Montefiore | Mount Vernon

ADMINISTRATIVE POLICY AND PROCEDURE

SUBJECT: FINANCIAL AID POLICY **NUMBER:**

OWNER: Office of the President

EFFECTIVE DATE: 11/2013

REVISED DATE: 04/26/2022

SUPERSEDES: 2/2020,2/2022

REFERENCE:

PURPOSE:

Montefiore Mount Vernon Hospital (the Medical Center) is guided by a mission to provide high quality care for all its patients. We are committed to serving all patients, including those in our service area who lack health insurance coverage and who cannot pay for all or part of the essential care they receive at the Medical Center. We are committed to treating all patients with compassion, from the bedside to the billing office, including our payment collection efforts. Furthermore, we are committed to advocating for expanded access to health care coverage for all New Yorkers.

The Medical Center is committed to maintaining financial aid policies that are consistent with its mission and values and considers an individual's ability to pay for medically necessary health care services.

POLICY GUIDELINES:

This policy is intended to cover the Medical Center's guidelines for administering financial assistance to patients requiring emergency and medically necessary care who lack sufficient health insurance coverage or after exhausting all sources of insurance payment. Financial aid is provided to patients with a demonstrated inability to pay, as contrasted to an unwillingness to pay, which is considered bad debt. The policy covers all services rendered in Montefiore Mount Vernon, the Infectious Disease Clinic, and ACT/ICM (Mental Health Program).

I. Financial aid shall be available to:

- Uninsured and Underinsured patients residing in the Medical Center's primary service area receiving medically necessary services or emergency care (See Attachment A for Financial Aid Chart and Levels); and

- Patients residing in the Medical Center's primary service areas that exhausted their medical benefits for medically necessary or emergent care.

- Except for emergency services, patients must reside within the Medical Center's primary service area for a particular service to be categorically eligible for financial aid. The Medical Center's primary service area is New York State. Patients residing outside of New York State that receive emergency care are eligible for financial assistance.

- Eligibility for financial assistance for non-emergent care for non-residents of New York State will be determined on a case-by-case basis and requires Vice President Approval. If the patient is approved to receive financial assistance as an exception, they will be screened using the same criteria as patients residing in the primary service area (gross income and family size tied to federal poverty level).

- Elective procedures that are not deemed medically necessary (e.g., cosmetic surgery, infertility treatment) are not eligible for financial aid. Patients can obtain a self-pay discount for non-covered services.

- The Financial Aid policy follows EMTALA guidelines.

- This Financial Aid policy also applies to medically necessary non-covered services and non-covered charges for days exceeding a length-of-stay limit for patients either eligible for or covered by Medicaid who otherwise meet the Medical Center's policy criteria

2. The Medical Center does not place a limit on services based on a patient's medical condition.

3. Financial aid offices where patients can apply for assistance are located at:

   - 12 North 7th Avenue Mt. Vernon, NY 10551 Main Cashiers Office:
     914-361-6899, the **e-mail address is MVFinancialAssistance@montefiore.org).**
   - 16 Guion Place, New Rochelle, NY I 0801 Main Cashiers Office:
     914-365-3812, the **e-mail address is NRFinancialAssistance@montefiore.org.**

Paper copies of the Financial Aid policy, the Financial Aid summary, and the Financial Aid application are available upon request, without charge, by mail, or by E-mail. E-mail requests can be sent to **MVFinancialAssistance@montefiore.org.** They can also be found on the facility's website at **http://www.montefiorehealthsystem .org/body.cfm? id =69.**

4. Uninsured and Underinsured patients receiving services at the Medical Center's outpatient clinic locations can apply for financial aid at the time of clinic registration. All patients receiving services throughout Montefiore can visit the financial aid office above to begin or complete their applications.

5. Determination of eligibility for financial aid will be made as early in the care planning and scheduling process as possible. Counselors will assist any patients who require assistance with completing financial aid applications. Emergency services will never be delayed pending financial determinations. Patients can apply for financial aid prior to services or after receipt of a bill. Patients can also apply for financial aid after a bill has been sent to a collection agency. There is no deadline for when a patient can request to complete a financial aid application.

6. Financial aid approvals will be valid for one year. Patients will be re-evaluated for financial aid annually.

7. Patients or financially responsible parties are expected to cooperate with the Medical Center in applying for available public insurance coverage (e.g., Medicaid, Child Health Plus, and Qualified Health Plans (during open enrollment) if deemed potentially eligible before final financial aid determinations are made. Financial aid eligibility is not contingent on completing a Medicaid application, nor will a decision be delayed pending a Medicaid decision.

8. Gross income tied to publish FPL income guidelines adjusted for family size shall be used to determine eligibility for financial aid. Decisions are based on annual income only. Assets are not considered.

9. The Medical Center shall verify current income. Acceptable proof of income is as follows:
    - Unemployment statement
    - Social Security/pension award letter
    - Pay stubs/employment verification letter
    - Letter of support
    - Attestation letter explaining income, support, and/or current financial situation if other proof of income is not available

10. Finance staff will be available to assist with financial aid consultations. Applications for financial aid will be reviewed and decided upon promptly and within 30 business days for non-emergency services. Patients have 30 days to appeal an initial financial aid decision. Patients will receive financial aid decisions via mail, with notification on the bottom of the approval/denial letter explaining how to appeal the decision. Patients are advised to disregard any bill received while an application is in process. Accounts for patients who have completed financial aid applications shall not be sent to collections while applications are in process.

11. Notice of the Medical Center's financial aid policies shall be communicated into patients, staff and local community service agencies. The Medical Center's financial aid policy shall be available in multiple languages (Spanish, Brazil-Portuguese, Arabic, Haitian-Creole, and Italian) to any party seeking such information at the following locations:

    - Admitting offices
    - Emergency Room Registration offices
    - **https://www.montefiorehealthsystem.org/body.cfm?id=69**
    - By mail upon request

- By contacting the financial aid office at 914-361-6899
- By e-mailing **MVFinancialAssistance@montefiore.org.**

Availability of Financial Aid is publicized on:

- On all facility billing statements
- Signs are posted at entranceways advising patients of the room locations for financial aid.
- http:// www.montefiorehealthsystem .org/body.cfm?id=69
- As a Question and Informational packet on Annual Non-Clinical In-service
- Wall signage in the Emergency Department, Admitting Office, Billing, and Medicaid
- Offices and other registration and waiting areas

All intake, registration, and collection agency staff are trained on the Medical Center's financial aid policy. An in-service is provided to all areas with instructions on where to send patients who need assistance.

12. Patients may appeal to the Medical Center's financial aid decisions if they are denied financial aid or deem a decision to be unfavorable. Patients appealing financial aid decisions must provide proof of current income and expenses. Patients have 30 days to complete appeals applications and will be notified of decisions via mail within 30 days of the submission of appeals applications. Based on the information provided, patients may be evaluated for further reductions or extended payment plans.

13. Patients are offered payment plans if they are not able to make reduced payments in full. Monthly payments are not to exceed 10% of a patient's monthly income. Extended payment plans are also offered through the appeals process. If a patient makes a deposit, it is included as part of payment towards his/her financial aid balance. The Medical Center does not charge interest on patient balances.

14. The Medical Center maintains a separate billing and collections policy. It can be found on the Medical Center's Website: http://www.montefiorehealthsystem.org/body.cfm?id=69 or a hard copy can be requested by contacting the Financial Aid Office.

15. Patients will receive a notice 30 days prior to any account being forwarded to a collection agency for failure to request or complete a financial aid application or failure to make payments on a financial assistance balance.

16. **Primacy Collection Agency Criteria:**

Once an account is referred to the Primary Collection agency they will go through their internal process looking for active Medicaid insurance, address and telephone verification, potential charity care eligibility if not already screened, and a return mail process. In addition, credit inquires and estate searches will be done. Upon completion of this process, the following collection efforts will be made:

- At least 1-4 letters sent
- At least 1-4 telephone calls made
- Deceased and Bankruptcy patient accounts will be returned for write off
- Accounts with mail return and no phone number are closed and returned to MMC for referral to secondary collection agency
- Accounts with no activity will be closed and returned 180 days from referral date for referral to secondary collection agency.

Secondary Collection Agency Criteria:

Once an account is referred to the Secondary Collection agency they will go through their internal processes looking for active insurance, address and telephone verification and a return mail process. In addition, credit inquires and estate searches will be done. Upon completion of this process, the following collection efforts will be made:

- At Least 1-4 letters sent
- At least 1-4 telephone calls made
- Deceased and Bankruptcy patient accounts will be returned for write-off
- Accounts with mail return and no phone number are closed and returned to MMC for write-off
- Accounts 180 days from referral date are to be closed and returned to MMC for write-off unless patient is actively paying on an account or agency is pursuing an estate for payment.

Both primary and secondary agencies are able to negotiate settlements on outstanding patient liability.

17. The Medical Center prohibits collections against any patient who is eligible for Medicaid at the time services are rendered.

18. All collection agencies affiliated with the Medical Center have a copy of the Medical Center's financial aid policy and will refer any patient needing assistance back to the Medical Center for evaluation and reduction of a bill based on annual income and family size.

19. The Financial Aid Office measures compliance with its policy by sending out its own "silent shoppers" to the intake and registration areas to ensure that signage and summaries are posted and available and that Associates are aware that the Medical Center offers financial aid.

20. Full financial aid will be granted to patients with outstanding self-pay bills and current Medicaid coverage.

21. Full Financial Aid will be granted to patients who are homeless. Ambulance Reports can be a source of reference if it is documented in the report that the patient is undomiciled.

22. Immigration status is not a criterion used to determine eligibility.

23. The Medical Center uses predictive analysis to assist in charity care determinations in the absence of completed financial aid applications. Such findings will not deem patient's ineligible for financial assistance. If a patient completes a financial aid application with documentation demonstrating that his/her income is lower than the category determined using predictive analysis, the patient's financial responsibility will be further reduced to the lower amount. For sites live on EPIC, Experian is utilized. Experian Healthcare Financial Assistance Screening/Presumptive Charity uses financial information that is contained in a patient's credit report and other patient specific attributes to estimate their income level and where they are in relation to the Federal Poverty Level to qualify for a hospital's charity care program. Inquiries through Experian Healthcare's Financial Assistance Screening are soft inquires that can only be seen by the consumer and do not affect credit score. If consumer has any questions or concerns regarding the inquiry, they can contact Experian Healthcare Customer Care at (763) 416-1030. For sites billed out via American Healthware/EGLU (legacy system) Transunion is utilized. If consumer has questions or concerns regarding the inquiry, they can contact Transunion Customer Care Credit line at (800)-916-8800.

24. The Medical Center's billing statements will advise patients if they have received financial aid or self-pay discount.

25. The Medical Center does not use extraordinary collection measures. The extraordinary collection measures we do not use include:
    - Garnishing of wages
    - Reporting to credit agencies
    - Sale of debt

26. Patients with any complaints about the Medical Center's financial aid policy or process may call the New York State Department of Health Complaint Hotline at 1-800- 804-5447. This information is also included in denial letters.

27. For uninsured individuals at or below 100% of FPL who are approved for financial aid, patient financial responsibility will be limited to the nominal payment amounts listed below for the following services (See Attachment A for rates):

- Inpatient - $150/discharge
- Ambulatory surgery - $150/procedure
- Adult Emergency Room and Clinic Services - $15/visit
- Prenatal and Pediatric Emergency Room and Clinic Services - no charge

28. For uninsured individuals at or below 300% of FPL who are approved for financial aid, patient financial responsibility will be based on a sliding fee scale capped at the amounts that would have been paid for the same services by Medicaid or Medicare (See Attachment A for rates).

29. The Medical Center's financial aid policy also extends to uninsured individuals between 300% and 500% of FPL who are approved for financial aid (See Attachment A for rates).

30. Uninsured individuals above 500% of FPL residing in the Medical Center's primary service area who receive medically necessary or emergency care are eligible for a self pay discount (See Attachment A for rates).

31. In circumstances where supporting documentation could not be substantiated and/or an Experian check is returned with no information, and charges will still be reduced to the highest category as a self-pay discount or 65% of charges whichever is lesser of the two

32. The Medical Center utilizes the look back method to calculate the amount generally billed. The financial aid rates and Amount Generally Billed are to be evaluated by April 30th of every calendar year. Medicare and commercial payer rates are used in the AGB calculation. The Amounts Generally Billed (AGB) percentage is available upon request at any of the financial aid locations. Following a determination of Financial Assistance eligibility, an FAP-eligible individual cannot be charged more than the amount generally billed for emergency or medically necessary care.

33. A comparison of the AGB % to the financial aid category rate is completed for patients that fall at or below 100% of FPL up to 500% of FPL. The capped amount for Hospital Services in Attachment A are as follows (up to 500% of FPL):

- ED visit rate is not to exceed 23% of hospital charges incurred.
- Ambulatory surgery rate is not to exceed 25% of hospital charges incurred.
- Clinic Visit/Pathology/Referred Amb are not to exceed 31% of hospital charges incurred.
- Emergency Inpatient Admission rate is not to exceed 26 % of hospital charges incurred.

34. The provider list (which is a list of providers (other than the hospitals) that provide emergency and medically necessary care in the hospital facilities.The list shows whether the providers are covered by the financial aid policy or not.) It is kept as a separate appendix and is updated quarterly. Patients can find a copy on the financial aid website at http://www.montefiorehealthsystemorg/body.cfm?id=69 or can request a hard copy by visiting or calling the financial aid offices free of charge: 12 North 7th Avenue Mt. Vernon, NY 10551 Main Cashiers Office 914-361-6899.

Any exceptions to the limits above shall be made on a case-by-case basis and require the approval of the Associate Vice President, Health Service Receivables; Vice President, Professional Services; or Vice President, Finance. In implementing this policy, the Medical Center's man agreement and facilities shall comply with all other Federal, State, and local laws, rules, and regulations that may apply to activities conducted pursuant to this policy.

Attachment A: Financial Aid Chart and Levels

2022	Gross Income Categories (Upper Limits)										
Federal Poverty Level	1	2	3	4	5	6	7	8	9	10	11
Family Size	100%	125%	150%	175%	185%	200%	250%	300%	400%	500%	over 500%
1	$13,590	$16,988	$20,385	$23,783	$25,142	$27,180	$33,975	$40,770	$54,360	$67,950	$67,950
2	$18,310	$22,888	$27,465	$32,043	$33,874	$36,620	$45,775	$54,930	$73,240	$91,550	$91,550
3	$23,030	$28,788	$34,545	$40,303	$42,606	$46,060	$57,575	$69,090	$92,120	$115,150	$115,150
4	$27,750	$34,688	$41,625	$48,563	$51,338	$55,500	$69,375	$83,250	$111,000	$138,750	$138,750
5	$32,470	$40,588	$48,705	$56,823	$60,070	$64,940	$81,175	$97,410	$129,880	$162,350	$162,350
6	$37,190	$46,488	$55,785	$65,083	$68,802	$74,380	$92,975	$111,570	$148,760	$185,950	$185,950
7	$41,910	$52,388	$62,865	$73,343	$77,534	$83,820	$104,775	$125,730	$167,640	$209,550	$209,550
8	$46,630	$58,288	$69,945	$81,603	$86,266	$93,260	$116,575	$139,890	$186,520	$233,150	$233,150
For each additional person Add.	$4,720	$5,900	$7,080	$8,260	$8,732	$9,440	$11,800	$14,160	$18,880	$23,600	$23,600

* Based on the 2022 Federal Poverty Guidelines

Emergency Room Visits:

up to 100% of Federal Poverty Level -- $15 for Adults and $0 for Prenatal and Pediatrics

up to 125%of Federal Poverty Level-$35

up to 150% of Federal Poverty Level- 45

up to 175% of Federal Poverty Level -- $65

up to 185% of Federal Poverty Level -- $110

up to 200% of Federal Poverty Level-- $155

up to 250% of Federal Poverty Level - $180

up to 300% of the Federal Poverty Level -- $225

up to 500% of Federal Poverty Level -- $700

over 500% of Federal Poverty Level -- the self-pay discount rate of $1500

Emergency Inpatient Admissions:

up to 100% of Federal Poverty Level -- $150 per discharge

up to 125% of Federal Poverty Level -- $300 per discharge

up to 150% of Federal Poverty Level -- $500 per discharge

up to 175% of Federal Poverty Level -- $2,800 per discharge

up to 185% of Federal Poverty Level -- $4,700 per discharge

up to 200% of Federal Poverty Level - $6,600 per discharge

up to 250% of Federal Poverty Level - $7,600 per discharge

up to 300% of Federal Poverty Level -- $9,500 per discharge

up to 500% of Federal Poverty Level - $11,000 per discharge

over 500% of Federal Poverty Level - the self-pay discount rate of $16,000 per discharge

Clinic Visits (for Montefiore Practice Locations, Mental Health Clinic, Oncology Office, Renal, Laboratory, and Pathology):

up to 100% of Federal Poverty Level -- $15 for Adults and $0 for Prenatal and Pediatrics

up to 125% of Federal Poverty Level -- $20

up to 150% of Federal Poverty Level -- $30

up to 175% of Federal Poverty Level-- $45

up to 185% of Federal Poverty Level -- $75

upto 200% of Federal Poverty Level -- $105

up to 250% of Federal Poverty Level -- $120

up to 300% of Federal Poverty Level -- $150

up to 500% of Federal Poverty Level -- $200

over 500% of Federal Poverty Level -- the self-pay discount rate of $350

Medically Necessary Procedures -Ambulatory (excluding Gastrointestinal):

up to 100% of Federal Poverty Level-- $150 per procedure

up to 125% of Federal Poverty Level -- $300 per procedure

up to 150% of Federal Poverty Level -- $400 per procedure

up to 175% of Federal Poverty Level -- $600 per procedure

up to 185% of Federal Poverty Level -- $1000 per procedure

up to 200% of Federal Poverty Level -- $1,400 per procedure

up to 250% of Federal Poverty Level -- $1,600 per procedure

up to 300% of Federal Poverty Level - $2,000 per procedure

up to 500% of Federal Poverty Level -- $3,500 per procedure

over 500% of Federal Poverty Level - the self-pay discount rate of $5,000

Medically Necessary Procedures - Gastrointestinal:

up to 100% of Federal Poverty Level -- $100 per procedure

up to 125% of Federal Poverty Level - $150 per procedure

up to 150% of Federal Poverty Level -- $200 per procedure

up to 175% of Federal Poverty Level -- $300 per procedure

up to 185% of Federal Poverty Level -- $500 per procedure

up to 200% of Federal Poverty Level -- $700 per procedure

up to 250% of Federal Poverty Level -- $800 per procedure

up to 300% of Federal Poverty Level - $1,000 per procedure

up to 500% of Federal Poverty Level - $1,800 per procedure

over 500% of Federal Poverty Level - the self-pay discount rate of $2,500

Radiology - X-Ray:

up to 100% of Federal Poverty Level -- $15

up to 125% of Federal Poverty Level - $15

up to 150% of Federal Poverty Level-- $15

up to 175% of Federal Poverty Level - $15

up to 185% of Federal Poverty Level - $15

up to 200% of Federal Poverty Level -- $15

up to 250% of Federal Poverty Level - $15

up to 300% of Federal Poverty Level -- $15

up to 500% of Federal Poverty Level -- $50

Over 500% of Federal Poverty Level – the self-pay discount at 100% of Blue Cross Indemnity Rate

Radiology - Ultrasound:

up to 100% of federal Poverty Level -- $15

up to 125% of Federal Poverty Level -- $20

up to 150% of Federal Poverty Level-- $25

up to 175% of Federal Poverty Level -- $30

up to 185% of Federal Poverty Level - $35

up to 200% of Federal Poverty Level - $40

up to 250% of Federal Poverty Level - $45

up to 300% of Federal Poverty Level -- $50

up to 500% of Federal Poverty Level - $100

Over 500% of Federal Poverty Level – the self-pay discount at 100% of Blue Cross Indemnity Rate

Radiology - Mammogram:

up to 100% of federal Poverty Level - $25

up to 125% of Federal Poverty Level - $30

up to 150% of Federal Poverty Level - $35

up to 175% of Federal Poverty Level -- $40

up to 185% of Federal Poverty Level - $50

up to 200% of Federal Poverty Level - $60

up to 250% of Federal Poverty Level - $70

up to 300% of Federal Poverty Level - $90

up to 500% of Federal Poverty Level - $130

Over 500% of Federal Poverty Level – the self-pay discount at 100% of Blue Cross Indemnity Rate

Radiology - CAT Scan:

up to 100% of Federal Poverty Level - $40

up to 125% of Federal Poverty Level - $45

up to 150% of Federal Poverty Level - $50

up to 175% of Federal Poverty Level -- $60

up to 185% of Federal Poverty Level - $75

up to 200% of Federal Poverty Level - $90

up to 250% of Federal Poverty Level--$105

up to 300% of federal Poverty Level - $130

up to 500% of Federal Poverty Level - $250

over 500% of Federal Poverty Level- self-pay discount at 100% of Blue Cross Indemnity Rate

Radiology- MRI

up to 100% of Federal Poverty Level - $150

up to 125% of Federal Poverty Level - $175

up to 150% of Federal Poverty Level - $200

up to 175% of Federal Poverty Level - $250

up to 185% of Federal Poverty Level - $ 300

up to 200% of Federal Poverty Level - $350

up to 250% of Federal Poverty Level - $400

up to 300% of Federal Poverty Level -$500

up to 500% of Federal Poverty Level - $550

Over 500% of Federal Poverty Level – the self-pay discount at 100% of Blue Cross Indemnity Rate

For the hospital rates for up to 500% of FPL there is a comparison to the Amount Generally Billed and the patient is responsible for the lesser of the two.

All amounts above include the New York State surcharge.

All unfavorable decisions or denied applications can be appealed within 30 days of the decision.

Approved by: C. Blye Date: April 26, 2022

Colleen Blye
Executive Vice President