Payment Plans and Collections

Hospital Discounted Care

Taryn Graf, State Programs Work Lead
Mercedes Vieira-Gomes, State Programs Health Care Coordinator
Chandra Vital, State Programs Sections Manager
Alondra Yanez Sanchez, State Programs Administrative Assistant

COLORADO
Department of Health Care Policy & Financing

Objectives

- Rates
- Payment Plan Rules
- Payment Plan Examples
- Collections Rules
- Different scenarios for Collections

From the Bill

- BEGINNING (SEPTEMBER) 1, 2022, IF A PATIENT IS SCREENED PURSUANT TO SECTION 25.5-3-502 AND IS DETERMINED TO BE A QUALIFIED PATIENT, A HEALTH-CARE FACILITY AND A LICENSED HEALTH-CARE PROFESSIONAL SHALL, FOR EMERGENCY AND OTHER NON-CICP HEALTH-CARE SERVICES:
  - LIMIT THE AMOUNTS CHARGED TO NOT MORE THAN THE DISCOUNTED RATE ESTABLISHED IN STATE DEPARTMENT RULE PURSUANT TO SECTION 25.5-3-505 (2)(j);
  - COLLECT AMOUNTS CHARGED, NOT INCLUDING AMOUNTS OWED BY THIRD-PARTY PAYERS, IN MONTHLY INSTALLMENTS SUCH THAT THE PATIENT IS NOT PAYING MORE THAN FOUR PERCENT OF THE PATIENT'S MONTHLY HOUSEHOLD INCOME ON A BILL FROM A HEALTH-CARE FACILITY AND NOT PAYING MORE THAN TWO PERCENT OF THE PATIENT'S MONTHLY HOUSEHOLD INCOME ON A BILL FROM EACH LICENSED HEALTH-CARE PROFESSIONAL; AND
  - AFTER A CUMULATIVE THIRTY-SIX MONTHS OF PAYMENTS, CONSIDER THE PATIENT'S BILL PAID IN FULL AND PERMANENTLY CEASE ANY AND ALL COLLECTION ACTIVITIES ON ANY BALANCE THAT REMAINS UNPAID

Definitions

- A Qualified Patient is an individual who resides in Colorado whose household income is not more than 250% of the federal poverty guidelines
  - Hospitals can extend to non-Colorado residents
- Household means any person living at the patient's address and any other members who live outside of the state or country that the patient or their guardian provides 50% or more of their support
- Income includes employment, self-employment, and a short list of unearned income sources

Rates

Rates

- Rates are set annually by the Department
- Rates are determined by using the higher of the Medicare and Medicaid Base rates
- Inpatient rates vary from Facility to Facility
- Outpatient rates vary from Facility to Facility, with the exception of a subset of clinical diagnostic laboratory service rates
- Professional rates do not vary by location and are the same statewide

Provider Rates

- Rates are published on the Department's Hospital Discounted Care Rates webpage: https://hcpf.colorado.gov/Hospital-Discounted-Care-Rates
  - Inpatient rates are contained in one file for all hospitals
  - Outpatient rates are split into multiple files organized by hospital name
    - Clinical Diagnostic rates are all in one file
  - Professional rates are contained in one file

Rates Rules

- Providers may not collect more than the established rate from any patient who qualifies for Hospital Discounted Care
  - Includes payments from third parties as well as allowable payment plan
  - Patients with a third-party payer may end up owing nothing if the third-party payment is more than the established rate
  - Patients cannot be sent to collections for more than the set rate less any payments from third parties or the patient

Collections Example

- A patient has services with an allowed billed amount of $8,298. Their insurance company pays $5,932, and the patient pays $300 prior to ceasing payments on their account
- The account can be sent to collections for $2,066
  - $8,298 - $5,932 = $2,366 - $300 = $2,066

Questions?

Payment Plans

Note

- There will be examples of payment plans throughout this section
- Please note that these are fictional examples only and are not the only options available to providers or patients
- Any payment plan that is no more than 4%/2% of the gross monthly household income and no more than 36 payments is allowable
- All bills must be written off once 36 payments have been made

Payment Plans

- Qualified patients must be allowed to set up payment plans for their medical bills under HDC
- Patients may not be sent to outside institutions to obtain loans to pay off their bills in lieu of setting up a payment plan directly with the provider
- Third party companies who agree to not charge interest and abide by HDC rules related to amount and length of payment plans may still be used

HDC/CICP

- Patients who qualify for both HDC and CICP must have their copays and payment plans follow the rules for both
- The patient would be responsible for the lower of the HDC rate or the CICP copay
- Patients must be allowed to set up payment plans for all services regardless of whether the service falls under CICP or HDC

HDC/CICP Example

- A patient has surgery that is discounted under CICP and needs follow up physical therapy after the surgery, which the facility does not discount under CICP
- The patient would be charged the CICP Ambulatory Surgery copay for the surgery and would be charged the HDC rate for the physical therapy sessions

Monthly Max

- Households cannot be billed more than 4% of their gross monthly household income for bills from a hospital, and 2% of their gross monthly household income for bills from each health care professional that bills separately from the hospital
- These maximums are per episode of care
- For CICP providers, the 10% annual copay cap applies to both CICP and HDC copays/payment plans

Episode of Care

- The definition of “episode of care” is determined by the provider
- Providers must use the same definition of episode of care for both the creation of payment plans and for the Screening process
  - In other words, anything that the provider would put under one payment plan would be covered by one Screening/Decline Screening form and vice versa

Question 1

- If a licensed health care professional provides a surgery within the hospital and the follow up care within their own private practice, does the billing for the follow up have to follow the 2% rule?
  - A. Yes
  - B. No

Max Payments

- Payment plans can be set for no longer than 36 months of payments for each episode of care
- Patients are allowed to pay more than their monthly amount due if they choose in order to pay their bill off faster
  - In these cases, the additional payment would reduce the number of months the payment plan is set for
- Patients are also allowed to skip payments and add the skipped payments to the end of their established payment plan

Question 2

- A patient is informed that their 4% monthly max is $135, and their payment plan total is $4,860. The patient makes four payments at $135 and their fifth payment is $250. Does the facility have to return the overpayment of $115 to the patient?
  - A. Yes
  - B. No

Setting up a Plan

- Uninsured patients should be contacted within 30 days of their determination to pay their bill or set up their payment plan
  - If a patient has submitted an appeal of their determination, this contact must occur after their appeal has been processed
- Insured patients should be contacted within 30 days of the insurance adjustment
- Patients have up to 181 days past their date of service (DOS) or date of discharge (DOD), whichever is later, to make a payment

Question 3

- A patient is part of a Health Sharing Ministry. When would a provider be able to set up a payment plan with this patient?
  - A. After the Health Sharing Ministry has paid or denied their claim
  - B. Immediately after their eligible determination

Immediate Bill Pay Offs, Pre-Payments, or "Paid in Full"

- Qualified Patients are allowed to:
  - pay their bill in full immediately after their determination, or
  - pre-pay for scheduled services, or
  - utilize a "Paid in Full" option
- In these situations, the most that the patient would be required to pay is the same amount as if they set up a 36-month payment plan at 4% of their monthly income for a facility bill, or 2% of their monthly income for a professional bill, or the allowed bill amount, whichever is lower

Pre-Pay Example

- A household of three has an annual income of $43,564 and a determination rating of 176. One household member is scheduled for a procedure and wants to pre-pay. The most that they could be charged is:
  - $43,564 / 12 = $3,630.33 x 4% = $145.21 x 36 = $5,227.68
- If the procedure has a set rate of $4,320, that is the amount the patient would be responsible for since it is lower than their maximum payment plan amount

Paid in Full Example

- A Qualified Patient wants to use the "Paid in Full" option for their bill. The hospital's normal discount for a bill paid in full is 50%.
  - The charge is $7,325, making the "Paid in Full" amount $3,662.50.
  - The allowed rate is $4,562
  - The patient's maximum payment plan is $4,140
- In this case, the hospital's normal discount is the lowest price, so the hospital can use their current policy and set the "Paid in Full" amount to $3,662.50.

Payment Plan Exceeds Rate

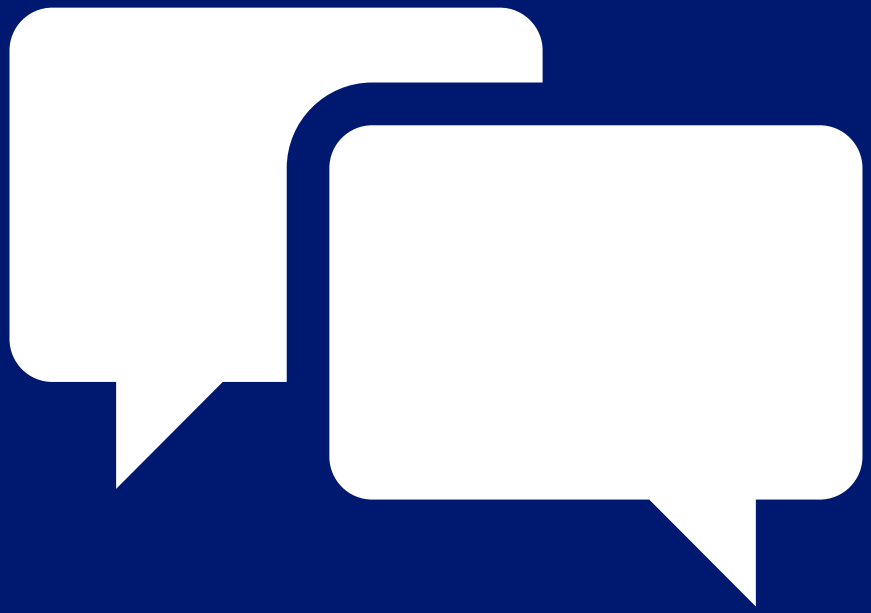
- It is possible that a household's maximum payment plan could exceed the set rate
- In this situation, the payment plan could be set for the maximum 4% for less months, or a lower amount for the full 36 months

Lower Rate Example

- The set rate for a procedure is $2,380. A household has a 4% max of $100 per month.
- First option: set monthly payments to $100 and have a 24-month payment plan (last month would be $80)
- Second option: set monthly payments to $67 and have a 36-month payment plan (last month would be $35)
- Households may be given an option on which they prefer, including anything in between

Question 4

- The set rate for a procedure is $4,350. A household has a 4% max of $250 per month. Which of the following would not be an acceptable payment plan?
  - A. $250 per month for 36 months
  - B. $120 per month for 36 months
  - C. $181 per month for 24 months
  - D. $241 per month for 18 months
  - E. All are acceptable



Questions?

Redeterminations

- Providers may not require a household to complete a redetermination at any point during their established payment plan
- Households may ask to complete a redetermination at any time or have a redetermination done when additional services are provided after the expiration of the first determination
- A redetermination that results in a higher FPG for the household changes nothing about established payment plans
- A redetermination that results in a lower FPG may require established payment plans to be adjusted

Redetermination Example

- A household is in month 19 of an established payment plan in which they are paying $120 per month, their full 4% max
- The household requests to complete a redetermination as they have had a change in their total income resulting in a lower monthly income amount
- The redetermination finds that the 4% max is now $100 per month
- Payment plan months 20-36 must be lowered to adhere to the 4% monthly max

Question 5

- A household is paying $150 per month on their payment plan, which is lower than their 4% max of $230. The household completes a redetermination that finds that their new 4% maximum is $175 per month. What needs to be done with their current payment plan?
  - A. Nothing, it is fine how it is
  - B. It must be adjusted to $175 per month
  - C. Additional payments must be added to the plan

Insured Patients

- Insured patients who apply and are found eligible for HDC would be responsible for the lesser of:
  - The remainder of the allowed rate less the insurance payment
  - 4%/2% of their gross monthly household income for a maximum of 36 payments
  - Their insurance copay/deductible

Insured Example

- An insured patient receives a service that has an allowed rate of $10,250. The insurance pays $7,260, and the patient's insurance copay is $500. In this situation, the patient would only be responsible for the $500 copay and could set up a payment plan for their copay amount.

Question 6

- An insured patient receives a service that has a charge of $12,980 an allowed rate of $7,560. Their insurance pays $9,700. What is the remaining balance on the patient's account?
  - A. $0
  - B. $2,140
  - C. $3,280
  - D. $5,420

New Services

- Patients may have multiple episodes of care that result in overlapping 36-month payment plans
- Providers have multiple options for these patients including:
  - Setting up new payment plans for each episode of care
  - Combining multiple episodes of care into a single payment plan with the amount due dropping once the first DOS has received 36 payments
  - Writing off current payment plans and beginning a new one for a new episode of care

New Services Example

- Household has a 4% max of $160 per month and receives services in September 2022 and March 2023
- A payment plan was established in October for the September services, and the family is six payments in when the March episode of care occurs
- A new 36-month payment plan is created that is $320 per month for 30 months, and $160 per month for the last six months.

Difference in Rate and Payment Plan Amount

- Providers are allowed to write off any difference between the set rate and the agreed to payment plan in their data submission to the Department
  - This includes the difference between the maximum payment plan and a lower payment plan granted to a household

Difference Example

- A household has a charge of $25,460, a set rate of $12,560, and a max payment plan of $230 per month for a total payment plan amount of $8,280
- The household communicates that they would be unable to pay more than $180 per month on a payment plan, and the hospital agrees on the lower payment amount
- The hospital would write off a total of $18,890
  - $25,460 – ($180 x 36) = $25,460 - $6,480 = $18,890
  - Providers will report charges, allowable rate, third party payments, and patient payments in their annual data

Completion of Payment Plans

- A patient's payment plan is considered complete after they have made 36 payments or paid the full amount for which they were billed, whichever is sooner
- Once a payment plan has been completed, the balance is considered paid in full for the associated bills, and any and all collection efforts on the remaining balance must be ceased

Questions?

Collections

From the bill

- BEGINNING (SEPTEMBER) 1, 2022, BEFORE ASSIGNING OR SELLING PATIENT DEBT TO A COLLECTION AGENCY, AS DEFINED IN SECTION 5-16-103 (3)(a), OR A DEBT BUYER, AS DEFINED IN SECTION 5-16-103 (8.5), OR BEFORE PURSUING, EITHER DIRECTLY OR INDIRECTLY, ANY PERMISSIBLE EXTRAORDINARY COLLECTION ACTION, AS DEFINED IN SECTION 6-20-201 (7):
  - A HEALTH-CARE FACILITY SHALL MEET THE SCREENING REQUIREMENTS IN SECTION 25.5-3-502;
  - A HEALTH-CARE FACILITY AND LICENSED HEALTH-CARE PROFESSIONAL SHALL PROVIDE DISCOUNTED CARE TO A PATIENT PURSUANT TO SECTION 25.5-3-503;
  - A HEALTH-CARE FACILITY AND LICENSED HEALTH-CARE PROFESSIONAL SHALL PROVIDE A PLAIN LANGUAGE EXPLANATION OF THE HEALTH-CARE SERVICES AND FEES BEING BILLED AND NOTIFY THE PATIENT OF POTENTIAL COLLECTION ACTIONS; AND
  - A HEALTH-CARE FACILITY AND HEALTH-CARE PROFESSIONAL SHALL BILL ANY THIRD-PARTY PAYER THAT IS RESPONSIBLE FOR PROVIDING HEALTH-CARE COVERAGE TO THE PATIENT. IF A HEALTH-CARE PROFESSIONAL IS AN OUT-OF-NETWORK PROVIDER UNDER A QUALIFIED PATIENT'S HEALTH INSURANCE PLAN, THE HEALTH-CARE PROFESSIONAL AND HEALTH INSURANCE CARRIER SHALL COMPLY WITH THE OUT-OF-NETWORK BILLING REQUIREMENTS DESCRIBED IN SECTIONS 10-16-704 (3) AND 12-30-113.

Collections Notification

- The letter explaining the services and billed amounts that includes notification of potential collections actions must be sent at least 30 days prior to collections being started
  - Letter must be in the household's preferred language
- Collections actions may not begin prior to 182 days after the DOS or DOD, whichever is later

Allowable Collection Amounts

- Providers may not send households to collections for more than the set rate minus any payments received from the patient or third-party payer
- Providers may not send households to collections seeking the full amount of their care

Collections and Payment Plans

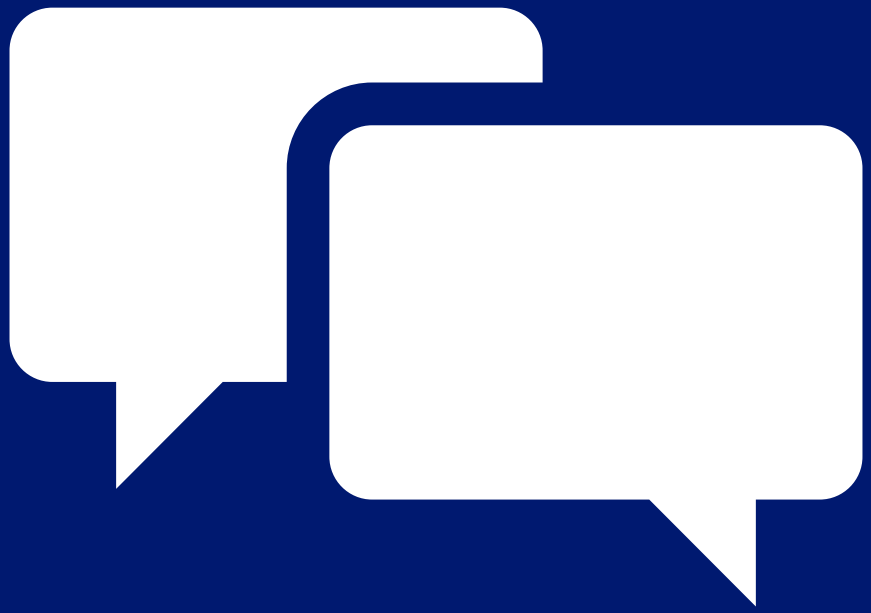
- Collections can be started for a patient with an established payment plan after the third consecutive month of missed payments
  - May not be started until 182 days after the DOS/DOD
- Written notification that collections actions may be started can be sent after the second consecutive missed payment
  - May not be sent prior to 152 days after the DOS/DOD

Partial or Missed Payments

- Partial payments are not necessarily missed payments
  - Burden is on the hospital to prove that any partial payments made were not made as a result of a reduction in patient income prior to starting collection activities
  - A reduction in income would make the original 4% calculation exceed the patient's current 4% limit

Collections Notice

- Notice should be sent via the patient's preferred method of contact
  - If preferred method is by phone, written notice should be sent via mail or email as well
- Must include an opportunity for the patient to report a change in household size or income
  - If a change has occurred, the facility must offer to complete a new application and adjust the remaining payments accordingly



Questions?

Additional Training

- Screening and Application Processes
  - April 24, 9:00 to 11:00 a.m.
  - April 27, 1:00 to 3:00 p.m.
- Payment Plans and Collections
  - April 26, 1:00 to 3:00 p.m.
  - May 2, 1:00 to 3:00 p.m.
- Data Template
  - April 27, 9:00 to 11:00 a.m.
  - May 4, 1:00 to 3:00 p.m.
- Q&A
  - May 11, 1:00 to 4:00 p.m.

Office Hours

- Every Wednesday starting at 9:00am
- Meeting link and call-in information available on the Hospital Discounted Care website
- Come with any and all questions about HDC or CICP

Contact Info

Taryn Graf

State Programs Work Lead

Mercedes Vieira-Gomes

State Program Health Care Coordinator

hcpf_HospDiscountCare@state.co.us

https://hcpf.colorado.gov/hospital-discounted-care

Thank you!