Purpose:
To identify the governing rules for the collection of all fees associated with facility patient care rendered at Hackensack University Medical Center (to be referred to as the “Medical Center” from this point on) and the processes for interaction between the patient, guarantor, and the Medical Centers’ Customer Service and Registration staff.

The adherence of this policy will result in the uniformity of the Medical Center’s revenue collections while maintaining the reputation that the Medical Center is known for. Adherence to this policy will also increase awareness of the financial assistance options available to eligible patients needing emergency or other medically necessary care, and outline the procedures by which these patients can apply for financial assistance.

The focus will be to improve communication with our patients, to increase price transparency, increase cash collections pre-service, and significantly improve patient/public relations by providing our patients with the information they need to understand the price of their care. Additionally, the Medical Center endeavors to increase access to its services by providing greater access to coverage by all members of the community.

Hackensack University Medical Center Philosophy:
Hackensack University Medical Center has established a mission to meet the medical needs of the communities it serves. A sound financial policy committed to reasonable credit and collection protocols, as well as comprehensive financial assistance options, is critically important and fundamental to the Medical Center’s mission. Hackensack University Medical Center will maintain a policy of price transparency by communicating financial responsibility to our patients prior to services rendered excluding emergency trauma services. The policy will always be respectful of our patients’ financial situations and preserve the dignity of those involved, consistent with applicable New Jersey law governing Charity Care, P.L. 1992, Chapter 160.

Please note that in accordance with the Emergency Medical Treatment & Active Labor Act of 1986 (EMTALA), persons with emergency medical conditions will be screened and stabilized regardless of their ability to pay. Such services will not be delayed, denied, or otherwise qualified for any reason, including but not limited to inquiries related to payment. See Administrative Policy 558-1, Patient Transfer and Emergency Medical Treatment & Active Labor Act (EMTALA).
I. Upfront Collections – General Patient Population

Policy:
For the purpose of this policy, “self-pay portion” for insured patients is defined as the amount owed by the patient (and/or guarantor) for all accounts as defined by the payer. The term “self-pay portion for the uninsured patient” is defined as our Compassionate Care rate. The term “facility” refers to prices for the “use of this facility” and not prices for the physician’s office. The term “cost share” refers to a deductible, coinsurance, or copayment amount.

Generally, a patient and/or guarantor will have a self-pay liability under the following circumstances:

A. The patient has no health care coverage for facility services.
B. The patient has health care coverage for facility services; however, the service to be rendered is not covered by his or her health care coverage (example, cosmetic surgery).
C. The patient has health care coverage, however, upon verification of the health care coverage, it is determined that the patient has a cost share amount due. This amount may come in the form of an annual deductible, applicable coinsurance, or copayment for facility services rendered.
D. The patient has a penalty for out-of-network services (the Medical center is non-participating for a specified network). This penalty is imposed by payers when a patient is treated by an out-of-network facility and/or physician. The penalty will vary based on the patients’ hospital coverage.
E. The patient has exhausted his or her health care coverage for the current benefit period (benefit year, calendar year, and/or lifetime maximums).

If a patient/guarantor has facility health care coverage one should use the following guidelines for determining and/or collecting self-pay balances:

A. Medicare Inpatient Deductible
The Medicare Inpatient Deductible for 2016 is $1,288.00.

B. Medicare Outpatient Coinsurance
If the patient is not covered by a secondary insurance, the coinsurance amount as indicated on the HUMC APC Payment Schedule must be collected. The correct amount can be found in the “Coinsurance” column. If the service rendered does not appear on the APC listing, refer to the appropriate Medicare Fee Schedule based on the service rendered (Rehabilitation Medicine, Mammograms, MICU/AMB, Clinical Lab, Diabetes Education, etc.)
Please advise beneficiary that this is an estimated out-of-pocket expense. If the liability is greater, patient will be billed for balance. If it is less than collected amount, patient will be refunded the excess amount.
C. Medicaid

Generally, there are no recipient/patient out-of-pocket expenses for covered services. Based on the Medicaid level of coverage, however, there may be an out of pocket expense for coinsurance and/or a non-covered service.

D. Blue Cross and Blue Shield Coverage

Confirm patient’s responsibility or out of pocket expense/price by verifying electronically (RTE or Payer website) or contacting Blue Cross. Verify if there is a patient responsibility and/or a non-covered service. Obtain the cost share amount and inform the patient. The ETC copayment amount should be verified via RTE Eligibility Verification or by accessing the Payer website. If unable to verify via RTE or the Payer website, the copayment amount can be found on the patient’s insurance identification card. As a last resort, contact the corresponding payer directly.

E. Commercial and Managed Care Payers

Confirm patient’s responsibility or out of pocket expense/price by verifying electronically (RTE or Payer website) or contacting the payer. Verify if there is a patient responsibility and/or a non-covered service. Obtain the cost share amount and inform the patient. The ETC copayment amount should be verified via RTE Eligibility Verification or by accessing the Payer website. If unable to verify via RTE or the Payer website, the copayment amount can be found on the patient’s insurance identification card. As a last resort, contact the corresponding payer directly.

1. Inpatient Elective Admissions, Same Day Surgery and Outpatients in a Bed (Scheduled Visits)
   a. Patients, with or without insurance must be financially cleared:
      i. Prior to or on the date of pre-admission testing; or
      ii. No later than 12:00 Noon, three (3) business days prior to the procedure

The term “financially cleared” refers to insurance verification, the collection of all out-of-pocket expenses for all patients and the attainment of all required pre-certifications, authorizations, and/or referrals for those patients with insurance. For those with insurance, out-of-pocket expenses may include deductibles, coinsurance, and co-pay amounts, as well as all costs that are excluded from coverage (non-covered procedures). For those without insurance, out-of-pocket expenses are subject to the Hackensack University Medical Center Compassionate Care rates.

If a patient is not financially cleared within the stated time frame, the Clinical Director or Administrator for the service area will be notified and
will subsequently make a determination as to the urgency of the patient’s condition regarding the procedure/test.

b. **Pre-admissions**

Hackensack University Medical Center will pre-register all elective services when possible. The method of payment should be identified prior to the patient being admitted, including self-pay portions and prior outstanding balances. Financial assessments will occur prior to the patient’s scheduled procedure. If necessary, a financial agreement will be secured prior to the patient’s scheduled procedure based on the payment alternatives outlined in this policy beginning in Section II (E) of this policy.

2. **Outpatient Elective Self-pay**

Patients, with or without insurance must be financially cleared no later than 12:00 Noon, three (3) business days prior to the procedure.

*The term “financially cleared” refers to insurance verification, the collection of all out-of-pocket expenses for all patients and the attainment of all required pre-certifications, authorizations and/or Referrals for those patients with insurance. For those with insurance, out-of-pocket expenses may include deductibles, coinsurance and, co-pay amounts as well as all costs that are excluded from coverage (non-covered procedures). For those without insurance, out-of-pocket expenses are subject to the Hackensack University Medical Center Compassionate Care rates.*

If a patient is not financially cleared within the stated time frame, the Clinical Director or Administrator for the Service Area will be notified and will subsequently make a determination as to the urgency of the patient’s condition regarding the procedure/test.

3. **Urgent Inpatient Admissions/Transfers/Direct Admits**

Benefit eligibility and verification will take place at time of admission for patients that are admitted to Hackensack University Medical Center as urgent, transfers or direct admits.

4. **Emergency Trauma Center (ETC)**

Hackensack University Medical Center will continue to triage and treat the patient’s medical condition before any financial payment arrangements are discussed. Hackensack University Medical Center will not deny service in the ETC. After verifying that the patient has been screened and approval has been given by the patient’s clinician, the patient will be approached in an attempt to collect insurance information and the out-of-pocket patient responsibility.
Hackensack University Medical Center will bill all health care coverage including Medicare, Medicaid and third party payers, after eligibility verification.

5. Managed Care Agreements – Patients with Insurance
Hackensack University Medical Center has specific managed care agreements. The patient’s responsibility will be determined by the third party payer. The dollar amount will be calculated using the contracted rate agreed upon with the payer.

Please refer to Appendix A of this policy for HackensackUMC’s Patient Collections Timeline for further information regarding the collection process and compliance with Internal Revenue Code §501(r)(6).

II. Financial Assistance Policy

For cases involving the treatment of qualified children or Medicaid patients, please refer to Administrative Policy 1846, Financial Assistance Policy (Charity Care/Kid Care/Medicaid).

Please note that not all services provided within the Medical Center’s hospital facilities are covered under this policy. Please refer to Appendix B for a list of providers by department that provide emergency or other medically necessary healthcare services within the hospital facility. This Appendix specifies which providers are covered under this policy and which are not. The provider listing will be reviewed quarterly and updated, if necessary.

A. HackensackUMC Compassionate Care Discounting Policy
When the Compassionate Care discount is applied to an account, the total amount due will be based on the Inpatient and Outpatient Self Pay Compassionate Care rates for the services rendered. The Inpatient Compassionate Care rates are the Medicare DRG rates for the current year. The Outpatient Compassionate Care rates are based on the Medicare APC Rate times two or the Medicare Fee Schedule Rate times two depending on the service rendered.*** These are the final rates. **No further discounts will be applied to these rates, however, no FAP-eligible individual will be charged greater than Amount Generally Billed (“AGB”) (defined later).**

When the Compassionate Care Rate is applied to a patient’s account, revise the primary payer from Self Pay to “Q75” – “HUMC Charity Care”. This action will automatically allowance the account to the Compassionate Care rate.

B. New Jersey State 15 Discounting Policy
Effective 2/4/09, uninsured patients whose family income falls between 300% and 500% of federal poverty guidelines will be screened using our
current Charity Care Screening process. Once qualified, revise the primary payer to “Q76” – “New Jersey State 15 Care”. The Inpatient New Jersey State 15 Care rates are the Medicare DRG rates for the current year. The Outpatient New Jersey State 15 Care rates are based on the Medicare APC Rate times 115% or the Medicare Fee Schedule Rate times 115% depending on the service rendered.

Self-Pay after Insurance balances (Deductibles, Coinsurances, and Copays) will not be discounted, unless the patient otherwise qualifies under this policy.

C. Amounts Generally Billed (“AGB”) Calculation for Emergency or Other Medically Necessary Care

In accordance with Internal Revenue Code §501(r)(5), in the case of emergency or other medically necessary care, patients eligible for financial assistance under this Policy will not be charged more than an individual who has insurance covering such care.

An individual deemed eligible for financial assistance that requires emergency or other medically necessary care will be charged the lesser of:

1. The amount as calculated per sections (II)(A)-(B) above; or
2. AGB.

The AGB is calculated utilizing the look-back Medicare fee for service plus private health insurers. The current AGB percentages are as follows:

1. Inpatient: 26%
2. Outpatient: 32%
3. Outpatient ER: 22%

D. Forms of Payment

Hackensack University Medical Center accepts the following forms of payment:

1. Cash
2. Money Order
3. Selected Credit Card- Visa, MasterCard, American Express, Discover
4. Debit Cards with the Visa or MasterCard Logo
5. Bank Check
6. Personal Checks

E. Hackensack University Medical Center Financial Agreement Plan

Financial agreements can be established upon request. A minimum deposit is to be taken and the balance thereafter can be placed on an interest free installment plan.

F. Financial Agreements for Accounts with Outstanding Balances
All arrangements will be initiated using the Financial Agreement Payment form. All completed forms are to be distributed as follows:
- One copy goes to the patient.
- One copy goes to the patient’s account/file
- One copy goes to the Manager of Customer Service
(Outpatient Financial Agreement, English) (Outpatient Financial Agreement, Spanish) and (Inpatient Financial Agreement, English) (Inpatient Financial Agreement, Spanish)

The financial agreement will be reviewed in its entirety with the patient/guarantor. The following section will appear in the agreement:
“I acknowledge that failure to meet obligations as defined in the payment plan will result in Hackensack UMC sending my account to collections. I also acknowledge that if this agreement is defaulted, any discounted rates agreed upon will revert to full charges” and, “All charges at the time of registration are estimated and based on a physician treatment plan and are subject to change. Please note that no FAP-eligible individual will be charged greater than AGB”

G. Financial Assistance Programs - New Jersey Medicaid or Charity Care
All patients that are unable to pay the HackensackUMC Compassionate Care rates will initially be referred to a Financial Counselor. If the Financial Counselor is unable to financially clear the patient, the patient will be referred to the Financial Assistance Unit. This unit will determine if the patient qualifies for one of the entitlement programs.

H. International Patients Policy (Foreign Patients):
HackensackUMC International Patient Definition:
Patients currently residing in a foreign country and who are traveling to the U.S. to receive treatment at Hackensack University Medical Center (the “Medical Center”) for specific services. These services are pre-arranged, and are NOT subject to the Financial Assistance provisions outlined in this policy

All international patients who pre-arrange to come to Hackensack University Medical Center from foreign countries to receive pre-arranged medical treatment will receive an approved reimbursement rate for services including but not limited to:
- Cardiology
- Organ Transplant Programs
- Oncology
- Orthopedics
- Urology Procedures

These patients will be prescheduled for these visits, at which time arrangements for a wire transfer of funds (including the wire transfer phone#) to cover the treatment will be made. The wire
transfer of funds must be made five (5) business days prior to the patient’s visit to the Medical Center. Any portion of the prepayment that is not used will be refunded.

I. Applying for Financial Assistance
   a. Available Languages
      i. The Medical Center’s FAP, Application and PLS are available in English and in the primary language of populations with limited proficiency in English (“LEP”) that constitute the lesser of 1,000 individuals or 5% of the Medical Center’s primary service area. These documents are available on the Medical Center’s website as well as free of charge upon request.
   b. View information on the Medical Center Website
      i. Website: An individual can view information about financial assistance online at the following website: http://www.hackensackumc.org/financialassistancepolicy
   c. Application
      i. An individual can apply for financial assistance by filling out a paper copy of the application. The paper application is available free of charge by any of the following methods:
         a) By Mail: By writing to the following address and requesting a paper copy of the financial assistance application:
            1) 100 First Street - Suite 300
               Hackensack, NJ 07601
         b) In Person: By stopping by the Financial Assistance Department in person (Monday thru Friday, 8:00AM-4:00 PM), located at the following address:
            1) 100 First Street - Suite 300
               Hackensack, NJ 07601
         c) By Phone: The Financial Assistance Department can be reached at (551)-996-4343
   d. Application Period:
      i. An individual has three hundred sixty-five (365) days from the date they are provided with the first post-discharge billing statement to apply for assistance.
      ii. Incomplete applications are not considered, but applicants are notified and given an opportunity to furnish the missing documentation/information.
   e. Completed Applications:
      i. Please mail all completed Applications to the Financial Assistance Department (refer to address above).

APPENDIX A: HackensackUMC Patient Collections Timeline - For both Inpatient and Outpatient Services
Hackensack University Medical Center provides billing statements for services rendered after insurance has processed the claim. Balances after insurance include the following:

1. Self-Pay (patient without insurance)
2. Self-Pay after Insurance (insurance has satisfied their responsibility, the remaining balance is patient responsibility)
3. HackensackUMC Charity Care (compassionate care – discounted charges)
4. Self-Pay after Medicare (patient responsibility as defined by Medicare).

For those patients without insurance a statement is mailed approximately five days after discharge or date of service.

**Non Medicare Statement Cycle** – The total billing cycle is 62 days before the balance is sent to collection. A bill is sent to patients after insurance has satisfied their portion. Payment in full must be received by due date stipulated on the statement. If the total past due is not received by the due date, then patient will continue to receive subsequent statements (up to three in total). If payment is not received, a final pre-collection letter will be sent to the patient requesting payment within ten days. If payment is still not received, the account will be referred to a Collection Agency.

**Medicare Statement Cycle** – The total billing cycle is 120 days before the balance is sent to collection. A bill is sent to patients after Medicare and any secondary insurances have paid. Payment in full must be received by due date stipulated on the statement. If the total past due is not received by the due date, then patient will continue to receive subsequent statements (up to four in total). If payment is not received, a final pre-collection letter will be sent to the patient requesting payment within ten days. If payment is still not received, the account will be referred to a Collection Agency.

Address for patient payments:
Hackensack University Medical Center
P.O. Box 48027
Newark NJ 07101-4827

Patients with inquiries regarding their balance may call Customer Service at 551-996-3355
Patients who are unable to pay the balance on their account may call customer service at 551-996-3355 to see if they qualify for a payment arrangement. Patients who are unable to pay may contact our Financial Assistance office at 551-996-4343 to see if they qualify for financial assistance.

**Extraordinary Collection Measures** may include, but are not limited to the following: placing liens on an individual’s property, foreclosure of a person’s property, seizing or attaching a person’s bank account or any other personal property, commencing a civil action against an individual, causing the individual’s arrest, and garnishing an individual’s wages. Extraordinary Collection Measures are governed by the following time periods:
1. **Notification period:** The Medical Center shall notify the individual about the Collection, Payment, and Financial Assistance Policy before initiating any extraordinary collection actions to obtain payment and refrain from initiating extraordinary collection actions for at least 120 days from the date the patient is provided the first post-discharge billing statement for care.

2. **Application Period:** An individual has 240 days from the date they are provided with the first post discharge billing statement to submit an application.

3. **Waiting time for extraordinary collection actions:** HackensackUMC must provide the patient with a minimum of thirty (30) days’ notice before engaging in any extraordinary collection actions.
## APPENDIX B: Providers by Department that Provide Emergency or other Medically Necessary Healthcare Services within the Hospital Facility

<table>
<thead>
<tr>
<th>Department/Entity/Group</th>
<th>Covered by Financial Assistance Policy?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Department of Anesthesiology</td>
<td>No</td>
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<tr>
<td>Department of the Cancer Center</td>
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<tr>
<td>Department of Dentistry</td>
<td>No</td>
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<tr>
<td>Department of Emergency Medicine</td>
<td>No</td>
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<tr>
<td>Department of Family Medicine</td>
<td>No</td>
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<tr>
<td>Department of Internal Medicine</td>
<td>No</td>
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<tr>
<td>Department of Neurosurgery</td>
<td>No</td>
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<tr>
<td>Department of Obstetrics and Gynecology</td>
<td>No</td>
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<tr>
<td>Department of Ophthalmology</td>
<td>No</td>
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<tr>
<td>Department of Orthopedic Surgery</td>
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<td>Department of Otolaryngology</td>
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<td>Department of Pathology</td>
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<td>Department of Pediatrics</td>
<td>No</td>
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<tr>
<td>Department of Plastic &amp; Reconstructive Surgery</td>
<td>No</td>
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<tr>
<td>Department of Podiatry</td>
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<tr>
<td>Department of Psychiatry and Behavioral Medicine</td>
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<tr>
<td>Department of Radiation Oncology</td>
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<tr>
<td>Department of Radiology</td>
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<tr>
<td>Department of Rehabilitation Medicine</td>
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<td>Department of Surgery</td>
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<td>Department of Urology</td>
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<td>Hospitalists</td>
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<tr>
<td>Laboratory Services</td>
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