

**MERIDIAN HEALTH SYSTEM, INC.
POLICY MANUAL**

**POLICY ON FINANCIAL ASSISTANCE, EMERGENCY CARE, AND LIMITATION
OF CHARGES BY CERTAIN SYSTEM HOSPITALS**

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I. PURPOSE

To ensure that Meridian Health System, Inc. (“**Meridian Health**”) and certain of the licensed hospital facilities owned by its affiliates (collectively referred to herein as the “**System**” and each affiliate referred to herein as a “**System Entity**”) are in compliance with applicable state and federal laws governing the provision of emergency medical care, financial assistance, and limitation on charges to patients qualifying for financial assistance. This Policy shall apply to the following licensed hospital facilities within the System (other System hospital facilities are subject to separate policies):

- Bayshore Community Hospital (Holmdel)
- Jersey Shore University Medical Center (Neptune)
- K. Hovnanian Children’s Hospital (Neptune)
- Ocean Medical Center (Brick)
- Raritan Bay Medical Center (Old Bridge and Perth Amboy)
- Riverview Medical Center (Red Bank)
- Southern Ocean Medical Center (Manahawkin)

For purposes of this policy, the term “patient” means the person receiving medical care or his or her guarantor.

II. EMERGENCY TREATMENT

It is the policy of the System, its facilities and all physicians with admitting privileges including ER, Trauma, Radiology, Pathology, Anesthesiology or any provider delivering medically necessary care to comply with the standards of the federal Emergency Medical Treatment and Active Labor Act of 1986 (“**EMTALA**”) and corresponding regulations in providing a medical screening examination and such further treatment as may be necessary to stabilize an emergency medical condition for any individual coming to the emergency department seeking treatment, regardless of the individual’s medical or psychiatric condition, race, religion, age, gender, color, national origin, immigration status, sexual preference, handicap or ability to pay. Meridian Health prohibits actions discouraging individuals from seeking emergency care, such as (i) requiring payment before treatment in the emergency department, or (ii) debt collection activities interfering with the provision of emergency care.

III. FINANCIAL ASSISTANCE

The System, its facilities, and any physician employed or contracted to provide clinical care to patients (including Emergency Department, Trauma, Radiology, Pathology, Anesthesiology, or Hospitalists and Intensivists) shall adhere to this Policy. See Exhibit A for a full list of departmental participation by hospital.

The System will provide financial assistance to patients in various forms, including pursuant to certain federal and state programs, the NJ Hospital Care Payment Assistance Program (“Charity Care”), and the System’s provision of discounts to uninsured patients.

Charity Care is available to those that do not qualify for state or federal programs. Patients earning up to 300% of the Federal Poverty Level (FPL) are eligible for New Jersey’s Charity Care program according to the regulations established in NJAC 10:52, Subchapters 11, 12, 13. Claims for individuals eligible for coverage under the NJ Charity Care program are adjudicated through the NJ Healthcare Subsidy Relief Fund. Charity Care accounts are reported to the State of New Jersey at gross charges for subsidy valuation.

Uninsured billing limits are in accordance with NJ P.L.2008 c.60. Patients who do not qualify for state or federal health insurance programs or the NJ Charity Care program are eligible for uninsured pricing at discounted rates.

The System Entities will ensure that any patient eligible for Charity Care or uninsured discounts under this policy is not billed more than the Amounts Generally Billed (AGB) to those who have insurance covering such care. In the case of patients eligible for Charity Care, the AGB will be determined prospectively using Medicaid rates then in effect. In the case of patients eligible for uninsured discounts, the AGB will be determined prospectively using Medicare fee-for-service rates then in effect. A billing statement will state the gross charges as a starting point for allowances, discounts, and deductions.

All uninsured patients will be screened by a Meridian Health Financial Assistance Counselor to determine if they qualify for insurance prior to the determination of charity care. The screening process will not occur until a patient has been assessed and stabilized by a physician. In addition, a System Entity may request a credit report for patients who identify that they have no income or for those who are self-employed. Below summarizes the different programs that individuals will be screened for:

- **Health Insurance Marketplace:** In compliance with the Affordable Care Act, Meridian Health Certified Application Counselors will screen patients to determine if they are eligible to purchase insurance through the Marketplace and/or receive a subsidy from the Federal Government to assist with the purchasing of insurance.
- **Medicaid:** Meridian Health Financial Assistance Counselors will assist patients, who meet the eligibility criteria, with the application process. There are several types of Medicaid available through the NJ Department of Health; we will help determine the program best suited for the patient’s circumstances.
- **SSI-Medicaid:** Supplements Medicaid benefits with a monthly income stipend that can help with basic needs. Assistance is available onsite to assist inpatients and certain outpatients who meet the eligibility criteria with the application process.

- **NJ Family Care (NJFC):** Insurance program designed to provide coverage for adults and children up to 138% of the FPL. Meridian Health’s Financial Assistance Counselors will assist in completing the online application.
- **Presumptive Eligibility-Medicaid:** Temporary one time per year coverage for persons who meet some basic eligibility criteria so that their healthcare costs can be covered while the NJ Family Care is being determined by the State of NJ. Meridian Health Financial Assistance Counselors will assist in completing the application.
- **Charity Care - NJ Hospital Care Payment Assistance Program:** Provide assistance to cover the costs of hospital services only. Patient must present a NJFC denial letter which identifies that the patient has been denied for NJFC due to being over income or does not meet residency/other requirements as per NJFC regulations. Denial due to non-compliance with NJFC is not sufficient to be granted charity care. Patients are asked to document income, family size and asset information based on the regulations established in NJAC 10:52, Subchapters 11, 12, 13. Patients requesting financial assistance are referred to an onsite Financial Assistance Counselor for consideration.
- **Uninsured Discounted Rates** – see below.

IV. CHARITY CARE ELIGIBILITY REQUIREMENTS

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. Charity Care is available for emergency and medically necessary hospital care. In accordance with New Jersey Administrative Code 10:49-5.1, medical necessity of the patient's condition is determined by the attending physician or other practitioner, and in accordance with standards generally recognized by health professionals and promulgated through the New Jersey Medicaid program. Outpatient prescriptions and other follow up care are separate from hospital charges and are not eligible for reduction under the Charity Care program. Financial need is determined in accordance with NJAC 10:52, Subchapters 11, 12, 13 Charity Care applications, approval, billing and processing.

Charity Care assistance is available to New Jersey residents who:

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

Charity Care is also available to non-New Jersey residents related to a date of service only, subject to specific provisions, and is not valid for a period of time.

A. Income Criteria Household income includes salaries, wages, business and investment income that is reportable for tax purposes. Household members include the applicant, spouse, any minor children whom he or she supports and any adults whom the applicant is legally responsible for. The following link to Medicaid.gov provides information relative to the federal poverty level.

<https://www.medicaid.gov/medicaid-chip-program-information/by-topics/eligibility/eligibility.html>

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

There will be no financial obligation for patients on the 20% to 80% sliding fee scale for those whose remaining balances (*i.e.*, amounts to be paid by the patient) exceed 30% of their gross annual income. Amounts above the 30% threshold will be written off entirely.

B. Assets Criteria

Individual assets cannot exceed \$7,500 and family assets cannot exceed \$15,000. Assets are items which are, or which can be readily converted into cash. This includes, but is not limited to, cash, savings and checking accounts, certificates of deposit, treasury bills, negotiable paper, corporate stocks and bonds, Individual Retirement Accounts (IRAs), trust funds, and equity in real estate other than the applicant's or family's, if applicable, primary residence. Should an applicant's assets exceed these limits, he/she may "spend down" the assets to the eligible limits through payment of the excess toward the hospital bill and other approved out-of-pocket medical expenses.

C. Method Used to Determine Amounts Generally Billed (AGB) for Emergency or Medically Necessary Care

System hospital outpatient and inpatient Charity Care claims are priced based on the New Jersey Medicaid program's pricing and program policies for hospital outpatient and inpatient hospital services based on NJAC 10:52-1.6, Covered Services (inpatient and outpatient services) and NJAC 10:52-4, Basis of Payment. For purposes of federal tax laws, the AGB for such services will be determined on a prospective basis using applicable Medicaid rates then in effect. Patients qualifying for less than full write-off will be charged a percentage of the applicable Medicaid rates; accordingly, all patients receiving Charity Care will be charged less than the AGB.

Billing statements issued to patients qualifying for Charity Care will state the gross charges as a starting point for allowances, discounts, and deductions.

V. METHOD FOR APPLYING FOR NJ CHARITY CARE

The System adheres to the patient notification requirements of Financial Assistance Programs that are available to patients who are eligible for assistance programs based on the regulations established in NJAC 10:52, Subchapters 11, 12, 13.

A request for Charity Care and a determination of financial need may be done at any point, starting from when a patient anticipates a medical visit up to two years after date of

service. Eligibility is from the date of service and length of eligibility is based on the type of charity received – see below.

- ER charity only – For Inpatients admitted through Emergency Room, good for that hospital stay only.
- 3 month charity – For Outpatient/Observation - Patients that are qualified for NJFC. This type of charity care covers the patients for any additional services they need from the hospital for the next 3 months while they are waiting for the NJFC approval.
- Up to one year, not to extend past the date of the next open enrollment period for the Healthcare Exchange – For Patients who would not qualify for NJFC (i.e.; already have insurance but no secondary, undocumented, Medicare no secondary, individuals who would qualify for Marketplace but can't apply due to Marketplace being closed).

Charity Care applications and department contact information are available at any System Entity facility, by accessing <http://www.meridianhealth.com/about-meridian/your-bill/index.aspx>, and hospital staff have been provided with contact information. The System Entities maintain financial assistance offices at Jersey Shore University Medical Center, Neptune, NJ, Ocean Medical Center, Brick, NJ, Riverview Medical Center, Red Bank, NJ, Southern Ocean Medical Center, Manahawkin, NJ, Bayshore Community Hospital, Holmdel, NJ, Meridian Family Health Center, Neptune, NJ, Jane H Booker Family Health Center, Neptune, NJ, Booker Behavioral Health Center, Shrewsbury, NJ, Parkway 100 Behavioral Health Center, Neptune, NJ, and Raritan Bay Medical Center, 530 New Brunswick Ave, Perth Amboy, NJ. Financial Assistance Counselors are available on site at these locations for interviews and to answer questions and otherwise assist with the completion of application forms. To make an appointment, applicants should call 732-212-6505. Applicants must provide the relevant System Entity with a completed Charity Care application. Required documents include identification, proof that he/she has been residing in New Jersey since the time of service and intend to remain in the State, proof of income for one month prior to the date of service, and bank statements that include the balance on the date of service, and a signed application attesting to the data submitted. Completed applications can be mailed, emailed, delivered personally or transcribed via the telephone (with original signature to follow) to any System Entity facility.

Upon receipt of all required documentation, the request will be processed promptly and the applicant will be informed of the status no later than 10 days from receipt. If the application does not include sufficient documentation to make the determination, the applicant will be notified in writing within 10 working days what is needed to complete the application. Ultimately, all applicants will receive a determination in writing. If the patient is determined to be eligible for discounted, but not free, care, the patient will be provided with a billing statement indicating the amount he or she owes for the care and how it was determined.

An applicant or responsible party can submit a completed application for determination for Charity Care at any time up to 24 months from the date of outpatient service or inpatient discharge.

A System Entity may grant Charity Care based on evidence other than described in the Financial Assistance/Charity Care Process and may be granted based on signed attestation even if the Financial Assistance Process or Charity Care application does not describe such evidence.

Information may be obtained from an individual either in writing or orally (or a combination of both). A System Entity may grant assistance based upon information provided by the individual on prior charity care applications if such information is relevant to the current application. A System Entity may utilize information from credit bureaus or other outside sources.

Patients who qualify for Charity Care at discounted, but not free, rates will not be billed at total charges for any balance owed. The patient will be charged 20%, 40%, 60% or 80% of the Medicaid reimbursement rate depending on financial review.

Denied charity care applicants will be notified in writing of the reasons for the denial and will be informed of the availability of the uninsured discount.

VI. UNINSURED PRICING AT DISCOUNTED RATES

The System Entities will maintain Uninsured Self Pay pricing for patients who have no insurance and do not qualify for NJ Charity Care. While physician fees may qualify for the Charity Care discount, physician fees are not eligible for the Uninsured Self Pay discount. Hospital services covered under the Uninsured Self Pay pricing include inpatient, outpatient surgery, obstetrics, recurring services, outpatient procedures, emergency department, outpatient diagnostic testing and laboratory services and do not include cosmetic services or other not medically necessary services. The Self Pay Pricing will be maintained by a committee comprised of representatives from Patient Financial Services, Access Services, Patient Accounting, and Management.

Pricing for uninsured patients who do not qualify for Charity Care will be based on Medicare fee-for-service reimbursement rates. The AGB for emergency and medically necessary services provided to uninsured patients will be determined on a prospective basis using applicable Medicare fee-for-service rates then in effect (considering the full amount to be paid by Medicare and the patient if the patient were a Medicare beneficiary). Accordingly, no patient receiving the uninsured discount will be charged more than the AGB.

Billing statements provided to patients receiving the uninsured discount will state the gross charges as a starting point for allowances, discounts, and deductions.

The list of standard charges is only for patients who have no insurance. Any patient who does not have insurance, at the time of scheduling a non-emergent appointment, pre-registration or registration at the hospital will be:

- a. Advised of the Medicare fee-for-service rate for their anticipated services and will be asked to pay upfront either by credit card, cash or check.
- b. Advised, if unable to pay upfront, to make an appointment with a Meridian Health Financial Counselor to determine if the individual meets the criteria for NJ Family Care or Charity Care. These individuals may be required to reschedule their appointments until the screening/application process is completed.

Any self-pay patient who pays the upfront estimate for an Outpatient Surgery, Inpatient, Obstetrics or Recurring Service will be advised that their upfront payment is considered an estimated charge. Actual fees and charges may vary based upon individual conditions and clinical outcomes. The bill will be reviewed by patient accounting and the patient will be balance billed at Medicare Fee for Service rates for additional charges.

VII. MEASURES TO WIDELY PUBLICIZE THE FINANCIAL ASSISTANCE POLICY IN THE COMMUNITY

In an effort to ensure that the community serviced by the System is aware of the Financial Assistance/Charity Care Programs, a conspicuous notice regarding the availability of all programs appears on all billing statements and collection letters (including a phone number for information about the FAP and application process and website where copies of FAP, application and PLS are available).

Notices regarding financial assistance are posted in emergency rooms, urgent care centers, admitting and registration departments, and patient financial services offices that are located at each campus. Hard copies of this Policy, a Plain Language Summary of this Policy (See exhibit B), and the financial assistance application are available in all of these locations. The foregoing materials (along with the System's Billing and Collection Policy) are available in English and in all other languages that meet the threshold of the lesser of 1,000 or 5% of the community, as applied to each hospital within the System. System Entities provide language interpreting and translation services, and provides information to patients with vision, speech, hearing or cognitive impairments in a manner that meets the patient's needs. Financial Counselors will participate in community outreach programs in an effort to ensure that the availability of financial assistance pursuant to this policy is made known to populations most likely to need such financial assistance. The Plain Language Summary is made available to and posted in Community Centers, Churches, public gathering areas and community events.

This Policy (including the Plain Language Summary), the financial assistance application, and the System's Billing and Collection Policy are posted on the Meridian Health website at <http://www.meridianhealth.com/about-meridian/your-bill/index.aspx> and are available free upon request. The guide contains information regarding all NJ Medicaid programs, SSI Medicaid, NJ Family Care, Presumptive Eligibility, and Charity Care.

VIII. SEPARATE, WRITTEN BILLING AND COLLECTIONS POLICY

If you fail to pay your bill, you may be subject to various collection actions, including extraordinary collection actions involving legal or judicial process (such as court judgements, liens and garnishments). For further information, see the System's Policy on Extraordinary Collection Actions, a copy of which is available at <http://www.meridianhealth.com/about-meridian/your-bill/index.aspx>.

IX. OFFICE OR AUTHORITATIVE BODY TO IMPLEMENT AND CARRY OUT POLICY

The Meridian Health Board of Trustees has granted the V.P. for Finance, Patient Financial Services to act as the authoritative body of the hospital to implement and carry out the policy and procedures.