PACIFIC GROVE HOSPITAL	Business Office	Policy # ALL.ACHC.BO.0160
	ACHC.BO.0160 – Financial Assistance	Effective: 06/01/2012
		Last Reviewed/Revised: 12/01/2022
		Superseded Policy #

1. SCOPE
   Acadia Healthcare Co., Inc., including all subsidiaries, affiliates, facilities, and their personnel.

2. PURPOSE
   To determine qualifications for financial assistance.

3. POLICY
   It is the company's policy to provide financial assistance based on federal poverty guidelines to patients with no health insurance or other state or federal health assistance or for whom the out of pocket expenses are significant, All financial assistance will be provided based on established protocols and completion of the Financial Disclosure Form (Attachment A) and supporting documentation.

4. PROCEDURE
   As stated in policy ACHC.BO.0140 Insurance Verification, all facilities must perform verification of benefits for each patient and each potential payer prior to or upon admission. If an admission occurs after normal business hours, the verification must be performed no later than the next business day. This Insurance verification process should be completed to identify any potential resources for the patient's medical services, whether federal or state governmental health care program (e.g. Medicare, Medicaid, state or local government agency, Champus, Medicare HMO, Medicare secondary payer), private insurance company, or other private, non-governmental third party payer source.

   Financial assistance is not considered to be a substitute for personal responsibility. It is the responsibility of the patient/responsible party to actively participate in the financial assessment process and provide timely, accurate information, as requested. This requested information may include information concerning actual or potentially available health benefits such as COBRA coverage or Medicaid/state or local government agency coverage, Failure to provide accurate and timely information may subject the patient/responsible party to a denial of financial assistance.

Self-pay/Uninsured Patients

All self-pay/uninsured patients (no current insurance coverage) will be requested to pre-pay for all services at time of admission/registration. Each facility must have a self-pay deposit schedule based on various estimated lengths of stay and the facility's established self-pay rate. This deposit schedule should be used to estimate the upfront payment that is required for self-pay patients.

If the patient is unable to pre-pay for services, the patient will be financially assessed during the pre-admission or admission process. The Financial Counselor, or designated Business Office staff member, will then meet with the patient and request that Attachment A - Financial Disclosure Form be completed. This form must be completed verbally or in person before the Equifax reporting tool can be utilized.

As stated in further detail in ACHC.BO.0150 Financial Counseling policy, the Financial Counselor or Business Office Representative will meet with each patient or guarantor expected to have an out-of-pocket liability to discuss payment arrangements and facilitate the completion of the Financial Disclosure Form.

Financially or Medically Indigent Patients

Financial assistance can be provided to qualified patients in accordance with the discount scale outlined in this policy. Financial Indigence can be determined by the verification of Medicaid eligibility for the dates of service. Financially and medically indigent patients are defined in further detail in the definitions found at the end of this policy.

If the patient is unable to pay estimated out-of-pocket expenses, the patient will be financially assessed during the pre-admission or admission process in accordance with ACHC.BO.0150 Financial Counseling policy. During the counseling session, the Patient Responsibility Worksheet (Attachment A -Policy ACHC.BO.0150 Financial Counseling) will be utilized by the facility to assist in determining the capacity of the patient/responsible party to pay their estimated liability.
During the financial counseling process, the facility may reasonably determine that COBRA coverage is available to the patient. In these cases, the patient will provide the facility with information necessary to determine the monthly COBRA premium by completing the
Application for COBRA Assistance (Attachment D). If the facility determines that the patient is financially unable to pay the COBRA premiums the facility may decide to pay the COBRA premium on behalf of the patient/responsible party. Payment of any COBRA premiums must be approved by the facility CEO and CFO prior to payment.

Determining Qualification for Financial Assistance

The Patient Responsibility Worksheet along with the Financial Disclosure Form will be reviewed by the Business Office Director (BOD) and facility CFO. These completed forms are required for the qualification of patients for financial assistance.

The BOD or Financial Counselor is responsible for ensuring the completion of the Financial Disclosure Form by the patient/responsible party during the financial counseling process to evidence their ability to pay. All supporting documentation should be attached to the Financial Disclosure Form such as insurance verifications, bank statements, proof of income and Equifax.

The BOD or Financial Counselor must verify the assets and income of the patient/responsible party during the qualification process. The facility must have at least one form of documentation from the list below in order to verify and analyze the information received on the Financial Disclosure Form to determine financial assistance available for a patient/responsible party.

Documentation for income verification must be provided to the facility within 30 days of discharge for the patient/responsible party to be eligible for financial assistance. To complete Income Verification, the facility must have one of the following:

- Most Recent Income Tax Return
- Most Recent Paystubs (must span 4 weeks or 30-day period)
- Social Security Statement of Earnings
- SSI Disability Benefit Letter or Current Bank Statement showing Monthly Deposit
    - SSI Income via Direct Express is acceptable when a bank statement is unavailable.
- Unemployment Vouchers (must span 4 weeks or 30-day period)
- Letter from a Third Patty Source such as a Shelter, Mission or Group Home confirming Financial Status

Equifax can be used to further analyze patient's financial status for medically indigent patients but cannot be the primary source of data in the qualification process. Income verification documentation is the primary method in which financial assistance will be determined. There are no exceptions to this documentation requirement to receive financial assistance.

Final approval of the financial assistance offered to the patient will be determined by the facility management (CFO/CEO) based on their review of the completed Patient Responsibility Worksheet, the completed Financial Disclosure Form and documentation required for verifying income and assets of the patient/responsible party.

Approval and Recording of Financial Assistance

Financial or medical indigence (categorized as charity or indigent care on the facility general ledger) must be identified prior to the patient's discharge and must be logged on the Charity Log within the month identified. Charity Adjustments will be written off in the patient accounting system no later than the end of the month following discharge with the exception of insured patients which can be adjusted at the time of the remittance advice posting, Facilities involved in a joint venture with a non-profit organization must be aware of the different guidelines for the time period in which a patient may qualify for charity care and follow the agreed upon policy.

Upon identifying a self-pay 100% charity patient at admission — enter the self-pay payer in the patient's account so that a self-pay contractual will post. Indigent accounts pending Medicaid approval should not be immediately written off as Charity. Patients who are in process of being qualified for Medicaid eligibility should be included in the Medicaid Pending Financial Class and contractualized at the Medicaid reimbursement rate. If it is determined after discharge that the patient is not eligible for Medicaid coverage, however the patient meets indigent criteria for the facility, move the account to financial class "SX" for self-pay charity and process the patient's account balance (gross charge less Medicaid contractual) for a charity adjustment.

Income Level	% of Discount on Total Charges
Equal to or less than 133% ofFPG	100%
133% - 150% of FPG	75%
150% - 200% of FPG	50%
200% - 400% of FPG	25%
Greater than 400% of FPG	0%

Definitions:

Equifax is one of the largest sources of consumer and commercial data in the world and has been providing business solutions using advanced analytics and the latest technologies for over 100 years.

Financial Assistance also known as Charity Care or Discount is defined as a reduction in the cost of health care services granted to patients based on their capacity to pay their estimated liability.

Financially Indigent is defined as those patients who are accepted for medical care who are uninsured with no or a significantly limited ability to pay for the services rendered. These patients are also defined as economically disadvantaged and have incomes at or below the federal poverty guidelines. An individual may also be classified as "categorically needy" by proof of entitlement to some state or federal government programs such as SSI, Food Stamps, Aid to Families with Dependent Children (AFDC), or Medicaid for which entitlement has been established, but for which coverage may not be available for the specific type or level of service.

Medically Indigent is defined as those patients who incur severe or catastrophic medical expenses but are unable to pay and/or payment would require substantial liquidation of assets critical to living or would cause undue financial hardship to the family support system.

As noted in Accounting Policy #115.00 — Administrative, Denial, and Charity Care Adjustments, the following approvals are required for any Administrative or Charity Care patient account adjustment.

- BOD/CFO approval is required for financial assistance up to $5,000.
- Additional approval by CEO is required for financial assistance greater than $5,000 with Divisional CFO approval being required above $10,000 as stated in Policy #115.00 — Administrative, Denial, and Charity Care Adjustments.

A form letter provided, Notification of Determination of Eligibility for Financial Assistance (Attachment B) can be used as a notification letter to inform patients/responsible parties of the facility's determination of financial assistance.

All documentation for financial assistance must be maintained in the patient financial file. The amount of financial assistance will only be applied after recovery from all third party payers has been verified, Reductions in revenue deemed financial assistance shall not result in a credit balance or a refund situation.

Method for the Calculating of the Amount of Financial Assistance (Discounts)

This method is intended to illustrate a sliding scale. It should be used as a guide for facilities in conjunction with the completion of the Financial Disclosure Form and determination of any financial assistance,

This method uses the Federal Poverty Guideline (FPG) Schedule. This schedule can be accessed from the internet by putting the following data in your web browser — https://aspe.hhs.gov/poverty-guidelines For Pacific Grove Hospital in the State of California scale is 100% discount up to 400% FPG. First, find the number of the guarantor's dependents under the column labeled "Family Size". Then, locate the guarantor's gross annual income on the same row as the Family Size. In most cases, the guarantor's income will fall between two percentage categories (much like the tax schedule individuals use each year in determining how much they owe the government).

- With this information, determine the discount percentage based on the discount scale included herein. Example: Mr. Jones is uninsured and has met the criteria for the financially indigent. According to his federal income tax return, Mr. Jones earned $35,000 and has 4 dependents. Mr. Jones's total charges are $20,000. In this example, Mr. Jones's income level is 139% of the FPG and would therefore be eligible for a 50% discount of $10,000. Mr.
  Jones will be responsible for the remaining balance of $10,000.

5. REFERENCES

Attachments:

Attachment A — Financial Disclosure Form
Attachment B — Notification of Approval/Denial for Financial Assistance Attachment C — Charity Log
Attachment C – Charity Log
Attachment D – Application for COBRA assistance

Related Policies:

ACC-115.00	Administrative, Denial, and Charity Care Adjustments
ACHC.BO.0150	Financial Counseling
ACHC.BO.0140	Insurance Verification

APPROVAL: _____ Date: 12/1/23

PACIFIC GROVE HOSPITAL

Policy Title: Collections-AR Review

Policy Number:

Effective Date: ~~July~~ 1, ~~2012~~

Revised Date: ~~May~~ 21, ~~2015~~ January 1, 2018

Policy:

Business Office Director (BOD) is responsible for the collection of the patient accounts and identifying/resolving any obstacles in the collection process. Business Office staff shall actively pursue payment from third party payors on all outstanding account balances. Collection efforts will continue until an account balance is zero by means of payment or the appropriate adjustment. All collection activity pertaining to patients and third parties will be conducted timely as well as accurately documented in the patient accounting system.

Procedures:

Accounts are assigned to the Business Office staff alphabetically and/or by Financial Class (FC). All Biller/Collectors are cross trained as backup for all payors when needed. Each Biller/Collector is required to work 35 to 45 accounts per day depending on the facility's payor mix and levels of care. All collection activity for all accounts should be clearly documented on the patient's account within the patient accounting system. This documentation should include, at a minimum, the following:

- ✓ Collector's name
- ✓ Date of Activity
- ✓ Name and phone number of person contacted
- ✓ Current status of the claim
- ✓ Summary of actions, discussions, resolutions, due dates, etc.
- ✓ Any check numbers and check dates, if applicable

Biller/Collectors should work all remittances and correspondence on a daily basis within 72 hours of receipt to ensure accounts are paid correctly. All contractual adjustments should be completed in accordance with policy **BO-109.00 Contractual and Patient Account Adjustments.** All Administrative, Charity and Denial Adjustments should be completed and processed by the BOD in accordance with policy **ACC-115.00 Administrative, Denial, and Charity Adjustments.**

All denials are to be accounted for by logging and tracking them in the patient accounting system. All denials should be handled in accordance with policy **BO-112.00 Denial Review.** Accounts in an appeal status shall have follow up no later than every twenty eight (28) days. Facilities may choose to use internal and/or external resources in appealing denials regardless of the level of appeal.

Patient complaints should be forwarded to the Business Office Director for review. BOD will review complaint with the facility CFO/CEO for the validity of any issue reported and work to resolve immediately.

Returned refunds and mail items will be followed up on within 10 business days of receipt. When bankruptcy notifications are received, Biller/Collector will do the process in policy **BO-114.00 Notification of Bankruptcy.**

For all accounts due by third party payors, the Business Office must confirm that the payor received the claim within 14 days of submission for paper claims and 7 to 10 days for electronic submissions.

- Collection efforts for these billed claims should take place every 14 days or more often as circumstances or payor practices may require.
- Subsequent follow up will occur no later than every 14 days, on average, until the expected payment amount is received.
- These minimum standards should be guided by the facility's service levels and payor philosophy.
- A follow up tickler system should be used to track the date of the next scheduled follow up and to notify the collector of such date.

For all self-pay/private pay accounts, the Business Office will send monthly statements and utilize an early out preferred vendor. Accounts are placed and returned through an automated process which must be reconciled by the Business Office Director on a monthly basis. The placement process goes as follows:

- Self-Pay accounts (FC = S) are placed with vendor 5 days post discharge.
- Self -Pay after Insurance/Medicare (FC =SI and SM) are placed with vendor once the accounts have been placed in these financial classes.
    - S and SI changes to F4 – returns are placed into R4
    - SM changes to F7 – returns are placed into R7
- Financial Classes – SR, ST, SC and SX are not a part of the automated process.
- Accounts are returned from the early out vendor within 120 days.
- The accounts in R4/R7 will need to be reviewed for collection agency placement. Once the early out vendor's efforts are exhausted, the accounts will be placed with agency in accordance with policy **BO-113.00 Bad Debt Write Offs.**

AR Meeting/Review

In order to identify/resolve obstacles to the collections of patient accounts receivables (AR), it is recommended that the BOD/CFO have regularly scheduled AR meetings involving key departments such as Admissions and Utilization Management as well as the Biller/Collectors. **Attachment A – AR Meeting Minutes** provides a recommended guideline for the content of such a meeting. These meetings should be held weekly with the frequency being modified dependent upon the ability of the facility to meet their key metrics such as Cash Collections, AR Days and Bad Debt Expense.

The AR Review process should be a part of the standard Business Office practice. A Summary Aging report from the patient accounting system should be tracked monthly to identify unfavorable trends. System generated payor specific work lists should be used as an efficient tool to address multiple accounts with payors. High dollar accounts and accounts aged over 60 days should be given special

priority and worked with greater urgency.

Each weekly AR Meeting should focus on accounts/payor issues affecting cash collections and bad debt expense. The BOD should **"Know the Bad Debt Roll"** which is defined by each facility's individual bad debt policy. A schedule of working aging buckets each week in addition to working current accounts will assist the BOD in knowing what issues are occurring in the patient accounts well before they become bad debt expense.

A recommended schedule for working aging buckets is as follows:

- Week 1/Month End – Accounts over 181 days old and Credit Balances
- Week 2 - Accounts 151-180 days old
- Week 3 - Accounts 121-150 days old
- Week 4 - Accounts 91-120 days old
- Start over with Week 1. If there is a Week 5 then it can be used to redouble your efforts on the significant known payor issues.

The patient accounting system and dashboard reports offer many ways to review the detail of the patient accounts as well as collector productivity. The key is to make use of all the available resources and be proactive in working patient accounts and the related payor issues.

Attachments:

Attachment A- AR Meeting Minutes

Related Policies:

ACC-115.00	Administrative, Denial, and Charity Adjustments
BO-109.00	Contractual and Patient Account Adjustments
BO-112.00	Denial Review
BO-113.00	Bad Debt Write Offs
BO-114.00	Notification of Bankruptcy

Approvals:

Administrative: _____ Date: 1/2/2018

David Duckworth, Chief Financial Officer

PACIFIC GROVE HOSPITAL

Policy Title:	Self Pay Discounts, Denial, Charity Care and Administrative Adjustments
Policy Number:	ACC - 115.00
Effective Date:	July 2012
Revised Date:	June 4, 2020

Policy:

Acadia policy requires appropriate management approval for all adjustments to accounts receivable and to maintain sufficient documentation of the justification for the adjustment in the patient file prior to posting to both the patient account and the general ledger. The facility will also record appropriate allowances for any anticipated write-offs each month end.

While applying discounts to patient charges is acceptable, it is important to note that according to state insurance codes, a person commits a legal offense if they intentionally or knowingly charge two different prices for providing the same product or service where the higher price is based on the fact that an insurer will pay all or part of the product or service. Therefore, negotiated discounts on charges are allowed. Each facility shall bill all charges based on the facility's chargemaster which is consistent between all payors and negotiated discounts on these charges will then be applied to the account.

Attachments:

Attachment A Patient Account Adjustment Authorization Form

Procedures:

Self Pay Discounts

Self pay patients with no current insurance coverage will be requested to pre-pay for all services at the time of admission/registration. Every facility must maintain a self-pay deposit schedule which details various estimated lengths of stay and the facility's established self-pay rate. The deposit schedule should be used to estimate the patient's upfront payment during the financial counseling process. See **Business Office Policy #103.00** ***Financial Counseling*** for additional information regarding financial counseling and the required documentation.

Additionally, payor plans should be set up in the facility's patient accounting system with the established self pay rates. If payor plans have not been set up in the patient accounting system, a self-pay contractual adjustment should be manually posted to the patient account at time of billing and a month-end allowance should be recorded for any unbilled self pay accounts. The month-end self pay contractual allowance should be recorded to GL accounts 1201700 to1201750. The appropriate patient accounting transaction codes should be utilized for self-pay contractual adjustments and GL accounts 5851000 to 5853500 should be utilized to record such revenue deductions to the general ledger.

Self pay contractual adjustments represent the difference between gross charges and the facility's established self pay rates and should exclude any other types of administrative or other adjustments.

Denial Adjustments

Denial adjustments shall be segregated in a separate account on the general ledger as a revenue deduction (GL accounts 5911000 to 5913000). Denial adjustments include, but are not limited to, clinical denials and procedural denials.

All denial adjustments are required to be written up on a **Patient Account Adjustment Authorization Form (see Attachment A)** which is to be reviewed and signed by the facility BOD and CFO prior to posting to the patient account or general ledger. Adjustments in excess of $5,000 must also be reviewed and signed by the Facility CEO and any adjustments in excess of $10,000 must also include the Division CFO approval prior to posting to the patient account or general ledger.

In accordance with **Business Office Policy BO – 112.00**, each facility should maintain and update a denial tracking log by patient detailing the reason for the denial, the status of any appeals if any and the balance at risk. The business office should coordinate with the utilization review department to keep the log updated. The log should be utilized to estimate and adjust the necessary allowances each month end, as well as evaluating the productivity of both the business office and utilization review departments.

The month-end denial reserve should establish appropriate reserves for denied accounts based on the likelihood of successful appeal using the following guidelines:

- All denials should be logged with the appropriate reserve % based on collectability projection, determined by the CFO.
- If the facility receives a second denial but believes a successful appeal to be possible, the established reserve should be set at between 75% and 90% of the denied amount.
- If a successful appeal of the denial is remote or if more than two denials have been received, the established reserve should be set at 100% of the denied amount.
- Denial reserves should be consistent with the status of denied accounts according to the denial tracking log.
- Any exceptions should be approved by the Division CFO, Operations CFO and Corporate CFO.

Charity Care Adjustments

Facilities shall make available charity care services to financially and medically indigent patients within the resources available. When a patient is determined to be "financially" or "medically indigent", the facility may discount all or a substantial portion of a patient's bill. See **Business Office Policy #104.00,** ***Financial Assistance*** for guidance on determining and approving financial assistance to financially or medically indigent patients.

Definitions

Charity Care - the unreimbursed cost to a facility of providing, funding, or otherwise financially supporting health care services" either to a) persons the facility classifies as "medically indigent" or "financially indigent" who seek inpatient or outpatient hospital services; or b) to financially indigent patients seeking services through other nonprofit or public clinics, hospitals, or health care organizations.

Financially Indigent - an uninsured or underinsured person who is accepted for care with no obligation or a discounted obligation to pay for the services rendered based on the hospital's financial criteria and procedure used to determine if a patient is eligible for charity care.

Medically Indigent - a person whose medical or hospital bills after payment by third party payors exceed a specified percentage of the patient's annual gross income as determined in accordance with the facility's eligibility system, and who is financially unable to pay the remaining bill.

Charity care or indigent care **must be identified prior to the patient's discharge** and must be written off in the patient accounting system no later than the end of the month following discharge with exception of insured patients which can be adjusted at the time of remittance advice. If a patient qualifies for 100% charity, the patient account financial class must be updated to the Charity/Indigent financial class in the patient accounting system. If a patient qualifies for partial charity, the patient account should remain in the self-pay financial class and charity adjustments should be recorded according to the facility's Financial Assistance policy.

Patient accounts pending Medicaid approval shall not be immediately written off as Charity Care. Patients that are in the process of being qualified for Medicaid eligibility should be included in the Medicaid Pending financial class and the necessary contractual allowance should be based on the Medicaid reimbursement rate. Additionally, If the patient is discharged and it is subsequently determined that the patient is not eligible for Medicaid coverage, but is determined to be indigent based on the criteria for the facility, the patient account may be written off as charity after discharge.

Administrative Adjustments

Administrative adjustments include the following:

- Prompt pay discounts (prompt pay discounts do not include the self-pay discounts provided in accordance with the facility's Financial Assistance policies)
- Discretionary adjustments

Administrative adjustments should be segregated in a separate account on the general ledger as a revenue deduction (GL accounts 5891000 to 5893000). Additionally, all administrative adjustments must be documented on a **Patient Account Adjustment Authorization Form (see attachment A)** which is to be reviewed and signed by the facility BOD and CFO prior to posting to the patient account or general ledger. Adjustments in excess of $5,000 must also be reviewed and signed by the facility CEO and any adjustments in excess of $10,000 must also include the Division CFO approval prior to posting to the patient account or general ledger.

Authorization forms must be maintained by the facility BOD.

Refunds

Refund requests must be fully documented on the Refund Request form, which is to be reviewed and signed by the facility BOD and CFO prior to the refund being issued and posting to the patient account or general ledger. Refunds in excess of $5,000 must also be reviewed and signed by the facility CEO and any refunds in excess of $10,000 must also include the Division CFO approval.

Approvals:

Administrative: _____ Date: _____

David Duckworth, Chief Financial Officer