



Hackensack  
Meridian Health

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Owner Warren Scott: Dir,  
Training &  
Compliance  
Policy Area Revenue Cycle  
-ENTERPRISE  
Applicability Hackensack  
Meridian Health  
Network

## HMH Hospitals -Billing and Collection Policy

### Description:

HMH Hospitals Billing and Collection Policy

### Scope:

- Bayshore Medical Center • HMH Carrier Behavioral Health • Hackensack Meridian LTACH • Hackensack Meridian JFK Johnson Rehabilitation Institute • Hackensack Meridian Johnson Rehabilitation Institute at Ocean University Medical Center • Hackensack Meridian Johnson Rehabilitation Institute at Riverview Medical Center • Hackensack University Medical Center • JFK University Medical Center • Jersey Shore University Medical Center • Joseph M. Sanzari Children's Hospital • K. Hovnanian Children's Hospital • Ocean University Medical Center • Old Bridge Medical Center • Palisades Medical Center • Raritan Bay Medical Center • Riverview Medical Center • Southern Ocean Medical Center • Hackensack Meridian Health and Wellness Center at Eatontown • Hackensack Meridian Health and Wellness Center at Clark • The Cancer Center at Totowa

### Purpose

This policy is to establish a consistent and proactive approach for managing all self-pay account balances, including both full self-pay and balances remaining after insurance adjudication. This policy ensures timely follow-up and resolution of outstanding balances to prevent delinquency. It also seeks to identify patients who may qualify for financial assistance and provide guidance and support to those requiring additional help in resolving their financial obligations, thereby minimizing the need for bad debt placement and external collections activity.

# Administration:

The Executive Vice President, Revenue Cycle Operations, is responsible for the administration and subsequent revisions to the procedure.

## Policy

Policy: This policy outlines the billing and collection procedures used by Hackensack Meridian Health Hospitals (“HMH”). Patients without insurance or with balances due after insurance payments are responsible for paying those balances. Patients will be offered resolution options such as reasonable payment plans, discount options, and financial assistance. If the balance remains unpaid, it may be referred to a collection agency where the collection actions outlined in this policy may be employed

### A. Definitions

- a. **Self-Pay Portion (Insured)**: Amount owed by the patient/guarantor after insurance adjudication.
- b. **Self-Pay (Uninsured)**: Full amount owed by the patient/guarantor. Compassionate Care rates may apply (see Section VI).
- c. **Facility**: Refers to hospital charges (prices for the “use of this facility”), excluding physician fees.
- d. **Cost Share**: Deductible, coinsurance, or co-payment.
- e. **Compassionate Care Rate**: is defined as the self-pay rate for uninsured patients.
- f. **Amounts Generally Billed (“AGB”)**: Calculation for Emergency or Other Medically Necessary Care per refers to the amount typically charged to individuals with insurance coverage for medically necessary services, including emergency care. Internal Revenue Code §501(r)(5), This section mandates that uninsured patients eligible for financial assistance cannot be charged more than the AGB for emergency or other medically necessary services. 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.

### B. Financial Clearance for Scheduled Services

- a. **For all scheduled inpatient and outpatient procedures:**
  - i. *Patients must be “financially cleared” at least three business days before their scheduled service.*
    - Insurance information has been verified.
    - We have collected all expected out-of-pocket costs (deductibles, co-pays, coinsurance, etc.). Uninsured patients will be given an estimate based on our Compassionate Care rates.
    - Any pre-certifications or authorizations required by the patient's insurance have been obtained.

- If a patient isn't financially cleared in time, a Clinical Director or Administrator will review the case to determine if the procedure can still happen.
- ii. Pre-admission Process for Inpatient Elective Admissions:
  - Whenever possible, HMH will pre-register patients for elective inpatient admissions.
  - Payment arrangements, including self-pay portions and any outstanding balances, will be discussed before admission.
  - A financial assessment and agreement may be required.
- b. **Urgent and Emergency Situations:**
  - i. For urgent inpatient admissions, transfers, and direct admits, insurance verification and benefit eligibility checks will happen upon admission.
  - ii. In the Emergency Trauma Center (ETC), patients will receive medical care before any financial discussions occur. After the patient is stable, HMH will collect out-of-pocket costs and bill their insurance.
- c. **Managed Care Agreements:**
  - i. For patients with managed care insurance, their financial responsibility is determined by their insurance plan's contract with HMH.

## C. Billing and Collections for Insured Patients

HMHN will follow these guidelines for insured patients (refer to payer coverage guidelines for specific details):

- a. **Medicare**
  - i. Medicare Part A (Inpatient Hospital Insurance): Medicare applies an Inpatient Deductible for each spell of care. The deductible is updated each year, as outlined by CMS. A coinsurance may also be applied in certain circumstances.
  - ii. Medicare Part B (Medical Insurance Applicable to Outpatient Hospital Services): Medicare will apply a deductible once per calendar year. Once the deductible is met, a 20% coinsurance will be applied for most services.
  - iii. HMHN will make its best attempt to estimate the cost of services and collect those estimated amounts due at the time of service. Any amounts not collected at the time of services will be billed to the patient after Medicare has paid the claim.
- b. **Medicaid**
  - i. Generally, there are no out-of-pocket expenses for recipients/patients related to 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 applied.
- c. **Blue Cross/Blue Shield & Commercial/Managed Care**
  - i. Benefit information provided by the payer or the patient's insurance card will be used

- to estimate the patient's cost share.
- ii. The patient will be informed of the estimated amount due, and we will make our best efforts to resolve before or at the time of service.
- iii. Any Amounts not collected at the time of service will be billed to the patient after the insurance has paid the claim.

## D. Self-Pay Portion

- a. **Generally, a patient and/or guarantor will have a self-pay liability under the following circumstances:**
  - i. They have no coverage for facility services (uninsured).
  - ii. Services are not covered by insurance (e.g., cosmetic surgery).
  - iii. They have a cost-share amount due (insured).
  - iv. They incur out-of-network penalties. If a patient chooses to receive care from a doctor or hospital outside of their insurance network (out-of-network), they may have to pay extra. This extra cost is determined by their insurance company and varies depending on their plan. HMHN will make its best effort to inform patients whether its facilities and doctors are in-network or out-of-network for their specific insurance. If HMH is in-network, the patient will only pay their usual in-network costs (unless they choose an out-of-network provider within an HMH facility). If HMH is out-of-network, the patient will have additional financial responsibility.
  - v. They have exhausted their coverage benefits.
- b. **Self Pay Portion (Insured):** Once the insurance company processes a bill, an Explanation of Benefits (EOB) is provided to both the provider and the patient, indicating the amounts that were covered and not covered, as well as the patient's Cost Share Amounts due for the service. HMH will use this information to determine the amount the patient owes after all insurance has paid.
- c. **Self Pay Portion (Uninsured):** Charges for uninsured patients will be entirely owed by the patient and/or guarantor. Many programs are available to help uninsured patients resolve their outstanding medical bills, including Financial Assistance Programs (See Financial Assistance Policy-1845 for detailed eligibility information), Compassionate Care Discounting (see section c. below), New Jersey State 15 Discounts, NJ Charity Care, and reasonable payment plans. Please review the information below for more information about these options.
- d. **Hackensack Meridian Health Compassionate Care Discounting Policy:**
  - i. **Compassionate Care I:** Any patient who does not have health insurance qualifies for the Compassionate Care I discount. Amount due from the patient will be discounted down to Medicare DRG rates (inpatient) and Medicare APC/Fee Schedule rates (outpatient). The discount will be applied at the time of billing and will automatically appear on the billing statement.
  - ii. **Compassionate Care II:** Uninsured patients with income levels at or below 600% of the Federal Poverty Level (FPL) will be eligible for an additional 50% discount on the Medicare rates applied under the Compassionate Care I program. To determine

- eligibility, guarantors are required to provide proof of income in the form of the most recent tax return or other income verification if no tax return information is available.
- iii. **Compassionate Care III:** Insured patients with income levels at or below 600% of the Federal Poverty Level (FPL) may be eligible for a 50% discount on cost-share amounts. To determine eligibility, guarantors are required to provide proof of income in the form of the most recent tax return or other income verification if no tax return information is available.
  - iv. Exclusions: Certain services (e.g., international patients, cosmetic surgery) are excluded from Compassionate Care discounts.
- e. No FAP eligible individual (See Financial Assistance Policy-1845 for detailed eligibility information) will be charged greater than Amounts Generally Billed (“AGB”) to individuals who have insurance covering such care.
  - f. 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 NJ Hospital Care Assistance Program (Charity Care) Screening process. If eligible, the program provides discounts on inpatient and outpatient services based on a percentage of Medicare rates.
  - g. The following services have specialized rates and do not fall under the Hackensack Meridian Health Compassionate Care Rates or New Jersey State 15 Care for discounting:
    - Services for pre-scheduled International Patients
    - Cosmetic Surgery Patients
    - High-Dollar Chemotherapy Drugs for Uninsured and Under-insured Patients
    - Executive Health Patients
    - Self-Pay Patients receiving Robotic Surgery
    - Patients receiving Vaso-Vasectomy Procedures
    - Self-Pay Patients receiving Lap Band/Gastric Bypass
    - Bone Marrow Transplants: Autologous & Allogeneic Related, Allogeneic Unrelated
    - Lifeline

## E. Financial Assistance

- a. **New Jersey Medicaid or Charity Care:** All patients who are unable to pay the Hackensack Meridian Health 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 state assistance programs.
- b. HMHN Hospitals will make all reasonable efforts to ensure that patients who may be eligible for financial assistance, per the Hospital’s Financial Assistance Policy-1845, are informed of and provided the opportunity to apply for such assistance. Available assistance programs include, but are not limited to, New Jersey Medicaid, NJ Hospital Care Assistance Program (Charity Care), or the Hospital’s Compassionate Care Programs.

- c. Information Regarding Financial Assistance will be available:
  - i. **On HMHN's website.** An individual can view information about financial assistance online at the following website: <https://www.hackensackmeridianhealth.org/en/pay-bill/financial-assistance>
  - ii. **In plain language.** At patient access points such as admissions areas, waiting rooms, and emergency rooms.
  - iii. **By Phone:** The Financial Assistance Department can be reached at 732-902-7080 for all the locations listed in the scope section of this policy.
  - iv. **On billing statements**
  - v. HMHN's FAP, Application and Plain Language Summary ("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 Hospitals' primary service area. These documents are available on the hospital's website as well as free of charge upon request.
- d. All patients who are unable to pay the Hospital's Compassionate Care I, II, or III rates will initially be referred to a Financial Counselor. This department will determine if the patient qualifies for any available assistance programs.
  - i. **Incomplete Applications:** If an incomplete application is received, the patient will be notified in writing of the missing information and/or documentation that is needed. The patient will also be notified that the collection actions may continue if the information is not received within 30 days.
  - ii. **Completed Applications:** Please mail all completed applications to the Financial Assistance Department (refer to address above, also listed on billing statements). Only data provided by the applicant will be used in approving financial assistance.
- e. International Patients Policy (Foreign Patients):
  - i. Hospitals International Patient Definition: Patients currently residing in a foreign country and who are traveling to the U.S. to receive treatment at HMHN for specific services.
  - ii. These services are pre-arranged and are NOT subject to the Financial Assistance provisions outlined in this policy.

## F. The Patient Billing And Collection Cycle

Once the self-pay portion has been determined for either insured or uninsured patients, the balance will be the patient's responsibility to pay. This will happen after all insurances (including any primary and secondary insurance carriers) have paid. HMHN will produce monthly billing statements for each guarantor showing the amount due for all services rendered by HMHN hospitals. Any accounts that have been referred to a collection agency will no longer be listed on the HMHN guarantor statement. Patients with inquiries regarding their balance may call Customer Service at 551-996-1960.

### a. **Statement Cycle (1-120)**

- i. Day 1 of the collection cycle is the day that the first billing statement is generated.

- ii. If the balance remains unresolved, subsequent billing cycles will be initiated in 30-day intervals.
- iii. The total billing cycle is 120 days, including up to 4 statements.
- iv. If payment is not received after that billing cycle completes, a final pre-collection letter will be sent to the patient requesting payment within ten days.
- v. If the balance remains unresolved, the account will be referred to a collection agency to pursue additional collection efforts.
- vi. The full billing cycle may not be completed before agency placement in certain circumstances (e.g, unable to contact the patient due to incorrect contact information or the patient is deceased).

b. **Payment Plans:** At any time during the statement cycle, a patient and/or guarantor can request to be placed on a reasonable payment plan either over the phone by contacting our customer service phone number or through our patient portal, MyChart. Payment plan options include:

- i. Internally managed zero-interest payment plans within the following guidelines:

Guarantor Balance From	Guarantor Balance To	Number of Months to Pay Balance	Minimum Monthly Payment
\$0.00	\$25.00	1	\$25.00
\$25.01	\$300.00	6	\$25.00
\$300.01	Any	12	\$25.00

- ii. For payment plans with more flexibility, including lower monthly payments or extended payment terms, zero-interest financing can be obtained through our external partner.
- iii. Guarantors who cannot comply with either option above can explore financial assistance or compassionate care discounting. If the guarantor does not qualify for these programs, reasonable payment plans will be developed based on the patient’s need in compliance with the *Louisa Carman Medical Debt Relief Act*.
- iv. Guarantors who stay current with the agreed-upon payment arrangement will not be referred to collection agencies. However, if guarantors do not comply with agreed-upon payment arrangements, balances will be referred to collection agencies for further collection efforts.

c. **Collection Agency Efforts**

- i. Uncollected balances indicated above will be placed with outside collection agencies (medical debt collectors) for additional collection efforts.
- ii. Collection agencies will not engage in any collection actions outside the actions detailed below under “Extraordinary Collection Actions”.

d. **Extraordinary Collection Actions (ECAs)** may include, but are not limited to, the following:

- i. Commencing a civil action against an individual
- ii. Entering judgment against an individual

- iii. Placing liens on an individual's property
- iv. Garnishing wages
- v. Attaching bank accounts
- vi. Extraordinary Collection Actions do not include any lien that a hospital is entitled to assert under state law on the proceeds of a judgment, settlement, or compromise owed to an individual (or his or her representative) as a result of personal injuries for which a hospital provided care.
- vii. Extraordinary Collection Actions are governed by the following periods and will begin only after reasonable efforts were made to determine if the patient is FAP eligible.
  - Notification period: Hospitals 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
  - Application Period: An individual has one year from the date they are provided with the first post-discharge billing statement to apply for financial assistance. If at any time within the application period an application is submitted, ECAs will be suspended.
  - Waiting time for extraordinary collection actions: Hospitals must provide the patient with a minimum of thirty (30) days' written notice before engaging in any extraordinary collection actions. The written notice must specify the type of action, and a copy of the Hospital's plain language summary must also be included.
  - At least 30 days prior written notice before the commencement of ECAs. The written notice must specify the type of action, and a copy of the Hospital's plain language summary must also be included.

**e. Prohibited Collection Practices: Hospital, Collection Agencies, and Outside Counsel:**

- Will not force the sale or foreclosure of an individual's primary residence to pay for an outstanding debt.
- Will not engage in collection activity against an individual who was eligible for Medicaid at the time services were rendered and for which Medicaid payment is available, provided the individual has submitted a completed application for Medicaid in connection with such services.
- Will not engage in collection activity against an individual approved for 100% NJ Hospital Care Assistance Program (Charity Care).
- Will not sell an individual's debt to a third party.
- Will not institute legal action against an individual unless it is determined that the individual is able but unwilling to pay.
- Will not institute legal action until making multiple attempts to reach and negotiate with patients before proceeding to legal action.

**f. Post-Judgment Practices. Outside Counsel:**

- Will conduct judgment evaluations on a case-by-case basis. Electronic “blind” sweeps are not permitted and shall not be performed.
- Will not cause an individual’s arrest or cause an individual to be subject to a writ of body attachment.
- Will not renew a judgment against an individual without prior approval from the Hospital.
- Will only institute legal action against an individual if the accounts are worth at least \$800 in the aggregate or such other higher threshold as the hospital may from time to time set in writing if it is determined that an individual is able but unwilling to pay.
- Consistent with the requirements of applicable law and this Policy, may issue Information Subpoenas to the individual and to:
  - a. Banks;
  - b. Place of employment;
  - c. Credit card companies, and/or
  - d. Mortgage companies
- Will not utilize a writ of capias (known as a “body attachment” in the popular press) as part of a collection effort.
- Will suspend all collection activity against any judgment debtors that submit a completed application for financial assistance, seeking to be re-evaluated for financial assistance under HMH’s FAP, until the application has been adjudicated.

**g. Billing Disputes:**

- a. If a patient disagrees with the bill that they are receiving, they should contact the phone number on their billing statement. The representative can help them resolve the issue.
- b. If the Customer Service Representative cannot resolve the dispute, it will be forwarded to the Supervisor/Manager/Director to resolve.

**h. Compliance:** This policy is subject to regular review and revision to ensure compliance with all applicable regulations , including 501(r)

## Approval Signatures

Step Description	Approver	Date
VP Revenue Cycle Integration	Erin Miller: VP, Revenue Cycle Integration	04/2026

## Applicability

Bayshore Medical Center, Carrier Clinic, HMH Nursing & Rehabilitation, Hackensack Meridian Health Inc., Hackensack Meridian Long Term Acute Care Hospital, Hackensack University Medical Center, Home Health and Hospice, JFK Medical Center EMS, JFK Muhlenberg Harold B. and Dorothy A. Snyder Sch, JFK University Medical Center, Jersey Shore University Medical Center, Legacy Meridian Health, Ocean University Medical Center, Old Bridge Medical Center, Palisades Medical Center, Physician Services Division, Raritan Bay Medical Center, Riverview Medical Center, Southern Ocean Medical Center, System Search Engine (All Sites)

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