SB 50 Hospital Financial Assistance Standards Committee

RECOMMENDATIONS

November 7, 2014

Executive Summary

This document contains recommendations developed by the Hospital Financial Assistance Committee established by Senate Bill 14-50. The committee - composed of representatives from the patient advocacy community, hospitals and the Department - was tasked with developing recommendations for uniform standards for hospital billing practices for patients who are low-income and uninsured. The statute requires the committee to submit these recommendations to the Board of Health. Although the statute authorizes the Board to adopt regulations on these issues, it also inadvertently repeals this authority as of December 31, 2014. If regulations regarding financial assistance standards can be established under other statutory authority, the Department anticipates presenting proposed regulations regarding these recommendations in the near future.

Background

Senate Bill 14-50 created the Hospital Financial Assistance Standards Committee to "develop recommendations for uniform standards for the consistent implementation of this section at all Colorado hospitals." The bill amended existing language under section C.R.S. 25-3-112 which requires hospitals to:

- Provide information about financial assistance, charity care and payment plans on the website, in patient waiting areas, prior to discharge if possible, and on the billing statement.
- Charge qualified patients (i.e., uninsured and at or below 250 percent of the federal poverty level) at a discounted rate for certain services.
- Provide a reasonable payment plan and a grace period for the first scheduled payment prior to sending accounts to collections.
- Report errors and omissions as self-reported incidents to the Department.

Committee Charge

The committee was charged with:

- Developing recommendations for uniform standards for all hospitals.
- Submitting recommendations to the state Board of Health (BOH) by December 6, 2014.

Committee Membership

The 7-member committee is composed of three representatives of Colorado hospitals and three representatives of organizations that represent consumers. The committee also had a representative from the Department. The committee membership is shown below:

Name	Title	Organization
Debra Judy	Policy Director	Colorado Consumer Health Initiative
Elisabeth Arenales	Health Care Director	Colorado Center on Law & Policy
Eliana Mastrangelo	Lead Organizer	Together Colorado
Ryan Westrom	Finance Director	Colorado Hospital Association
Stephanie Warth	Revenue Cycle Director	Gunnison Valley Health
Jonathan Wiik	Chief Revenue Officer	Boulder Community Health
Judy Hughes	Senior Branch Chief	CDPHE

BOH Charge

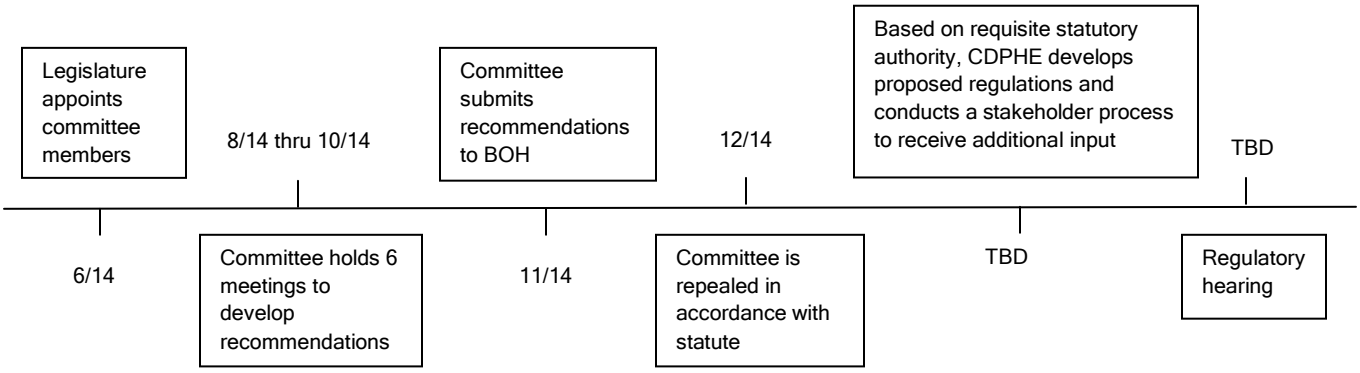
The statute authorizes BOH to adopt rules. C.R.S. § 25-3-112 (7)(c) reads as follows:

> The state board of health may adopt by rule the recommendations for uniform standards made by the hospital financial assistance standards committee to evaluate whether the hospital is in compliance with this section.

However, since the subsection associated with this authorization is repealed effective December 31, 2014, the Department is determining whether regulations on financial standards can be promulgated under other statutory authority.

Timeline

The Executive Director appointed the committee member representing the Department. The remaining members were appointed by the General Assembly. Below is a timeline of committee activities to date as well as projections for regulation development.



Committee Discussion and Recommendations

Issues Discussed. The committee identified the following five issues for establishing uniform standards:

1. Make information about the hospital's financial assistance, charity care and payment plan policies readily accessible.
2. Establish a uniform methodology for calculating the patient's federal poverty level (FPL).
3. Establish a uniform methodology for calculating the "lowest negotiated rate from a private health plan."
4. Inform patients about the availability of a reasonable payment plan.
5. Determine what constitutes a hospital "self reported incident."

Shown below are:

- committee's recommendations, and
- areas identified for further discussion.

Although statutory deadlines require the submission of recommendations to the Board of Health by November, the committee is not repealed until December 31, 2014. The committee anticipates conducting additional discussions to develop recommendations on these issues, and incorporating them as an addendum to this report.

Issue 1. Make information about the hospital's financial assistance, charity care and payment plan policies readily accessible.

Committee Recommendations. Develop proposed regulatory language such as:

- Information about the hospital's financial assistance, charity care, and payment plan policies must be readily accessible on the hospital's website, either on the front page or via a link that is easily understood on the front page. In addition, there shall be either signage or written materials conspicuously displayed in the waiting areas that address how patients can access the hospital's financial assistance, charity care, and payment plan policies and where to direct complaints. Information will be provided in a clear and understandable manner and in languages appropriate to the communities and patients the hospital serves.
- If the hospital applies a discount, the amount of such discount shall be made evident on the billing statement.
- As part of the discharge process, whenever possible, patients shall receive information stating 1) that patients have the right to be informed about financial assistance, charity care, and payment plans, 2) that in accordance with C.R.S. 25-3-112 (1)(d), qualified patients (those who are uninsured and meet certain income requirements) are eligible for financial assistance and a reasonable payment plan, 3) where patients can obtain

information on the website and how to contact financial personnel for assistance, and 4) where patients can direct inquiries or complaints regarding their bill or other related issues.

Areas for Further Discussion. The committee identified the following areas where additional discussion is needed to develop consensus:

- Define "patient waiting areas" to include waiting areas for admissions, the emergency department and the business office or conversely areas that receive and register patient accounts on a regular basis.
- How to provide information on the billing statement, including how to register complaints with the hospital and the Department.

Issue 2. Establish a uniform methodology for calculating the patient's federal poverty level (FPL)

Committee Recommendations. Develop proposed regulatory language such as:

- When calculating a patient's federal poverty level for the purposes of determining whether a patient qualifies for financial assistance, pursuant to C.R.S. 25-3-112 (2), the hospital shall use income and household size, but shall not take into account patient assets.

Issue 3. Establish a uniform methodology for calculating the "lowest negotiated rate from a private health plan"

Committee Recommendations. Develop proposed regulatory language such as:

- The lowest negotiated rate from a private health plan shall be calculated annually, within 6 months of the end of the hospital's fiscal year, using the following methodology or any similar method that achieves the same result:

  a) Takes all claims submitted to a private health plan for the last fiscal year and captures the total dollars on those claims (billed amounts) to those insured, as well as the net reimbursement (paid amounts) made by the health plan.
  b) Determines the annual net reimbursement from the health plan as a percentage (net deduction in revenue) and establishes the net deduction in revenue (NDR) for each payer.
  c) Lists those amounts in a table as shown in the sample table below:

PAYER	BILLED	REIMBURSED	PERCENT NDR
Payer A	$10,000,000	$7,500,500	25%
Payer B	$5,000,000	$2,500,500	50%

Payer C	$10,000,000	$3,000,000	70%

d) Uses the highest percent NDR (i.e., the highest discount) from the table as the lowest negotiated rate from a private health plan in determining the discount required pursuant to C.R.S. 25-3-112 (2). (In the sample table shown above, the highest discount is for Payer C with an NDR of 70%.)

Issue 4. Inform patients about the availability of a reasonable payment plan

Committee Recommendations. Develop proposed regulatory language such as:

- Before initiating collection proceedings a hospital shall offer a qualified patient:
  a) a reasonable payment plan that is negotiated with and agreed to by the patient in accordance with the hospital's policies and procedures. The negotiated plan shall take into account the patient's essential living expenses.
  b) If the hospital and the patient are not able to reach agreement as provided for in paragraph (a) above, the hospital shall offer a monthly payment plan not to exceed 10% of the patient's monthly income, as determined during the calculation of the patient's federal poverty level.

Areas for Further Discussion. The committee identified the following areas where additional discussion is needed to develop consensus:

- Feasibility of preventing undue duress for the patient during the payment plan negotiation process.

Issue 5. Determine what constitutes a hospital "self reported incident"

Committee Recommendations. None.

Areas for Further Discussion. The committee identified the following areas where additional discussion is needed to develop consensus:

- Define self-reported incidents. Possible definitions are:
  a) Any error or omission in the billing process that had a financial or potential financial impact to the patient if such error or omission was not corrected in a timely manner by the hospital.
  b) Systemic failures associated with:
     [1] inadequate provision of public information,
     [2] failure to develop and apply the lowest negotiated rate,
     [3] the incorrect calculation of the eligibility criteria for qualifying patients, and
     [4] inappropriate collection processes.