STATE OF NEW YORK
DEPARTMENT OF HEALTH

Corning Tower The Governor Nelson A. Rockefeller Empire State Plaza Albany, New York 12237

Richard F. Daines, M.D.
Commissioner

Wendy E. Saunders
Executive Deputy Commissioner

May 11, 2009
09-05

Dear Hospital Chief Executive Officer:

In a June 22, 2007 letter, the Department requested specific information regarding each hospital's implementation of the Financial Aid legislation (Subdivision 9-a of Section 2807-k of the Public Health Law). The Department has reviewed a sample of financial aid summaries and the financial aid policies and procedures submitted by all hospitals. This letter is written to provide feedback to hospitals on the information received and to clarify expectations regarding certain key elements that such policies must include.

The Department's review identified the following points as most frequently not addressed or not adequately addressed in facility financial aid policies. To assist hospitals with their policy and procedure review, the Department has attached an interpretive guidance document (Attachment A) that outlines requirements and expectations regarding these statutory provisions, a form to inform the Department of a hospital's intention to use assets in eligibility determinations (Attachment B), the 2009 Federal Poverty Level (FPL) guidelines (Attachment C), and a sample application form (Attachment D).

- ***Eligibility*** – For patients whose income is equal to or less than 300% of the FPL, hospitals should assume that patients are eligible for financial assistance through the hospital's program for emergency services for NYS residents, and for all other services, if they reside within the hospital's primary service area. As a result, bills and collection notices must be held until the financial aid paperwork is fully processed and a final determination of eligibility is made.

  For financial aid eligibility purposes, the hospital may ask for verification of residency within the state with regard to emergency services or residency within the hospital's primary service area for non-emergent services.

  Immigration status is not an eligibility criterion under this statute.

- ***Financial Aid Summary*** – Each hospital's financial aid summary must clearly identify the geographic service area within which the facility's financial aid policies will apply for non-emergency services. If the hospital chooses to extend its financial aid policies to the entire state or to an extended geographic area, the hospital's policies and summary should clearly so state. Such summaries must also clearly set forth income limits for determining eligibility for financial aid. In addition, the summary must specifically identify a contact number at

each facility where additional information is available. A specific contact person and a contact number may be identified but at a minimum a contact phone number must be listed.

The full text of the hospital's required summary must be publicly available in hard copy where medical care is provided and at public access points, including the registration and billing offices. In addition, the Department strongly recommends that summaries are posted to a hospital's website.

- ***Application*** - The application must clearly indicate the time frame allowed for patients to submit and complete an application. The minimum time frame allowed for submission of an application under the law is 90 days from the date of service. In addition, patients must be given at least 20 days from the receipt of application materials, for a total of 110 days. Hospitals are free to extend these time frames, but if they do, they should so state in their application forms.

  Eligibility for financial aid is based on current income. The application process utilized by the hospital may not require applicants to consent to extraneous inquiries to the Internal Revenue Service (IRS) as a condition of eligibility. In addition, the hospital may not require that an applicant submit copies of tax returns or other past IRS documentation. Information concerning the applicant's monthly bills is also not relevant to income determinations under the law.

  Hospitals should consider self attestations of income levels in appropriate circumstances or simple application forms, such as the sample provided in Attachment D. As another strategy for reducing or eliminating documentation, hospitals may use credit scoring software for purposes of establishing income eligibility and approving financial assistance, but only if the hospital makes clear to patients that social security numbers are helpful but not mandatory, and the scoring does not negatively impact the patient's FICO. Credit scoring software cannot be used to deny applications for financial aid, and language referring to credit scoring should not appear on financial assistance applications.

  Application materials must 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 written decision on the application. Hospitals may not forward accounts to collection while an application is pending.

  Applications forms for financial aid should be available at any site where medical care is being provided, e.g. clinics and outpatient areas. Hospitals should consider posting financial aid forms to their hospital's website to promote accessibility.

- ***Medicaid or Public Insurance Plan*** – Hospitals that have a reasonable basis for believing that an applicant may be eligible for Medicaid or other government sponsored health insurance coverage may require the applicant to cooperate in applying for such coverage as a condition of receiving financial aid. However, hospitals may *not* require applicants to apply for and be denied benefits from Medicaid or any other public insurance plan prior to accepting and processing an application for financial aid from the hospital. To minimize

delays in making financial aid available, financial aid applications submitted to the hospital should be processed concurrent with any application for public funds.

- ***Assets*** - Under the terms of the statute, hospitals have the option, with the Department's prior approval, of taking assets into account, but only in accord with the following:

    1. The use of an asset test must be set forth and described in writing in the hospital's financial assistance policies and procedures and in the summary information given to potential financial aid applicants.

    2. The use of an assets test requires the prior approval of the Department. Currently only those hospitals which indicated an intention to use assets tests in response to the written survey issued by the Department in December of 2006 have the requisite Department approval and authorization to use an assets test. However, hospitals may contact the Bureau of HCRA Operations and Financial Analysis at 518-474-1673 to gain approval to use assets or to refile/recertify the intent to use assets in financial aid determinations.

    3. Asset tests cannot be used to deny financial assistance, but only to "upgrade" a patient's level of payment obligation, up to the legal maximum permitted under the financial assistance law (i.e. the Maximum Payment Amount (MPA)).

    4. Under the terms of the statute, assets can only be used to "upgrade" the payment obligations of patients with income levels described in subparagraph (i) and (ii) of paragraph (b), that is, patients with incomes up to 150% of the Federal Poverty Level (FPL). Assets may not be used with regard to patients with income levels described in subparagraph (iii) (151% - 250% of FPL) and patients with incomes between 250% and 300% of FPL may already be charged the MPA.

    5. Various categories of assets may not be included in an assets test. These are: an applicant'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.

- ***Financial Aid Information Included on Bills and Statements*** – Information that explains how qualified patients can access financial assistance through the hospital, must be included on bills and statements to patients.

- ***Collection Policies*** – Information about collection practices must be included in a hospital's financial aid policies and procedures. This information was routinely omitted from the reviewed policies. In addition, hospitals should consider the following with respect to collection policies:

    - Hospitals must require any contracted collections agencies to comply with the hospital's financial assistance policy;
    - Contracted collection agencies must provide information to patients on how to apply for financial assistance;

- Hospitals may not force the sale or foreclosure of patient's primary residence to collect on an outstanding bill;
- Hospitals may not send an account to collection if the patient has submitted a completed application for financial assistance and the hospital's eligibility determination is pending;
- A patient bill with a notification that the account will be referred to collections must be sent to the patient at least 30 days prior to referral to a collection agency ;
- Contracted collections agencies must obtain the hospital's written consent before commencing a legal action; and
- Collections are prohibited against any patient who was eligible for Medicaid at the time services were rendered.

- ***Payment Deposits*** – While hospitals are permitted to require deposits from financial aid eligible patients, such requirements must be clearly described in the hospital's policies and in the financial aid information provided to patients. Any such deposit provisions must consider the applicant's ability to pay and must not be an undue obstacle to a financial aid eligible applicant's access to services.

- ***Installment Payment Plans*** - Hospital financial aid policies must include installment payment plans with regard to the patient's remaining payment obligations. Any interest imposed must not exceed what is permitted under the financial aid law and monthly payments may not exceed 10 % of the eligible individual's gross monthly income.

- ***Denial Appeals*** – When a patient is denied financial aid, a hospital is required to issue the denial in writing with information on how to appeal the denial. The hospital's financial aid policies and procedures must outline the appeals process under which it will evaluate the denial of an application.

- ***Training*** – Hospital staff that interacts with patients, especially those in billing and collections, must receive training about the hospital's financial aid policies and procedures.

- ***Signs***– For hospitals with 24-hour emergency departments, conspicuous posting of language appropriate information is required in public care as such as waiting rooms, outpatient clinics, billing and Medicaid offices. For specialty hospitals, posting of language appropriate information is strongly encouraged. The Department has developed a poster in multiple languages that may be used to satisfy this requirement. The poster can be accessed on the Department's Health Provider Network (HPN) at the following link: https://commerce.health.state.ny.us/hpn/hco/hospitalguide.shtml.

Enforcement

Complaints about a hospital's financial aid program are received by the Department's Centralized Complaint hotline at 800-804-5447 and reviewed by staff within the Division of Certification and Surveillance. Staff will work with both the hospital and complainant to address and to remedy identified concerns.

An amendment to the financial aid statute was enacted as part of the SFY 2008-09 State budget. This amendment, which is contained in a new paragraph (k) added to the statute, provides that if the Department determines that it will be unable to secure needed federal approvals for conditioning hospital indigent care pool payments on compliance with the provisions of the financial aid law, then the Department may deem that part of the statute null and void and, in its place, impose civil penalties of up to $10,000 for each failure to comply with the provisions of the financial aid law. The Department has determined that it is necessary to invoke this statutory option, effective January 1, 2009, and accordingly on and after that date violations of the FA statute will make facilities subject to such civil penalties.

It is expected that each facility will review/amend, as appropriate, its financial aid policies to conform to the elements outlined above. Policies found to be inconsistent with the information detailed in this letter are non-compliant with State law. Should you have any questions regarding the information provided in this letter or specific to the obligations of each hospital, please contact Ruth Leslie at 518 402-1003 or RWL01@health.state.ny.us.

Sincerely,

James W. Clyne, Jr.
Deputy Commissioner
Office of Health Systems Management

Attachments

Attachment A
DOH Interpretation of Subdivision 9-a of PHL Section 2807-K

The text of the financial aid law is set forth below, section by section, and the Department's interpretive guidelines each part of the statute are set forth in red.

Section	Statutory Language	DOH Interpretation
9-a. (a)	As a condition for participation in pool distributions authorized pursuant to this section and section twenty-eight hundred seven-w of this article for periods on and after January first, two thousand nine, general hospitals shall, effective for periods on and after January first, two thousand seven, establish financial aid policies and procedures, in accordance with the provisions of this subdivision, for reducing charges otherwise applicable to low-income individuals without health insurance, or who have exhausted their health insurance benefits, and who can demonstrate an inability to pay full charges, and also, at the hospital's discretion, for reducing or discounting the collection of co-pays and deductible payments from those individuals who can demonstrate an inability to pay such amounts.	These provisions impose upon facilities an obligation to implement a financial aid program. As of January 1, 2007, it is expected that each hospital within New York State will have developed policies and procedures that will offer financial assistance to the following: (a) low income patients with no health insurance; or (b) low income patients who have exhausted their insurance benefits; or (c) low income patients who have an inability to pay co-pays and deductible amounts, at the hospital's discretion. Under this paragraph, hospitals are legally obliged to make financial assistance available to patients who have no health insurance or who have "exhausted" their insurance coverage, meaning that the insurance company has put a monetary or utilization cap on available benefits in a given year, and the patient is unable to receive further coverage. The hospital's determinations of financial assistance eligibility should be based on the patient's current level of income. Hospitals are encouraged to extend financial aid to patients who have insurance but who can demonstrate an inability to pay required co-pays and deductibles. Through the adoption of PHL 2807 9-a (k), the Department may impose civil penalties of up to $10,000 for each failure to comply with the provisions of the financial aid law, as per page 5 of this letter.
9-a (b)	Such reductions from charges for uninsured patients with incomes below at least three hundred percent of the federal poverty level shall result in a charge to such individuals that does not exceed the greater of the amount that would have been paid for the same services by the "highest volume	For individuals with incomes at or below the 300% of the Federal Poverty Level (FPL), medical charges must not exceed the higher of the amount that would be paid to the hospital for the same services by Medicaid, Medicare or by the hospital's "highest volume payor", as defined by

	payor" for such general hospital as defined in subparagraph (v) of this paragraph, or for services provided pursuant to title XVIII of the federal social security act (medicare), or for services provided pursuant to title XIX of the federal social security act (medicaid), and provided further that such amounts shall be adjusted according to income level as follows:	subparagraph (v) below. This amount is the "maximum payment amount" (MPA) for any patient covered by the hospital's financial aid policies and procedures.
9-a (b)(i)	For patients with incomes at or below at least one hundred percent of the federal poverty level, the hospital shall collect no more than a nominal payment amount, consistent with guidelines established by the commissioner	For patients with incomes at or below 100% of the FPL, the hospital may not charge more than the nominal amounts established in the Department's February 2006 letter. Those amounts are: • Inpatient Services - $150/Discharge • Ambulatory Surgery - $150/Procedure • MRI Testing - $150/Procedure • Adult ER/Clinic Services - $15/Visit • Prenatal and Pediatric ER/Clinic Services – No Charge A hospital may charge less, but may not charge more than these amounts.
9-a (b)(ii)	For patients with incomes between at least one hundred one percent and one hundred fifty percent of the federal poverty level, the hospital shall collect no more than the amount identified after application of a proportional sliding fee schedule under which patients with lower incomes shall pay the lowest amount. Such schedule shall provide that the amount the hospital may collect for such patients increases from the nominal amount described in subparagraph (i) of this paragraph in equal increments as the income of the patient increases, up to a maximum of twenty percent of the greater of the amount that would have been paid for the same services by the "highest volume payor" for such general hospital, as defined in subparagraph (v) of this paragraph, or for services provided pursuant to title XVIII of the federal social security act (medicare) or for services provided pursuant to title XIX of the federal social security act (medicaid);	For patients whose incomes are between 100% and 150% of the FPL, the hospital must establish a sliding fee schedule that ranges from the nominal payment amount established by the Department up to a maximum of 20% of the applicable MPA.
9-a (b)(iii)	For patients with incomes between at least one hundred fifty-one percent and two hundred fifty percent of the federal poverty level, the hospital shall collect no more than the amount identified after application of a proportional sliding	For patients with incomes between 151% and 250% of the FPL, the hospital must establish a sliding scale fee schedule ranging from 20% of the MPA amount to 100% of the MPA.

	fee schedule under which patients with lower income shall pay the lowest amounts. Such schedule shall provide that the amount the hospital may collect for such patients increases from the twenty percent figure described in subparagraph (ii) of this paragraph in equal increments as the income of the patient increases, up to a maximum of the greater of the amount that would have been paid for the same services by the "highest volume payor" for such general hospital, as defined in subparagraph (v) of this paragraph, or for services provided pursuant to title XVIII of the federal social security act (medicare) or for services provided pursuant to title XIX of the federal social security act (medicaid); and	
9-a (b)(iv)	For patients with incomes between at least two hundred fifty-one percent and three hundred percent of the federal poverty level, the hospital shall collect no more than the greater of the amount that would have been paid for the same services by the "highest volume payor" for such general hospital as defined in subparagraph (v) of this paragraph, or for services provided pursuant to title XVIII of the federal social security act (medicare), or for services provided pursuant to title XIX of the federal social security act (medicaid).	For patients with incomes between 251% and 300% of the FPL, the hospital must not charge more than 100% of the MPA.
9-a (b)(v)	For the purposes of this paragraph, “highest volume payor” shall mean the insurer, corporation or organization licensed, organized or certified pursuant to article thirty-two, forty-two or forty-three of the insurance law or article forty-four of this chapter, or other third party payor, which has a contract or agreement to pay claims for services provided by the general hospital and incurred the highest volume of claims in the previous calendar year.	Definition of highest volume payor.
9-a (b)(vi)	A hospital may implement policies and procedures to permit, but not require, consideration on a case-by-case basis of exceptions to the requirements described in subparagraphs (i) and (ii) of this paragraph based upon the existence of significant assets owned by the patient that should be taken into account in determining the appropriate payment amount for that patient's care, provided, however, that such proposed policies and procedures shall be subject to the prior review and approval of the commissioner and, if approved, shall be included in the hospital's financial assistance policy established pursuant to this section, and	Under the terms of the statute, hospitals have the option of taking assets into account, but only in accord with the following: 1. The use of an asset test must be set forth and described in writing in the hospital's financial assistance policies and procedures and in the summary information given to potential financial aid applicants. 2. The use of an asset test requires the prior approval of the Department. Currently only those hospitals which indicated an intention to use assets tests in response to

	provided further that, if such approval is granted, the maximum amount that may be collected shall not exceed the greater of the amount that would have been paid for the same services by the "highest volume payor" for such general hospital as defined in subparagraph (v) of this paragraph, or for services provided pursuant to title XVIII of the federal social security act (medicare), or for services provided pursuant to title XIX of the federal social security act (medicaid). In the event that a general hospital reviews a patient's assets in determining payment adjustments such policies and procedures shall not consider as assets 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.	the written survey issued by the Department in December of 2006 have the requisite Department approval and authorization to use an assets test. . However, hospitals may contact the Bureau of HCRA Operations and Financial Analysis at 518-474-1673 to gain approval to use assets or to refile/recertify the intent to use assets in financial aid determinations. 3. Asset tests cannot be used to deny financial assistance, but only to "upgrade" a patient's level of payment obligation, up to the legal maximum permitted under the financial assistance law (ie, the MPA). 4. Under the terms of the statute, assets can only be used to "upgrade" the payment obligations of patients with income levels described in subparagraph (i) and (ii) of paragraph (b), that is, patients with incomes up to 150% of the Federal Poverty Level (FPL). Assets may not be used with regard to patients with income levels described in subparagraph (iii) (151% - 250% of FPL) and patients with incomes between 250% and 300% of FPL may already be charged the MPA. 5. Various categories of assets may not be included in an assets test. These are: an applicant'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.
9-a (b)(vii)	Nothing in this paragraph shall be construed to limit a hospital's ability to establish patient eligibility for payment discounts at income levels higher than those specified herein and/or to provide greater payment discounts for eligible patients than those required by this paragraph	Hospitals are encouraged, but not required, to extend their financial aid policies to other individuals who are not mandated as eligible for financial assistance under this statute, but who can nonetheless demonstrate an inability to pay some or all of their medical expenses.
9-a(c)	Such policies and procedures shall be clear, understandable, in writing and publicly available in summary form and each general hospital participating in the pool shall ensure that every patient is made aware of the existence of such policies and procedures and is provided, in a timely manner, with a summary of such policies and procedures upon request. Any summary provided to patients shall, at a minimum, include specific information as to income levels used to determine eligibility for assistance, a description of the primary service	A hospital's summary must be clear and understandable and publicly available. At a minimum, the summary must include: • Specific information as to income levels used to determine eligibility for assistance, • A description of the primary service area of the hospital, and • How to apply for assistance. For all hospitals, the financial assistance summary must be

	area of the hospital and the means of applying for assistance. For general hospitals with twenty-four hour emergency departments, such policies and procedures shall require the notification of patients during the intake and registration process, through the conspicuous posting of language-appropriate information in the general hospital, and information on bills and statements sent to patients, that financial aid may be available to qualified patients and how to obtain further information. For specialty hospitals without twenty-four hour emergency departments, such notification shall take place through written materials provided to patients during the intake and registration process prior to the provision of any health care services or procedures, and through information on bills and statements sent to patients, that financial aid may be available to qualified patients and how to obtain further information. Application materials shall include a notice to patients that upon submission of a completed application, including any information or documentation needed to determine the patient's eligibility pursuant to the hospital's financial assistance policy, the patient may disregard any bills until the hospital has rendered a decision on the application in accordance with this paragraph.	publicly available in the Emergency Department and during the intake and registration process. In addition, for hospitals with 24-hour emergency departments, conspicuous posting of language appropriate information is required in public care as such as waiting rooms, outpatient clinics, billing and Medicaid offices. For specialty hospitals, posting of language appropriate information is strongly encouraged. Further, patient notification of the availability of financial assistance is required to take place during the intake and registration process through the conspicuous posting of language-appropriate information in the general hospital and information on bills and statements sent to patients. To meet the posting requirement, the Department has developed a sign that announces the availability of financial aid in multiple languages. This sign is available on the Department's Health Provider Network (HPN) at the following link: https://commerce.health.state.ny.us/hpn/hco/hospitalguide.shtml. The full text of the hospital's required summary must be publicly available to patients in hard copy where medical care is provided. In addition, the Department strongly recommends that summaries are posted to a hospital's website to promote accessibility. In addition, information that explains how qualified patients can apply for financial assistance must be prominently displayed on all bills and statements sent to patients by the hospital or by any third party employed or contracted by the hospital. The financial aid application must include a notice to patients that once a complete application has been submitted for consideration of eligibility, the applicant can disregard any hospital bills received while the hospital is considering the application. The hospital may not refer an account to a collection agency while a financial aid application is pending.
9-a(d)	Such policies and procedures shall include clear, objective	A hospital's financial assistance policies and procedures

	criteria for determining a patient's ability to pay and for providing such adjustments to payment requirements as are necessary. In addition to adjustment mechanisms such as sliding fee schedules and discounts to fixed standards, such policies and procedures shall also provide for the use of installment plans for the payment of outstanding balances by patients pursuant to the provisions of the hospital's financial assistance policy. The monthly payment under such a plan shall not exceed ten percent of the gross monthly income of the patient, provided, however, that if patient assets are considered under such a policy, then patient assets which are not excluded assets pursuant to subparagraph (vi) of paragraph (b) of this subdivision may be considered in addition to the limit on monthly payments. The rate of interest charged to the patient on the unpaid balance, if any, shall not exceed the rate for a ninety-day security issued by the United States Department of Treasury, plus .5 percent and no plan shall include an accelerator or similar clause under which a higher rate of interest is triggered upon a missed payment. If such policies and procedures include a requirement of a deposit prior to non-emergent, medically-necessary care, such deposit must be included as part of any financial aid consideration. Such policies and procedures shall be applied consistently to all eligible patients.	must include specific criteria for determining a patient's financial eligibility and the level of discount that the patient will receive based on their income and, if applicable, their assets. Policies and procedures should include a description of the discount mechanism applied, such as the sliding fee schedule and payment installment plans available to patients. Payments under the hospital's payment installment plan must not exceed 10% of the patient's gross monthly income. If interest on unpaid balances is to be assessed, a hospital may not charge more than the rate for a ninety-day security issued by the United States Department of Treasury, plus .5 percent. Installment payment limits and applicable interest rates may not be increased based on late or missed payments. Deposits may be required prior to the provision of medically necessary, non-emergency care. However, in no case should the deposit amount serve as a barrier to the receipt of medical care. In determining the amount of deposit, the hospital needs to consider the gross monthly income of the patient and his/her realistic ability to pay the deposit prior to the receipt of care.
9-a(e)	Such policies and procedures shall permit patients to apply for assistance within at least ninety days of the date of discharge or rate of service and provide at least twenty days for patients to submit a completed application. Such policies and procedures may require that patients seeking payment adjustments provide appropriate financial information and documentation in support of their application, provided, however, that such application process shall not be unduly burdensome or complex. General hospitals shall, upon request, assist patients in understanding the hospital's policies and procedures and in applying for payment adjustments. Application forms shall be printed in the "primary languages" of patients served by the general hospital. For the purposes of this paragraph, "primary languages" shall include any language that is either (i) used to communicate, during at	Patients may seek to apply for financial assistance at any time within 90 days of the date of discharge or service. In addition, patients must be given at least 20 days after receiving application materials to submit a completed application, for a total of 110 days. A hospital may request appropriate supporting financial documentation from an applicant. However, hospitals are cautioned that that such documentation requirements must pertain directly to the applicant's current income (and, if applicable, the applicant's non-excludable assets) and must not be "overly burdensome and complex" and an undue barrier to financial assistance. For example, copies of state or federal tax returns should not be required to verify income since they do not directly address current income

	least five percent 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 (ii) spoken by non-English speaking individuals comprising more than one percent 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. Decisions regarding such applications shall be made within thirty days of receipt of a completed application. Such policies and procedures shall require that the hospital issue any denial/approval of such application in writing with information on how to appeal the denial and shall require the hospital to establish an appeals process under which it will evaluate the denial of an application. Nothing in this subdivision shall be interpreted as prohibiting a hospital from making the availability of financial assistance contingent upon the patient first applying for coverage under title XIX of the social security act (medicaid) or another insurance program if, in the judgment of the hospital, the patient may be eligible for medicaid or another insurance program, and upon the patient's cooperation in following the hospital's financial assistance application requirements, including the provision of information needed to make a determination on the patient's application in accordance with the hospital's financial assistance policy.	and may be burdensome to produce. Additionally, information regarding the applicant's monthly bills and other expenses should not be required for purposes of determining income. Hospitals should consider self attestations of income levels in appropriate circumstances. In addition, hospitals may use "soft" credit scoring software that does not negatively impact an applicant's FICO score for purposes of presumptively qualifying an individual for financial aid. At the applicant's request, the hospital must assist the applicant to apply for financial assistance. Applications must be available in the primary languages of the population that utilizes the services of the hospital. The hospital will identify its primary languages during its annual language needs assessment as required by 10NYCRR Section 405.7, using one of the following two criteria. First, primary languages can be defined as the languages used during 5% of the patient visits annually. Second, a primary language can be defined as any language that is spoken by at least 1% of the total population of the hospital's service area. For the purposes of primary language determination, the Department allows the hospital to self-determine their language service area based on their annual needs assessment and to utilize multiple sources of data, including U.S. Census Bureau reports and data from local school systems. Patients should be notified in writing of the approval/denial of their application within 30 days of the hospital's receipt of the completed application. Notifications approving financial aid must include a detailed explanation of what the patient does or will owe and how the amount was derived from an application of the hospital's financial aid policy to the patient's particular situation. Notifications of denial must detail the basis for the denial and include information on how to appeal the denial through the hospital's mandated appeal process.

		Hospitals have the right to require patients who are potentially eligible for Medicaid or other publicly sponsored insurance programs to apply for such coverage as a condition for receipt of financial aid. However, the hospital must have a reasonable, good-faith basis for believing that the patient may be eligible for such coverage and should document the reason for that conclusion in the patient's financial aid application records. An across-the-board requirement that all applicants first apply for Medicaid or other programs is not acceptable.
9-a(f)	Such policies and procedures shall provide that patients with incomes below three hundred percent of the federal poverty level are deemed presumptively eligible for payment adjustments and shall conform to the requirements set forth in paragraph (b) of this subdivision, provided, however, that nothing in this subdivision shall be interpreted as precluding hospitals from extending such payment adjustments to other patients, either generally or on a case-by-case basis. Such policies and procedures shall provide financial aid for emergency hospital services, including emergency transfers pursuant to the federal emergency medical treatment and active labor act (42 USC 1395dd), to patients who reside in New York state and for medically necessary hospital services for patients who reside in the hospital's primary service area as determined according to criteria established by the commissioner. In developing such criteria, the commissioner shall consult with representatives of the hospital industry, health care consumer advocates and local public health officials. Such criteria shall be made available to the public no less than thirty days prior to the date of implementation and shall, at a minimum: (i) prohibit a hospital from developing or altering its primary service area in a manner designed to avoid medically underserved communities or communities with high percentages of uninsured residents; (ii) ensure that every geographic area of the state is included in at least one general hospital's primary service area so that eligible patients may access care and financial assistance; and (iii) require the hospital to notify the commissioner upon	For patients who reside in the hospital's primary service area whose income is equal to or less than 300% of the FPL, hospitals should assume that patients are eligible for financial assistance through the hospital's program. As a result, bills and collection notices must be held until the financial aid paperwork is fully processed and a final determination of eligibility is made. Hospitals are encouraged to extend financial assistance to include persons who are not otherwise mandated for such aid under the statute, but who can nonetheless demonstrate financial need. In its February 2007 letter, the Department defined the primary service area (PSA) for each New York State hospital based on the county where the hospital is located and its contiguous counties. The five counties that lack hospitals were assigned to the primary service areas of other nearby hospitals. A hospital is obligated to provide financial assistance to qualified residents of their PSA who are seeking non-emergent, medically necessary care. The Department must be notified if a hospital requests to change their PSA so that the information can be changed on the Department's Hospital Profile website. Revision requests can be directed to the Division of Certification and Surveillance at 518-402-1003 or hospinfo@health.state.ny.us. However, in no case can the hospital change their PSA to exclude areas assigned in the Department's February 2007 letter.

	making any change to its primary service area, and to include a description of its primary service area in the hospital's annual implementation report filed pursuant to subdivision three of section twenty-eight hundred three-l of this article.	
9-a(g)	Nothing in this subdivision shall be interpreted as precluding hospitals from extending payment adjustments for medically necessary non-emergency hospital services to patients outside of the hospital's primary service area. For patients determined to be eligible for financial aid under the terms of a hospital's financial aid policy, such policies and procedures shall prohibit any limitations on financial aid for services based on the medical condition of the applicant, other than typical limitations or exclusions based on medical necessity or the clinical or therapeutic benefit of a procedure or treatment.	Hospitals are encouraged to extend their financial aid policies and procedures to patients who reside in counties outside their assigned PSA, especially if they provide specialty services for which there is limited availability. Hospital policies and procedures may not deny or limit financial assistance for some patients based on how costly their medical conditions are to treat (e.g. cancer or AIDS) but may deny financial aid for treatments the hospital deems medically unnecessary or therapeutically contraindicated.
9-a(h)	Such policies and procedures shall not permit the forced sale or foreclosure of a patient's primary residence in order to collect an outstanding medical bill and shall require the hospital to refrain from sending an account to collection if the patient has submitted a completed application for financial aid, including any required supporting documentation, while the hospital determines the patient's eligibility for such aid. Such policies and procedures shall provide for written notification, which shall include notification on a patient bill, to a patient not less than thirty days prior to the referral of debts for collection and shall require that the collection agency obtain the hospital's written consent prior to commencing a legal action. Such policies and procedures shall require all general hospital staff that interact with patients or have responsibility for billing and collections to be trained in such policies and procedures, and require the implementation of a mechanism for the general hospital to measure its compliance with such policies and procedures. Such policies and procedures shall require that any collection agency under contract with a general hospital for the collection of debts follow the hospital's financial assistance policy, including providing information to patients on how to apply for financial assistance where appropriate. Such policies and procedures shall prohibit collections from a patient who is determined to be eligible for medical	A hospital's policies and procedures may not permit the forced sale of a patient's home to collect debt, either by the hospital directly or by a collection agency retained by the hospital. In addition, an unpaid balance may not be subject to collection procedures or referred to a collection agency while a financial aid application is pending. Prior to referring an account to a collection agency, the hospital must send written notification to the patient at least 30 days in advance, including statements of such proposed actions on their bills. The collection agency must obtain the hospital's written consent for the commencement of each legal action to collect a debt and must follow the hospital's financial aid policy, including notification of patients on how to access the hospital's financial assistance program. The hospital's policies and procedures must further specify that collection action may not be taken against patients who were Medicaid eligible at the time medical services were provided. Hospital staff that interacts with patients, especially those in billing and collections must be trained in the hospital's financial aid policies and procedures. In addition, the hospital must have a system in place to internally monitor

	assistance pursuant to title XIX of the federal social security act at the time services were rendered and for which services Medicaid payment is available.	its compliance with such policies and procedures.
9-a(i)	Reports required to be submitted to the department by each general hospital as a condition for participation in the pools, and which contain, in accordance with applicable regulations, a certification from an independent certified public accountant or independent licensed public accountant or an attestation from a senior official of the hospital that the hospital is in compliance with conditions of participation in the pools, shall also contain, for reporting periods on and after January first, two thousand seven: (i)a report on hospital costs incurred and uncollected amounts in providing services to eligible patients without insurance, including the amount of care provided for a nominal payment amount, during the period covered by the report; (ii)hospital costs incurred and uncollected amounts for deductibles and coinsurance for eligible patients with insurance or other third-party payor coverage; (iii) the number of patients, organized according to United States postal service zip code, who applied for financial assistance pursuant to the hospital's financial assistance policy, and the number, organized according to United States postal service zip code, whose applications were approved and whose applications were denied; (iv) the reimbursement received for indigent care from the pool established pursuant to this section; (v) 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; (vi)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 title IX of the social security act (medicaid) that the hospital assisted patients in completing and the number denied and approved; (vii)the hospital's financial losses resulting from services provided under medicaid; and	The reporting requirements outlined in i-vii of subsection (i) are all elements of the Institutional Cost Report (ICR)'s Exhibit 50. By completing Exhibit 50 as directed as part of the ICR, hospitals will satisfy the requirements of Section (i).

	(viii) the number of liens placed on the primary residences of patients through the collection process used by a hospital.	
9-(j)	Within ninety days of the effective date of this subdivision each hospital shall submit to the commissioner a written report on its policies and procedures for financial assistance to patients which are used by the hospital on the effective date of this subdivision. Such report shall include copies of its policies and procedures, including material that is distributed to patients, and a description of the hospital's financial aid policies and procedures. Such description shall include the income levels of patients on which eligibility is based, the financial aid eligible patients receive and the means of calculating such aid, and the service area, if any, used by the hospital to determine eligibility.	The Department of Health has required hospitals to submit their financial aid policies and procedures on two occasions, before and after the implementation of the law on January 1, 2007. These submissions satisfy the requirement outlined in subsection (j). However, this does not preclude the Department from periodically requiring hospitals to submit current copies of their financial aid policies and procedures, and also the summaries of such policies that are required to be provided to patients. Hospitals that maintain publicly accessible, current copies of their financial aid policies and procedures and related summaries on their internet websites may be excused from providing such information to the Department in the future.
9-a(k)	In the event it is determined by the commissioner that the state will be unable to secure all necessary federal approvals to include, as part of the state's approved state plan under title nineteen of the federal social security act, a requirement, as set forth in paragraph one of this subdivision, that compliance with this subdivision is a condition of participation in pool distributions authorized pursuant to this section and section twenty-eight hundred seven – w of this article, then such condition of participation shall be deemed null and void and, notwithstanding section twelve of this chapter, failure to comply with the provisions of this subdivision by a hospital on and after the date of such determination shall make such hospital liable for a civil penalty not to exceed ten thousand dollars for each such violation. The imposition of such civil penalties shall be subject to the provisions of section twelve – a of this chapter.	Effective January 1, 2009, the Department may assess a fine of up to $10,000 for each failure to comply with the provisions of the financial aid law.

Attachment B

Patient Financial Assistance Asset Test Survey/Attestation
For 2007 and Subsequent Years' Policies and Procedures

Hospital: _____

Operating Certificate Number: _____

(1) Will your hospital take into consideration assets owned by a patient, and/or other legally responsible individuals, which have annual income at or below 150% of the federal poverty level in determining the patient's potential eligibility for financial assistance as specified in Subdivision 9-a(b)(i) & (ii) of Section 2807-k of the NYS Public Health Law? **YES / NO (circle appropriate response)**

(a) If **NO,** STOP here, certify below, and submit.

(b) If **YES**, your hospital is required to comply with conditions which are either statutorily required or, deemed necessary by the Department, to ensure that your hospital's consideration of assets doesn't unduly deny mandated financial assistance for patients in the above referenced low-income categories. Pursuant to Subdivision 9-a(b)(vi) of Section 2807-k of the NYS Public Health Law, you must obtain Department approval to consider assets in your eligibility procedures for patients with annual income at or below 150% of the federal poverty level. This approval shall be granted upon receipt of the following certification attesting that established eligibility policies and procedures related to services rendered on and after January 1, 2007, shall be in full compliance with the below stated conditions.

(2) Approval conditions for hospital consideration of assets in eligibility policies and procedures for mandated financial assistance for patients with annual income at or below 150% of the federal poverty level:

(a) The hospital will not consider as assets a patient's, and/or legally responsible individual's, primary residence, tax deferred or other comparable retirement account savings, college account savings, or cars (and other comparable primary transportation vehicles) regularly used by the patient or, immediate family, in determining potential eligibility for financial assistance.

(b) For the 2007 calendar year, assets which are not required to be disregarded pursuant to (a) above will only be considered if they exceed the asset levels specified in the below referenced chart.

Household Size	**Asset Levels**
One	$4,200
Two	$5,400
Three	$6,600
Four	$6,650
Five	$6,700
Six	$6,800
Seven	$7,650
Eight	$8,500
Each Additional Person	$850

(c) For subsequent calendar years, the hospital will revise the asset levels referenced in (b) above to comply with amended levels which will be annually published by the Department prior to the effective calendar year.

2007 PATIENT FINANCIAL ASSISTANCE ASSET TEST SURVEY
CERTIFICATION

I, (*NAME*: *PLEASE PRINT*) _____, CERTIFY THAT I AM THE CHIEF EXECUTIVE/FINANCIAL OFFICER AND/OR ADMINISTRATOR OF THE HOSPITAL NOTED IN THE BEGINNING OF THIS SURVEY, AND FURTHER CERTIFY TO ALL OF THE FOLLOWING:

THAT THE RESPONSE PROVIDED TO THE QUESTION IN PARAGRAPH (1) OF THIS SURVEY CONFORMS TO THE APPLICABLE POLICIES AND PROCEDURES USED BY OUR HOSPITAL AND, IF OUR RESPONSE WAS YES, SUCH POLICIES AND PROCEDURES WILL BE IN FULL COMPLIANCE WITH THE CONDITIONS SPECIFIED IN PARAGRAPH (2).

SIGNATURE: _____

DATE: _____

TYPE/PRINT NAME: _____

TITLE: _____

HOSPITAL NAME

Attachment C
2009 HHS Poverty Guidelines

Persons in Family or Household	48 Contiguous States and D.C.
1	$10,830
2	14,570
3	18,310
4	22,050
5	25,790
6	29,530
7	33,270
8	37,010
For each additional person, add	3,740

SOURCE: *Federal Register*, Vol. 74, No. 14, January 23, 2009, pp. 4199–4201

Attachment D
Sample Application

Name_____

Address_____

_____

Phone_____

Family size / number in household_____

	Patient Income	Spouse Income
Wages		
Social Security payment		
Unemployment compensation		
Disability		
Workers compensation		
Alimony/child support		
Dividends/interest/rentals		
All other income		
Total		

I affirm that the above information is true, complete, and correct to the best of my knowledge.

Signed_____ Date_____

If you have questions or need help completing this application, call [PERSON OR DEPARTMENT] at [DIRECT NUMBER].

If you have received a bill or bills from the hospital, check here: ____

You do not have to make any payment to the hospital until the hospital sends you a letter with its decision on your application.

Please send completed form and attachments to:
[DEPARTMENT]
[HOSPITAL]
[ADDRESS]