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Healthcare Assistance Program

POLICY:

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.

SCOPE:

Director of Revenue Cycle, Chief Financial Officer and Administrator

RESPONSIBILITIES:

Director of Revenue Cycle, Chief Financial Officer and Administrator

CONTROL:

Director of Revenue Cycle, Chief Financial Officer and Administrator

A. POLICY AND DEFINITIONS

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

- Abbreviations used in this document: Health care Assistance Program Application (HAPA), Patient Account Representative (PAR), Director of Revenue Cycle (DRC).

B. NOTIFICATION

- 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 hospital/clinic will provide verbal communication to all patients informing them about the availability of HAP at the time of admission.
- Information regarding HAPA will be posted on every statement generated and made available on Mid Valley Hospital and Mid Valley Clinic websites in a easy to read summary in both English and Spanish.

C. ELIGIBILITY CRITERIA

- HAP is secondary to any other financial resources available to the patient including a government subsidized program, third party liability carriers or any other situation in which another person or entity may have a legal responsibility to pay for the costs of medical service.
- In those situations where appropriate primary payment sources are not available, patients may be considered for HAP based on the following criteria:
    a. 1. The full amount of patient or guarantor responsibility for hospital charges
    will be determined to be indigent for a patient or their guarantor whose income is at or below 200% of the current federal poverty level, adjusted for
    family size.
    a. Mid Valley Hospital will not consider the value of assets to reduce charity care
    discounts for individuals in category 1.
    2. Seventy-five percent of patient or guarantor responsibility for hospital charges will be determined to be eligible for a patient or their guarantor whose income is between 201% and 250% of the current federal poverty level, adjusted for family size , which percentage discount may be reduced by amounts reasonably related to assets considered as set forth in category 2.
    3. Fifty percent of uncovered hospital charges will be determined to be eligible for a patient or their guarantor
    whose income is between 251% and
    300% of the current federal poverty level, adjusted for family size, which percentage discount may be reduced by amounts reasonably related to assets considered as set forth in category 3.
    4. Patients that fall in category 4 are over income and no not qualify for any financial assistance.

b. All deceased patients will be verified by certificate of death or death notice in newspaper along with verification of no estate filed with county and/or a letter from the family indicating no estate exists.

c. 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 for assistance at anytime, including any time is a change in a patient's financial circumstances.

d. Timing of Income Determinations: Annual Family Income of the Applicant will be determined as of the time the Appropriate Medically Necessary Hospital based medical services were provided, or at the time of application for Health Assistance if the application is made within two years of the time the appropriated hospital-based medical services were provided, the applicant has been making good faith effort towards payment for the services and applicant demonstrates eligibility for assistance..

e. Family is defined as a group of two or more persons related by birth, marriage, or adoption who live together. Documentation of income can be requested of members of the family over 18.

f. Income is defined 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 paid to the individual.

g. 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 or the patient and/or guarantor to reduce the amount of the discount granted. In doing so, Mid Valley Hospital will exclude from consideration:

h. • The first $5000 in monetary assets for an individual, $8000 for a family of two,
and $1500 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 asset
after the penalty has been paid;
• Equity in a primary residence;
• Retirement plans other than 401(k) plans;
• One motor vehicle (and a second motor vehicle if it is necessary for employment
or medical purposes);
• Prepaid burial contracts or burial plots; and
• Life insurance policies with a face value of $10,000 or less.
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.
1. 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.
a. Such information may include reporting of assets convertible to cash and
unnecessary for the patient's daily living.
2. Duplicate forms of verification will not be requested.
a. Only one current account statement is required to verify monetary assets.
3. If no documentation for an asset is available, a written and signed statement
from the patient or guarantor is sufficient.
4. Asset information will not be used for collection activities.

i. Mid Valley Hospital uses a standard charge calculation of APC (average propensity to consume) with a mixture of MFS (Medicare fee shcedule) 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.

D. CATASTROPHIC HEALTH ASSISTANCE

E. 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 make 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).

PROCEDURE:

A. IDENTIFICATION OF POTENTIAL HEALTH CARE ASSISTANCE PROGRAM (HAP) RECIPIENTS AT TIME OF ADMISSION
RESPONSIBILITY: Admitting Staff

1. 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.
2. All HAPA's will be forwarded to the Patient Account Representative (PAR) on a daily basis.
3. In the event that a patient is unable or has not been screened during the course of the admission, the financial counselor is expected to review all potential uncompensated accounts and conduct a financial screening with the guarantor and initiate HAP when appropriate.

B. PROCESSING HEALTH CARE ASSISTANCE PROGRAM APPLICATIONS (HAPA) RESPONSIBILITY: Patient Account Representative (PAR)

C.

1. 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:
    a. Payroll check stubs
    b. Bank statements for the last six months
    c. Income tax returns for recent year with W2 withholding statement
    d. Unemployment benefits
    e. Proof of Social Security Benefits
    f. Asset check

2. 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).
3. 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.
4. 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 last page of this Policy.
5. 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.
6. 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.
7. Each month a report will be ran and submitted to the Board of Commissioners for approval.
8. After determination of the HAPA, any financial obligation that is owed shall be payable in monthly installments over a reasonable period of time. The responsible

party will not be turned over to a collection agency unless payments are missed and no satisfactory contact has been made with the responsible party. WAC 246-453-050(1)(c).

D. IDENTIFICATION OF HEALTH CARE ASSISTANCE PROGRAM ACCOUNTS DURING PRE-COLLECTION ACTIVITY
RESPONSIBILITY: Patient Account Representative

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 in B1-B7, above.

E. HEALTH CARE ASSISTANCE PROGRAM (HAP) APPROVAL AUTHORITY LEVELS & Training

1. All balances will be tentatively approved on a daily basis by the Director of Revenue Cycle.
2. The Board will review and approve all write-offs during regularly scheduled Board Meetings.
3. MVH/MVC patient account representatives will receive yearly training in the Health Care Assistance Program in order for them to be able to assist patients with questions or concerns.

F. APPEAL PROCESS

1. All applications will receive written notice of 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 DRC, who will invite a review committee to and shall be responded to 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.

G. QUALIFIED PROVIDERS: For a list of our current providers, please click here. 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.

Attachments

2022 HAP INCOME CHART.pdf

Approval Signatures

Step Description	Approver	Date
	Randy Coffell: HR Director/ Education	06/2022
	Holly Stanley: CFO	05/2022
	Jerri Dion: Director of Revenue Cycle	05/2022