Hospital Financial Assistance Programs: Are New York Hospitals Complying with New Requirements?

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Public Policy and Education Fund of New York

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Executive Summary

In April of 2006, New York State enacted a groundbreaking law providing protections for uninsured and underinsured patients who face large hospital bills. The new law requires hospitals, as a condition of participation in the $847 million Indigent Care Pool, to have financial assistance policies and procedures based on a series of provisions that took effect as of January 1, 2007. Through the required policies and procedures, the law restricts the charges hospitals are allowed to apply to low income and uninsured patients, regulates the methods by which hospitals can collect payment from patients, and requires hospitals to inform all patients of the availability of financial assistance.

The current report looks at 97 of the largest hospitals in every region of New York to see if the hospitals are complying with the new law. The report examines the hospitals' financial assistance policies as reported to the New York State Department of Health and compares those policies to the statute's requirements. Hospitals are issued grades on compliance with the law's requirements. The report also provided "extra credit" to hospitals who voluntarily adopted polices that provide more extensive financial assistance than the law requires.

The survey found good news and bad news when determining whether hospitals are complying with the new law. Analysis showed that many hospitals were voluntarily offering greater financial assistance than the law requires. However, analysis also showed that the great majority of hospital policies were not compliant with critical provisions of the law, with almost four-out-of-ten receiving an F or D grade.

Hospitals did well on expanding income eligibility requirements for patients in need of financial assistance, with 42 out of 97 hospitals providing discounts to patients with incomes above 300% of the Federal Poverty Level (FPL). Hospitals are also providing larger discounts to patients who meet eligibility criteria – 68% of hospitals provide some discount beyond that required by the law. The vast majority of hospitals, 82 out of 97, extend their financial assistance programs to patients who have exhausted their health insurance benefits, and 26 of those hospitals provide assistance to underinsured patients beyond what the law requires (e.g., high co-pays and deductibles). Many hospitals, 40 out of 97, extend their geographic eligibility requirements beyond those required by law.

The survey found that most hospitals are not complying with the law's requirement that any patient with an income below 300% FPL is presumptively eligible for financial assistance, with 80 out of 97 hospitals failing this question. Many hospitals neglect to inform patients about the methods by which they can appeal a denied financial assistance application, with 35 hospitals making no mention of any appeals process. Hospitals frequently did not provide low-interest installment plans in their financial assistance policies and procedures as required by law, resulting in hospitals getting an average grade of F in this category.

Some hospitals are not complying with other crucial provisions in the law:

- 17 hospitals consider all of a patient's assets to determine financial assistance eligibility (hospitals may not consider 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).
- 57 hospitals are not in compliance with the legally required time limits for submission of applications and supporting documentation.
- Saratoga Hospital, which met the criteria to be included in the survey, was the only hospital to not provide any submission to the Department of Health, thus they received an F grade.
- Three hospitals, Mercy Medical Center (Rockville Centre), St. Clare's (Schenectady), and Arnot Ogden (Elmira) did not submit the required public summary of their financial assistance program to the Department of Health.

Regional and Statewide Average Grades by Category

Region → / Category ↓	Long Island	New York City	Hudson Valley	Capital District	Central New York -Syracuse	Western NY-Rochester	Western NY – Buffalo	Statewide Averages by Category
Eligibility	B	B	A	B	B	B	A	**B**
Discount Amount	A	A	A	A	B	A	A	**A**
Notice to Patients	C	D	C	F	F	D	D	**D**
Application, Approval, Appeal	B	C	B	D	C	C	C	**C**
Installment Plans	A	F	F	F	F	F	F	**F**
Billing and Collections	D	F	F	F	F	F	F	**F**
Consistency in Submission	A	A	C	C	A	A	A	**B**
Regional Averages	**B**	**C**	**B**	**F**	**D**	**C**	**B**	**C**

In light of these findings, PPEF recommends that there be enforcement of the new law by the New York State Department of Health and by the Attorney General's Health Care Bureau, as well as legislative action. The Department of Health should immediately notify all hospitals that their financial assistance policies must comply with the new law. The Department of Health should provide to each hospital a copy of the law, supplemental regulations, and sample documents previously distributed. The Department of Health should allow hospitals 30 days to correct their policies and resubmit them. The Department of Health should review all submitted material and inform hospitals of non-

compliance. This report provides the basis for which hospitals should be prioritized by the Department of Health for ensuring compliance. Upon receipt of non-compliance documentation, hospitals should be given 30 days to adjust their policies to comply with the new law. Given the majority of hospitals' non-compliance with the "presumptive eligibility" provision, the Department of Health should consult with stakeholders on this provision and issue a ruling to all hospitals on how to comply.

The Attorney General's Health Care Bureau should work with the Department of Health to review all submitted policies and procedures and determine legal compliance. After compliance is determined, the Attorney General's Health Care Bureau should seek enforcement agreements with any hospital not in compliance.

The New York State Legislature should adopt provisions in the 2008-09 executive budget proposal that change the complicated accounting methods for distribution of the $847 million indigent care pool to link reimbursement to the patients who actually receive financial assistance from each hospital. Hospitals would be reimbursed at the Medicaid rate less what is received from the patient. A priority would be given to uninsured patients, although 15% would be reserved for underinsured patients. Adopting this accounting change would result in hospitals having a direct financial incentive to make sure that their financial assistance policies are used by patients.

For working families with low or modest incomes, hospital bills can very quickly become an extreme financial burden. Some 2.2 million New Yorkers have no health insurance to help pay these bills. The protections afforded to New Yorkers through this new law have resulted in a vast improvement in the financial assistance programs that New York hospitals offer their patients. Most hospitals scored well on the discounts they provide to patients. Most hospitals also followed the law's requirements for inclusion of eligibility standards within their financial assistance policies. However, hospitals often neglected to include required provisions within their financial assistance policies to protect patients from unfair collections practices. Because hospital's financial assistance policies and procedures are used to determine legal compliance, the findings in this report show that hospitals must be far more diligent in ensuring that their policies are up to the required standards.

Introduction

In April of 2006, New York State enacted a groundbreaking law providing protections for uninsured and underinsured patients who face large hospital bills. The new law requires hospitals, as a condition of participation in the $847 million Indigent Care Pool, to have financial assistance policies and procedures based on a series of provisions that took effect as of January 1, 2007. Through the required policies and procedures, the law restricts the charges hospitals are allowed to apply to low income and uninsured patients, regulates the methods by which hospitals can collect payment from patients, and requires hospitals to inform all patients of the availability of financial assistance.

In 1983, the New York State Legislature created a fund to reimburse hospitals for providing financial assistance to uninsured patients. This fund, then called the Bad Debt Charity Care Pool, had very limited accountability measures or reporting requirements attached. Now called the Indigent Care Pool, it is the largest annual expense resulting from the Health Care Reform Act of 2000, $847 million per year.

Reports by several organizations, including The Long Island Access Project, The Legal Aid Society of New York and The Public Policy and Education Fund of New York (PPEF) between 2002 and 2006 found that it was often impossible for patients to access hospital financial assistance programs despite the large amount of funding hospitals received from the state to provide such programs.

In response to inadequate hospital industry voluntary guidelines and the subsequent studies showing continued failure on the part of hospitals to set up and administer effective financial assistance programs for uninsured patients, a series of legislative proposals were introduced in the New York State Assembly between 2004 and 2006 to enact new legislation making certain provisions regarding hospital financial assistance programs law. The Legislature passed the new financial assistance law as part of the 2006-2007 New York State Budget agreement.

The current report looks at 97 of the largest hospitals in every region of New York to see if the hospitals are complying with the new law. The report examines the hospitals' financial assistance policies as reported to the New York State Department of Health and compares those policies to the statute's requirements. Hospitals are issued grades on compliance with the law's requirements. The report also provided "extra credit" to hospitals who voluntarily adopted polices that provide more extensive financial assistance than the law requires.

Hospital Financial Assistance Requirements

The new law, NYS PBH § 2807-k. 9-a., effective January 1, 2007, requires certain provisions to be included in financial assistance policies and procedures for all inpatient and outpatient hospitals in New York State. Key details include:

- Hospitals will include a notice about applying for financial assistance on all hospital bills and statements
- Patients who make less than three times the federal poverty level will be charged no more for hospital services than the hospital would charge an insurance company, Medicare, or Medicaid
- Patients who earn less than 250% of the federal poverty level will receive a sliding scale discount that is lower than the amount paid by insurers, Medicare, or Medicaid
- Hospitals must give patients a chance to apply for financial assistance before starting collection practices and there are restrictions on the assets that hospitals can consider in collecting bills
- Hospitals must set up reasonable payment arrangements with patients and are not allowed to foreclose on a patient's home to collect a bill
- Hospitals must file annual reports with the New York State Department of Health detailing their financial assistance policies and procedures

The provisions can be categorized as follows: notification to patients; eligibility; services covered; application, approval, and appeal; billing and collections; reporting; and compliance. Each category of provision is further explained below.

Notification to Patients

Each hospital must develop and have publicly available a clear and understandable written summary of its financial assistance policies and ensure that every patient is made aware of the existence of the policies. If a hospital has a 24-hour emergency department, it must notify patients that financial assistance may be available during the intake and registration process, through the posting of conspicuous and language appropriate information, and through information on all bills and statements sent to patients. For hospitals without a 24-hour emergency department, written notification must take place during the intake and registration process prior to the provision of services or procedures, and be included on all bills and statements.

The required summary of policies must include the specific income levels used to determine eligibility for financial assistance, a description of the primary service area of the hospital, and information about how patients can apply for assistance.

Additionally, hospitals must require contracted outside collections agencies to, when appropriate, provide information to patients about how to apply for financial assistance.

Eligibility

Hospitals' financial assistance policies must state that a patient is presumptively eligible for financial assistance if his or her income is below 300% of the federal poverty level (FPL). A hospital may also provide financial assistance to patients with incomes above 300% FPL. To be eligible for financial assistance, a patient can be either uninsured or have exhausted their health insurance benefits without ability to pay full charges. There can be no limits in eligibility based on the medical condition of the applicant. Hospitals are not required by the law to consider assets when determining eligibility. If a hospital does choose to consider assets in determining payment adjustments, it may not consider 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.

Hospitals' financial assistance policies must allow for all residents of New York State to be eligible for financial assistance for emergency hospital services. For any medically necessary, non-emergent medical care, hospitals' policies must allow for residents of that hospital's primary service (as defined by the Commissioner of the Department of Health), to be eligible to receive financial assistance. The law in no way restricts hospitals from expanding their financial assistance coverage areas.

Services Covered

Under the law, hospitals must provide financial assistance for all medically necessary and therapeutically beneficial services and procedures, and all emergency hospital services including emergency transfers pursuant to the federal Emergency Medical Treatment and Active Labor Act.

Application, Approval, and Appeal

The hospital financial assistance policies must allow patients to apply for assistance up to 90 days after discharge or receipt of services. Hospitals may require applicants to submit financial documents to support their application, as long as the entire application process is not unduly burdensome or complex. Hospitals must allow at least 20 days for patients to submit additional documents and information needed to complete an application.

The application materials for financial assistance programs must include a statement informing applicants that he or she may disregard any bills or statements sent until a decision on the application has been rendered.

Hospitals are also required to assist patients in the application process, including understanding the policies and procedures. Patients are required to cooperate with the requirements of the application, such as providing required information and documentation necessary to render a decision on the application.

Hospitals are required to provide application forms in the primary language of patients served by the hospital.[1]

Decisions regarding financial assistance applications must be made by the hospital within 30 days of receipt of a completed application. The decision must be provided to the patient in writing, and include the method by which the patient can appeal a denial. In addition, hospital financial assistance policies must establish an appeals process to re-evaluate denied applications.

Hospitals may require a patient to first apply for Medicaid or another insurance program, if, in the judgment of the hospital, the patient may be eligible for Medicaid or another insurance program.

Payment Adjustment, Billing, and Collections

Hospitals must provide information about the availability of a financial assistance program on all bills and statements sent to patients. Additionally, hospitals must require outside contracted collections agencies to provide to patients information about the financial assistance programs when appropriate.

Hospitals may not charge uninsured patients with incomes below 300% FPL more than the greater amount paid by Medicaid, Medicare, or the highest volume payor[2]. In March 2006, PPEF released a report showing that the charges hospitals apply to "self-pay" patients' accounts are often considerably greater than the cost the hospital incurs for providing that service – charges were 2.3 times the cost on average – illustrating that hospitals were charging the highest rates to those who had the most difficulty paying.[3] This provision in the law seeks to provide those with lower income the same discounts in charges granted to government or private insurance companies through negotiation.

If hospitals do require a deposit before providing non-emergent, medically necessary care, the hospital's policy must state that the deposit must be included as part of any financial assistance consideration.

For individuals whose incomes are at or below 100% FPL, a hospital may collect no more than a nominal payment amount, consistent with guidelines established

[1] "Primary languages" includes any language that is either: a) used to communicate during at least 5% of patient visits in a year, by patients who cannot speak, read, write, or understand the English language at the level of proficiency necessary for effective communication with health care providers, or b) spoken by non-English speaking individuals comprising more than 1% of the primary hospital service area population, as calculated using demographic information available from the United States Bureau of the Census, supplemented by data from school systems.

[2] Highest volume payor refers to the third-party payor (insurance company or organization), which has a contract or agreement to pay claims for services provided by the hospital and incurred the highest volume of claims in the previous calendar year.

[3] Public Policy and Education Fund of New York, *The Great Hospital Heist: How New York Hospitals Charge the Most to Those Least Able to Pay*, March 2006.

by the New York State Commissioner of Health. The new financial assistance law allows the Commissioner of the Department of Health to define guidelines for the amount hospitals can charge to self-pay patients. The current guidelines are "based upon a review of the maximum amounts charged to patients in this income category by our largest public provider of uninsured services," The New York City Health and Hospitals Corporation. The current guidelines – the maximum amount that can be charged to eligible patients (Hospitals are free to charge less) are: $150/discharge for inpatient services, $150/procedure for ambulatory surgery, $150/procedure for MRI testing, $15/visit for adult ER/clinic services, and no charge for prenatal and pediatric ER/clinic services.[4]

For individuals with incomes between 101% and 150% FPL, a hospital may collect no more than a proportional sliding fee schedule that increases from the nominal payment amount up to a maximum of 20% of the greater of the amount that would have been paid for the same services by the highest volume payor, Medicare, or Medicaid. For individuals with incomes between 151% and 250% FPL, a hospital may collect no more than a proportional sliding fee schedule that increases from 20% in equal increments up to the maximum of the greater of the amount that would have been paid for the same services by the highest volume payor, Medicare, or Medicaid. For individuals with incomes between 251% and 300% FPL, a hospital may collect no more than the greater amount that would have been paid for the same services by the highest volume payor, Medicare, or Medicaid.[5]

Hospitals have discretion to reduce or discount the collection of co-pays and deductibles from those individuals who can demonstrate they cannot pay such amounts. Hospitals are precluded from neither offering greater discounts than the above required discounts, nor offering discounts to individuals with incomes above 300% FPL.

The new law requires that the use of installment plans for the payment of outstanding balances be included in hospitals' financial assistance policies. The installment plans may not include monthly payments to exceed 10% of the patient's gross monthly income[6] or an interest rate to exceed the rate for a 90-day security issued by the US Department of Treasury, plus 0.5%. There can be no accelerator or similar clause under which a higher rate of interest is triggered when a patient misses making a payment.

There are very specific guidelines hospitals must include in their financial assistance policies regarding collections practices. Hospitals must include a

[4] David Wollner, Director of Office of Health System Management for New York State Department of Health, to All Article 28 General Hospitals (CEOs), 16 February 2007.
[5] Please note the allowed asset-income adjustments in *Eligibility*, above.
[6] The exception to the 10% monthly income limit is that if the hospital has secured the New York State Department of Health's prior approval to determine that a patient has significant assets, the hospital can, although is not required to, consider those assets in addition to the monthly payment amount.

written notice on patients' bills and statements at least 30 days prior to referring the account to collections. Hospital must require that any collections agencies with which they contract follow the financial assistance policies of that hospital. Collections are prohibited against any patient who was eligible for Medicaid at the time services were rendered. Hospitals may not force the sale or foreclosure of a patient's primary residence to collect on an outstanding bill. Finally, contracted collections agencies must obtain the hospital's written consent before commencing a legal action.

Reporting

Each hospital, as a condition for participation in the Indigent Care Pools, must include a certification from an independent certified or licensed public accountant or an attestation from a senior official of the hospital that the hospital is in compliance with the new law.

Each report must include the following: The hospital costs incurred and the uncollected amounts in providing services to eligible patients without insurance, including the amount of care provided for a nominal payment amount; the hospital costs incurred and uncollected amounts for deductibles and coinsurance for eligible patients with insurance or other tired-party payor coverage; the number of patients organized by United State zip code, who applied for financial assistance, the number of applications approved, and the number denied; the reimbursement received for indigent care from the Indigent Care Pool; the amount of funds that have been expended on charity care from charitable bequests made or trusts established for the purpose of providing financial assistance to patients who are eligible in accordance with the terms of such bequests or trusts; for hospitals located in Social Services districts in which the district allows hospitals to assist patients with such applications, the number of applications for eligibility under Medicaid that the hospital assisted patients in completing and the number denied and approved; the hospital's financial losses resulting from services provided under Medicaid, and; the number of liens placed on the primary residences of patients through the collections process used by a hospital.

Compliance

To participate in the Indigent Care Pool starting January 1, 2009, hospitals must have financial assistance policies in compliance with the new law by January 1, 2007. Within 90 days of the effective date of this new law, each hospital shall submit to the New York State Commissioner of Health a written report on its policies and procedures for financial assistance to patients. The report must include copies of the hospital's policy and materials distributed to patients. The description of the policy must include the income levels used to determine eligibility, the amount of financial assistance provided to eligible patients, how aid is calculated, and the service area used to determine eligibility. The policy must

include clear, objective criteria for determining a patient's ability to pay and for providing adjustments to payment requirements as are necessary. The policies must be applied consistently to all eligible patients.

All hospital staff that interact with patients or have responsibility for billing and collections must be trained in the hospital's financial assistance policy. Each hospital must implement mechanisms to ensure compliance with its financial assistance policy.

Methodology

In a letter sent to every New York State hospital's Chief Executive Officer dated June 22, 2007, Martin Conroy, the Director of the Division of Primary and Acute Care Services of the New York State Department of Health, requested that each hospital submit to the Department of Health copies of their financial assistance policy summary, the policy itself, and any hospital-developed signage used to notify patients of the financial assistance program. The letter also included templates for developing a summary of the policy and a one-page application form.

On July 30, 2007, Public Policy and Education Fund of New York (PPEF) staff formally requested all returned documents relating to this letter under provisions of the Freedom of Information Law.

The documents submitted by hospitals to the Department of Health were obtained by PPEF staff in two sets, the first on October 9, 2007, the second on December 4, 2007; both sets of documents were on compact discs containing both Microsoft Word and Adobe PDF documents organized by individual hospital, or by hospital system where applicable.

Hospitals Included

In an effort to measure overall compliance with the new law among hospitals in New York State, the 236 hospitals currently operating in New York State were divided up based on Department of Health defined regions: Capital District, Central New York, NY Metro - Long Island, NY Metro - New Rochelle, NY Metro - New York City, Western NY - Buffalo, Western NY - Rochester. A total bed count was then assigned to each hospital based on figures obtained from the Department of Health website. Hospital bed counts were then added for all hospitals within each region, and the average bed count by region was determined. Any hospital with a higher-than-average bed count within its region was included for this study; 97 of the 236 hospitals in New York State met this criterion.

Report Card

After determining which hospitals to grade for compliance, a report card was developed to score hospital's compliance with each provision of the new law. *See Appendix B for Report Card.* The report card contains 46 individual questions on which each hospital is graded. Each hospital's submission to the Department of Health was reviewed and applied to the report card.

The report card and its 46 questions are divided into seven categories: eligibility; discount amount; notice to patients; application, approval, and appeal; installment plans; billing and collections; and consistency within submission.

The 46 questions on which each hospital was graded could earn one of three grades: P, P+, or F. A numerical value of 1 is assigned to P, 2 to P+, and 0 to F. A P is given in cases where a hospital is in compliance with the law. A P+ is given in cases where a hospital goes above and beyond the law in providing a better policy for health care consumers (e.g., if a hospital provides a discount to patients with incomes at 400% FPL or below, as opposed to the required 300% FPL).

See Appendix A for descriptions of each question used on the report card.

After each of the 97 hospitals' submissions were analyzed, each submission was applied to the 46 question test. The numerical scores for each question (0, 1, or 2) were averaged together, resulting in a final numerical grade for each hospital. Each hospital's numerical grade was given a letter grade based on the following rubric: greater than 1 = A, 0.8-0.999 = B, 0.7-0.799 = C, 0.6-0.699 = D, and less than 0.6 = F. If a hospital passed every question on the test, it would receive a perfect 1.0 average, resulting in an A. Hospitals were able to get 2 points on certain questions that showed provisions within a hospital's policy that went above and beyond the requirements of the new law. Average grades were also developed for each individual question on the test and each category of question of the test. Individual question and category averages were also developed for each region.

Findings and Data Analysis

Statewide Averages

Overall eleven hospitals (12%) earned an A, twenty-four hospitals (25%) earned a B, twenty-four hospitals (25%) earned a C, nineteen hospitals earned a D (20%) and seventeen hospitals (17%)earned an F. The average grade for hospitals statewide was a C. Hospitals in the New York metro area generally did better than hospitals upstate. *See Table 1.*

Hospitals performed best in two key areas to consumers: eligibility and amount of financial assistance: the statewide average grade for Discount Amounts was an A and Eligibility was a high B. Hospitals on average performed only fairly on

Applications, Approval, and Appeal with a C. Hospitals generally failed to comply with the law in the following areas: Notice to Patients, earning a D, Installment Plans, earning an F, and Billing and Collections, also with an F. *See Table 2.*

Table 1 – Quantities and Percentages of Grades by Region

Regions → Grades ↓	Long Island	New York City	Hudson Valley	Capital District	Central NY – Syracuse	Western NY – Rochester	Western NY – Buffalo	Total
A	4	5	2	0	0	0	0	**11 – 12%**
B	2	7	6	1	1	2	5	**24 – 25%**
C	0	8	1	5	2	2	6	**24 – 25%**
D	3	4	3	2	4	1	2	**19 – 20%**
F	0	5	2	4	5	1	0	**17 – 18%**
Total # of Hospitals	**9**	**29**	**14**	**12**	**12**	**6**	**13**	**95**

Table 2 – Regional and Statewide Average Grades by Category

Region → / Category ↓	Long Island	New York City	Hudson Valley	Capital District	Central New York - Syracuse	Western NY- Rochester	Western NY – Buffalo	Statewide Averages by Category
Eligibility	B	B	A	B	B	B	A	**B**
Discount Amount	A	A	A	A	B	A	A	**A**
Notice to Patients	C	D	C	F	F	D	D	**D**
Application, Approval, Appeal	B	C	B	D	C	C	C	**C**
Installment Plans	A	F	F	F	F	F	F	**F**
Billing and Collections	D	F	F	F	F	F	F	**F**
Consistency within Submission	A	A	C	C	A	A	A	**B**
Regional Averages	**B**	**C**	**B**	**F**	**D**	**C**	**B**	**C**

Hospitals did well on expanding income eligibility requirements for patients in need of financial assistance, with 42 out of 97 hospitals providing discounts to patients with incomes above 300% of the Federal Poverty Level (FPL). Hospitals also provided larger discounts to patients who met eligibility criteria – 68% of hospitals providing some discount beyond that required by the law. The vast majority of hospitals, 82 out of 97, extended their financial assistance programs to patients who had exhausted their insurance benefits, and 26 of those hospitals provided assistance to underinsured patients beyond what the law requires (e.g., high co-pays and deductibles). Many hospitals, 40 out of 97, extended their geographic eligibility requirements beyond those required by law.

The survey found that most hospitals were not complying with the law's requirement that any patient with an income below 300% FPL is presumptively eligible for financial assistance, with 80 out of 97 hospitals failing this question. Many hospitals neglected to inform patients about the methods by which they can appeal a denied financial assistance application, with 35 hospitals making no mention of any appeals process. Hospitals frequently did not provide low-interest installment plans in their financial assistance policies and procedures as required by law, resulting in hospitals getting an average grade of F in this category.

Some hospitals did not comply with other crucial provisions in the law. 17 hospitals considered all of a patient's assets to determine financial assistance eligibility (hospitals may not consider 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). 57 hospitals did not comply with the legally required time limits for submission of applications and supporting documentation. Saratoga Hospital, which met the criteria to be included in the survey, was the only hospital to not provide any submission to the Department of Health, thus they received an F grade. Three hospitals, Mercy Medical Center (Rockville Centre), St. Clare's (Schenectady), and Arnot Ogden (Elmira) did not submit the required public summary of their financial assistance program to the Department of Health.

Eligibility

Hospitals earned an average grade of B on their programs' eligibility criteria. The New Rochelle and Western NY Buffalo regions averaged an A in the eligibility category because most programs in these regions offered discounts to individuals residing outside the required geographic criteria. Only 16 hospitals out of the 97 studied received a passing grade on "presumptive eligibility." The law requires that hospitals' policies state that patients with incomes below 300% FPL are presumptively eligible for financial assistance. The study showed that most hospitals failed to comply with this provision of the law.

Most hospitals, 64, complied with the law's assets provision. 17 hospitals did not consider assets at all in determining eligibility, which earned those hospitals an

extra point on the asset question. Only 16 hospitals failed to comply with the law's assets provision by considering assets without explicitly excluding primary residence, college savings accounts, tax-deferred retirement savings accounts, and regularly used cars.

Most hospitals also made their programs available to both uninsured and underinsured patients. 26 hospitals went beyond the requirement to make financial assistance available to underinsured patients by also allowing financial assistance to be used for co-pays and deductibles when a patient is able to show inability to pay. 41 hospitals extended their geographic eligibility criteria beyond what is required by law.

Discount Amount

The average grade for hospitals in the Discount Amount category was an A. 64 hospitals, almost two-thirds, provided discounts beyond what is required by law. Central New York, the Syracuse area, was the only region that scored below an A, with a very high B. The only instances of hospitals failing on discount amount questions were because their submissions to the Department of Health did not specify the method by which the hospital determined income eligibility.

Notice to Patients

Hospitals on average earned a D in this category. The Capital District and Central New York regions were the worst in this area, both failing this category. Surprisingly, three hospitals, Mercy Medical Center (Rockville Centre), St. Clare's (Schenectady), and Arnot Ogden (Elmira) did not submit any public summary of their financial assistance program to the Department of Health, which was explicitly requested, resulting in those hospitals failing this category. Hospitals that did submit summaries almost always passed all three questions relating to the summaries. Hospitals' policies often left out information about training of staff and collection practices, resulting in many hospitals failing the final two questions in this category, bringing the average scores down heavily.

Application, Approval, and Appeal

Hospitals earned a C for this category. Regional averages ranged from Long Island and New Rochelle getting the highest averages – a B, to the Capital District earning a D. Hospitals were not likely to extend the period during which patients can apply for financial assistance. At least five hospitals did not comply with the law's required provision to differentiate the ninety days from service to apply and twenty days to complete the application. Hospitals also brought scores down by not specifying that a denial or approval would be sent in writing, and often, even for hospitals that submitted a sample letter of denial, the letter did not include notice about appeal.

Installment Plans

Forty-seven, about half, of the hospitals neglected to make mention of installment plans. A large percentage of the hospitals that did mention installment plans did not go far enough to mention rates of interest. Long Island had a regional average of A for this category – only one hospital in the Long Island region failed. Every other region of the state failed this category, with Capital District and Western NY Buffalo having the lowest averages, with only four and two hospitals complying, respectively.

Billing and Collections

In the area of collections practices, hospitals' policies were often silent. Considered by the Department of Health and many health care advocacy organizations to be one of the major sections of the law, hospitals on average failed this category, largely on the basis of neglecting to include any mention of it. Long Island was the only region to pass this category, and just barely with a D. The Capital District and Central NY received the lowest averages by region with no hospitals and two hospitals passing, respectively.

Consistency within Submission

Hospitals earned an average grade of B in this section. Only New Rochelle and the Capital District had hospitals that did not pass this question, each with three hospitals that did not pass.

Regional Averages

The highest averages among the regions were Long Island, New Rochelle, and Western NY Buffalo, each earning a B. Western NY Rochester and New York City each earned Cs. Central NY (Syracuse) earned a D. The Capital District was the only region to fail.

On the whole, the submissions by downstate hospitals were more complete and more often reflected the language in the law. The Capital District averages suffered because Saratoga Hospital neglected to make any submission to the Department of Health by the time that PPEF staff obtained the second set of information (December 4, 2007).

Hospital systems only made one submission to the Department of Health, regardless of the number of hospitals within the system. For the sake of regional and total averages, the hospitals were counted individually, but all hospitals within a system received the same set of grades. In table 3 below, please note the following abbreviations listed in parentheses after each hospital name indicating an individual hospital's affiliation with a hospital system:

- NSLIJ – North Shore Long Island Jewish Health System
- HHC – New York City Health and Hospitals Corporation
- CNTM - Continuum Health Partners
- NYP – NewYork-Presbyterian Healthcare System
- NH – Northeast Health
- SH – Strong Health
- KH – Kaleida Health
- CHS – Catholic Health System

Deserving Mention

All tolled, eleven hospitals earned an A, all of which were in Long Island, New York City, or New Rochelle. The North Shore Long Island Jewish (NSLIJ) hospital system, with four hospitals meeting the criteria to be graded, and the New York Presbyterian hospital system, with three hospitals graded, both earned an A. The hospital with the highest numerical average was White Plains Hospital Center, which only failed one question – presumptive eligibility – and provided greater discounts than required by law.

Northern Westchester Hospital (Mount Kisco) provides very large discounts, well beyond those required by law, and extends the discounts to patients with incomes up to 700% FPL. Westchester Medical Center (Valhalla) also provides much larger discounts and extends their discounts to patients with incomes up to 500% FPL. Catholic Health System (Buffalo) provides smaller discounts, but still greater than the law requires, and extends some discount to patients with incomes up to 500% FPL.

Kaleida Health (Buffalo) provides much higher discounts than required by law – a 50% discount on charges for patients up to 400% FPL and a 90% discount on charges for patients up to 250% FPL. Champlain Valley Physicians Hospital (Plattsburgh) extends their nominal payment amounts to patients with incomes up to 150% FPL (increased from the required 100% FPL) and provides larger discounts than required by law to patients with incomes up to 400% FPL. Strong Memorial and Highland Hospitals (Rochester) provide a 20% discount on charges for patients with incomes up to 400% FPL, a 40% discount up to 350% FPL, and a 60% discount up to 300% FPL. NYU Hospitals Center (aka, Joint Diseases), provides a 25% discount on charges for patients with incomes up to 400% FPL. Mercy Medical Center and Good Samaritan Hospital (both part of Catholic Health Services of Long Island) provide a 100% discount on charges for patients with incomes up to 300% FPL and extend a 20-80% discount for patients with incomes up to 400% FPL. St. Peter's Hospital (Albany), also provides much greater discounts than required by law, and extends those discounts to patients with incomes up to 400% FPL.

St. Francis Hospital (Poughkeepsie) provides an automatic 40% discount on charges to any patient who is uninsured. Lourdes Hospital (Binghamton)

provides an automatic 20% discount on charges to any patient who is uninsured. Arnot Ogden (Elmira) extends their discount program to uninsured patients with incomes between 300 and 400% FPL.

Orange Regional Medical Center (Middletown) and White Plains Hospital Center both provide patients with incomes up to 300% FPL a 50% discount on charges and a 25% discount on charges to patients with incomes up to 350% FPL. The New York City Health and Hospitals Corporation sets the standard in the state for nominal payments for patients with incomes at or below 100% FPL, and also extends their discount program to patients with incomes up to 400% FPL.

Continuum (NYC), New York Methodist, NewYork-Presbyterian, Nyack Hospital, and Ellis Hospital (Schenectady) each provide some discount to patients with incomes up to 400% FPL.

Recommendations and Conclusion

After complete analysis of the survey data, PPEF recommends that there be enforcement of the new law by the New York State Department of Health and by the Attorney General's Health Care Bureau. The Department of Health should immediately notify all hospitals that their financial assistance policies must comply with the new law. The Department of Health should provide to each hospital a copy of the law, supplemental regulations, and sample documents previously distributed. The Department of Health should allow hospitals 30 days to correct their policies and resubmit them. The Department of Health should review all submitted material and inform hospitals of non-compliance. This report provides the basis for which hospitals should be prioritized by the Department of Health for ensuring compliance. Upon receipt of non-compliance documentation, hospitals should be given 30 days to adjust their policies to comply with the new law. Given the majority of hospitals' non-compliance with the "presumptive eligibility" provision, the Department of Health should consult with stakeholders on this provision and issue a ruling to all hospitals on how to comply.

The Attorney General's Health Care Bureau should work with the Department of Health to review all submitted policies and procedures and determine legal compliance. After compliance is determined, the Attorney General's Health Care Bureau should seek enforcement agreements with any hospital not in compliance.

The limitation of this report is that while we can review whether hospitals are issuing policies that can comply with the law, we cannot tell how well those policies are being executed in practice. Policies are the first step. The key is whether those policies are effectively getting financial assistance to uninsured and underinsured New Yorkers. The 2008-2009 executive budget proposal recommends changing the way that the $847 million in the indigent care pool is spent that would provide hospitals with a strong incentive and a way of

measuring how effectively the financial assistance policies are working. Instead of the very complicated accounting for financial assistance in the current law, which is not directly related to giving financial assistance to individual patients, the Governor's budget proposes linking reimbursement to the patients who actually receive financial assistance from each hospital. Hospitals would be reimbursed at the Medicaid rate, less whatever was received from the patient. A priority would be given to uninsured patients although 15% would be reserved for underinsured patients. PPEF strongly recommends that the Legislature adopt this accounting change, which would result in hospitals having a direct financial incentive to make sure that their financial assistance policies are used by patients.

For working families with low or modest incomes, hospital bills can very quickly become an extreme financial burden. Some 2.2 million New Yorkers have no health insurance to help pay these bills.[7] The protections afforded to New Yorkers through this new law have resulted in a vast improvement in the financial assistance programs that New York hospitals offer their patients. Most hospitals scored well on the discounts they provide to patients. Most hospitals also followed the law's requirements for inclusion of eligibility standards within their financial assistance policies. However, hospitals often neglected to include required provisions within their financial assistance policies to protect patients from unfair collections practices.

Many hospitals in New York are complying with the new law, which proves that compliance with this law is possible. However, because the Department of Health uses hospitals' policies to determine legal compliance, the findings in this report show that hospitals must be far more diligent in ensuring that their policies are up to the required standards.

[7] *Health Insurance for New Yorkers*, United Hospital Fund, www.uhfnyc.org

Appendix A – Individual Hospital Category and Total Averages Organized by Region

Category → Hospital ↓	Eligibility	Discount Amount	Notice to Patients	Application, Approval, Appeal	Installment Plans	Billing and Collections	Consistency within Submission	Average Grade
Long Island								
Good Samaritan Hospital Medical Center	A	A	A	F	A	C	A	A
Huntington Hospital	A	A	B	B	A	A	A	A
Mercy Medical Center	F	A	F	F	A	F	A	D
Nassau University Medical Center	A	A	C	B	A	B	A	B
North Shore University Hospital (NSLIJ)	B	A	B	A	A	A	A	A
South Nassau Communities Hospital	C	A	D	A	A	D	A	B
Southside Hospital (NSLIJ)	B	A	B	A	A	A	A	A
University Hospital	B	A	D	B	F	F	A	D
Winthrop-University Hospital	B	A	F	D	A	F	A	D

Category → Hospital ↓	Eligibility	Discount Amount	Notice to Patients	Application, Approval, Appeal	Installment Plans	Billing and Collections	Consistency within Submission	Average Grade
New York City								
Bellevue Hospital Center (HHC)	A	A	F	C	F	F	A	C
Beth Israel Medical Center (CNTM)	C	A	C	C	A	F	A	B
Bronx-Lebanon Hospital Center	A	A	A	B	F	A	A	B
Brookdale Hospital Medical Center	B	F	F	F	A	F	A	F
Brooklyn Hospital Center	A	A	C	B	F	F	A	C
Cabrini Medical Center	A	A	D	B	F	F	A	C
City Hospital Center at Elmhurst (HHC)	A	A	F	C	F	F	A	C
Coler-Goldwater (HHC)	A	A	F	C	F	F	A	C
Jacobi Medical Center (HHC)	A	A	F	C	F	F	A	C

Category → Hospital ↓	Eligibility	Discount Amount	Notice to Patients	Application, Approval, Appeal	Installment Plans	Billing and Collections	Consistency within Submission	Average Grade
Kings County Hospital Center (HHC)	A	A	F	C	F	F	A	C
Lenox Hill Hospital	A	A	C	D	F	F	A	D
Long Island College Hospital (CNTM)	C	A	C	C	A	F	A	B
Long Island Jewish Medical Center (NSLIJ)	B	A	B	A	A	A	A	A
Lutheran Medical Center	A	F	A	F	F	F	A	D
Maimonides Medical Center	B	A	B	A	F	A	A	B
Memorial Hospital for Cancer and Allied Diseases (Sloan Kettering)	A	A	A	F	F	F	A	D
Montefiore Medical Center	A	F	D	D	F	F	A	F
Mount Sinai Hospital	F	A	F	D	F	F	A	F
New York Hospital Medical Center of Queens	F	A	D	B	F	F	A	D

Category → Hospital ↓	Eligibility	Discount Amount	Notice to Patients	Application, Approval, Appeal	Installment Plans	Billing and Collections	Consistency within Submission	Average Grade
New York Methodist Hospital	F	A	F	F	F	F	A	F
New York Presbyterian Hospital - Columbia Presbyterian Center (NYP)	A	A	A	A	A	A	A	A
New York Presbyterian Hospital - New York Weill Cornell Center (NYP)	A	A	A	A	A	A	A	A
NYU Hospitals Center (Joint Diseases)	A	A	A	B	A	C	A	A
Richmond University Medical Center	B	A	B	B	F	F	A	B
St. Barnabas Hospital	A	A	F	D	F	D	A	C
St. Lukes Roosevelt Hospital - St Lukes Hospital Division	C	A	C	C	A	F	A	B
St. Lukes Roosevelt Hospital - Roosevelt Hospital Division	C	A	C	C	A	F	A	B
Staten Island University Hospital	B	A	B	A	A	A	A	A
SVCMC - St Vincent's Manhattan	B	A	F	F	F	F	A	F

Category → Hospital ↓	Eligibility	Discount Amount	Notice to Patients	Application, Approval, Appeal	Installment Plans	Billing and Collections	Consistency within Submission	Average Grade
Hudson Valley								
Benedictine Hospital	A	A	C	C	F	F	A	C
Good Samaritan Hospital of Suffern	A	A	A	B	A	B	F	B
Lawrence Hospital Center	A	A	C	B	F	C	A	B
New York Presbyterian Hospital - Westchester Division	A	A	A	A	A	A	A	A
Northern Westchester Hospital	A	A	B	F	A	B	A	B
Nyack Hospital	A	F	A	A	A	B	A	B
Orange Regional Medical Center	A	A	F	C	F	F	F	D
Phelps Memorial Hospital Assn	-	-	-	-	-	-	-	N/A
SJRH	F	F	C	B	F	F	A	F

Category → Hospital ↓	Eligibility	Discount Amount	Notice to Patients	Application, Approval, Appeal	Installment Plans	Billing and Collections	Consistency within Submission	Average Grade
Sound Shore Medical Center of Westchester	A	A	F	F	A	F	A	D
St Francis Hospital	B	A	F	F	F	F	A	F
St Luke's Cornwall Hospital/Newburgh	A	A	F	D	F	F	A	D
Vassar Brothers Medical Center	A	A	F	A	F	F	F	B
Westchester Medical Center	A	A	B	A	F	F	A	B
White Plains Hospital Center	B	A	A	A	A	A	A	A

Category → Hospital ↓	Eligibility	Discount Amount	Notice to Patients	Application, Approval, Appeal	Installment Plans	Billing and Collections	Consistency within Submission	Average Grade
Capital District								
Albany Medical Center Hospital	F	A	D	F	F	F	A	F
Albany Memorial Hospital	A	A	D	B	F	F	A	C
Champlain Valley Physicians Hospital Medical Center	D	A	F	C	F	F	A	D
Columbia Memorial Hospital	B	A	C	B	F	F	A	C
Ellis Hospital	A	A	B	F	F	F	A	C
Glens Falls Hospital	A	B	F	F	F	F	F	F
Mary Imogene Bassett Hospital	F	F	F	F	F	F	F	F
Samaritan Hospital	A	A	D	B	F	F	A	C
Saratoga Hospital	F	F	F	F	F	F	F	F
Seton Health System	A	A	F	A	F	F	A	B
St Clares Hospital	C	A	F	B	F	F	A	D
St Peters Hospital	B	A	D	D	F	F	A	C

Category → Hospital ↓	Eligibility	Discount Amount	Notice to Patients	Application, Approval, Appeal	Installment Plans	Billing and Collections	Consistency within Submission	Average Grade
Central NY - Syracuse								
Auburn Memorial Hospital	A	F	F	B	F	F	A	F
Cayuga Medical Center at Ithaca	D	A	F	B	A	C	A	C
Community-General Hospital of Greater Syracuse	F	A	F	D	F	F	A	F
Cortland Regional Medical Center Inc	B	F	D	C	F	F	A	F
Crouse Hospital	A	F	F	B	F	F	A	D
Faxton-St Lukes Healthcare	B	F	F	D	F	F	A	F
Our Lade of Lourdes Memorial Hospital Inc	A	A	D	F	F	F	A	D
Samaritan Medical Center	D	A	F	A	F	F	A	D
St Elizabeth Medical Center	A	A	F	D	F	F	A	D

Category → Hospital ↓	Eligibility	Discount Amount	Notice to Patients	Application, Approval, Appeal	Installment Plans	Billing and Collections	Consistency within Submission	Average Grade
St Josephs Hospital Health Center	A	A	C	D	A	F	A	C
United Health Services Hospitals	B	A	C	B	F	A	A	B
University Hospital SUNY Health Science Center (Upstate)	D	F	B	F	F	F	A	F

Western NY - Rochester								
Arnot Ogden Medical Center	F	A	F	D	D	C	A	C
Highland Hospital	B	A	C	D	A	C	A	B
Park Ridge Hospital	A	F	B	B	F	F	A	C
Rochester General Hospital	C	F	F	C	F	F	A	F
St Josephs Hospital	B	A	F	B	F	F	A	D
Strong Memorial Hospital	B	A	C	D	A	C	A	B

Category → Hospital ↓	Eligibility	Discount Amount	Notice to Patients	Application, Approval, Appeal	Installment Plans	Billing and Collections	Consistency within Submission	Average Grade
Western NY - Buffalo								
Buffalo General Hospital	A	A	F	B	F	F	A	C
Erie County Medical Center	A	A	F	B	F	F	A	C
Kenmore Mercy Hospital	A	A	C	B	F	B	A	B
Mercy Hospital	A	A	C	B	F	B	A	B
Millard Fillmore Hospital	A	A	F	B	F	F	A	C
Millard Fillmore Suburban Hospital	A	A	F	B	F	F	A	C
Mount St Marys Hospital and Health Center	A	A	F	D	F	F	A	D
Niagara Falls Memorial Medical Center	A	A	C	F	F	D	A	C
Olean General Hospital	A	A	B	B	A	A	A	B
Sisters of Charity Hospital	A	A	C	B	F	B	A	B
St Josephs Hospital of Cheektowaga New York	A	A	C	B	F	B	A	B
Woman's Christian Association	B	A	F	C	F	F	A	D
Women and Children's Hospital of Buffalo	A	A	F	B	F	F	A	C

Appendix B – Detailed Description of Each Grading Question

Eligibility

1. **Patients with incomes below 300% of the FPL are presumptively eligible**: to earn a passing grade on this question, a hospital's policy must define eligibility as having an income below 300% FPL.
2. **Excludes assets**: the law allows hospitals to consider assets only under very narrow parameters and does not require consideration of assets. A passing grade on this question will be earned if a hospital does consider assets within the allowable parameters. An extra point will be earned by a hospital if it does not consider assets when determining program eligibility or payment adjustments.
3. **Uninsured and underinsured**: a hospital's financial assistance policy must allow for assistance to be given to people who are uninsured or those who "have exhausted their health insurance benefits." A passing grade will be earned by a hospital if their policy explicitly states that a payment adjustment is available to those who are both uninsured and those who have exhausted their health insurance benefits in accordance with the described income levels. An extra point will be earned of a hospital provides financial assistance to those who cannot pay their hospital bill beyond what their insurance covers (e.g., co-pays, deductibles, extremely high medical costs).
4. **No limits on financial assistance based on the medical condition of the applicant**: A passing grade will be earned on this question as long as there is no limit to financial assistance based on medical condition included within the policy.
5. **Clear, objective criteria for determining a patient's ability to pay and for providing adjustments to payment requirements**: This question will only be counted if a hospital's eligibility criteria are unreasonable or subjective.
6. **Shall provide financial assistance for emergency hospital services to patients who reside in New York State**: A passing grade will be earned by a hospital if its policy states that financial assistance will be provided for emergency services to all patients who reside in New York State. An extra point will be earned by a hospital if it extends financial assistance to emergency patients who reside outside of New York State.
7. **Shall provide financial assistance for medically necessary hospital services for patients who reside in the hospital's primary service area**: A hospital will earn a passing grade on this question if its policy states that financial assistance is available for medically necessary hospital services to those who reside within the hospital's primary service area. An extra point will be earned by a hospital if it extends its geographic eligibility requirements beyond its primary service area.
8. **Hospital financial assistance policies may extend discounts to other patients, either generally or on a case-by-case basis**: A hospital will earn a passing grade on this question if its policy explicitly states that the

hospital reserves the right to extend discounts beyond the required criteria. A hospital will earn an extra point if its policy states that it does generally extend discounts beyond required criteria (e.g., if a hospital's policy states that it provides a discount to all uninsured patients regardless of the income level of the patient). If neither statement exists within a hospital's policy, this question will not be counted.

Discount Amount

1. **Nominal Payment up to 100% FPL**: A hospital will earn a passing grade on this question if its policy states that individuals with incomes at or below 100% FPL will receive a payment adjustment not to exceed the Department of Health defined nominal payment amount.
2. **Sliding fee up to 20% other payor for 101% to 150% FPL**: A hospital will earn a passing grade if its policy states that individuals with incomes between 101% and 150% FPL will receive a payment adjustment based on a sliding fee up to 20% of the amount for a the same services that would have been paid by other payor as defined above. A hospital may earn an extra point on this question if it provides a greater discount than required.
3. **Sliding fee up to amount paid by other payor for 151% to 250% FPL**: A hospital will earn a passing grade if its policy states that individuals with incomes between 151% and 250% FPL will receive a payment adjustment based on a sliding fee up the full amount for a the same services that would have been paid by other payor as defined above. A hospital may earn an extra point on this question if it provides a greater discount than required.
4. **Full amount paid by other payor for 251% to 300% FPL**: A hospital will earn a passing grade if its policy states that individuals with incomes between 251% and 300% FPL will receive a payment adjustment based on the full amount for a the same services that would have been paid by other payor as defined above. A hospital may earn an extra point on this question if it provides a greater discount than required.
5. **If a deposit is required prior to non-emergent medically-necessary care, such deposit must be included as part of any financial assistance consideration**: A hospital will earn a passing grade on this question if its policy explicitly states that required deposits will be included as part of a financial assistance consideration. A hospital will earn a passing grade on this question if its policy states that it does not require a deposit on hospital services. A hospital will fail this question if it mentions that a deposit is required, but does not state that the deposit will be part of a financial assistance consideration. If there is no mention of a deposit, this question will not be included in the hospital's average grade.
6. **Financial assistance policy must be applied consistently to all eligible patients**: This question will only be counted if it is clear from the hospital's financial assistance policy that they do not consistently apply

financial assistance policies to all eligible patients, in which case a hospital will earn a failing grade (e.g., a hospital will earn a failing grade on this question if their materials state all available funds will be used on a first come, first served basis).

7. **Hospital financial assistance policies may provide greater discounts**: This question will only be counted if a hospital's policy provides greater discounts beyond those required by law (i.e., the income eligibility criteria is greater than 300% FPL).

Notice to Patients

1. **Summary must include income levels used to determine eligibility**: A hospital will earn a passing grade on this question if their submission included a summary and the summary showed income criteria. If the hospital's submission did not include a document clearly entitled "summary," any document that is publicly available was used to grade this question.
2. **Summary must include description of primary service area**: A hospital will earn a passing grade on this question if their submission included a summary and the summary included a description of the hospital's primary service area. If the hospital's submission did not include a document clearly entitled "summary," any document that is publicly available was used to grade this question.
3. **Summary must include how to apply for assistance**: A hospital will earn a passing grade on this question if their submission included a summary and the summary included application information. If the hospital's submission did not include a document clearly entitled "summary," any document that is publicly available was used to grade this question.
4. **Notification of program during intake and registration process**: A hospital will earn a passing grade on this question if its financial assistance policy states that patients are notified of the existence of a financial assistance program during the intake and registration process.
5. **Conspicuous posting of language-appropriate information**: A hospital will earn a passing grade on this question if it's policy states that language-appropriate signage is posted in 24-hour emergency departments, or if a hospital's submission included images of signage.
6. **Information on bills and statements sent to patients**: A hospital will earn a passing grade on this question if its policy states that information about the program is included on all bills and statements sent to patients, or if its submission included a sample bill or statement with notification.
7. **All general hospital staff that interact with patients or have responsibility for billing and collections must be trained in the hospital's financial assistance policy**: A hospital will earn a passing grade on this question if its policy states that all required hospital staff

receive training. If no mention of training exists in a hospital's policy, that hospital will receive a failing grade on this question.

8. **Hospital's collection agency shall provide information to patients on how to apply for financial assistance when appropriate**: For the purposes of this question, the only occasions that it is not "appropriate" for a collection agency to provide information to patients on how to apply for financial assistance are 1) if the patient has already applied for financial assistance and has been denied, or 2) if the patient's bill was paid through insurance. Therefore, if no mention of collection agencies providing information about financial assistance policies is present within a hospital's financial assistance policy, the hospital will receive a failing grade on this question.

Application, Approval, and Appeal

1. **Application materials include a notice to patients that once they submit a completed application and documentation, they may disregard any bills until the hospital has rendered a decision on the application**: A hospital will earn a passing grade if an application included with the submission or a summary included with the submission includes notice to patients that bills may be disregarded until a decision on the application is rendered. A hospital can also earn a passing grade if its policy states that application materials include this notice.
2. **Patients may apply at least 90 days after discharge or receiving service**: A hospital will earn a passing grade on this question if any submitted documents state that patients have 90 days after discharge or receipt of services to apply for financial assistance. A hospital can earn an extra point on this question if it allows for a period of longer than 90 days to apply for assistance.
3. **Patients have at least 20 days to complete an application and supporting documentation**: A hospital will earn a passing grade on this question if any submitted documents state that patients have 20 days to complete an application and provide supporting documentation. A hospital can earn an extra point on this question if it allows for a period of longer than 20 days to complete the application. A hospital will fail this question if it provides less than 20 days, or it does not distinguish between the original application period and the additional 20 day period for completion of the application (i.e., 110 days from discharge or date of service to apply is not an acceptable policy unless it provides an additional 20 days to complete the application).
4. **Application process shall not be unduly burdensome or complex**: A hospital will receive a failing grade on this question if it is clear from its policy or other submitted materials that unnecessary background information or supporting documents are required for processing of an application.

5. **Hospitals shall assist patients in understanding its policies and procedures**: A hospital will earn a passing grade on this question if any submitted documents state that the hospital provides assistance to patients in understanding its financial assistance policy.
6. **Hospitals shall assist patients in applying for discounts**: A hospital will earn a passing grade on this question if any submitted documents state that the hospital provides assistance with applying for financial assistance.
7. **Patient may apply for Medicaid if the hospital judges that a patient may qualify**: A hospital will receive a failing grade on this question if any submitted materials state that all applicants for financial assistance will be required to produce a Medicaid denial letter for their application to be considered.
8. **Decisions regarding applications shall be made by the hospital within 30 days for receipt of a completed application**: A hospital will earn a passing grade on this question if any submitted materials state that it will render a decision on completed applications within 30 days. A hospital will earn an extra point on this question if any submitted materials state that it will render a decision on completed applications in less than 30 days. A hospital will fail this question if its policy is silent on the timeframe with which it will render a decision or if its policy states that a decision will be rendered in a timeframe greater than 30 days. Additionally, statements referring to a hospital making a best effort to render a decision within 30 days are unacceptable, and thus will also result in a hospital receiving a failing grade on this question.
9. **Denial/approval of such application is in writing**: A hospital will earn a passing grade if any submitted materials state that a hospital's decision on applications will be provided to the applicant in writing. If submission is silent, a hospital will receive a failing grade.
10. **Denial contains information on who to appeal the denial**: A hospital will earn a passing grade on this question if any part of the submission states that denials contain information on how to appeal the denial. If a submission is silent, a hospital will receive a failing grade.
11. **Hospital must have an appeals process to evaluate the denial of an application**: A hospital will earn a passing grade on this question if any form of an appeals process is mentioned within its submission. A hospital can earn an extra point on this question if the mentioned appeals process includes a means for external review.

Installment Plans

1. **Installment plans may not have monthly payments exceeding10% of the gross monthly income of the patient**: A hospital will earn a passing grade on this question if its policy states that installment payments will not exceed 10% of the patient's gross monthly income. Because the law explicitly requires the use of installment plans for the payment of

outstanding balances, a hospital will fail this question if its policy is silent on installment plans.

2. **The rate of interest charged on the unpaid balance shall not exceed the rate for a 90-day US Treasury bond, plus 0.5%**: A hospital will earn a passing grade on this question if its policy states that interest on outstanding balances will not exceed the interest rate for a 90-day US Treasury bond plus 0.5%. A hospital can earn an extra point on this question if its policy states that its installment plans are interest free. Because the law explicitly requires the use of installment plans for the payment of outstanding balances, a hospital will fail this question if its policy is silent on installment plans.
3. **No accelerator or similar clause that triggers a higher rate of interest if a payment is missed**: A hospital will pass this question if its policy states that no higher rates of interest will be applied to an account if a payment is missed. Because the law explicitly requires the use of installment plans for the payment of outstanding balances, a hospital will fail this question if its policy is silent on installment plans.

Billing and Collections

1. **Charges to uninsured individuals with incomes below 300% FPL cannot exceed the greater amount paid by Medicaid, Medicare, or the highest volume payor**: To earn a passing grade on this question, a hospital submission must include either: 1) fixed charge amounts for services in relation to income levels and required discount amounts that do not exceed the amount paid by an other payor, or 2) define the payor by which discounted charge are determined.
2. **Hospitals may not force the sale or foreclose of a patient's primary residence to collect an outstanding bill**: A hospital will receive a passing grade on this question if its policy explicitly states that it will not seek sale or foreclosure of a patient's primary residence.
3. **Hospitals may not send an account to collections if the patient has submitted a completed application for financial assistance and the hospital's eligibility determination is pending**: A hospital will receive a passing grade on this question if its policy explicitly states that it will not send an account to collections while an eligibility determination is pending.
4. **There must be written notice on a patient's bill at least 30 days before referring the debt to collections**: A hospital will earn a passing grade on this question if its policy explicitly states that it will not send a patients bill to collections unless there has been a written notice to that effect on a patient's bill at least thirty days prior to sending the account to collections. A hospital can earn an extra point on this question if it provides more than 30 days written notice on a patient's bill before referring the account to collections, or if it prohibits collections to be initiated on any account that has been approved for financial assistance.

5. **The collection agency must obtain the hospital's written consent before commencing legal action**: A hospital will earn a passing grade on this question if its policy explicitly state that contracted collection agencies must obtain prior written approval from the hospital before commencing legal action.
6. **Hospitals shall require any collection agency with which it contracts to comply with the hospital's financial assistance policy**: A hospital will earn a passing grade on this question if its policy explicitly states that the hospital requires all contracted collection agencies to comply with the policy.
7. **Collections are prohibited against any patient who was eligible for Medicaid at the time services were rendered**: A hospital will earn a passing grade on this question if its policy explicitly states that it will not pursue collections against any patient who was eligible for Medicaid at the time services were rendered.
8. **Hospital has mechanism to measure its compliance with its own policies and procedures**: A hospital will earn a passing grade on this question if any submitted documentation makes reference to an internal mechanism to measure compliance with its own financial aid policy.

Consistency within Submission

1. **Consistency within submission**: A hospital will earn a passing grade on this question if there is consistency among all materials submitted to the Department of Health.

Appendix C – Report Card Used to Grade Hospitals

	Criteria			
Eligibility	1. Patients with incomes below 300% of the FPL are presumptively eligible		P/F	
	2. Excludes assets		P+	
	3. Uninsured and underinsured		P+	
	4. No limits on financial aid based on the medical condition of the applicant		P/F	
	5. Clear, objective criteria for determining a patient's ability to pay and for providing adjustments to payment requirements		0	
	6. Shall provide financial aid for emergency hospital services, including emergency transfers pursuant to the federal emergency medical treatment and active labor act (EMTALA), to patients who reside in NYS		P+	
	7. Shall provide financial aid for medically necessary hospital services for patients who reside in the hospital's primary service area as determined by DOH criteria		P+	
	8. Hospital financial aid policies and procedures may extend discounts to other patients, either generally or on a case-by-case basis		5	
Discount Amount	9. Nominal Payment up to 100% FPL		P+	
	10. Sliding fee up to 20% other payor for 101% to 150% FPL		P+	
	11. Sliding fee up to amount paid by other payor for 151% to 250% FPL		P+	
	12. Full amount paid by other payor for 251% to 300% FPL		P+	
	13. If a deposit is required prior to non-emergent, medically-necessary care, such deposit must be included as part of any financial aid consideration		P+	
	14. Financial aid policies and procedures must be applied consistently to all eligible patients.		0	
	15. Hospital financial aid policies may provide greater discounts		5	
Notice to patients	16. Summary must include:		-	
	a. Income levels used to determine eligibility		P/F	
	b. Description of the primary service area		P/F	
	c. How to apply for assistance		P/F	
	17. Every patient is made aware that financial aid may be available and how to obtain further information:		-	
	a. Notification during the intake and registration process		P/F	
	b. Conspicuous posting of language-appropriate information		P/F (E only)	
	c. Information on bills and statements sent to patients		P/F	
	18. All general hospital staff that interact with patients or have responsibility for billing and collections must be trained in the hospital's financial aid policies and procedures.		P/F	
	19. Hospital's collection agency shall providing information to patients on how to apply for financial assistance when appropriate		P/F	
Application, Approval, and Appeal	20. Application materials include a notice to patients that once they submit a completed application and documentation, they may disregard any bills until the hospital has rendered a decision on the application		P/F	
	21. Patients may apply at least 90 days after discharge or receiving service		P+	
	a. Patients have at least 20 days to complete an application and documentation		P+	
	b. Application process shall not be unduly burdensome or complex		P/F	
	c. Hospitals shall assist patients in understanding its policies and procedures		P/F	

	d. Hospitals shall assist patients applying for discounts		P/F	
	22. Patient may have to apply for Medicaid if hospital judges patient may qualify		P/F	
	23. Decisions regarding applications shall be made by the hospital within 30 days of receipt of a completed application		P+	
	a. Denial/approval of such application is in writing		P/F	
	b. Denial contains information on how to appeal the denial		P/F	
	24. Hospital must have an appeals process to evaluate the denial of an application		P+	
	25. Installment plans for the payment of outstanding balances:		-	
Installment plans	a. Monthly payment shall not exceed 10% of the gross monthly income of the patient		P+	
	b. Rate of interest charged on the unpaid balance shall not exceed the rate for a 90-day US Treasury bond plus ½%		P+	
	c. No accelerator or similar clause that triggers a higher rate of interest if a payment is missed		P/F	
	26. Charges to uninsured with incomes below 300% FPL cannot exceed the greater amount paid by Medicaid, Medicare, or the highest volume payor		P/F	
Billing and Collections	28. Hospitals may *not* force the sale or foreclosure of a patient's primary residence to collect on an outstanding bill		P/F	
	29. Hospitals may *not* send an account to collections if the patient has submitted a completed application for financial aid and the hospital's eligibility determination is pending		P/F	
	30. There must be a written notice on the patient's bill at least 30 days before referring the debt to collections		P+	
	31. The collection agency must obtain the hospital's written consent before commencing a legal action		P/F	
	32. Hospital shall require any collection agency it contracts with to comply with the hospital's financial assistance policy		P/F	
	33. Collections are prohibited against any patient who was eligible for Medicaid at the time services were rendered		P/F	
	34. Hospital has mechanism to measure its compliance with its own financial policies and procedures		P/F	
	35. Consistency in Materials/Policies		P/F	

Hospital Financial Assistance Programs: Are New York Hospitals Complying with New Requirements was authored by Charlie Albanetti and edited by Richard Kirsch.