HB 21-1198 Rules Presentation

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Agenda

- Purpose of the Law
- Sections of the Law/Rule
  - Screening and Application
  - Household and Income
  - Discounted Services
  - Rates
  - Patient Rights
  - Reporting Requirements
  - Collections
  - Appeals
  - Complaints
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- Next Steps

Purpose of the Law

- The Legislative intent behind House Bill 21-1198 is for the cost of hospital care for low income, uninsured patients receiving services through hospitals' financial assistance programs to be transparent and easy to understand
- The law and the rules set minimum standards for hospitals to follow when assessing these patients for discounted care and setting up payment plans for them
  - Applies to single households up to $33,975 and households of four up to $69,375

Screening and Application - What the Law Requires

- Defines which patients must be screened for programs and discounts
- Directs the Department to set timelines that the screening and application must be completed
- Directs Health Care Facilities to use the Uniform Application developed by the Department and provide a notice of determination to patients

Screening and Application – What the Rule Stipulates

- Defines when uninsured and insured patients must be screened and on what timelines
- Defines how and when an insured patient can request to be screened
- Defines what must be included in the determination notice including how and when the notice must be provided

Screening and Application - Operating Manual

- Defines the process for how Health Care Facilities should complete the screening and application for patients
- Expands on information that must be included in the determination notice

Screening and Application - FAQs

- Q: Does the screening and application have to be completed for every service?
  - A: The screening and application cover at least one episode of care, however Health Care Facilities can extend the "shelf life" of a determination
- Q: Does an opt out form have to be signed every time the patient receives a service?
  - An Opt Out form must be signed for each episode of service and any services related to the original episode of service. For example, if a patient was seen for an injury in the ER and subsequently needed PT, one Opt Out form can be used for the ER visit and the PT visits.

Household and Income – What the Law Requires

- Directs the Department to establish a methodology that Health Care Facilities must use to determine monthly household income
- Directs the Department to identify the documents that may be required to establish income eligibility using the minimum amount of information necessary
- Prohibits use of assets when determining household income

Household and Income – What the Rule Stipulates

- Defines who can be included in the patient's household (minor and adult children, siblings, roommates, etc.) and who must be included (spouse or civil union partner)
- Defines household income to be determined using income from adults 18 and older and adjusting by household size, and prohibiting the inclusion of assets

Household and Income – Operating Manual

- Explains circumstances in which household members should or should not be included in the household size
  - Ex. Minors should not be rated separately from their parents unless a special circumstance exists, unrelated members of communal religious groups should all have their own applications, etc.
- Defines various methods of calculating monthly income depending on the types of income the household members have
- Defines which income sources can be counted

Discounted Services - What the Law Requires

- Directs Providers to limit the amounts billed for patients who qualify to the discounted rates as established annually by the Department
- Limits the amount Providers may collect from patients to 4% of the patient's gross monthly household income for Health Care Facilities and 2% of the patient's gross monthly household income for each Licensed Health Care Professional who bills separately from the facility

Discounted Services – What the Law Requires (cont.)

- Limits payment plans to 36 months of payments
- Directs Providers to permanently cease any and all collections activities on any balance remaining after the patient makes 36 months of payments
- Establishes that Health Care Facilities may not deny discounted care on the basis that the patient has not applied for public benefits, or due to the patient lacking insurance coverage, may qualify for discounted care, requires extended or long-term treatment, or has an unpaid medical bill.

Discounted Services - What the Rule Stipulates

- Clarifies that Providers may not send patients to outside institutions to obtain loans or credit to pay for their health care in lieu of setting up a payment plan directly with the Provider
- Clarifies that loans offered by the Provider are subject to the 4%/2% and 36 payment maximums
  - Clarifies that patients who default on these loans are subject to the same rules that apply to collection actions for payment plans

Discounted Services – Operating Manual

- Contains examples of how payment plans may be set up, including adding new services to existing payment plans or setting up parallel plans

Payment Plan Example

- Patient is seen in July 2022 and February 2023
- Patient's 4% limit is calculated to be $100
- Examples of Acceptable Payment Plans:
  - One 36-month $100 payment plan for July 2022 and one 36-month $100 payment plan for February 2023 = total of $7,200
  - A $100 payment plan for July running July through January that is replaced by a 36-month $150 payment plan in February 2023 = $6,100
  - A $100 payment plan for July running July through January that is canceled in January, with a new 36-month $100 payment plan created in February = $4,300

Rates – What the Law Requires

- Directs the Department to annually establish rates for discounted care
  - Rates should approximate and not be less than one hundred percent of the Medicare rate or one hundred percent of the Medicaid base rate, whichever is greater
- Directs the Department to publicly post the rates on the Department's website

Rates – What the Rule Stipulates

- Language in the rule mirrors the bill language

Rates – Operating Manual

- Contains the web address for where the rates are posted

Patient Rights – What the Law Requires

- Directs Health Care Facilities to make the Patient's Rights and Uniform Application developed by the Department available to the public and each patient by:
  - Posting the information in all required languages conspicuously on the Health Care Facility's main landing page of their website
  - Making the information available in patient waiting rooms
  - Verbally expressing the information to patients or their guardians prior to the patient being discharged
  - Informing patients on their billing statement of their right, including the right to apply for discounted care and how to do so

Patient Rights – What the Rule Stipulates

- Defines Billing Statement
- Allows for providers to present the Patient's Rights in a format other than the format distributed by the Department
  - Providers must submit an example of how the rights will be presented to the Department for approval
  - Clarifies that Providers may not make any part of the Patient's Rights information part of a footnote or other format that may downplay its importance

Patient Rights – Operating Manual

- Expands upon other formats that Providers may present rights to patients

Reporting Requirements - What the Law Requires

- Directs each Health Care Facility to report, beginning June 1, 2023, data that the Department determines necessary to evaluate compliance across race, ethnicity, age, and primary language spoken with the screening, discounted care, payment plan, and collections practices required by the bill
- If a facility is unable to report this data beginning June 1, 2023, the facility must report what steps are being taken to improve data collection and reporting, and the date the facility will be able to disaggregate the data

Reporting Requirements – What the Rule Stipulates

- Clarifies that Health Care Facilities must report data to the Department in a format and timeline developed by the Department

Reporting Requirements – Operating Manual

- Lists out the data elements that will be required for Health Care Facilities to report on beginning June 1, 2023
  - These have not been finalized, but the elements listed in the Operations Manual will be the minimum required data

Collections – What the Law Requires

- Directs the Department to define the steps Providers must take prior to sending patient debt to collections
- States that prior to sending patient debt to collections:
  - Health Care Facilities must screen the patient for eligibility for discounted care
  - Providers shall provide discounted care to eligible patients
  - Providers shall provide a plain language explanation of the services and fees being billed and notify the patient of potential collections actions
  - Providers shall bill any third-party payer that is responsible for providing health care coverage to the patient, regardless of if the Provider is out of network

Collections – What the Law Requires (cont.)

- States that Providers must notify the patient of potential collection actions at least 30 days before actions are started
- Limits the amount patients are allowed to be sent to collections for to the rates established by the Department
- States Permissible Extraordinary Collection Actions may not begin prior to 182 days past the patient's date of service

Collections – What the Rule Stipulates

- Defines Patient Contact Best Efforts that Providers must make that will meet the screening requirement if a patient has not been screened, including documentation requirements
  - Includes attempting to contact the patient via phone call, text message if available, email, and portal messages at least once a month for six months after the date of service or date of discharge, whichever is later
  - Provides for these contact attempts to cease if the patient requests the Provider stop contacting them

Collections – What the Rule Stipulates (cont.)

- Sets a standard for when collections actions may be started for patients with established payment plans
- Clarifies that patients may only be sent to collections for the rate determined by the Department less any payments from the patient or third-party payer

Collections – Operating Manual

- Clarifies the process for Patient Contact Best Efforts
- Expands on the collections process, including patient notification in their preferred language

Appeals - What the Law Requires

- Directs Health Care Facilities to provide an opportunity for a patient to appeal their determination
- Directs the Department to outline a process for patients to appeal their determinations
- Directs the Department to align the appeals processes for Hospital Discounted Care and the Colorado Indigent Care Program

Appeals – What the Rule Stipulates

- Establishes the timeline for the appeals process, including the number of days that:
  - The patient has to appeal,
  - The Health Care Facility has to complete the redetermination and notify the patient and Department of the result,
  - The patient has to appeal the redetermination to the Department
  - The Department has to review the redetermination and make a final determination

Appeals – What the Rule Stipulates (cont.)

- Establishes that the patient has the right to appeal a determination that used incorrect information that resulted in a higher determination and payment plan than the patient would have received if the correct information was used
- States the Department will keep records of all appeals and final determinations for each Health Care Facility and how the Department will monitor appeals for patterns of errors

Appeals – Operating Manual

- Expands on appeal requirements for Providers and Department monitoring of appeals
- For example, the operations manual stipulates the process that was determined by the Department per the bill.

Complaints – What the Law Requires

- Directs the Department to establish a process for patients to submit a complaint related to noncompliance of the bill requirements
- Directs the Department to conduct a review of the complaint within 30 days after receiving the complaint

Complaints – What the Rule Stipulates

- Defines how patients may submit complaints to the Department, including the phone number, email address, and mailing address that complaints can be submitted to
- States the Department will keep records of all complaints submitted for each Provider and will use those complaints to determine patterns of complaints
  - Providers found to have a pattern of complaints may be subject to a corrective action plan

Complaints – Operating Manual

- Expands on complaint process and Department monitoring of complaints against Providers
- For example, it allows for household members and advocacy groups to assist the patient in filing the complaint

Audits – What the Law Requires

- States Department shall periodically review Providers to ensure compliance
  - Department shall notify Providers if they are found to be out of compliance
  - Provider will have 90 days to submit a corrective action plan with the Department able to extend the deadline to 120 days at the Department's discretion
  - Department may require a Provider to operate under a corrective action plan until the Department determines the Provider is in compliance.

Audits – What the Law Requires (cont.)

- A Provider whose noncompliance is determined to be knowing or willful or that has a repeated pattern of noncompliance may be fined up to $5,000 per week until the Department determines the Provider is in compliance
- The Department shall make information about corrective action plans and fines available to the Legislature during the Department's annual SMART hearing.

Audits – What the Rule Stipulates

- Defines that Providers must retain documentation related to discounted care for the purpose of auditing for seven state fiscal years

Audits – Operation Manual

- Reiterates the Bill and Rule information
  - Audits will not begin until 2023, therefore the full internal auditing process has not been decided

Next Steps

- Draft rule is available on the Hospital Discounted Care website: hcpf.colorado.gov/hospital-discounted-care
  - Send any comments to hcpf_HospDiscountCare@state.co.us
- Rules will be presented to Medical Services Board on March 11, 2022
  - Meeting starts at 9:00 a.m.
  - hcpf.colorado.gov/medical-services-board
- Sign up for the Hospital Discounted Care Newsletter

Next Steps (cont.)

- Training will be held at the end of April and beginning of May
- Office Hours will be held at the end of May and beginning of June
  - Open forum for providers to ask questions as the rules go into place and patients begin being screened and completing applications
- Dates of training and office hours forthcoming, will be announced in the newsletter and on the website

Questions?

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Thank you!