Comment Form

Thank you for taking the time to comment on the WAC 246-453 draft rules. Please submit any comment(s) you have as soon as possible prior to a scheduled meeting. Please submit a separate form for each section of the rules on which you would like to comment via email to: CharityCare@DOH.WA.GOV. Questions can also be directed to charitycare@doh.wa.gov.

Step 1: Please provide your contact details in case we need to contact you for further information or clarification.

Name: Cara Helmer

Phone/email: carah@wsha.org

Step 2: The following statements help inform rule recommendations; please complete to your best ability.

1. Section commented on:
   WAC 246-453-010 (Definitions)
2. Position (support/oppose): Choose an item.

I. Oppose: Modifiers for the defined term "hospital," such as "hospital-based" or "component of a hospital" as suggested by NoHLA and CLS

II. Support: Using EITHER a definition of "emergency medical condition" that means the same as described in EMTALA, 42 U.S.C. Sec. 1395dd and implementing guidance OR a longer-form paragraph definition as WSHA previously proposed. Oppose: Using both definitions combined.

III. Oppose: Defining "Family Size" instead of "Family." Family is used on its own multiple times throughout the WAC, and therefore needs its own definition.

IV. Oppose: Defining "Good Faith Effort Toward Payment." If it is defined, WSHA opposes the definition proposed by NoHLA and CLS as it is not consistent with legislative intent. If the department requires the term to be defined it should be defined in a manner consistent with an authoritative sources, such as Black's Law Dictionary or Webster's Dictionary.

V. Oppose: The proposed definition of medically necessary hospital healthcare from NoHLA and CLS

   a) Comments on "hospital-based" and "services provided by a component of a hospital" are above/below in section I
   b) Oppose: adding the additional word "prevent" which expands the coverage of charity care beyond the intentions of the legislature.
   c) Oppose: additional language changes proposed by NoHLA and CLS based on the "Mead" 1978 consent decree. Consent decrees are specific to the facts and circumstances of the individual case at the time it was entered into. The charity care law has been updated by the legislature and the department several times since 1978 without adopting the suggested language.

VI. Oppose: Specific portions of the proposed revised definition to "Publicly Available" from NoHLA and CLS:
   a) Oppose: "including any such communications by the hospital's vendor, contractor, or collections agency." Hospital vendor and contractors are not necessarily required to provide charity care under current law and this language would create confusion.
   b) Oppose: "or any other higher standard that may apply under state or federal civil rights laws, including but not limited to U.S.C. Sec. 18116 (Sec. 1557 of the Affordable Care Act)." Hospitals already must comply with other laws, including laws imposing a higher standard than that set forth in charity care law. 1557 is different from charity care law – not necessarily a law that imposes a higher standard. Specifically calling it out in rules implementing a state-based program creates confusion.

VII. Oppose: Adding a definition of "guarantor" because the word is not used in WAC.

VIII. Oppose: Adding "group health plan sponsor" to the definition of "Third-party Coverage," as it is against legislative intent.

3. Suggested solution/proposed language:

I. Using Hospital vs. "Hospital-Based" or "Component of a Hospital" or any other modifier

"Hospital" is a defined term in RCW and WAC. It has a precise meaning, which defines what entities are and are not responsible for providing charity care. Modifying the defined term, suggests that the language means something different than that defined term: something other than "hospital." These language additions are both confusing and unnecessary with the likely result of expanding or modifying which entities are required to provide charity care. This is outside the scope of rulemaking authority and the legislative intent.

In the case of "hospital-based," this term commonly encompasses providers who are not employees of the hospital. Non-employee providers are not required to provide charity care under Washington State law, and therefore this language could create substantial confusion as it appears to create a new obligation on hospital-based non-employee providers that the legislature did not intend to reach. We note that hospital-based is also already used several times in current WAC and strongly recommend that it is removed completely and replaced with the defined term "hospital."

Similarly, any other modification of "hospital" such as the proposed "component of a hospital," carries a similar risk of misinterpretation and confusion. Hospital means "any health care institution which is required to qualify for a license under RCW 70.41.020(8); or as a psychiatric hospital under chapter 71.12 RCW," but what does "component"

mean? Many hospitals have clinics and facilities that are not under the hospital license that would not be required to provide charity care under current statute. Would those clinics be a "component"? That seems to be outside of the legislative intent. This proposed language is confusing, unclear, and unnecessary.

Because of the likely confusion and potential for impermissibly expanding charity care obligations beyond the intentions of the legislature, WSHA opposes any modifiers to the defined term "hospital."

II. NoHLA and CLS proposed a definition of "emergency medical condition" which included both a reference to EMTALA ("42 U.S.C. Sec. 1395dd and implementing guidance") and a long descriptive definition. The effect of combining these definitions would be to have an EMTALA "plus" standard. WSHA opposes this. WSHA previously proposed a definition of "emergency medical condition" which is sufficient. WSHA would similarly be satisfied with the definition that refers strictly to 42 U.S.C. Sec. 1395dd and implementing guidance: "Emergency medical condition means the same as described in the Emergency Medical Treatment and Active Labor Act, EMTALA, 42 U.S.C. Sec. 1395dd and implementing guidance."

III. NoHLA and CLS proposed defining "family size" as opposed to "family." WSHA objects to this as "family" is used on its own multiple times throughout current WAC (including several instances in which the term "family size" does not make sense in context). WSHA previously submitted comments in support of maintaining the current definition of "family."

IV. NoHLA and CLS proposed a definition of "good faith effort toward payment." WSHA opposes this definition for multiple reasons:

WSHA opposes defining "good faith effort toward payment" in general because it is a nebulous and difficult term to define. It is WSHA's preference to leave the term undefined.

If, however, "good faith effort toward payment" is going to be defined, the definition proposed by NoHLA and CLS is not consistent with legislative intent. The legislature chose the phrase "good faith" to indicate that patients receiving the benefit of their current income under the two-year exception must meet a higher standard than is required for other charity care patients. These patients do not simply need to submit applications, as is required for general charity care eligibility, but they also must have demonstrated the higher standard of "good faith" efforts toward payment. Merriam-Webster defines "good faith" as "honesty, fairness, and lawfulness of purpose; absence of any intent to defraud,

act maliciously, or take unfair advantage."[1] The second edition of Black's Law Dictionary alternatively states "Focused efforts to produce desired or required results by deliberate action."[2] Unlike the language used in the proposed definition by NoHLA and CLS, which require "*some attempt* to communicate," and allows patients, who could possibly be acting in bad faith in a dispute to "fail to make a payment," these dictionary definitions clarify the higher expectations intended by the legislature with their word choice. The WAC language must give effect to this legislative intent to establish a heightened standard.

Additionally, we note that the only patients that this "good faith" language applies to are those that were originally not eligible for a full charity care discount. In other words, if a patient needs the benefit of time of application, instead of time of service, it is because at time of service, the patient's income was too high for a 100% discount on care and the patient was obligated to make a payment of some amount of money.

Therefore, WSHA's proposed definition is as follows:

> "'Good faith effort towards payment of healthcare services' means deliberate, actionable, steps with honest intent to resolve, or make payments toward, the relevant outstanding account balance. Depending on individual circumstance, "good faith" may, in part, be demonstrated by:
>
> - Responsiveness and maintained communication by the responsible party with the hospital, and if applicable, the patient's insurance company;
> - Cooperation by the responsible party with the insurance navigator, if applicable;
> - An established a payment plan between the responsible party and the hospital;
> - Consistent payments made to the relevant hospital balance by the responsible party; and
> - If there is a dispute, the responsible party has shown clear efforts to resolve the dispute including responsiveness to the hospital, and provided necessary, relevant documentation."

V. WSHA opposes components of NoHLA and CLS's proposed definition to "medically necessary hospital health care."

[1] "Good faith." Merriam-Webster.com Dictionary, Merriam-Webster, https://www.merriam-webster.com/dictionary/good%20faith. Accessed 23 May. 2023

[2] Blacks Law Dictionary. 2nd Ed. https://thelawdictionary.org/?s=%22good+faith%22. Accessed 23 May. 2023

a. WSHA opposes adding “hospital-based” and “services provided by a component of a hospital” as noted above.

b. NoHLA and CLS added the word “prevent” to the definition of “medically necessary hospital health care.” The current definition already includes “diagnosis” and “prevent[ion]” of the “worsening” of any conditions. This new proposed addition, however, is extremely broad and would have the effect of requiring hospitals to cover any care that’s “reasonably calculated” to “prevent” “conditions that cause suffering or pain, or result in illness….” This would add requirements for hospitals to cover care for costly procedures that insurance companies consider elective including, for example, various weight loss treatments and surgeries.

   The legislature’s intent for charity care was not to create a new comprehensive insurance system funded by hospitals. Charity care is intended for situations when insurance has been “exhausted,” or a person is uninsured. If the word “prevent” is added to this WAC section, hospitals will be required to cover a much broader scope of treatments than insurance companies are required to, or consider necessary to cover. This would effectively force hospitals to go uncompensated for these treatments, and potentially, in some cases, stop providing them completely. WSHA strongly objects to this language change.

c. WSHA also opposes the additional language changes proposed by NoHLA and CLS to the definition of “Medically necessary hospital health care” based on the *Mead* consent decree. A consent decree from 1978 is not useful for legal precedent, and WSHA has found no evidence that this alternative language is in use elsewhere in Washington law or rule. The language that the healthcare authority uses, appears to be consistent with current DOH WAC and WSHA recommends maintaining that language.

Accordingly, WSHA’s proposed definition is:

> “‘Medically necessary hospital health care’ means hospital services, which are reasonably calculated, diagnose, correct, cure, alleviate, or prevent the worsening of conditions that endanger life, or cause suffering or pain, or result in illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and there is no other equally effective more conservative or substantially less costly course of treatment available or suitable for the person requesting the service. For the purposes of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all.”

VI. WSHA opposes two specific portions of the proposed revised definition to “Publicly Available” from NoHLA and CLS.

a. First, WSHA opposes the addition of the language "including any such communications by the hospital's vendor, contractor, or collections agency." Hospitals work with many vendors and contractors that would not have reason to include charity care information in their patient communications. And in fact, for some contractors, the language would be confusing for patients. For example, physician groups that are not employed by the hospital but contract with the hospital may send separate bills for patient care and those bills are not covered by charity care. It can already be confusing which bills are eligible for charity care and which are not. If the physician contractors were now required to include charity care information in the billing statements, even though their bills are not eligible to be covered by charity care, it would lead to even further patient confusion.

   Additionally, the charity care statute does not contemplate any of these requirements or obligations on these third parties. Collections agencies have their own notification obligations under the debt collection statute and vendors and contractors all vary depending on what they are contracting for. It is not the Department's role to impose new obligations on these third parties. This exceeds the scope of the charity care statute and therefore exceeds the scope of this rulemaking.

b. WSHA additionally opposes the language "any other higher standard that may apply under state or federal civil rights laws, including but not limited to U.S.C. Sec. 18116 (Sec. 1557 of the Affordable Care Act)."

   The addition of this language could have the effect of expanding the obligations of Sec. 1557 of the Affordable Care Act. Under Sec. 1557 only "significant" publications, as defined by the federal Office of Civil Rights, are covered. Furthermore, the Sec. 1557 rules have been in constant flux since the Affordable Care Act was passed and are likely to continue changing as different presidents are elected to office.

   In contrast, the definition of "Publicly Available" applies to "all written notifications." Mixing the federal standard, which has a limited and regularly changing application, with the state charity care definition, is ultimately very confusing.

   WSHA would alternatively be open to adding language that is identical to 70.170.060(9): "Hospital obligations under federal and state laws to provide meaningful access for limited English proficiency and non-English-speaking patients apply to information regarding billing and charity care," outside of WAC

246-453-010, so that it is a generalized requirement and not part of a specific definition.

VII. WSHA opposes adding a definition of "guarantor" because the word is not used in WAC.

VIII. WSHA opposes adding "group health plan sponsor" to the definition of "third-party coverage" because the legislature has specifically enumerated a list of what constitutes "third-party coverage" and adding to that list is outside the scope of rulemaking.

4. Statement of problem/comment and substantiation:
   See above.
5. Applicable research and/or substantiation of suggested solution/proposed language:
6. Benefit of suggested solution/proposed language to the public:
7. Benefit of suggested solution/proposed language to hospitals:
8. Identified impacts (cost or otherwise) of suggested solution/proposed language to hospitals:

Discussion Notes (DOH staff only):

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Step 1: Please provide your contact details in case we need to contact you for further information or clarification.

Name: Cara Helmer

Phone/email: carah@wsha.org

Step 2: The following statements help inform rule recommendations; please complete to your best ability.

1. Section commented on:
   WAC 246-453-020 (Uniform procedures for the identification of indigent persons)
2. Position (support/oppose): Choose an item.

WSHA supports adding language to WAC 246-453-020 similar to the language proposed by DOH, NoHLA, and CLS regarding income at time of services vs. time of application, but with necessary modifications noted below.

3. Suggested solution/proposed language: (WSHA edits in red to previously proposed language)

(11) Except as provided in subsections (12) and (13), a final determination of eligibility must be made using the responsible party's annual family income as of the time the health care services were provided.

(12) A final determination of eligibility may be made using the responsible party's annual family income at the time the responsible party applies for charity care sponsorship if:

~~If the responsible party was previously denied sponsorship or granted less than a full discount of the charges, a final determination of eligibility may be made using the responsible party's annual responsible party applies for charity care sponsorship if:~~

(a) the application is made within two years of the time the health care services were provided; and

(b) the responsible party has been making good faith efforts toward payment of health care services provided.

(13) If the responsible party was previously denied sponsorship or granted less than a full discount of the charges, and meets criteria in subsection (12)(a) and (b) of this

section, the responsible party may apply using family income as of the time of the new application.

4. Statement of problem/comment and substantiation:
   The draft language provided by NoHLA/CLS and DOH is confusing because it implies that patients are only eligible under the two-year rule if they have previously been denied sponsorship or granted less than a full discount. We have replaced it with language formatted as it was in the CR 102 from the previous rulemaking which makes it clearer that this option is for all patients who meet the criteria in 12 (a) and (b).

   We also changed the word "must" to "may" because some patients will have a higher income at the time of application than they did at the time of service. Using the word "must" would disadvantage those patients. The word "may" prevents this from becoming a requirement that could punish patients, when its supposed to be a benefit.

5. Applicable research and/or substantiation of suggested solution/proposed language:

6. Benefit of suggested solution/proposed language to the public:

   The proposed language is clearer regarding who is eligible.

7. Benefit of suggested solution/proposed language to hospitals:
   The proposed language is clearer regarding who is eligible.

8. Identified impacts (cost or otherwise) of suggested solution/proposed language to hospitals:

Discussion Notes (DOH staff only):

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Name: Cara Helmer

Phone/email: carah@wsha.org

Step 2: The following statements help inform rule recommendations; please complete to your best ability.

1. Section commented on:
   WAC 246-453-040 (Uniform criteria for the identification of indigent persons)
2. Position (support/oppose): Choose an item.

WSHA is neutral on the proposal by NoHLA/CLS to include asset guidance in WAC. WSHA has specific language edits, however, to ensure the WAC language is consistent with statute.

WSHA is neutral on language giving hospital's authority to exceed statutory minimums, however, WSHA opposes language that could be read to limit the ability of hospitals to provide more generous or expansive charity care and respond to individual patient/family situations .

3. Suggested solution/proposed language: (WSHA edits in red to previously proposed language)

(3) Hospitals may only request or consider assets when calculating discount eligibility for responsible parties who are not have been determined ineligible for charity care sponsorship for the full amount of hospital charges. ~~Assets may not be requested or considered when reviewing a charity care application for an individual who meets the requirements of (1)(a) and (2)(a) in this section.~~

(a) If a hospital ~~requires the reporting~~ considers the existence, availability, and value of assets in order to reduce the discount extended ~~under (1)(b) and (c) and 2(b) and (c)~~, ~~the hospital~~ it must establish and make publicly available ~~its~~ a policy on asset considerations and corresponding discount reductions.

(b) ~~In~~ If considering assets, a hospital may not impose procedures which place an unreasonable burden on the responsible party.

(c) ~~Information requests for verification of assets shall be limited to what is reasonably necessary and readily available to substantiate the information and may not be used to discourage charity care applications.~~

Information requests from the hospital to the responsible party for the verification of assets shall be limited to that which is reasonably necessary and readily available to substantiate the responsible party's qualification for charity sponsorship and may not be used to discourage application for such sponsorship.

(d) ~~The hospital shall exclude t~~ The following types of assets shall be excluded from consideration.

(i) The first $5,000 of monetary assets for an individual or $8,000 of monetary assets for a family of two, and $1,500 of monetary assets for each additional family member. The value of any asset that has a penalty for early withdrawal shall be the value of the asset after the penalty has been paid;

(ii) Any equity in a primary residence;

(iii) Retirement plans other than 401(k) plans;

(iv) One motor vehicle and a second motor vehicle if it is necessary for employment or medical purposes;

(v) Any prepaid burial contract or burial plot; and

(vi) Any life insurance policy with a face value of $10,000 or less.

(4) In considering monetary assets, one current account statement shall be considered sufficient for a hospital to verify a patient's assets.

(5) In the event that no documentation for an asset is ~~readily~~ available, a hospital shall rely upon a written and signed statement from the responsible party.

(6) Asset information obtained by the hospital in evaluating a patient for charity care eligibility shall not be used for collection activities by the hospital, the hospital's ~~vendor, contractor, or~~ collections agency.

(7) Nothing in this section prevents a hospital from considering assets as required by the centers for medicare and medicaid services related to medicare cost reporting.

(~~7~~8) Hospitals may exceed the minimum standards of this section~~, so long as any additional eligibility standards are documented and publicly available in the hospital's policy, approved by the department as aligned with the purposes of this chapter, and uniformly applied.~~

4. Statement of problem/comment and substantiation:
   WSHA is neutral on the proposal to add language around asset requirements to WAC. However, the CLS/NoHLA proposed language is inconsistent with the statute in several places. WSHA encourages DOH to consider how proposed WAC language aligns with the plain meaning of the statutory language and specific words in the statute to ensure the rules are clear and what meaning will be read into the rules. WSHA's proposed edits align with rule language with the language as used in statute.

   WSHA has also deleted the words "vendor" and "contractor" because WSHA is not aware of any hospital vendors or contractors that perform collections activities separate from collections agencies.

   WSHA added a provision to reflect the RCW language that the state charity care law/regulations do not prevent a hospital from considering assets as required by the centers for medicare and medicaid services related to medicare cost reporting. This is an important provision to ensure hospital compliance with medicare cost reporting.

   Finally, WSHA is open to including language allowing hospitals to exceed the minimum charity care requirements required by law. But WSHA opposes the second half of the proposed language: "so long as any additional eligibility standards are documented and publicly available in the hospital's policy, approved by the department as aligned with the purposes of this chapter, and uniformly applied." This language would have the effect of adding risk to hospitals for exceeding the law's minimum requirements and could have a chilling effect on hospital generosity. If this language were to be included in WAC, hospitals may not feel comfortable granting exceptions to charity care policy for patients with uniquely difficult, but unforeseen circumstances. This would not benefit anyone.
5. Applicable research and/or substantiation of suggested solution/proposed language:

6. Benefit of suggested solution/proposed language to the public:

7. Benefit of suggested solution/proposed language to hospitals:

8. Identified impacts (cost or otherwise) of suggested solution/proposed language to hospitals:

Discussion Notes (DOH staff only):