TITLE: FINANCIAL ASSISTANCE POLICY

Replaces:	EVALUATION OF ABILITY TO PAY POLICY		
Section:	Finance	Date Last Reviewed	2023/02
Source:	Patient Financial Services	Date Last Revised	2022/11
Stakeholder:	VP Revenue Cycle		
		Replaces	2022/11
Approval:	Administration	Date Last Approved	2023/02
		NEXT POLICY REVIEW	2026/02

PURPOSE:

To remain fiscally viable as it fulfills our mission, to appropriately bill and collect for psychiatric and medical services provided to patients. This policy outlines the following with respect to all medically necessary care provided by Brattleboro Retreat facilities:

- Eligibility criteria for financial assistance
- Method by which patients may apply for financial assistance
- Basis for calculating amounts charged to patients eligible for financial assistance and limitation of charges.
- Measures to publicize the policy within the community served.

This policy is intended to comply with the requirements of Internal Revenue Code Sections 501(i) and 501(r)(5) and the Patient Protection and Affordable Care Act of 2010 and will be updated periodically to the extent required by applicable law.

POLICY:

Brattleboro Retreat is committed to the mental health wellness and recovery of our community. Financial assistance is intended to help low-income patients who do not otherwise have the ability to pay for their healthcare services and considers each individual's ability to contribute to the cost of his or her own care.

DEFINITIONS

Financial assistance (also known as “charity care"): The provision for healthcare services free or at a discounted rate for individuals who meet the criteria established pursuant to this policy.

Financial Counselors: The Retreat staff members who are responsible for working with patients applying for financial assistance and for administration of the program.

Family: is defined by the U.S. Census Bureau as a group of two or more people who reside together and who are related by birth, marriage, or adoption.

- The state law regarding marriage or civil union and the federal guidelines are used to determine who is included in a family.

In the case of applicants who earn income by caring for disabled adults in their homes, the disabled adult will be counted as a family member and their income included in the determination.

- The Internal Revenue Service rules that define who may be claimed as a dependent for tax purposes are used as a guideline to validate family size in granting financial assistance.

Presumptive financial assistance: The provision of the financial assistance policy for medically necessary services to patients for whom there is not a completed Brattleboro Retreat Financial Assistance application due to lack of supporting documentation or response from the patient. Determination of eligibility for assistance is based upon individual life circumstances demonstrating financial need. Presumptive financial assistance is not available for balances after Medicare.

Household: A group of individuals primarily residing in the same household who have a legal union (blood, marriage, adoption), as well as unmarried parents of a shared child or children. A patient's household includes the patient, a spouse, a dependent child, unmarried couples with a mutual child dependent living under the same roof, same sex couple (married or civil union), and parents claimed on adult chi1d 's tax return.

Family Income: As defined under the federal poverty level (FPL) guidelines as published annually by the U.S. Department of Health and Human Services based on:

- Earnings, unemployment compensation, Workers Compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates. trusts, educational assistance, alimony, child support, assistance from outside the household. and other miscellaneous sources;
- noncash benefits (such as food stamps and housing subsidies) do **not** count
- pre-tax income
- the income of all family members (non-relatives, such as housemates, do **not** count)

Annual updates: Poverty Guidelines | ASPE (hhs.gov)

Uninsured patient: A patient with no insurance or other third-party source of payment for
his/her medical care.

Underinsured patient: A patient with insurance or other third-party source of payment, whose out-of-pocket expenses exceed his/her ability to pay as determined according to this policy.

Gross Charges: The total charges at the organization' s full established rates for the patient's healthcare services.

PROCEDURE

Introduction:

Brattleboro Retreat is committed to providing financial assistance to persons who have healthcare needs but do not have the financial means to pay balances that are their responsibility. Brattleboro Retreat strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care. A patient can apply for financial assistance any time before, during, and after service is provided.

Financial assistance is not considered to be a substitute for personal responsibility. Patients are expected to cooperate with Brattleboro Retreat procedures for obtaining financial assistance or other forms of payment and to contribute to the cost of their care based on their ability to pay. Individuals with the financial capacity to purchase health insurance are required to do so, as a means of ensuring access to health care services. for their overall personal health, and for the protection of their individual assets.

Brattleboro Retreat will not impose extraordinary collections actions for any patient without first making reasonable efforts to determine whether or not the patient is eligible for financial assistance. Any exceptions must be approved by the Director of Revenue Cycle. For information on actions Brattleboro Retreat may take in the event of nonpayment, please refer to our credit and collections policy. Copies of the Credit and Collection Policy is available online or can be requested at the Patient Financial Services Offices or can be mailed to you by calling 802-258-6745.

A. Eligibility Criteria for Financial Assistance. In order to qualify for financial assistance under this Policy, a patient must meet the following criteria:

- Be uninsured or underinsured, ineligible for any government health care benefit program, and unable to pay for their care as outlined in the Credit and Collections Policy, based upon a determination of financial need under this Policy.
- Have Gross Family Income. inclusive of a11 members of the patient's household, during the past 12 months of less than 400% of FPL.
- Have Gross Family Income exceeding 400% of FPL and aggregate balances owed for services performed at. Brattleboro Retreat in excess of 10% of 2 years Family Income, plus 10% of the value of household assets in excess of sheltered amounts (as described below).
- For purposes of determining value of assets, assets include, but are not limited to: savings, alimony, certificates of deposit, IRAs, stocks, bonds, 401Ks, and mutual bonds. In calculating the amount of assets for purposes of qualifying a patient for charity above:
    - Savings (which include savings accounts, alimony, or certificate(s) of deposit) are sheltered up to 100% of FPL.
    - Retirement accounts (which include IRAs, stocks, bonds, 401Ks and mutual funds) are sheltered up to $300,000, equity in a primary residence is sheltered up to $500,000.

- When dividends are noted on a tax return, the source of the dividends will be requested along with a recent market value statement.
- Documentation of all trust fund payments and ability to access funds is required.

- Demonstrate compliance with the requirements to apply for a qualified health plan if eligible. Exceptions to this requirement may be approved by the Financial Assistance Committee for good cause on a case-by-case basis. "Good Cause" will depend on facts and circumstances, and may include:
  - Those that missed the open enrollment period and do not fall into a life changing event category outside of open enrollment.
  - Those for whom the financial burden will be greater for the patient to enroll in a qualified health plan than not to do so.

If there is no interaction with the patient concerning financial assistance, or the patient is unable to complete the application procedures required under this Policy, such patients may be considered for eligibility through presumptive financial assistance.

B. Method by Which Patients May Apply for Financial Assistance

1. Brattleboro Retreat will explore alternative sources of coverage and/or payment from federal. state, or other programs and assist patients in applying for such programs. With respect to any balances remaining after other sources have been exhausted, Brattleboro Retreat will conduct an individual assessment of a patient's financial need in order to determine whether an individual qualifies for assistance under this policy, using the following procedures:
   - A patient or guarantor is required to complete and submit an application, and provide such personal, financial, and other information with documentation as required to determine whether such individual qualifies for assistance. Documentation required to verify Family Income and available assets or other resources. If Brattleboro Retreat is unable to obtain an application and supporting documentation from the patient or the patient's guarantor, Brattleboro Retreat may consider whether the patient is eligible for presumptive financial assistance.
   - ln lieu of an application and supporting documentation ·from the patient. staff may use any of the following to support a recommendation for approval of presumptive financial assistance:
     - Brattleboro Retreat may utilize one or more vendors to screen individuals using public data sources.
     - Current eligibility for Medicaid
     - Current statement from a Federal or State housing authority
     - Verification of incarceration with no source of payment from the correction facility
     - Financial Applications approved from other local facilities

- For an individual patient, a patient's verbal attestation of income and assets, in lieu of written income verification, may be accepted with respect to one (1) account only, provided that the balance on such account is less than $1,000.

2. A request for financial assistance and a determination of financial need may occur prior to rendering non-emergent medically necessary services. However, a patient may be considered for financial assistance at any point in the collection cycle. An approved financial assistance application applies to all medically necessary balances outstanding at the time the patient has applied. After that time, or at any time, additional information relevant to the eligibility of the patient for financial assistance becomes known, Brattleboro Retreat will re-evaluate the individual's financial need in accordance with this Policy.

Brattleboro Retreat recognizes decisions made by the following assistance programs without requesting copies of applications. Brattleboro Retreat reserves the right to accept or deny decisions made outside Brattleboro Retreat guidelines by the Organizations listed below. All applicable co-pays or other patient responsibility amounts should be requested in accordance with requirements of such programs.

- Current Medicaid eligibility if not retroactive to cover past services
- Financial Assistance approved from local facilities
- Deceased patient with no estate (as outlined by executor or state)

3. It is the goal of Brattleboro Retreat to process a financial application and notify the patient of a decision in writing within 30 days of receipt of the completed application and documentation.

4. **Appeals Process**: If Brattleboro Retreat denies partial or total financial assistance then the patient (or his/her agent) can appeal the decision within 30 days. The patient must write a letter to the Director of Revenue Cycle to explain why the decision made by Brattleboro Retreat was inappropriate. The appeal letter will be reviewed by Brattleboro Retreat and a final decision will be sent to the patient within 30 days of the receipt or the request for appeal.

C. Determination of Amount of Financial Assistance

All insurance payments, contractual adjustments and uninsured discounts are taken prior to the financial assistance adjustment being applied.

If an individual is approved, the amount of financial assistance to be provided for applicable care will be as follows:

- Family income at or below 250% of FPL will receive 100% financial assistance
- Family income between 251% - 300% of FPL will receive a 75% discount
- Family income between 301% - 350% of FPL will receive a 50% discount
- Family income between 351% - 400% of FPL will receive a 25% discount.
- Any discounts other than those described above, must be approved by the Financial Assistance Committee.

- Patients meeting criteria for Presumptive Financial Assistance will receive 100% financial assistance.

Patients without insurance, including uninsured patients who qualify ·for financial assistance under this Policy, may not be charged any more than the amount generally billed to patients who have insurance covering the same care. Brattleboro Retreat applies a discount against gross charges for patients who have no insurance resulting in a discounted balance which the patient is expected to pay. The discount is based on the "look-back Medicare fee for service plus private payers" method as described under applicable regulations implementing Section 501(r) of the Internal Revenue Code[1,2]. This discount is applied prior to billing the patient and prior to applying any financial assistance adjustments. This discount does not apply to any co-payments, co-insurance, deductible amounts, pre-payment or package services which already reflect any required discount, or to services classified as non-covered by all insurance companies.

Hospital facilities must calculate their AGB percentages at least annually by dividing the sum of the amounts of all its claims for emergency or other medically necessary care that have been allowed by the certain health insurers during a prior 12-month period divided by the sum of the associated gross charges for those claims.

The hospital facility must include the claims allowed during the 12-month period by:

- Medicare fee-for-service alone,
- Medicare fee-for-service and all private health insurers paying claims to the hospital facility, or
- Medicaid, either alone or in combination with Medicare and all private health insurers.

The self-pay discount will be established annually utilizing the report: Reimbursement Details by Guarantor Rpt – for self-pay discount

- Prior calendar year 1/1 – 12/31 dates of service for fully adjudicated claims.

For example: Calendar year 1/1/2023-12/31/2023, dates of service utilized were 1/1 – 12/31/22

Calendar Year	Discount Rate
1/1/2023-12/31/2023	63%

Duration of Financial Assistance:

Financial assistance is granted for a period of six (6) months from the date of application approval.
Exceptions can be brought to the Financial Assistance Committee for approval.

[1] https://www.irs.gov/charities-non-profits/limitation-on-charges-section-501r5

[2] Discounts established annually utilizing report: Reimbursement Details by Guarantor Rpt – for self-pay discount using data from prior year (1/1 – 12/31).

Patients who Paid for Portions of their Bill Subsequently Approved for Financial Assistance

If a patient who applies for the Financial Assistance Program is approved at any level, and they made a payment for their services prior to being approved, the following will apply:

1. If the patient was approved for 100% financial assistance, the amount written off to financial assistance will be reduced by the amount paid. The payment the patient made will not be refunded. It will be credited to the services they received plus up to the amount of financial assistance approved to bring their account to a zero balance.

   a. EXAMPLE: Patient One. who is uninsured and does not qualify for their state's Medicaid program, was an inpatient for ten days. They incurred $15,000 in charges. At discharge the patient paid $500. Upon receiving a statement for the balance of $14,500, Patient One decides to apply for financial assistance. They are approved for 100% financial assistance adjustment. Therefore, the $500 is applied to their inpatient bill and $14,500 is applied as a financial assistance adjustment.

2. If the patient was approved for LESS THAN 100% financial assistance, and they previously made a payment, the way the account is credited will be as follows:

   a. If the amount paid is less than the total amount owed, the patient will still owe the difference once the full amount of financial assistance approved is credited to the account.

      - EXAMPLE: Patient Two, who is uninsured and does not qualify for their state's Medicaid program was an inpatient for ten days. They incurred $15,000 in charges. At discharge the patient paid $500. Upon receiving a statement for the balance of $14,500 Patient Two decides to apply for financial assistance. Based on their qualifications they are approved for a 75% financial assistance adjustment Patient Two is responsible for $3,750 of their $15,000 bill. The $500 previously paid is applied to the amount they owe and $11,250 is applied as a financial assistance adjustment. The patient is sent a statement for $3,250 ($3750 - $500).

   b. If the amount paid is more than the total amount owed, the patient will not be refunded the difference.

      - EXAMPLE: Patient Three, who is uninsured and does not qualify for their state's Medicaid program, was an inpatient for ten days. They incurred $15,000 in charges. At discharge the patient paid $4000. Upon receiving a statement for the balance of $11,000, Patient Two decides to apply for financial assistance. They do so and based on their qualifications they are approved for 75% financial assistance adjustment. Patient Two is responsible for $3,750 of their $15,000 bill. The $4,000 previously paid exceeds the $3,750 by $250. The

account is posted as follows: $4,000 as a patient payment and $11,000 as a financial assistance adjustment, which brings the account to a zero balance.

Presumptive Eligibility for Financial Assistance:

Brattleboro Retreat may utilize a third-party to review the patient' s information to assess financial need. This review utilizes a healthcare industry-recognized, predictive model that is based on public record databases. The model incorporates public record data to calculate a socio-economic and financial capacity score that includes estimates for income, resources, and liquidity. The model's rule set is designed to assess each patient to the same standards and is calibrated against historical financial assistance approvals for the Brattleboro Retreat.

Information from the predictive model may he used by the Brattleboro Retreat to grant presumptive eligibility in cases where there is an absence of information provided directly by the patient. **Presumptive financial assistance is not available for balances after Medicare.**

Presumptive screening is used, without respect to outstanding balance, on accounts greater than 120 days after statements and notices to collect the debt and prior to referral of the account to an outside collection agency to provide financial assistance to patients who have not been responsive to the notification of the option to complete a Financial Assistance Application. Probate accounts that have exceeded time limits are eligible are presumptive screening.

D. Communication Regarding the Brattleboro Retreat Financial Assistance Policy to Patients and Within the Community

- Referral of patients for financial assistance may be made by any Brattleboro Retreat staff member or agent, including physicians, nurses, financial counselors, social workers, case managers, chaplains, and religious sponsors. A request for financial assistance may be made by the patient or a family member, close friend or associate of the patient, subject to applicable privacy laws.
- Information regarding financial assistance from Brattleboro Retreat, including but not limited to this policy, a plain language summary of this policy, an application form and information concerning Brattleboro Retreat's patient collection policies and procedures, will be available to the public and to Brattleboro Retreat patients through at least the mechanisms described below:
    - On the Brattleboro Retreat website,
    - Posted in patient care areas,
    - Available on Information Cards in the registration and admitting departments,
    - Available in other public spaces as determined by Brattleboro Retreat,
    - Provided in the primary languages spoken by the population serviced by the Brattleboro Retreat; translation services are utilized as needed.
- If the balance is approved, the patient is sent a letter indicating approval.

E. Assistance in Completing the Application

You can receive in person assistance completing this application, by appointment, at the following location:

Brattleboro Retreat
l Anna Marsh Lane
Brattleboro, VT 05302
ATTN: Patient Financial Counselor
802-258-6745

Patients will continue to be financially responsible for any services they receive until their application is approved.

F. Administration of the Financial Assistance Program

Brattleboro Retreat's Financial Counselors are responsible for administering the Financial Assistance Program. The steps the Financial Counselors take to do this are listed below as well as documents, timeliness and other requirements patients applying for financial assistance must meet.

Documentation Requirements (All):

Along with a fully completed Financial Assistance application, a patient must provide the following documents to accompany the application:

- Copy of their home state driver's license or other government issued ID or a government issued document that verifies their current residence and includes their name.
- All applicable forms of income verification with their name and an address on them to include:
    - A copy of the patient/guarantor' s most recent IRS tax return (1040,
      1040A, 1040EZ forms only)
    - Current checking and/or savings account statement
    - A statement from the Unemployment Office if they have been receiving unemployment benefits
    - A statement from the Social Security Administration showing what they receive in social security pension benefits
    - A statement from the Veterans Administration showing VA disability
      or other payments
    - A statement from any companies they receive an annuity or pension payment from
    - A statement or court document showing the amount of child support
      or alimony they are paid or were awarded

- A statement listing any rental income received from rental property
- A statement listing any benefits you paid as the result of a workers compensation claim
- A statement that lists any dividends or interest income received from investments, money market funds, savings accounts or any other securities owned.

Other Requirements (Only those without insurance):

We also require the following be done or documentation provided before a determination is made regarding a patient's financial assistance application:

- If a patient has applied for Medicaid within the past six (6) months, but was denied, they must present the denial letter.
- If a patient has not applied for Medicaid within the past six (6) months or is unable to produce a Medicaid denial letter, we may require that the patient be screened for Medicaid.
    - If it is determined that the patient might qualify, they are required to submit an application to their state's Medicaid program.
        - A determination must be made by the patient's state Medicaid program before a determination regarding their financial assistance application can be made.
- If a patient has applied for Medicaid and was denied we may, at our discretion. require them to re-apply if:
    1) it has been more than six (6) months since they applied, or
    2) they no longer live in the state where they originally applied for Medicaid.

Timeliness:

Documentation:

Required documents must be provided within 30 days of submitting a completed and signed financial assistance application.

- A thirty-day (30 day) extension may be granted if the person requesting financial assistance asks for one within 30 days of the financial assistance application being submitted. If no response during the extension period, the application will be reviewed for presumptive financial assistance and/or denied. If denied, patient will be notified via letter (i.e., FAP - Denial letter).

Tracking of Financial Assistance Applications:

Activity related to the financial assistance application process should be tracked in the FAP Tracker.

- Patient/Guarantor demographics
- If they are applying for assistance with a balance after Insurance or a true self-pay balance
- Application date
- Documentation received
- Screening done/Medicaid status
- Follow-up letters sent
- Due date(s)
- Disposition

The FAP Tracker will be located in Smartsheet. Based on due dates Smartsheet will generate an email to notify the Financial Counselor to review a certain account to see if the patient/guarantor has complied with our request:

- The Financial Counselor' s actions will be based on the response (or non-response) from the patient

G. Financial Assistance Process:

Once the patient has submitted everything required for a decision to be made the Financial Counselor should refer to Section "C" of this Policy and Procedure, "Determination of Amount of Financial Assistance". That section provides guidance whether a patient/guarantor qualifies for financial assistance and if so, how much.

- Complete the FAP Disposition" form to indicate if the application is approved or denied
    - If approved:
        - On the FAP Disposition form:
            - Note the adjustment percentage approved (i.e., 100%, 75%, 50%, 25%)
            - Note the charge amount the adjustment percentage is applied towards
            - The FC signs the FAP Disposition form
                - **The FAP Disposition form is sent to the CFO for notification with a signature as an acknowledgment**
    - If denied:
        - Note that the FAP application was denied on the PAP Disposition form and in EHR.
        - Send the Financial Assistance Denial letter (FAP - Denial letter) to the patient/guarantor
            - The FAP Denial letter asks the

patient/guarantor to contact us to discuss their outstanding balance

- If the Financial Counselor believes there may be extenuating circumstances that may cause us to consider offering the patient "Presumptive Eligibility for Financial Assistance" as described in Section "C", this should be discussed with the Financial Assistance Committee.
- FAP tracking log is sent to CFO indicating the patient applications that have been denied.

H. Financial Assistance Appeals Process

If the balance is not approved, the patient will be sent a denial letter (i.e., FAP – Denial letter) or if requested, a copy of the application highlighting the reason for disapproval. A letter outlining the formal appeals process is also sent with every denial or those letters providing only a partial reduction.

- The Financial Assistance Committee will review the appeal and make recommendations on all denial appeals.

Financial Assistance Committee:

- VP, Revenue Cycle Management
- Director, Revenue Cycle Management
- Manager, Revenue Cycle Management
- Cash Applications Supervisor
- Financial Aid Counselor(s)

Linda Rossi
President and Chief Executive Officer

William King
Interim Chief Medical Officer

Valerie Ostrander
Valerie Ostrander
Vice President Revenue Cycle

Vermont Medicaid Eligibility Tables: https://info.healthconnect.vermont.gov/compare-plans/eligibility-tables

Annual Federal Poverty Level (FPL) tables:

https://www.healthcare.gov/glossary/federal-poverty-level-fpl/

Poverty Guidelines | ASPE (hhs.gov)

IRS Limitation on Charges – Section 501 (r)(5) : https://www.irs.gov/charities-non-profits/limitation-on-charges-section-501r5