Colorado Hospital Billing and Collection Practices

A Formal Inquiry

by the

Colorado Civil Rights Commission

March 2004

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Introduction

The access to and cost of health care is the subject of considerable debate and discussion. The cost for health care and the impact of hospital billing and collection practices on the uninsured or "self-pay" patients has been characterized as unfair. Recent reports indicate that approximately 70% of the uninsured are minority. Hospitals have been encouraged and challenged to examine their written policies and actual practices. The Colorado Civil Rights Commission has conducted a formal inquiry of billing and collection practices of Colorado hospitals over the past year. This inquiry was in response to a request to "…fully investigate the alleged discriminatory practices of Denver hospitals and healthy care systems." The Commission conducted its inquiry pursuant to 24-305(1)(c) C.R.S., and specifically under the Public Accommodations provisions, 23-34-601 C.RS. , which state in part that public accommodation includes "clinics, hospitals, convalescent homes, or other institutions for the sick, ailing or infirm," and further "makes it a discriminatory practice to directly or indirectly refuse or deny full and equal enjoyment of the services or facilities because of race or national origin", 24-34-601(2) C.R.S.

The provisions governing public accommodations, also allow the Commission to "investigate and study the existence, character, causes, and extent of unfair or discriminatory practices…" A recent report by the Colorado Turning Point Initiative concluded, " The factors that contribute to health disparities among minority communities are complex. There are an array of critical influences that determine the health of an individual and of communities, including income and educational level, access to health care, **discrimination** (emphasis added), and living environment. Strategies to eliminate health disparities must be developed by considering the social, cultural, political, and historical context in which health disparities continue to exist."

The formal inquiry began with questions regarding hospital billing and collection practices that were sent to all Colorado hospitals. The results of the analysis of these responses, as well as meetings with representatives of the Regional Office of the Department of Health and Human Services, Office of Civil

Rights (OCR) and Centers for Medicare and Medicaid Services(CMS), a presentation by a representative of the Director of Colorado Turning Point Initiative, and review of literature, reports, and research are documented and presented in the pages that follow.

Background

In February of 2003, the Commission was contacted by Mr. K.B. Forbes, Executive Director of Consejo De Latinos Unidos, a national non-profit organization based in Los Angeles, California that assists Latinos and others in areas of immigration, education, health care, and police protection. The initial request and discussion focused on the hospitals and health systems in Denver, and a "Denver Post" article written in January of 2003. The Commission's inquiry included all Colorado hospitals and examined their billing and collection practices, and their impact on self-pay patients based on their race, national origin, or ancestry.

A formal letter of inquiry was sent to a list of Colorado hospitals provided by the Colorado Hospital Association (CHA). The CHA also provided comments on the initial draft of questions and material provided by Consejo. A final set of questions was sent in late August of 2003 to the CHA list of hospitals. A variety of responses were provided to the questions by over 90% of Colorado hospitals including all the major hospitals.

Methodology

Responses from Colorado hospitals were analyzed to determine what patient information was available regarding race, ethnicity or ancestry. These three categories were included in the set of questions sent to the hospitals. How, if at all, this information was utilized in the billing and collections process was also noted as part of the initial or preliminary review of questions.

Hospitals that appear to have provided the most complete information in response to the questions were identified and utilized as a "test group" for further analysis and study. More specific information from this test group of hospitals was compiled, analyzed and reviewed by the Commission.

The Director of the Regional U. S. Department of Health and Human Services, Office of Civil Rights, (OCR), met with the Commission in October, and offered to assist the Commission in providing technical

assistance. Information and materials regarding federal laws and regulations related to hospital billing and collection practices were provided, reviewed, and discussed. Finally, several meetings were held with representatives from OCR and the Center for Medicaid and Medicare Services, CMS.

General Finding

The completeness and accuracy of data collected on race and ethnicity and variation of practices is problematic. Further research has documented the "lack of systematic procedures in hospitals to collect patient information on race, ethnicity, and birthplace." Also…"the lack of a standardized approach to collecting these data has implication on other national data collection efforts that depend on data collected at the local level."

Preliminary findings determined that most Colorado hospitals acknowledge having the ability to track patient information by race, ethnicity, or ancestry. Most that do track or have the ability to track this information have limited ability to consistently track and accurately report this information. Therefore, a rigorous analysis of the potential impact that hospital billing and collections practices have on the target population is not possible. Without a more in depth investigation, the ability to determine whether hospital billing and collection practices have a discriminatory impact on "self-pay" or the uninsured is not possible given the scope of this inquiry.

However, there is substantial value in providing findings and recommendations that may prevent hospitals from intentionally or unintentionally engaging in questionable practices.

Major Findings

1. Data collection by Colorado hospitals regarding race, ethnicity, and ancestry is inconsistent because although federal regulations prohibit discrimination, there is no clear, comprehensive, uniform mandate to collect and maintain this information. Information regarding race, ethnicity, and ancestry may be

collected at the time of admission for disease control, to meet program requirements, and concerning births and deaths. It is not clear how and even whether this information is utilized in patient billing and collection. The ability therefore to conduct an analysis utilizing one or more traditional legal theories where discrimination is alleged is greatly compromised without significant additional resources for further investigation, and the information still may not be available to the extent it is statistically significant.

2. Limited remedial action is available under Colorado's public accommodations statute. Currently, if a violation is found, the party bringing an action may obtain a "cease and desist" order from the Commission. Further, parties may be and are in some instances, precluded from further relief in other forums. While a private right of action may not exist under Title VI of the Civil Rights Act, action by federal agencies is not precluded. Additional options that may be considered in the future include utilizing other techniques to obtain information such as zip codes, developing sufficient documentation to establish discrimination based on disparate treatment of individuals who are "similarly situated", and taking positive steps to insure equality in treatment of patients.

3. Patient information is collected in the categories of admissions, clinical treatment, billing and collections, but the categories do not appear to be integrated. The major question for hospitals as it relates to their billing and collections activity, is whether or not patient information should be integrated. The information provided by hospitals was of questionable accuracy, incomplete, somewhat inconsistent or non-existent. Given the changing demographics and increasing attention focused on health care and the role of providers in providing health care to the uninsured, clarification is needed from the federal government. However, the need for clarification to eliminate confusion must be balanced against the requirement for patient privacy.

4. Most Colorado hospitals utilize the Colorado Indigent Care Program (CICP) guidelines to determine eligibility for charity care and other discount programs. What is not clear from the responses and

materials provided is the degree of access self-pay or uninsured patients have to this information, or how well it is understood. Some hospitals in the "test group" collect information on race and ethnicity as it relates to charity care and discount programs. The ability of patients to have access, understand, and be able to utilize the information is crucial to a determination of the impact of the practice.

5. The extent to which Medicare and Medicaid regulation prescribe the amount a hospital provider may charge a "private pay" patient (which would include self pay patients and the uninsured) cannot be determined based upon the scope of this inquiry.

The Regional Center for Medicare and Medicaid Services (CMS) was very cooperative and extremely helpful in providing information and materials regarding the certification of hospitals and the impact their regulations may have on health care costs and rates charged to the uninsured. If a hospital wishes to become certified to receive Medicare or Medicaid funds, it must complete a process which insures that it comply with the prohibitions on discrimination which are enforced by the Office of Civil Rights (OCR).

Hospitals and others have argued that federal laws and regulations determine what they may charge patients and to what extent they may offer discounts or waive payments. Recently, Secretary Thompson addressed this issue in a letter. This was followed by a Member Advisory from the American Health Association (AHA) Board of Trustees that included "Hospital Billing and Collections Practices-Statement of Principles and Guidelines," and a report titled "Federal Regulations Hamper Hospitals Efforts to Assist Patients of Limited Means." As an indication of the constantly evolving nature of this issue, one month ago Secretary Thompson issued yet another letter on February 19, 2004 "to be sure there will be no further confusion on this matter."

Recommendations-Data Collection

1. Data Collection - Hospitals that receive monies from the federal government and are thus subject to the prohibitions against discrimination should ensure that their practices do not directly or indirectly

deny or refuse full and equal enjoyment of the services or facilities because of race, national origin, or ancestry. Current statutory provisions, regulations, and practices will be enforced.

The absence of data may not be conclusive to a determination involving an individual claim of discrimination. Hospitals should carefully examine the business and legal requirements for collecting demographic information, and fully understand how, if at all, the information is to be utilized.

2. Outreach and Education - Hospitals should become proactive by communicating effectively and clearly their charity care and discount programs, policies, and practices. Information and materials should be reviewed and readily available to the general population. If a hospital receives federal funds, it should become familiar with the program requirements for limited English proficiency (LEP), and Civil Rights requirements in Title 45 of the Code of Federal Regulations, Parts 80, 84, and 91.

Specific outreach should be conducted to communities, to the extent they are ascertainable, that are impacted significantly by hospital billing and collection practices. The Civil Rights Division is available to facilitate, within available resources, meetings with various communities upon request.

3. Hospital billing and collection practices and charges, charity care, and discounts - Close collaboration between the federal government, hospitals, and other interested parties is recommended. Meetings with federal officials and representatives were extremely helpful. Discussion of laws and regulation that are applicable to hospital billing and collection practices should dominate the agenda. Agreement at the local level regarding their applicability, intent, and impact on hospital billing and collection practices is necessary to avoid the perception of unfair practices such as "price gouging".

The interaction and application of laws regulations, and policies pertaining to charges, charity care, and discounts should be clarified and subsequently communicated to the general public and groups identified in Recommendation two.

Conclusion

This report has attempted to document Colorado hospital billing and collection practices and their impact on the uninsured by virtue of their race, ethnicity, or ancestry. A summary of the information, materials, and correspondence that served as the basis for the recommendations and conclusions contained herein are attached for review and further reference. Specific responses from hospitals that were the subject of discussion by the Commission and staff in executive sessions should not be made available for inspection pursuant to Section 24-72-204(2)(a) I of the Colorado Open Records Act.

Access to and the cost of health care remain challenges for the future. Access to health care involves matters of life and death. Equality of treatment is not only a civil right, it is a human right. The Colorado Anti-Discrimination Act prohibits discrimination against persons. Although the Commission's initial inquiry does not clearly reveal the existence of discriminatory practices regarding hospital billing and collection, the findings and recommendations if accepted should further equitable access to quality health care at a reasonable cost. Questions regarding this report should be forwarded to the Director of the Colorado Civil Rights Division at 303-894-2997 or CCRD@dora.state.co.us.

Reference material and bibliography for hospital billing and collection practices report

Section 1- Cover letter to Colorado Hospitals

An inquiry had been sent out August 27, 2003 to 79 hospitals all located within the state of Colorado in regards to hospital billing and collection practices. Seven questions in all, the intention of the letter was to inquire aboutpotential discriminatory practices based upon the race, ethnicity, or ancestry of the uninsured individual.

Section 2- Information from Consejos

Introductory letter. K.B. Forbes, February 19, 2003. A letter addressing the purpose of the non-profit organization Consejos De Latinos Unidos and the unjust discrimination against uninsured minorities.
10 Questions, K.B .Forbes
Consejo: HCA Plans For the Uninsured "Worthless Fluff". K.B. Forbes, March 11, 2003. Forbes comments on the "financial relief program" offered by the nation's largest hospital chain.
Activist relies on political experiences. John Welsh, The Press Enterprise. K.B. Forbes leadership role in the grass roots group Consejos against injustices against minorities.
Report for Commissioners. K.B. Forbes, July 16, 2003. Introduction to investigatory report Infeirno . K.B. Forbes July 16, 2003. This is a report that documents the collection behavior of hospitals in Chicago, Denver, Oklahoma City, and Orlando.
Letter one: Three important points. K.B. Forbes, July 22, 2003. An inquiry sent out by the civil rights commission is not considered to be a violation of the hospital's right. The issue of price gouging is not a federal issue. The uninsured are individuals who are those who are not poor enough to qualify for Medicaid or charity care yet not wealthy enough t purchase private insurance.
Letter two: Tracking Concerns. K.B. Forbes, November 6, 2003. For the hospitals who deny that they "request, track or otherwise collect of have access to data on the race, national origin or ancestry"
Letter three: Centura Health. K.B. Forbes, December 15, 2003. Centura Health has engaged in deceptive practices and displays a refusal to change.

Section 3- Literature review- selected articles

Turning Point: Colorado Initiative. Jill A. Hunsaker, 2001. Background in the culture of Colorado and it's disparities in the health of individuals.

Section 4- Media coverage

Government Regulations Contribute to Medical Debt of Uninsured and Underinsured. Mary Mahon, June 4, 2003. New research reveals that large medical bills can result in long-term debt for those who do are not insured. Many hospitals lack the knowledge or procedure to assist the underinsured or uninsured.
Covering the Uninsured: Prospects and Problems. Juliette Cubanski and Janet Kline, April 2003. The level of Americans without insurance or are underinsured are on the rise due to many different factors such as gaps in public coverage, lack of access to employment based insurance, state budget restriction and financial inability to pay the high premiums.
Unintended Consequences: How Federal Regulations and Hospital Policies Can Leave Patients in Debt. Carol Pryor, Robert Seifert, Deborah Gurewich, Leslie Oblak, Brian Rosman and Jeffrye Prottas, June 2003. With rising health care costs, increased insurance premiums, cutbacks in public insurance programs more and more individuals are forced into debt when medical care is necessary. Both the insured and the uninsured pay the consequences of financial hardship therefore potentially delaying or abstaining from receiving the medical

attention they need. The policies that may be perpetuating the medical indebtness must be identified to be able to mitigate the issues at hand.

Issues and Answers-Hospital Pricing: The Outrage of Our Time. The Council for Affordable Health Insurance, July 2003. This article covers how the hospital pricing and intent has changed over the last twenty years, and has grossly distorted the original objective of helping the poor and uninsured. U. S. Health care systems now financially favor the wealthy and middle-income workers with the best prices while overcharging the uninsured and at the same time pursuing an aggressive collection tactic to acquire the funds. The history of change includes the increase of Medicare's estimated target pay, cost to charge ratio's, and the lack of knowledge the uninsured possess in regards to how the system operates therefore allowing hospitals to charge whatever they want.

Medical Shift-Hospitals Will Give Price Breaks To Uninsured, if Medicare Agrees. Lucette Lagnado. Medicare has created confusion and heartache for many uninsured patients who seek financial assistance due to the confusing language of the program which ultimately cause the pricing disparities. Some hospitals contend that their aggressive billing and collecting practice is due to the presumption that it is a necessary step to take.

Hospitals may assist Uninsured. Mark Sherman. The Denver Post. December 18, 2003. The hospital industry has announced that they would be willing to consider cutting the price for medical care for the uninsured contingent on the role that the government will play in the regulation of the Medicare program. Hospitals claim that they are discouraged to reduce charges and medical debt to their patients because of federal regulations that risk them the possibility of a run in with the law.

Centura Backs Off Discount for Poor. Marsha Austin Colorado's largest hospital system, Centura, has chosen to back off from the plan to discount services to the uninsured. Their attorney, Chris Ordelheide, explains the decision as being in agreement with the federal laws that prohibits them from charging different prices for the same care. K.B. Forbes, Consejo's executive director, and Lorez Meinhold, Colorado's Consumer Health Initiative advocate, worked together to create a new policy that would offer discounts to the uninsured but then the hospital pulled back unexpectedly.

Target: Medical Bills. Bill Hewitt, People Magazine, October 16, 2003. K.B. Forbes, the founder of *Consejo de Latinos Unidos* (Council of United Latinos), is actively disputing the grossly overcharging medical billing practices of large hospitals. The inflated costs of care can easily be identified by comparing the out of pocket cost of the insured and the uninsured for the same medical procedure. Hospitals negotiate deals with insurers that explains the discount for the cost of treatment for those who have insurance while the uninsured may be charged has much as ten times the cost the insured has to pay since they are customarily charged the full price. He is currently targeting the HCA to implement some type of discounted care for low-income patients.

Hospital billing probe proceeds. Marsha Austin, *Denver Post,* July 23, 2003. The Colorado Civil Rights Commission has chosen to proceed with an investigatory inquiry in respect to the hospital billing and collection practices. Information about whether minority patients without health insurance pay compared to those who do have insurance will be gathered with the assistance from the Colorado Health and Hospital Association.

Section 5- AHA report

Hospitals take steps to better meet needs of the patients they serve. Amy Lee, American Hospital Association, December 17, 2003. The American Hospital Association (AHA) is a not for profit association of health care provider organization that is working on helping patients with their needs, both financially and medically, and with the needs of the community. While helping hospitals follow principles such as helping patients qualify for existing coverage option, communicating payment options, and ensuring fair and balanced billing and

collection practices, the AHA works as a guide to other hospitals by providing them with innovative values of health care.

Hospital Billing and Collection Practices-Statement of Principles and Guidelines. American Hospital Association.. The purpose of a hospital is to provide care to the people of their community regardless of their financial means. American hospitals are united in providing care based on the following principles:

1. Treat all patients equitably, with dignity, with respect and with compassion.
2. Serve the emergency health care needs of everyone, regardless of the patient's ability to pay for care
3. Assist patients who cannot pay for part or all of the care they receive.
4. Balance needed financial assistance for some patients with broader fiscal responsibilities in order to keep hospitals doors open for all who may need care in a community.

Section 6- Letter from Secretary Thompson

A concern was expressed to Secretary Thompson in regards to the administrative aspect that the hospitals face when complying with the Medicare regulations and the request for the Department of Health and Human Services (HHS) to give hospitals flexibility in billing and the ability to offer discounts. In return, Secretary Thompson believes that the changes requested are not necessary due to the nature of Medicare. Medicare already provides for the application of the above. Due to the varying circumstance of each patient, indigence determination is based on a patient-to-patient basis and discounts may be offered as long as the regulation and policies are abided by the providers.

Section 7- Letter and materials from Center for Medicare and Medicaid Services

Letter from Mark Gilbert, Center for Medicare and Medicaid Services (CMS). Hospitals who desire to implement Medicare and Medicaid must qualify and be certified by CMS. Discrimination is strictly prohibited. Those facilities that do not comply with the regulations of the program are subject to termination. Upon the successful completion of the HCFA-1514 form, the hospital must comply with Civil Rights requirements in Title 45 of the Code of Federal Regulations, Part 80, 84, and 91. CMS' regulation does not state how much of an amount that a hospital provider must charge a self-pay patient.

Materials from CMS- Any providers may request participation in Medicare but acceptance is contingent on the ability of the provider to present them with the basic requirement. Compliance with the civil rights requirements includes:

1. Title VI of the Civil Rights act of 1964 which provides that no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subject to discrimination under, any program or activity receiving Federal Financial assistance.
2. Section 504 of the Rehabilitation Act of 1973 which provides that no qualified handicapped person shall, on the basis of handicap, be excluded from participation in, be denied the benefits of, or otherwise be subject to discrimination under any program or activity receiving Federal financial assistance.
3. Age Discrimination Act of 1975
4. Other pertinent requirements of the Office of Civil Rights of HHS

Social Security Act

Lower Cost or Charges. Reimbursement to providers for services to Medicare beneficiaries will be based upon the lower of the reasonable cost of providing those services. Payments to providers will be based on the short-term rate, which approximates reasonable cost as nearly as practicable, but cannot exceed 100 percent of the customary charges for the same service. Application of the lower of reasonable cost or customary charges

provision requires that a comparison be made between the total reasonable cost and the total customary charges of the items furnished Medicare beneficiaries.

Medicare Regulation's Effect on Billing and Collection Policies of Healthcare Providers for the Uninsured. Lexis Publishing, December 1, 2003. Comments on "Unintended Consequences: How Federal Regulations and Hospital Policies Can Leave Patients in Bad Debt", Margot Warren. Medicare pays Medicare bad debt less 30 percent so their policy encourages the provider to make some effort to collect the amount owed by the Medicare beneficiary. As long as a "reasonable" collection effort is implemented, after 120 days the amount can be included in allowable bad debt. How "reasonable" can be interpreted is not apparent. They do not describe exactly how this must be done, nor do they require that a certain collection policy must be followed for non-Medicare patients. They only require that the same effort be made to collect bad debts from non-Medicare patients as is made for Medicare patients.

Section 8- Letter and Materials regarding research studies on collection of data on race, ethnicity and birthplace and other related information.

Hospital Policy and Practice Regarding the Collection of Data on Race, Ethnicity, and Birthplace. Scarlett Lin Gomez., Research and Practice. A study was implemented to observe the collection of data on race, ethnicity, and birthplace. What concluded from the study materials gathered from the 70 hospitals in the San Francisco area was the apparent inconsistency of information. The frequency of collection of data ranged from vast majority claiming to always collecting data on race while only half report on ethnicity. Since the information is not considered mandated, some hospitals may have viewed collecting such information as "too sensitive and possibly irrelevant".

Agreement Between Administrative Data and Patients' Self Reports of Race/Ethnicity.
Veterans Affairs administrative data and VA 1999 Large Health survey race/ethnicity data were utilized to examine agreement of administrative data with self-reported race/ethnicity and identified correlates of agreement. The percentage agreement was calculated for each race/ethnicity group reported from the survey. For Native Americans, Asians, Pacific Islanders, and Hispanics, agreement existed when people who selected these groups in the survey were classified as "other" in the administrative data. The results indicated whereas rates of agreement were very similar for Hispanics, African Americans, and Whites (approximately 60%), agreement rates were markedly lower for Pacific Islanders (38.4%), Asians (36.6 %), and Native Americans (15.8%). Race/ethnicity was designated as unknown in the administrative files for 36% of patients. Other significant correlations occur between self-reported data and VA recorded data. The results indicate that the more opportunities the VA has to record race/ethnicity, the more likely its data are to agree with patient self-reports.