determine amounts to be written off as Charity Care:

Medical Debt between 25% and 50% of annual income will be eligible for a 15% reduction.

Medical Debt between 50% and 75% of annual income will be eligible for a 30% reduction.

Medical Debt over 75% of annual income will be eligible foe a 50% reduction.

Charity Care/Health Care Assistance Program reductions may be awarded for patients who are uninsured, under insured, ineligible for any government health care benefit program or who are otherwise unable to pay for their care based upon a determination in accordance with this policy.

The following services are eligible for Charity Care per WAC 246-453-010 (7): those hospital services which are reasonably calculated to diagnose, correct, cure, alleviate, or prevent the worsening of conditions that endanger life, or cause suffering or pain, or result in illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and there is no other equally effective more conservative or substantially less costly course of treatment available or suitable for the person requesting the service. For purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all.

When determining eligibility, MVH does not consider, race, creed, color, national origin, age, ancestry, marital status, religion, domestic or civil status, military status, sexual orientation or lack there of, or any protected class or status into consideration of the reduction of the debt.

The remaining balance after sliding scale application, shall be made in monthly installments with and agreed dollar and due date for those payments to be made. Payment arrangements will be made and offered in accordance with MVH's Credit and Collection or Self pay policy. the account will not be placed in collection with a formal agency as long as payment arrangement are kept as agreed.

Asset Policy

Asset testing cannot and will not be used to assess income for patients and families with annual incomes at or below 200% of the FPL

Liquid assets will be considered for those applicants between 201% and 300% FPL or to the extent the law allows.

These assets will not be considered:

First $5000.00 in monetary assets, $8000.00 if a family and an additional $1500 per family member.

Primary residence equity

Retirements plans other than 401(k)

Prepaid burial plots or prepaid burial contract

Life insurance policies values at $10,000 or less.

One vehicle and second vehicle if needed for employment or medical purposes.

Tools of the trade required to perform a job.

In the event that the responsible party is not able to provide any of the documentation described above, MVH shall rely upon a written and signed document from the responsible party supporting their claim of need or indigency. (WAC 246-453-030(4)

Amounts Generally Billed

Amounts generally billed calculation (AGB) in accordance with the Patient Protection and Affordable Care Act (PPACA)if a patient receives charity care, MVH will not charge that patient more for emergency or medically necessary care than the amounts generally billed (AGB) to insured patients. A patient eligible for charity care is considered to be " charged" on the amount he/she/they are personally responsible for paying, after discounts and insurance payments have been applied to the account relating to the episode of care.

Patients are eligible for pre-screening to determine if sponsorship is possible based on the current FPL adjusted for family size. This determination can be done pre-service or post service. Final charity care sponsorship will be determined within 14 days of the completed application being returned and notes can be made on all accounts to be considered. The credit adjustment will be applied to the account when the amount becomes patient responsibility.

Mid Valley Hospital uses a standard charge calculation of APC (average propensity to consume) with a mixture of MFS (Medicare fee schedule) ratios for calculating our charging to patients. If you have further questions regarding our basis for charges, please contact our DRC at 509-826-7638.

COMMUNICATIONS TO THE PUBLIC

Notice shall be made publicly available through the posting of signs in public areas of the hospital and clinic, including admissions and/or registration, the emergency department, billing/financial services, that charges for services provided to those persons meeting the criteria established within WAC 246-453-040 may be waived or reduced.The Policy is available to anyone that wants it and is available on the website at www.mvhealth.org. Information will be assembled in an easy to read summary in both English and Spanish.

Charity Care forms, instruction and written applications shall be furnished to the responsible party when requested or otherwise indicated by request from another party on behalf of the patient or when screening indicates potential need. /a written notice is available in pamphlet, plain language flier, on the website as well as at the facility in hard copy

If for some reason the patient is not made aware of the existence of charity care before treatment such as in an emergency, he or she will be notified as soon as possible. All applications, whether initiated by the patient, their representative or an employee of MVH, should be accompanied by documentation to verify the information in the application. Information requests to verify assets are limited to information that is reasonable necessary and readily available, and may not be used to discourage applications.

Procedure

PROCESS FOR DETERMINING ELIGIBILITY

An annual application for program consideration and eligibility be filled out for each calendar year. the application and supporting documents should be returned within 2 weeks of receipt or communication with MVH to request additional time (2 weeks) to submit proper documentation.

Eligibility is based solely on family size and income; and • At a minimum, applicable to all individuals and families with annual incomes at or below 200 percent of the most current Federal Poverty Guidelines. a Sliding Fee Discount Program is intended to minimize financial barriers to care for patients at or below 200 percent of the current Federal Poverty Guidelines. Sliding Fee Discounts for eligible patients will be applied after third party insurance coverage unless the third party insurance contract prohibits the application of the Sliding Fee Discount Program.

Deceased patients will be verified by certificate of death or death notice in newspaper. Verification of no estate filed with county and/or a letter from the family indicating no estate exists IF family members can be located and will cooperate.

If a patient has qualified for HAP and continues to receive services for an extended period of time, the hospital, at it's discretion, may require the responsible person to reapply if there is a change in a patient's financial circumstances or at the end of the fiscal year.

Timing of Income Determinations: Annual family income of the applicant will be determined as of the time the appropriate medically necessary medical services were provided, or at the time of application for health assistance and applicant demonstrates eligibility for assistance.Charity care applies to both future care and past bills. It does not matter how old the bills are, or whether they have been sent to collections. If you are eligible, charity care can apply to your hospital bill.

The following may be used to verify income:

1. Pay stubs from employment during the relevant time period.
2. Bank statement
3. Income tax returns for recent fiscal year or last tax return.
4. W2 withholding statement
5. Forms approving or denying sponsorship of Medicaid and or other state funded medial assistance.
6. Forms approving or denying Unemployment benefits
7. Proof of Social Security Benefits

8. Letter from employer.

Consideration of Assets:

When determining eligibility for financial assistance under this policy for care received on or after July 1, 2022, for patients and/or guarantors not eligible for financial assistance for the full amount of hospital charges, Mid Valley Hospital may take into consideration the existence, availability, and value of assets of the patient and/or guarantor to reduce the amount of the discount granted. In doing so, Mid Valley Hospital will exclude from consideration : With respect to those assets that may be taken into consideration, Mid Valley Hospital will seek only such information regarding assets as is reasonably necessary and readily available to determine the existence, availability, and value of such assets.Mid Valley Hospital will consider assets and collect information related to such assets as required by the Centers for Medicare and Medicaid (CMS) for Medicare cost reporting. Such information may include reporting of assets convertible to cash and unnecessary for the patient's daily living.

Duplicate forms of verification will not be requested. Only one current account statement is required to verify monetary assets.

If no documentation for an asset is available, a written and signed statement from the patient or guarantor is sufficient.

Asset information will not be used for collection activities.

Mid Valley Hospital uses a standard charge calculation of APC (average propensity to consume) with a mixture of MFS (Medicare fee schedule) ratios for calculating our charging to patients. If you have further questions regarding our basis for charges, please contact our DRC at 509-826-7638

CATASTROPHIC HEALTH ASSISTANCE

A patient who exceeds 300% FPL but has medical debt in excess of 25% of their annual income will be considered "Catastrophic Charity Care".The hospital may also assign HAP in those instances when families with income in excess of three 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 DRC, in accordance with WAC 246-453-030(3) and WAC 246-453-030(4).

The following sliding scale shall be used to determine amounts to be written off as Catastrophic Charity Care:

Medical debt between 25% and 50% annual income, the patient is eligible for a 15% reduction.

Medical debt between 50% and 75% annual income, the patient is eligible for a 30% reduction.

Medical Debt over 75% annual income, the patient is eligible for a 50% reduction.

At time of admission or registration, admitting staff will offer the HAP to each patient or responsible party and indicate on the electronic form provided at time of registration whether application was

accepted or rejected. Meaning the patient was offered the application. Basic information and a pamphlet are available for patient consideration at that time.

All applications for consideration will be forwarded to the (PAR) on a daily basis. Processing the applications shall be the responsibility of the Patient Account Representative (PAR)

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:

Patients applying for our HAP must make reasonable effort to exhaust all 3rd party resource, which means apply for state insurance. If applicable for their income category, outlined in the statute. In accordance with the statue, patients who decline to apply as the statute suggests they should, will not be eligible to apply for our HAP.

If patients are undocumented and they have no recourse to apply for insurance, Mid Valley Hospital complies with the law that states the below language. These patients can apply for our HAP.

(1) No hospital or its medical staff shall adopt or maintain admission practices or policies which result in:

(a) A significant reduction in the proportion of patients who have no third-party coverage and who are unable to pay for hospital services;

(b) A significant reduction in the proportion of individuals admitted for inpatient hospital services for which payment is, or is likely to be, less than the anticipated charges for or costs of such services; or

(c) The refusal to admit patients who would be expected to require unusually costly or prolonged treatment for reasons other than those related to the appropriateness of the care available at the hospital. RCW 70.170.060.

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).

1. If information in our HAPA indicates that patients and their guarantor may be eligible for coverage, Mid Valley Hospital will assist the patient and their guarantor in applying for coverage. Depending on the patients needs, our team will answer any questions, walk through any applications, and provide assistance linking them to any other resources they may need.
2. Mid Valley hospital has Navigators (WSN) on staff to help assist patient and family with their health care coverage needs, if during their review they find they would qualify for Medicaid or managed care health coverage plans.
3. If the WSN finds that a patient and/or family will qualify for health coverage, they will assist them with an on-line application and walk them through the questionnaire process and/or assist in anyway possible.
4. The WSN will assist all patients and family with their questions or needs when it comes to

applying for state insurance or assist with the insurance exchange to help purchase insurance.

5. It is Mid Valley Hospitals goal to screen all uninsured patients and pro-actively assist them towards better health-care opportunities through state or financial assistance funding. If any patient or family member has any third party coverage needs, our PAR will assist them with their questions and/or HAP application needs.
    a. 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.
    b. 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 sliding scale of this Policy.
    c. Upon receipt of all verification documentation from the patient, the PAR shall *review* and determine the percentage of the adjustment, make the appropriate adjustment using the appropriate transaction code that corresponds with the General Ledger, and a work item will be sent to the Director of Revenue Cycle for review, approval or denial.
    d. After review by the DRC 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.
    e. On a monthly basis a report will be submitted to the Board of Commissioners for approval indicating the total dollars assigned to the HAP.
    f. After determination of the HAPA, any financial obligation that is owed shall be payable in monthly installments in accordance with our policy. The responsible party will not be turned over to a collection agency unless payment arrangements are in default and no satisfactory contact has been made with the responsible party. WAC 246-453-050(1)(c).

IDENTIFICATION OF HEALTH CARE ASSISTANCE PROGRAM ACCOUNTS DURING PRE-COLLECTION ACTIVITY

RESPONSIBILITY: Patient Account Representative (PAR)

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 above.

HEALTH CARE ASSISTANCE PROGRAM (HAP) APPROVAL AUTHORITY LEVELS & TRAINING

1. All balances will be approved on a daily basis by the Patient Account Representative.
2. The Director of Revenue Cycle will review completed applications on an as needed basis.

3. The Board will be advised of the total applications and the total dollars written off as Charity Care.
4. MVH/MVC patient account representatives will receive yearly training in the Health Care Assistance Program to comply with state law as well as be an educated resource for our patients and their families.

APPEAL PROCESS

1. All applications will receive written notice of approval or 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 Director of Revenue Cycle, who will meet with a review committee and shall respond 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.
8. QUALIFIED PROVIDERS: For a list of our current providers, please visit our website at https://www.mvhealth.org. In some instances services provided by a physician not employed by Mid Valley Hospital or Mid Valley Clinic may provide services for you during your visit at Mid Valley Hospital. Those providers will bill you separately for their services which will not be included in Mid Valley's Health Care Assistance Program. You may contact them directly for their assistance programs.
9. https://www.mvhealth.org/wp-content/uploads/2024/03/HAP-2024-Updated-PGL.pdf
10. **APPROVALS:**
11. Director of Revenue Cycle, Chief Financial Officer and Administrator

All Revision Dates

10/2024, 10/2024, 10/2024, 04/2024, 11/2023, 01/2023, 08/2022, 06/2022, 09/2021, 05/2021, 11/2020, 10/2019, 10/2019, 03/2018, 04/2016, 01/2016, 05/2012, 04/2011, 05/2009, 01/2008

Attachments

- FPL detailed annual guidelines-2024.pdf
- HAP-2025 Spanish sliding scale.xlsx
- HAP-2025-Updated-PGL-English (1).xlsx
- HAP-Application-English_Updated-12-16-2024.docx
- HAP-Application-Spanish_Updated-12-16-24.rtf

Approval Signatures

Step Description	Approver	Date
	Randy Coffell: HR Director	02/2025
	Holly Stanley: CFO	02/2025
	Jana Symonds: Director of Revenue Cycle	02/2025