

August 4, 2023

Via Email to: kristi.jordan@hhs.texas.gov

Ms. Kristi Jordan
Associate Commissioner
Health Care Regulation
Texas Health & Human Services Department

Re: Interpretation Questions & Concerns with SB 490 – Itemized Billing Legislation

Dear Ms. Jordan:

On behalf of our more than 450 member hospitals, including public, rural, urban, children’s, teaching, and specialty hospitals, the Texas Hospital Association (“THA”) appreciates the opportunity to provide feedback to the Texas Health & Human Services Commission (“HHSC”) regarding the interpretation questions and concerns hospitals have with respect to the implementation of, and compliance with, SB 490.

THA looks forward to HHSC’s guidance and hopes it is provided to hospitals prior to, or shortly after, September 1, 2023. Below are implementation questions and concerns compiled using feedback from THA member hospitals. We strongly urge HHSC to prioritize flexibility, within the statutory mandates, as we believe this will allow hospitals to achieve full compliance sooner rather than later. Our discussion herein reflects this aim. THA supports reasonable and efficient transparency efforts and wants to ensure hospitals are providing the information and transparency needed for patients to adequately review and assess their medical bills.

Applicability

1) Which facilities does SB 490 apply to? More specifically, does it apply to hospital outpatient departments and rural health clinics?

In addition to a main hospital campus, there are a number and variety of other health care facilities licensed and regulated by state and federal law. To ensure correct application of SB 490, THA asks HHSC for guidance about which specific facilities in the Texas health care continuum are contained in the definition of SB 490.

THA interprets SB 490 to exclude hospital outpatient departments (HOPD) located off the hospital’s campus. Since off-campus HOPDs do not operate under the hospital license and are not required to be independently licensed by any Texas regulatory agency, it is our

interpretation that they are not “facilities” within the definition of health care provider and therefore SB 490 does not apply to those operations.

Additionally, THA requests clear guidance on whether rural health clinics (RHC) should comply with SB 490. A clinic can be classified as an RHC if they are able to satisfy certain federal requirements listed in Title 42, Part 491 of Code of Federal Regulations. Like off-campus HOPDs, they are not licensed by the state. RHCs can be owned or affiliated with hospitals, or they can operate independently.

[HHSC’s website](#) further describes RHCs as being able to be “accredited or certified to participate in the federal Medicare program, or both.” This federal (non-state) certification is not sufficient to include RHCs as a “health care provider” as the term is defined under SB 490.

During the legislative process, amendments to SB 490 removed “individuals” from the definition of health care provider. Representative Caroline Harris remarked “...I worked with Dr. Bonnen and Dr. Oliverson and we came to the conclusion that this really doesn’t impact doctors. So we went ahead and took them out of it[,]”¹ thus excluding individual physicians and practitioners.

Moreover, the definition of “health care provider” in SB 490 specifically means a “facility.” Individual physicians or physician groups who operate solely within a hospital and bill patients separately for their services are clearly not included in SB 490’s scope. However, THA requests clarity on whether any other primary care or specialty clinic that does not operate under a hospital’s license are not “facilities” and therefore are not required to comply with SB 490. This may affect clinics operated by organizations described in Section 162.001(b) of the Texas Occupations Code. This interpretation is further bolstered by the fact that HHSC has no regulatory authority over physicians and the management of their clinics. SB 490 does not grant HHSC authority to oversee non-licensees and an interpretation to the contrary would be *ultra vires*.

Therefore, we urge HHSC to confirm that THA’s interpretation that SB 490 is applicable only to the types of facilities listed by HHSC and denoted in the descriptor as a [facility type regulated by HHSC](#).

2) Does the effective date mean that hospitals are only required to provide itemized bills for health care services and supplies provided on or after September 1, 2023?

THA believes SB 490 applies only to health care services and supplies provided on or after September 1, 2023. Section 311.022 of the Government Code states that “[a] statute is presumed to be prospective in its operation unless expressly made retrospective.” SB 490 does not expressly make any requirement retrospective to health care services and supplies

¹ [Page 3728 of the House Journal, May 10, 2023.](#)

provided prior to September 1, 2023. Consistent with fundamental principles of code construction, we urge HHSC to adopt this interpretation so that hospitals have a definitive starting point for implementation and application.

Definitions

3) What constitutes “debt collection” as defined in SB 490?

Hospitals request HHSC clarify, definitively, the scope of “debt collection” under SB 490.

New Section 185.002(e) states that “[a] health care provider may not pursue debt collection against a patient for a provided health care service or supply unless the provider has complied with this section.” New Section 185.001(1) defines “debt collection” as having “the meaning assigned by Section 392.001, Finance Code” which further defines the term as “an action, conduct, or practice in collecting, or in soliciting for collection, consumer debts that are due or alleged to be due a creditor.” The Finance Code further provides definitions for consumer debt and creditor.

Senator Bryan Hughes, author of SB 490, and Representative Caroline Harris, the House sponsor of the legislation both specifically clarified that SB 490 *only* applies to third-party debt collection meaning debt collection that is pursued by a person to collect debts owed or due or asserted to be owed or due another. On May 16, 2023, Senator Hughes said:

“I want to make clear that this bill regarding debt collection, this bill’s intent regarding debt collection, which was also discussed on the House floor. *To prevent any confusion* for health care providers to implement this legislation, SB 490 applies to *third-party debt collection*. Our constituents are now receiving itemized bill before any health care provider *turns the bill over* for debt collection.”² (emphasis added).

On May 10, 2023, Representative Caroline Harris said:

“The bill says that before someone is *sent to collections* they have to receive that itemized bill...And so *before they send the patient to collections* to collect on that bill is when they have to provide the itemized. Anytime *up until they send the person to collections*.”³ (emphasis added)

In considering SB 490’s statutory definition coupled with the legislative intent provided by Sen. Hughes and Rep. Harris, the definition and scope of “debt collection” is limited to efforts taken by third-party debt collectors.

² [Page. 1942 of the Senate Journal \(May 16, 2023\).](#)

³ [Page 3729 of the House Journal, May 10, 2023.](#)

THA requests that HHSC confirm this interpretation. A continued lack of clarity around this definition significantly impacts the operational scope and complexity of implementation. Additionally, a delay in clarity or a broad interpretation of the definition will impact the ability of a hospital provider to collect any payment from patients (per SB 490) upon the effective date of the bill or until the hospital can implement SB 490. Existing requirements around payments further complicate this issue and provide additional need for this clarity, as some hospitals are contractually bound under their third-party payer agreements to seek payment from patients within a certain time period (e.g. 30 days) after a receiving payment from the payer. If a hospital is prohibited from requesting payment based on the statutory requirements and timelines contained in SB 490, that could potentially result in them breaching their contractual agreements.

An interpretation contrary to the clearly stated and unambiguous legislative intent would have disastrous consequences for hospitals and their ability to provide health care services to patients in urban and rural areas. For example, hospitals will have to consider implementation of strict and rigid policies with respect to non-emergent services, potentially leading to the delay in scheduling non-emergent services, in order to ensure payment of patient responsibility, as dictated by health plan benefit designs, is received. A broad interpretation will also impact the ability of hospitals owned and operated by the state from collecting payment for services provided – threatening state-owned hospitals from meeting their duty to safeguard public funds.

4) What constitutes compliance with “plain language” as required by Sec. 185.002(b)(1)?

Please clarify how HHSC will interpret “plain language” and what criteria will be used in assessing compliance, with the applicable requirement under new Section 185.002(b)(1). THA further requests that HHSC provide examples of specific patient-friendly billing guidelines that HHSC will deem acceptable and compliant.

The [Healthcare Financial Management Association](#) provides guidance on patient-friendly billing as does the American Medical Association. THA believes that hospitals that follow this guidance would be compliant with the plain language requirement. Additionally, the use of commonly well-known abbreviations and terms to describe items and services should continue to be encouraged and permitted. Because enforcement of SB 490 is likely to be the result of complaints made to HHSC, hospitals need assurance that they will not be disciplined as a result of the subjective individual interpretations of the phrase by reviewers or surveyors. If a hospital can demonstrate compliance with an industry accepted patient friendly billing practice, a hospital can rest assured they are in compliance and providing the transparency patients need to review their medical bills.

5) What is considered “final payment” in Sec. 185.002(a)?

Please clarify the scope of “final payment” from a third party for purposes of the timeline to provide an itemized bill to a patient. Hospitals are commonly subjected to denials, disputes, and administrative hurdles imposed by health insurance companies that make it difficult to determine both reimbursement to the hospital and the patient’s responsibility. THA interprets “final payment” as *the final adjudication of a claim*; meaning, the hospital has addressed initial denials or other (often arbitrary) administrative burdens imposed by third-party payers, which leads to the most accurate patient balance on the hospital’s ledger.

Some hospitals also have contractual provisions with third-party payers which allow for “interim billing” (e.g. the patient is still in the hospital but the hospital is allowed to bill for current days of service). Under this arrangement, a hospital would submit a claim and a payer would deduct what the *payer believes* is the patient’s responsibility for the stay to date. Such an arrangement typically also requires hospitals to bill the patients for their portion within a designated time period such as 30 days. If this interim payment is considered a “final payment” this will result in patients having an inaccurate picture of their *total* patient responsibility since additional amounts could be owed following discharge.

HHSC is well aware that third-party payers routinely engage in denials, retrospective reviews, and other utilization reviews that directly impact a patient’s financial responsibility. These tactics can delay payment for months and even years. THA requests confirmation that THA’s interpretation of “final payment” is accurate and hospitals who use this interpretation of “final payment” to provide an itemized bill no later than 30 days from this final adjudication are compliant and not subject to disciplinary action, and may engage in debt collection. Any subsequent actions taken by a third-party payer after this final adjudication that increases a patient’s financial responsibility should not “restart the clock.” However, we also believe SB 490 allows hospitals to provide an itemized bill before final adjudication if the hospital so chooses. We simply seek confirmation that use of our interpretation herein is compliant with SB 490.

Please also clarify whether a hospital is required to provide an additional itemized bill if the patient does not pay a hospital balance in full or pays under an installment plan. THA believes that once an itemized bill has been provided as noted in the paragraph above, SB 490 does not mandate a hospital to provide an updated itemized bill upon each subsequent payment request.

Billing

- 6) If a third-party payer reimburses hospitals using “bundles” and the hospital is required by the payer to submit claims to the third-party payer using bundled codes and charges, are hospitals allowed to simply include the bundle in the itemized bill to the patient and be in compliance with new Section 185.002(2)? Additionally, if a hospital is not reimbursed by a third-party on a line-item basis, how can a hospital be expected to comply with new Sec. 185.002(b)(2) and (3) if there is no method available for them to accurately and uniformly assign the patient’s responsibility for each line-item service or supply?**

Healthcare.gov [defines “payment bundling”](#) as a “payment structure in which different health care providers who are treating [a patient] for the same or related conditions are paid an overall sum for taking care of [a patient’s] condition *rather than being paid for each individual treatment, test, or procedure*. In doing so, providers are rewarded for coordinating care, preventing complications and errors, and reducing unnecessary or duplicative tests or treatments.” THA believes hospitals paid by third-party payers using payment bundling, may include the payment bundle plain language description, any necessary billing codes associated with the payment bundle, and the patient’s responsibility associated with that payment bundle to comply with SB 490. In other words, services paid using a bundle are, altogether, a health care service. It is not possible for hospitals to break out the services included in a payment bundle by line item and then apply the patient’s financial responsibility for that specific line item because there is no separate reimbursement amount for the line item detail.

Many third-party payers do not break down their payments by line item in their remittances for inpatient services and for some outpatient services. Inpatient encounters are usually paid by the Diagnosis Related Group (DRG) grouper weight multiplied by the Standard Dollar Amount for the payer contract. Payers do not provide individual payment lines per service or supply and certain payers may not provide individual payment amounts per service or supply. If they do, some payers will pay at the revenue code level, and others will pay at the Current Procedural Termination (CPT) code level. Overall, there is currently no technical mechanism for hospitals to break down the third-party payment by line-item when the third-party payers reimburse hospitals in this manner and thus comply with Section 185.002(b)(2) and (3). THA requests confirmation that hospitals may tailor the itemized bill to align with third-party payer remittances and provide an aggregate of the “amounts billed to and paid by the third-party payer” and “the amount the provider alleges is due” rather than by line-item if paid in this manner or through a bundle.

- 7) Does SB 490 apply to co-pays, cost sharing amounts, or co-insurance invoiced to the patient *after* health care services and supplies are provided?**

There are situations where a hospital or other providers may request payment for co-pays, cost-sharing, or co-insurance amounts after patients are discharged or receive health care

services or supplies. There are also scenarios where these payments are collected at the time of service. SB 490 was amended during the legislative process to ensure that providers would not have to provide an itemized bill for amounts paid prior to, or on the day, health services or supplies are provided – specifically to ensure itemized bills would not be required for these types of payments. Plainly, cost sharing amounts determined by health insurance companies should not be encompassed in itemized bills. Patients already receive this information from their health insurance companies through their plan documents and explanations of benefits.

It will be difficult, if not impossible, for hospitals to prorate the lump sum co-pay, cost share, or co-insurance payment across all line items for an inpatient stay, and even at times for outpatient services. To reiterate an example provided by the Teaching Hospitals of Texas, if an itemized bill contains 500 line items and the patient has a \$500 deductible, it could result in pennies being attributed to the line items – resulting in inaccuracy and ultimately confusing patients.

Additionally, collection of a co-pay after services are provided may occur prior to any final adjudication of a claim between the hospital and a third-party payer. Requiring hospitals to provide itemized bills in this instance would conflict with the requirement that hospitals provide itemized bills 30 days after final payment is made by third-party payers. Practically speaking, this would result in systematic patient confusion.

Please confirm that (a) SB 490 does not apply to requests for payment of co-pays, including after health care services and supplies are provided and (b) that if all that is requested from the patient is a lump sum deductible payment that cannot be prorated among hundreds of line items, hospitals have the flexibility to simply include the deductible amount as a line item on the patient’s itemized bill.

- 8) If a hospital submits multiple codes to a third party on a uniform claim form, what codes are expected to be provided to the patient and must be included in the itemized bill to prevent patient confusion? If a hospital’s electronic health/medical record (EHR/EMR) system generates different codes than those submitted to third party payers, are hospitals permitted to use the codes generated by the EHR/EMR system?**

Please clarify the types of billings codes that are required for inclusion in the itemized bill. Many hospitals utilize a standard claim form to bill third-party payers, including Medicare and Medicaid. Insurance forms may require hospitals to provide revenue codes, Healthcare Common Procedure Coding System (HCPCS) codes, Health Insurance Prospective Payment System (HIPPS) codes, DRG codes, CPT codes, International Classification of Diseases (ICD) codes, and various other treatment authorization codes. One suggestion might be simply requiring the revenue and/or HCPCS codes for clarity and efficiency. THA requests specific clarification on what “billing codes” are required to be included in the itemized bill to comply with new Section 185.002(b)(2).

Operations

- 9) SB 490 allows hospitals to provide itemized bills electronically. If a hospital makes the itemized bill available electronically through a patient portal or website, with the option to request a paper copy be sent via regular mail, is that compliant with SB 490?**

New Section 185.002(c) states that hospitals “may issue the itemized bill electronically, including through a patient portal on the provider’s internet website.” This section should allow hospitals to include, as an example, the following statement on a paper or electronic invoice or other request for payment:

“Please view or download your itemized bill at [applicable Internet address link]. You can also call (XXX) XXX-XXXX to request an itemized bill be mailed to you.”

This is a simple and effective way to provide patients with their itemized bills in accordance with SB 490. THA believes SB 490 allows hospitals to utilize this method regardless of whether a patient has enrolled in the hospital’s patient portal and/or electronic system. By making an itemized bill immediately available for access or download at the time a request for payment is made (or within 30 days of final payment by third party) hospitals have submitted the itemized bill to the patient in accordance with Section 185.002(a). While this is not the only method hospitals can use to comply with SB 490 – nor does THA advocate it should be – it is one of the easiest, cost-effective methods available for hospitals to achieve full compliance. THA urges HHSC to confirm that this method (and similar methods) complies with the legislation.

- 10) If a patient requests not to be sent an itemized bill, and the hospital complies with the patient’s wishes, will a hospital still be deemed to be non-compliant with SB 490?**

If a patient voluntarily notifies the hospital they do not wish to receive an itemized bill either in paper or electronic format, SB 490 should not force a hospital to ignore the patient’s wishes and provide the itemized bill. SB 490 is silent on the process a hospital should follow in this scenario.

[Under current law](#),⁴ patients have the right to personal privacy and for medical information to remain confidential. Patients may not want an itemized bill to ensure their privacy is maintained within their household or for other reasons that are not for the hospital or the state to question. THA requests clarity on the process hospitals should follow when a patient rejects the provision of the itemized bill and confirmation that SB 490 does not require a hospital to go against patient wishes when declining an itemized bill.

⁴ 25 TAC §133.42(a)(1)(H).

11) How should a hospital reconcile the requirement of SB 490 to provide an itemized bill with the requirement to provide an itemized statement upon request outlined in Section 311.002 of the Texas Health & Safety Code?

Please clarify how to reconcile SB 490 with Section 311.002(c) of the Health & Safety, requiring hospitals to notify patients of their ability to request *itemized statements*. SB 490 seems to make the “on request” portion of Section 311.002(b) moot. Section 311.002(g) allows the Department of State Health Services (now HHSC) to enforce Section 311.002 by assessing an administrative penalty, obtaining an injunction, or providing any other appropriate remedy, including suspending, revoking, or refusing to renew a hospital’s license. Section 311.002 was not repealed by SB 490. Therefore, hospitals are potentially forced to comply with conflicting laws which could be irreconcilable in certain circumstances.

Section 311.025, Government Code states “...if statutes enacted at the same or different sessions of the legislature are irreconcilable, the statute latest in date of enactment prevails.” THA requests clarification on reconciling these two statutes and confirmation that SB 490 prevails in the event of an irreconcilable conflict.

Enforcement

12) When will HHSC begin enforcement of SB 490? For hospitals not compliant by 9/1/23, but working towards compliance, will HHSC take good faith efforts to comply in account before taking any disciplinary action?

Full compliance may not be possible by September 1, 2023, but earnest, good faith efforts are underway to achieve compliance with this new vague, unclear, and potentially impossible (given the varying reimbursement practices of third-party payers and the technical capabilities of current EHR/EMRs or billing systems) to implement legislation of great importance to Texans.

THA urges HHSC to delay any disciplinary action, specifically financial, for at least one year for hospitals making good faith efforts to comply but who may not achieve full compliance on September 1, 2023. For some hospitals, achieving full compliance may take a much more monumental and financial effort than others. For example, one rural hospital system is being forced to migrate to a new electronic medical record platform because their current vendor has decided to sunset their existing platform. The rural hospital system’s affected facilities do not currently possess the technical capabilities nor financial resources to export the necessary information to generate this required itemized bill for their patients and will have to expend considerable resources to achieve compliance using other more expensive and inconvenient methods. Hospitals also utilize different EHR/EMR systems or may be on different levels of development with respect to the same system meaning for some, compliance may be easier to achieve than others given the technical resources currently available.

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As previously stated, THA supports price transparency in healthcare but wants to ensure these price transparency efforts are useful and effective – resulting in clarity rather than confusion for patients. THA implores HHSC to consider reasonable leniency with hospitals who are taking the necessary steps to comply with SB 490.

13) What types of disciplinary action will HHSC take against hospitals it finds to be non-compliant, especially since no rules will have been adopted by HHSC prior to 9/1/23?

THA requests clarity on the disciplinary action a hospital might face if in violation of SB 490. Specifically, please clarify whether suspension or termination of the hospital's license are potential disciplinary actions, especially where hospitals are making good faith efforts to comply with SB 490 and are hampered by technical, logistical, and administrative delays. Additionally, please clarify how a hospital is expected to prove to HHSC that an itemized bill was submitted to the patient.

Thank you for the opportunity to participate in this process, and for your time and attention to this matter. Again, THA recognizes the importance of providing transparency to patients regarding their medical bills but wants to ensure that such transparency is provided consistent with operational realities and in a manner that does not in fact increase the cost of health care. THA's interpretations and requests for guidance attempt to minimize this expense as much as possible, and hospitals appreciate any and all additional clarity that can be provided by the agency. We look forward to working with you and please feel free to contact me at (512) 465-1003 or hdelagarza@tha.org with any questions, comments, or if there is anything else THA can assist with.

Respectfully submitted,

/s/Heather De La Garza

Heather De La Garza
Assistant General Counsel
Texas Hospital Association