Mather Hospital

Northwell Health

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Reference:	Please refer to 501.002 for detail on the AGB's.

Policy

As a tax-exempt, nonprofit organization, Mather Hospital serves the health care needs of its community and is committed to providing financial assistance to persons who cannot pay for all or part of the essential care they receive at the Hospital. Mather Hospital strives to ensure that the ability to pay for health care is not a barrier for needed health care services and does not prevent patients from seeking or receiving care.

The Mather Hospital Financial Assistance Policy ("FAP") was developed to ensure that the Hospital continues to uphold its mission of providing quality health care to the community, while carefully taking into consideration the ability of the patient to pay, as applied in a fair and consistent manner. Mather Hospital will provide care, without discrimination, for Emergency Medical Care regardless of an individual's ability to pay. This policy will be made readily available to prospective and current patients and to the community at large.

This policy, together with the Plain Language Summary, is intended to meet the requirements of applicable federal, state, and local laws, including, without limitation, Section 501(r) of the Internal Revenue Code of 1986, as amended, Section 1.501(r) of the Internal Revenue Service's regulations promulgated thereunder and the New York Public Health Law.

Procedure

A. Purpose

1. "Charity" or "financial assistance" refers to health care services provided by Mather Hospital, physicians employed by Mather Hospital and Harbor View Medical Services, P.C. (the "Hospital") at a discount to qualifying patients. A list of physicians employed by Mather Hospital can be found on the Hospital's website:

   (https://www.matherhospital.org/patients-visitors/for-patients/paying-for-your-hospital-care/employed-physicians-listing/)

2. Patients who need Emergency Medical Care can receive care and qualify for a discount if they meet certain income levels as described below. For non-emergent cases financial assistance will be considered for patients within the Mather Hospital region who are uninsured, underinsured, ineligible, for governmental programs that would pay for service or otherwise unable to pay for their care/or have exhausted their benefits for covered services.

3. This policy does not cover bills for non-employed physicians' services unless such professional services are included in the Hospital's bill for its services. A listing of health care providers in the Hospital that are NOT covered under this policy is available on the Hospital's website (https://www.matherhospital.org/patients-visitors/for-patients/paying-for-your-hospital-care/contracted-physicians-listing/) and from the Financial Assistance Services Department.

4. Financial Assistance will be utilized in those cases where any Mather Hospital patients who are eligible for financial assistance under this Program on an inpatient or outpatient account, due to their financial position, or assets, are unable to pay for all or part of their care (including: deductibles, co-payments, coinsurance and/or services not covered by insurance or other third party payer).

5. In the event that a patient's bill is not eligible for financial assistance, either in part or in its entirety, the hospital provides payment plans that correlate with the patient's ability to pay within their income and assets, but will not exceed ten percent of the patient's gross monthly earnings. If a patient is cooperating with an agreed-upon extended payment plan to settle an outstanding bill, the hospital will not send the unpaid bill to a collection agency/attorney.

B. Definitions

1. **Amounts Generally Billed** means the amounts generally billed for emergency or other medically necessary care to individuals who have insurance covering such care, determined in accordance with IRS regulations specified at § 1.501(r)–5(b) . The Hospital calculates the AGB annually using the "look-back method."

2. **Application Period** means the period during which the Hospital must accept and process an application for financial assistance under the FAP. The application process is 30 days once the application is returned with the required documentation. The application process will be extended for any applications submitted without all the required documentation.

   All accounts are placed on a collection hold when the application is sent to the patient for a 3-month period. Patients will still receive bills but may disregard them during this 3-month period. The account will automatically resume the collection process and no longer be on hold once the 3-month period expires.

3. **Billing Deadline** means the date after which the Hospital may initiate an Extraordinary Collection Action ("ECA") (as defined below) against a Responsible Individual (as defined below) who has failed to submit an application for financial assistance under the FAP. The Billing Deadline must be specified in a written notice to the Responsible Individual provided at least 30 days prior to such deadline.

4. **Emergency Medical Care** means medical care required to be provided for Emergent Conditions pursuant to the Emergency Medical Treatment and Labor Act, section 1867 of the Social Security Act (42 U.S.C. 1395dd) to individuals, regardless of their eligibility for Financial Assistance under this policy**.** More specifically, Emergency Medical Care refers to services required to be provided under Subchapter G of Chapter IV of Title 42 of the Code of Federal Regulations and Treas. Reg. § 1.501(r)-4(c) (or any successor regulations), to the extent such regulations are applicable to Mather Hospital.

5. **Emergent Condition** means a medical condition that has resulted from the sudden onset of a health condition with acute symptoms of sufficient severity (including severe pain) which, in the absence of immediate medical attention, are reasonably likely to place the patient's health in serious jeopardy, result in serious impairment to bodily functions or result in serious dysfunction of any bodily organ or part.

6. **Extraordinary Collection Action (ECA)** means any action against an individual related to obtaining payment of a self-pay account such as selling an individual's debt to another party; reporting adverse information about the Responsible Individual (as defined below) to consumer credit reporting agencies or credit bureaus; deferring or denying or requiring a payment before providing medically necessary care because of an individual's nonpayment of one or more bills for previous care covered under the Hospital's FAP; or certain other actions that require a legal or judicial process.

7. **Medically Necessary** means those services necessary to prevent, diagnose, correct or cure conditions in a person that cause acute suffering; endanger life; result in illness or infirmity; interfere with his/her capacity for normal activity; or threaten some significant handicap.

8. **Notification Period** means the period during which the Hospital must notify a Responsible Individual about Financial Assistance eligibility prior to commencing an

ECA. The Hospital must make reasonable efforts to determine a patient's eligibility under the FAP.

The Notification Period begins once the application is reviewed and approved. The patient will be notified by mail of their charity care disposition.

9. **Plain Language Summary (PLS)** means a written statement that notifies an individual that the Hospital offers financial assistance under its FAP and provides necessary information in language that is clear, concise, and easy to understand.

10. **Responsible Individual** means the patient or any other individual having financial responsibility for a self-pay account. There may be more than one Responsible Individual.

C. Publication/Public Access

1. It is the hospital's policy to conspicuously display signs in the language population that is likely to be affected or encountered by the hospital. These signs will inform patients about our FAP in the Emergency Room, Admissions and outpatient registration areas. Postcards with the Financial Assistance Services Representative's contact information, (Mather Patient Financial Services Department, 100 Highlands Blvd Suite 301, Port Jefferson, NY 11777) are provided to patients who express a need for financial assistance. Each admission packet contains an insert informing patients about the Financial Assistance Program.

2. The PLS must be offered to patients upon intake or discharge, including in any bill notifying patients about potential ECAs. Conspicuous notice concerning the existence of the FAP must be included on all patient bills along with the physical location and telephone number of the Financial Assistance Services Department and the Hospital's website address.

    a. The hospital's website has a dedicated Financial Assistance section which includes the FAP, the application form and the PLS. The website posting prominently states that there is no charge to download these materials, and patients are not required to create an account or provide personally identifiable information. Patients are thus well-notified that they may receive a free copy of this policy, the PLS or an application for financial assistance.

3. Notification about the availability of financial assistance is also widely publicized to members of the community served by the Hospital by various means, which may include, but are not limited to an advertisement in the quarterly hospital newsletter.

D. Application Process

1. Financial assistance and charity is not a replacement for financial responsibility. Patients are expected to fully cooperate with Mather Hospital financial assistance application process and procedures for obtaining charity or other forms of payment

or financial assistance, and to contribute to the cost of their care based on their individual ability to pay.

Individuals with the financial capacity to purchase health insurance shall be encouraged to do so to ensure access to health care services, personal health and for the insulation of their individual assets.

If the patient believes they are unable to afford their bill, he or she may then complete a Financial Assistance Application. Any discount the patient is eligible for under the Financial Assistance guidelines is applied to the balance after the AGB reduction.

2. Patients who inquire about Financial Assistance to help satisfy their balance after insurance, for example allocated copays, coinsurances, and deductibles**,** are first to be offered to settle their account using the Amounts Generally Billed discount (AGB). The patients' responsibility is reduced to the calculated AGB percentage of the current balance. The Patient is expected to pay in full and if deemed eligible, given their ability to pay, enter into an appropriate payment arrangement. If the patient believes they are still unable to afford the bill, they may then complete a Financial Assistance Application. Any discount the patient is eligible for under the Financial Assistance guidelines is applied to the balance after the AGB reduction.

3. Patients without health insurance or those who choose not to elect insurance billing, who do not qualify for Financial Assistance under this Policy, and who pay for medically necessary services in full prior to receiving services may be eligible for a prompt pay discount, in the Hospital's sole discretion. For medically urgent or emergency admissions where it is not practical to collect payment in advance of receiving services, the prompt payment discount will be accepted for 72 hours following discharge.

   If actual billed charges exceed the estimated amount paid at the time of service, a prompt-pay discount will be applied to the total charge amount. When actual charges exceed the amount originally estimated by the hospital, an effort will be made on a case-by-case basis to adjust the charges if requested by the patient. Financial Assistance under this Policy and a prompt-pay discount cannot be combined together, nor combined with any other discount offered by the hospital or its affiliates. Please Refer to the Business Office for a current listing of services eligible for a prompt pay discount.

E. Application Criteria

1. Patients are encouraged to apply for financial assistance within 90 days from the date of the first post-discharge billing statement; however applications will not be accepted after two hundred and forty (240) days has elapsed from the date of discharge.

2. A Financial Assistance Application is provided to all patients who inquire about the program. Each application includes a checklist of all required documentation and a self-addressed return envelope.

3. The Hospital may deny financial assistance based on failure to provide documentation/information.

4. Once the application and all required documentation have been returned, Mather Hospital utilizes guidelines for the current Federal Poverty Level to determine eligibility under the Financial Assistance Program. If Financial Assistance in part or whole is determined to be applicable, the designated Financial Services Representative uses the Charity Care Allowance code to make all necessary adjustments.

F. Presumptive Eligibility

1. A Financial Assistance determination may not require extensive documentation based on account balance criteria. Accounts below a certain dollar amount may not require extensive documentation to administer a Financial Assistance allowance.

2. The Hospital considers significant assets owned by a patient and or a legally Responsible Individual for all cases including patients at or below 150% of the Federal Poverty Level. A decision may be made by Mather Hospital to grant Financial Assistance based on the following: account balances, information received via phone calls, face to face interviews, admitting information and/or medical record information. An example of these types of cases might include homeless patients, foreign patients, drug rehabilitation, non-retroactive Medicaid coverage, Medicaid co-payments, etc.

3. The Hospital also runs an estate search on all deceased patients with an open balance. If the estate search deems the patient is without an estate, all open balances are written-off as Charity Care using the presumptive eligibility allowance.

4. In the event Mather Hospital lacks evidence to support a patient's eligibility for Financial Assistance, Mather Hospital will use outside agencies and/or data sources in determining estimated income amounts for the basis of determining Financial Assistance eligibility and potential discount amounts. Patients without health insurance or other verified funding sources, who meet any of the following criteria, can be granted eligibility presumptively by Mather Hospital:

    a. Verified resident address of the [Shelter/Homeless/Other Name], without a signed financial assistance application on file

    b. Presence of a financial assistance application on file

    c. Verified "homeless" or "transient" status, without a signed financial assistance application on file

d. For medically urgent or emergent services, that are verified with current eligibility in a Medicaid or other public assistance program in a state other than the State of New York, of which Mather Hospital is not an enrolled provider

e. Account is identified in official bankruptcy notice

f. Accounts in which the patient is deceased and there are no estate assets

g. Undocumented patients as applicable under Section 1011, Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens

G. Time Requirements for Determination:

1. Patients have up to 240 days from the date of the first "post-discharge" bill to apply for Financial Assistance. The patient must provide all required documentation proving they are eligible, including self-attestations of income.

2. Once an application has been received and a comprehensive review has been conducted, a letter will be provided to the patient, via mail, explaining the result of the application. This letter is mailed within 30 days of the hospital's receiving the Financial Assistance application.

3. All discounts received through the Financial Assistance program are effective for one year. Therefore, if a patient continues to require financial assistance, they must re-apply for Financial Assistance on an annual basis.

H. Appeal Process

In the event a Financial Assistance applicant is denied or does not agree with the determination, they must appeal the decision within 30 days by contacting the Financial Assistance Services Representative at extension 4037 for a Financial Assistance Appeal Form.

I. Determining Applicable Discounts

1. Basis for Calculating Amounts Generally Billed:

The Hospital has adopted the look-back method as the Amount Generally Billed (AGB) as is defined in the IRS regulations at 26 CFR 1.501(r)-5.

To obtain the current AGB, the Hospital ran encounter financial data for DOS in for the prior twelve month period. For each payer (i.e., Medicare fee-for-service, Medicaid and all private health insurers that pay claims to the hospital), the total expected reimbursement was divided into the total charges to calculate the percentage of dollars anticipated to collect based on our contractual agreements. Lastly, the average of all of these percentages was calculated to create a current

AGB of 26.31% of charges including NYS surcharge for hospital services and 24% of charges for professional services.

To adhere with the 501(r) regulations, all Financial Assistance-eligible patients have their bills reduced to the AGB at the time of bill. In order to reduce the charges efficiently, a self-pay insurance plan was created in Soarian Financials. The use of this plan reduces the charges to 26.31% including NYS surcharge for hospital services and 24% for professional services. The remaining charges are allowanced to the designated GL (General Ledger) code.

2. **Discounts**

The discount a patient receives is based on the family income, the size of the family, and how it aligns with the Federal Poverty Guidelines. Patients who fall below 150% of the Federal Poverty guidelines are eligible for a 100% discount, with the exception of a nominal fee when applicable. Patients who fall 451% and above the federal poverty guidelines are responsible for the Amounts Generally Billed. For a full breakdown of all discounts, please see table A below.

*All Patients eligible for a 100% discount are subject to a nominal fee as defined by New York State.

Table A

Family Size	Family Income	* Eligible for 100% Charity Care (Up to 150%)	Eligible for 75% Charity Care (Up to 250%)	Eligible for 50% Charity Care (Up to 350%)	Eligible for 25% Charity Care (Up to 450%)
1	$12,760.00	$19,140.00	$31,900.00	$44,660.00	$57,420.00
2	$17,240.00	$25,860.00	$43,100.00	$60,340.00	$77,580.00
3	$21,720.00	$32,580.00	$54,300.00	$76,020.00	$97,740.00
4	$26,200.00	$39,300.00	$65,500.00	$91,700.00	$117,900.00
5	$30,680.00	$46,020.00	$76,700.00	$107,380.00	$138,060.00
6	$35,160.00	$52,740.00	$87,900.00	$123,060.00	$158,220.00
7	$39,640.00	$59,460.00	$99,100.00	$138,740.00	$178,380.00
8	$44,120.00	$66,180.00	$110,300.00	$154,420.00	$198,540.00

Source: Calculated using data from the *Federal Register*, January 2020
For families/households with more than 8 persons, add $4,480 for each additional person
U.S. Department of Health and Human Services (HHS)

- 150% & Below: Patient's bill is discounted 100%
- 151–250%: Patient's bill is discounted 75%
- 251–350%: Patient's bill is discounted 50%
- 351–450%: Patient's bill is discounted 25%
- 451% & Above: Patient is responsible for full charges

Any patient eligible for discounting will be required to pay their copay or percentage due upon determination of their eligibility, or they must sign an approved payment plan contract. Discounts will be applied to any and all outstanding hospital bills of a patient determined to be currently eligible for any charity or public assistance program that Mather Hospital participates in, including Medicaid. Discounted charges will not exceed the lowest average commercial and/or Medicare payer reimbursement rate, whichever is lower. Mather Hospital will limit the amounts that the hospital will collect for emergency or other medically necessary care provided to individuals eligible for financial assistance to amounts generally billed (received by) the hospital for commercially insured and Medicare patients. This amount generally billed will be calculated not less than annually within three (3) months of the fiscal year.

J. Nominal Payment Guidelines

In accordance with New York State regulations, a nominal fee is charged to patients who are eligible for 100% Financial Assistance. They are as follows:

- Interventional Radiology - $150
- ER - $50
- Infusion - $15 with a cap of $150 per month.
- MRI's, Mammogram, sonogram, Cat Scan, Bone Scans, Nuclear Medicine test, other radiology services - $150
- X-Ray - $15
- Inpatient - $150
- Neurology Services - $150
- Physical Therapy, Occupational Therapy, Speech Therapy - $15 with a cap of $150 per month.
- Pre-surgical Testing - $15
- Hyperbarics - $150 per visit
- Ambulatory Surgery – $150/Procedure
- Clinic Services – $15/Visit with a cap of $150 per month.
- Prenatal and Pediatric ER/Clinic Services – No Charge

K. Billing/ECAs

Subject to compliance with the provisions of this policy, the Hospital may take any and all legal actions, including ECAs, to obtain payment for medical services provided. The Hospital recognizes that a patient's ability to pay over an extended period may be substantially altered due to illness or financial hardship, resulting in a need for charity services.

The Hospital will not engage in ECAs, either directly or by any debt collection agency or other party to which the hospital has referred the patient's debt, before reasonable efforts are made to determine whether a Responsible Individual is eligible for assistance under the FAP.

At least three separate Patient Account statements will be mailed to the last known address of each Responsible Party prior to the end of the Notification Period; provided, however, that no additional Patient Account statements need be sent after a Responsible Individual submits a complete application for financial assistance under the FAP. At least 120 days must elapse between the first and last of the required three mailings. All Patient Account statements of Self-Pay Accounts will include:

- An accurate summary of the hospital services covered by the statement;
- The charges for such services; and
- The amount required to be paid by the Responsible Individual (or, if such amount is not known, a good faith estimate of such amount as of the date of the initial statement).

Detailed itemizations for hospital charges will be provided upon request.

At least one of the Patient Account statements sent during the Notification Period will include written notice that informs the Responsible Individual about the ECAs that may be taken if the Responsible Individual does not apply for financial assistance under the FAP or pay the amount due by the Billing Deadline (i.e., the last day of the Notification Period). Such statement must be provided to the Responsible Individual at least 30 days before the deadline specified in the statement, if commencing ECAs.

A letter indicating intent to transfer the Patient Account to a collection agency shall be mailed to the last known address of each Responsible Individual at least 30 days prior to the transfer of a Self-Pay Account to a collection agency or the initiation of any ECA. A reasonable effort to orally notify the Responsible Individuals by telephone at the last known telephone number must also is made. During all conversations, the Responsible Individual will be informed about the financial assistance that may be available under the FAP.

ECAs may be commenced as follows:

1. If all Responsible Individuals fail to apply for financial assistance under the FAP by the last day of the Notification Period, and the Responsible Individuals have received the 30-day written notice described above, then the Hospital may initiate ECAs.
2. If all Responsible Individuals apply for financial assistance under the FAP, and the Hospital determines definitively that the Responsible Individuals are ineligible for any financial assistance under the FAP (including because the patient was not uninsured), the Hospital may initiate ECAs.

3. If any Responsible Individual submits an incomplete application for financial assistance under the FAP prior to the end of the Application Period, then ECAs may not be initiated until after each of the following steps has been completed:

a. The Financial Assistance Services Department provides the Responsible Individual within a reasonable time (i.e., no less than 30 days) with a written notice that describes the additional information or documentation required under the FAP in order to complete the application for financial assistance, which notice will include a copy of the PLS.

b. The Financial Assistance Services Department provides the Responsible Individual with at least 30 days' prior written notice of the ECAs that the Hospital may initiate against the Responsible Individual if the FAP application is not completed or payment is not made; provided, however, that the deadline for completion or payment may not be set prior to the end of the Application Period.

4. If the Responsible Individual who has submitted the incomplete application completes the application for financial assistance, and the Financial Assistance Services Department determines definitively that the Responsible Individual is ineligible for any financial assistance under the FAP, the Hospital may initiate ECAs.

5. If the Responsible Individual who has submitted the incomplete application fails to complete the application by the deadline set in the notice provided pursuant to the above, then ECAs may be initiated.

6. If an application, complete or incomplete, for financial assistance under the FAP is submitted by a Responsible Individual, at any time prior to the end of the Application Period, the Hospital will suspend ECAs while such financial assistance application is pending.

7. Any Responsible Individual, or representative thereof, who contacts the Hospital for information concerning any possible financial assistance, shall be provided with information concerning the Financial Assistance Program under the FAP.

8. All collection agencies must follow the Hospital's FAP and provide information to patients on how to apply for financial assistance.

9. Collection actions are prohibited against Responsible Individuals who were Medicaid eligible at the time the Covered Services were provided.

10. Sending an account to collection for those individuals who have submitted applications with eligibility determinations still pending is prohibited.

11. After the commencement of ECAs is permitted, external collection agencies shall be authorized to file litigation, obtain judgment liens and execute upon such judgment liens using lawful means of collection; provided, however, that prior written approval of The Financial Assistance Services Department shall be required before any legal action may be initiated and prior approval of the Financial Assistance Services Department shall be required before collection

agencies may use any means of collection that involves physical detention or arrest of any Responsible Individual.

12. Collection agencies are prohibited from forcing the sale of or foreclosure on a Responsible Individual's primary residence.

13. Patients who are able, but unwilling, to pay for Hospital services are considered uncollectible bad debts and will be referred to outside agencies for collection. Patients who qualify for assistance under the Financial Assistance Program and who fail to pay the balance when due, after application of the appropriate discount, are considered uncollectible bad debts for the amount of such balance and will be referred to outside agencies for collection.

14. If the Hospital refers or sells patient debts to another party during the Application Period, the written agreement with such party must obligate such party to:

    a. Refrain from engaging in ECAs until the Billing Deadline;

    b. Suspend any ECAs if the individual submits a Financial Assistance Program application during the Application Period;

    c. If the Responsible Individual is determined to be Financial Assistance Program-eligible, ensure that the individual does not pay and is not obligated to pay more than required, and to reverse any ECA previously taken; and

    d. Obtain similar provisions in a written agreement if such party refers or sells the debt to yet another party.

L. Recordkeeping/Reporting

The Business Office maintains a detailed log of all Financial Assistance applicants and recipients in accordance with the necessary criteria required for annual reporting to various governmental agencies.

On a monthly basis, the Systems Analyst sends Transunion the Bad Debt qualified accounts. When returned from Transunion, the accounts are divided into four tiers which include the following: Presumptive Eligibility, Low Collectability, Medium Collectability and High Collectability:

- Presumptive Eligibility: Accounts are automatically written off using the Presumptive Eligibility allowance.

- Low Collectability/Medium Collectability: Accounts continue through the collections process and are assigned to an agency. If the patient contacts the agency inquiring about Financial Assistance, these cases require the Senior Director's approval. A full and completed Financial Assistance application must be returned promptly within 30 days in order to be considered for financial assistance.

- High Collectability: These accounts are reviewed by our credit and collection unit and held from collections for 30 days. If after 30 days the patient has not created a payment arrangement or paid in full, the account is sent for further collection efforts.

M. Approval Authorizations Levels

Effective January 1, 2013 the facility has assigned specific members of the management team to oversee write-off approvals by specific dollar amount ranges. Below are the individuals assigned to the three approval tiers:

- $25,000 and Under – Assistant Director of Patient Financial Services
- $25,001 and Over – Senior Director of Patient Financial Services

N. Board Approval

Each year the hospital includes in the Annual Operating Budget an amount which is approved by the Board of Directors for the purpose of providing Financial Assistance.

The Board of Directors approves the Financial Assistance Policy.