HackensackUMC Palisades	**TITLE: Patient Financial Services** **COMPASSIONATE BILLING AND FINANCIAL ASSISTANCE POLICY (FAP)**
REFERENCE MANUAL: Patient Accounts Policy/Procedure Manual	**DISTRIBUTION: Departmental**
RECOMMENDED BY: Director of Patient Financial Services	**APPROVED BY: VP of Finance and Chief Financial Officer (CFO)**
EFFECTIVE DATE: January 2000	**REVISED: August 2008,** **September 2015** **November 2015**

POLICY

The purpose of this policy is to ensure all patients receive essential emergency and other medically necessary healthcare services provided by the hospital and any other substantially related entity, regardless of ability to pay.

AT NO TIME WILL ANY PATIENT BE DENIED NECESSARY EMERGENCY MEDICAL CARE BASED UPON THE PATIENT'S ABILITY TO PAY OR WILLINGNESS OR ABILITY TO PARTICIPATE IN THE FINANCIAL SCREENING PROCESS.

It is the policy of HackensackUMC Palisades ("Medical Center") to offer "Compassionate Billing" to all members of the community served by the Medical Center, including patients who seek emergency or other medically necessary care and are uninsured, patients who are insured but are not covered by their health care reimbursement benefit programs, or whose co-payment obligations present a financial hardship, and patients who are beneficiaries of insurance products with which HackensackUMC Palisades is considered an out-of-network provider.

For Emergency or other medically necessary healthcare services provided by the HackensackUMC Palisades and billed by HackensackUMC Palisades, the Compassionate Billing and Financial Assistance Policy ("FAP") only applies to services billed by HackensackUMC Palisades. Other services which are separately billed by other providers, such as physicians, are not eligible under the FAP. The professional fees for such services necessarily are controlled by the physicians and their medical practices, and patients are required to make separate financial arrangements with these physicians and medical practices.

A list of all providers, other than the hospital facility itself, providing emergency or other medically necessary care in the hospital facility specifying which providers are covered by this FAP and which are not can be found at Appendix A. The provider listings will be reviewed quarterly and updated if necessary.

The FAP consists of policies and procedures, consistently and fairly applied, that (a) require the Patient Financial Services Department, through its financial counselors, to take steps to identify uninsured patients eligible for government or state sponsored or supported medical assistance and to help those patients obtain such medical assistance, (b) provide discounts against charges for uninsured patients who are ineligible for government or state sponsored or supported programs but who meet the medical center's financial criteria and payment requirements, (c) provide on a fee-for-service or case-rate basis certain services not ordinarily covered by third party payor programs, or services deemed not to be medically necessary which fees and rates may represent discounts against charges, (d) allow the reduction or waiver of patient co-payments in cases of substantiated financial hardship and (e) allow the reduction or waiver of patient co-payments for services rendered to patients who are beneficiaries of third party payor programs with respect to which the Medical Center is deemed an out-of-network provider. For additional information please refer to criteria set forth in the separate Self Pay Policy.

The Medical Center bases eligibility upon insurance status and an individual's household income. The Medical Center's FAP includes the method for applying for financial assistance.

FAIR BILLING PRACTICES/ASSISTANCE WITH FAP:

The Medical Center will bill patients or third parties only for services actually rendered. Assistance will be provided to those individuals with questions or who are unable to complete the application process on their own. Those requiring such assistance may visit HackensackUMC Palisades Patient Financial Services Dept., 7600 River Road, North Bergen, NJ 07047 or call 201-854-5092.

APPLICATION:

The FAP only applies to all emergency or other medically necessary healthcare services provided and billed by the Medical Center, including, inpatient and outpatient services. The FAP does not apply to other services or professional fees charged and collected by physicians, medical practices or other providers for services rendered in the Medical Center's facilities, including, for example, services provided by hospital based physicians, such as radiologists, anesthesiologists, emergency department physicians and pathologists. A list of all providers, other than the hospital facility itself, providing emergency or other medically necessary care in the hospital facility specifying which providers are covered by this FAP and which are not can be found at Appendix A.

HOW TO APPLY/WIDELY PUBLICIZING:

The FAP, the Plain language Summary ("PLS") and related Application Form ("Application") will be conspicuously displayed in the following manner:

- Download the documents from the HackensackUMC Palisades website: https://www.palisadesmedical.org.
- Paper copies of the FAP, Application and PLS are available upon request by mail, without charge, and are provided in various areas throughout the Medical Center including Main Registration desk, Emergency Room, and Patient Financial Services Department.
- Request documents to be mailed, by calling the Medical Center's Patient Financial Services Dept. at 201-854-5092.

- Visiting in-person (1st Floor – Lobby):

  HackensackUMC Palisades
  Patient Financial Services Department
  7600 River Road
  North Bergen, New Jersey 07047.
- Mail completed applications or deliver in person (with all documentation/information specified in the application instructions) to:

  HackensackUMC Palisades
  Patient Financial Services Department
  7600 River Road
  North Bergen, New Jersey 07047

- Signs or displays will be posted in public locations including Main Registration desk, Emergency Room, and Patient Financial Services offices that notify and inform patients about the availability of financial assistance.
- A PLS will be provided to all patients as part of the patient access/intake process.

If an applicant does not have any of the documents proving household income, the applicant can contact Patient Financial Services to discuss other documents that may be provided to demonstrate financial assistance eligibility.

All applications must be completed within twelve (12) months from the issuance of the post discharge billing statement. If the Medical Center receives an incomplete Application, written notice will be provided to the patient, or the financially responsible individual, outlining the additional information and/or documentation needed in order to determine FAP-eligibility. Patients, or the financially responsible individual, will be given the greater of 30 days or amount of days remaining in the Application Period (365 days from the date of the first post-discharge billing statement) to submit a completed Application including any additional information requested by Palisades.

The Medical Center also translates its FAP, Application and PLS in other languages wherein the primary language of the residents of the community served by the medical center represents 5 percent or 1,000; whichever is less; of the population of individuals likely to be affected or encountered by the Medical Center. Translated versions FAP are available upon request in person at the address above; and on the Medical Center's website at www.palisadesmedical.org.

PURPOSES:

This FAP is intended to assist patients in coping with the financial hurdles that often create a barrier to health care services. The FAP is implemented through procedures that require the determination of eligibility for government sponsored or supported medical assistance programs, including Medicaid, Family Care, and Charity Care programs, that provide standards for fees and reductions in certain recurring circumstances, such as non-covered services and out-of-network benefits, and that allow for case-by-case fee reductions in response to reasonably substantiated financial hardship. In all cases, the FAP is intended to offer opportunities for the Patient Financial Services Department to be respectful of our community's needs while also furthering

the Medical Center's need to be fiscally responsible and to comply with all applicable Federal and State law.

NJ CHARITY CARE (Charity Care):

Have no health insurance coverage or have coverage that pays only for part of the bill;

- Are ineligible for any private or government sponsored coverage; and
- Meet both the income and assets eligibility criteria established by the State.

New Jersey Charity Care is a State program available to New Jersey residents who:

Additional criteria required in order to be eligible for Charity Care:

- Patients will be screened for the Charity Care program which covers 100% of charges for patients with a family income less than 200% of the Federal Poverty Level ("FPL") and which covers a portion of charges for patients with family income between 200% and 300% of the FPL. Free care or partially covered charges will be determined by use of the New Jersey Department of Health Fee Schedule.
- The Charity Care eligibility thresholds are an individual asset threshold of $7,500 and family asset threshold limitation of $15,000.
- For purposes of this section, family members whose assets must be considered are all legally responsible individuals as defined in N.J.A.C. 10:52-11.8(a).

Documentation required per the Charity Care Section of Hospital Services Manual N.J.A.C. 10:52 includes:

- Proper patient and family identification documents. This can include any of the following: driver's license, social security card, alien registry card, birth certificate, paycheck stub, passport, visa, etc.

- Proof of New Jersey Residence as of the date of service (note: emergency care is an exception to the residency requirement). This can include any of the following: driver's license, voter registration card, union membership card, insurance or welfare plan identification card, student identification card, utility bill, Federal income tax return, state income tax return, or an unemployment benefits statement.

- Proof of gross income. This should include the detail required by the hospital to determine the patient's gross income (one of the following):

    - Actual gross income for the 12 months preceding services.
    - Actual gross income for the 3 months preceding services.
    - Actual gross income for the month immediately preceding services.

- Proof of assets as of the date of service. These are items which are readily convertible into cash.

If no Family Income is reported, information will be required as to how daily needs are met. Occasionally, additional documentation may be requested to confirm eligibility. Such documentation may include, but is not limited to, marriage certificates or divorce decrees.

NJ UNINSURED DISCOUNT:

Eligibility for Discounted Care Under N.J.S.A. 26:2H-12.52:

Uninsured patients who are New Jersey residents with family gross income below 500% of the FPL will be eligible to receive discounted care. Documentation requirements applicable to Charity Care and set forth above apply to eligibility determinations under this Section, except that the individual and family asset thresholds shall not apply to eligibility for discounted care under this Section. In these instances, patients determined to be FAP-eligible for discounted care will be charged the lesser of AGB or 115% of Medicare.

PROCESS:

1. Financial Screening.

During the registration process all patients will be asked to produce insurance documentation in addition to other identification required. Any patient unable to produce insurance documentation, including participation in any government or state sponsored health care reimbursement program, will be encouraged to provide the information necessary for the Medical Center to conduct a financial screening. The financial screening will be conducted in accordance with the New Jersey Hospital Care Assistance Program.

The financial screening will be used to determine the patient's eligibility for medical assistance under Medicaid, Family Care, Charity Care Assistance or any other government sponsored or supported programs, or self-pay fee schedule offered by the Medical Center under the FAP.

Except in the event of an emergency or otherwise when the circumstances may prevent it, the Medical Center will encourage each patient to submit the information necessary to conduct the financial screening before services are rendered. In the case of an emergency, or if other circumstances prevent the prior screening, or if the patient first objects to the screening, the financial screening may be conducted at any time after the services are rendered. The financial counselors shall encourage uninsured patients to participate in the financial screening even after the services are rendered.

AT NO TIME WILL ANY PATIENT BE DENIED NECESSARY EMERGENCY MEDICAL CARE BASED UPON THE PATIENT'S ABILITY TO PAY OR WILLINGNESS OR ABILITY TO PARTICIPATE IN THE FINANCIAL SCREENING PROCESS.

2. Medicaid; Family Care; Charity Care.

If a patient satisfies the financial and other criteria for participation in the Medicaid or Family Care or other government sponsored medical reimbursement programs, the financial counselors shall provide to the patient and assist the patient in completing and submitting the appropriate application and supplemental documentation necessary to register for the available coverage. If eligible for Medicaid, Family Care, or any other government sponsored health care

reimbursement program, the Medical Center's fees and its billing and collection of such fees will be governed by the applicable program or programs.

If the patient is ineligible for Medicaid or Family Care, or any other regularly available government sponsored health care reimbursement program, a determination will be made as to the patient's eligibility for Charity Care Assistance. If eligible for Charity Care Assistance, the Medical Center will reduce or waive its fees and charges for the services it provides in accordance with the policies and procedures governing the NJ Charity Care Assistance program.

NON-COVERED SERVICES:

1. Identification of Non-Covered Services.

The Medical Center acknowledges that patients often seek or require health care services that are not covered under available government or state sponsored or private health care reimbursement programs. The Patient Financial Services Department may identify specific services or categories of services that are often not covered under generally available health care reimbursement plans, but that are sought by members of the community served by the Medical Center. For these such services, referred to herein for convenience only as "Non-Covered Services".

Upon adoption of this policy, the Patient Financial Services Department has identified and established fees for various services and procedures that are not deemed to be medically necessary as Non-Covered Services. Generically these services may not be medically necessary but exceptions may exist.

2. Inpatient and Outpatient Payment Requirements.

For all Non-Covered Services identified under the Self-Pay Policy, including the the payment provisions as set forth in the policy will appl.

PATIENT CO-PAYMENTS

It is the policy of the Medical Center, generally, to bill and collect all patient co-payments, including, for example, co-payments required to be collected at the date of service by health maintenance organizations, deductibles for traditional insurance plans or for out-of-network benefits, and co-insurance amounts, as and when required under the applicable government or state sponsored or private health care reimbursement program.

The Medical Center acknowledges that patient co-payments may restrict access to health care services or otherwise subject individual patients to financial hardship. Therefore, in furtherance of this FAP, and to ensure that all members of the community served by the Medical Center are afforded access to the health care services at the Medical Center, the Patient Financial Services Department may, in strict compliance with the procedures set forth below, reduce or waive certain patient co-payments.

1. Government Payors.

The Medical Center shall comply with all obligations under government-sponsored health care reimbursement programs in which it participates, including, Medicare and Medicaid. Accordingly, the Medical Center shall use good faith efforts to collect the co-payments from all beneficiaries of such programs, including deductibles and coinsurance amounts. The Medical

Center may not waive or reduce patient co-payments under these programs except in accordance with the procedures for hardship waivers set forth below.

2. Non-Government Payors.

The Medical Center shall comply with its contractual obligations to health maintenance organizations, commercial insurance carriers, preferred provider organizations and other non-government health care reimbursement programs. Accordingly, the Medical Center shall use good faith efforts to collect the co-payments from all beneficiaries of such programs, including deductibles, point-of-service co-payments and coinsurance amounts, as and when required under these programs. Unless otherwise expressly permitted in the applicable participation agreement or other contract between the medical center and the third party payor, the Medical Center may not waive or reduce patient co-payments under these programs except in accordance with the procedures for hardship waivers set forth below and, in such cases, only to the extent that such hardship waivers are not prohibited under the applicable participation agreement or other contract or for persons eligible for financial assistance under this FAP.

3. Hardship Waivers.

On a case by case basis, the Patient Financial Services Department may consider a particular patient's financial hardship, and elect to waive a co-payment required under a government sponsored health care reimbursement program or a private health care reimbursement program in which it participates. It may do so, however, only if (i) the Medical Center bills the patient and attempts to collect the co-payment in accordance with its ordinary billing and collection procedures, (ii) the patient account status is such that it would otherwise ordinarily be referred to the Medical Center's collection procedures for delinquent accounts, (iii) the patient or other responsible party requests a hardship waiver, and the patient or other responsible party provides the information and documentation required for the Patient Financial Services Department to conduct a financial screening in accordance with the Financial Screening Policy, (iv) analysis of the financial screening information substantiates the patient's inability to pay the outstanding co-payments, (v) the foregoing steps are well documented and maintained along with the patient's financial records, and (iv) the waiver decision is approved by Financial Planning Manager in consultation with the Chief Financial Officer or his designee.

4. Accommodations for Out-Of-Network Services.

The Patient Financial Services Department may identify non-government health care reimbursement programs that cover a notable portion of the members in the community served by the Medical Center, but with which the Medical Center does not participate as an in-network provider. The Patient Financial Services Department should consider it preferable to reach agreement with such non-government payors, but the Medical center is not compelled by this policy to participate or to accept unfavorable terms or conditions for participation.

In order to extend the benefits of the FAP to all members of the community served by the Medical Center, including insured as well as uninsured members of the community, and to improve access to health care services in its community, the Medical Center may elect to waive or accept reduced co-payments from beneficiaries of non-government sponsored or supported

health care reimbursement plans with which it is not contractually bound, that is, with which the Medical Center is deemed an out-of-network provider. This discretionary waiver or accommodation may be applied by the Patient Financial Services Department without conducting a financial screening or without substantiated financial hardship, but only in strict compliance with the following principles:

a. Except as provided below, the discretionary waiver or accommodation must remain within the Medical Center's discretion: no agreement or contract may be offered or entered into with any patient, or any organization representing patients, or any employer, or any physician or other health care provider, under which the Medical Center is obligated to waive co-payments or make other accommodations concerning out-of-network benefits. The Medical Center may, however, enter into an agreement directly with the applicable third party payor, under which it remains out-of-network, but which provides for certain waivers or other accommodations for network beneficiaries.

b. The discretionary waiver or accommodation must be approved by the Credit Department, in consultation with the Chief Financial Officer. If the discretionary waiver or accommodation is or will be applied, or is of the kind or nature that could be applied, in any routine manner, then it must be approved by the Chief Financial Officer, in consultation with the Chief Executive Officer.

c. If the discretionary waiver or accommodation is or will be applied, or is of the kind or nature that could be applied, in any routine manner, then the Medical Center must provide written notice to the applicable payor of its intent to waive or make other accommodations. Such notice must be in a form and substance so as to provide adequate notice of its intent to the payor. Such notice, for example, could be in the form of a statement attached to each paper insurance claim or a statement inserted in the comments section of each electronic claim, or a general notice provided to an officer of the payor of sufficient authority to accept and respond to such notices. The statement or notice must be approved by the Chief Financial Officer, in consultation with the Chief Executive Officer.

d. The discretionary waiver or accommodation may be provided only if no portion of the patient's health care benefits is funded or paid for by any government sponsored health care reimbursement program, such as Medicare, whether such government benefits are primary or secondary.

AMOUNTS GENERALLY BILLED ("AGB")

The Medical Center utilized the Look-Back method, Medicare fee for service plus private health insurers to calculate the AGB % for each of its hospital facilities. Using this method, the Medical Center determined AGB by multiplying the gross charges for any emergency or other medically necessary care it provides to FAP-eligible individuals by a percentage of gross charges. The AGB percentage is calculated annually based on all claims allowed by Medicare

fee for service plus private health insurers over a prior twelve (12) month period, divided by the sum of associated gross charges for those claims.

The resultant AGB percentage is 18.72%.

The Medical Center calculates the maximum amount a patient owes by multiplying the AGB percentage times gross charges. Gross charges refers to the full, established price for medical care the Medical Center charges patients before applying any contractual allowances, discounts, or deductions.

Patients determined to be eligible for any of the financial assistance programs outlined above will be charged the lesser of AGB or the discounted rate available through these programs for which they may qualify.