

HackensackUMC Pascack Valley Medical Center

FINANCIAL ASSISTANCE POLICY

Effective date: January 1, 2017

POLICY/PRINCIPLES

It is the policy of HackensackUMC Pascack Valley Medical Center (the “Organization”) to ensure a socially just practice for providing emergency or other medically necessary care at the Organization’s facilities. This policy is specifically designed to address the financial assistance eligibility for patients who are in need of financial assistance and receive care from the Organization.

1. All financial assistance will reflect our commitment to the common good, our special concern for persons living in poverty and other vulnerable situations, as well as our commitment to stewardship.
2. This policy applies to all emergency and other medically necessary services provided by the Organization, including employed physician services and behavioral health. This policy does not apply to payment arrangements for elective procedures or other care that is not emergency care or otherwise medically necessary.
3. The List of Providers Covered by the Financial Assistance Policy provides a list of any providers delivering care within the Organization’s facilities that specifies which are covered by the financial assistance policy and which are not.

DEFINITIONS

For the purposes of this Policy, the following definitions apply:

- “**501(r)**” means Section 501(r) of the Internal Revenue Code and the regulations promulgated thereunder.
- “**Amount Generally Billed**” or “**AGB**” means, with respect to emergency or other medically necessary care, the amount generally billed to individuals who have insurance covering such care.
- “**Community**” means geographic area of the State of New Jersey
- “**Emergency Care**” means labor or a medical condition of such severity that the absence of immediate medical attention could reasonably be expected to result in seriously jeopardizing the health of the patient (or unborn child), serious impairment to bodily function, or serious dysfunction of any body organ or part.
- “**Medically Necessary Care**” means care that is determined to be medically necessary following a determination of clinical merit by a licensed physician in consultation with the admitting physician.
- “**Organization**” means HackensackUMC Pascack Valley Medical Center.
- “**Patient**” means those persons who receive emergency or medically necessary care at the Organization and the person who is financially responsible for the care of the patient.

Financial Assistance Provided

1. Patients with income less than or equal to 200% of the Federal Poverty Level (“FPL”), will be eligible for 100% charity care write off on that portion of the charges for services for which the Patient is responsible following payment by an insurer, if any.
2. Patients with an income greater than 200% of the Federal Poverty Level (“FPL”), will be eligible for charity assistance based on the criteria below:

<u>Income Criteria</u>	
<u>Income as a Percentage of HHS Poverty Income Guidelines</u>	<u>Percentage of Charge Paid by Patient</u>
less than or equal to 200%	0%
greater than 200% but less than or equal to 225%	20%
greater than 225% but less than or equal to 250%	40%
greater than 250% but less than or equal to 275%	60%
greater than 275% but less than or equal to 300%	80%
greater than 300%	100%

3. If patients on the 20% to 80% sliding fee scale are responsible for qualified out-of-pocket paid medical expenses in excess of 30% of their gross annual income (i.e. bills unpaid by other parties), then the amount in excess of 30% is considered hospital care payment assistance.
4. Eligibility for financial assistance may be determined at any point in the revenue cycle and may include the use of presumptive scoring to determine eligibility notwithstanding an applicant’s failure to complete a financial assistance application (“FAP Application”).
5. Eligibility for financial assistance must be determined for any balance for which the Patient with financial need is responsible.

Charity Care Program:

- The New Jersey Hospital Care Payment Assistance Program (Charity Care Assistance) is free or reduced charge care which is provided to patients who receive inpatient and outpatient services at acute care hospitals throughout the State of New Jersey. Hospital assistance and reduced charge care are available only for necessary hospital care. Some services such as physician fees, anesthesiology fees, radiology interpretation, and outpatient prescriptions are separate from hospital charges and may not be eligible for reduction.
- The source of funding for hospital care payment assistance is through the Health Care Subsidy Fund administered under Public Law 1997, Chapter 263.

Other Assistance for Patients Not Eligible for Financial Assistance

Patients who are not eligible for financial assistance, as described above, still may qualify for other types of assistance offered by the Organization. In the interest of completeness, these other types of assistance are listed here, although they are not need-based and are not intended to be subject to 501(r) but are included here for the convenience of the community served by HackensackUMC Pascack Valley Medical Center.

1. Uninsured Patients who are not eligible for financial assistance will be provided a discounted rate based on the below criteria:
 - (a) Inpatient procedures: 100% of Medicare Rate
 - (b) Emergency Department visits: 115% of Medicare Rate
 - (c) Elective outpatients: 200% of Medicare Rate
 - (i) Obstetrics and Cosmetic procedures have established self-pay fee schedules, and are not subject to a rate based on Medicare reimbursement.

Limitations on Charges for Patients Eligible for Financial Assistance

Patients eligible for Financial Assistance will not be charged individually more than AGB for emergency and other medically necessary care and not more than gross charges for all other medical care. The Organization calculates one or more AGB percentages using the “look-back” method and including Medicare fee-for-service and all private health insurers that pay claims to the Organization, all in accordance with 501(r). A free copy of the AGB calculation description and percentage(s) may be obtained by request in any admissions area. Patients may also request a free copy of the AGB calculation and percentage by mail by calling Patient Financial Services at (201)383-1043 to request a copy be sent to the Patient’s mailing address.

Applying for Financial Assistance and Other Assistance

A Patient may qualify for financial assistance through presumptive scoring eligibility or by applying for financial assistance by submitting a completed FAP Application. The FAP Application and FAP Application instructions will be made available upon Patient request at the time of service. If a Patient wishes to apply for financial assistance after the day(s) of service, a Patient may access the FAP Application and FAP Application instructions and print directly from HackensackUMC Pascack Valley’s website. Patients may also request a copy of the FAP Application and FAP Application Instructions by mail. To request a copy of the documents by mail, Patients should call the Patient Financial Services department at (201)383-1043. In each of the aforementioned accessible locations, the FAP Application and FAP Application instructions are available in both English and Spanish.

Patient Collections Timeline – Inpatient and Outpatient Services

HackensackUMC Pascack Valley Medical Center provides billing statements for services rendered after insurance has processed the claim, or immediately for patients without insurance.

Balances that are the responsibility of the patient include the following:

- Self-Pay (Patient without insurance)
- Self-Pay after Insurance (Insurance has satisfied their responsibility, with the remaining balance being the responsibility of the patient)
- Charity Care (Discounted charges based on charity percentiles)
- Self-Pay after Medicare (Patient responsibility as defined by Medicare)

Statement Cycle

For all patients, a statement is mailed approximately five days after the balance becomes the responsibility of the patient.

All self-pay balances – The total billing cycle is 120 days before the balance is sent to collections. A statement is sent to the patient after insurance has satisfied their portion, if applicable. If the total past-due patient responsibility is not collected by the due date, the patient will continue to receive subsequent statements (up to 5 total). If payment is still not received, the account will be sent to a collections agency.

Patients with inquiries regarding their balance may call Customer service at (866) 525-5557 to see if they qualify for a payment arrangement. Patients who are unable to pay may contact our Financial Assistance office at (201) 383-1043.