COLORADO
Department of Public
Health & Environment

Dedicated to protecting and improving the health and environment of the people of Colorado

May 15, 2015

To: Colorado Hospital's Chief Executive Officers

As you may be aware, C.R.S. 25-3-112 in part, requires hospitals to make information available to each patient regarding the hospital's financial assistance, charity care, and payment plan policies. The statute also requires the Department of Public Health and Environment (the department) to periodically review hospitals to ensure compliance to the statute and to investigate valid complaints received by the department regarding individual patients.

As required in the statute, the department convened a Hospital Financial Assistance Standards Committee to develop recommendations for uniform standards for the consistent implementation of the statute. Committee discussions and recommendations were utilized to draft implementation guidance and survey probes for hospitals to consider. The Hospital Financial Assistance Standards Committee's report, the department's guidance for implementing the statute requirements and the authorizing legislation are attached here for reference.

In June, the department will be initiating hospital surveys to assess compliance to statute requirements. These will be scheduled surveys and we will work with hospital's risk management/quality representatives to schedule surveys. Survey findings and complaint investigations will be used to assist with departmental regulation development anticipated in 2016.

We look forward to working with you and your staff regarding compliance to this statute. If you have questions, please contact Cheryl McMahon at 303.692.2588 or cheryl.mcmahon@state.co.us, or contact Margaret Mohan at 303.692.6486 or margaret.mohan@state.co.us.

Respectfully,

D. Randy Kuykendall

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Division Director
Health Facilities and Emergency Medical Services

Date: 05/15/15

Guidance for Implementation of Hospital Financial Assistance Requirements

This document provides guidance for hospitals on the implementation of statutory requirements regarding financial assistance, pending rulemaking before the Board of Health (BOH). Rulemaking on financial hospital assistance will take place in the Fall of 2016 because the current BOH calendar precludes scheduling a hearing until next year. Further, the interim implementation period allows the Department to gather compliance data and use this to target those areas where rules are necessary. Appendix A contains the statutory provisions regarding the Department's oversight authority, for reference.

The financial assistance statute - Section 25-3-112, C.R.S - requires hospitals to:

A. provide financial assistance information for all patients,
B. provide financial assistance screening for uninsured patients,
C. provide discounted billing for "qualified" patients, i.e., uninsured patients that meet certain income criteria,
D. report omissions of required information for all patients and billing errors for qualified patients, and
E. establish certain collection practices for qualified patients.

The statute also created a Hospital Financial Assistance Standards Committee to develop uniform standards for the implementation of hospital financial assistance. Information about the committee is provided in Appendix B.

This following guidance contains:

- statutory provisions pertaining to hospital financial assistance,
- associated survey probes, and
- suggested approaches for compliance based on recommendations made by the Hospital Financial Assistance Standards Committee and the Department. Suggested approaches are only provided where uniformity is deemed to be of value. In recognition that there may not be a "one-size-fits-all" method of achieving compliance, hospitals may implement alternatives to the suggested approaches. Such alternatives must align with the statutory provisions.

A. Financial Assistance Information for All Patients

25-3-112. Hospitals - charges for the uninsured - collections protection - charity care information

C.R.S. 25-3-112 **(1) Each hospital shall make information available to each patient about the hospital's financial assistance, charity care, and payment plan policies. Each hospital shall communicate this information in a clear and understandable manner and in languages appropriate to the communities and patients the hospital serves. The hospital shall:**

(a) Post the information conspicuously on its web site;

Survey probes: Is information about financial assistance, charity care, and payment plan policies conspicuously on the website? Is the information in languages appropriate to the community?

Suggested approach: Information about the hospital's financial assistance, charity care, and payment plan policies is either on the front page or accessible via a link that is easily understood on the front page.

(b) Make the information available in patient waiting areas;

Survey probes: Is information about financial assistance, charity care, and payment plan policies available in patient waiting areas?

Suggested approach: Define "patient waiting areas" to include waiting areas for admissions, the emergency department and the business office; areas that receive and register patient accounts on a regular basis.

(c) Make the information available to each patient, when possible, before the patient's discharge from the hospital; and

Survey probes: How is information about financial assistance, charity care, and payment plan policies made available upon discharge?

Suggested approaches: During admission, have signoff form that notifies patient that the hospital has financial assistance for which they may apply. Also, include discharge packet information about who to call if you cannot afford to pay your bill and the ability to direct questions/ concerns to the Department if your annual family income is at or below 250 FPL.

(d) Inform each patient on each billing statement of his or her rights pursuant to this section and that financial assistance or charity care may be available and, where applicable, provide the website, e-mail address,

and telephone number where the information may be obtained.

Survey probes: Do billing statements inform patients of rights re: financial assistance and charity care and where to obtain this information? Do the statements have information of where to call if they have questions or concerns?

B. Financial Assistance Screening for Uninsured Patients

C.R.S. 25-3-112 (2) *(a) When possible, each hospital shall offer to screen each uninsured patient for eligibility for financial assistance as described by this subsection (2).*

Survey probes: For uninsured patients, did the hospital screen for eligibility for financial assistance and document the result?

C. Discounted Billing for "Qualified" Patients

Each hospital shall offer financial assistance for qualified patients on a community-specific basis. In determining eligibility for financial assistance, each hospital shall, at a minimum, take into consideration federal, state, and local government requirements.

(b) For purposes of this section, a qualified patient is an individual:

(I) Who is uninsured;

(II) Whose annual family income is not more than two hundred fifty percent of the federal poverty guidelines; and

(III) Who received a service at a hospital for which the "Colorado Indigent Care Program" established in part 1 of article 3 of title 25.5, C.R.S., was not available.

Survey probes: Was CICP available to the patient? If no, was financial assistance offered for qualified patients? 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), were only income and household size taken into account? (The hospital cannot take into account patient assets.)

C.R.S. 25-3-112 (3) *A hospital shall limit the amounts charged for emergency or other medically necessary care provided to individuals eligible for assistance under the financial assistance policy described in subsection (2) of this section to not more than the lowest negotiated rate from a private health plan.*

Survey probes: Was the hospital bill for qualified patients for emergency or other medically necessary care no more than the lowest negotiated rate from a private health plan?

Suggested Approaches

Discount on Billing Statement. If the hospital applies a discount for qualified patients, the amount of such discount is provided to the consumer in writing and documented by the hospital.

Calculation of Lowest Negotiated Rate. The lowest negotiated rate from a private health plan is calculated annually, within 6 months of the end of the hospital's fiscal year, using the following methodology:

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%.)

D. Self Reported Incidents: Omission of Required Information for All Patients & Billing Errors for "Qualified" Patients

C.R.S. 25-3-112 *(3.5) If a hospital discovers and omission of required information, incorrect billing, or other noncompliance with this section by the hospital, the hospital shall correct the error or omission, inform the patient, and provide a financial correction consistent with this section to persons affected by the error or omission. The hospital shall inform the department of the*

errors, omissions, and corrective actions taken by the hospital in the same manner and form as the reports required in section 25-1-124.

Suggested approach:

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.

E. Collections Practices for "Qualified" Patients

C.R.S. 25-3-112 *(4) Before initiating collection proceedings, a hospital shall:*

(a) Offer a qualified patient a reasonable payment plan; and

(b) Allow for at least thirty days past the due date of any scheduled payment that is not paid in full. A hospital must allow the thirty-day period only for the first late payment.

(c) A hospital shall not initiate collections proceedings once the hospital is notified that it must submit a corrective action plan or when the hospital is operating pursuant to a corrective action plan pursuant to subsection (3.7) of this section

Survey probes: Were collection proceedings initiated? If so, was a qualified plan offered prior to initiating? Was the first late payment at least 30 days past due?

Suggested approach: Before initiating collection proceedings that result in a report to a credit bureau, a hospital offers 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 takes 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 offers 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.

Appendix A

Department Oversight Authority

(The headings below are not part of the legislation, they are provided for ease of reference.)

Investigation of Self-Reported Incidents
Public Information – Self Reported Incidents and Complaints

(3.5) If a hospital discovers an omission of required information, incorrect billing, or other noncompliance with this section by the hospital, the hospital shall correct the error or omission, inform the patient, and provide a financial correction consistent with this section to the persons affected by the error or omission. The hospital shall inform the department of the errors, omissions, and corrective actions taken by the hospital in the same manner and form as the reports required in section 25-1-124. The department shall not investigate a hospital because that hospital has corrected an error, omission, or noncompliance with this section, unless there is good cause to open an investigation. If the department investigates a self-reported incident, the department shall investigate, document, and identify the self-reported errors, omissions, or noncompliance related to this section as a self-reported incident investigation, and not as a complaint investigation. The department shall make information concerning investigations and complaints available to the public in the same manner as section 25-1-124 (6) and (7). The department shall make hospital self-reported incidents submitted to the department pursuant to this section available to the public upon request.

Complaints and Periodic Reviews

(3.7) (a) If the department receives a valid complaint regarding a hospital's compliance with this section, the department may conduct a review. In addition, the department shall periodically review hospitals to ensure compliance with this section.

Corrective Action Plans

(3.7) (b) If the department finds that a hospital is not in compliance with this section, including the rules adopted pursuant to paragraph (c) of subsection (7) of this section, the department shall notify the hospital, and the hospital has ninety days to file with the department a corrective action plan that includes measures to inform the patient or patients, and provide a financial correction consistent with this section to the persons affected by the noncompliance. A hospital may request up to one hundred twenty days to submit a corrective action plan if necessary. The department may require a hospital that is not in compliance with this section, or with rules adopted pursuant to paragraph (c) of subsection (7) of this section, to develop and operate under a corrective action plan until the hospital is in compliance.

Fines

(c) If a hospital's noncompliance with this section is determined by the department to be knowing or willful, the department may fine the hospital up to five thousand dollars. In addition, if the hospital fails to take corrective action or fails to file a corrective action plan with the department within ninety days, or up to one hundred twenty days if approved by the department, the department may fine the hospital up to five thousand additional dollars. The department shall consider the size of the hospital and the seriousness of the violation in setting the fine amount.

Public Information – Corrective Actions re: Fines
Confidential Information – Lowest Negotiated Rate

(8) The department shall make information available regarding any corrective actions for which fines were imposed pursuant to this section. Any information regarding the lowest negotiated rate provided to the department pursuant to this section is confidential and not a public record.

Date: 05/15/15

Appendix B

Hospital Financial Assistance Standards Committee

Section 25-3-112, C.R.S., created a 7-member committee to develop uniform standards for the implementation of financial assistance requirements by hospitals. The committee was composed of a representative from the Department; three members from organizations that represent consumers; and three representatives of Colorado hospitals to include representation from an urban hospital, a rural hospital and the Colorado Hospital Association. The committee membership is shown below:

Name	Organization	Appointed by:
Judy Hughes	CDPHE	Executive Director, CDPHE
Debra Judy	Colorado Consumer Health Initiative	General Assembly
Elisabeth Arenales	Colorado Center on Law & Policy	General Assembly
Eliana Mastrangelo	Together Colorado	General Assembly
Ryan Westrom	Colorado Hospital Association	General Assembly
Stephanie Warth	Gunnison Valley Health	General Assembly
Jonathan Wiik	Boulder Community Health	General Assembly

The committee was charged with submitting recommendations to the state Board of Health (BOH) by December 6, 2014. BOH was authorized, but not required, to adopt the recommendations as rules. You can access a copy of the committee's report submitted to BOH on the Department website by going to www.healthfacilities.info, clicking on "Engage with us" then on "Advisory meetings" and then on "SB 14-50: Financial Assistance Standards Committee." Since there were no formal votes taken during committee discussions, the recommendations within the report represent general rather than full consensus. The financial assistance standards committee was repealed effective December 31, 2014.