Comment Form

Thank you for taking the time to comment on the WAC 246-453 draft rules. Please submit any comment(s) you have as soon as possible prior to a scheduled meeting. Please submit a separate form for each section of the rules on which you would like to comment via email to: CharityCare@DOH.WA.GOV. Questions can also be directed to charitycare@doh.wa.gov.

Step 1: Please provide your contact details in case we need to contact you for further information or clarification.

Name: Cara Helmer

Phone/email: carah@wsha.org

Step 2: The following statements help inform rule recommendations. 1-3 must be completed; 4-8 may be completed to your best ability or left blank.

1. **Section commented on**:

   246-453-010

2. **Position (support/oppose): Choose an item.**

(1) Maintain the definition of "family" as it currently exists in the WAC

(2) Revise the definition of "emergency medical condition"

3. **Suggested solution/proposed language**:

WSHA proposes maintaining the definition of "family" currently used in 246-453-010 (18). WSHA's proposed language for "emergency medical condition" is below.

(6)(a)"Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in:

(i)Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

(ii) Serious impairment of bodily functions; or

(iii) Serious dysfunction of any bodily organ or part.

(b)With respect to a pregnant woman who is having contractions, "emergency medical condition" also means:

(i)That there is inadequate time to effect a safe transfer to another hospital before delivery; or

(ii) That transfer may pose a threat to the health or safety of the woman or the unborn child.

4. Statement of problem/comment and substantiation:

At the March 14, 2023, stakeholder meeting, the Department of Health (DOH) recommended revising the definition of family and updating the definition of "emergency medical condition."

For the reasons below, WSHA does not believe that it is advisable, or within the scope of this rulemaking, to update the definition of family.

DOH's suggested edits to "emergency medical condition" included some language that added confusion, as discussed at the last stakeholder meeting. WSHA's proposed edits are designed to remedy those issues.

5. Applicable research and/or substantiation of suggested solution/proposed language:

Definition of Family:

Because the charity care statute explicitly states that a charity care determination depends on where a person's income falls relative to the federal poverty level (FPL), redefining family to mean anything other than the definition provided by US Census Bureau, is not within the scope of this rulemaking. The definition of "family" is established by the US Census Bureau as part of the definition of Federal Poverty Level (FPL) (https://www.census.gov/topics/income-poverty/poverty/guidance/poverty-measures.html).

The definition of family in 246-453-010 (18) comes from the US Census bureau, which defines "family" as "a group of two people or more … related by birth, marriage, or adoption and residing together; all such people … are considered as members of one family." (https://www.census.gov/programs-surveys/cps/technical-documentation/subject-definitions.html#family). The Census Bureau is responsible for setting the Federal Poverty Level (FPL). Under the RCW, FPL is the metric which defines who is and is not eligible for receiving charity care.

FPL includes a definition of family, used to interpret the poverty ranges. In other words, 300% of the federal poverty level is set by the US Census Bureau to mean a specific amount of money for a *family* of a specific size, as determined by the US Census Bureau's definition of family. If DOH redefines "family" in this rulemaking, it is no longer using FPL, as defined by the US Census Bureau, to determine who is or is not eligible for charity care. Instead, it would be some combination of DOH and Census Bureau metrics: using a new definition of family, who qualifies for charity care would change. Because the RCW explicitly states that charity care depends on an individual's FPL, redefining family is not within the scope of this rulemaking.

Moreover, it is within the interest of the public, hospitals, and the Department, to make charity care as easy to understand as possible. Adding complexity leads to more difficult compliance for hospitals and makes it more challenging for individuals to understand their eligibility status. To

do that, it is helpful to keep the laws consistent. Changing the definition of "family" is inconsistent with this goal. If the RCW says that charity care is dependent on an individual's federal poverty level, and an individual is familiar with federal poverty levels, that individual should feel confident about their charity care status. If this rulemaking redefines "family" for charity care purposes, charity care will be an outlier in what "federal poverty level" means, and each person applying for charity care will have to learn their unique *charity care specific FPL*, which will not match their FPL status for other financial aid benefit purposes. Maintaining a definition of "family" consistent with the Census Bureau allows for a less complex statutory structure which benefits both the public and hospitals.

Emergency Medical Condition:

WSHA's suggested edits to the emergency medical condition definition are purely technical. The goal is for the language to read more clearly.

6. Benefit of suggested solution/proposed language to the public:

The definition of "family" follows the RCW requirement to use federal poverty level and maintains a more consistent and understandable statutory structure.

The definition of "emergency medical condition" is understandable and clear.

7. Benefit of suggested solution/proposed language to hospitals:

The definition of "family" follows the RCW requirement to use federal poverty level and maintains a more consistent and understandable statutory structure.

The definition of "emergency medical condition" is understandable and clear.

8. Identified impacts (cost or otherwise) of suggested solution/proposed language to hospitals:

Discussion Notes (DOH staff only):

Comment Form

Thank you for taking the time to comment on the WAC 246-453 draft rules. Please submit any comment(s) you have as soon as possible prior to a scheduled meeting. Please submit a separate form for each section of the rules on which you would like to comment via email to: CharityCare@DOH.WA.GOV. Questions can also be directed to charitycare@doh.wa.gov.

Step 1: Please provide your contact details in case we need to contact you for further information or clarification.

Name: Leslie Bennett, Northwest Health Law Advocates

Phone/email: leslie@nohla.org

Name: Tony Gonzalez, Columbia Legal Services

Phone/email: tony.gonzalez@columbialegal.org

Step 2: The following statements help inform rule recommendations. 1-3 must be completed; 4-8 may be completed to your best ability or left blank.

1. **Section commented on:**

   246-453-010/DOH comment on definitions

2. **Position (support/oppose): Choose an item.**

   Support and oppose.

3. **Suggested solution/proposed language:**

   We offer the following feedback and proposals related to the Definitions section at this preliminary phase of the comment process. As we proceed in the rulemaking process and gauge possible interactions with other sections, we may revisit this feedback.

   a. Support alphabetizing the definitions.

   b. Support deleting the definition of manual.

c. Oppose adoption of reference to the RCW for definitions of terms within the WAC, in favor of including the full definitions as stated in the RCW for all terms therein defined: “Department,” “Hospital,”, “Secretary,” “Charity Care,” “Indigent Persons,” “Third-party coverage,” and “Special studies,” with specific modifications below to clarify ambiguity in the legislative language.

d. Support defining “Charity care” with these modifications:

“Charity care” means medically necessary hospital-based 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 copayments, deductibles, or coinsurance amounts required by a third-party payer, as determined by the department.

e. Oppose suggested changes to the definition of “Emergency medical condition” and recommend including a reference to EMTALA and these modifications:

“Emergency medical condition” means the same as described in the Emergency Medical Treatment and Active Labor Act, EMTALA, 42 U.S.C. Sec. 1395dd and implementing guidance,
(a) a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in:
(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
(ii) serious impairment of bodily functions;
(iii) serious dysfunction of any bodily organ or part; or
(b) with respect to a pregnant woman who is having contractions the term shall mean:
(i) that there is inadequate time to effect a safe transfer to another hospital before delivery; or
(ii) that transfer may pose a threat to the health or safety of the woman or the unborn child;

f. Propose changing the definition of “Family” to “Family size” with these modifications:

"Family size" means ~~a group of two or more persons~~ the total number of people in a household who are related by birth, marriage, or adoption who live together ~~all such related persons are considered as members of one family~~;

g. Propose a definition of "Good faith efforts towards payment of health care services" be included:

"Good faith efforts towards payment of health care services" means that the patient has made some attempt to communicate with the hospital to make payment arrangements on the related outstanding balance or to inform the hospital of a financial or other inability to make payments. It is consistent with good faith to refuse or fail to make a payment or payments where the amount due is in dispute.

h. Support renaming "Appropriate hospital based medical services: to "Medically necessary hospital health care" with these modifications:

"Medically necessary hospital health care" means hospital-based services and services provided by a component of a hospital, which are reasonably calculated to prevent, 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 t~~There is no other equally effective and either more conservative or substantially less costly course of treatment that is available or suitable for the person requesting the service. For the purposes of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all.

i. Support defining "Publicly available" with these modifications:

"Publicly available" means ~~all of the following~~:
(a) Posted or prominently displayed within public areas of the hospital, including at least the following:
(i) Areas where patients are admitted or registered;
(ii) Emergency departments; and
(iii) Financial service or billing areas accessible to patients.
(b) Provided to the individual in writing and explained, at the time that the hospital requests information from the responsible party with regard to the availability of any third-party coverage;

(c) Posted to the hospital's website~~, if any,~~ in the form of the hospital's approved charity care policy, a plain language summary of the hospital's charity care policy, and the hospital's charity care application form;
(d) On all written estimates of the cost of care, hospital billing statements, and communications intended to solicit payment of a hospital bill in accordance with chapter 70.170 RCW, including any such communications by the hospital's vendor, contractor, or collections agency; and
(e) All written notifications are available in any language spoken by more than 10 percent of the population in the hospital's service area, and verbal explanations are interpreted for non-English speaking or limited-English speaking or other patients who cannot read or understand the writing and explanation, or any other higher standard that may apply under state or federal civil rights laws, including but not limited to U.S.C. Sec. 18116 (Sec. 1557 of the Affordable Care Act).

j. Recommend the term "Guarantor" be included in the definition of "Responsible party" as follows:

"Responsible party" or "guarantor" means that individual who is legally responsible for the payment of ~~any~~ hospital charges which are not ~~subject to~~ covered by third-party sponsorship or charity care;

k. Support defining "Third-party coverage" with these modifications:

"Third-party coverage" means an obligation on the part of an insurance company, health care service contractor, health maintenance organization, group health plan or group health plan sponsor, government program, tribal health benefits, or health care 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 which have resulted in the medical condition for which the patient has received hospital health care service. The pendency of such settlements, judgments, or awards must not stay hospital obligations to consider whether a patient is ~~an~~ eligible ~~patient~~ for charity care.

"Third-party coverage" should replace all references to "third-party sponsorship" or "sponsorship" in the WAC; 246-453 010(14); 246-453-010(20); 246-453-020(4); and 246-453-040(1).

Washington State Department of Health

4. Statement of problem/comment and substantiation:

We support alphabetizing definitions and eliminating “manual” to improve readability and reduce confusion. We believe it is appropriate to include the following revised definitions in the WAC to clarify charity care requirements for hospitals and the public.

We recommend that the definitions articulated in the RCW be included in the WAC for two reasons: (1) it is in keeping with how the rest of the definitions are provided, and (2) it is easier to have the definitions all in one place, rather than requiring the public and regulated entities to have to refer to the RCW for some of the definitions. In our experience, some people may be intimidated by statutory language cross-references and it is easier to provide one resource that is more consumer-friendly.

The proposed addition of copayments to “charity care” is geared toward capturing all cost-sharing that may be associated with the delivery of health care to an indigent person. The current statute describes two common forms of cost-sharing, coinsurance and deductibles, but fails to include flat dollar copayments, another common form of patient cost-sharing for those enrolled in insurance. We believe this is a technical oversight, particularly because in many cases, copayments are smaller than coinsurance. As a practical matter, we are not aware of hospitals that differentiate between copayments and other forms of cost-sharing, so we expect other stakeholders will be amenable to this change.

The proposed additions to “emergency medical condition” clarify the definition by incorporating reference to EMTALA requirements and suggesting grammatical changes to improve flow and readability. Because hospitals are familiar with EMTALA in other contexts, we expect that adding this reference to explain the underlying source of the current standard will serve as a helpful reference point.

The proposed changes to the definition of “family” address two problems with the current definition. First, the charity care statute at RCW 70.170.060 uses the term “family size” rather than “family” because this definition is intended to relate only to the number of people counted for purposes of the FPL-based eligibility standard. Second, the current definition in the WAC appears to exclude households of one. The proposed “family size” definition would address both issues.

We propose adding a definition for “good faith efforts towards payment of health care services” because this term is used in RCW 170.70.060(10)(b), but it is not defined. The proposed definition would clarify the obligations of patients and hospitals relative to patients who are not offered charity care in accordance with RCW requirements.

The proposed amendments to the definition of “medically necessary hospital health care” address two problems in the current definition. First, the current definition does not address the fact that many hospitals in Washington have increasingly complex care delivery systems, such as multiple physical locations or multi-hospital systems with integrated care delivery. The proposed amendments would modernize “hospital services” to account for this changing landscape. Second, the current definition fails to properly articulate the long-standing standard in the *Mead v. Burdman* consent decree, which defines medical necessity for analogous state medical assistance programs.. Under the correct standard, the alternative treatment must be equally effective and also must be either more conservative or less costly. The *Mead v. Burdman* decision is attached, the standard is on pages 2-3.

The proposed amendments to the definition of “publicly available” address two flaws in the current rules. First, the current language does not address the role that vendors, collection agencies, and other subcontractors now play in administering patient billing and collections on behalf of hospitals. The ongoing litigation involving Providence and their collection agencies make clear that this guidance is now necessary to ensure that business partners execute the rules properly when performing billing-related duties on behalf of hospitals. Second, the current reference to specific language access standards does not fully capture the statutory language in RCW 70.170.060(6), which states that hospitals are subject to “federal and state laws to provide meaningful access for limited English proficiency and non-English-speaking patients…” The proposed amendments clarify that additional standards apply beyond the “ten percent of the population” standard, including but not limited to the Affordable Care Act’s Section 1557 nondiscrimination law and rules. Section 1557 requires all hospitals that receive federal funding– that is, all hospitals in WA state, given their Medicaid and Medicare patients– to provide meaningful access for individuals with limited English proficiency according to specific standards articulated in federal rule (see 45 CFR § 92.101). Without including a reference to Sec. 1557 and other applicable laws, regulated hospitals may not understand that their

charity care-related notices must also meet these parallel laws, as specifically contemplated in the language of RCW 70.170.060(9).

It is appropriate to replace "third-party sponsorship" with "third-party coverage," as the latter is now the term that is defined in the revised RCW. We also recommend clarifying the requirement that a hospital must determine whether a patient is eligible for charity care at the time of service regardless of whether there may be recovery at a later time for costs associated with treatment provided due to another's negligence. It is often the case that liability for the costs related to the medical care resulting from third-party negligence can take years to resolve. It is inappropriate for a hospital to delay a charity care determination given the requirements of RCW 70.170.06(10), "A hospital is required to make every reasonable effort to determine . . . [t]he existence or nonexistence of private or public sponsorship which might cover in full or in part the charges for care rendered by the hospital to a patient."

5. **Applicable research and/or substantiation of suggested solution/proposed language:**

6. **Benefit of suggested solution/proposed language to the public:**

7. **Benefit of suggested solution/proposed language to hospitals:**

8. **Identified impacts (cost or otherwise) of suggested solution/proposed language to hospitals:**

Discussion Notes (DOH staff only):

IN THE SUPERIOR COURT OF THE STATE OF WASHINGTON FOR KING COUNTY

CARL MEAD, SVEA GUSTAFSON, DEBORAH HAUGLAND, MARGARET LANCE, BESSIE DICKERSON, and ELIZABETH HOUSE, individually and on behalf of all other persons similarly situated, Plaintiffs, vs. MILTON BURDMAN, in his capacity as Secretary of the Washington State Department of Social and Health Services; DR. JOHN BEARE, in his capacity as Director of Health Services Division of the Washington State Department of Social and Health Services; RICHARD NELSON, in his capacity as Chief of the Medical Assistance Office of the Washington State Department of Social and Health Services; and ROBERT P. HALL, in his capacity as Chief of the Office of Personal Health Services of the Washington State Department of Social and Health Services, Defendants.	CLASS ACTION NO. 818663 CONSENT ORDER FOR DECLARATORY AND INJUNCTIVE RELIEF

THIS MATTER having come on before the undersigned Judge of the above-entitled Court, and this Court having certified this action as a Class Action pursuant to CR 23(a) and (b)(2), and the parties now having reached agreement as to the issues, and the Court having considered the records and being fully advised in this matter, IT IS HEREBY

FILED

EVERGREEN LEGAL SERVICES
5300 Ballard Avenue N.W.
Seattle, Washington 98107
464-5921

ORDERED that:

1. Defendant Harlan McNutt shall be substituted as a Defendant in this action and replace his predecessor in office, Defendant Milton Burdman, as one of the Defendants in this suit.

2. Defendants are permanently enjoined from denying requests for medical services from financially eligible Medicaid recipients for fiscal rather than medical reasons. For the purposes of the injunctive relief granted in this section, pursuant to CR 23(a) and (b)(2), such relief shall extend to the class of persons who are Washington residents who are financially eligible to participate in the Washington Medicaid program.

3. A. The Defendants shall approve all requests for inpatient hospital medical services provided pursuant to the State Title XIX plan which are "medically necessary" as that term is defined in this section.

B. Consistent with this Court's order of April 12, 1977 certifying this action as a class action pursuant to CR 23(a) and (b)(2), for the purposes of the relief granted in this section the class that plaintiffs represent shall include all Washington residents who are or were financially eligible to participate in the Medicaid program whose applications for inpatient hospital services were denied by Defendants for the fiscal and other reasons set forth in the Complaint in this matter which are inconsistent with the controlling federal regulations and the state and federal constitutions, provided that such denials occurred between April 1, 1975 and the date of this order.

C. In determining whether a requested service is medically necessary the Department shall apply the standard and follow the procedure set forth below.

(1) A requested service is "medically necessary" if:

a. The requested service is reasonably calculated to prevent, diagnose, correct, cure, alleviate, or prevent the worsening of conditions in the recipient that:

i. endanger life; or
ii. cause suffering or pain; or
iii. result in illness or infirmity; or
iv. threaten to cause or aggravate a handicap; or
v. cause physical deformity or malfunction; and

b. There is no other equally effective

i. more conservative, or
ii. substantially less costly

course of treatment available or suitable for the recipient requesting the service. For the purpose of this section "course of treatment" may include mere observation or, where appropriate, no treatment at all.

(2) In all cases where such evidence is obtainable, the Defendants shall approve the request if the recipient or provider submits sufficient objective clinical information (including, but not limited to, a physiological description of the disease, injury, impairment or other ailment; pertinent laboratory findings; x-ray reports; and patient profiles) to establish medical necessity.

(3) A request for medical services may be denied by the Defendants if the requested service is:

a. not medically necessary according to the standards set forth in section 3(c)(1) above,

b. generally regarded by the medical profession as experimental in nature, or

c. generally regarded by the medical profession as unacceptable treatment,

unless the recipient can demonstrate through sufficient objective clinical evidence the existence of particular circumstances which render the requested service medically necessary.

4. The Defendants shall approve or deny all requests for medical services within fifteen days of the receipt of the request, except that if additional justifying information is necessary before a decision can be made, the request shall be neither

approved nor denied but shall be returned to the provider within 5 working days of the original receipt. If additional justifying information is not returned within 30 days of the date it was returned to the provider, then the original request shall be approved or denied. However, if such information is returned to the Defendants, the request shall be acted upon within 5 working days of the receipt of the additional justifying information.

5. Whenever the Defendants deny a request for medical services the Defendants shall, within 5 working days of the decision, give written notice of the denial to the recipient and the provider. In order to fully inform the recipient, the notice shall state:

A. The specific reasons for the Defendant's conclusion to deny the requested service.

B. If a fair hearing is requested, a medical assessment other than that of the person or persons involved in making the original decision may be obtained at the expense of the Department of Social and Health Services, and instructions on how to obtain such assessment.

C. That the recipient has a right to a fair hearing if the request is made within 30 days of receipt of the denial, with the instruction on how to request the hearing.

D. That the recipient may be represented at the hearing by legal counsel or other representative.

E. That upon request, the local public assistance office shall furnish the recipient the name and address of the nearest Legal Services office.

6. The Defendants shall promulgate new regulations to effectuate the terms of this order. Such regulations shall be promulgated and in effect within 20 days of the date of this order.

7. The Defendant shall reimburse the providers and/or the following named Plaintiffs and class members for all medical expenses which have been the subject of this action: Carl Mead, Svea Gustafson, Margaret Lance, Bessie Dickerson, Elizabeth House, Diane Wood, Eudora Cameron, Gladys Short, Carol Watson, Marie

Bogner, Leonard Greer, and Debra Haugland.

8. The Defendants shall, no later than April 6, 1978, give written notice by way of warrant insert by regular mail to all persons now on Medical Assistance. Said notice shall be in the form set out in Appendix A attached hereto.

9. The Defendants shall, commencing no later than April 2, 1978, publish the notice attached hereto as Appendix A, on three consecutive Sundays, in a section or page of the following newspapers, such publication not to appear within the classified advertisements: Aberdeen Daily Record, Bellingham Herald, Bremerton Sun, Ellensburg Daily Record, Grant County Journal, Everett Herald, Tacoma News Tribune, Port Angeles Daily News, Seattle Times, Seattle Post Intelligencer, Daily Olympian, Spokane Chronicle, Spokeman Review, Vancouver Columbian, Centralia Daily Chronicle, Longview Daily News, Columbia Basin Herald, Skagit Valley Herald, Walla Walla Union Bulletin, Wenatchee Daily World, Yakima Herald Republic, and Tri-City Herald. In the event any of the above newspapers do not have Sunday editions, said notice shall appear in the newspaper on the day of the highest circulation.

10. The notice contained in Appendix A shall be duplicated and placed in all Economic and Social Services offices of the Department of Social and Health Services.

11. The Defendants shall, no later than March 6, 1978, advise the Washington State Medical Association of the settlement of this lawsuit and provide the Association with a copy of this order.

12. All class members shall have until September 30, 1978, to request the Department of Social and Health Services to review their requests for inpatient hospital services.

13. All requests for review shall be submitted to:

Office of Medical Assistance
DSHS
LK-11
Olympia, Washington 98504

and the requests will be approved or denied no longer than 30 days after submission. If the request is denied, written notice will be sent by the Defendants to the applicant and his or her physician, when known, and will contain the provisions mandated by paragraph five of this order.

14. When conducting reviews mandated by this order, it shall be the Department's responsibility to fully inform the recipient of any additional evidence which the recipient or his or her physician must submit to complete the review.

15. The requests for review will be approved or denied on the basis of medical necessity utilizing the standards set forth in paragraph three of this order.

16. Nothing in this order shall prevent the Department from changing the regulations adopted pursuant to this order, provided that such changes are made in a manner consistent with the applicable administrative procedure act provisions; and provided that in no event shall the Department adopt changes which are in violation of applicable federal statutes and regulations.

17. Defendants shall pay Plaintiffs' attorneys reasonable attorneys fees and costs of litigation in an amount to be determined by agreement or at a subsequent hearing.

DONE IN OPEN COURT this 20 day of March, 1978.

David P. Hunter
DAVID HUNTER, Judge

NOTICE TO CLASS

The King County Superior Court has issued an order that requires the Department of Social and Health Services (Public Assistance-Medicaid) to approve or deny requests for medical services on the basis of "medical necessity", rather than on whether funds exist to pay for requested services. From April 1, 1975 to the present time, certain persons may have been denied approval for surgery and other hospital services because the Department said it lacked the funds to pay for them.

If you were denied approval for surgery or other hospital services during this period because of lack of Medicaid funds or if the bills were not paid by the Department for this reason, you may still be eligible to receive such services and have them paid for.

If you believe that you may be affected by this ruling, please contact your physician and fill out and mail this form to: Office of Medical Assistance, DSHS, LK-11, Olympia, Washington 98504.

If you desire to have your request for hospital services reviewed, you must send in the attached form no later than September 30, 1978. If you have any questions, contact:

JEFF SPENCE
5308 Ballard Ave. N.W.
Seattle, WA 98107
(206) 464-5921

ARNOLD WHEDBEE
2018 Smith Tower
Seattle, WA 98104
(206) 464-5933

----------DETACH HERE----------

REQUEST FOR REVIEW OF DENIAL OF HOSPITAL SERVICES

Mail this form to: Office of Medical Assistance
DSHS, LK-11
Olympia, Washington 98504

Your Name _____ Address _____

_____

Your Physician's Name (if known) _____ Your Phone Number _____

Your Birthdate _____ Date of Denial (if known) _____

Today's Date _____ Name of Hospital (if known) _____

Presented by:

JEFF SPENCE, Attorney for Plaintiffs

ARNOLD WHEDBEE, Attorney for Plaintiffs

Approved as to Form, Notice of Presentation Waived by:

WALTER WHITE, Assistant Attorney General
Attorney for Defendants

EVERGREEN LEGAL SERVICES
5308 Ballard Ave. N.W.
Seattle, WA. 98107
(206) 464-5921

¶ 28,957 WASHINGTON—MEDICAL NECESSITY OF INPATIENT HOSPITAL SERVICES

Carl Mead v. Milton Burdman, Secretary. Washington Superior Court, King Co Class Action No. 818663, Mar. 20, 1978.

Washington—Medical necessity of inpatient hospital services.—Medicaid recipien the state of Washington must be given medically necessary inpatient hospital ser A service is "medically necessary" if it is reasonably calculated to prevent, diagn correct, cure, alleviate, or prevent the worsening of conditions that endanger life, c suffering or pain, result in illness or infirmity, threaten to cause or aggravate a hand or cause physical deformity or malfunction, and if there is no other equally effe (although more conservative or less costly) course of treatment available or suitable the recipient requesting the service. For this purpose, a "course of treatment" include mere observation or (where appropriate) no treatment at all. Coverage may denied if the requested service is not medically necessary according to the foreg criteria, or is generally regarded by the medical profession as experimental or unaccepta unless objective clinical evidence demonstrates circumstances making the requested ser necessary. Recipients whose requests for inpatient hospital services were denied betw April 1, 1975, and March 20, 1978, have until September 30, 1978, to resubmit their pitalization requests for review in light of this decision. Reimbursement of certain viders and recipients is ordered. The state's Medicaid agency must publish notice of decision and must make it known to all recipients. *Back references:* ¶ 14,511.51, 14, 15,654.

HUNTER, Judge: This matter having come on before the undersigned Judge of the above-entitled Court, and this Court having certified this action as a Class Action pursuant to CR 23(a) and (b)(2), and the parties now having reached agreement as to the issues, and the Court having considered the records and being fully advised in this matter, It Is Hereby Ordered that:

1. Defendant Harlan McNutt shall be substituted as a Defendant in this action and replace his predecessor in office, Defendant Milton Burdman, as one of the Defendants in this suit.

2. Defendants are permanently enjoined from denying requests for medical services from financially eligible Medicaid recipients for fiscal rather than medical reasons. For the purposes of the injunctive relief granted in this section, pursuant to CR 23(a) and (b)(2), such relief shall extend to the class of persons who are Washington residents who are financially eligible to participate in the Washington Medicaid program.

3. A. The Defendants shall approve all requests for inpatient hospital medical services provided pursuant to the State Title XIX plan which are "medically necessary" as that term is defined in this section.

B. Consistent with this Court's order of April 12, 1977 certifying this section as a class action pursuant to CR 23(a) and (b)(2), for the purposes of the relief granted in this section the class that plaintiffs represent shall include all Washington residents who are or were financially eligible to participate in the Medicaid program wh applications for inpatient hospital servi were denied by Defendants for the fis and other reasons set forth in the Compla in this matter which are inconsistent w the controlling federal regulations and state and federal constitutions, provic that such denials occurred between April 1975 and the date of this order.

[*Medical Necessity*]

C. In determining whether a request service is medically necessary the Depa ment shall apply the standard and follc the procedure set forth below.

(1) A requested service is "medically nece sary" if: a. The requested service is reaso ably calculated to prevent, diagnose, corre cure, alleviate, or prevent the worsening conditions in the recipient that:

i. endanger life; or

ii. cause suffering or pain; or

iii. result in illness or infirmity; or

iv. threaten to cause or aggravate handicap; or

v. cause physical deformity or malfunc tion; and

b. There is no other equally effective

i. more conservative, or

ii. substantially less costly

course of treatment available or suitable for the recipient requesting the service. For the purpose of this section "course of treat-

Exhibit B

ment"' may include mere observation or, where appropriate, no treatment at all.

(2) In all cases where such evidence is obtainable, the Defendants shall approve the request if the recipient or provider submits sufficient objective clinical information (including, but not limited to, a physiological description of the disease, injury, impairment or other ailment; pertinent laboratory findings; x-ray reports; and patient profiles) to establish medical necessity.

(3) A request for medical services may be denied by the Defendants if the requested service is:

a. not medically necessary according to the standards set forth in section 3(c)(1) above,

b. generally regarded by the medical profession as experimental in nature, or

c. generally regarded by the medical profession as unacceptable treatment,

unless the recipient can demonstrate through sufficient objective clinical evidence the existence of particular circumstances which render the requested service medically necessary.

[*Approval and Denial of Requests*]

4. The Defendants shall approve or deny all requests for medical services within fifteen days of the receipt of the request, except that if additional justifying information is necessary before a decision can be made, the request shall be neither approved nor denied but shall be returned to the provider within 5 working days of the original receipt. If additional justifying information is not returned within 30 days of the date it

was returned to the provider, then the original request shall be approved or denied. However, if such information is returned to the Defendants, the request shall be acted upon within 5 working days of the receipt of the additional justifying information.

5. Whenever the Defendants deny a request for medical services the Defendants shall, within 5 working days of the decision, give written notice of the denial to the recipient and the provider. In order to fully inform the recipient, the notice shall state:

A. The specific reasons for the Defendant's conclusion to deny the requested service.

B. If a fair hearing is requested, a medical assessment other than that of the person or persons involved in making the original decision may be obtained at the expense of the Department of Social and Health Services, and instructions on how to obtain such assessment.

C. That the recipient has a right to a fair hearing if the request is made within 30 days of receipt of the denial, with the instruction on how to request the hearing.

D. That the recipient may be represented at the hearing by legal counsel or other representative.

E. That upon request, the local public assistance office shall furnish the recipient the name and address of the nearest Legal Service office.

[Corrective Measures]

6. The Defendants shall promulgate new regulations to effectuate the terms of this order. Such regulations shall be promulgated and in effect within 20 days of the date of this order.

7. The Defendant shall reimburse the providers and/or the following named Plaintiffs and class members for all medical expenses which have been the subject of this action: Carl Mead, Svea Gustafson, Margaret Lance, Bessie Dickerson, Eliz House, Diane Wood, Eudora Cam Gladys Short, Carol Watson, Marie Bo Leonard Greer, and Debra Haugland.

8. The Defendants shall, no later April 6, 1978, give written notice by w warrant insert by regular mail to all per now on Medical Assistance. Said n shall be in the form set out in Append attached hereto.

9. The Defendants shall, commencin later than April 2, 1978, publish the n attached hereto as Appendix A, on t consecutive Sundays, in a section or pag the following newspapers, such publica not to appear within the classified adver ments: Aberdeen Daily Record, Bellingl Herald, Bremerton Sun, Ellensburg D Record, Grant County Journal, Eve Herald, Tacoma News Tribune, Port geles Daily News, Seattle Times, Sea Post Inteiligencer, Daily Olympian, Spok Chronicle, Spokeman Review, Vancou Columbian, Centralia Daily Chronicle, Lo view Daily News, Columbia Basin Her Skagit Valley Herald, Walla Walla Un Bulletin, Wenatchee Daily World, Yaki Herald Republic, and Tri-City Herald. the event any of the above newspapers not have Sunday editions, said notice sh appear in the newspaper on the day of t highest circulation.

10. The notice contained in Appendix shall be duplicated and placed in all Ec nomic and Social Services offices of the D partment of Social and Health Services.

11. The Defendants shall, no later th March 6, 1978, advise the Washington Sta Medical Association of the settlement this lawsuit and provide the Associatic with a copy of this order.

12. All class members shall have unt September 30, 1978, to request the Depar ment of Social and Health Services to r view their requests for inpatient hospit services.

Comment Form

Thank you for taking the time to comment on the WAC 246-453 draft rules. Please submit any comment(s) you have as soon as possible prior to a scheduled meeting. Please submit a separate form for each section of the rules on which you would like to comment via email to: CharityCare@DOH.WA.GOV. Questions can also be directed to charitycare@doh.wa.gov.

Step 1: Please provide your contact details in case we need to contact you for further information or clarification.

Name: Leslie Bennett, Northwest Health Law Advocates

Phone/email: leslie@nohla.org

Name: Tony Gonzalez, Columbia Legal Services

Phone/email: tony.gonzalez@columbialegal.org

Step 2: The following statements help inform rule recommendations. 1-3 must be completed; 4-8 may be completed to your best ability or left blank.

1. **Section commented on:**

246-453-020/DOH comment on uniform procedures for the identification of indigent persons.

2. **Position (support/oppose): Choose an item.**

Support with modifications.

3. **Suggested solution/proposed language:**

We offer the following feedback related to 246-453-020 at this preliminary phase of the comment process. As we proceed in the rulemaking process and gauge possible interactions with other sections, we may revisit this feedback.

We support the addition of the following new sections to 246-453-020 Uniform procedures for the identification of indigent persons**:**

For the purpose of identifying those patients that will be classified as indigent persons, all hospitals shall adopt and implement the following procedures:

(1) The initiation of collection efforts directed at the responsible party shall be precluded pending an initial determination of sponsorship status, provided that the responsible party is cooperative with the hospital's efforts to reach an initial determination of sponsorship status;
(a) Collection efforts shall include any demand for payment or transmission of account documents or information which is not clearly identified as being intended solely for the purpose of transmitting information to the responsible party;
(b) The initial determination of sponsorship status shall be completed at the time of admission or as soon as possible following the initiation of services to the patient;
(c) If the initial determination of sponsorship status indicates that the responsible party may meet the criteria for classification as an indigent person, as described in WAC 246-453-040, collection efforts directed at the responsible party will be precluded pending a final determination of that classification, provided that the responsible party is cooperative with the hospital's reasonable efforts to reach a final determination of sponsorship status;
(d) During the pendency of the initial determination of sponsorship status and/or the final determination of the applicability of indigent person criteria, hospitals may pursue reimbursement from any third-party coverage that may be identified to the hospital;
(e) The requirements of this subsection shall not apply to clinics operated by disproportionate share hospitals, as defined and identified by the department of social and health services, medical assistance services, provided that patients are advised of the availability of charity care at the time that services are provided and when presented with a request for payment.

(2) Notice shall be made publicly available that charges for services provided to those persons meeting the criteria established within WAC 246-453-040 may be waived or reduced.

(3) Any responsible party who has been initially determined to meet the criteria identified within WAC 246-453-040 shall be provided with at least fourteen calendar days 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 as described within WAC 246-453-030 prior to receiving a final determination of sponsorship status.

(4) Hospitals must make every reasonable effort to determine the existence or nonexistence of third-party sponsorship that might cover in full or in part the charges for services provided to each patient.

(5) Hospitals may require potential indigent persons to use an application process attesting to the accuracy of the information provided to the hospital for purposes of determining the person's qualification for charity care sponsorship. Hospitals may not impose application procedures for charity care sponsorship which place an unreasonable burden upon the responsible party, taking into account any physical, mental, intellectual, or sensory deficiencies or language barriers which may hinder the responsible party's capability of complying with the application procedures. The failure of a responsible party to reasonably complete appropriate application procedures shall be sufficient grounds for the hospital to initiate collection efforts directed at the patient.

(6) Hospitals may not require deposits from those responsible parties meeting the criteria identified within WAC 246-453-040 (1) or (2), as indicated through an initial determination of sponsorship status.

(7) Hospitals must notify persons applying for charity care sponsorship of their final determination of sponsorship status within fourteen calendar days of receiving information in accordance with WAC 246-453-030; such notification must include a determination of the amount for which the responsible party will be held financially accountable.

(8) In the event that the hospital denies the responsible party's application for charity care sponsorship, the hospital must notify the responsible party of the denial and the basis for that denial.

(9) All responsible parties denied charity care sponsorship under
WAC 246-453-040 (1) or (2) shall be provided with, and notified of, an appeals procedure that enables them to correct any deficiencies in documentation or request review of the denial and results in review of the determination by the hospital's chief financial officer or equivalent.
(a) Responsible parties shall be notified that they have thirty calendar days within which to request an appeal of the final determination of sponsorship status. Within the first fourteen days of this period, the hospital may not refer the account at issue to an external collection agency. After the fourteen day period, if no appeal has been filed, the hospital may initiate collection activities.
(b) If the hospital has initiated collection activities and discovers an appeal has been filed, they shall cease collection efforts until the appeal is finalized.

(c) In the event that the hospital's final decision upon appeal affirms the previous denial of charity care designation under the criteria described in WAC 246-453-040 (1) or (2), 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.
(d) The department will review the instances of denials of charity care. In the event of an inappropriate denial of charity care, the department may seek penalties as provided in RCW 70.170.070.

(10) Hospitals should make every reasonable effort to reach initial and final determinations of charity 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 the income standards in WAC 246-453-040 ~~two hundred percent of the federal poverty standard~~ as adjusted for family size. 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.

(11) Except as provided in subsections (12) and (13), ~~A~~ a final determination ~~of eligibility~~ must be made using the responsible party's annual family income ~~at~~ as of the time the health care services were provided. ~~responsible party applies for charity care sponsorship if~~:

~~(a) Application is made within two years of the time the health care services were provided; and~~
~~(b) The responsible party has been making good faith efforts toward payment of health care services provided.~~

(12) If the responsible party was previously denied sponsorship or granted less than a full discount of the charges, a final determination of eligibility may be made using the responsible party's annual ~~and meets criteria in subsection (11)(a) and (b) of this section, the responsible party may apply using~~ family income ~~as of~~ at the time ~~of~~ the ~~new application~~responsible party applies for charity care sponsorship if:
(a) the application is made within two years of the time the health care services were provided; and
(b) the responsible party has been making good faith efforts toward payment of health care services provided.

~~(13) Except as provided in subsections (11) and (12) of this section, a final determination must be made using the responsible party's annual family income as of the time the health care services were provided.~~

(13~~4~~) The hospital may, at its discretion, and at the request of the responsible party, make a final determination of eligibility using the responsible party's annual family income as of the time of the application at any time there is a change in the responsible party's financial circumstances, even if a previous application was denied or approved in part, regardless of whether the criteria in subsection (12)(a) and (b) of this section are met.

(14~~5~~) 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 charity care criteria at the time that services were provided, any payments in excess of the amount determined to be appropriate in accordance with WAC 246-453-040 shall be refunded to the patient within thirty days of achieving the charity care designation.

4. Statement of problem/comment and substantiation:

We support DOH's intention in proposing this language, but recommend changes to improve flow and readability. These additions make clear to hospitals and patients that the income amount used to determine charity care eligibility may be the income at the time the services were rendered or later, depending on the applicant's circumstances and is aligned with the requirements of RCW 70.170.060.

5. Applicable research and/or substantiation of suggested solution/proposed language:

6. Benefit of suggested solution/proposed language to the public:

7. Benefit of suggested solution/proposed language to hospitals:

8. Identified impacts (cost or otherwise) of suggested solution/proposed language to hospitals:

Washington State Department of Health

Discussion Notes (DOH staff only)

Comment Form

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Step 1: Please provide your contact details in case we need to contact you for further information or clarification.

Name: Leslie Bennett, Northwest Health Law Advocates

Phone/email: leslie@nohla.org

Name: Tony Gonzalez, Columbia Legal Services

Phone/email: tony.gonzalez@columbialegal.org

Step 2: The following statements help inform rule recommendations. 1-3 must be completed; 4-8 may be completed to your best ability or left blank.

1. **Section commented on:**

   246-453-040/WSHA Comment on uniform criteria for the identification of indigent persons

2. **Position (support/oppose): Choose an item.**

   Support with modifications.

3. **Suggested solution/proposed language:**

   We offer the following feedback related to the insertion of tiering language in WAC 246-453-040 at this preliminary phase of the comment process. As we proceed in the rulemaking process and gauge possible interactions with other sections, we may revisit this feedback.

   Support inserting the tiering language from RCW 70.170.060(5) in WAC 246-453-040, as proposed by WSHA with the proposed modifications:

(1) For the purpose of identifying indigent persons, hospitals owned or operated by a health system that owns or operates three or more acute hospitals licensed under chapter 70.41 RCW, an acute care hospital with over 300 licensed beds located in the most populous county in Washington, or an acute care hospital with over 200 licensed beds located in a county with at least 450,000 residents and located on Washington's southern border shall use the following criteria:
(a) All responsible parties with family income equal to or below 300 percent of the federal poverty level, adjusted for family size, shall be determined to be indigent persons qualifying for charity sponsorship for the full amount of hospital charges related to medically necessary hospital health care that are not covered by private or public third-party coverage;
(b) All responsible parties with family income between 301 and 350 percent of the federal poverty level, adjusted for family size, shall be determined to be indigent persons qualifying for a 75 percent discount from charges related to medically necessary hospital health care that are not covered by private or public third-party coverage;
(c) All responsible parties with family income between 351 and 400 percent of the federal poverty level, adjusted for family size, shall be determined to be indigent persons qualifying for a 50 percent discount from charges related to medically necessary hospital health care that are not covered by private or public third-party coverage.

(2) All remaining hospitals shall use the following criteria for the purpose of identifying indigent persons:
(a) All responsible parties with family income equal to or below 200 percent of the federal poverty level, adjusted for family size, shall be determined to be indigent persons qualifying for charity sponsorship for the full amount of hospital charges related to medically necessary hospital health care that are not covered by private or public third-party coverage;
(b) All responsible parties with family income between 201 and 250 percent of the federal poverty level, adjusted for family size, shall be determined to be indigent persons qualifying for a 75 percent discount from charges related to medically necessary hospital health care that are not covered by private or public third-party coverage;
(c) All responsible parties with family income between 251 and 300 percent of the federal poverty level, adjusted for family size, shall be determined to be indigent persons qualifying for a 50 percent discount from charges related to medically necessary hospital health care that are not covered by private or public third-party coverage.

(3) Hospitals may only request or consider assets when calculating discount eligibility for responsible parties who ~~are not~~ have been determined ineligible for charity care sponsorship for the full amount of hospital charges. Assets may not be requested or considered when reviewing a charity care application for an individual who meets the requirements of (1)(a) and (2)(a) in this section.
(a) If a hospital requires the reporting of assets in order to reduce the discount extended under (1)(b) and (c) and 2(b) and (c), the hospital must establish and make publicly available its policy on asset consideration and corresponding discount reductions.
(b) In considering assets, a hospital may not impose procedures which place an unreasonable burden on the responsible party.
(c) Information requests for verification of assets shall be limited to what is reasonably necessary and readily available to substantiate the information and may not be used to discourage charity care applications.
(d) The hospital shall exclude the following types of assets from consideration.
(i) The first $5,000 of monetary assets for an individual or $8,000 of monetary assets 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 asset after the penalty has been paid;
(ii) Any 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) Any prepaid burial contract or burial plot; and
(vi) Any life insurance policy with a face value of $10,000 or less.

(4) In considering monetary assets, one current account statement shall be considered sufficient for a hospital to verify a patient's assets.

(5) In the event no documentation for an asset is readily available, a hospital shall rely upon a written and signed statement from the responsible party.

(6) Asset information obtained by the hospital in evaluating a patient for charity care eligibility shall not be used for collection activities by the hospital, the hospital's vendor, contractor, or collections agency.

(7) Hospitals may exceed the minimum standards of this section, so long as any additional eligibility standards are documented and publicly available in the hospital's policy, approved by the department as aligned with the purposes of this chapter, and uniformly applied.

4. **Statement of problem/comment and substantiation:**

We support including the tiering language in the WAC rather than refer to the RCW for consistency and propose the inclusion of the requirements of RCW 70.070.060(5)(c) to provide clarity and complete guidance to hospitals about what is appropriate to consider when evaluating assets as part of a charity care application. We also clarified that hospitals may only request asset information for applicants who exceed the maximum income standards, as contemplated by the statute. Finally, we propose adding a new subsection to clarify that hospitals may voluntarily exceed the minimum standards required by law, as many hospitals currently do.

Note that while we have proposed importing the asset standard as it appears in the statute with minor modifications for clarity, we intend to suggest additional language to further clarify the asset standard later in the rulemaking process.

5. **Applicable research and/or substantiation of suggested solution/proposed language:**

6. **Benefit of suggested solution/proposed language to the public:**

7. **Benefit of suggested solution/proposed language to hospitals:**

8. **Identified impacts (cost or otherwise) of suggested solution/proposed language to hospitals:**

Discussion Notes (DOH staff only):

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Step 2: The following statements help inform rule recommendations. 1-3 must be completed; 4-8 may be completed to your best ability or left blank.

1. **Section commented on:**

   246-453-050/DOH comment on sliding fee schedules

2. **Position (support/oppose): Choose an item.**

   Support.

3. **Suggested solution/proposed language:**

   We offer the following feedback related to WAC 246-453-050 at this preliminary phase of the comment process. As we proceed in the rulemaking process and gauge possible interactions with other sections, we may revisit this feedback.

   We support the elimination of 246-453-050 and all references to hospitals' sliding fee schedules, since hospitals no longer have discretion to develop them and must comply with the requirements of RCW 70.170.060(5). Instead, we recommend amending WAC 246-453-040 to incorporate the revised statutory eligibility standards.

Washington State Department of Health

4. **Statement of problem/comment and substantiation:**

5. **Applicable research and/or substantiation of suggested solution/proposed language:**

6. **Benefit of suggested solution/proposed language to the public:**

7. **Benefit of suggested solution/proposed language to hospitals:**

8. **Identified impacts (cost or otherwise) of suggested solution/proposed language to hospitals:**

Discussion Notes (DOH staff only):