YALE-NEW HAVEN HOSPITAL
NON-CLINICAL ADMINISTRATIVE POLICY & PROCEDURE MANUAL

Administrative Policy Title:	**Financial Assistance Programs for Hospital Services**	**Manual Code:**	**NC:F-4**
Reviewed:	**8/1/05, 7/1/07, 7/1/10**	**Revised:**	
Supersedes Manual Code:		**Dated:**	**8/1/05**
Approved By:	**James Staten – Senior Vice President of Finance**		

I. PURPOSE:

Yale-New Haven Hospital ("YNHH" or the "Hospital") recognizes that many patients may be uninsured, may not have adequate insurance or may otherwise lack the financial resources to pay for quality health care services without financial assistance. Consistent with its mission, YNHH is committed to assuring that ability to pay will be considered carefully when settling amounts due for health care services.

In recognition of its role to help those in need of financial assistance, the Hospital has established the YNHH Financial Assistance Programs for Hospital Services ("the Programs"). Those Programs include free care policies, sliding scale discounting policies, prompt pay discount, and certain billing/collection policies. The objectives of the Programs are to:

A. Maintain a humane environment for our patients and their families;

B. Assist patients in gaining access to government insurance programs;

C. Provide clear information regarding the Programs;

D. Ensure easy and timely access to the Programs.

E. Consistently apply the Programs to all patients;

F. Apply fair and equitable business practices with respect to collections for patient services; and

G. Comply with all applicable laws, rules and regulations.

All patients will have the option to apply for government or hospital financial assistance programs based on financial need.

II. PROCEDURES:

A. Scope

1. The Programs apply to hospital inpatient, outpatient and ancillary services billed by the Hospital.

2. The Programs **apply to:**
   a. Uninsured patients (as defined by CT Public Act 03-266)
   b. Patients with no insurance coverage.
   c. Non-covered services (as determined by the patient's third party payer benefits) that are medically necessary.

d. Under-insured patients with significant co-payments and deductibles.
e. Charges incurred after patients' exhaustion of third party payer benefits.

3. The Programs **exclude:**

   a. Routine waiver of deductibles, co-payments and co-insurance imposed by third party payers on hospital claims.
   b. Private room or private duty nurses.
   c. Services that are not medically necessary, such as elective cosmetic surgery.
   d. Other fees that may not be charged directly by YNHH (e.g., television or telephone charges).

4. The patient will be ineligible for some or all financial assistance if any of the following occur:

   a. It is determined that false information fundamentally related to financial eligibility and/or status was provided by the patient or responsible party during the application or billing and collection process.
   b. The patient or responsible party fails to apply for government insurance programs, and such an application is an eligibility requirement for certain types of assistance in the Programs.
   c. The patient or responsible party fails to provide information necessary to complete the eligibility process.

5. YNHH reserves the right to evaluate a patient's eligibility on a case-by-case basis, especially where complex medical, scientific or financial situations exist.

B. Access to Information

Patients will obtain information on eligibility for government or hospital programs primarily from the Hospital's Patient Account Representative. Patients will be alerted to the Financial Assistance Programs in a number of ways, including notices in English and Spanish posted in appropriate locations throughout the Hospital, a summary of free care availability and information on how to apply for free care, information distributed in the admission package, and information on the Hospital's web site. Information will also be provided when direct inquiries are made to YNHH. The Hospital will provide notice and information in a manner that complies with the requirements of law, including the Connecticut law concerning hospital bed funds, and that is designed to make information easily available and accessible to patients.

All patients will have access to information regarding estimated charges for particular services or actual charges for hospital services that have been provided.

C. Summary of Financial Assistance Programs

1. Free Care Funds

Yale-New Haven Hospital has various hospital Free Bed Funds to assist those patients who meet the specific criteria and are unable to pay for services rendered. The Hospital also has other funds that have been designated by YNHH to provide free care. Additional information regarding these funds is contained in the Hospital's Policy for Free Care Funds.

The Hospital will use the same Free Care Application ("Application") to assess both eligibility for Free Care Funds as well as the Sliding Scale Discounting Programs. A Patient Account Representative will perform a financial screening on all patients with payment obligations not covered by insurance for the purpose of determining potential eligibility for financial assistance with any unpaid balances and encouraging patients to apply for assistance.

2. **Sliding Scale Discounting Programs**

Yale-New Haven Hospital offers a Sliding Scale Discounting Program for eligible patients who do not meet the criteria in the Policy for Free Care Funds, but do meet criteria in the Financial Assistance/Charity Care Policy: Sliding Scale Discounting Program. Additional information regarding this program is contained in the Hospital's Sliding Scale Discounting Program.

3. **Prompt Payment and Extended Payment Plans**

For patients who do not qualify for assistance either under the Policy for Free Care Funds or the Hospital's Sliding Scale Discounting Program, the Hospital provides financial assistance to patients through discounts for prompt payment and offers extended, interest-free payment options.

D. Credit, Collections and Bad Debt

YNHH will identify, and distinguish between, the accounts of those patients who have the financial resources to pay for all or some portion of their Hospital bills and the accounts of those who do not. The Hospital will evaluate all past-due accounts for appropriate disposition and follow-up, consistent with this policy, the Hospital's Administrative Policy for Credit and Collection, and Connecticut law.

The Hospital will maintain contractual relationships with one or more collection agencies and law firms for collection of past due accounts. Each such collection agency or law firm must comply with the Hospital's Administrative Policy for Credit and Collections and Connecticut law.

If, at any time, the Hospital, or a collection agency or law firm, receives information that a patient is or may be eligible for financial assistance under one of these Programs or under any governmental or other program, the Hospital, collection agency, or law firm shall, consistent with Connecticut law, cease collection efforts until the Hospital determines the patient's eligibility for assistance.

The Hospital will classify a past due account as bad debt in accordance with the Hospital's Administrative Policy for Credit and Collections and relevant financial accounting standards and law. In determining bad debt, the Hospital may use a variety of collection efforts, including subsequent billings, follow up letters, telephone calls, personal contacts and referral to a collection agency or law firm.

E. Management Oversight Committee

1. **Purpose**

The Programs will be overseen by a management oversight committee ("Committee"). The Committee will, among other oversight responsibilities, review the case of any patient who may not qualify for a specific Financial Assistance Program, but nevertheless may demonstrate compelling hardship or personal circumstances which warrant financial assistance. The Committee will also review financial assistance requests from patients who are insured, but demonstrate financial hardship in paying co-payments or deductibles.

2. **Composition of Committee**

The Committee will be chaired by a Senior Vice President of Yale-New Haven Hospital. Additional Committee members may include System Business Office senior management, patient financial services representatives, patient relations representatives, finance and medical staff liaisons as needed. The Committee will meet on a bi-monthly basis or more frequently, if necessary.

3. **Operating Protocols**

Patient accounts may be referred to the Committee for review by Patient Financial Services, Patient Relations Representatives, or other appropriate referral sources. In general, the Committee will review patient accounts that do not meet the standard eligibility requirements for the various Financial Assistance Programs.

Typical referrals to the Committee will include:

a. Insured patients with co-payments and deductibles that present financial hardship.
b. Self-pay patients with income/assets above 400% of the poverty level with a significant bill that presents a financial hardship.
c. Insured patients who have exhausted insurance benefits or maximum coverage amounts with a significant bill that presents financial hardship.

d. Medicaid enrollees with a Medicaid spend down and demonstrated financial hardship.

The Committee will typically deny financial assistance requests for the following situations:

a. Services denied by an insurance plan as experimental or non-FDA approved.
b. Financial hardship caused by the intentional failure of a patient to follow through with; a) medical advice, or b) health plan requirements such as payment of premium, notification of admission, or other requirements outlined in the patient's subscriber Certificate.

The Committee will maintain minutes of meetings and will communicate findings to the appropriate departments as well as writing to the affected patient.

F. Accounting and Reporting of Financial Assistance Programs

The System Business Office will collect and distribute information to senior management regarding these Programs on a quarterly basis. This information may include, but is not limited to:

a. Number of cases referred;
b. Number of cases processed;
c. Number of cases determined eligible for and referred to government insurance programs;
d. Number of Free Care Applications distributed;
e. Number of Free Care Applications received (complete and incomplete), accepted and rejected and reasons for rejection; and
f. Average time required to process Free Care Applications.

The Budget and Finance Committee of the Board of Trustees of Yale-New Haven Hospital will be provided at least annually with a report concerning the status of these Programs.

YALE-NEW HAVEN HOSPITAL
NON-CLINICAL ADMINISTRATIVE POLICY & PROCEDURE MANUAL

Administrative Policy Title:	**Distribution of "Free Care" Funds**	**Manual Code:**	**NC:F-2**
Reviewed:	**9/20/00, 9/1/01, 6/1/05, 7/1/07, 7/1/10**	**Revised:**	**3/1/91, 9/11/01, 9/1/03, 3/28/12**
Supersedes Manual Code:		**Dated:**	
Approved By:	**James Staten – Senior Vice President of Finance**		

I. PURPOSE:

To establish the policy for the use of funds that have been donated to Yale-New Haven Hospital (YNHH or the "Hospital") and other funds that have been designated by YNHH to provide free care. The Hospital also has other policies related to charity care.

II. PROCEDURES:

A. General Statement of Need

The Hospital has received charitable contributions to endowment that are restricted by the donors to use to provide free care to patients (hereinafter referred to as "Free Bed Funds"). Some of the donated funds contain additional restrictions (home address of patient, church, nominator, etc.); other funds have no additional restrictions. The Hospital has established a spending policy on the distribution of these Free Bed Funds. In addition, YNHH provides additional free care to patients from Hospital operating funds (hereinafter referred to as "YNHH designated funds" or "free care funds").

B. Notice

The Hospital will provide notice and information to patients about Free Care Funds in a number of ways, including publishing notices in newspapers of general circulation; posting notices in appropriate locations throughout the Hospital; ensuring the availability of a one-page summary description of Free Bed Funds and how to apply for them; providing individual written notice to patients; making available written information in other forms that may be helpful to patients; and holding open houses.

The Hospital will provide notice and information in a manner that complies with the requirements of law, including the Connecticut law concerning hospital bed funds, and is designed to make information easily available and accessible to patients.

The Hospital may develop a more detailed policy and procedure specifically describing how notices and information will be provided.

C. Eligibility for Donated Free Bed Funds with No Specified Nominator

The Hospital has Free Bed Funds where the historical dollar value is restricted and the net appreciation and income are available to support free beds for patients unable to pay, but no specific nominator is named. The allocation of the availability of these funds is based on the Hospital's Endowment Spending Policy.

These Free Bed Funds will be available only to patients with no specified nominator after all possibilities of third party reimbursement have been exhausted. Patients must have applied for State assistance, and provide formal documentation showing legitimate denial.

Patients will be considered eligible for the use of Free Bed Funds if their income level does not exceed two and a half times (250%) the poverty level and in appropriate cases and circumstances, the Hospital has determined that they do not have liquid assets that can be used to pay all or some portion of the bill without financial hardship or distress. The Hospital will establish appropriate documentation requirements to verify eligibility.

In addition, the Hospital, at its discretion and on a case by case basis, may provide Free Bed Funds to patients with insurance, assuming they satisfy the other criteria outlined above and there are no other prohibitions on them receiving such assistance. If the patient is insured by a governmental program (Medicare, Medicaid or Tricare) or a private insurer, the Hospital will consider requests for Free Bed Funds for co-pays, deductibles, and/or spenddowns on a case by case basis. If granted, these amounts will be relieved at the amounts determined under the contract or program in question. In addition, the Hospital will consider requests for Free Bed Funds when a patient's insurance or maximum coverage benefits have been exhausted. In making these decisions, the Hospital will consider medical and financial hardship. It may also choose to provide Free Bed Funds for only a portion of the request, if in its judgment, awarding Free Bed Funds for the entire request would adversely affect other applicants who meet the qualifications, but are without insurance (and thus may carry a larger debt).

D. Eligibility for Donated Free Bed Funds with Geographic or other Additional Restrictions but no Specified Nominator

Patients must fulfill the above eligibility guidelines for "Donated Free Bed Funds with No Specific Nominator", and reside in the specific geographic location dictated by the original gift or meet the other additional eligibility restrictions contained in the original gift.

E. Eligibility for YNHH Designated Funds

Once Free Bed Funds with no nominator or other special restriction are exhausted up to the annual endowment spending policy limit, if there are patients eligible for Free Bed Funds who do not meet the restrictions for eligibility for any available restricted Free Bed Funds, YNHH will provide additional free care to patients from YNHH designated funds. Patients must fulfill the eligibility guidelines for "Donated Free Bed Funds with No Specified Nominator" to be eligible for free care designation from YNHH designated funds.

YNHH will also make available additional free care funds from operations for other types of requests where the patient demonstrates a compelling hardship or personal circumstance which warrants providing financial assistance. These requests will be identified and recommended for free care funds by a committee comprised by Management.

F. Eligibility for Donated Funds Restricted to Use by an Outside Nominator

The Hospital has Free Bed Funds where the historic dollar value is restricted and the net appreciation and income are available to support free beds for patients unable to pay and a nominator is named. The allocation of the available funds is based on the Hospital's Endowment spending policy.

The Hospital will notify nominators semi-annually of the status of Free Bed Funds for which they have a nomination role. The nominator may request the use of Free Bed Funds for any eligible patient who meets the guidelines for a given fund. Each nominator will receive an annual report of Free Bed Funds utilized by patient (subject to privacy restrictions). Nominators may request to rollover unused funds to the subsequent year for their purposes or designate remaining funds to be used by YNHH for general free care purposes. In addition, YNHH may award funds in cases in which the donor provided that the Hospital has the power to award the funds if the nominator did not.

G. Accounting of Free Funds

1. For donated Free Bed Funds with no specified nominator and donated Free Bed Funds with geographic or other additional restrictions but no specified nominator:

The Free Bed Funds available on an annual basis will be based on the Endowment Spending Policy and will be applied to the patient requests up to 90 days after the close of the Funds' fiscal year. During this 90-day period, accounts will be identified and recommended for Free Bed Funds by a committee comprised by Management. The funds will be relieved at cost.

2. For YNHH Designated Funds:

For patients whose income level does not exceed two and a half times (250%) the poverty level and deemed eligible for the use of free funds, YNHH designated funds will be available subsequent to the exhaustion of the Free Bed Funds available according to the Endowment Spending Policy for "donated Free Bed Funds with no specified nominator." The funds will be relieved at cost.

3. For donated Free Bed Funds restricted to Use by an Outside Nominator:

The Free Bed Funds available on an annual basis will be based on the Endowment Spending Policy and will be applied to the nominator requests up to 90 days after the close of the Free Funds' fiscal year. If the total amount available to be spent in a year is not applied based on nominator request, the remaining amounts can be carried forward and made available for use in the following year or may, depending on the nominator's wishes and/or the terms of the original gift, be awarded by the Hospital to eligible patients. Funds utilized for patients who meet the financial criteria for other Free Bed Funds will be relieved at cost.

YALE-NEW HAVEN HOSPITAL
NON-CLINICAL ADMINISTRATIVE POLICY & PROCEDURE MANUAL

Administrative Policy Title:	**Financial Assistance/Charity Care Policy Sliding Scale Discounting Program**	**Manual Code:**	**NC:F-5**
Reviewed:	**7/1/07, 7/1/10**	**Revised:**	
Supersedes Manual Code:		**Dated:**	**6/1/05**
Approved By:	**James Staten – Senior Vice President of Finance**		

I. PURPOSE:

To establish the policy for providing financial assistance under a sliding scale discounting program to uninsured patients who are determined under the hospital's eligibility criteria to lack the ability to pay for care at full charges. Yale-New Haven Hospital (the "Hospital") is guided by a mission to provide high quality care to all patients, including those who cannot pay for all or part of the essential care they receive at the Hospital. The Hospital is committed to treating all patients with compassion, from the bedside to the billing office, including payment and collection efforts. Furthermore, the Hospital is committed to advocating for expanding access to health care coverage.

The Hospital will maintain financial aid policies that are consistent with its mission and values and that take into account an individual's ability to pay for medically necessary health care services.

In addition to charity care provided under this sliding scale discounting program established by the Hospital, free care is provided to uninsured and insured patients in accordance with the Hospital's Policy for Free Care Funds. The free care is provided to patients eligible for it and is funded by free bed funds given to the Hospital as well as by Hospital operating funds. Further, the Hospital provides Relief and assistance to insured patients by waiving or reducing co-payments and/or deductibles and Medicaid spend-down requirements on a case-by-case basis determined on grounds of medical and financial hardship.

II. PROCEDURES:

A. General Statement of Need

Recognizing its charitable mission, it is the policy of the Hospital to provide a reasonable amount of its services to eligible patients that do not have the ability to pay for care at full charges.

Charity care is defined as care provided to a patient who is determined under the Hospital's eligibility criteria to lack the ability to pay. The Hospital will establish appropriate documentation requirements to verify financial status.

B. Notice

The Hospital will provide notice and information to patients about the availability of charity care under the sliding scale discounting program in a number of ways, including describing this policy on the one page summary description of free bed funds and other free or reduced care policies.

The Hospital will provide notice and information in a manner that complies with requirements of law and is designed to make information easily available and accessible to patients.

The Hospital may develop a more detailed policy and procedure specifically describing how notices and information will be provided.

C. Eligibility for Sliding Scale Program:

The Hospital provides care through the sliding scale discounting programs to uninsured patients that do not have the ability to pay for medically necessary services at full charges. The sliding scale discounting program is designed to assist uninsured patients eligible for the sliding scale who are not otherwise eligible or do not comply with the application process for assistance under the Hospital's Policy for Free Care Funds.

Additional financial assistance programs are provided by the Hospital for patients who do not qualify for the sliding scale program or free care under the Hospital's Policy for Free Care Funds. These programs include prompt pay discounts and extended payment terms with no interest. In addition, the Hospital provides relief to patients not eligible for free care or the sliding scale program on a case-by-case basis.

Patients must fulfill the following eligibility guidelines:

1. <u>At or below 400 percent of the federal poverty level</u>

Patients will be considered eligible for the sliding scale discount program if their income level does not exceed 400 percent of the federal poverty level and the Hospital, having considered the patient's resources, has determined that they lack the ability to pay all or some portion of the bill. The Hospital will establish appropriate documentation requirements to verify eligibility. Generally, the patient must apply for consideration under the sliding scale program within 30 days of determining self-pay or uninsured status. Eligibility will be granted for one-year, unless otherwise determined by the Hospital, at which time the patient may reapply for sliding scale status. For patients that qualify for the sliding scale program and whose annual family income is at or below 400 percent of the federal poverty level, the patient's bill for services will reflect full charges and then be discounted to a percentage that approximates cost. This cost to charge percentage will be reviewed and set on an annual basis. The discount will be considered free/charity care. The balance will be the patient's financial responsibility.

2. <u>Over 400 percent of the federal poverty level</u>

For patients whose annual family income is greater than 400 percent of the federal poverty level, the patient will not be eligible for the sliding scale discount program, and unless provided relief under a case-by-case review, will be billed for services at gross charges; the charges billed will be the patient's financial responsibility.

Any patient with aggregate Yale-New Haven Hospital bills that exceed 10% of the patient's annual household income will be eligible for a discount equal to the hospital's average managed care reimbursement rate.

D. Charity Care Determination

Charity care is defined as care provided to a patient who is determined under the Hospital's eligibility criteria to lack the ability to pay. Free care is a component of charity care based on established eligibility criteria that awards free care to qualified individuals. The Hospital's determination of charity care for eligible patients may occur at any time during the patient's admission, dates of service, discharge or collection process. The collection process may further allow the Hospital to determine whether patients qualify for sliding scale programs or ultimately are designated as charity care based on inability to pay.

E. Payment Guidelines

Extended payment arrangements may be established with the patient whether they qualify for sliding scale payment, or they are ineligible. If the patient does not honor the payment arrangement based on the eligibility guideline, the amount is referred to a collection agency at the discounted rate.

F. Accounting for Charity and Free Care

Only that portion of a patient account that meets the sliding scale program criteria is recognized as charity care; charity and free care is a reduction in charges made by the Hospital because of the patient's inability to pay for services at charges.

YALE-NEW HAVEN HOSPITAL

ADMINISTRATIVE POLICY

FOR CREDIT AND COLLECTIONS

I. Purpose

The primary goal of Yale-New Haven Hospital ("YNHH or the "Hospi tal") is to provide the highest quality of medical care to its patients at the lowest cost. In order to do so, an efficient and equitable system must be established that will maximize the collection of patient account receivable balances in order to provide the cash flow required to operate the institution effectively.

In accordance with the above, the following credit and collection policy is hereby established for Yale-New Haven Hospital. Detailed procedures will be included in a credit and collection manual as maintained by the System Business Office. As references to this policy, the Table of Contents from various Credit and Collections Operation Manuals from the System Business Office (" SBO") are attached as Exhibits to this policy:

- Exhibit A: SBO Procedure Manual
- Exhibit B: Inpatient Access and ED Dept Reg.Procedure Manual
- Exhibit C: Medical Oncology, One Day Surgery and PT Manual
- Exhibit D: Private Referred Operations Manual
- Exhibit E: PCC and Women's Cen ter Operations Manual

II. Source of Payment

A. Patient

The primary responsibility of settlement of the account will rest with the patient. Except in an emergency, all patients capable of doing so, will be required to sign a payment guarantee prior to admission or receipt of inpatient service.

The patient portion of the hospital bill is to be satisfied through payment via one or more of the following sources:

1. Cash, money order, personal check, bank check, or travelers checks
2. Credit cards acceptable to the hospital
3. Savings accounts, income tax refunds

4. Sale of investments, conversion of insurance policies
5. Loans from banks, credit unions, finance companies, etc.
6. Money Transfer
7. ATM Debit Cards

B. Third Party Coverage

Yale-New Haven Hospital will extend credit on third party benefits assigned to the hospital upon proper validation of coverage. Principal third party payers recognized in the hospital system are as follows:

Blue Cross
Managed Care Payers (HMO and PPO programs)
Medicare
Tricare
Commercial Insurance Companies
(upon assignment of benefit to Hospital)
Workers Compensation
Medicaid

Yale-New Haven Hospital will cooperate with all third party payers to the fullest extent in order to facilitate the collection of patient bills.

C. Payment of Hospital Charges For Elective Hospital Services Not Covered By Insurance

Yale-New Haven Hospital will require, or request payment for the difference between the estimated patient bill and the total available insurance coverage or approved social assistance. This procedure will be applied after giving consideration to the amount of the "patient portion", employment history and other hospital indebtedness. Consideration of these factors will result in the distinction between required and requested payments, which are defined as follows:

Required Payment

Any non-emergency patient will be required to make a deposit or pay estimated charges prior to visit. All past due accounts would also be required to be paid prior to the current admission. This encompasses co-payments, co-insurance, and deductibles.

Requested Payment

Patients will be informed of the estimated patient portion of the bill, and a request for a deposit or payment of charges will not affect the admission procedure. These payments include co-payments, co-insurance, and deductibles.

D. Free Care Funding

Yale-New Haven Hospital has various hospital Free Bed Funds to assist those patients that meet the specific criteria and are unable to pay for services rendered. The Patient Financial Services Representative will perform a financial screening on all self-pay patients for the purpose of potential financial assistance with any unpaid balances. Please refer to the Hospital's Free Car e Policy for additional information.

E. Sliding Scale Discounting Program

Yale-New Haven Hospital offers a Sliding Scale Discounting Program for eligible patients that do not meet the criteria for Free Bed Funds, but meet criteria to receive hospital services at cost. Please refer to the Hospital's Slidin g Scale Discounting Program for additional information.

F. Prompt Payment and Extended Payment Plans

For patients who do not qualify for either Free Care Bed Funds or the Hospital's Slidin g Scale Discounting Program, the Hospital provided financial assistance to patients through discounts for prompt payment and offers extended, interest-free payment options. Please refer to Section V below for additional information.

G. Patient Inquiries

Patient inquiries related to the credit and collection policies of the hospital may be answered or addressed only by those individuals designated within Patient Financial & Admitting Services.

IV. Admission Procedures

A. Pre-Admissions

Yale-New Haven Hospital will pre-admit patients whenever possible. The payment sources chosen for settlement of a patient's account must be verified prior to admission (i.e. confirmation directly with insurance

plan, employer, or by examination and photocopy of appropriate insurance data).

B. Elective Admissions

Elective admission referrals must be received in the Admitting office no later than 12 (noon) the business day prior to the expected admission date. All Elective admissions are subject to the payment of Hospital charges not covered by insurance.

C. Emergency Admissions

Yale-New Haven Hospital will admit all emergency cases irrespective of the financial condition of the patient. All admissions of an emergency nature will be handled and controlled through the Admitting office. The admitting physician must certify as to the emergency status when requesting the admission. If the Admitting/Registration Department needs assistance, the Chairman of the Respective Department will handle the admission.

V. Prompt Payment and Extended Payment Terms

The Hospital, at its discretion, may enter into an agreement for settlement of a patient's bi ll through monthly payments not to exceed 24 months. Under this plan, patients with account balances greater than $100 that are determined to be the patient's respons ibility (after Sliding Scale discount eligibility has been determined) may satisfy their accounts through interest-free monthly payments. The Hospital may also entertain settlement offers of no less than 80% of the balance for Sliding Scale and other patients if payments are made within 30 days.

Patients who are unable to settle bills under the 24 month arrangements must make alternate arrangements for repayment within a twenty-four months repayment period with the collection manager's approval. Any exc eptions to the extended payment policy requires pre-approval from the Senior Vice President, YNHH and will be coordinated with the Management Oversight Committee.

VI Billing Policy and Procedures

All patients/guarantors will receive a series of statements, when there is any third party coverage, and/or bills when there is no third party coverage or all third party coverage has been satisfied (paid or rejected).

VII Collection Policies and Procedures

These collection policies and procedures apply to all pending Welfare, non-contractual insurance and self-pay (pure self-pay and residual self-pay) accounts. All rejected third party accounts will also be classified as self-pay until such time as further insurance is verified. Final bills are processed after discharge and are referred to the collection section of the Systems Business Office ("SBO").

VIII Analysis of accounts prior to collection turnover.

Prior to the turnover of any account into the outside collection process (collection agency or collection attorney), the System Business Office, specifically a Turnover Expeditor, will review each account in detail. The Expeditor will verify the following:

a) All third party insurance opportunities have been exhausted; this will include review of previous patient accounts for third party insurance coverage, including Medicaid coverage.
b) Employment.
c) Liquid asset values if they can be obtained.
d) No free care application is currently in process.

Based on the account review, and if the account value is under $1000, the account may be referred to the collection agency. If the account is over $1000, and is determined under the Hospital' s eligibility criteria that the patient lacks the ability to pay, the account may be referred to the collection agency, or referred to an outside collection attorney if the Expeditor believes that the patient has the financial ability to pay as determined under the Hospital' s eligibility criteria.

In all cases, the cycle detailed for all accounts in this procedure will be interrupted by the following occurrences:

a. Receipt and verification of third party coverage

b. Payment arrangements are agreed to and followed by the patient/guarantor

c. Evidence that the accounts, or other legal consideration may result in an expedited referral to an agency or attorney.

d. If at any time the patient indicates potential eligibility or interest in initiating an application for free care or sliding scale discount services. Patient will be referred to a Free Care Coordinator to receive a Free Care Application in this situation.

IX Bad Debt

1. General Statement of Need

Bad Debts are amounts considered to be uncollectible for which no likelihood of recovery at anytime in the future is expected. Bad debts are differentiated from charity care, which is defined as the inability to pay versus bad debt as the unwillingness of the patient to pay.

2. Patient Responsibility

The patient is deemed responsible for the payment of provided services. Patient's respons ibility also refers to all non-covered third party charges, such as insurance deductibles and copayments.

3. Uncollectible Debt

If after reasonable and customary attempts to collect a bill, the debt remains unpaid, the debt may be deemed as uncollectible. The Hospital's collecti on efforts may include the use of a collection agency or attorney in addition to subsequent billings, follow up letters, telephone calls, and personal contact.

4. Account for Bad Debt

Amounts determined as bad debt are recorded as expense net of recoveries and classified accordingly on the Hospital's Financia l Statements.

X. Policies Governing Collection Attorneys

1. Free care eligibility.

If at any time in the collection process the collection attorney becomes aware of a potential eligibility for free care, the collection is stopped and the account is referred back to the Hospital for pursuit of free care or other financial assistance

programs. Collection attorneys will include Summary Notice of Free Care Availability in all communications with debtors.

2. **Prior approval.**

Collection attorneys are instructed that pre-approval from YNHH is required prior to the initiation of any legal action concerning a referred account.

3. **Property Liens.**

Collection attorneys are instructed to severely limit the placement of property liens unless they can demonstrate significant financial assets by the debtor beyond the assets in the property. Pre-approvals will not be granted unless the account balance is over $1000 and the property(s) to be liened are at least $200,000 in assessed value. Even if the account meets these criteria, a property lien may not be approved if in the view of YNHH, the placement of the lien will cause financial hardship on the debtor.

4. **Wage Garnishments.**

Pre-approvals will be granted for wage garnishments if the following criteria are met and a written letter has been provided to the patient reiterating the following:

- The debtor has had an opportunity to apply for free care and has either refused or been found ineligible for free care assistance.
- The debtor does not fall under the definition of "uninsured" as set by the State of Connecticut.
- The debtor has not applied or qualified for sliding scale discounts to assist in the payment of their debt, or has qualified and has not paid.
- The debtor has not elected to make voluntary payments towards their debt.
- The placement of a wage garnishment is being approved as a last course of legal remedy.

Wage garnishments, if approved, will only apply to account balances over $500. Additionally, any State Marshall fee for administering the wage garnishment will be absorbed by YNHH as a cost of collection. No interest will accrue on wage garnishments.

Any wage garnishments for employees of Yale New Haven Health, Yale-New Haven Hospital, Bridgeport Hospital or Greenwich Hospital, or their affiliates, will require special review and attempts will be made through Human Resources to develop an alternative payment arrangement.

5. **Bank Executions.**

   All bank executions, in addition to pre-approval, require special review by YNHH to verify that the execution will not cause undue financial hardship on the debtor. If this cannot be determined, no bank execution will be ordered.

6. **Foreclosures and Writs of Capias.**

   No foreclosures for property liens or the use of a Writ of Capias will ever be approved by YNHH.

7. **Interest and Court Costs.**

   Interest will be allowed to accrue on accounts after legal court judgment is received. Interest will accrue at the new statutory rate of 5%. We will not allow interest to accrue greater than 50% of the account balance. If the principal is paid in full, the Hospital will waive payment of interest. Court costs will be assumed by the hospital as a cost of collections and not charged to the debtor.

8. **Collection Agency and Collection Attorney Reporting**

   Monthly performance reports will be prepared by each collection attorney firm and sent to YNHH each month. Quarterly meetings will be held with each firm to discuss collection activities, pending legal proceedings, and problematic collection accounts. Performance reports will include the following information:

   - Number and value of accounts in current inventory.
   - Number and value of accounts received monthly from YNHH.
   - Number and value of accounts returned as uncollectible from law firm.
   - Recoveries, net of costs and fees
   - Court costs and fees due from YNHH.
   - Number of property liens approved and placed.
   - Number of wage executions approved and placed.
   - Number of bank executions approved and placed.

XI. Administrative Write-offs

Due to the availability of specialized and tertiary level services at Yale-New Haven Hospital, requests will be made from time to time by Hospital medical staff members and/or outside special interest groups for the Hospital to care for an adult or child from

YALE-NEW HAVEN HOSPITAL

ADDENDUM TO
FINANCIAL ASSISTANCE POLICIES
March, 2006

1. Yale New Haven Health System hospitals will begin to employ in early 2006 a financial screening tool in conjunction with the major credit reporting agencies. Such screening tool will allow member hospitals to triage self-pay accounts as well as potential accounts with underinsurance for ability to pay. Threshold criteria will be established to triage accounts for further collection.

2. Policies will be modified to allow Yale-New Haven and Bridgeport Hospital to consider a patient's financial assets when determining an ability to pay. (Greenwich Hospital currently has the ability to review assets)

3. The current policies at Yale-New Haven and Bridgeport Hospitals require a Medicaid denial prior to approval for free care. We have been asked to review the wisdom of this policy in light of the high certainty of denials for undocumented residents. After careful review and discussion, we believe that this requirement should stand. There are many examples of coverage by Medicaid for services that were originally thought ineligible. We also do not want to set up special consideration for undocumented residents when we require documented residents to obtain a Medicaid denial. Greenwich Hospital currently does not require a Medicaid denial.

4. The sliding scale program should be made available to as many patients as possible. Currently, patients are required to submit proof of income prior to obtaining the sliding scale discount. We recommend that this process continue to be considered, but all patient denials for sliding scale should be reviewed by a manager prior to rejection to confirm that any and all attempts have been made to obtain the required information.

5. Currently, patients who present for non-emergency services and who have no ability to pay, are denied access to services without full or partial payment. In all cases, the physician is notified and asked to determine the emergent or non-emergent condition. Patients may complete a financial assistance application for coverage and when approved, are granted access to services. We propose that this policy be modified to restrict access to services only until a patient has completed our financial assistance application and provided proof of income. Patients who are ultimately denied financial assistance will be noted in the records and upon the patient's next visit, must comply with the non-emergent payment policy.

6. Patients who complete a financial assistance application, provide proof of income, but do not provide a Medicaid denial (50% of cases) will be screened for income eligibility. If the patient meets the income criteria, the account would be referred to Century, even if the patient is employed or owns property. No accounts will be referred to a collection attorney if income is below 400% of FPL.

7. Any patient may avail themselves of a payment plan for their portion of the hospital bill. Such payment plans shall be limited to balances of greater than $50. Greenwich Hospital currently uses and may continue to use a $10 threshold. Depending upon the balance due, payment plans may be established for up to 12 months interest free. Larger balance payment plans for an extended period may be established upon the approval of the Vice President, Corporate Business Services, or an SVP of the health system (including hospital CFOs). In 2006, the health system will establish credit arrangements with one or more health care credit card companies to assist patients with a periodic payment plan. This plan will be initially rolled out at Yale-New Haven and Bridgeport Hospitals.

8. Any care provided to patients that do not complete the appropriate financial assistance applications and are deemed to be unable to pay their health care bill will be classified as charity care. This includes international patients for whom the hospital agrees to provide services at no cost, either prospectively or retrospectively due to the patient's financial circumstances. These will no longer be classified as administrative allowances.

9. The policy will be modified to automatically write off small balances of under $50 after the full cycle of bills have been provided to a patient. The previous ceiling was $100. As a note, any balance of under $1000 is always referred to Century collections as only balances over $1000 are referred to collection attorneys. Greenwich Hospital currently has established a write off threshold of $10 and will continue to use this amount.