

VIRTUA HEALTH

<b><u>MANUAL TITLE</u></b> PBS—PATIENT ACCOUNTING		<b><u>POLICY NAME</u></b> Financial Assistance Policy		
<b><u>MANUAL OWNER</u></b> Patient Accounting	<b><u>DATE OF ISSUE</u></b>	<b><u>DATE OF LAST REVIEW</u></b> 12/2016,03/20/2018 11/2019	<b><u>DATE OF REVISION</u></b> 12/2015 11/2019	<b><u>EFFECTIVE DATE</u></b> 12/2015
<b><u>REVIEW INTERVAL</u></b> 12 Months <b><u>This policy is applicable to:</u></b>	<b><u>REVIEWED / APPROVED BY:</u></b> Officers of the Virtua Health Board of Trustees Virtua - Memorial Hospital Burlington County, Inc Virtua - West Jersey Health System, Inc. Virtua Memorial Burlington - Psych			

**1. Policy**

The goal of Virtua’s Financial Assistance Policy (“FAP”) is to assist those who do not have adequate financial resources (including health insurance) to pay for the care that they, or someone for whom they are responsible, received. Virtua’s FAP pertains to the provision of emergency and other medically necessary care. It does not pertain to non-medically necessary or elective cosmetic procedures. Patients whom receive emergency or other medically necessary care at Virtua are commonly also seen by private physician groups or other third party healthcare providers while being cared for by Virtua. Please refer to Appendix A for a list of providers within our hospital facilities that provide emergency or other medically necessary healthcare services. The appendix specifies which providers are covered under this FAP and which are not. The provider listing will be reviewed quarterly and updated, if necessary.

**2. Financial Assistance Programs, Eligibility, and Methods for Applying/Procedures**

Subject to qualification, financial assistance may be available through the following programs:

- a) Government programs such as Medicaid and Social Security
- b) The State of New Jersey’s Hospital Care Payment Assistance Program (“HCPAP”)

The source of funding for hospital care payment assistance is through the Health Care Subsidy Fund administered under New Jersey Public Law 1997, Chapter 263. HCPAP approval results in free or discounted care for 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 emergency or other medically necessary care.

Patients may be eligible for the HCPAP if they are New Jersey residents whom:

- i. Have no health coverage or have coverage that pays only part of the hospital bill (uninsured or underinsured);

- ii. Are ineligible for any private or governmental sponsored coverage (such as Medicaid); and
- iii. Meet the following income and asset eligibility criteria included below:

*Income Criteria:* Patients with family gross income less than or equal to 200% of Federal Poverty Guidelines (“FPG”) are eligible for 100% charity care coverage. Patients with family gross income greater than 200% but less than or equal to 300% of FPG are eligible for discounted care. Free care or partially covered charges will be determined by use of the New Jersey Department of Health Fee Schedule.

*Asset Criteria:* HCPAP includes asset eligibility thresholds which state that individual assets cannot exceed \$7,500 and family assets cannot exceed \$15,000.

HCPAP is also available to non-New Jersey residents, requiring immediate medical attention for an emergency medical condition.

Patients who wish to apply for HCPAP must submitted a completed New Jersey Hospital Care Assistance Program Application for Participation, including family/household information, proof of New Jersey residency (ex. driver’s license, county identification card), and documentation of income (ex. pay stub(s), Form W-2, social security statement) and assets (ex. bank statements). If a patient has no income or assets, an attestation provided by the patient would circumvent the need for documentation.

c) New Jersey Uninsured Discount (Public Law 2008, Chapter 60)

All uninsured patients with family gross income less than 500% of FPG will be eligible for discounted care under this program. Under this program an eligible patient will be charged an amount no greater than 115% of the applicable payment rate under the Federal Medicare program for the healthcare services rendered.

d) NJ FamilyCare

NJ FamilyCare is New Jersey’s publicly funded health insurance program which includes CHIP, Medicaid and Medicaid expansion populations. NJ FamilyCare is a federal and state funded health insurance program created to help qualified New Jersey residents of any age access to affordable health insurance. NJ FamilyCare is for people who do not have employer insurance.

Financial eligibility for individuals seeking eligibility for NJ FamilyCare will be based on their Modified Adjusted Gross Income or MAGI. Additional information can be found at: [www.njfamilycare.org/default.aspx](http://www.njfamilycare.org/default.aspx).

e) New Jersey Cancer Education and Early Detection (“NJCEED”)

The NJCEED program provides comprehensive outreach, education and screening services for breast, cervical, colorectal and prostate cancers.

A patient must be uninsured or underinsured and must have family gross income at or below 250% of FPG to be eligible. Additional information can be found at: [www.nj.gov/health/cancer/njceed](http://www.nj.gov/health/cancer/njceed).

f) The Catastrophic Illness in Children Relief Fund

The Catastrophic Illness in Children Relief Fund provides financial assistance to families of children with a catastrophic illness.

In order to be eligible hospital expenses must exceed 10% of the family's gross income, plus 15% of any excess income over \$100,000, the child must have been 21 years or younger when the medical expenses were incurred and the family must have lived in New Jersey for 3 months immediately prior to the date of application. Migrant workers may be eligible, temporary residents are not. Additional information can be found at [www.state.nj.us/humanservices/cicrf/home](http://www.state.nj.us/humanservices/cicrf/home).

g) New Jersey Victims of Crime Compensation Office

The State of New Jersey has established the New Jersey Victims of Crime Compensation Office to compensate victims of crime for losses and expenses, including certain medical expenses, resulting from certain criminal acts.

In order to be eligible for New Jersey Victims of Crime Compensation Office the crime must have occurred in New Jersey or must relate to a New Jersey resident victimized outside of the State, the victim must have reported the crime to police within 9 months and victim must cooperate with the investigation and prosecution of the crime. The claim must be filed within 3 years of the date of the crime and the patient must be an innocent victim of the crime. Additional information can be found at [www.nj.gov/oag/njvictims/index.html](http://www.nj.gov/oag/njvictims/index.html).

h) ABG

Pursuant to IRC Section 501(r)(5), in the case of emergency or other medically necessary care, eligible patients will not be charged more than amounts generally billed to individuals who have insurance covering such care.

Patients may be eligible for this discount if they are uninsured and have family gross income less than 500% of FPG. Additionally, underinsured patients may be eligible if their family gross income is greater than 200% but less than or equal to 300% of FPG.

i) Virtua's Charity Assistance Program ("CAP")

Uninsured patients who are not eligible for Medicaid and cannot qualify for a 100% discount under the HCPAP may be eligible for CAP if they are United States citizens and their family gross income does not exceed 500% of FPG. Those who qualify for assistance under CAP will receive an 88% discount on the amount charged for emergency or medically necessary procedures.

To apply for financial assistance under CAP a Virtua Charity Assistance Program Application must be submitted. CAP applicants must provide family/household information as well as documented proof of income (see proof of income examples included in Section 2(b), HCPAP).

The New Jersey Hospital Care Assistance Program Application for Participation and Virtua Charity Assistance Program Application ("applications") may be downloaded from the Virtua web site, [www.virtua.org](http://www.virtua.org), under Virtua Charity Assistance Program.

Paper copies of the applications may be obtained by calling our customer service bureau at (833)335-4010.

Patients have 365 days from the date of the first post-discharge bill to submit completed applications, which include the required documentation.

Please mail completed applications (with all required documentation) to:

Virtua Patient Accounting  
2000 Crawford Place, Suite 100  
Mount Laurel, NJ 08054

If an incomplete application is received, Virtua will provide the patient with written notice which describes the additional information/documentation needed to make a FAP-eligibility determination and give the patient a reasonable amount of time (30 days) to provide the requested documentation. Virtua will also provide the patient with a copy of a Plain Language Summary (“PLS”) of this FAP. The PLS is a written statement that notifies an individual that Virtua offers financial assistance under the FAP and provides additional information in a language that is clear, concise and easy to understand. Additionally, Virtua, and any third parties acting on Virtua’s behalf, will suspend any extraordinary collection actions (“ECAs”) to obtain payment for a reasonable amount of time.

### **3. Basis for Calculating Amounts Charged**

Annually, Virtua will establish the AGB percentages for its hospital facilities using the Look-back method. The AGB percentages are calculated by dividing the Medicare fee-for-service program + Private Health Insurers claims by the gross charges associated with those claims. The resulting AGB percentages are multiplied by the gross charges for specific procedures to determine the AGB amount.

The calculated AGB percentages as well as an accompanying description of the calculations are available upon request and free of charge by calling our customer service bureau at (833) 335-4010.

An individual determined to be FAP-eligible will not be charged more than AGB for emergency and other medically necessary healthcare services pursuant to IRC Section 501(r)(5). AGB is the maximum amount charged to any FAP-eligible individual. In accordance with this FAP, a FAP-eligible individual will be charged the lesser of AGB or any other discounted rates for which they qualify for under this FAP.

### **4. Widely Publicizing the FAP**

Virtua’s Patient Accounting Department will use its best efforts to provide financial assistance fairly and consistently, using reasonable efforts to determine whether an individual is eligible for financial assistance. As Virtua must balance our patients' needs for financial assistance with our own broader fiscal responsibility, assistance is not considered to be a substitute for personal responsibility. Individuals deemed to have the financial means to pay for their care shall be expected to do so, and Virtua reserves the right to take action as permissible under the law to protect its assets as necessary.

For the benefit of our patients, our FAP, applications and PLS are available on Virtua’s website: [www.virtua.org](http://www.virtua.org)

Paper copies of the FAP, applications and PLS are available free of charge upon request in the following public locations of our hospital facilities:

- Emergency Rooms; -  
Outpatient Registration;

and - Admission  
Registration.

Additionally, paper copies of the FAP, applications and PLS may be requested by calling Virtua's customer service bureau at (833)335-4010.

Virtua has set up conspicuous displays in public hospital locations in an effort to notify and inform our patients and members of the community of the financial assistance available.

Virtua will also make reasonable efforts to inform members of the community about the availability of financial assistance.

Virtua will offer a copy of the PLS to all patients as part of the intake or discharge process.

In an effort to accommodate all significant populations within Virtua's primary service area, the FAP, applications and PLS are all available in English and in the primary language of populations with limited proficiency in English ("LEP") that constitute the less of 1,000 individuals or 5% of the community served by Virtua.

## **5. Billing and Collection Policy**

Virtua will comply with all regulations and agreed upon contractual provisions with regards to its billing and collection practices. The Patient Accounting Department will be responsible for billing and following up to ensure receipt of payment with regards to all accounts. If, following payment by the payer with primary responsibility for the amount outstanding, there is a residual balance due (for example, a deductible or coinsurance amount), the residual account balance will be billed to the party with secondary responsibility for the account balance. With regards to patients who are uninsured or without secondary insurance coverage for a residual balance, Virtua will not engage in extraordinary collection actions ("ECAs") against an individual to obtain payment for care until reasonable efforts can be made to determine whether the individual is eligible for assistance under Virtua's FAP.

The accounts of patients for which there is no identified third party health insurance coverage will follow the defined self-pay collection cycle, with the responsible party being made aware of the availability of discounts offered under the FAP.

Once a completed FAP application is received, Virtua will:

- a) Suspended any ECAs against the individual (any third parties acting on Virtua's behalf will also suspend ECAs undertaken);
- b) Make and document a FAP-eligibility determination in a timely manner; and
- c) Notify the responsible party or individual in writing of the determination and basis for determination.

If a patient is deemed FAP-eligible Virtua will:

- i. Provide a billing statement indicating the amount the FAP-eligible individual owes, how that amount was determined and how information pertaining to AGB may be obtained;

- ii. Refund any excess payments made by the individual; and
- iii. Third Parties will take all reasonable available measures to reverse any ECAs taken against the patients to collect the debt.

Any remaining unpaid accounts that are not in the process of making payment arrangements or being approved for financial assistance at the end of the defined self-pay collection cycle (120 days after the date of the first postdischarge bill) will be transferred to a third party agency (“agency”) for collection. Prior to this transfer, however, an estimation of the responsible party’s annual income may be obtained from an outside credit agency. If it can be determined based on the income estimation that the individual would be FAP-eligible, the aforementioned reduction to charges will be applied with the net remaining balance transferred to an agency for collection. Additionally, Virtua will notify the individual regarding the basis for the presumptive FAP-eligibility determination.

The account will remain with the agency for 180 days. After this time period, absent an arrangement to resolve the outstanding balance, Virtua, or any third parties acting on its behalf, may engage in the following ECAs:

- a) Reporting adverse information about the individual to consumer credit reporting agencies or credit bureaus;
- b) Placing a lien on an individual’s property;
- c) Attaching or seizing an individual’s bank account or other personal property;
- d) Commencing a civil action against an individual; and
- e) Garnishing an individual’s wages.

Virtua may authorize collection agencies and attorneys working on Virtua’s behalf to initiate ECAs on delinquent patient accounts after the 120-day notification period. Virtua will ensure reasonable efforts have been taken to determine whether an individual is eligible for financial assistance under the FAP and that the following actions have been taken prior to initiating an ECA:

1. The patient has been provided with written notice (included on all billing statements) which:
  - Indicates that financial assistance is available for eligible patients;
  - Identifies the ECA(s) that Virtua intends to initiate to obtain payment for the care; and - States a deadline after which such ECAs may be initiated.
2. The patient has received a copy of the PLS with their 3rd billing statement; and
3. Reasonable efforts have been made to orally notify the individual about the FAP and how the individual may obtain assistance with the financial assistance application process.

#### Third Party Insurance

1. Virtua will bill Medicare and Medicaid;
2. Virtua will bill all third party insurers on behalf of the patient. Insurers are allowed 45 days to submit payment before Virtua will begin contacting patients about their unpaid insurance balance;
3. Virtua will bill third parties covering motor vehicle and workers compensation claims; and

4. Patients are ultimately responsible for their bills if no payment is received unless prohibited by contract or regulations

#### Uninsured, Unresolved, and Self Pay Balances

1. Emergent, Urgent, and Labor and Delivery services covered under EMTALA (Emergency Medical Treatment and Active Labor Act) are not subject to prior payment. Virtua will not engage in any actions that discourage individuals from seeking emergency medical care, such as by demanding the emergency department patients pay before receiving treatment for emergency medical conditions or by permitting debt collection activities in the emergency department or other areas where such activities could interfere with the provision of emergency care on a non-discriminatory basis.
2. Payment for known deductibles, copay, and coinsurance amounts are due by the time of service.
3. Payment for non-covered, uninsured and "life-style" services are payable by the time of service (Life style procedures are defined as medically unnecessary procedures such as non-restorative cosmetic surgery).
4. Patient balances that cannot be paid prior to service and balances due after insurance payment or denial must be resolved by one of the following methods:
  - a. Payment in full from personal funds, credit card;
  - b. Limited term time payments (see payment arrangement policy); or
  - c. Approved financial assistance. (See Virtua's FAP)
5. Once an account balance becomes the patient's responsibility a statement mailer is sent to the patient within 3-5 business days. This date marks the beginning of the notification period. The "notification period" is a 120 day period in which no ECAs may be initiated against the patient.
6. At this time Virtua's self-pay vendor will enter an activation date on the account in order to begin their billing cycle.
  - a. The patient will receive 3 letters. These letters include information about the above payment options as well as Virtua's FAP. Phone calls/attempts will be made to the patient prior to sending an account to collections. These steps will allow all accounts to be processed the same;
  - b. Transfers to a collection agency will not occur for at least 120 days from the initial post-discharge bill to the patient;
  - c. Accounts with incorrect addresses and those related to patients who are deceased may be transferred to a collection agency only if there is supporting documented research on the account. The appropriate procedures for bad addresses and deceased patients with no family/estate must be followed and documented on the account.
7. Prior to being forwarded to a collection agency, accounts are adjusted down prior to being forwarded to a collection agency.