SHORE MEDICAL CENTER

Date of Origin: 10/01/2015
Latest Review Date: 08/1/2019

Policy Title: Charity Care and Financial Assistance

Scope: This Policy shall cover medically necessary health care services provided by Shore Medical Center (SMC) and does not include professional charges associated with physician services provided by Advanced Radiology Solutions (ARS), Bayfront Emergency Physicians, Shore Pathology Associates (SPA), Envision Physician Services)Anesthesia, and other consulting physicians and vendors. SMC is committed to treating patients with emergency medical conditions regardless of their ability to pay. It is not the intent of this policy to offer free or discounted care to patients who have health insurance with high deductibles or coinsurance unless they otherwise qualify for Financial Assistance under this policy. Any person who does not have insurance or does not have the ability to pay all or part of their financial responsibility to SMC for SMC provided services may apply for charity care and financial assistance. Patients who are receiving elective cosmetic or plastic surgery are not eligible.

Policy: Shore Medical Center is committed to providing financial assistance to persons who are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay, for medically necessary care based on their individual financial situation. SMC is committed to treating patients who have financial needs with the same dignity and consideration that is extended to all of its patients. SMC intends, with this policy, to establish financial assistance procedures that are compliant with applicable federal, state and local laws.

Definitions:

Federal Poverty Guidelines (FPG) - Financial guidelines issued by the federal government at the beginning of each calendar year are used to determine eligibility for poverty programs. The current FPG can be found on the U.S. Department of Health and Human Services website at www.hhs.gov.

Uninsured Patient - An individual who does not have any third-party health care coverage with (a) a third party insurer, (b) an ERISA plan, (c) a Federal Health Care Program (including without limitation Medicare, Medicaid, SCHIP and TRICARE), (d) Workers' Compensation, Medical Savings Accounts or other coverage for all or any part of the bill, including claims against third parties covered by insurance to which a SMC entity is subrogated, but only if payment is actually made by such insurance company.

Family - Using the Census Bureau definition, a group of two or more people who reside together and who are related by birth, marriage, or adoption. According to Internal Revenue Service rules, if the patient claims someone as a dependent on their income tax return, they may be considered a dependent for purposes of the provision of financial assistance.

Family Unit Income - Family income is determined using the Census Bureau definition, which uses the following income when computing federal poverty guidelines:

- Includes earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household and other miscellaneous sources
- Noncash benefits (such as food stamps and housing subsidies) do not count;
- Determined on a before –tax basis
- Excludes capital gains or losses; and
- Excludes the income of non-relatives, e.g. housemates, who reside in the same dwelling

Assets - Defined as cash on hand or any tangible item that can be liquidated into cash, typically within 30 days. Cash and checking accounts, IRA's, 401K Savings accounts, stocks, short term bonds will be considered liquid assets. Certificates of deposit, money market funds, bonds, mutual funds, and the cash value of a life insurance policy are examples of investments that could provide quick cash when necessary. Tangible assets may also include fixed assets, such as machinery, buildings, land and inventory. Jointly owned assets may be considered liquid depending on the type of asset and ownership. For the purpose of financial assistance, an applicant's primary residence will not be considered as an asset for liquidation.

Self-Employment Income - Defined as the amount of remaining after business operating expenses. A personal monthly income and expense form and a previous quarterly income statement are needed to assist with the determination of eligibility.

Emergency Medical Conditions - Defined as condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the individual's health (or the health of an unborn child) in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ.

Medically Necessary - Defined by Medicare as services or items reasonable and necessary for the diagnosis or treatment of illness or injury.

Presumptive Charity Care - A determination that a patient is presumed eligible for Charity Care based on financial and historical qualifiers.

Charity Care - Charity Care means the ability to receive "free care". Patients who are uninsured for the relevant, medically necessary service, who are ineligible for governmental or other insurance coverage, and who have family incomes not in excess of 200% of the Federal Poverty Level will be eligible to receive "free care".

Financial Assistance - Financial Assistance means patients who are uninsured for the relevant service and who are ineligible for governmental or other insurance coverage, and who have family incomes in excess of 200%, but not exceeding 300%, of the Federal Poverty Level, will be eligible to receive Financial Assistance in the form of amounts Generally Billed-Medicare reimbursement.

Eligibility - Any person who does not have insurance or does not have the ability to pay all or part of their financial responsibility to SMC for SMC provided services is eligible for charity care and financial assistance. Patients undergoing elective cosmetic or plastic surgery are not eligible. It is recognized that there is a small percentage of the uninsured patient population that have substantial assets and thus the ability to pay for health care services. These individuals may have tax-exempt income or other assets not reflected on a tax return. This policy is not intended to provide free care or Medicare Fee Schedule rates to this portion of the uninsured patient population. They are eligible for the Self Pay discount detailed in the Participation section of this policy.

Amounts Generally Billed – (AGB): Pursuant to Internal Revenue Service Code 501 (R) (5), in the case of emergency or other medically necessary care, FAP-eligible patients will not be charged more than an individual who has insurance covering such care.

AGB

In accordance with IRC §501(r) (5) SMC utilizes the Look-Back Method to calculate the AGB. The AGB % is calculated annually and is based on all claims allowed by Medicare Fee-for-Service + all Private Health Insures over a 12-month period, divided by the gross charges associated with those claims. The applicable AGB % is applied to gross charges to determine the AGB.

The calculated AGB percentages as well as an accompanying description of the calculations are available upon request and free of charge by calling the Financial Counseling Office at (609)653-3717, prompt 1.

Any individual determined to be eligible for financial assistance under this FAP will not be charged more than AGB for any emergency or other medically necessary healthcare services.

Any FAP-eligible individual will always be charged the lesser of AGB or any discount available under this policy.

Procedure:

ELIGIBILITY FOR FINANCIAL ASSISTANCE CONSIDERATION

- To begin the process for financial assistance, the patient or responsible party must complete a "Financial Assistance Application" and provide the necessary documentation to support their financial situation.

- The granting of financial assistance shall be based on the determination of financial need, and shall not take into account age, gender, race, or immigration status, sexual orientation, or religious affiliation.

- Applicants must fully cooperate and comply with all verification of income and assets to be considered.

- The applicant's medical care must be medically necessary to be considered for financial assistance. Medical services solely for cosmetic purposes, and services or procedures that are elective will not be considered.

- An applicant's accounts that have progressed to legal action will not be considered. However, prior to legal action, external collection agencies will notify the hospital of any accounts that may qualify for financial assistance or accounts where the patient/guarantor has requested financial assistance.

- Financial assistance adjustments will be applied to qualifying accounts prior to referral to an external collection agency. Assistance my take the form of indigent or charity care.

- Because the hospital makes many efforts to communicate to patients about the financial assistance program during registration and billing processes, excessive collections (such as litigation as defined by the IRS) will not occur on an account where the patient has not been informed of the opportunity to applying for financial assistance.

- If there is adequate information provided by the patient or through other sources, which provides sufficient evidence the patient will be deemed presumptive charity. In the event there is no evidence to support a patient's eligibility for charity care, Shore Medical Center could use outside agencies in determining estimated income amounts for the basis of determining charity care eligibility or potential discount amounts. Presumptive Financial Assistance will be determined prior to any outside collection activity. The following types of accounts may be considered eligible for financial assistance without documentation under the Presumptive Charity Program (1) Accounts referred to collection agencies that are returned as uncollectible; (2) Bankruptcies; (3) Referrals from approved community agencies; (4) No estate (deceased);

DETERMINATION OF FINANCIAL NEED

- Financial need will be determined through an individual assessment that may include:

➢ A completed financial assessment application in which the applicant is required to cooperate and provide documentation necessary to make a financial need determination.

➢ The use of external sources to help determine an applicant's ability to pay, and the value of assets. Non-physical assets such as bank accounts, bonds, etc., will be used to help determine ability to pay, while the physical assets such as real estate, automobiles, etc., will be used to help determine debt ratios.

➢ A reasonable effort by Shore Medical Center to explore and assist patients in applying for alternative sources of payment and coverage from public and private payment programs.

➢ Use of a data analytics model to identify patients who may be used to qualify for financial assistance but have not requested this assistance.

- Financial assistance determinations will be made timely, no longer than 15 business days after receipt of **all** required documentation. If all necessary documentation is provided during an interview with a financial counselor, the applicant may be informed of the determination at that time. A written determination will be mailed to the applicant within 15 business days.

- Non-emergent surgical services and other non-emergent scheduled procedures will not be considered as a financial need.

- The need for financial assistance may be re-evaluated at any time additional information relevant to the eligibility of the patient becomes known. Applications are valid for 90 days only.

- Financial assistance account adjustments posted before payments are received from insurance companies, Medicare, Medicaid, third party liability carriers, or court settlements, will be reversed. This situation would occur when the hospital is not aware of other payers or when coverage is retroactively applied.

- A credit check may be processed for applicants and household members to assist in determining the overall financial status and value of the assets. A credit report may be used solely in the determination of charity when a financial application cannot be obtained. If the applicant's credit report indicates the family unit income provided by the applicant is unrealistic, financial assistance may be denied.

- The value of assets and household income will be added together to total the gross income. The gross income will be compared to the Federal Poverty Guideline Sliding Scale and discounts will be applied accordingly.

New Jersey Hospital Care Payment Assistance Program ("Charity Care")

Charity Care is a New Jersey program in which free or discounted care is available 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 only available for necessary emergency or other medically necessary care.

Patients may be eligible for Charity Care if they are New Jersey residents who:

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

2) Are ineligible for any private or governmental sponsored coverage (such as Medicaid); and

3) Meet the following income and asset eligibility criteria described below.

Income Eligibility Criteria

Patients with family gross income less than or equal to 200% of Federal Poverty Level ("FPL") are eligible for 100% charity care coverage.

Patients with family gross income greater than 200% but less than or equal to 300% of FPL are eligible for discounted care.

Asset Criteria

Charity Care includes asset eligibility thresholds which states that individual assets cannot exceed $7,500 and family assets cannot exceed $15,000 as of the date of service.

Residency Criteria

Charity Care may be available to non-New Jersey residents, requiring immediate medical attention for an emergency medical condition.

Charity Care eligibility guidelines are set by the State of New Jersey and additional information can be found at the following website:

http://www.state.nj.us/health/charitycare/documents/charitycare_factsheet_en.pdf.

New Jersey Uninsured Discount Public Law 2008, C. 60 ("Uninsured Discount")

The New Jersey Uninsured Discount is available to uninsured patients with family gross income less than 500% of FPL may be eligible for discounted care under this program. Eligible individuals must be New Jersey residents.

Financial Assistance Guidelines

Shore Medical Center uses the Federal Poverty Guidelines (FPG) in effect at the time an application is completed and submitted to determine eligibility for financial assistance. Criteria are set as follows:

- Household incomes that are at or below 200% of the FPG are eligible to receive free care. This is classified as indigent care

- Household incomes that exceed 200% of the FPG, but are at or below 300% of the FPG qualify for a discounted payment based on a sliding scale. This is classified as charity care.

- Those who are uninsured, underinsured and do not qualify for assistance under State, Federal or local programs will be eligible for a hospital discounted rate. Qualification under the SMC program will result in a reduction of gross charges to equal 115% or less of the Medicare rate for the provided service. This reduction is as per the NJ State Statute P.L.2008, Chapter 60, approved on August 8, 2008. This reduction results in an amount typically less than what is generally billed to individuals who have insurance coverage based on a review of the relationship between gross charges and the payments for care provided by insured individuals.

Basis for Calculating Amounts Charged

The following outlines the basis for calculating the amount charged to FAP-eligible individuals for full or partial financial assistance under this policy.

Charity Care

If a patient is eligible for Charity Care, the patient's out-of-pocket expense will be determined by use of the New Jersey Department of Health Fee Schedule (shown below).

Income as a Percentage of HHS Poverty Income Guidelines	**Percentage of Charges To Be 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%	Uninsured Discount Rate Available

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.

Uninsured Discount

Pursuant to P.L. 89-97 (42.U.S.C.s.1395 et seq) eligible individuals will be charged an amount which represents the lesser of 115% of the applicable payment rate under the federal Medicare programs or AGB (as outlined below) for the healthcare services rendered to the patient.

NONPAYMENT PROCESS (related to a partial account adjustment or balance remaining after insurance payment)

The accounts of patients for which there is no identified third party insurance will follow a predefined self pay collection cycle. Any remaining unpaid accounts that are not in the process of making payment arrangements after a defined self pay collection cycle of 120 days will be transferred to a third party agency for collection. The account will remain with this agency for 180 days. After this time period, without any agreed upon payment arrangements to satisfy the unpaid balance, the account will be transferred to another thirds party

collection agency. At this time, the unpaid balance may be reported to a credit agency, and as such, appear on the account guarantor's credit report.

APPEAL PROCESS FOR FINANCIAL ASSISTANCE DENIALS

An applicant may appeal a financial assistance determination within 15 days of denial notice. An appeal must be submitted in writing, either by letter or email, and sent to the Shore Medical Center Business Office.

Written appeals should be sent to:
Shore Medical Center
Attention: Billing Office Manager
100 Medical Center Way
Somers Point, NJ 08244

Email appeals should be sent to: jboehler@shoremedicalcenter.org

The Billing Office Manager will respond to the appeal within 10 business days.

COMMUNICATION OF THE FINANCIAL ASSISTANCE PROGRAM

Shore Medical Center makes information readily available to patients about its financial assistance program by posting and distributing information in the patient registration areas, other public places throughout the hospitals, on patient bills, and on its website. The posting are provided in English and Spanish and are available on the website or upon request as follows:

- By asking at a hospital registration area or financial counselor office
- By telephone at 609-653-3717, prompt 1.
- By emailing Financial Counseling at FinancialCounseling@ShoreMedicalCenter.org

Our Financial Counseling Team is available Monday through Friday from 8:00 am to 4:30pm on a scheduled or walk-in basis to interview applicants and accept financial assistance applications.

Policy Title: Financial Assistance Policy

Director/Administrative Director:

Name: Michael J. Smith
Title: Administrative Director of Revenue Cycle