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Owner	Mary Taggart: Sr. Manager of Patient Financial Services
Policy Area	Patient Financial Services

Charity Care Policy & Procedure

Purpose

This policy shall provide guidelines for the determination of eligibility for Whitman Hospital and Medical Clinics' (WHMC) Charity Care program and provide guidelines to ensure that individuals eligible for financial assistance (as defined below) are not charged more than the amounts generally billed for emergency or other medically-necessary care (as per required under IRC Section 501(r)4.

Definitions

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.

Family - Family is defined 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 Level (FPL) - An economic measure established by the Department of the 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 its poverty guidelines annually, illustrating the set minimum amount of income that a family needs for food, clothing, transportation, shelter, and other necessities, adjusted for inflation.

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 online 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.

Indigent person- The term "indigent person" is defined as a patient, or the patient's guarantor, who qualifies for charity care based on the FPL, adjusted for family size and who has exhausted any third-party coverage.

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 consider a liquid asset.

Real Property- Fixed property, principally land and buildings.

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 medical assistance programs, workers' compensation, veterans benefits) tribal health 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.

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.

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

Policy

This policy allows for a partial or complete reduction of charges incurred for medical services. This amount owed is considered for charity care when all other means have been exhausted and all benefits have been applied against the debt. Only the patient responsibility is considered for charity care.

A sliding scale shall be used to determine the amount to be written off for patients with thresholds as follows:

- Applicants up to 200% FPL shall be written off at 100% without a 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.
- Applicants from 251% to 300% FPL will have a reduction in the amount of 50% with an asset test requirement.

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 Catastrophic Charity Care:

- Medical Debt between 25% and 50% Annual Income, patient eligible for a 15% reduction.
- Medical Debt between 50% and 75% Annual Income, patient eligible for a 30% reduction.
- Medical Debt over 75% Annual Income, patient eligible for a 50% reduction.

Charity care 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.

Services eligible for charity care include emergency services or urgent care or care deemed medically necessary to prevent death or adverse to a patients' life or limb or will otherwise adversely effect the patient's health. Additionally, preventative services, well visits, screening mammograms and screening colonoscopy will be included.

When determining eligibility, WHMC does not consider race, creed, color, national origin, age, ancestry, marital status, religion, domestic or civil union status, sex, gender expression, military affiliation or any protected class or status into considering a reduction of the debt.

The remaining balance after the sliding scale application shall be made payable in monthly installments if full payment is unavailable. Payment arrangements will be made in connection with WHMC's Credit and Collection Policy. The account will not be turned to a collection agency as long as payments are made as agreed.

ASSET POLICY

Liquid assets will be considered for those charity care applicants between 201%-300% FPL.

These assets will not be considered:

- First $5000 in monetary assets, $8000 if a family and an additional $1500 per family member
- Primary residence equity
- Retirement plans other than 401(k)
- Prepaid burial plots or prepaid burial contract
- Life insurance policies valued at $10,000 or less
- One vehicle and second vehicle if needed for employment or medical purposes.
- Tools of the trade required to perform job

In the event that the responsible party is not able to provide any of the documentation described above, WHMC shall rely upon a written and signed document from the responsible party for making that determination for classification on indigency. (WAC 246-453-030(4)

Procedure

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, WHMC 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" only the amount he/she is 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 Federal Poverty Guidelines 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 and can be noted on the account or accounts. The credit adjustment will be applied to the account when the amount due becomes patient responsibility.

WHMC elects to use the "Prospective Method" to determine AGB. Additionally, WHMC elects to calculate AGB using Medicare fee-for-service (traditional Medicare, excluding Medicare Advantage) as a basis for determination. Under this method, WHMC will use the billing and coding process that would be normally used if the charity eligible patient were a Medicare fee-for service beneficiary. The AGB is calculated as the amount that Medicare would allow for the care (includes the amount Medicare would pay as well as any beneficiary responsibility such as co-payments, co-insurance and deductibles).

COMMUNICATIONS TO THE PUBLIC

Charity care information shall be made publicly available with signs posted in key areas of the WHMC including admitting locations, emergency department and all clinics and ancillary departments that directly register patients. The Charity Care policy is available to anyone who requests it, either by mail telephone or in person.

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 WHMC website and well as hard copy.

If for some reason the patient is not made aware 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 or WHMC, should be accompanied by documentation to verify the information in the application. Information requests to verify assets are limited to information that is reasonably necessary and readily available, and may not be used to discourage applications.

PROCESS FOR DETERMINING ELIGIBILITY

When considering monetary assets, one current account statement is sufficient for asset verification. If documentation for an asset is not available, a written and signed statement from the party must be considered adequate. WHMC may not use asset information for collection activities.

Any one of the following documents shall be considered sufficient evidence upon which to base the final determination of charity care eligibility:

- A W-2 withholding statement.
- Pay stubs from employment during the relevant time period.
- An income tax return from the most recent tax filing year.

- Forms approving or denying eligibility for Medicaid and/or state funded medical assistance.
- Forms approving or denying unemployment compensation.
- Written statement from employers.

A patient or patients representative shall complete WHMC's charity care application, along with required supporting documentation. The application and supporting documentation is reviewed and determination made of the patients eligibility for charity care reductions by the billing company, the Patient Financial Services Manager or the Revenue Cycle Director. Such eligibility determination will be communicated to the patient via letter, which also outlines the appeal process.

In those situations where appropriate primary payment sources are not available, this policy criteria shall be calculated using information from the 12 months prior to the request if the condition is temporary or current financial situation if the condition is permanent or long term.

During the initial request period, the patient and WHMC may pursue other funding including Medicare and Medicaid. The responsible party will be required to provide written proof of state insurance ineligibility. We ask that the patient apply for retroactive state insurance coverage to cover the dates of service being reviewed for charity care. WHMC may not require a patient applying for a determination of indigent status to seek bank or other loan funding. Charity care is available to patients eligible and ineligible for third party coverage.

WHMC staff will identify patients eligible for medical assistance programs under Medicaid. WHMC personnel will assist the patient/guarantor in applying for such programs. If it is determined the patient or the patient's guarantor qualifies for retroactive health care coverage through medical assistance programs, WHMC is not obligated to provide charity care if the patient or the guarantor fails to make reasonable efforts to assist WHMC in applying for the coverage.

WHMC will not adopt application procedures for charity care or for assistance in applying for retroactive medical assistance coverage that place an unreasonable burden on the patient or guarantor with respect to physical, mental, intellectual, or sensory conditions, as well as language barriers. It is declared to be an unreasonable burden to require a patient to apply for coverage that the patient is obviously or categorically ineligible for or has been determined to be ineligible for within the prior 12 months.

Relevant documentation will be three months worth, prior to the date of the application. If documentation does not accurately reflect the patients current financial situation, documentation will only be requested for the time period after the event that changed their financial situation.

WHMC will allow a patient to apply for charity care at any point from pre-admission to final payment of the bill, recognizing that a patients ability to pay over an extended period may be substantially altered due to illness or financial hardship, resulting in the need for Charity Care. If the change in financial status is temporary, WHMC may choose to suspend payments temporarily rather than initiate financial assistance.

All of the balances will be considered on a case by case basis according the patient's ability to pay. Determinations will be made within fourteen days of receiving a completed application.

Prima Facie Indigency

In the event the responsible party's identification as an indigent person is obvious to WHMC personnel, and can establish the applicant's income is clearly within the range of eligibility, WHMC will grant charity care based solely on this initial determination. In these cases, WHMC is not required to complete full verification or documentation (in accordance with WAC246-453-030(3). This includes cases where the patient is deceased and it has been determined that there is not asset to which we can expect a dividend or full payment.

ADMINISTRATIVE APPEALS

A patient may appeal a charity care final determination by submitting a formal, written request to WHMC within 30 days of receipt of their final determination letter. Appeals may be done by supplying additional documentation and compelling arguments. An account having been determined to be eligible will be refunded any personal payments made within 30 days of such notice.

Matters requiring administrative review will be reviewed by the Senior Manager of Billing and Reimbursement or the Chief Financial Officer. The issues that could be subject to appeal include the determination decision, charge adjustments, payment plans not in accordance with established policies and procedures, patient grievances and other matters relating to the final determination.

Appeals may be done by supplying additional documentation and compelling arguments. A account having been determined to be eligible will be refunded any personal payments made within 30 days of such notice.

Any second round appeals will be considered by the CFO or the CEO.

If the applicant doesn't provide ample documentation to make a determination a denial may be sent as well as notice to accordance with the law. If a denial is made with full documentation a copy of the denial and requested documentation will be sent to the DOH, by secure email at charitycare@doh.wa.gov.

The remaining balance after the application and sliding scale application shall be made payable in monthly installments if full payment is unavailable. Payment arrangements will include a minimum amount to be paid each month with a due date. This shall be in accordance to WHMC's self pay policy. The account will not be turned to a collection agency as long as payments are made as agreed. It is the guarantors responsibility to communicate if any payments are missed prior to the time they are due.

ADEQUATE NOTICE OF DENIAL

When an application for charity care is denied, the responsible party shall receive a written notice of denial, which includes:

- reasons for denial
- date of the decision
- instructions for appeal or reconsideration

If the applicant doesn't provide the necessary information, a deficiency notice will be sent. The notice will include the date and description of what was requested and not presented as well as a statement that the decision couldn't be made without that information it will include that if not received in 30 days

the determination will be made.

STAFF TRAINING REQUIREMENTS

WHMC staff will identify patients eligible for medical assistance programs under Medicaid. WHMC has personnel to assist the patient/guarantor in applying for programs.

WHMC will provide training to front-line staff who work in registration, admissions and billing or any other appropriate staff, to answer questions regarding medical assistance programs or WHMC's charity care policy in an appropriate and effective manner.

DOCUMENTATION AND RECORDS

All information relating to the application will be kept confidential. Copies of documents supporting the application will be kept with the application form, according to WHMC's records retention policy.

Copies of this policy will be kept updated on the Whitman Hospital website as well as being submitted to Washington State Department of Health Website. Email updated policy to: CharityCare@doh.wa.gov.

This will be submitted annually by the manager of administrative services.

Approvals

Board Approval on the 15th day of June, 2022.

References

- 26 U.S.C. Sec. 5000A
- WAC 246-453
- RCW 70.170
- IRS 501(r)
- 501(c)(3)-Treasury Regulation 1.501(r)-1 to 1.501(r)-7).

Attachments

- 2024 Charity Care Application Form and Instructions.docx
- 2024 Credit Collection Policy Pamphlet.docx
- FPL Guidelines-2024.pdf

Approval Signatures

Step Description	Approver	Date

Abby Smith: Chief Financial Officer	10/2/2024, 1:09PM EDT
Mary Taggart: Sr. Manager of Billing & Reimbursement	9/26/2024, 7:57PM EDT