

Diamond State Hospital Cost Review Board Meeting

Delaware Department of Health and Social Services (DHSS)
Herman M. Holloway Sr. Health and Social Services
Main Administration Building
Conference Room 2CR
1901 N. DuPont Highway
New Castle, DE 19720

September 8, 2026



Agenda

- I. Welcome/Call to Order
- II. Approval of August 11, 2026, Draft Meeting Minutes
- III. Meeting Ground Rules
- IV. Update on Admin Regulation (5003 Hospital Information Review)
- V. Review Public Comments on Hospital Guidance & Board Vote on Hospital Submission Guidance
- VI. Charity Care Presentation: Eva Stahl, Vice President of Policy, Engagement, & Research, Undue Medical Debt
- VII. Brief Overview of Information Currently Collected on Charity Care
- VIII. Amended Hospital Charity Care and Financial Assistance Program: Administrative Regulation Development
- IX. Public Comment





Welcome/Call to Order

David Singleton, Chair



Approval of August 11, 2026, Draft Meeting Minutes

David Singleton, Chair



Meeting Ground Rules

David Singleton, Chair



Update on Admin Regulation (5003 Hospital Information Review)

Update on Administrative Regulation 5003: Hospital Information Review

While filing the regulation, a few non-substantive changes were made:

- Definitions required for the Uniform Reporting Manual were moved back to section 5, in a new section 5.5. Section 1.0 now contains only 4 terms that fulfill that criterion.
 - The introductory language of subsection 5.5 is numbered, identifies the terms as the uniform definitions for hospital information submissions under the Manual, and the definitions themselves are unnumbered.
 - Subsection 5.1 has been conformed to describe the Manual as providing the uniform definitions and to point to subsection 5.5.
- Additional clarity in language:
 - Commission and State are struck and the Commission's full name is used instead.
 - Replacing instances of "this subsection" with "this Section" in 5.2.1 and 5.3.2.



Review Public Comments on Hospital Guidance & Board Vote on Hospital Submission Guidance

Proposed Guidance and Exhibits

The [proposed guidance and exhibits were posted to the DSHCB website for public comment](#) from **Tuesday, August 18th through Tuesday, September 1st.**

The guidance established 10 mandatory and 2 optional, draft exhibits:

Standard	DSHCRB
1. Audited Financial Statement (AFS) (including consolidating statements)	7. Narrative
2. <i>AFS Explanatory Statement (optional)</i>	8. Standardized AFS
3. Letters accompanying the AFS (e.g., management letters)	9. Utilization summary
4. Hospital Price Transparency file (per CMS standards)	10. Revenue summary
5. IRS Form 990 series	11. <i>Redaction statement and proposed public version of submission with proposed redactions (optional)</i>
6. Medicare Hospital Cost Report	12. Certification

Proposed Guidance and Exhibits: Public Comment

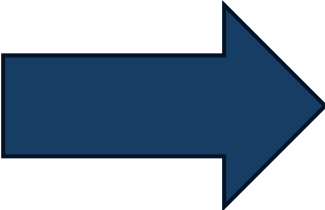
There was 1 public comment submitted from the DHA:

The Patient Revenue Summary, Section 2 “Reconciliation of Gross to Net Patient Revenue (Total), requires hospitals to break down Total Gross Patient Revenue by contractual adjustments, charity care, and implicit price concessions. We support providing the charity care information, but contractual adjustments and implicit price concessions are competitively sensitive information and sharing it would potentially create anti-trust issues. This may also go beyond providing information regarding “revenues,” by requiring hospitals to provide contractual terms that *impact* revenues, rather than the revenue itself.

Potential Change

Update the Revenue Summary template to combine contractual adjustments and implicit price concessions and any other deductions aside from charity care:

Total Gross Patient Revenue
Less: Contractual Adjustments
Less: Charity Care
Less: Implicit Price Concessions
Net Charge-Based Patient Revenue



Total Gross Patient Revenue
Less: All Other Deductions from Revenue
Less: Charity Care
Net Charge-Based Patient Revenue



Charity Care Presentation:

Eva Stahl, Vice President of Policy, Engagement, & Research, Undue Medical Debt

FROM FINANCIAL ASSISTANCE TO MEDICAL DEBT PREVENTION

A presentation on the state policy landscape for financial assistance access, accountability and hospital implementation

**Briefing for the Diamond State Hospital Cost Review Board
with Delaware hospital leadership**

Eva Marie Stahl, PhD
Undue Medical Debt

September 2026

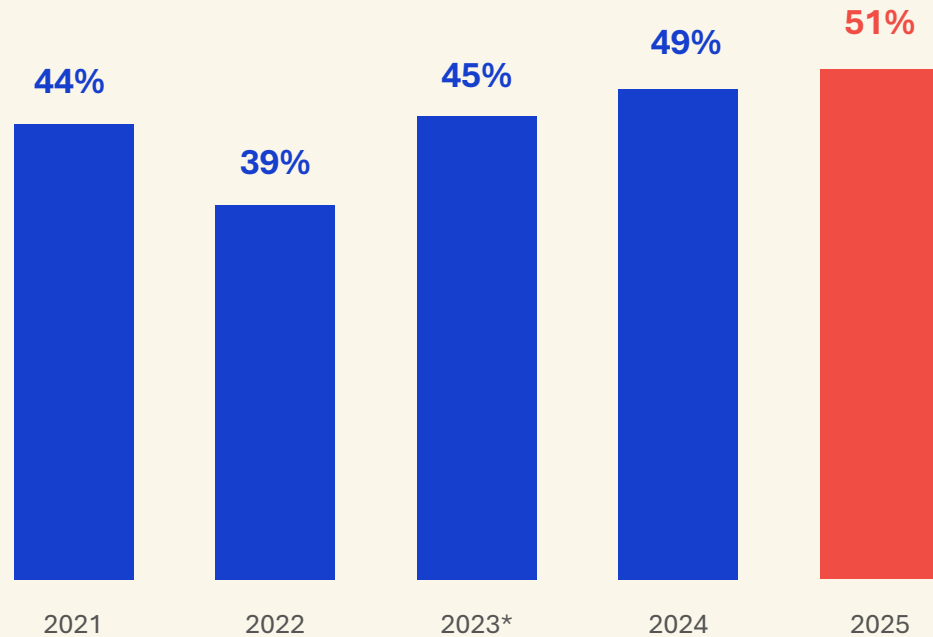
Agenda

- Medical debt, a growing pressure on patients
- Charity care/financial assistance as a tool to protect patients
- Emerging practices – lessons from states
- A roadmap for collaboration
- Q & A

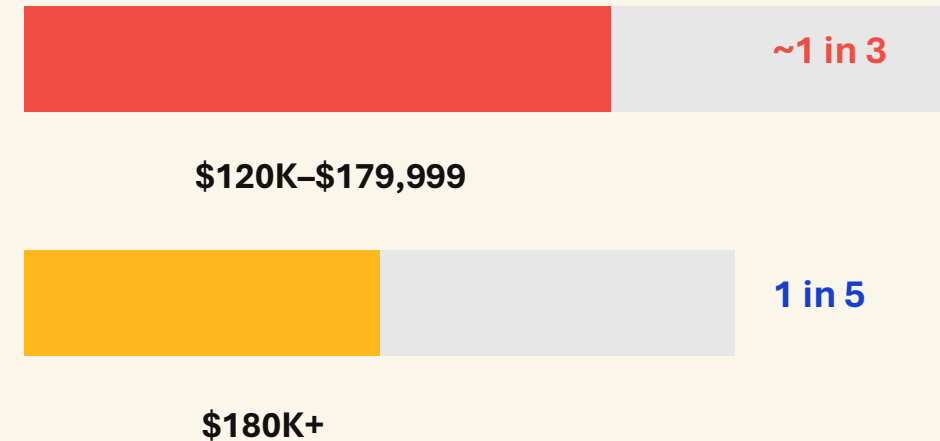
Rising costs are pushing more people into medical debt, extending well into the middle class

Coverage gains have not stopped health costs from outpacing household protection. Rising uninsured and underinsured risks more medical debt.

SHARE OF U.S. ADULTS WHO CANNOT AFFORD AND PAY FOR THEIR CARE



NOT COST SECURE, 2025



*2023 shown as reported in the 2024 index series, West Health Gallup, 2026.

\$84,954 = DE median income

Insurance is not immunity from medical debt

The relevant dividing line is affordable coverage, not simply covered versus uninsured.

44%

of underinsured adults were paying medical or dental debt over time

HOW COVERAGE STILL BECOMES DEBT

COVERED

Employer, Marketplace or Medicare including monthly premium



EXPOSED

Deductible, coinsurance, denial or uncovered provider



STRAINED

Bill exceeds available cash or savings

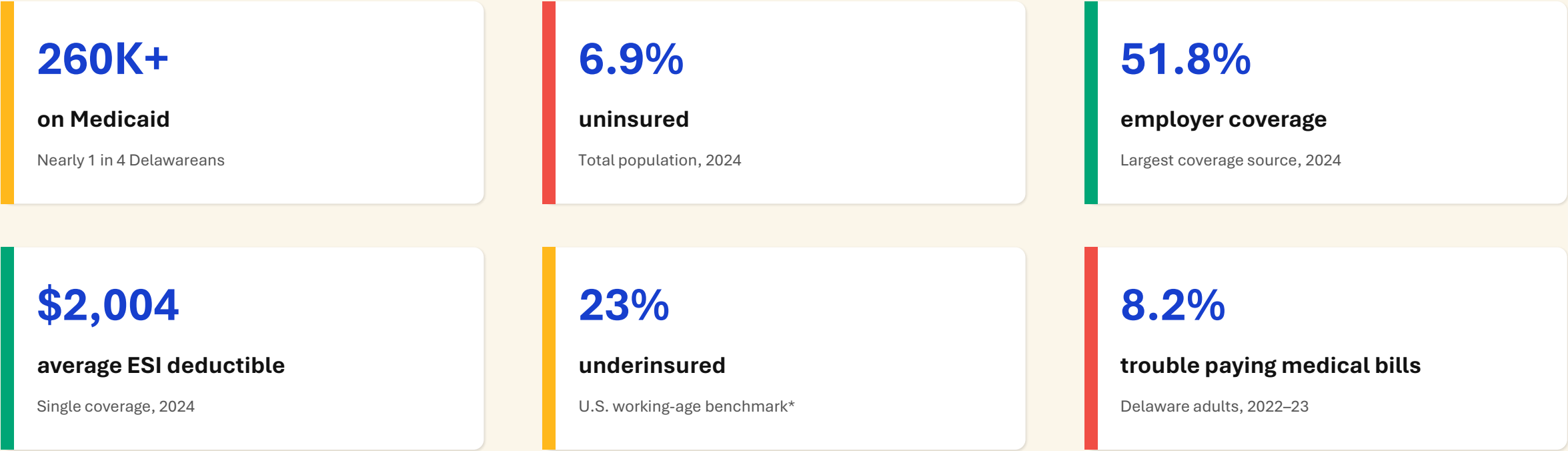


IN DEBT

Payment plan, credit card, loan or collections

Delaware’s coverage landscape

Coverage is broad, but affordability risk extends well beyond the uninsured.



THE POLICY TAKEAWAY

Insurance status alone does not measure ability to pay.

Pair Medicaid and uninsured measures with deductible burden, underinsurance and bill-payment difficulty.

**23% is the Commonwealth Fund’s national estimate for working-age adults insured all year; over 50% have insurance through their employer.*

For Delaware, financial assistance becomes a coverage-transition strategy

HR1 increases the risk that patients move from Medicaid to uninsured status, or into coverage with greater out-of-pocket exposure while the cost of ESI goes up and Marketplace enhanced subsidies are no longer available.



DELAWARE APPROACH:

1 SCREEN EARLY

Screen before the first bill and at coverage loss or renewal failure.

2 DO NOT STOP AT MEDICAID

Use other public programs as categorical approval, not as the outer boundary of assistance.

3 COVER THE GRAY ZONE

Include insured and moderate-income patients facing unaffordable bills or medical hardship.

Financial assistance is an upstream affordability tool

It reduces what an eligible patient owes before an unpaid bill becomes medical debt.

THE CORE DEFINITION

Free or discounted medically necessary hospital care for people who meet a hospital or state eligibility standard.

Often called “charity care,” financial assistance applies to the patient-responsibility portion after insurance and other coverage are considered.

Can include insured patients

Not the same as bad debt



FINANCIAL ASSISTANCE

Adjusts the bill based on eligibility, ideally before billing.



BAD DEBT

An accounting category after expected payment is not received.



DEBT RELIEF

Cancels qualifying debt that has already been incurred.

Policy aim: move assistance earlier so fewer accounts ever enter a debt collections workflow.

Federal law sets a floor. States fill gaps.

Section 501(r) links baseline patient protections to federal tax exemption but leaves major policy choices to hospitals and states.

WHAT 501(R) REQUIRES OF 501(C)(3) HOSPITALS

- 1 Written policies** A financial assistance policy and an emergency medical care policy
- 2 Charge limits** FAP-eligible patients cannot be charged more than amounts generally billed to insured patients
- 3 Collection safeguards** Reasonable efforts to determine FAP eligibility before extraordinary collection actions (ECAs)
- 4 Community accountability** A community health needs assessment at least once every three years, including annual reporting on activities

WHY STATES FILL IN GAPS

- Coverage gap** 501(r) applies to tax-exempt hospital organizations, not every hospital or every separately billing provider.
- Eligibility gap** Federal law requires a policy but does not prescribe a national income threshold, discount schedule or medical-hardship standard.
- Access gap** Federal rules allow hospital-specific applications and procedures, creating variation and administrative burden.
- Oversight gap** Tax-status enforcement is not a substitute for accessible state complaints, hospital-level reporting, refunds and remedies.

State role: make eligibility consistent, assistance easy to access, protections broader and enforcement closer to patients.

The national landscape is growing, but still patchwork

Strong rules combine substantive standards, accessible procedures and credible oversight.

21

states + DC set minimum financial assistance standards

8

states require screening before some bills advance to collections

19

states collect no relevant hospital data on assistance, billing or lawsuits

THREE RECURRING GAPS

LEGAL STANDARDS

Who qualifies, which providers and debts are covered

PROCESS PITFALLS

Burdensome applications, weak notice and no appeal

ACCOUNTABILITY

Too little reporting, unclear accountability and weak remedies

No single state closes every gap. Delaware can borrow the strongest, most operationally workable pieces.

Washington and Oregon: clear floors plus broad access

Both reach insured patients; Oregon adds automatic prescreening and a tiered statewide schedule.

WASHINGTON

Broad eligibility

- All licensed hospitals
- Insured and uninsured patients, regardless of immigration status
- Large-system tier: free care $\leq 300\%$ FPL; discounts through 400% FPL
- Screen certain patients before sending to collections

Strength: simple income-facing message and broad patient scope.

OREGON

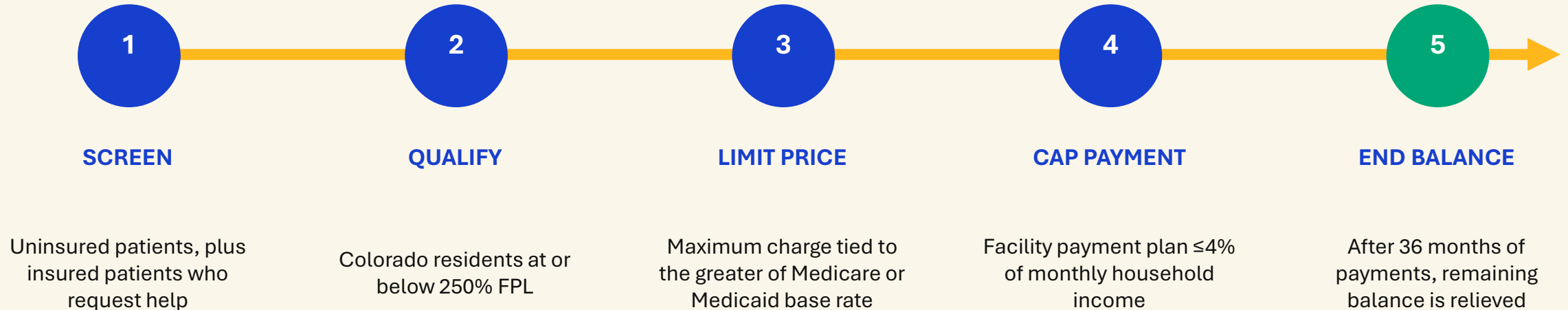
Prescreening + tiers

- Nonprofit hospitals and affiliated nonprofit clinics
- Insured and uninsured patients, regardless of immigration status
- Free care $\leq 200\%$ FPL; 75% / 50% / 25% discounts through 400% FPL
- Prescreen certain patients before the first bill

Strength: predictable discounts and reduced application burden.

Colorado: connect eligibility to an affordable payment endpoint

The innovation is not just a discount. It is a defined rate, income-based payment cap and finish line.

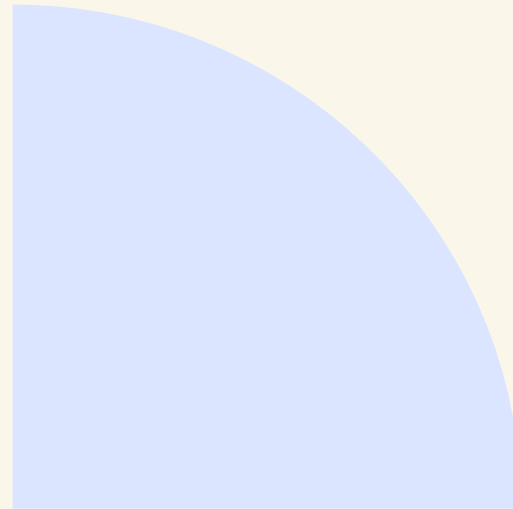


Takeaway: define affordability in both the adjusted price and the monthly cash-flow obligation.

North Carolina: use incentives to align every hospital

The first-in-the-nation model pairs enhanced Medicaid payments with debt relief and prospective reforms.

99
eligible hospitals
participating



\$6.5B+

debt relieved for 2.5M+ people
as reported Oct. 13, 2025

RELIEVE

Retrospective debt relief for Medicaid enrollees and qualifying low- and middle-income residents

PREVENT

50%–100% discounts through 300% FPL and presumptive eligibility

PROTECT

Limits on aggressive collections including a ban on credit reporting

Why it works: a material incentive, uniform expectations, phased milestones and hospital participation in implementation.

California: pair broad standards with a dedicated compliance home

Statewide rules cover financially qualified insured patients and are backed by policy review, complaints and penalties.

ELIGIBILITY

Financial assistance (& discounted care) up to 400% FPL, including uninsured patients and insured patients with high medical costs

BILLING + COLLECTIONS

Government-rate (Medicare or Medi-Cal) payment limits, interest-free extended plans, 180-day protections and no adverse credit reporting

ADMINISTRATION

CA Department of Health Care Access & Information (HCAI) policy lookup, patient complaint process, policy review and administrative penalties

NEXT PHASE

Prescreening and presumptive eligibility requirements begin July 1, 2027

Takeaway: standards become real when patients and hospitals know who interprets rules, resolves disputes and publishes results.

Presumptive eligibility flips the burden

Instead of waiting for a patient to find and complete an application, the hospital identifies likely eligibility and adjusts the bill early.

TRADITIONAL MODEL

PATIENT MUST

-  Learn assistance exists
-  Locate the policy and form
-  Gather documents
-  Apply and wait

Eligible people can fall out before assistance is applied.



LEADING-STATE MODEL

-  **TRIGGER** Uninsured status, Medicaid or means-tested enrollment, prior approval, homelessness, or a qualifying balance
-  **SCREEN** Use existing records, categorical eligibility, or a carefully governed third-party income tool
-  **ADJUST** Apply the assistance supported by reliable data before the first bill
-  **ENGAGE** Notify the patient and preserve a simple path to seek more help, correct data, or appeal

Critical guardrail: use automation to approve, never to silently deny.

OR: prescreen before billing

NC: statewide incentive model

CA: required beginning 7/1/27

Leader practice: earlier + easier

Promising practices can fail at the implementation seams

Design rules for the messy cases, not only the ideal workflow.

PITFALL

- ✗ Eligibility limited to uninsured patients
- ✗ Medicaid application used as a precondition
- ✗ Separate facility and clinician bills follow different rules
- ✗ Collections continue while an application or appeal is pending
- ✗ Reporting measures dollars, but not access or denials

DESIGN SAFEGUARD

- ✓ Include underinsured patients and medical hardship
- ✓ Screen in parallel and offer enrollment help
- ✓ Define provider scope and require aligned notices
- ✓ Pause all collection activity and recall accounts
- ✓ Track screening, approvals, denials, appeals, refunds and demographics

DELAWARE IMPLEMENTATION: KEY CONSIDERATIONS

North star: fewer FAP eligible patients billed, fewer accounts collected, more assistance delivered early.

Move from minimum compliance to a shared operating model that protects patients and is administratively workable for hospitals.

- 1 Standardize** Uniform eligibility tiers, covered services, hardship policy and transferable determinations
- 2 Screen early** Presumptive approval pathways, parallel coverage screening and a clear manual fallback
- 3 Pause harm** No collections during screening or appeal; prompt corrections, refunds and account recall
- 4 Measure** Hospital-level reporting on reach, denials, appeals and patient outcomes, not only charity-care dollars
- 5 Co-govern** Implementation table with the Board, hospitals, patient representatives and technical experts

Q & A



Brief Overview of Information Currently Collected on Charity Care

Health Resources Management Plan (HRMP)

- [Health Resources Management Plan \(HRMP\)](#)
- As a condition of receiving a Certificate of Public Review (CPR), the applicant must develop a formal written charity care plan and file a copy of it with the Delaware HRB at the time of application for a CPR approval.
- The Health Resources Board may require that the applicant amend its charity care plan if it is determined to be unsatisfactory.
- If CPR approval is granted, the applicant will annually submit to the HRB a report from an independent, Delaware-licensed, certified public accountant that documents the amount of charity care they have provided during the previous fiscal year.



Community Benefits Reporting

- Title 17, Chapter 93A, § 9301 [Delaware Code Online](#)
- Hospitals must develop an annual community benefits activity
- Report submitted to: Delaware Health Care Commission, the Department of Health and Social Services, the Office of Management and Budget, the Department of Finance, the Office of the Governor, the Clerk of the House of Representatives, the Secretary of the Senate, and the Director and Librarian of the Division of Legislative Services.



Community Benefits Reporting cont.

Report must include at a minimum the following:

- (1) A publicly-available website link to the reporting hospital's most recent community health needs assessment, updated on 3-year reporting cycles in accordance with applicable federal regulatory requirements, including 26 C.F.R. § 1.501(r)-3.
- (2) A list of the activities that were undertaken by the hospital to address the identified community health needs within the hospital's community.
- (3) The cost to the hospital of each community benefit activity.
- (4) A description of gaps in the availability of providers to serve the community.
- (5) A description of efforts undertaken by the hospital to track and reduce health disparities in the community that the hospital serves.
- (6) A list of the unmet community health needs identified in the most recent community health needs assessment.
- (7) Any additional information the hospital deems relevant to its community benefit activities, including Medicare and Medicaid shortfalls.
- (8) Amount of community benefit funding going to community-based organizations, with a list of organizations and the funding amounts.
- (9) Total amount of community benefits, not including Medicare and Medicaid shortfalls.





Amended Hospital Charity Care and Financial Assistance Program: Administrative Regulation Development



Charity Care Program: Orientation and Administrative Regulation Development

Goals for Today's Charity Care Discussion

- Review Charity Care Program Requirements and Board Obligations.
- Orient to Charity Care Program components that must be established by Regulation.
- Highlight decision points and input required for plain language Administrative Regulation draft.
- Prepare for working session with Delaware HealthCare Association.

High-level Summary of Board Duties

- The Diamond State Hospital Cost Review Board is required to:
 - Oversee the program
 - Set the standard application and rules
 - Post hospital policies and reports
 - Review compliance.
- The Board may adopt regulations to administer, enforce, or implement its duties as prescribed by the Act.
 - **Financial assistance income standards take effect January 1, 2027.**
 - **Everything else will take effect when the Board publishes notice of final regulations or July 1, 2027, whichever is first.**

Patient Eligibility Tiers per § 9962(a)(1)

Hospitals are subject to these standards effective **January 1, 2027**.

Federal Poverty Level (FPL)	Minimum assistance	2026 Income Guidelines	
		2-person household	4-person household
≤ 300%	Full (100%)	≤ \$64,920	≤ \$99,000
> 300% to ≤ 350%	≥ 75% off	\$64,920 to \$75,740	\$99,000 to \$115,500
> 350% to ≤ 400%	≥ 50% off	\$75,740 to \$86,560	\$115,500 to \$132,000
> 400%	Optional	> \$86,560	> \$132,000

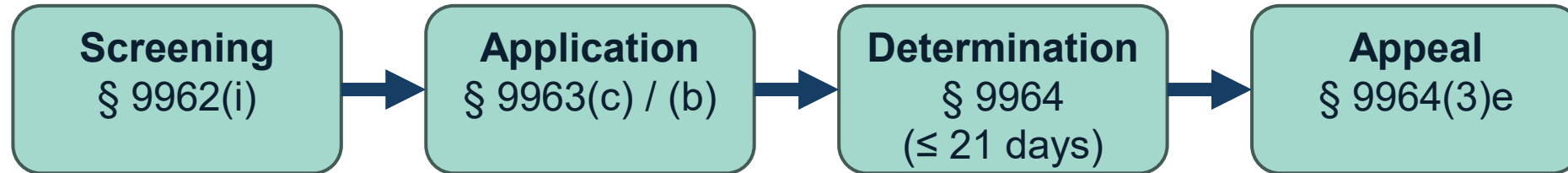
Charity Care Tiers vs Medicaid Programs

Eligibility for medical assistance through Medicaid in Delaware varies by program and applicant circumstance.

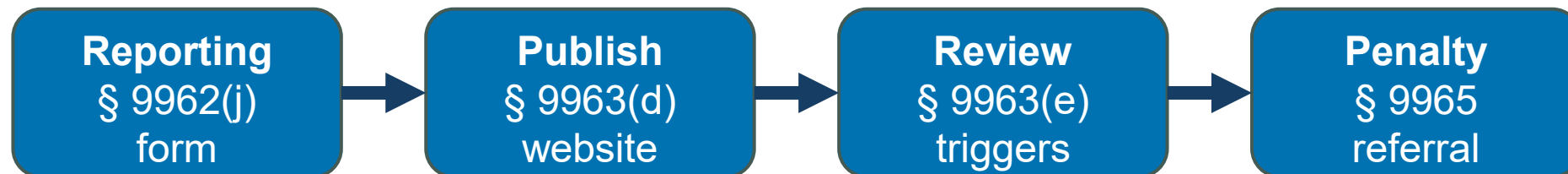
Program	FPL Limit	Annual income (2026)
Aged, Blind, and Disabled (ABD)	≤ 100%	≤ \$15,960
Medical assistance	≤ 138%	≤ \$22,025
Pregnant individuals and Delaware Healthy Children Program (CHIP)	≤ 218%	≤ \$34,763
Diamond State Health Plan (DSHP) / Long-Term Care	≤ 250%	≤ \$39,900

The charity care statute provides financial assistance to Delawareans that may not qualify for a Medicaid program based on income or other circumstances.

ESTABLISH PATIENT ELIGIBILITY



OVERSEE HOSPITAL COMPLIANCE



Shall establish by regulation, with input from the Delaware Healthcare Association:

- Establish categories of information/documentation hospitals may request from applicants.
 - Information is limited to what's reasonably necessary to verify income and household size (hospitals cannot ask for anything outside these categories).
- Establish categories of presumptive eligibility (e.g., enrollment in income-based public benefits, subsidized housing residency, homeless services receipt, or other income indicators).
- Establish methodologies for identifying presumptively eligible patients (historical data, predictive modeling, etc.)
 - The Board may require, permit, or restrict specific methodologies.
- Establish by regulation that recipients must be Delaware residents.

Shall prescribe:

- A standard financial assistance application all hospitals must use
 - Must approve modified applications that reduce applicant burden
 - May not approve modified applications requiring documentation beyond the established categories
- A standardized list of acceptable forms of income verification.
- A list of income-based public assistance programs and associated verification forms.

The Board shall maintain a public website posting including the following:

- Hospital financial assistance policies and reports (within 30 days of receipt).
- Information on financial assistance rights, hospital policies, and Board-prescribed items.
- All documents the Board is required to prescribe per (§ 9963(c)).

- **The Board may initiate** reviews triggered by:
 - Credible complaints of noncompliance.
 - Outlier reporting patterns (high denial/closure rates, long determination times, low presumptive eligibility usage).
 - Evidence of missing written communication during billing/collection while a determination was pending.
 - Other risk indicators the Board may **establish by regulation**.

- Receive hospital reports (applications received; approvals/denials/closures with reasons; presumptive screenings and determinations; time-to-determination; assistance provided at cost and as a percentage of operating expenses) in a form, manner, and frequency the Board sets (§ 9962(j)).
- **May specify by regulation** which categories of services are or are not "hospital services" (§ 9961(8)d).
- Prescribe the appeals process hospitals must follow for denied applications (§ 9964(3)e).
- Notify the Division of Health Care Quality upon finding a hospital noncompliant (§ 9965(a)).
- Publish notice in the Register of Regulations when final implementing regulations are adopted.

Must Be Established BY REGULATION

§ 9963(b): “shall establish by regulation”

- Categories of information/documentation hospitals may request
§ 9963(b)(1)
- Categories of presumptive eligibility
§ 9963(b)(2)
- Methodologies for identifying presumptively eligible patients
§ 9963(b)(3)
- Delaware residency requirement for recipients
§ 9963(b)(4)

FOCUS FOR TODAY

Must Be Prescribed

§ 9963(c): “shall prescribe” (no “by regulation”)

- Standard financial assistance application, incl. modified-application approval standard
§ 9963(c)(1)
- Standardized list of acceptable income verification
§ 9963(c)(2)
- List of qualifying public assistance programs
§ 9963(c)(3)
- Patient appeals process for a denied eligibility determination
§ 9964(3)e. *Not listed as a § 9963 duty*

Regulation is optional: § 9963(a) rulemaking is permissive (“may”), so the Board could prescribe these by vote, form, or bulletin instead of a formal regulation.

FHC Recommends using the regulation to define the process by which the application and list of acceptable income verification and qualifying assistance documents will be developed and for defining the patient appeals process.

Summary of Board Decision Points

Citation	Decision(s)	Notes
§ 9963(b)(1)	Information & documentation categories	With input from the Delaware Healthcare Association, all components to be defined in Regulation
§ 9963(b)(2)	Presumptive eligibility categories	
§ 9963(b)(3)	Presumptive methodologies / modeling	
§ 9963(b)(4)	Delaware residency	
§ 9963(c)(1)	Standard application and modified application process	
§ 9963(c)(2)-(3)	Income verification and program list	
§ 9963(e)	Compliance review triggers and thresholds	
§ 9962(j)	Reporting definitions and mechanics	
§ 9964(3)e	Appeals process	
§ 9961(8)d	Hospital services categories	Discretionary

States With Similar Initiatives

WA

Washington

RCW 70.170.060 (2022)

Source of Delaware's 300/350/400 FPL tier math. Tiered by hospital size. Residency reading is in active litigation.

OR

Oregon

HB 3076 (2019) / HB 3320 (2021)

Earlier ancestor of the model. Mandatory presumptive prescreening; reliance on vendor modeling tools.

CO

Colorado

HB 21-1198 (2021) / SB 24-116 (2024)

Single statewide uniform application built by the state. Income-only determination; homeless auto-qualify; hospitals as presumptive-eligibility sites.

NC

North Carolina

Medical Debt Relief / Healthcare Access and Stabilization Program (2024)

Mandatory automatic charity care for homeless, Medicaid / SNAP / WIC. Tied to enhanced Medicaid directed payments.

CA

California

Hospital Fair Pricing Act (2006) / AB 1020 (2021)

400% FPL reach; asset test barred; no application deadlines. State agency centrally collects and posts hospital policies.

DECISION

Establish the categories of information and documentation a hospital may request from an applicant. The categories may not exceed what is reasonably necessary to verify income and household size, and a hospital may not request anything outside them.

OPTIONS

- **Self-attestation and documentation?**,
- Which **specific documents** are acceptable (e.g., pay stubs, tax returns, W-2 or 1099 forms, benefit award letters, employer statements), all confined to proof of income and household size.
- How **“household size”** is defined.

Hospital FA Applications vs. Delaware's Medicaid Application

SS1 for SB13

Dimension	State-Issued Hospital FA Apps (NY / MD / CO)	Delaware Medicaid (ASSIST / Form 100)
Who completes it	The patient (NY, MD); hospital staff transfer patient documents in Colorado	The applicant, or anyone helping them; one adult listed as household contact
Income verification	Required — pay stubs, tax return, or employer letter; NY accepts a Marketplace determination in lieu of documents	Required — income verification requested; electronic data matches used first where available
Asset/resource verification	Barred or discouraged (CA bars considering assets; CO bars asking about assets)	Not required for most programs — explicitly waived except for Long Term Care applicant categories
Immigration status	Not a factor (NY, MD expressly bar it as an eligibility criterion)	Medicaid emergency coverage for non-citizens for medical conditions including labor and delivery and full Medicaid for pregnant persons and children who are not U.S. Citizens
Household definition	Set by each state's own statute/regulation	Federal MAGI household rules — tax-filer/dependent based, varies by program category

DECISION

Establish the categories of information and documentation a hospital may request from an applicant. The categories may not exceed what is **reasonably necessary to verify income and household size**, and a hospital may not request anything outside them.

OTHER STATES

State	Decision
Colorado	Income-only determination; resident applicants provide only household income and third-party liability information
California	Verification limited to income and family size; consideration of a patient's monetary assets is barred
Oregon	Application collects income information only
North Carolina	Documentation burden reduced through presumptive screening rather than full submission
Washington	n/a (assets not applicable under Delaware regulation)

Of the comparison states, only Colorado and California consider household size, and both rely on self-attestation.

	Colorado	California
Where defined	HCPF regulation / guidance, not in the statute.	Health & Safety Code § 127400(c), in statute.
Adults 18+	Anyone living at the patient's address.	Spouse/domestic partner, plus dependent children under 21 (any age if disabled).
Under 18	Same address-based rule applies.	Parent/caretaker relative, plus their other dependent children under 21.
Spouse / partner	Mandatory if legally married or common-law.	Included by definition for adult patients.
Other members	Counted if patient attests to ≥ 50% support (incl. out-of-state).	Not counted.
Verification	Self-attested, no documentation.	Self-attested, no documentation.

DECISION

Establish the categories of presumptive eligibility such as enrollment in or eligibility for income-based public benefits, residency in publicly subsidized housing, current or recent receipt of homeless services, or other indicators of household income reasonably available to the hospital.

OPTIONS

- Which **enumerated categories form the statewide floor** (e.g., Medicaid, SNAP, TANF, WIC, free or reduced-price school meals, Low Income Home Energy Assistance Program (LIHEAP), subsidized housing, homeless-services receipt, prior eligibility for hospital financial assistance within the last 12 months).
- Whether **hospitals may add categories beyond the floor** (hospital categories may be no more restrictive in scope than the Board's).
- The **treatment of homelessness**.

DECISION

Establish the categories of presumptive eligibility such as enrollment in or eligibility for income-based public benefits, residency in publicly subsidized housing, current or recent receipt of homeless services, or other indicators of household income reasonably available to the hospital.

OTHER STATES

State	Decision
Colorado	Patients experiencing homelessness qualify automatically
California and Washington	Rely on screening rather than a prescribed statutory list of deemed categories
Oregon	Medicaid, SNAP, TANF, WIC, free or reduced-price meals, and LIHEAP serve as presumptive bases
North Carolina	Enrollment in Medicaid, SNAP, or WIC, homelessness, or incapacitation without a representative results in automatic charity care.

DECISION

Establish the methodologies for identifying presumptively eligible patients, governing the use of historical data, predictive modeling, and other approaches. The Board may require, permit, or restrict specific methodologies.

OPTIONS

- Whether to permit, require, or restrict **predictive-modeling and third-party vendor tools**.
- The **historical-data lookback window and the data sources** hospitals may draw on.
- Any **accuracy, validation, or audit standard** imposed on a methodology, and whether a **full-application fallback** must remain available.
- Whether **specific vendor methods** are approved.

DECISION

Establish the methodologies for identifying presumptively eligible patients, governing the use of historical data, predictive modeling, and other approaches. The Board may require, permit, or restrict specific methodologies.

OTHER STATES

State	Decision
Colorado	Use of existing patient data for presumptive screening is optional, not required
Oregon	Hospitals rely on third-party financial-assessment vendors
North Carolina	Streamlined automatic screening, without requiring a patient application for deemed groups

DECISION

Establish the standard of proof and its administration.

OPTIONS

- The proof-of-residency standard (**self-attestation versus documentation**, and **which documents**).
- The **definition of “resident”** (fixed or domicile test; any duration requirement).

DECISION

Establish the standard of proof and its administration.

OTHER STATES

State	Decision
Colorado	A “currently lives in the state” attestation, applied regardless of documentation or lawful status
California, North Carolina, Washington, and Oregon	n/a (no residency requirement)
Delaware Medicaid	For individuals age 21 and older who are not institutionalized, residency generally means living in Delaware and either intending to remain in the state—including without a fixed address—or entering Delaware with a commitment to work or to seek employment (17 DE Reg. 503)

State Residency Requirements for Financial Assistance

SS1 for SB13

State	Residency required?	Basis	Notable features
Colorado	Yes; Self-attestation only	C.R.S. § 25.5-3-501(5)	Patient attests to CO residency; lawful presence not required; undocumented residents qualify
California	No	H&S Code §§ 127400/127405	Eligibility is purely income-based; explicitly available regardless of residency or immigration status
Oregon	Not clearly	ORS 442.610	“Resident of this state” appears only re: limits on info collection, not as an eligibility gate; no definition given
North Carolina	Not codified	HASP (Medicaid directed-payment agreement, not a standalone statute)	No statewide statutory test; some hospitals use “NC resident” in their own policies, but that's hospital-level
Washington	No; affirmatively barred	RCW 70.170; DOH guidance	DOH has told hospitals they may not restrict eligibility by zip code, city, county, or state of residence
Vermont	Optional for facility to require; if required, broadly defined	18 V.S.A. § 9481(12); § 9482(d)	Live, work, or attend school in VT (or lack stable housing there); includes undocumented immigrants; no durational requirement allowed

Three states (CA, OR effectively, WA) impose no residency bar; Colorado uses a self-attested test; only Vermont statutorily defines residency in detail.

§ 9961(8)d – Hospital services categories

Discretionary

DECISION

The Board may specify categories of services that are or are not “hospital services” consistent with the definition.

OPTIONS

- Whether to specify any inclusions or exclusions at all in year one, or to defer.
- If specifying, which categories to clarify (for example, facility versus professional claims; retail pharmacy).

DECISION

The Board may specify categories of services that are or are not “hospital services” consistent with the definition.

OTHER STATES

State	Decision
California	Fair-pricing includes hospital and emergency physician services
North Carolina	Discounts may be limited to inpatient and outpatient hospital facility claims, excluding retail pharmacy and professional services



Upcoming Meetings

Upcoming Meeting Topics

Board Meeting	Topics
October 2026 *will require additional board meetings	• Working session with DHA • Charity care Administrative Regulation • Review expenses and revenue from AFS analysis and introduce IRS 990 data • Hospital Panel
November 2026	• Review/discuss plain language draft Charity care regulation • Introduce Medicare Cost Reports
December 2026	• Finalize plain language draft of Charity Care regulation • Outline process for reviewing annual hospital data submissions
February – April 2027	• Review hospital submissions and conduct hearings
February 2027	• Target date for Board approval of Charity care regulation
June 2027 - July 2027	• Initiate development of amendment (Phase 2) to Administrative Regulation #1 to incorporate Benchmark Compliance Plan and Meaningful Cost Containment provisions

Thank you.

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Public Comment

Adjourn

