COULEE MEDICAL CENTER	Policy Area:	Patient Financial Services
	Policy Holder:	Patient Accounting Manager

Financial Assistance/Charity Care

POLICY: Coulee Medical Center is committed to the provision of health care services to all persons in need of medically necessary care regardless of ability to pay. In order to protect the integrity of operations and fulfill this commitment, the following criteria for the provision of financial assistance and Indigent care, consistent with the requirements of the Washington Administrative Code (WAC), Chapter 246-243 and Section 501(r)(4) of the Internal Revenue Code, to establish in this policy. These criteria will assist staff in making consistent objective decisions regarding eligibility for financial assistance and Charity Care while ensuring the maintenance of a sound financial base for CMC.

Definitions:

Charity Care: Charity Care and/ or Financial Assistance means medically necessary hospital 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 deductibles or coinsurances amounts required by a third-party payer.

Indigent Persons: Indigent persons are 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.

Third-Party Coverage: An obligation on the part of the insurance company, health care services coordinator, health maintenance organization, group health plan, government program, tribal health benefits, or health care sharing ministry 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 health care services. The pend-ency of such settlements, judgments, or awards must not stay hospital obligations to consider an eligible patient for charity care.

PROCEDURE: Communications to the Public:

Information about CMC's financial assistance/charity care program shall be made publicly available as follows:

A. A notice advising patients that the hospital provides charity care shall be posted in key public areas of the hospital and clinic including Admissions, the Emergency Department, and Financial Services that are located in public areas.

B. The written notices, the verbal explanations, the policy summary and the application form shall be available in any language spoken by more than ten percent of the population in the hospital's service area, and interpreted for other non-English speaking or Limited-English speaking patients who cannot understand the writing and/or explanation.

C. The hospital shall train front-line staff to answer charity care questions effectively or direct such inquires to the appropriate department in a timely manner.

D. Written information about the hospital's Financial Assistance/Charity Care policy shall be made available to any person who requests the information, either by mail, by telephone, or in person.

E. CMC will make available on its website current versions of this policy, a plain language summary of this policy, the most current federal poverty scale, and the Charity Care application form.

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F. CMC billing statements, and other written communications concerning billing or collection of a hospital bill by CMC, will include the following statement on the first page of the statement, in both English and the second most spoken language in CMC's service area:
You may qualify for free care or a discount on your hospital bill, whether or not you have insurance. Please contact one of our financial assistance counselors at www.cmccares.org or (509)633-6266 Option 2
Eligibility Criteria:
A. Financial assistance and charity care are generally secondary to all other financial resources available to the patient, including group or individual medical plans, worker's compensation, Medicare, Medicaid or medical assistance programs, other state, federal, or military programs, third party liability situations (e.g. auto accidents or personal injuries), or any other situation in which another person or entity may have a legal responsibility to pay for the costs of medical services.
B. Financial assistance and charity care will be granted regardless of race, creed, color, national origin, sex, sexual orientation, or the presence or any sensory, mental or physical disability or the use of a trained dog guide or service animal by a disabled person.
C. Financial assistance and charity care shall be limited to all emergency and medically necessary care provided by the hospital and "appropriate hospital – based medical services" as defined in WAC 246-453-010(7)

D. All providers located in our facility are covered by our Financial Assistance/Charity Care policy. A list of providers can be found at http://www.cmccares.org/providers

1. Services provided by and billed for by external facilities other than CMC do not qualify for our charity care policy such as Inland Imaging.
2. When referred to an external facility by one of our providers the care that is provided by that facility is not covered by our Financial Assistance/Charity Care policy.
3. When faced with a bill from an external facility please inquire to their policy on Financial Assistance.

E. In those situations where appropriate primary payment sources are not available, patients shall be considered for financial assistance and charity care under this policy based on the following criteria:

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 who income is at or below 200% of the current federal poverty level.
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%-250% of the current federal poverty level.
3. Fifty 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 251%-300% of the current federal poverty level.

F. 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.
G. Initial determination of sponsorship status means an indication, pending verification, that the services

provided by the hospital and/or clinics may or may not be covered by third party sponsorship, or an indication from the responsible party, pending verification, that he or she may meet the criteria for designation as an indigent person qualifying for indigent care.
H. Final determination of sponsorship status means the verification of third party coverage or lack of third party coverage, as evidenced by payment received from the third party sponsor or denial of payment by the alleged third party sponsor, and verification of the responsible party's qualification for classification as an indigent person, subsequent to the completion of any appeals to which the responsible party may be entitled and which on their merits have a reasonable chance of achieving third-party sponsorship in full or in part.

I. Catastrophic Charity. Coulee Medical Center may write off as charity care, amounts for patients with family income in excess of 300 % of the federal poverty level when circumstances indicate severe financial hardship or personal loss.
J. The responsible party's financial obligation, which remains after the application process and eligible charity care has been applied, shall be payable as negotiated between Coulee Medical Center and the responsible party. The responsible party's account shall not be turned over to a collection agency unless payments are missed or there is some period of inactivity on the account, and there is no satisfactory contact with the patient.

1. In the event of non-payment the patient will be sent to collections after 120 days but not before three statements and a final letter have been sent to the address of the guarantor on the account as well as two phone calls to the number listed on the account.

K. Eligibility Groupings:

Patients who are:
0-200% FPL- Free Care
201-250% FPL- 75% discount
251-300% FPL- 50% discount

PROCESS FOR ELIGIBILITY DETERMINATION:

A. Initial Determination:
1. Coulee Medical Center shall use an application process for determining eligibility for financial assistance/charity care. Referrals to provide financial assistance/ charity care will be accepted from sources such as physicians, community or religious group, social services, financial services personnel and the patient, provided that any further use or disclosure of the information contained in the request shall be subject to the Health Insurance Portability and Accountability Act privacy regulations and Coulee Medical Center's privacy policies. All requests shall identify the party that is financially responsible for the patient as the "responsible Party".

2. The initial determination of eligibility for financial assistance/charity care shall be completed at the time of admission or at the time of application for Financial Assistance/Charity

Care, if the application is made within two years of the time the medical services were provided, and demonstrates eligibility for Financial Assistance and or Charity Care.

3. Pending final eligibility determination, Coulee Medical Center will not initiate collection efforts or request deposits, provided that the responsible party is cooperative with the hospital's efforts to reach a final determination of sponsorship status.
4. If Coulee Medical Center becomes aware of factors which might qualify the patient for financial assistance or charity care under this policy, it shall advise the patient of this potential and make an initial determination that such account is to be treated as qualified to receive financial assistance or indigent care.

B. Final Determination:
1. Prima Facie Write-Offs. In the event that the responsible party's identification as an indigent person is obvious to Coulee Medical Center personnel, and Coulee Medical Center can establish that the applicant's income is clearly within the range of eligibility, Coulee Medical Center will grant charity care based solely on this initial determination. In these cases, Coulee Medical Center is not required to complete full verification or documentation. WAC 246-453-030(3).
2. Financial Assistance/ Charity Care forms, instructions, and written applications shall be furnished upon request, when need is indicated, or when financial screening indicates potential need.
3. Applications can be obtained by the patient:
Upon check in/check out of the hospital

- By telephone at 509.633.1753
- On our website at cmccares.org
- In person or written request sent to 411 Fortuyn Rd, Grand Coulee, WA 99133
- All applications, whether initiated by the patient or the hospital, should be

accompanied by documentation to verify information indicated on the application form. Any of the following documents shall be considered sufficient evidence upon which to base the final determination of charity care eligibility:

a. A “W-2” withholding statement; or
b. Current pay stub (Gross Monthly Income) during the relevant time period; or
c. Last year’s income tax return, including schedules if applicable; or
d. Written, signed statements from employers or others; or
e. Approval/ denial of eligibility for Medicaid and/ or state- funded medical assistance; or
f. Approval/denial of eligibility for unemployment compensation.

4. During the initial request period, the patient and the hospital may pursue other sources of funding, including Medical Assistance and Medicare.
5. Usually, the relevant time period for which documentation will be requested will be

twelve months prior to the date of application. However, if such documentation does not accurately reflect the applicant's current financial situation, documentation will only be requested for the period of time after the patient's financial situation changed.
6. 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 (WAC 246-453-030(4).

C. When to Apply

1. The hospital will allow a patient to apply for charity care at any point from pre-admission to final payment of the bill, recognizing that a patient's ability to pay over an extended period may be substantially altered due to illness or financial hardship, resulting in a need for charity care services. If the change in financial status is temporary, the hospital may choose to suspend payments temporarily rather than initiate charity care.
    a. Application may be made for outstanding balances

D. Time Frame - The time frame for final determination and appeals is as follows:

1. Each charity care applicant who has been initially determined eligible for charity care shall be provided with at least 14 calendar days, or such time as reasonably be necessary, to secure and present documentation in support of his or her care application prior to receiving a final determination of sponsorship status.
2. The hospital shall notify the applicant of its final determination within 14 days of receipt of all application and documentation material.
3. The responsible party may appeal the determination of eligibility for charity care by providing additional verification of income or family size to the Administrator within thirty (30) days of receipt of notification.
4. The timing of reaching a final determination of charity care status shall have no bearing on the identification of charity care deductions from revenue as distinct from bad debts, in accordance with WAC 246-453- 202(10).

5. If the patient or responsible party has paid some or all of the bill for medical services, and is later found to have been eligible for charity care at the time services were provided, he/she shall be reimbursed for any amounts in excess of what is determined to be owed. The patient will be reimbursed after receiving the charity care designation.

A. Any reimbursement given will be applied to prior outstanding encounters that are owed to Coulee Medical Center, the applicant will be notified.

6. Adequate Notice of Denial: When an application for charity care is denied, the responsible party shall receive a written notice of denial, which include:

a. The reason or reasons for the denial
b. The date of the decision

c. Instructions for appeal or reconsideration

7. When the applicant does not provide requested information and there is not enough information available for the hospital to determine eligibility, the denial notice also includes:

a. A description of the information that was requested and not provided, including the date that the information was requested.

b. A statement that eligibility for charity care cannot be established based on information available to the hospital.

c. The eligibility will be determined if, within thirty days from the date of the denial notice, the applicant provides all specified information previously requested but not provided.

8. The Chief Financial Officer (CFO) and the Revenue Cycle Director will review all appeals. If this review affirms the previous denial of charity care, written notification will be sent to the responsible party and the Department of Health in accordance with state law.

E. Remaining Eligible:

1. A patient may continue to receive services and be eligible for charity care without completing a new charity care application. The hospital may re-evaluate the patient's eligibility for charity care at any time, but must re-evaluate at least annually. Applicants whose sole source of incomes is SSA, SSI, and/or SSDI will remain eligible for 2 years unless the hospital, at its discretion, requests the applicant to reapply. The hospital may require the responsible party to submit a new charity care application and documentation.

Documentation and records:

A. Confidentiality – All information relating to the application will be kept confidential. Copies of documents that support the application will be kept with the application form.

B. Retention – Documents pertaining to charity care shall be retained for five years.

Fraud

A. False Statements

1. Including but not limited to;
   a. Falsifying household size
   b. Falsifying Marital status
   c. Falsifying Income status and sources
   d. Falsifying any documents asked for as part of application
2. Concealing information
   a. This includes financial status change within thirty (30) days of occurrence
   b. Change in household size/ marital status
3. Consequences of a falsified account will be reviewed with the accurate

information and a decision will be based on the new information.

4. Notification of possible Fraud
    a. The patient will be notified in writing of an 'audit' on their account
    b. The patient will have thirty (30) days to provide the documentation proving status

Services excluded from Charity Care: Charity care shall be limited to “medically necessary” and “appropriate hospital-based medical services” as defined in WAC 246-453-010(7).

N. 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, CMC 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. If information in the application indicates that the patient or their guarantor is eligible for coverage, CMC will assist the patient or their guarantor in applying.
    a. In providing assistance to the application process, CMC will take into account any physical, mental, intellectual, sensory deficiencies or language barriers which may hinder 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 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, CMC will not require the patient or their guarantor to apply for such coverage.

O. Consideration of Assets:

When determining eligibility for financial assistance under this policy for care received on or after July 1, 2022. Coulee Medical Center will take into consideration the existence, availability, and value of assets of the patient and/ or guarantor to reduce the amount of financial assistance granted. In doing so, Coulee Medical Center will exclude from consideration:

i. The first $5,000 in monetary assets for an individual, $8000 for a family of two, and $1,500 of monetary assets for each additional family member; the value of any asset that has a penalty for early withdrawal shall be the value of the assets after the penalty has been paid;
ii. Equity in a primary residence;
iii. Retirement plans other than 401 (k) plans;
iv. One motor vehicle (and a second motor vehicle if it is necessary for employment or medical purposes);

v. Prepaid burial contracts or burial plots; and
vi. Life insurance policies with a face value of $10,000 or less.

With respect to those assets that may be taken into consideration, Coulee Medical Center will seek only such information regarding assets as in reasonably necessary and readily available to determine the existence, availability, and value if such assets.

i. Coulee Medical Center will take into consideration assets and collection 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.
ii. Duplicate forms of verification will not be requested. Only one current account statement is required to verify monetary assets.
iii. If no documentation for an asset is available, a written and signed statement from the patient or guarantor is sufficient.
iv. Asset information will not be used for collection purposes.

P. Coulee Medical Center 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 facility at 509-633-1753.

Q. Staff Training

a. All relevant and appropriate staff who work in scheduling, registration, and billing shall participate in the 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.

References:

WAC 246-453-010(7) "Appropriate hospital-based medical services" means 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.
WAC 246-453-030.3 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 the broad criteria described in WAC 246-453-040 or within income ranges included in the hospital's sliding fee schedule, 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.

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WAC 246-453-030.4 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 the broad criteria described in WAC 246-453-040 or within income ranges included in the hospital's sliding fee schedule, 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.
WAC 246-453-020.10 Hospitals should make every reasonable effort to reach initial and final determinations of indigent care designation in a timely manner; however, hospitals 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 indigent care status shall have no bearing on the identification of indigent care deductions from revenue as distinct from bad debts.

**Note: Policy must be published on DOH Hospital website as updates occur.

Last Revised- 01/15/2024

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