

Hospitals' Commitment to Charity Care

In 2006, as part of the enacted State budget, New York's hospital community helped to establish minimum requirements for providing charity care and financial assistance to uninsured and low-income patients. As a result, as of January 1, 2007, hospitals in New York State will be required to cap fees to low-income uninsured patients in order to continue to receive State uncompensated care funding. The new policy reflects a continuing tradition of public and not-for-profit hospitals' deep commitment to providing charity care. This issue of *Health Care News In-Depth* looks at New York State's requirements for hospitals' financial assistance policies, hospital expenditures on charity care, and the recent focus of various government bodies on the tax-exempt sector.

New York State's not-for-profit and public hospitals provide an extraordinary amount of care to uninsured and underinsured patients. The Aug. 8, 2005, issue of *Health Care News In-Depth* presented data showing that not-for-profit hospitals are much more likely than for-profit hospitals to provide services that benefit patients, families, and their communities, but that are often performed at a financial loss. According to the NYS Department of Health, in 2004 hospitals in New York State provided \$1.7 billion worth of uncompensated care—which does not even include the more than \$1.5 billion that New York State's hospitals lose annually as a result of insufficient Medicaid payment rates. While New York State provides \$497 million in funding to hospitals to help cover uncompensated care costs (net of the 1% tax the hospitals themselves pay to help fund the State uncompensated care

pool), as well as supplemental support to high-need and rural hospitals, the State subsidies that hospitals receive pale in comparison with the losses they incur caring for the poor and uninsured.

NYS's New Charity Care Law

In 2006 the hospital community and advocacy groups worked with the NYS Legislature to include language in the enacted 2006–07 budget requiring hospitals to establish minimum requirements for providing charity care and financial assistance to uninsured and low-income patients. The requirements must be implemented as of Jan. 1, 2007, as a condition of receiving distributions from the indigent care pool in 2009, and must include provisions for eligibility, maximum payments for eligible patients, notice requirements, applications and appeals, collections, reporting, and certifica-

tion of compliance. A hospital may provide more charity care according to its own policy, as long as statutory minimums are met.

Eligibility: The new law requires hospitals to give financial assistance to uninsured patients and those who have exhausted their insurance benefits who reside in New York State. Hospitals are permitted but not required to offer discounts on the coinsurance and deductible amounts that insured patients owe. For emergency services, including emergency transfers under the Emergency Medical Treatment and Labor Act, all hospitals will have to offer financial assistance to all uninsured New York State residents with income under 300% of the Federal poverty guideline (FPG). For medically necessary, non-emergency services, hospitals will have to offer financial assistance to uninsured patients with incomes below 300% of the FPG who reside in the hospital's primary service area.

Maximum Payments: The hospital's fee to patients who are eligible for financial assistance must be capped at the "applicable rate"—the higher of what Medicare, Medicaid, or the highest-volume commercial payer (the contracted health plan or payer that had the highest volume of use in the hospital during the prior year) will pay for the service. Thus, a hospital can compute payment based on a percentage of charges for outpatient services so long as that amount was below the applicable rate. The hospital can also use different

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Meeting Community Service Needs

In NYS, each voluntary, not-for-profit hospital is required by law to issue a mission statement identifying the communities it serves and its commitment to meeting their health care needs. In addition, at least every three years, each hospital must develop a community service plan by reviewing and amending (as needed) its mission statement; soliciting the views of the communities served as to its performance and service priorities; demonstrating its commitment to meeting the community's health care needs, providing charity care services, and improving access to underserved populations; and preparing a public statement about the financial resources it allocates to hospital purposes, including the provision of free or reduced-charge services.

Each hospital must also prepare, at least annually, an implementation report on its performance in meeting the community's health care needs, providing charity care services, and improving access for the uninsured. All documents must be filed with the NYS Department of Health. ■

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methodologies for inpatient and outpatient services. For example, a hospital can use a percentage of the Medicaid rate for inpatient services and a percentage of charges for outpatient services so long as the amounts were below the applicable rate. Additional payment limits are based on patient income. Patients with an income that is less than or equal to the FPG can be charged only a nominal fee within State guidelines; patients with an income of 101–150% of the FPG can be charged up to 20% of the applicable rate; patients with an income of 151–250% of the FPG will be charged according to a proportional fee scale up to the applicable rate; and the fee charged to patients with an income of 251–300% of the FPG must be capped at the applicable rate.

In addition, hospitals must offer installment plans, which are subject to State caps, for patients living below 300% of the FPG.

Applications & Appeals: Patients must have at least 90 days from the date of discharge or service to apply for financial assistance and at least 20 days to submit a completed application. Hospitals must respond in writing within 30 days of receiving a completed application and must establish an appeals process and inform the patient in writing how to appeal. Hospitals can require patients to first apply for Medicaid or another program such as workers' compensation or no-fault insurance if they believe the patient is eligible.

Hospitals can develop their own application forms as long as they are not unduly burdensome or complex. Application packages must inform patients that, once they submit a completed application with all required documentation, they can disregard any bill they might receive until a decision about their financial assistance has been made.

Notices & Reports: Hospital financial policies will have to be in writing and available in summary form to the public or upon request. All hospital bills and statements must state that patients who are unable to pay a bill might be eligible for financial assistance, and must describe how to obtain information. Hospitals with 24-hour emergency departments must notify patients during intake and registration and by clearly posting language-appropriate information in the hospital. Specialty hospitals

without 24-hour emergency departments must notify patients in writing during intake and registration before services are provided.

Hospitals will be required to report costs incurred and uncollected amounts in providing services to the uninsured and underinsured, including uncollected coinsurance and deductible amounts; number of patients, organized by zip code, who applied for financial assistance, and the number by zip code who were approved and denied; amount of distributions from the hospital indigent care pool; amount spent from charitable funds or bequests established to provide financial assistance to eligible patients as defined by such bequests; if the local social services district in which the hospital was located permits hospitals to help patients complete Medicaid applications, the number of Medicaid applications the hospital helped patients complete and the number approved and denied; and the hospital's gain or loss from providing services under the Medicaid program.

Reviews and Legislation

Despite the rigorous financial assistance policies of not-for-profit and public hospitals—both mandated and self-imposed—the U.S. Senate Finance Committee, the Internal Revenue Service (IRS), and other government bodies have been reviewing hospitals' community benefit practices, charity care and billing policies, and care of the indigent or uninsured.

• In FY 2005, IRS Commissioner Mark Everson ramped up the emphasis on enforcement in the tax-exempt sector. The IRS specified that, in FY 2006, it would focus “potentially on compensation and community benefit standards” in the hospital sector. In 2005, the IRS examined the executive compensation decisions of 1,200 not-for-profit entities, including hospitals. In summer 2006, the IRS began distributing a “Compliance Check Questionnaire” to around 600 tax-exempt hospitals, focusing mainly on their practices related to the IRS's community benefit standard and their process for determining executive compensation.

• From June 2005 to June 2006, the U.S. Government Accountability Office conducted a voluntary survey of executive compensation issues at a sample of private, not-for-profit hospital systems nationwide.

GNYHA Support for Member Compliance Efforts

GNYHA's efforts to help its members understand and comply with tax-exempt rules and regulations include the following: a roundtable discussion on an array of tax-exempt issues; presentations to the GNYHA Board of Directors and Executive Committee; dissemination of materials on tax-exempt issues via e-mails and bulletins; briefings on executive compensation requirements and best practices; briefings on IRS regulations; presentations to individual GNYHA members on tax-exempt developments; and technical support to members regarding IRS and Congressional inquiries. ■

• In March 2006, Senate Finance Committee Chair Senator Charles Grassley (R-Iowa) followed up with the American Hospital Association (AHA) on legislative options the AHA had presented to the Senate Finance staff on Jan. 25, 2006. During the summer of 2006, he called repeatedly for improved regulations governing tax-exempt hospitals and questioned the amount of charity care they provide. On Sept. 13, 2006, Chairman Grassley convened a Finance Committee hearing on the tax-exempt sector that focused entirely on not-for-profit hospitals. He has also sought statements from hospitals about their charity care, billing, and executive compensation practices.

Federal Activity: The Pension Protection Act of 2006 incorporated the following key provisions affecting the not-for-profit sector: an increase in the so-called intermediate sanctions levied on certain individuals who enter into excessively favorable transactions with an exempt organization; enhanced disclosure of certain information about exempt organizations to requesting state officials; extension of current public inspection and disclosure requirements to an exempt organization's unrelated business income-tax returns; and new requirements for supporting organizations and empowering the Secretary of the Treasury to promulgate new regulations requiring distributions of assets. ■

More detailed information on NYS's new charity care policy is available on the Advocacy page of the GNYHA Web site at www.gnyha.org, under State Policy Issues, in the “Charity Care” section.