Hospital Feedback on the First Quarter Implementation of HB 3320 Financial Assistance Prescreening

January 2025

Introduction

After the financial assistance (FA) prescreening component of House Bill (HB) 3320 began on July 1, 2024, multiple hospitals reached out to the Oregon Health Authority (OHA) Hospital Reporting Program asking to provide feedback on the first three to five months of implementation. OHA invited all hospitals to participate and met with hospitals or health systems representing 34 hospitals from October to December 2024. This document provides a summary of the findings from those interviews so that hospitals, the Hospital Association of Oregon, other partners and OHA leadership can learn from the collective experiences of hospitals. It does not reflect the position of OHA and is not meant to provide policy recommendations.

Background

HB 3320 (2023) created requirements for hospitals to screen certain patients for presumptive eligibility of FA and to apply that FA to the patient's bill prior to sending the first billing statement. The bill further required hospitals to adopt a process to allow a patient to appeal a denial of FA and a mechanism for a patient to correct FA applications that have errors or missing documentation. Finally, the bill created new data reporting obligations for hospitals related to FA approvals, denials, accounts in collections and other related data. The bill authorized OHA to create rules for the screening, appeals and data collection processes. HB 3320 was codified as ORS 442.615.

Summary of interview findings

Hospitals reported significant challenges with HB 3320 (section 1) directing them to prescreen patients for presumptive eligibility for FA.

Hospitals expressed concerns about the software tools they used for prescreening, reporting that the third-party vendor tools hospitals are currently using often lead them to provide FA to patients that do not qualify. The use of software tools is not required by statute and hospitals are free to independently contract with any software solution available or not use a tool at all. Hospitals and OHA are investigating availability of more accurate

tools. The eligibility decision based on these software tools remains in effect for nine months, whether or not the decision accurately reflected true eligibility. According to those interviewed, this extended time period of eligibility exacerbates the problem of inaccurate screening.

Hospitals are using different versions of these tools and integrating them into their electronic health records in varying ways, so hospitals reported differing challenges and successes. Hospitals that fully integrated the software tools into their electronic health records and use the full functionality of their software tool reported the most success with prescreening.

Hospitals doing more front-end work, such as asking patients questions or prescreening prior to the time of service, reported greater success than hospitals with entirely back-end prescreening processes. Back-end processes prescreen patients by querying tools after service and prior to billing.

Hospitals are struggling to implement and manage the high volume of prescreenings they must conduct. The increase in FA awards translates into significant lost hospital revenue.

The following sections report hospital concerns in more detail.

Concerns about the accuracy of prescreening software tools

HB 3320 requires hospitals to prescreen certain patients for FA presumptive eligibility. Many hospitals, especially health systems serving thousands of patients per day, opted to use software tools to prescreen. While using a software tool is not required by law, the volume of patients makes it a practical requirement for most large hospitals. Most high-volume hospitals noted that manually screening patients would be infeasible.

Hospitals use two third-party vendor tools to prescreen for FA eligibility: Experian and Waystar. These tools offer multiple packages that can be purchased, and hospitals have chosen different versions. Experian uses 2020 Census data, loan applications, mortgages, credit and debt information in a waterfall method to evaluate a patient's household size and income. Waystar uses census data at the zip code +4 digit extension level to estimate income based on census tract. Additionally, Waystar employs a proprietary algorithm, PARO, a presumptive charity scoring tool. The exact details of the PARO algorithm are not available, but Waystar reports "it is a dynamic measure that adjusts the weighting of the data points in every individual score based on what is publicly available for the individual in question."

Currently, Experian and Waystar do not use tax returns or any other confirmed source of actual income in their evaluations, so they can only provide an estimate of income and household size based on secondary data. When there are discrepancies between a

person's actual income and household size and the estimates from secondary and census data, errors occur. For example, consider someone who does not work or have credit or debt but is financially supported by family. If they live on their own, their household size of one and lack of credit or debt would result in presumptive eligibility of 100% FA, regardless of how much financial support the family provides. Specific to Waystar's location-based assessments, if an expensive new housing development is built in a previously less expensive neighborhood, patients who live in one of the costly new homes would be prescreened to receive more FA than they would qualify for based on their actual income.

The two tools vary in how accurately and consistently they identify household size and estimate income.

Despite these concerns, most hospitals estimate an overall accuracy rate of 85%. For a hospital that serves thousands of patients per day, even 15% inaccuracy translates to a large amount of lost revenue. Only a few hospitals provided specific details on increases in FA amounts, while most hospitals provided estimations and projections.

Before implementing prescreening, OHA held pre-implementation interviews and Rules Advisory Committee (RAC) meetings in which hospitals emphasized the accuracy and validity of these tools and their ability to prescreen. Hospitals did not raise concerns about these tools during those meetings. In one RAC meeting, when a partner raised the question of potential inaccuracies in the tools, hospitals that already used these tools dismissed the idea and reaffirmed their accuracy.

Prior to HB 3320, hospitals generally used these tools to screen patients after billing if the hospital did not receive payment to determine whether to send the patient to collections. Hospitals reported that they originally assumed that the efficacy of the tool would be similar for the new use case of prescreening. However, patients screened for collections were more likely to be in financial distress than the broader population to be prescreened for presumptive eligibility, and hospitals report that these tools are not as accurate for the broader prescreening population.

Several hospitals suggested adding propensity to pay into the tools' screening criteria to improve accuracy. Propensity to pay evaluates a patient's likelihood to be able to pay, rather than just determining their income. Waystar and Experian both have the capability to include propensity to pay in their screening criteria. Currently, Oregon law requires the FA determination to be based on income and not the ability to pay. While untested, hospitals posit that the small amount of data points they are currently allowed to use could be causing the inaccuracies, so adding propensity to pay may provide more accurate results. In HB 3320, the prohibition against propensity to pay only intended to prevent propensity to pay from replacing income as a determining factor. The rules as currently written are

intended to prevent a screening tool from indicating that a patient could pay, even if their income is below a threshold, and result in a denial of FA.

The degree to which propensity to pay can enhance or improve the income estimation ability of the software tools requires further examination.

Hospitals are using varying implementations of screening tools

Hospitals are implementing these tools in different ways and integrating them at varying levels into their electronic health records systems. This results in different levels of success and implementation experiences.

Hospitals that use the full Experian FA tool expressed smoother prescreening implementation. Experian offers multiple tools for prescreening and FA. Hospitals that use both the prescreening and FA module linked to EPIC reported better tracking and results than hospitals that are not using the full functionality. Hospitals must check to see if a patient has existing eligibility prior to prescreening, which can be built into the workflow process, yet most hospitals are screening again each time they bill a patient. The FA module's tracking features help by automatically registering the existing patient's FA status in subsequent visits, reducing administrative workload.

Few hospitals are doing front-end work

Nearly every hospital screens patients after they provide services during the billing process. We refer to this as back-end work as opposed to collecting information prior to services or during check in and registration which would be front-end work. Hospitals with high patient volume are trying to find the most efficient way to screen as many patients as quickly as possible.

The lack of front-end work may be adding to back-end burden. Notably, few hospitals apply tracking or workflow solutions to their electronic health records. For instance, a patient with a previous FA award in the applicable time period does not need to be prescreened. Hospitals reported not using known patient information to aid in the prescreening process, which increases the number of patients prescreened on the back end.

Implementation is still in its early phases, and all hospitals noted that they are still developing and refining their processes and evaluating prescreening tools including integration into their electronic health records systems.

Balancing front-end work could help streamline the back-end billing process. Some hospitals reported adding household size and income questions to appointment scheduling and check-ins, which they then use as a check against the software tools' prescreening

result. One hospital that does not use a software tool reported smooth implementation of their manual prescreening process, successfully using any existing information on the patient as well as information the patient opted to provide prior to an appointment,

Lack of access to true income information

As previously mentioned, none of the software tools have information on actual patient income. OHA spoke with the Department of Revenue about the possibility of hospitals accessing tax returns for FA prescreening. There is currently no automated, central database for tax returns to be pulled from. This means accessing tax returns would be a manual process for thousands of requests per day. The Department of Revenue does not have the staff to meet these demands. To create an accessible tax return database for hospital use would take legislative action, funding, and a significant IT investment.

Hospitals requested that the state provide one source of patient household size and income information so all hospitals can access consistent and accurate information.

Continued eligibility following prescreening exacerbates the low accuracy issue

Due to the concerns about the inaccuracy of the prescreening software tools that they have chosen to use, hospitals expressed frustration that prescreened patients remain eligible for FA for nine months. Continued eligibility was in part intended to relieve administrative burden for hospitals, so hospitals do not have to prescreen a patient each time they come in over a nine-month period. However, for patients whose prescreening resulted in an overestimation of FA, that overestimation is in effect for nine months. Multiple hospitals requested shortening the prescreening eligibility period to 30 days if tool inaccuracies cannot be remedied.

Hospitals report that some patients want to be able to opt out of prescreening and FA

Many hospitals reported receiving calls, emails and letters from patients who do not want their financial information accessed and do not want to be prescreened. Hospitals have directly received the majority of the complaints; however, OHA has also received several similar comments. By statute, prescreening is required for all patients who meet the prescreening criteria. Some patients are concerned about their privacy and do not want hospital staff accessing their financial data. Some hospitals reported that the tools do not show exact patient income, only the result of the prescreening (approved/denied) and where the patient falls within the FA tiers.

Hospitals voiced that some patients do not want to accept FA for other reasons, such as believing they should not qualify due to high income and want to ensure that the FA funding

goes to those who need it. OHA reaffirmed previous guidance that patients can refuse FA after prescreening. Hospitals have requested an opt out process, which would require a legislative solution. However, this would likely create a requirement to collect front-end information in the form of a signed patient acknowledgement. Most hospitals have expressed that collecting front end information is too administratively burdensome.

Concerns about patients taking advantage of the prescreening process

Multiple hospitals raised concerns about the potential for patients to take advantage of prescreening. One concern is medical tourism – that patients who qualify for FA could come from out of state or country to access care for cheaper than they could get it at home. This is especially pressing for hospitals near state borders. OHA provided guidance from the Department of Justice on this and addressed it in interviews. Hospitals should consult their in-house counsel and address this issue in their FA policy in compliance with revised state statutes and federal nonprofit hospital laws.

Another concern is that patients who qualify for FA will opt out of enrolling in health insurance and instead depend on hospital FA. This concern was expressed throughout the legislative and rule-making processes. Hospitals have not yet provided examples of this happening, and we know from the 2023 Oregon Health Insurance Survey (OHIS) that 97% of people living in Oregon are insured. New OHIS data, reflecting the time frame after the FA implementation, will not be available until late 2026. However, patients are required to provide all third-party payer information, including that of any health insurance, to hospitals for payment prior to a patient's responsibility amount being billed. Hospitals may deny FA to patients who do not comply. OHA has encouraged hospitals to keep records of patient concerns and what actions the patients take when possible about such events to assist OHA and policymakers in addressing this.

A third concern is that prescreening cannot access the health savings accounts of patients with high deductible health plans. A health savings account is a source of funding the hospital normally would be able to draw from and would be included in a FA application. Health savings accounts are not addressed in the law.

Conclusion: Implementation has been challenging and hospitals are still working through issues

All hospitals described the first months of prescreening implementation as an enormous undertaking. Hospitals report that this new law adds a large amount of work and staff time. One hospital estimated that it takes 3.5 FTE to run prescreening for their single, small hospital. Hospitals reported convening staff from information technology, revenue, finance, and leadership to collaborate on implementation, with ongoing meetings to fix issues and find solutions to unexpected scenarios. Large health systems reported the roll out being especially challenging, with tools incorrectly overproviding FA and sending presumptive

eligibility letters to their own leadership and other high-income earners. OHA conducted interviews after three to five months of prescreening implementation and hospitals anticipate another six to nine months of challenging implementation before the programs run smoothly.