

MAIMONIDES MEDICAL CENTER

CODE: FIN-028 (Reissued)

DATE: November 07, 2022

ORIGINALLY ISSUED: March 21, 2005

SUBJECT: FINANCIAL ASSISTANCE POLICY

I. POLICY

Maimonides Medical Center (“Maimonides” or the “Hospital”) strives to provide high quality health care services to every patient who comes to one of our facilities, regardless of ability to pay. This Financial Assistance Policy (“FAP” or “Policy”) implements Maimonides’ financial assistance program, through which patients who lack insurance coverage, have exhausted their health insurance benefits, and are deemed eligible for financial assistance in compliance with this Policy may access free or discounted emergency and other medically necessary care.

II. ACCESS TO INFORMATION

Maimonides widely publicizes its FAP in accordance with this Policy.

Maimonides makes this FAP, the FAP application form and a summary of the FAP (“Plain Language Summary”) available on a designated Financial Assistance page on Maimonides’ website (<http://www.maimonidesmed.org/main/FinancialInformation.aspx>). Paper copies of these documents are available upon request and without charge, by mail and at public locations in the Hospital, including the Emergency Room, admission areas and points of patient service.

Maimonides notifies and informs Hospital patients about the FAP by: offering a paper copy of the Plain Language Summary as part of intake and registration; including a written notice on billing statements that informs recipients about availability of financial assistance under the FAP and includes the telephone number of the Hospital’s Financial Services Department and the direct web site address where copies of the FAP, FAP application form and Plain Language Summary can be obtained; and conspicuous public displays that inform patients about the FAP in public locations in the Hospital, including the Emergency Room and admission areas. Patients will be informed of Maimonides’ FAP by multi-lingual signage.

In addition, the FAP, FAP application form and Plain Language Summary will be translated into the primary languages spoken by populations with Limited English Proficiency (“LEP”) serviced by the Hospital each year, including the language spoken by each LEP language group that constitutes the lesser of 1,000

Individuals or 5 percent of the community served by the Hospital or the population likely to be affected or encountered by the Hospital. Maimonides will also notify and inform members of the community served by the Hospital that it offers financial assistance under a FAP, and where to obtain more information and documents related to the FAP, in a manner that community members can understand (including translations into relevant languages).

Patients with specific inquiries about financial assistance will be provided with the Plain Language Summary, informed of the related information on the Maimonides Medical Center website, and referred to a Financial Counselor. Where an individual indicates that he/she prefers to access documents or information about the FAP electronically, Maimonides may provide such documents or information electronically (including on an electronic screen, by email or by providing the direct website address or URL, of the web page where the document or information is posted).

III. FINANCIAL ASSISTANCE

A. Eligibility

Individuals that meet the following criteria are eligible for free or discounted care under this Policy:

For medically necessary non-emergency services, low income residents of the five boroughs of New York City (Kings, New York, Queens, Richmond and Bronx counties) who are uninsured or who have exhausted their health insurance benefits are eligible for financial assistance.

For emergency services, low income residents of New York State who are uninsured or who have exhausted their health insurance benefits are eligible.

The maximum charge that may be billed to a patient who receives emergency or other medically necessary care at the Hospital, and is eligible for financial assistance under this FAP is known as the Amount Generally Billed (“AGB”). Maimonides sets the AGB at the total amount Medicaid would allow (for inpatient care) and the total amount that Medicare would allow (for outpatient ambulatory surgery, clinic, emergency department, referred ambulatory and ancillary services). Pursuant to the discount fee schedules described in Attachments A and B, discounts offered to FAP-eligible patients under the FAP are less than or equal to the AGB. Following determination of FAP-eligibility, a FAP-eligible individual may not be charged more than the AGB for medically necessary or emergency care.

Financial criteria for eligibility and discounts under the FAP are described

further below and in Attachments A and B. **Patients with incomes below**

300% of the Federal Poverty level are presumptively eligible for assistance under the FAP, based on information described in Section III.D, below. An additional condition of eligibility is that patients (and for patients who are minors, their parent/s and/or legal guardian/s) provide the necessary documentation for the financial assistance application, and otherwise cooperate fully with the staff helping them in the process.

To the extent that patients are eligible for a publicly sponsored insurance program (e.g., Medicaid, Child Health Plus (“CHP”), Prenatal Care Assistance Program), patients must utilize that program for coverage of their treatment rather than the Maimonides financial assistance program. Patients seeking financial assistance (and for patients who are minors, their parent/s and/or legal guardian/s) must provide all information and documentation requested to determine eligibility for a publicly sponsored insurance program to the Hospital. Once a patient has applied for coverage under a publicly sponsored insurance program, he or she will be eligible for financial assistance from Maimonides up to the date on which the patient is deemed to be covered by the other program, as long as he or she is otherwise eligible for financial assistance.

Financial assistance may be made available, as determined on a case-by-case basis, for patients who do not meet the financial eligibility criteria but face extraordinary medical costs. Requests for financial assistance in these circumstances will be directed to the Financial Services Department at 983 48th Street, Brooklyn, NY 11219, (718) 283-7790.

Patients with HMO/commercial insurance that is not accepted at Maimonides Medical Center are not eligible for financial assistance, unless the patient has exhausted their insurance benefits.

Patients will be ineligible for financial assistance if the Financial Services Department determines that false information was provided by the patient (or for patients who are minors, their parent/s and/or legal guardian/s) during the application process.

B. Covered Services

Maimonides’ financial assistance program covers emergency and other medically necessary services at Maimonides Medical Center. Medicare guidelines are used to determine whether services are medically necessary. Ancillary services ordered in connection with clinic visits will be charged at the sliding scale percentage rate that corresponds to that clinic visit.

The following are not covered under this Policy:

- Items that are not medically necessary (e.g., cosmetic procedures);

- Items without clinical or therapeutic benefit (e.g., telephones, televisions and private room differential charges);
- Services not billed by the Hospital (e.g., anesthesia services and professional services by physicians and independent contractors, such as private duty nurses, home care services, and ambulette services), other than services provided by substantially related entities of the Hospital, as such term is defined under federal regulations; and
- Copayments and deductibles.

Patients who qualified for emergency Medicaid as inpatients at Maimonides are eligible for one post-operative clinic visit without charge and any related ancillary services within 90 days of the surgery, and are not required to complete the documentation request to be eligible for that visit.

Patients who are seen in the Emergency Room but who are not admitted as inpatients are eligible for one follow-up clinic visit without charge for the specific condition which brought them to the Emergency Room, and are not required to complete the documentation requests to be eligible for that visit.

Outpatient mental health services are covered under FIN-29, "Outpatient Mental Health Services Financial Assistance Policy," and not under this Policy. Inpatient mental health services and related ancillary services are covered under this Policy.

Attachment C to this Policy lists providers delivering emergency or other medically necessary care in the Hospital that are covered by this FAP, and those that are not covered under the FAP.

C. General Application Procedures

In order to obtain assistance with the FAP application process, apply for financial assistance under, or obtain additional information about the FAP, an individual may contact the Hospital's Financial Services Department at (718) 283-7790, located at 983 48th Street, Brooklyn, NY 11219.

Each individual requesting financial assistance will be referred to a Financial Counselor for screening. The Financial Counselor will:

1. Discuss various alternatives available to the patient (e.g., publicly sponsored insurance programs, payment arrangements, discounted rates, sliding scales, free care) based on the information received.
2. In appropriate circumstances, (a) complete a Medicaid application and submit it to the Local Department of Social Services on behalf

of the patient; or (b) refer the patient to the appropriate local Medicaid office to complete a CHP application.

3. Assess whether the patient may be eligible for additional discounts or funding that may be available through special grants or programs at Maimonides Medical Center separate from the general financial assistance program.
4. If appropriate, provide a financial assistance application for the applicant to complete. Upon request, the Financial Counselor will provide assistance to patients on understanding the financial assistance policies and complete the application on their behalf during a face to face interview.

FAP application forms will be translated, in accordance with Section II, above. In addition, translation services will be available to all patients needing such services to access financial assistance at the Hospital. Staff will access translation services in accordance with AD-120 Translation and Interpreter Services.

The application forms will include a notice to patients that upon submission of a completed application, including any information or documentation needed to determine the patient's eligibility under the Policy, the patient may disregard any bills until the Hospital has rendered a decision on the application.

Patients are permitted to apply for financial assistance for at least 240 days from the date that the first post-discharge bill is provided. (See FIN-55, Billing and Collections Policy for more information about application periods). Requests to waive these requirements may be directed to the Senior Vice President of Finance for review.

D. Eligibility Criteria For Financial Assistance

1. Eligibility Determination Procedures

Determinations of eligibility will be made by the Financial Services Department. As described in more detail below at Subpart III.D.2 below, eligibility shall be based on the following information:

- Place of Residence;
- Annual, pre-tax income;
- Liquid assets; and
- Family size.

Information provided in the patient's application for a publicly sponsored insurance program will be used to obtain this data. If no such application

has been made or is available, the necessary information for determinations of financial assistance eligibility must be provided by the patient. If any required information is missing, patients will be advised by phone or mail of the missing information.

2. **Income and Liquid Assets Tests**

Attachment A to this Policy, “Sliding Scale Fee Discount Schedule for Inpatient Services,” sets forth the discounts for covered inpatient services. Attachment B, “Sliding Fee Scale Discount Table for Ambulatory Surgery, Clinic, Emergency Department, Referred Ambulatory and Ancillary Services,” sets forth the discounts for covered outpatient, clinic, emergency, ambulatory, and ancillary services.

Each Attachment sets forth two tests – an Income Test and a Liquid Asset Test:

- The *Income Test* is calculated by comparing the patient’s “family size” with his or her family’s annual, pre-tax income.
- **Family Size.** If the patient is an adult, the patient’s family size is calculated by adding the patient, the patient’s spouse (if any and if he/she resides with the patient) and any dependents of the patient or the patient’s spouse. If the patient is a child, the patient’s family size is calculated by adding the patient, the patient’s parent/s and/or legal guardian/s with which the patient resides, and any dependents of the patient’s parent/s and/or legal guardians with which the patient resides (other than the patient). A pregnant woman is counted as two family members.
- **Annual Pre-Tax Income.** If the patient is an adult, the family’s annual pre-tax income is the sum of the patient’s and the patient’s spouse’s (if any and if he/she resides with the patient) income. If the patient is a minor, the family’s annual pre-tax income is the income of the patient’s parent/s and/or legal guardian/s with which the patient resides. Income is based on the calculation of last four weeks earnings prior to the date of service.
- Annual, pre-tax income will be the total of the following sources of income, as evidenced by the documentation required on the FAP application:
 1. Salary/Wages Before Deductions.
 2. Social Security Benefits.
 3. Unemployment & Workmen’s Compensation.
 4. Veteran’s Benefit.
 5. Alimony/Child Support.
 6. Other Monetary Support

7. Pension Payments.
8. Insurance or Annuity Payments.
9. Dividends/Interest.
10. Rental Income.
11. Net Business Income (self-employed/verified by independent source).
12. Other (strike benefits, training stipends, military family allotments, income from estates and trusts).

Source of income should be calculated by adding amounts actually received, as opposed to those amounts that the individual may be entitled to but are not being paid to him or her (e.g., when the ex-spouse of a patient fails to pay child support, insurance or pension payments are in dispute).

- Each patient's *liquid assets* will be calculated based on the total value of the patient's and his or her spouse's assets (whether held individually or jointly).

If the patient is a minor, the patient's liquid assets will be calculated based on the total value of the assets held by the patient's parent/s and/or legal guardian/s with which the patient resides. The types of assets that will be taken into consideration include cash; savings accounts; checking accounts; Certificates of Deposit; equity in real estate (other than primary residence); and other assets (Treasury Bills, negotiable paper, corporate stocks and bonds). The asset test will not take into consideration a patient's primary residence, assets held in a tax-deferred or comparable retirement savings account, college savings accounts, or cars used regularly by a patient or immediate family members.

A patient with liquid assets totaling twice the amount of the resource levels allowed by Medicaid will be considered to have "*Significant Liquid Assets.*" **If the patient has Significant Liquid Assets, the amount of assistance for the patient will be the LESSER of the discount for which the patient is eligible under the Income Test and the Liquid Asset Test.** For example, if a patient is eligible for a 50% discount under the Income Test and a 25% discount under the Liquid Asset Test, the 25% discount shall apply. If the individual is eligible for financial assistance under either the Income Test or Asset Test, the maximum charge that he or she may incur is 100% of the greater of the Medicare or Medicaid rate, as applicable, or the AGB (as discussed above).

The *Liquid Asset Test – Inpatient* is calculated by dividing the amount of the full Medicaid rate for the patient's services by the patient's "Liquid Assets."

The *Liquid Asset Test – Outpatient* is calculated by dividing the amount of the full Medicare rate for the patient's services by the patient's "Liquid Assets."

- **If the patient does not have Significant Liquid Assets, then the amount of assistance for the patient will be the discount for which the patient is eligible under the Income Test.**
- Special consideration may be made on a case-by-case basis if a patient has recently become unemployed or may not be able to pay for routine living expenses (i.e., rent, utilities and food) if the patient is required to self-pay at the rate set in Attachments A or B.

Any cases where special consideration is requested should be directed to the Director of the Financial Counseling Unit at (718) 283-7796. The patient may be required to document the nature of the circumstances that require special consideration.

E. Process for Review of Applications

Within 30 days of receipt of the completed application for financial assistance and all required documents, the Financial Services Department will notify the patient in writing whether the application for financial assistance has been approved or declined. If the application has been approved, the patient will be informed of the percentage discount (e.g., 90% of applicable fees) for which he or she is eligible and given a detailed explanation of amounts owed. If the application has been denied, the written notice shall describe how to appeal the denial and include information on how to contact the Department of Health. FAP-denial notifications must also detail the basis for the denial. In cases where a face to face interview is conducted, the patients are informed immediately of approval of the application and the amount of discount the patient will receive or of denial of the application. In such cases the written notice is also mailed to the patient's home.

In addition, if the patient is approved for financial assistance, the Financial Services Department will document the determination of eligibility in the "comments" section of the registration system (AHS), including the specific applicable discounts for (a) inpatient services and (b) outpatient services, even if only one type of service (e.g., inpatient services) is required in the current care of the patient.

Approval of eligibility is valid for one year, at which point recalculation of eligibility will be necessary. Future changes to the established sliding scales set forth in Attachments A and B shall apply to all new and currently qualified patients.

F. Installment Payment Arrangement

Upon request, patients receiving financial assistance will be given an opportunity to obtain an installment payment arrangement interest free. The monthly payment will not be greater than 10% of the patient's gross monthly income plus any assets eligible for consideration under the Hospital's asset test. No interest will be charged on the unpaid balance even in the event a payment is missed. In the event of a missed payment, there will be no acceleration of payments.

G. Appeals

A patient has the right to appeal a decision on eligibility for financial assistance based on the following criteria:

- Incorrect information was provided;
- Changes in patient financial status occurred; or
- Extenuating circumstances.

The Senior Vice President of Finance (Financial Services) will decide appeals. Appeals must be made in writing (or in person, by appointment) to the Senior Vice President of Finance (Financial Services) at the following address:

983 48th Street
Brooklyn, NY 11219
Telephone: (718) 283-7790

The appeal must be made within 30 days of notification of the eligibility determination. The Senior Vice President of Finance (Financial Services) will strive to make appeal decisions within 10 business days of receipt of a patient appeal (i.e., after receipt of a letter or an in person appeal).

H. Separate Billing and Collections Policy

The actions that Maimonides may take in the event of non-payment are described in a separate Billing and Collections Policy (FIN-55). This policy is available on a designated Financial Assistance page on Maimonides' website (<http://www.maimonidesmed.org/main/FinancialInformation.aspx>). Paper copies of this policy are available upon request and without charge, by mail and at public locations in the Hospital, including the Emergency Room, admission areas and points of patient service.

I. Access to Emergency Medical Care

There will be no discrimination in the provision of a medical screening examination and necessary stabilizing treatment against those eligible for financial assistance under this policy. Maimonides provides, without discrimination, care for emergency medical conditions to individuals, regardless of whether they are eligible for financial assistance under this FAP. See FIN-034 EMTALA - Medical Screening Examination And Stabilization Policy.

J. Training and Further Information

All staff who interact with patients or have responsibility for billing and collections will receive a copy of this Policy and will be trained on the appropriate procedure for the financial assistance program. Staff will also be periodically informed of additional discounts or funding that may be available through special grants or programs separate from the general financial assistance program. Any further inquiries by staff on this Policy should be directed to the Manager of the Financial Counseling Unit at (718) 283-7796.

Employees of Maimonides and their dependents will be treated per established Medical Center Policy (FIN-022).

K. Evaluation of Compliance with Law

The Department of Internal Audit shall evaluate compliance with the Financial Assistance Law and this policy at least annually. The results of such audit shall be shared with the SVP for Patient Accounts, SVP, Finance (Financial Services) the EVP for Legal Affairs and the Compliance Officer.

IV. CONTROLS

The Senior Vice President of Finance (Financial Services), in conjunction with A.V.P. of Ambulatory Health Services network, and Senior Vice President of Patient Accounts, will periodically review patient master records and accounts for adherence to the Financial Assistance protocol set in this Policy.

The Senior Vice Presidents of Finance (Financial Services) and Patient Accounts will direct the appropriate Department Heads to revise the Financial Assistance protocol set forth in this Policy as changes are approved or mandated by regulatory agencies.



Kenneth D. Gibbs
President & CEO

INDEX: Charity Care, Self-Pay, Financial Assistance
REFERENCES: PHL 2807-k (9 and 9-a)
Dear Administrator letter dated February 15, 2007
Patient Protection and Affordable Care Act §9007(a)
(March 23, 2010) (Adding 501(r) to IRC);
FIN-034 EMTALA - Medical Screening Examination
And Stabilization Policy
FIN-029 (Revised) - Outpatient Mental Health Services
Financial Assistance Policy
FIN-055 - Billing and Collections Policy
Dear Administrator Letter dated November 15, 2013
Additional Requirements for Charitable Hospitals;
Community Health Needs Assessments for Charitable
Hospitals; Requirement of a Section 4959 Excise Tax
Return and Time for Filing the Return; Final Rule, 79
Fed. Reg. 78954 (Dec. 31, 2014).
26 C.F.R. 1.501(r)-1, 1.501(r)-4 - 1.501(r)-6

DEPARTMENT
RESPONSIBLE: Legal Department/Financial Services

MAIMONIDES MEDICAL CENTER**2020 SLIDING SCALE FEE DISCOUNT SCHEDULE FOR INPATIENT SERVICES BASED ON MEDICAID RATES****Attachment A****Test A – Income Test¹**

Family size	Federal Poverty Guidelines LEVEL I	Income Range LEVEL II		Income Range LEVEL III		Income Range LEVEL IV		Income Range LEVEL V		Income Range LEVEL VI		Income Range LEVEL VII		Asset Test Minimum Resource Level
1	\$12,760	\$12,761	\$15,951	\$15,952	\$19,142	\$19,143	\$25,522	\$25,523	\$31,902	\$31,903	\$38,283	\$38,284	Amt. Above	\$31,500
2	\$17,240	\$17,241	\$21,550	\$21,551	\$25,860	\$25,861	\$34,482	\$34,483	\$43,102	\$43,103	\$51,723	\$51,724	"	\$46,200
3	\$21,720	\$21,721	\$27,151	\$27,152	\$32,590	\$32,591	\$43,442	\$43,443	\$54,302	\$54,303	\$65,163	\$65,164	"	\$50,026
4	\$26,200	\$26,201	\$32,751	\$32,752	\$39,301	\$39,302	\$52,402	\$52,403	\$65,503	\$65,504	\$78,603	\$78,604	"	\$56,550
5	\$30,680	\$30,681	\$38,351	\$38,352	\$46,022	\$46,023	\$61,362	\$61,363	\$76,703	\$76,704	\$92,043	\$92,044	"	\$63,078
6	\$35,160	\$35,161	\$43,951	\$43,952	\$52,742	\$52,743	\$70,322	\$70,323	\$87,903	\$87,904	\$105,480	\$105,481	"	\$69,600
7	\$39,640	\$39,641	\$49,326	\$49,327	\$59,462	\$59,463	\$79,282	\$79,283	\$99,103	\$99,104	\$118,923	\$118,924	"	\$76,128
8	\$44,120	\$44,121	\$55,121	\$55,152	\$66,182	\$66,183	\$88,242	\$88,243	\$110,303	\$110,304	\$132,363	\$132,364	"	\$82,650
9	\$48,600	\$48,601	\$60,751	\$60,752	\$72,902	\$72,7903	\$97,202	\$97,203	\$121,503	\$121,504	\$145,803	\$145,804	"	\$89,176
10	\$53,080	\$53,081	\$66,351	\$66,352	\$79,621	\$79,622	\$106,162	\$106,163	\$137,703	\$137,704	\$159,243	\$159,244	"	\$95,700
For each Addtl person add	\$4,480	\$5,600		\$6,720		\$8,960		\$11,200		\$13,440		N/A		\$6,526
Discount amount based on Medicaid DRG	100%	90%		80%		70%		60%		50%		0%		
Percentage Over FPL	100% of FPL	101% to 125% of FPL		126% to 150% of FPL		151% to 200% of FPL		201% to 250% of FPL		251% to 300% of FPL		Over 300% of FPL		

Test B – Liquid Assets Test (only applies if patient has twice (2x) the amount of Medicaid Allowable Resources)

Medicaid DRG / Total Liquid Assets	Greater than 90%	90% to 80%	79% to 70%	69% to 60%	59% to 50%	49% to 0%	
Discount Amount	100%	75%	50%	25%	15%	0%	
Example: Full Medicaid Rate is \$15,000	\$0	\$3,750	\$7,500	\$11,250	12,750		
	Rate 15,000	$\frac{\text{Assets}}{\text{Rate}} = 47\%$ Patient's entitled 0% discount. Patient responsibility full Medicaid DRG rate					
	Assets 31,600						

Full Medicaid Rates are due from patients whose income exceeds 300% of the FPL, or whose charges to liquid assets ratio is 49% or less.

MAIMONIDES MEDICAL CENTER

2020 SLIDING FEE SCALE DISCOUNT SCHEDULE FOR OUTPATIENT AMBULATORY SURGERY, CLINIC, ER DEPT., REFERRED AMBULATORY AND ANCILLARY SERVICES BASED ON MEDICARE APC RATES

Test A – Income Test²

Attachment B

Family size	Federal Poverty Guidelines LEVEL I	Income Range LEVEL II		Income Range LEVEL III		Income Range LEVEL IV		Income Range LEVEL V		Income Range LEVEL VI		Income Range LEVEL VII		Asset Test Minimum Resource Level
1	\$12,760	\$12,761	\$15,951	\$15,952	\$19,142	\$19,143	\$25,522	\$25,523	\$31,902	\$31,903	\$38,283	\$38,284	Amt. Above	\$31,500
2	\$17,240	\$17,241	\$21,550	\$21,551	\$25,860	\$25,861	\$34,482	\$34,483	\$43,102	\$43,103	\$51,723	\$51,724	"	\$46,200
3	\$21,720	\$21,721	\$27,151	\$27,152	\$32,590	\$32,591	\$43,442	\$43,443	\$54,302	\$54,303	\$65,163	\$65,164	"	\$50,026
4	\$26,200	\$26,201	\$32,751	\$32,752	\$39,301	\$39,302	\$52,402	\$52,403	\$65,503	\$65,504	\$78,603	\$78,604	"	\$56,550
5	\$30,680	\$30,681	\$38,351	\$38,352	\$46,022	\$46,023	\$61,362	\$61,363	\$76,703	\$76,704	\$92,043	\$92,044	"	\$63,078
6	\$35,160	\$35,161	\$43,951	\$43,952	\$52,742	\$52,743	\$70,322	\$70,323	\$87,903	\$87,904	\$105,480	\$105,481	"	\$69,600
7	\$39,640	\$39,641	\$49,326	\$49,327	\$59,462	\$59,463	\$79,282	\$79,283	\$99,103	\$99,104	\$118,923	\$118,924	"	\$76,128
8	\$44,120	\$44,121	\$55,121	\$55,152	\$66,182	\$66,183	\$88,242	\$88,243	\$110,303	\$110,304	\$132,363	\$132,364	"	\$82,650
9	\$48,600	\$48,601	\$60,751	\$60,752	\$72,902	\$72,7903	\$97,202	\$97,203	\$121,503	\$121,504	\$145,803	\$145,804	"	\$89,176
10	\$53,080	\$53,081	\$66,351	\$66,352	\$79,621	\$79,622	\$106,162	\$106,163	\$137,703	\$137,704	\$159,243	\$159,244	"	\$95,700
For each Addtl person add	\$4,480	\$5,600		\$6,720		\$8,960		\$11,200		\$13,440		N/A		\$6,526
Discount amount based on Medicare-APC Rates	100%	90%		80%		70%		60%		50%		0%		
Percentage Over FPL	100% of FPL	101% to 125% of FPL		126% to 150% of FPL		151% to 200% of FPL		201% to 250% of FPL		251% to 300% of FPL		Over 300% of FPL		

Test B – Liquid Assets Test (only applies if patient has twice (2x) the amount of Medicaid Allowable Resources)

Medicare APC Rate / Total Liquid Assets	Greater than 90%	90% to 80%	79% to 70%	69% to 60%	59% to 50%	49% to 0%
Discount Amount	100%	90%	80%	70%	60%	0%
Example: Amb/Surg \$1,000 APC Rate	\$0	\$100	\$200	\$300	\$400	\$1,000
<p style="text-align: center;"> APC Rate $\frac{1,000}{31,600}$ = 32% Patient entitled 0% discount Patient responsibility is Full Medicare APC rate Resources 31,600 </p>						

Full APC Medicare Rates are due from patients whose income exceeds 300% of the FPL, or whose charges to liquid assets ratio is 49% or less.

Attachment C
Covered and Excluded Providers Under FAP

Providers and Service Settings Covered under FAP

Providers employed by Maimonides Medical Center (limited to those services provided at the hospital's main campus (including the Emergency Room) or at its Article 28 clinics).

Providers and Service Settings Excluded from FAP

Services Provided by Maimonides Employed Faculty Practice Doctors in their private offices and other settings (i.e., homes)

Erik Altman, M.D.

Advanced Implant and Oral Surgery, P.C. (services provided by Dr. Yuriy Yusupov)

Anesthesiology Associates of Boro Park, LLP

Discreet Plastic Surgery, P.C. (services provided by Dr. Daniel Kaufman)

Fifth Ave Plastic Surgery, P.C. (services provided by Dr. Eric K. Cha)

Gary Kimmel, M.D., P.C.

George Philip Smith, M.D., P.C.

Gila R. Weinstein M.D., PLLC

Himansh Khanna, M.D., P.C.

J.A. Personal Medical Care Practice, PLLC (services provided by Dr. Tshering Amdo and Dr. Shahid Badin)

Jonathan Lazare, M.D., P.C.

Millennium Urology, PLLC (services provided by Dr. Omid Hakimian)

Icahn School of Medicine at Mount Sinai (pediatric nephrology services provided by Dr. Corinne Benchimol, Dr. Hilary Hotchkiss, Dr. Jessica Reid-Adam, or Dr. Jeffrey Saland)

Norman Maurice Rowe, M.D., M.H.A., L.L.C.

New York University School of Medicine (pediatric neurosurgery services provided by Dr. David Harter, Dr. Eveline Teresa Hidalgo, Dr. Donato Pacione, Dr. Jeffrey Wisoff, or Dr. Amanda L. Yun)

NS Medical PLLC (services provided by Nicholas Bastidas, M.D.)

Pediatric Urology Associates, P.C. (services provided by Dr. Steven Friedman or Dr. Jaime Freyle)

R R Plastic Surgery, P.C. (services provided by Dr. Roman Rahyam)

Staten Island Oral and Maxillofacial Surgery, P.S. (services provided by Dr. David Hoffman, D.D.S.)

The Medical and Surgical Eye site, P.C. (a/k/a Nassau County Ophthalmology, P.C.) (services provided by Dr. Norman Saffra)

University Physicians of Brooklyn, Inc. (a/k/a University Ophthalmic Consultants) (traumatic eye injury services provided by Dr. Kichiemon Asoma, Dr. Sonya Dhar, Dr. Douglas Lazzaro, Dr. Allison Rizzuti, or Dr. Jonathan Zwerling)