

<b>Service Area:</b> Corporate Business Services	<b>YALE NEW HAVEN HEALTH POLICIES &amp; PROCEDURES</b>	
<b>Title:</b> Financial Assistance Programs Policy		
<b>Date Approved:</b> 09/20/2013, 06/15/2020	<b>Approved by:</b> YNHHS Board of Trustees	
<b>Date Effective:</b> 09/20/2013, 06/15/2020 1/1/2017 Lawrence + Memorial Hospital and Westerly Hospital	<b>Date Reviewed/Revised:</b> 01/21//2015, 09/30/2016, 12/16/2016, 6/1/2017, 7/15/2018, 6/15/2020, 1/27/2021	
<b>Distribution:</b> MCN Policy Manager	<b>Policy Type (I or II):</b> Type I	
<b>Supersedes:</b> Yale New Haven Hospital Financial Assistance Programs for Hospital Services (NC:F-4) Bridgeport Hospital Financial Assistance Programs for Hospital Services (9-13) Greenwich Hospital Overview of Financial Assistance Programs for Hospital Services Lawrence + Memorial Hospital and Westerly Hospital Charity Care, Financial Assistance, Free Bed Fund Policy		

## PURPOSE

Yale New Haven Health (“Yale New Haven Health” or “YNHHS”) is committed to providing medically necessary care by offering financial assistance to qualifying individuals in need. The purpose of this Financial Assistance Policy (“FAP”) is to:

- A. Explain what financial assistance is available under the FAP;
- B. Describe who is eligible for financial assistance and how to apply;
- C. Describe how patient charges are calculated for emergency or other medically necessary care for FAP-eligible patients;
- D. Identify providers who are and are not covered by the FAP;
- E. Describe the steps YNHHS hospitals take to widely publicize this FAP within the communities served by YNHHS; and
- F. Explain what collection actions may be taken for non-payment of Yale New Haven Health bills.

## APPLICABILITY

This policy applies to each licensed hospital affiliated with YNHHS, including Bridgeport Hospital, Greenwich Hospital, Lawrence + Memorial Hospital, Yale New Haven Hospital and Westerly Hospital (each a “Hospital”). In addition, the financial assistance programs are followed by Northeast Medical Group, Visiting Nurse Association of Southeastern Connecticut, and Home Care Plus.

## POLICY

**A. Responsible Officer.** The YNHHS Senior Vice President, Finance or his designee will oversee the YNHHS FAP.

### **B. Scope and Provider List**

1. **Emergency and Other Medically Necessary Care.** This FAP applies to emergency and other medically necessary care, including inpatient and outpatient services, billed by a Hospital. The FAP excludes: (a) private room or private duty nurses; (b) services that are not medically necessary, such as elective cosmetic surgery; (c) other elective convenience fees, such as television or telephone charges, and (d) other discounts or reductions in charges not expressly described in this policy.

2. **Provider List.** A list of providers who provide emergency and other medically necessary care at a Hospital can be found here:

<https://www.ynhh.org/patients-visitors/billing-insurance/Financial-assistance>

The list indicates if the provider is covered under the FAP. If the provider is not covered under this FAP, patients should contact the provider's office to determine if the provider offers financial assistance and if so what the provider's financial assistance policy covers.

3. **Compliance with EMTALA.** Hospitals are required to comply with the Emergency Medical Treatment and Active Labor Act (EMTALA) in accordance with their policies and are also prohibited from engaging in activities that would discourage an individual from seeking emergency medical care. Nothing in this FAP limits a Hospital's obligations under EMTALA to treat patients with emergency medical conditions.

### **C. Financial Assistance Program**

Financial assistance is available to individuals who live in the United States who complete the required financial assistance application and meet the additional eligibility requirements described below. All patients should be encouraged to investigate all available sources of financial assistance including government and private assistance programs.

Decisions about financial assistance are made on a case-by-case basis and based only on financial need. Decisions never take into account age, gender, race, color, national origin, marital status, social or immigrant status, sexual orientation, gender identity or expression, religious affiliation, disability, veteran or military status or any other basis prohibited by law. The Financial Assistance Application outlines the documents required to verify family size and income. YNHHS or a Hospital may, in their discretion, approve financial assistance outside of the scope of this Policy.

1. **Free Care.** If gross annual family income is verified to be at or below 250% of the Federal Poverty Level Guidelines (*see Attachment 1*), you may qualify for free care (a 100% discount against the patient's account balance).

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2. **Discounted Care.** If gross annual family income is verified to be between 251% and 550% of the Federal Poverty Level Guidelines, you may qualify for a discount based on a sliding scale, as shown in Attachment 1. For patients who have insurance, the discount will be applied to the patient's account balance that remains after payments from insurance or third-party payers are applied.
3. **Hospital Bed Funds.** You may be eligible to receive financial assistance from hospital bed funds, which are funds that have been donated to the Hospital to provide medical care to patients who may be unable to afford hospital care. Eligibility is determined on a case-by-case basis and take into account donor-restrictions and, if applicable, nominations made by fund nominators. All patients who fill out the requisite financial assistance application will automatically be considered for hospital bed funds.
4. **Other Hospital-Specific Financial Assistance programs.**
  - a. **Yale New Haven Hospital Me & My Baby Program.** This program is available to Yale New Haven Hospital patients. It provides prenatal, labor and delivery services, and some post-partum care free of charge. You may be eligible if you live in New Haven County, do not have any type of health insurance and your family earns less than 2 ½ times the Federal Poverty Level. For more information or to request an application see our representatives at the Yale New Haven Hospital Women's Center or call **203-688-2481**.
  - b. **Greenwich Hospital Outpatient Clinic** serves patients insured by Medicare, Medicaid, or insurances offered through Access Health CT and whose family income is less than 4 times the Federal Poverty Level Guidelines. Further, the clinic provides discounted care to individuals who are not eligible for insurance and who reside in Greenwich and have family income less than 4 times the Federal Poverty Level. For more information or to obtain an application please call 203-863-3334.
5. **Medically Indigent.** Consideration for financial assistance also may be given to patients who do not meet the criteria, but whose medical bills exceed a certain percentage of the family's income or assets.

### D. Limitation on Charges

When a patient qualifies under this policy for discounted care, but not free care, the patient will not be charged more than the amount generally billed ("AGB") to individuals who have insurance covering such care.

1. **How Calculated.** YNHHS calculates AGB annually for each Hospital using the "look back method" under federal tax regulations and based on Medicare fee-for-service rates, including Medicare beneficiary cost-sharing amounts and all private health insurers that pay claims to each Hospital facility for the prior fiscal year. YNHHS may apply the percentage discount by Hospital, or may elect to use the percentage discount most favorable to YNHHS patients. AGB discounts are shown in Attachment 1.

## E. Financial Assistance Application

1. **How to apply.** To apply for financial assistance, you must complete the YNHHS application for financial assistance (“Application”), except as provided below. You can get an Application:
  - a. Online at [www.ynhhs.org/financialassistance](http://www.ynhhs.org/financialassistance) and on each YNHHS Hospital’s website.
  - b. In-person at any YNHHS Hospital patient admission or registration area. Signs and written information about financial assistance will be available in each Hospital emergency departments and patient registration areas.
  - c. By mail by calling and requesting a free copy from Patient Financial Services at (855) 547-4584.
2. **Application.** The Application describes (i) financial assistance programs and eligibility requirements, (ii) the documentation requirements for determinations of eligibility, and (iii) the contact information for FAP assistance. The Application also explains that (i) the Hospital will respond to each Application in writing, (ii) patients may re-apply for financial assistance under the FAP at any time, and (iii) additional free bed funds become available every year. Hospitals may not deny financial assistance under the FAP based on failure to provide information or documents that the FAP or the Application do not require as part of the Application.
3. **FAP-eligible patients.** YNHHS Hospitals will make reasonable efforts to determine eligibility and document any determinations of financial assistance eligibility in the applicable patient accounts. Once a Hospital determines that a patient is FAP-eligible, the Hospital shall:
  - a. Provide a billing statement indicating amount the individual owes as a FAP-eligible patient, including how the amount was determined and states, or describes, how the individual can get information regarding the AGB for the care;
  - b. Refund to the individual any amount he or she has paid for the care that exceeds the amount he or she is determined to be personally responsible for paying as a FAP-eligible individual, unless such excess amount is less than \$5, or such other amount set by the IRS; and
  - c. Take reasonable measures to reverse any extraordinary collection actions.
4. **Presumptive Eligibility.** YNHHS may determine eligibility for free or discounted care under this Policy based on information regarding a patient’s life circumstances obtained from sources other than the individual seeking financial assistance, including the following or similar sources:
  - a. YNHHS on behalf of each Hospital uses a third party screening tool to assist in identifying individuals with self-pay balances who have not applied for financial assistance, but whose income is less than or equal to 250% of the Federal Poverty Level

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- (*i.e.*, eligible for free care). If a patient is identified through this process outstanding hospital balances may be adjusted to charity (free) care.
- b. YNHHS is affiliated with Yale University and is the academic health center for the Yale School of Medicine. Uninsured patients served by Yale University student-run primary care clinics for low-income individuals, including the Haven Free Clinic, may be presumed eligible for free or discounted care without further need to complete a financial assistance application, upon YNHHS receiving confirmation in a form acceptable to the Senior Vice President, Finance that a person is a patient of any such clinic.
  - c. YNHHS may use prior eligibility determinations to presumptively determine that the individual is again eligible for charity care under this Policy.

### **F. Relationship to YNHHS Collection Practices**

A Hospital (and any collection agency or other party to which it has referred debt) will not engage in any extraordinary collection action (“ECA”) prior to 120 days after the issuance of the first post-discharge billing statement for the care and before making reasonable efforts to determine if a patient or any other individual having financial responsibility for a self-pay account (Responsible Individual(s)) is eligible for financial assistance under this FAP. Any ECA must be approved by the Sr. Vice President, Finance or his designee(s) who shall confirm prior to approval that the reasonable efforts requirements in this FAP have been met.

The Hospital will follow its A/R billing cycle in accordance with internal operational processes and practices. As part of such processes and practices, the Hospital will, at a minimum, notify patients about its FAP from the date care is provided and throughout the A/R billing cycle (or during such period as is required by law, whichever is longer) by:

1. All patients will be offered a plain language summary and an application form for financial assistance under the FAP as part of the discharge or intake process from a Hospital.
2. At least three separate statements for collection of self-pay accounts will be mailed or emailed to the last known address of the patient and any other Responsible Individual(s); provided, however, that no additional statements need be sent after a Responsible Individual(s) submits a complete application for financial assistance under the FAP or has paid in-full. At least 60 days shall have elapsed between the first and last of the required three mailings. It is the Responsible Individual(s) obligation to provide a correct mailing address at the time of service or upon moving. If an account does not have a valid address, the determination for "Reasonable Effort" will have been made. All single patient account statements of self-pay accounts will include but not limited to:
  - a. An accurate summary of the hospital services covered by the statement;
  - b. The charges for such services;
  - c. The amount required to be paid by the Responsible Individual(s) (or, if such amount is not known, a good faith estimate of such amount as of the date of the initial statement);

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and

- d. A conspicuous written notice that notifies and informs the Responsible Individual(s) about the availability of financial assistance under the FAP including the telephone number of the department and direct website address where copies of documents may be obtained.
3. At least one of the statements mailed or emailed will include written notice that informs the Responsible Individual(s) about the ECAs that are intended to be taken if the Responsible Individual(s) does not apply for financial assistance under the FAP or pay the amount due by the billing deadline. Such statement must be provided to the Responsible Individual(s) at least 30 days before the deadline specified in the statement. A plain language summary will accompany this statement. It is the Responsible Individual(s) obligation to provide a correct mailing address at the time of service or upon moving. If an account does not have a valid address, the determination for "Reasonable Effort" will have been made.
  4. Prior to initiation of any ECA, an oral attempt will be made to contact Responsible Individual(s) by telephone at the last known telephone number, if any, at least once during the series of mailed or emailed statements if the account remains unpaid. During all conversations, the patient or Responsible Individual(s) will be informed about the financial assistance that may be available under the FAP.
  5. Subject to compliance with the provisions of this policy, a YNHHS Hospital may take the ECA listed on Attachment 2 of this Policy to obtain payment for medical services provided.

### **G. Policy Availability**

Copies of the FAP, a plain language summary of the FAP and FAP application are available at [www.ynhhs.org/financialassistance](http://www.ynhhs.org/financialassistance).

Each Hospital makes available copies of the FAP, a plain language summary of the FAP and FAP application on request, free of charge, by mail or in the Hospital Emergency Department and at all points of registration in paper form in English and the primary language of any population with limited English proficiency that constitutes the lesser of 1,000 individuals or 5% or more of the population the Hospital serves. See Attachment 3 for a list of languages.

Contact Corporate Business Services toll free at (855) 547-4584 for information regarding eligibility or the programs that may be available to you, to request a copy of the FAP, plain language summary of the FAP, FAP application form, or Billing and Collection Policy to be mailed to you, or if you need a copy of the FAP, plain language summary, or FAP application form translated to a language other than English. Further, patients may ask Patient Registration, Patient Financial Services and Social Work/Case Management about initiating the FAP application process.

Further efforts to widely publicize the FAP include publishing notices in newspapers of general circulation; providing written notice of the FAP in billing statements; providing notice of the FAP

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in oral communications with patients regarding the amount due; and holding open houses and other informational sessions.

### **H. Compliance with State Law**

Each Hospital shall comply with relevant State laws, including, without limitation, Connecticut General Statutes governing Collections by Hospitals from uninsured Patients and Rhode Island *Statewide Standard for the Provision of Charity Care* set forth in Section 11.3 of the Rhode Island Department of Health Rules and Regulations Pertaining to Hospital Conversions (the “RI Regulations”) and the *Statewide Standard for the Provision of Uncompensated Care* set forth in Section 11.4 of the RI Regulations.

### **REFERENCES**

Internal Revenue Code 501(c)(3)  
Internal Revenue Code 501(r)  
Conn. Gen. Stat. § 19a-673 et seq.  
RI Regulations 11.3 and 11.4

### **RELATED POLICIES**

YNHHS Billing and Collections Policy  
YNHHS EMTALA Policy: Medical Screening/Stabilization, On-Call and Transfer  
Yale New Haven Hospital Policy – Distribution of Free Care Funds NC:F-2  
Greenwich Hospital Outpatient Center Policies and Procedures

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### Attachment 1

#### Federal Poverty Guidelines (FPG) & Sliding Scale for Financial Assistance

FPG amounts are updated periodically in the Federal Register by the United States Department of Health and Human Services. Current FPG amounts are available at <http://aspe.hhs.gov/poverty-guidelines>.

As of January 27, 2021, FPG amounts were as follows. *These amounts are subject to change.* Patients eligible for financial assistance under this Policy will receive assistance at all Yale New Haven Health Hospitals as follows:

	FAP Name	Free Care	Discounted Care	Sliding Scale A	Sliding Scale B	Sliding Scale C
	Coverage Eligibility	Insured or Uninsured Patients	Uninsured Patients	Insured Patients	Insured Patients	Insured Patients
	FAP Discount	100%	70%	35%	25%	15%
	Gross Income Eligibility	0% - 250% FPL	251% - 550% FPL	251% - 350% FPL	351% - 450% FPL	451% - 550% FPL
Family Size	1	\$0 - \$32,200	\$32,201 - 70,840	\$32,201 - \$45,080	\$45,081 - \$57,960	\$57,961 - \$70,840
	2	\$0 - \$43,550	\$43,551 - \$95,810	\$43,551 - \$60,970	\$60,971 - \$78,390	\$78,391 - \$95,810
	3	\$0 - \$54,900	\$54,901 - \$120,780	\$54,901 - \$76,860	\$76,861 - \$98,820	\$98,821 - \$120,780
	4	\$0 - \$66,250	\$66,251 - \$145,750	\$65,251 - \$92,750	\$92,751 - \$119,250	\$119,251 - \$145,750
	5	\$0 - \$77,600	\$77,601 - \$170,720	\$77,601 - \$108,640	\$108,641 - \$139,680	\$139,681 - \$170,720
	6	\$0 - \$88,950	\$88,951 - \$195,690	\$88,951 - \$124,530	\$124,531 - \$160,110	\$160,111 - \$195,690

#### AGB Calculations

AGB percentages are calculated annually. Calendar year 2021 AGB (% of charges) per Hospital are: BH 32.6%, GH 34.8%, LMH 37.7%, YNHH 34.6% and WH 30.1%. Accordingly, the percentage discount most favorable to YNHHS patients eligible for discounted care under this Policy for 2021 would be to pay no more than 30% of gross charges.

**Attachment 2**

**EXTRAORDINARY COLLECTION ACTIONS**

**Property Liens**

Liens on personal residences are permitted only if:

- a) The patient has had an opportunity to apply for free bed funds and has either failed to respond, refused, or been found ineligible for such funds;
- b) The patient has not applied or qualified for other financial assistance under the Hospital's Financial Assistance Policy, to assist in the payment of his/her debt, or has qualified, in part, but has not paid his/her responsible part;
- c) The patient has not attempted to make or agreed to a payment arrangement, or is not complying with payment arrangements that have been agreed to by the Hospital and patient;
- d) The aggregate of account balances is over \$10,000 and the property(ies) to be made subject to the lien are at least \$300,000 in assessed value; and
- e) The lien will not result in a foreclosure on a personal residence.

**Attachment 3**

**Limited English Proficiency Languages**

Albanian
Arabic
Bengali
Simplified Chinese
French
French Creole (Haitian Creole)
German
Greek
Hindi
Italian
Japanese
Korean
Pashto
Persian Dari
Persian Farsi
Polish
Portuguese
Portuguese Creole (Cape Verdean)
Russian
Spanish
Swahili
Tagalog
Tigrinya
Turkish
Vietnamese