

POLICY AND PROCEDURE

NUMBER: 853000-006	REVIEWED AND REVISED: 01/11/2024	EFFECTIVE DATE: 10/11/2021	SUPERSEDES NO./DATE: 07/15/2019
DISTRIBUTION: PATIENT ACCTNG, ADMITTING, SOC SERV, EMER, CLINIC, ACCTNG AND ADMINISTRATION			
SUBJECT: FINANCIAL ASSISTANCE POLICY		APPROVED BY: <hr/> DEPARTMENT DIRECTOR <hr/> ADMINISTRATION	

POLICY:

Columbia Basin Hospital is an open-door hospital by virtue of it's being a non-profit public Hospital District hospital. The Hospital is the community's only hospital and recognizes its obligation under the Community Service Act. Services in this facility are available to all persons without discrimination on the basis of race, color, national origin, citizenship, immigration status, creed, or any other grounds unrelated to an individual's need for the service. Emergency or medically necessary services will not be denied because the person is unable to pay for those services. Persons receiving medical services will, however, be billed for such services unless financial Assistance eligibility has been established prior to services rendered. All patients receiving services are charged for those services without discrimination between payer type or ability to pay. (see policy #853000-005.)

In order to protect the integrity of operations and fulfill this commitment, the following criteria for the provision of charity care are established, consistent with the requirements of the Washington Administrative Code, Chapter 246-453 and RCW 70.170. These criteria will assist staff in making consistent objective decisions regarding eligibility for financial assistance while ensuring the maintenance of a sound financial base.

Patients of Columbia Basin Hospital and Columbia Basin Family Medicine receiving medically necessary services (Acute Inpatient Care, Outpatient Hospital Services, or Physician Services) who feel they are unable to pay for their services may request financial assistance.

Our facility will make interpretive services available to provide assistance for limited speaking or non-English speaking patients in understanding and applying for financial assistance thru the use of our Language Line. (See policy for Interpretive Services # 8721-052)

CBH will make reasonable efforts to determine financial assistance eligibility on an account before any extraordinary collection actions may occur. This includes reporting to collection agencies,

legal or judicial processes, selling debt, or deferring or denying medically necessary care because of failure to pay for previous care.

PROCEDURE:

Any patient, family member, or responsible party who feels they may qualify for our Financial Assistance Program, may request an application at any admitting desk, the Business Office, or online. This application should be completed as soon as possible of the date of treatment. Hospital District personnel may suggest and offer Financial Assistance applications if they feel that the patient would meet criteria for the Financial Assistance Program and/or refer the patient to the Business Office for further information on the program.

ELIGIBILITY:

Applications for financial assistance are evaluated according to the following criteria:

1. Qualification under Federal poverty guidelines that are published and updated annually. The poverty income figures in effect for the time period that the services were received will be the guideline used in making a determination of eligibility.
2. Income will include all members of the household whether related by birth, marriage, or adoption, regardless of age, who live together. Combined gross income cannot exceed 300% of the poverty guideline for uninsured persons and 200% for insured persons. (See poverty guideline attachment for most current income levels.)
 - A. Eligible persons with income below 100% of the poverty income guidelines will have their balance written off with no obligation to pay.
 - B. Persons with income from 101 – 200% of the poverty guidelines will have their balance reduced per the Reduced Payment Schedule of:

101 – 133%	75% of account balance
134 – 166%	50% of account balance
167 – 200%	25% of account balance
 - C. Uninsured persons with income between 201 – 300% of the poverty guidelines will be eligible for a reduction of charges to reduce their balance due to an amount equal to 130% of the estimated cost to charge ratio currently in effect for the Hospital. If the cost to charge ratio is equal to 77% or above, then this discount would not apply for that year.
 - D. Insured persons will be eligible for financial assistance when their income does not exceed 200% of poverty level and their balances will be reduced as listed in A and B above.
3. Determination of Financial Assistance coverage is considered on the balance after all insurance has paid for insured patients, and 100% of gross charges for uninsured patients. Uninsured patients with annual income between 201 – 300%

of poverty level may be discounted based on our facility ratio of cost to charges for the prior year as noted in #2C above.

The charity application will include an income disclosure section with a request for documentation to be attached to verify the data reported. The following documents will be accepted as proof of income upon which to base eligibility: W-2 withholding statements, pay stubs from all employment, income tax return from the most recently filed calendar year, Medicaid approvals or denials, unemployment compensation notices, or written statements from employers. Determination is based on one full year's income from the time period that services were rendered. Income consideration may be used based on the time the application is received providing that the patient has been making a good faith effort towards payment for their health care services and the application is received within two years of the time of services rendered.

Income is defined as: total gross wages before taxes derived from wages and salaries, Medicaid benefits, Social Security payments, strike benefits, unemployment or disability benefits, child support, alimony, and net earnings from business and investment activities paid to the individual. Supporting documentation is needed for all forms of income listed.

If the applicant's income is below 100% of the poverty level it is not necessary to fill out the optional asset disclosure section of the application. The asset disclosure section of the application requests asset information that is required if the patient does not meet the 100% poverty guideline and wishes to be considered for a reduction in the cost of their services based on a sliding fee scale. Asset information requested are: stocks, bonds, 401K or retirement plan, Health Savings Account balances, Trusts, Property or business ownership.

The hospital will not initiate collection efforts on an account once a request for financial assistance is received providing the responsible party is cooperative with the Hospital's efforts to reach a final determination and supplies the information necessary in order to make that determination. This is normally within 14 days of the request for assistance unless a person's medical condition may require more time.

Business Office Staff will work with the patient in order to obtain the documentation needed to complete the determination of eligibility for financial assistance. If the applicant is unable to furnish the information, eligibility will be determined based on the information given and a signed statement from the applicant attesting to the correctness of the information.

In the event that hospital personnel can clearly establish that an indigent person qualifies for financial assistance, the account can be granted Financial Assistance without an application based on this determination.

THIRD PARTY PAYMENT SOURCE

Any and all insurance or third party payment sources must be exhausted prior to financial assistance being available. All available benefit funds on such coverage must be paid to the hospital. If there is insurance coverage, an explanation of benefits or insurance information should be attached to the application form. This includes an obligation on the part of the insurance Policy #853000-006

company, health care service contractor, health maintenance organization, group health plan, government program, tribal health benefits, or health care sharing ministry as defined on 26U.S.C. Sec. 5000A to pay for care of the covered patient and services, and may include settlements, judgements, 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. Patient balances that are pending settlements, judgement, or awards will still be considered for financial assistance eligibility.

If a patient is uninsured, CBH personnel are available to assist our patients in determining whether they are eligible for Medicaid or other government sponsored health insurance programs available. Staff is available to answer questions or assist in the sign up process. As Medicaid is a third party payment source, applicant may be required to apply for determination of eligibility before financial assistance is granted. If patient is found to be eligible for Medicaid or other no cost insurance, patient must cooperate in signing up so that services will be covered. Eligibility for Financial Assistance is determined by the patient or Guarantor's ability to pay after all available insurance has been utilized.

Balances after insurance payments are eligible for consideration of coverage under the Financial Assistance program.

EXCLUSIONS

Elective and cosmetic services will be reviewed for financial assistance consideration but are generally excluded from financial assistance.

Financial assistance shall be limited to appropriate hospital-based medical services as defined in WAC 246-453-010(7) and consist of Acute care and hospital outpatient services received at Columbia Basin Hospital, and appropriate and necessary professional services received at Columbia Basin Family Medicine.

Nursing Home, Swing Bed, and Assisted Living services will not be considered under the Financial Assistance Program.

Non-employee Providers consisting of: Ambulance transportation services, the provider who interprets your Echo test or Mammography test; or physicians who provides care to Hospital Acute Care Inpatients are not covered under the Financial Assistance Program of the Hospital. The patient will be billed separately for these services from the performing physician's Office.

Accounts that have been assigned to a collection agency and have a judgment granted through the court system will still be considered for financial assistance. A patient may apply for financial assistance at any time.

REVIEW PROCESS

Policy #853000-006

Information, applications, and interviews for financial assistance will be handled by the Business Office. All requests for Financial Assistance Services will be processed within fourteen (14) business days of receipt of application and the applicant notified of the approval, denial, or need for more documentation. An application missing information needed for processing may be held up to 14 days, or such time as may reasonably be necessary from the date the applicant is notified of the need for additional documentation, in order to allow the applicant time to secure and present supporting documentation prior to receiving a determination. Missing information needed to determine eligibility may result in a denial of financial assistance until the information is received and the application can be reprocessed. Once documentation is received, the Hospital will make the determination and notify the applicant within 14 days.

Completed applications with documentation will be reviewed by the Billing/Collection Clerk with assistance from the Director of Business Services as needed. He/she will approve or disapprove the applications based on the documentation attached. The applicant will be sent an Eligibility Determination notifying them of the approval or disapproval, the reason for the denial, and the amount of their balance that is their responsibility.

APPEAL RIGHTS

Included in the notice of eligibility are the appeal rights. The patient has 30 days from the date of determination to request an appeal. This request must be made in writing to the Director of Financial Services providing any additional information necessary to process the reconsideration. The Director of Financial services will reconsider the application and issue a determination to the patient and Business Office. A copy will be sent to the WA Dept. of Health as per State Regulation.

PATIENT RESPONSIBILITY FOR PAYMENT

Payment arrangements will need to be set up for any balance due after receiving determination of eligibility. The applicant's financial obligation which remains after the Financial Assistance reduction is applied shall be payable as negotiated between the Hospital and the responsible party allowing a reasonable time for payments to be made without interest or late fees.

No extraordinary collection action may be taken on approved accounts for 120 days after notice of eligibility has been sent to the patient. If payments are missing or there are periods of inactivity on the account, normal contacts may be made by the facility or its representative. No extraordinary collection action will be taken for 120 days from the last payment from the patient or the date of eligibility determination, whichever is greater. Extraordinary collection actions are defined as Reporting to Credit Agencies, legal processes such as regular liens, attachments, garnishments, or foreclosures, selling of debt, or denying medically necessary care because of non-payment. (See policy on Bad debts for further information. #853000-005)

CONTINUING SERVICES

If a patient has qualified for financial assistance and continues to receive services for an extended period of time, the Hospital, at their discretion, may require the responsible party to submit a new Policy #853000-006

application and income documentation at least yearly, or when there is an increase in the Poverty Level guidelines, to ensure that they still qualify under the program.

CONFIDENTIALITY

Use and disclosure of any information contained in the request and processing of financial assistance shall be subject to the Health Insurance Portability and Accountability Act Privacy Regulations and the hospital's Privacy Policies.

All information and documents pertaining to the financial assistance application will be kept with the application and shall be retained for five years.

REFUNDS:

Any personal payment made on an account later determined by approval of an application to have been eligible for financial assistance will be refunded to the patient within 30 days of that approval. The patient must have been eligible at the time the payment was received.

PUBLIC NOTIFICATION:

Columbia Basin Hospital strives to make Financial Assistance information publicly available to fulfill its obligation to our patients and public notification of the availability of the Charity Care Program.

Signs indicating availability of the financial assistance program are posted in key public areas of the Hospital including the Clinic, Admitting, and Emergency Room areas. A Notice of Availability of Financial Assistance may also be published in the legal notices of the local newspaper or posted in the community to inform of financial services availability.

CBH will make reasonable efforts to ensure that each patient will receive written notice of financial assistance availability with their first registration into our Billing systems and a signature of receipt signed by the patient or responsible party.

The hospital will include a written notice of the availability of financial assistance to patients at the time of their first billing or statement. In addition, any letters sent by Columbia Basin Hospital for the purpose of collecting a debt will include a notice of availability of the Financial Assistance program. This will include contact information for inquiries about the program or application process. Further written information shall be made available to any person who requests it and at each Admitting/registration area.

Any Collection Agency used by the Hospital District will be required to include a notice to the debtor that they may be eligible for Financial Assistance along with contact information for the Hospital on the initial written notice sent to the debtor for hospital bills referred to them for collection.

INTERPRETER AVAILABILITY

Our facility will make interpretive services available, as necessary, to provide assistance for non-English speaking patients in understanding and applying for financial assistance.

In addition, the written notices, verbal explanations, the policy summary, and the application form will 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 and for other patients who cannot understand the writing and/or explanation. The following non-english translation(s) of these are currently made available:

The Hospital will make available on its website, www.columbiabasinhospital.org, current versions of this policy in English. In addition, a plain language summary of the Hospital's Policy, Notices of Availability of Financial Assistance, and applications with directions are posted in English, Spanish, and Russian on our website. These are also available in the Business Office and Admitting areas.

STAFF TRAINING

Columbia Basin Hospital has established a standardized Training Program on its Financial Assistance and Charity Care policy and the use of interpreter services to assist persons with limited english proficiency and non-english speaking persons in understanding information about its Financial and Charity Care Policy. The hospital will provide regular training to front-line staff who work in registration, admissions, and billing, and any other appropriate staff, to answer Financial Assistance and Charity Care questions effectively, obtain any necessary interpreter services, and direct inquiries to the appropriate department in a timely manner.

Any changes to this policy will be submitted to the WA Department of Health for approval as required by state law before changes are put into effect.