STATE OF NEW YORK

6027

2023-2024 Regular Sessions

IN ASSEMBLY

March 30, 2023

Introduced by M. of A. PAULIN, SEAWRIGHT, REYES, RAMOS, SIMON, EPSTEIN, BICHOTTE HERMELYN, STECK, MITAYNES, McDONOUGH, L. ROSENTHAL, BENEDETTO, FORREST, BURGOS, GONZALEZ-ROJAS, RIVERA, GIBBS, KELLES, THIELE, ZINERMAN, DE LOS SANTOS, JACKSON, JEAN-PIERRE -- read once and referred to the Committee on Health

AN ACT to amend the public health law, in relation to the general hospital indigent care pool; and to repeal certain provisions of such law relating thereto

The People of the State of New York, represented in Senate and Assembly, do enact as follows:

Section 1. Subdivision 9 of section 2807-k of the public health law, as amended by section 17 of part B of chapter 60 of the laws of 2014, is amended to read as follows:

9. In order for a general hospital to participate in the distribution of funds from the pool, the general hospital must [~~implement minimum collection policies and procedures approved~~] **use only the uniform financial assistance policy and form provided** by the commissioner.

§ 2. Subdivision 9-a of section 2807-k of the public health law, as added by section 39-a of part A of chapter 57 of the laws of 2006, paragraph (k) as added by section 43 of part B of chapter 58 of the laws of 2008, is amended to read as follows:

9-a. (a) **(i)** 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~~] **assistance** policies and procedures, in accordance with the provisions of this subdivision, for reducing **hospital** charges otherwise applicable to low-income individuals without **third-party** health [~~insurance~~] **coverage**, or who have [~~exhausted their~~] **third-party** health [~~insurance benefits~~] **coverage that does not cover or limits coverage of the service**, and who

EXPLANATION--Matter in *italics* (underscored) is new; matter in brackets [-] is old law to be omitted.

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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. **Immigration status shall not be an eligibility criterion for the purpose of determining financial assistance under this section.**

(ii) A general hospital may use the New York state of health marketplace eligibility determination page to establish the patient's household income and residency in lieu of the financial application form, provided it has secured the consent of the patient. A general hospital shall not require a patient to apply for coverage through the New York state of health marketplace in order to receive care or financial assistance.

(iii) Upon submission of a completed application form, the patient is not liable for any bills until the general hospital has rendered a decision on the application in accordance with this subdivision.

(b) [~~Such~~] **The** reductions from charges for [~~uninsured~~] patients **described in paragraph (a) of this subdivision** with incomes below [~~at least three~~] **six** 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 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~~] **XVIII** of the federal social security act [~~(medicaid)~~] **(medicare)**, and provided further that such [~~amounts~~] **amount** shall be adjusted according to income level as follows:

(i) For patients with incomes at or below [~~at least one~~] **two** 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[~~;~~]**.**

(ii) For patients with incomes [~~between at least one~~] **above two** hundred [~~one~~] percent and [~~one~~] **up to four** 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~~] **The** schedule shall provide that the amount the hospital may collect for [~~such patients~~] **the patient** 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~~] **XVIII** of the federal social security act [~~(medicaid);~~] **(medicare).**

(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 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~~

~~(iv)~~] For patients with incomes [~~between at least two hundred fifty-one percent and three hundred~~] **above four hundred percent and up to six 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~~] **XVIII** of the federal social security act [~~(medicaid)~~] **(medicare)**.

[~~(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.~~

~~(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 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.~~

~~(vii)~~] **(c)** Nothing in this [~~paragraph~~] **subdivision** 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~~] **subdivision**.

[~~(c)~~] **(d)** 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~~] **the** policies and procedures and is provided, in a timely manner, with a summary **and a copy** of [~~such policies and procedures~~] **the policy and form** 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 area of the hospital and the means of

applying for assistance. [~~For general hospitals with twenty-four hour emergency departments, such policies and procedures~~] A general hospital shall [~~require the notification of patients~~] notify patients by providing written materials to patients or their authorized representatives during the intake and registration process, through the conspicuous posting of language-appropriate information in the general hospital, and by including information on bills and statements sent to patients, that financial [~~aid~~] assistance 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~~] General hospitals shall post the financial assistance application policy, procedures and form, and a summary of the policy and procedures, in a conspicuous location and downloadable form on the general hospital's website.

[~~(d) Such~~] (e) The hospital's application materials shall include a notice to patients that upon submission of a completed application form, the patient shall not be liable for any bills until the general hospital has rendered a decision on the application in accordance with this subdivision. The application materials shall include specific information as the income levels used to determine eligibility for financial assistance, a description of the primary service area of the hospital and the means to apply for assistance. Nothing in this subdivision shall be construed as precluding the use of presumptive eligibility determinations by hospitals on behalf of patients. The policies and procedures shall include clear, objective 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~~] five 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~~]. Installment plan payments may not be required to begin before one hundred eighty days after the date of the service or discharge, whichever is later. The policy shall allow the patient and the hospital to mutually agree to modify the terms of an installment plan. 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~~] two percentum per annum 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~~] The policies and procedures shall not 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~~]. The hospital shall refund any payments made by the patient before the determination of eligibility for financial assistance that exceeds the patient's liability after discounts are applied. Such policies and procedures shall be applied consistently to all eligible patients.

[~~(e) Such policies and procedures shall permit patients to~~] (f) In any legal action by or on behalf of a hospital to collect a medical debt, the complaint shall be accompanied by an affidavit by the hospital's chief financial officer stating that on information and belief the patient does not meet the income or residency criteria for financial assistance. Patients may apply for financial assistance [~~within at least ninety days of the date of discharge or date of service and provide at least twenty days for patients to submit a completed application~~] at any time during the collection process, including after the commencement of a medical debt court action or upon the plaintiff obtaining a default judgment. A hospital may use credit scoring software for the purposes of establishing income eligibility and approving financial assistance, but only if the hospital makes clear to the patient that providing a social security number is not mandatory and the scoring does not negatively impact the patient's credit score. However, credit scoring software shall not be solely relied upon by the hospital in denying a patient's application for financial assistance. [~~Such~~] The policies and procedures [~~may require that~~] shall allow patients seeking [~~payment adjustments~~] financial assistance to provide [~~appropriate~~] the following financial information and documentation in support of their application[~~, provided, however, that such application process shall not be unduly burdensome or complex~~]: pay checks or pay stubs; unemployment documentation; social security income; rent receipts; a letter from the patient's employer attesting to the patient's gross income; or, if none of the aforementioned information and documentation are available, a written self-attestation of the patient's income may be used. General hospitals shall, upon request, assist patients in understanding the hospital's application and form, policies and procedures and in applying for payment adjustments. Application forms shall be printed and posted to its website 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 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~~] The policies and procedures shall require that the hospital issue any [~~denial/approval~~] denial or approval of [~~such~~] the 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~~] The hospital shall inform patients on how to file a complaint against the hospital or a debt collector that is contracted on behalf of the hospital regarding the patient's bill.

[~~(f) Such~~] (g) The policies and procedures shall provide that patients with incomes below [~~three~~] six 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~~] The policies and procedures shall provide financial [~~aid~~] assistance 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~~] the criteria, the commissioner shall consult with representatives of the hospital industry, health care consumer advocates and local public health officials. [~~Such~~] The 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 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.

[~~(g)~~] (h) 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~~] assistance under the terms of a hospital's financial [~~aid~~] assistance policy, [~~such~~] the policies and procedures shall prohibit any limitations on financial [~~aid~~] assistance 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.

[~~(h) Such policies and procedures shall not permit the forced~~] (i) A hospital or its agent shall not issue, authorize or permit an income execution of a patient's wages, secure a lien or force a 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~~] not send an account to collection if the patient has submitted a completed application for financial [~~aid, including any required supporting documentation~~] assistance, while the hospital determines the patient's eligibility for [~~such aid~~] financial assistance. [~~Such~~] The

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~~] **The** policies and procedures shall require all general hospital staff who interact with patients or have responsibility for billing and collections to be trained in [~~such~~] **the** policies and procedures, and require the implementation of a mechanism for the general hospital to measure its compliance with [~~such~~] **the** policies and procedures. [~~Such~~] **The** policies and procedures shall require that any collection agency**, lawyer or firm** 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~~] **The** policies and procedures shall prohibit collections from a patient who is determined to be eligible for medical assistance [~~pursuant to title XIX of the federal social security act~~] **under title eleven of article five of the social services law** at the time services were rendered and for which services medicaid payment is available.

[~~(i)~~] **(j)** 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,~~] **shall contain: (i)** 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)~~] **(ii)** a report on hospital costs incurred and uncollected amounts in providing services to [~~eligible~~] patients [~~without insurance~~] **found eligible for financial assistance**, including the amount of care provided for a nominal payment amount, during the period covered by the report;

[~~(ii)~~] **(iii)** hospital costs incurred and uncollected amounts for deductibles and coinsurance for eligible patients with insurance or other third-party payor coverage;

[~~(iii)~~] **(iv)** the number of patients, organized according to United States postal service zip code, **race, ethnicity and gender,** who applied for financial assistance [~~pursuant to~~] **under** the hospital's financial assistance policy, and the number, organized according to United States postal service zip code, **race, ethnicity and gender,** whose applications were approved and whose applications were denied;

[~~(iv)~~] **(v)** the reimbursement received for indigent care from the pool established [~~pursuant to~~] **under** this section;

[~~(v)~~] **(vi)** the amount of funds that have been expended on [~~charity care~~] **financial assistance** 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~~] **the** bequests or trusts;

[~~(vi)~~] **(vii)** 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 **for medicaid** under title [~~XIX of the social security act (medicaid)~~] **eleven of article five of the social services law** that the hospital assisted patients in completing and the number denied and approved;

[~~(vii)~~] **(viii)** the hospital's financial losses resulting from services provided under medicaid; and

[~~(viii)~~] (ix) the number of referrals to collection agents or contracted external collection vendors, court cases and liens placed on [~~the primary~~] any residences of patients through the collection process used by a hospital.

[~~(j)~~] (k) Within ninety days of the effective date of the chapter of the laws of two thousand twenty-three which amended 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~~] as of such effective date [~~of this subdivision~~]. Such report shall include copies of its policies and procedures, including material which 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.

[~~(k)~~] (l) The commissioner shall include the data collected under paragraph (j) of this subdivision in regular audits of the annual general hospital institutional cost report.

(m) In the event [~~it is determined by the commissioner that~~] the state [~~will be~~] is 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~~]. Notwithstanding section twelve of this chapter, failure to comply with [~~the provisions of~~] this subdivision by a general hospital [~~on and after the date of such determination~~] shall make [~~such~~] the hospital liable for a civil penalty not to exceed ten thousand dollars for each [~~such~~] violation. The imposition of [~~such~~] the civil penalties shall be subject to [~~the provisions of~~] section twelve-a of this chapter.

(n) A hospital or its collection agents shall not report adverse information about a patient to a consumer or financial reporting entity, or commence civil action against a patient or delegate a collection activity to a debt collector for nonpayment for one hundred eighty days after the first post-service bill is issued; and a hospital shall not report adverse information to a consumer reporting agency, or commence a civil action against a patient or delegate a collection activity to a debt collector, if: the hospital was notified that an appeal or a review of a health insurance decision is pending within the immediately preceding sixty days; or the patient has a pending application for or qualified for financial assistance. A hospital shall report the fulfillment of a patient's payment obligation within thirty days after the obligation is fulfilled to a consumer or financial reporting entity to which the hospital had reported adverse information about the patient.

§ 3. Subdivision 9-a of section 2807-k of the public health law as amended by section two of this act, is amended to read as follows:

9-a. (a) (i) 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~~] twenty-five, adopt and implement the uniform financial assistance [~~policies and procedures,~~

~~in accordance with the provisions of this subdivision,~~] form and policy, to be developed and issued by the commissioner. General hospitals shall implement the uniform policy and form for reducing hospital charges and charges for affiliated providers otherwise applicable to low-income individuals without third-party health coverage, or who have third-party health coverage that does not cover or limits coverage of the service, 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. Immigration status shall not be an eligibility criterion for the purpose of determining financial assistance under this section. As used in this section, "affiliated provider" means a provider that is: (A) employed by the hospital; (B) under a professional services agreement with the hospital; or (C) a clinical faculty member of a medical school or other school that trains individuals to be providers and that is affiliated with the hospital or health system.

(ii) A general hospital may use the New York state of health marketplace eligibility determination page to establish the patient's household income and residency in lieu of the financial application form, provided it has secured the consent of the patient. A general hospital shall not require a patient to apply for coverage through the New York state of health marketplace in order to receive care or financial assistance.

(iii) Upon submission of a completed application form, the patient is not liable for any bills until the general hospital has rendered a decision on the application in accordance with this subdivision.

(b) The reductions from charges for patients described in paragraph (a) of this subdivision with incomes below six hundred percent of the federal poverty level shall result in a charge to such individuals that does not exceed the amount that would have been paid for the same services provided pursuant to title XVIII of the federal social security act (medicare), and provided further that such amount shall be adjusted according to income level as follows:

(i) For patients with incomes at or below two 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.

(ii) For patients with incomes above two hundred percent and up to four hundred 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. The schedule shall provide that the amount the hospital may collect for the patient 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 amount that would have been paid for the same services provided pursuant to title XVIII of the federal social security act (medicare).

(iii) For patients with incomes above four hundred percent and up to six hundred percent of the federal poverty level, the hospital shall collect no more than the amount that would have been paid for the same services provided pursuant to title XVIII of the federal social security act (medicare).

(c) Nothing in this subdivision 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 subdivision.

(d) [~~Such policies and procedures shall be clear, understandable, in writing and publicly available in summary form and each~~] **Each** general hospital participating in the pool shall ensure that every patient is made aware of the existence of [~~the policies and procedures~~] **the uniform financial assistance form and policy** and is provided, in a timely manner, with [~~a summary and~~] a copy of the policy and form 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 area of the hospital and the means of applying for assistance.~~] A general hospital shall notify patients by providing written materials to patients or their authorized representatives during the intake and registration process, through the conspicuous posting of language-appropriate information in the general hospital, and by including information on bills and statements sent to patients, that financial assistance may be available to qualified patients and how to obtain further information. General hospitals shall post the **uniform** financial assistance application policy[~~, procedures~~] and form, and a summary of the policy [~~and procedures~~], in a conspicuous location and downloadable form on the general hospital's website. **The commissioner shall post the uniform financial assistance form and policy in downloadable form on the department's hospital profile page or any successor website.**

(e) The [~~hospital's~~] **commissioner shall provide application materials to general hospitals, including the uniform financial assistance application form and policy. These** application materials shall include a notice to patients that upon submission of a completed application form, the patient shall not be liable for any bills until the general hospital has rendered a decision on the application in accordance with this subdivision. The application materials shall include specific information as the income levels used to determine eligibility for financial assistance, a description of the primary service area of the hospital and the means to apply for assistance. Nothing in this subdivision shall be construed as precluding the use of presumptive eligibility determinations by hospitals on behalf of patients. The [~~policies and procedures~~] **uniform application form and policy** shall include clear, objective 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~~] **the uniform policy** 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 five percent of the gross monthly income of the patient. Installment plan payments may not be required to begin before one hundred eighty days after the date of the service or discharge, whichever is later. The policy shall allow the patient and the hospital to mutually agree to modify the terms of an installment plan. The rate of interest charged to the patient on the unpaid balance, if any, shall not exceed two percentum per annum and no plan shall include an accelerator or similar clause under which a higher rate of interest is triggered upon a missed payment. The [~~policies and procedures~~] **uniform policy** shall not include a requirement of a deposit prior to medically-necessary care. The hospital shall refund any payments made

by the patient before the determination of eligibility for financial assistance that exceeds the patient's liability after discounts are applied. Such policies and procedures shall be applied consistently to all eligible patients.

(f) In any legal action by or on behalf of a hospital to collect a medical debt, the complaint shall be accompanied by an affidavit by the hospital's chief financial officer stating that on information and belief the patient does not meet the income or residency criteria for financial assistance. Patients may apply for financial assistance at any time during the collection process, including after the commencement of a medical debt court action or upon the plaintiff obtaining a default judgment. A hospital may use credit scoring software for the purposes of establishing income eligibility and approving financial assistance, but only if the hospital makes clear to the patient that providing a social security number is not mandatory and the scoring does not negatively impact the patient's credit score. However, credit scoring software shall not be solely relied upon by the hospital in denying a patient's application for financial assistance. The [~~policies and procedures~~] **uniform policy and form** shall allow patients seeking financial assistance to provide the following financial information and documentation in support of their application: pay checks or pay stubs; unemployment documentation; social security income; rent receipts; a letter from the patient's employer attesting to the patient's gross income; or, if none of the aforementioned information and documentation are available, a written self-attestation of the patient's income may be used. General hospitals shall, upon request, assist patients in understanding the [~~hospital's application and form, policies and procedures~~] **uniform financial assistance application form and policy** and in applying for payment adjustments. [~~Application forms shall be printed and posted~~] **The commissioner shall translate the uniform financial assistance application form and policy into the "primary languages" of each general hospital. Each general hospital shall print and post these materials** to its website 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 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. The [~~policies and procedures~~] **uniform financial assistance policy** shall require that the hospital issue any denial or approval of the 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. The hospital shall inform patients on how to file a complaint against the hospital or a debt collector that is contracted on behalf of the hospital regarding the patient's bill.

(g) The [~~policies and procedures~~] **uniform financial assistance policy** shall provide that patients with incomes below six hundred percent of the federal poverty level are deemed 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. The [~~policies and procedures~~] **uniform policy** shall provide financial assistance 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 the criteria, the commissioner shall consult with representatives of the hospital industry, health care consumer advocates and local public health officials. The 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 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.

(h) 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 assistance under the terms of [~~a hospital's~~] **the uniform** financial assistance policy, the [~~policies and procedures~~] **financial assistance policy** shall prohibit any limitations on financial assistance 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.

(i) A hospital or its agent shall not issue, authorize or permit an income execution of a patient's wages, secure a lien or force a sale or foreclosure of a patient's primary residence in order to collect an outstanding medical bill and shall not send an account to collection if the patient has submitted a completed application for financial assistance, while the hospital determines the patient's eligibility for financial assistance. The [~~policies and procedures~~] **uniform policy** 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. The [~~policies and procedures~~] **uniform policy** shall require all general hospital staff who interact with patients or have responsibility for billing and collections to be trained in the [~~policies and procedures~~] **policy**, and require the implementation of a mechanism for the general hospital to measure its compliance with the [~~policies and procedures~~] **policy**. The [~~policies and procedures~~] **uniform policy** shall require that any collection agency, lawyer or firm under contract with a general hospital for the collection of debts follow the [~~hospital's~~] **uniform** financial assistance policy, including providing information to patients on how to apply for financial assistance where appropriate. The [~~policies and procedures~~] **uniform policy** shall prohibit collections

from a patient who is determined to be eligible for medical assistance under title eleven of article five of the social services law at the time services were rendered and for which services medicaid payment is available.

(j) Reports required to be submitted to the department by each general hospital as a condition for participation in the pools shall contain:

(i) 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;

(ii) a report on hospital costs incurred and uncollected amounts in providing services to patients found eligible for financial assistance, including the amount of care provided for a nominal payment amount, during the period covered by the report;

(iii) hospital costs incurred and uncollected amounts for deductibles and coinsurance for eligible patients with insurance or other third-party payor coverage;

(iv) the number of patients, organized according to United States postal service zip code, race, ethnicity and gender, who applied for financial assistance under the [~~hospital's~~] uniform financial assistance policy, and the number, organized according to United States postal service zip code, race, ethnicity and gender, whose applications were approved and whose applications were denied;

(v) the reimbursement received for indigent care from the pool established under this section;

(vi) the amount of funds that have been expended on financial assistance 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 the bequests or trusts;

(vii) 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 for medicaid under title eleven of article five of the social services law that the hospital assisted patients in completing and the number denied and approved;

(viii) the hospital's financial losses resulting from services provided under medicaid; and

(ix) the number of referrals to collection agents or contracted external collection vendors, court cases and liens placed on any residences of patients through the collection process used by a hospital.

(k) [~~Within ninety days of the effective date of the chapter of the laws of two thousand twenty-three which amended 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 as of such effective date. Such report shall include copies of its policies and procedures, including material which 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.~~

~~(l)~~] The commissioner shall include the data collected under paragraph (j) of this subdivision in regular audits of the annual general hospital institutional cost report.

[~~(m)~~] (l) In the event the state is 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

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. Notwithstanding section twelve of this chapter, failure to comply with this subdivision by a general hospital shall make the hospital liable for a civil penalty not to exceed ten thousand dollars for each violation. The imposition of the civil penalties shall be subject to section twelve-a of this chapter.

[~~(n)~~] **(m)** A hospital or its collection agents shall not report adverse information about a patient to a consumer or financial reporting entity, or commence civil action against a patient or delegate a collection activity to a debt collector for nonpayment for one hundred eighty days after the first post-service bill is issued; and a hospital shall not report adverse information to a consumer reporting agency, or commence a civil action against a patient or delegate a collection activity to a debt collector, if: the hospital was notified that an appeal or a review of a health insurance decision is pending within the immediately preceding sixty days; or the patient has a pending application for or qualified for financial assistance. A hospital shall report the fulfillment of a patient's payment obligation within thirty days after the obligation is fulfilled to a consumer or financial reporting entity to which the hospital had reported adverse information about the patient.

§ 4. Subdivision 14 of section 2807-k of the public health law is REPEALED and subdivisions 15, 16 and 17 are renumbered subdivisions 14, 15 and 16.

§ 5. This act shall take effect immediately; provided that (a) section two of this act shall take effect on the one hundred twentieth day after it shall have become a law; and (b) sections one and three of this act shall take effect October 1, 2024 and apply to funding distributions made on or after January 1, 2025. Effective immediately, the commissioner of health may make regulations and take other actions reasonably necessary to implement sections one, two and three of this act on their respective effective dates.