ACADIA HOSPITAL FREE CARE & DISCOUNT POLICY

PURPOSE

This policy addresses free care and discounted prices and supports Acadia Hospital's commitment to provide access to affordable, high quality healthcare, in a fiscally responsible manner, regardless of the patient's ability to pay.

In order to promote the health and well-being of the communities served, uninsured or under insured individuals with limited financial resources who do not qualify for various entitlement programs shall be eligible to apply for free or discounted health care based on established criteria as outlined in this policy.

All open self-pay balances may be considered for financial assistance at any time. If a determination is made that the patient has the ability to pay all or a portion of the bill, such a determination does not prevent a reassessment of the person's ability to pay at a later date. Eligibility for financial assistance may be re-evaluated at the following times:

- Subsequent rendering of services,
- Income change,
- Family size change,
- When a closed account is to be reopened, or
- Six months following the last financial evaluation.

To be considered for financial assistance, the patient must cooperate to the best of their ability to provide the information and documentation necessary to apply for other existing financial resources that may be available to pay for his or her health care, such as MaineCare. Patients are responsible for completing the required application forms and cooperating fully with the information gathering and assessment process, in order to determine eligibility for financial assistance.

Appropriate signage will be visible in the facility, specifically at patient intake areas, creating awareness for the financial assistance program. Information, such as brochures, will be included in patient services/information folders and/or at patient intake areas. All public information and/or forms regarding the provision of financial assistance will use languages that are appropriate for the facility's service area and will be available on the facility's website.

The necessity for medical treatment of any patient will be based on the clinical judgment of the provider without regard to the financial status of the patient. All patients will be treated with respect and fairness regardless of their ability to pay.

This policy applies only to facility charges and not private practice physician or other independent providers. The provision for financial assistance is consistent, appropriate and essential to fulfill our mission, vision and values.

The intent is to assure that Financial Assistance is made available to those who are in need and least able to pay.

This policy is also in compliance with the guidelines set forth by the Maine Department of Health and Human Services.

What is Not Covered
Financial Assistance:

- Does not provide health insurance
- Does not act as a substitute or supplement for health insurance
- Does not guarantee benefits
- Does not cover non-Acadia medical care providers
- Does not preclude minimum co-payments required by regulation or for clinical reasons (e.g. batterers intervention program; narcotics treatment program)
- Currently, eligibility determination for financial assistance is not portable among all EMHS affiliate hospitals. A separate application at each facility is required

POLICY GUIDELINES

I. Financial Application Definitions

A. **Assets:** MaineCare asset testing criteria will be used to screen patients that could be eligible for coverage.

B. **Disposable Income:** Annual family income, less annual expenses as identified on the ***Application for FINANCIAL ASSISTANCE***.

C. **Family Income:** Gross wages, salaries, dividends, interest, Social Security benefits, workers compensation, veterans benefits, training stipends, military allotments, regular support from family members not living in the household, government pensions, private pensions, any insurance income and annuity payments, income from rents, royalties, estates and trusts. All forms of self-employment income are included. **Multiple Family Household -** If a household includes more than one family and/or more than one unrelated individual, the income guidelines are applied separately to each family and/or unrelated individual, and not to the household as a whole.

D. **Family:** The patient, his/her spouse (including a legal common law spouse) and his/her legal dependents according to the Internal Revenue Service rules. Therefore, if the patient claims someone as a dependent on their income tax return, they may be considered a dependent for purposes of the provision of financial assistance.

E. **Income Calculation**: A person's family income is calculated as the lesser of the following methods (if one method does not apply the other must be calculated):

(1) Multiply by four the person's family income for three months preceding the determination; or
(2) Using the person's actual family income for the 12 months preceding the determination of eligibility.

F. **Medical Necessity:** Services or supplies which meet the following tests: ordered by a physician and appropriate and necessary for the symptoms, diagnosis, or treatment of the

medical or mental health condition; provided for the diagnosis or direct care and treatment of the medical or mental health condition; meet the standards of good medical practice within the medical and mental health community in the service area; not primarily for the convenience of the patient or a provider; and the most appropriate level or supply of service which can safely be provided.

G. **Third-Party Payer:** Any organization, public or private, that pays or insures health or medical expenses on behalf of beneficiaries or recipients. An individual pays a premium for such coverage in all private and in some public programs; the payer organization then pays bills on the individual's behalf. Such payments are called third-party payments and are distinguished by the separation among the individual receiving the service (the first party), the individual or institution providing it (the second party), and the organization paying for it (third party).

H. **Federal Poverty Level Guidelines (FPL):** The FPL income is based on the federal non farm income poverty level as determined by the United States Secretary of Health and Human Services. This is updated annually and published in the Federal Register. Each year's FPL is available on the Internet at http://aspe.hhs.gov/poverty. An individual can also obtain a copy of the current FPL by contacting the local Department of Health and Human Services office; by calling 1-800-321-5557, ext. 79368 or 1-207-287-9368; or by writing to: Office of MaineCare Services (formerly the Bureau of Medical Services), Division of Policy and Provider Services, 11 State House Station, Augusta, Maine 04333-0011

II. Financial Assistance Minimum Criteria

Acadia Hospital provides financial assistance/free care based on criteria as defined below.

- Gross income is at or below 150% of the FPL
- Patient is a resident of Maine
- Non Maine resident seeking emergency care
- For services or supplies that are a Medical Necessity
- All Third Party Payer sources have been exhausted

PROCEDURE

I. Identification of Potentially Eligible Patients

A. When possible, prior to the service date of the patient, Acadia will conduct a pre-admission interview with the patient, the guarantor, and/or his/her legal representative. If a pre-admission interview is not possible, this interview should be conducted at time of service or as soon as possible thereafter. In the case of an emergency admission, the Acadia Hospital's evaluation of payment alternatives should not take place until the required medical care has been provided. At the time of the initial patient interview, the following information should be gathered:
   1. Routine and comprehensive demographic data.
   2. Complete information regarding all existing third party coverage.

B. All patients will be offered the opportunity to apply for financial assistance. When a patient requests financial assistance after leaving the facility, a Patient Account Representative will mail an ***Application for FINANCIAL ASSISTANCE*** to the patient/guardian for completion.

C. Identification of potentially eligible patients can take place at any time until the account reaches a zero balance including accounts that have been referred to outside collections.

II. Determination of Eligibility

A. The patient should receive and complete a written ***Application for FINANCIAL ASSISTANCE*** and provide all supporting data required to verify eligibility.

B. The ***Application for FINANCIAL ASSISTANCE*** will serve as the record reflecting approval or denial of ***FINANCIAL ASSISTANCE***. The approval process includes various levels of approval (ie Collection Manager, Director Patient Account Services, Chief Financial Officer, etc.).

C. Upon completion of the ***Application for FINANCIAL ASSISTANCE***, and submission of appropriate documentation, the Patient Account Representative will make a determination. The information shall be forwarded to Administrative Personnel or designee as determined by the individual hospital for approval. ***FINANCIAL ASSISTANCE*** approvals will be made in accordance with the guidelines, and documented on the lower portion of the application.

III. Monitoring and Reporting

A. A ***FINANCIAL ASSISTANCE*** application log from which periodic reports can be generated shall be maintained aside from any other required financial statements.

B. ***FINANCIAL ASSISTANCE*** activity will be reported to the community annually, based on estimated costs of the services.

Adjustments under each level will be recorded by separate adjustment codes for reporting purposes.