Barnabas Health

Life is better healthy.

Affiliates: Clara Maass Medical Center Community Medical Center Monmouth Medical Center Monmouth Medical Center Southern Campus Newark Beth Israel Saint Barnabas Medical Center Jersey City Medical Center Barnabas Behavioral Health Center	Department: Patient Financial Services
Title of Policy: Financial Assistance Policy	
Effective Date:	
Approved Date: **Revision Date:**	**Approved by:**

Purpose Statement

To ensure that all eligible patients receive emergency and other medically necessary healthcare services provided by at partially or fully discounted rates.

Policy Statement:

It is the policy of Barnabas Health to encourage and assist all uninsured and underinsured patients to explore and apply for third party sponsorship programs. Third party sponsorship offers for the best financial outcome for both the patient and the health system. Emergent cases shall never be delayed or declined due to lack of financial sponsorship and will follow EMTALA guidelines.

It is the policy of Barnabas Health to pursue collection of patient balances from patients who have the ability to pay for these services. All collection procedures will be applied consistently and fairly for all patients regardless of insurance status. Patients who are unable to meet their financial obligation will be referred to Financial Counseling for evaluation of the individual/family's financial status and assistance in identifying alternative sources of payment.

Procedure:

All patients will be informed of the availability of Financial Assistance and a copy of the Plain Language Summary (PLS) will be provided to all patients at the point of registration. The Financial Counsellor is responsible for ensuring all accounts assigned to their worklists are screened for all applicable sponsorship programs and all processes are completed.

It is the responsibility of the Financial Counselor to screen all self-pay patients who are admitted to the hospital with no secondary insurance as well as patients who are deemed underinsured during the Insurance Verification Process. Financial Counselors will also conduct Point of Service payment collections for all account that have been assigned to their worklists for insured out of pocket patient responsibility. No patient determined to be FAP-eligible will be responsible for more than Amounts Generally Billed (AGB - see Appendix A)

The Financial Assistance Policy will be available in English and in the primary language of any populations with limited proficiency in English that constitute the lessor of 1,000 individuals or 5 percent of the community served by the hospital. Every effort will be made to ensure that the FAP documents are clearly communicated to patients whose primary languages are not included among the available translations. The FAA "Financial Assistance Application" and the PLS are available on the Barnabas Health website at (www.barnabashealth.org).

Signage in the Hospital access areas (registration, admissions, etc…) will disclose the availability of Financial Assistance for all medically necessary healthcare.

All of the care provided by hospital employees is eligible for the discounts set forth in this policy. Care provided in specific departments by independent physicians who are **not** hospital employees (Emergency, Oncology, Surgery, Lab-Pathology, Radiology, Consulting Physicians, Clinics, Hospitalists, Physician Offices, Cardiology, Anesthesia) do not fall under this policy and are ineligible for the discounts noted. This list will be reviewed quarterly and updated as appropriate.

The FAP, Application and PLS will be available upon request and without charge at the various hospital registration sites listed below or by visiting the website listed above or by calling 1-877-221-7809. Patients may complete their application on site with the assistance of the financial counsellors or may mail it to the below addresses for review and approval. Upon review the patient may be contacted for additional information to complete the application and/or notified of approval or denial and the specific reasons.

St Barnabas Medical Center
Patient Financial Services
94 Old Short Hills Road
Livingston, NJ 07039

Newark Beth Israel Medical Center
Patient Financial Services
201 Lyons Avenue
Newark, NJ 07112

Clara Maass Medical Center
Patient Financial Services
1 Clara Maass Drive
Belleville, NJ 07109

Jersey City Medical Center
Patient Financial Services
355 Grand Street
Jersey City, NJ 07302

Monmouth Medical Center
Patient Financial Services
300 Second Avenue
Long Branch, NJ 07740

Monmouth Medical Center Southern Campus
Patient Financial Services
600 River Avenue
Lakewood, NJ 08701

Community Medical Center
Patient Financial Services
99 Highway 37 West
Toms River, NJ 08755

Barnabas Health Behavioral Center
Patient Financial Services
1691 US Highway 9
Toms River, NJ 08754

Third Party Sponsorship Program Matrix:

Program	Pre-requisites
Violent Crimes Compensation	Admission is the result of a Violent Crime in the state of New Jersey
Catastrophic Illness and Relief Fund	Eligible expenses must exceed 10% of the family's income, plus 15% of any excess income over $100,000.
Medicaid	Patient must meet the eligibility requirements of their state of residence.
NJ State Charity Care (NJCC)	Patient must meet the eligibility requirements of NJCC program
NJ Uninsured Discount Program	Patient is not eligible for any program. Financial Counsellor to follow BH guidelines in an attempt to collect payment. The account is allowanced to 115% of Medicare or AGB whichever is less.

1. Patient Screening Process
   The Financial Counselors will make every effort to complete the screening process on all non-scheduled patients once the patient has been admitted to the hospital and/or once they have been stabilized and seen by a provider. Screen the patient and/or guarantor by asking all pertinent questions related to the eligibility requirements outlined in the Third Party Sponsorship Matrix (TPSM) and in accordance with the Barnabas Health

FAP.

Determine the appropriate program and have the application filled out completely and collect all required documentation. It is strongly recommended to complete the patient's application and gather all documents while they are still "in-house". If the patient and/or guarantor are uncooperative or incapacitated the Financial Counselor should try to obtain the needed information from medical charts, hospital information systems, family members or other designated care givers to the patient.

2. Patient Follow-Up Process
   Continuous follow up is needed in order to complete many of the assistance applications. The Financial Counselor will need to contact the patient, guarantor or third parties for further documentation. The patient and or guarantor should be given a list of all the required documentation needed for the application. Schedule follow up appointments as necessary to receive the information. In order to make a timely determination, the average timeline to complete the application is 60 days but may be longer. Any closed or denied application can be reopened within 1 year if missing data is provided to the financial counsellor.

Third Party Sponsorship Program Details:

NJ Violent Crimes Compensation-
This program compensates victims of crime for losses and expenses resulting from certain criminal acts.

- Must be a resident of the State of NJ or the crime had to occur in this State.
- Patient has compensable financial losses as a result of the criminal act.
- The crime was reported to law enforcement within 9 months, and the application was submitted within 3 years from the date of the crime.
- www.njvccb.com

NJ Catastrophic and Illness Relief Fund-
The Catastrophic Illness in Children Relief Fund is a Financial Assistance program for New Jersey Families whose children have an illness or condition otherwise not covered by insurance, State or Federal programs or other source, such as fundraising. The Fund is intended to assist in helping a family's ability to cope with the responsibilities which accompany a child's significant health problems.

To be eligible for this program applications must meet the criteria listed below:

- Any illness can be catastrophic based on uncovered eligible medical expenses and the family's income in a prior 12-month time period.
- Eligible expenses must exceed 10% of the family's income, plus 15% of any excess income over $100,000.
- The child must be 21 years or younger when the medical expenses occur.
- The family must have lived in New Jersey for 3 months immediately prior to the date of the application. Migrant workers may be eligible, temporary residents are not.

To apply for Catastrophic Illness in Children Relief Fund Program - 1-800-355- FUND (3863)

Medical Assistance (Medicaid)-
New Jersey Medicaid provides health insurance to parents/caretakers and dependent children, pregnant women and people who are deemed aged, blind or disabled as well as adults below a certain income level. These programs pay for hospital services, doctor visits, prescriptions, nursing home care and other healthcare needs, depending on what program a person is eligible for.

Eligibility Requirements for NJMA

- A resident of New Jersey
- A U.S. Citizen or qualified alien. (Most immigrants who arrived after August 1996 are barred from Medicaid but could be eligible for New Jersey Family Care and certain programs for pregnant women.

- NJ Family Care is New Jersey's publicly funded health insurance program which includes CHIP, Medicaid and Medicaid Expansion Populations. Qualified residents of any age may be eligible for free or low cost health insurance that covers doctor visits, prescriptions, vision, dental care, mental health and substance use services and even hospitalization. NJ Family Care covers children, pregnant women, parents/caretaker relatives, single adults and childless couples.
    - Eligibility Requirements for New Jersey Family Care
    - A resident of New Jersey
    - A U.S. Citizen or qualified alien. (Most immigrants who arrived after August 1996 are barred from Medicaid but could be eligible for New Jersey Family Care and certain programs for pregnant women.
    - In addition, a patient must fall into one of the following categories
    - Children 18 an under
    - Parents/Caretaker Relatives
    - Adults without dependent children
    - Pregnant Women up to 200% FPL
    - Aged, Blind or Disabled programs or Long Term Care
- In addition, a patient must fall into one of the following categories
    - Families with dependent children
    - People who are 65 years of age or older, blind, or permanently disabled or Pregnant Women.

New Jersey Charity Care

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 hospitals throughout the State of New Jersey. Hospital assistance and reduced charge care are available only for necessary hospital care. Emergency care is an exception to the residency requirement. The timeline for application is within 1 year from the date of service.

New Jersey Charity Care is available to New Jersey residents who:

1. Have no health coverage or have coverage that pays only for part of the bill: and
2. Are ineligible for any private or governmental sponsored coverage (such as Medicaid); and
3. Meet both the income and assets eligibility criteria listed below.

Charity Care assistance is also available to non-New Jersey residents subject to specific provisions.

Hospitals post signs in English and Spanish. These signs are posted in appropriate areas of the facility such as the admissions area, outpatient clinic areas, and the emergency room.

In order to apply for NJ Charity Care all applicants must submit proof of:

- Income
- Assets
- Identity
- Resident

If more documentation is needed in order to complete the application and make a determination, the Financial Counselor may also ask in addition to the above but not limited to:

Bank Statements including any retirement account(s) information
- Letter of Support
- Social Security Award letters and Pension payment letter
- Court Orders of Child Support stating income
- Court Order for Alimony stating income

- Marriage Certificates
- Divorcee Decrees

<u>Income Criteria</u>

Income as a Percentage of HHS Poverty Income Guidelines	Percentage of Charge Paid by Patient
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%

<u>PARO (Patient Account Rank Order)– Presumptive Financial Assistance</u>

A patient that either did not comply with the Charity Care Application and Documentation Process or those patients that did not apply are classified as Self Pay patients and run through our Self Pay flow for the 120 day period. Prior to these accounts being referred to Bad Debt they are “Pre-Listed” and run through our vendor, PARO Decision Support, LLC to see if they would have qualified for Charity Care. This process helps us to more effectively, efficiently identify patient who are presumed to have qualified for Charity Care.

Using a scale from 1 to 1000, PARO assigns a numeric value to each account based on the evaluation of a complex set of criteria used to define that patient’s financial condition.

Once the account is identified as meeting these criteria they are “Presumed” eligible for Charity Care at 100% and written off the system. The account balance is zero and no further collection activity will occur.

Barnabas Health System Payment Plan Policy

True Self Pay Patients:
Once it has been determined that the patient does not meet any of the Third Party Sponsorship Programs, the patient is considered a true self pay patient. The patient’s responsibility should be calculated after applying the self-pay rate. (See facility specific self-pay guidelines). This only applies to patient’s who do not have insurance and not to patients with deductibles and/or co-pays or large out of pocket expense.

It is the responsibility of the Financial Counselor to stress to the patient/guarantor that the total liability is expected on or before the actual date of service. Patients should be encouraged to make their liability payment during their scheduled Pre-Admission Testing times.

If the patient/responsible party insists that he/she can only satisfy a portion of their liability, the Financial Counselor must specify the payment requirement and inform the patient that they will be billed for the remainder.

-for an *INPATIENT* liability of $250.00 or higher, at least 50% is due upon admission and all balances paid within 3 to 12 months.

-For an *OUTPATIENT* liability of $100.00 or higher at least 50% is due upon admission and all balances paid within 3 to 12 months.

If the patient cannot satisfy the above specified amounts, the FC counselor must then request 25% of the total liability.

If a patient cannot pay an amount greater than or equal to 25% of the total liability, management must review the account for payment approval. Exceptions may occur and in these cases it is up to the Site Director or their designee.

APPENDIX A

Barnabas Health initiated a "look back" methodology including Medicare fee for service, commercial and managed care health insurers' claims data to calculate the AGB % (Amount Generally Billed) for each of its hospitals. Using this method, Barnabas Health calculated AGB by multiplying the gross charges for any emergency or other medically necessary care it provides to FAP eligible patients by a percentage of gross charges. The AGB percentage is calculated annually based on all claims allowed by Medicare fee for service and commercial and managed care health insurers over a 12-month period (10/1/2014-9/30/2015), divided by the sum of gross charges for those encounters.

The AGB percentages are as follows:

- St Barnabas Medical Center – 28.58%
- Newark Beth Israel Medical Center - 25.83%
- Clara Maass Medical Center – 23.52%
- Jersey City Medical Center – 22.16%
- Monmouth Medical Center - 28.39%
- Monmouth Medical Center Southern Campus - 19.32%
- Community Medical Center – 21.30%
- Barnabas Health Behavioral Center – 51.94%

Barnabas Health calculates the maximum amount a patient owes by multiplying the AGB percentage times gross charges or 115% of the Medicare amount whichever is less. Gross charges refers to the full, established charge for medical care that Barnabas Health charges patients before applying any contractual allowances, discounts, or deductions.

If the calculated AGB percentage results in an amount **less than** the amount the patient owes, the patient will only be responsible for the amount calculated under AGB or 115% of Medicare whichever is less.

If the calculated AGB percentage or 115% of Medicare results in an amount **more than** the amount the patient owes, the patient will be responsible for the amount calculated under Barnabas Health's FAP.