

# Payment Plans and Collections

## Hospital Discounted Care

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# Objectives

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



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# 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 C/CP 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



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## 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


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## Rates


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## 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


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## 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



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## 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



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## 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
  - $\$8,298 - \$5,932 = \$2,366 - \$300 = \$2,066$



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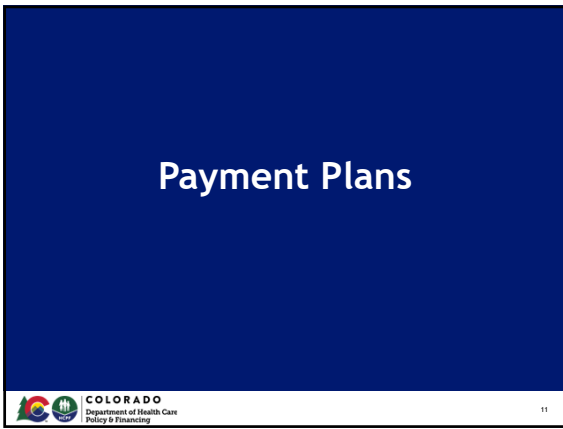
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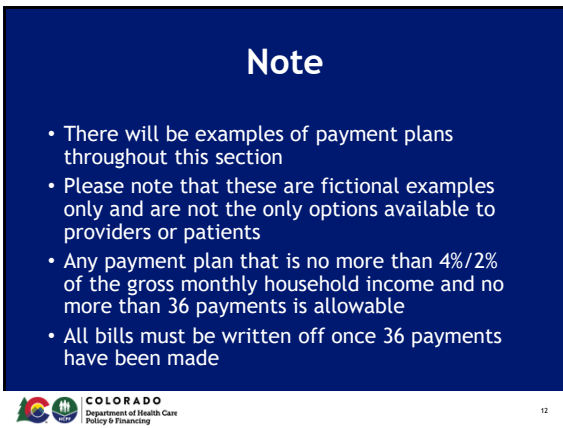
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## Payment Plans

- 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



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## 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



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## 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



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## 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

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## 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

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## 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

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## 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

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## 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

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## 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

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### 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

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### 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

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### 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:
  - > $\$43,564 / 12 = \$3,630.33 \times 4\% = \$145.21 \times 36$   
\$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

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## 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.



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## 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



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## 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



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## 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

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## 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

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## 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



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## 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



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## 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



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## 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.

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## 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 the patient is responsible for?
  - >A. \$0
  - >B. \$2,140
  - >C. \$3,280
  - >D. \$5,420

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## 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

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## 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.



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## 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



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## 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
  - $\$25,460 - (\$180 \times 36) = \$25,460 - \$6,480 = \$18,890$
  - Providers will report charges, allowable rate, third party payments, and patient payments in their annual data



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## 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

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## Questions?

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## Collections

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## 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 25-5-3-903;
  - 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.



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## 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



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## 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



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## 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

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## 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

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## 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

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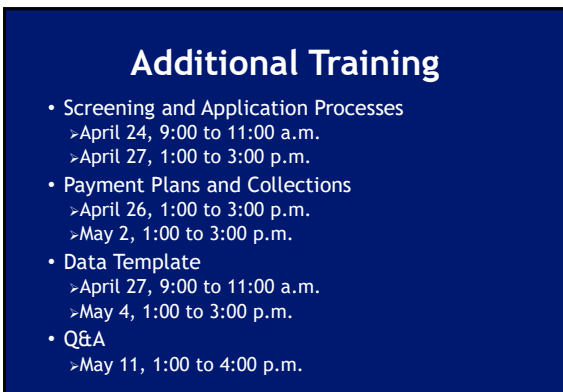
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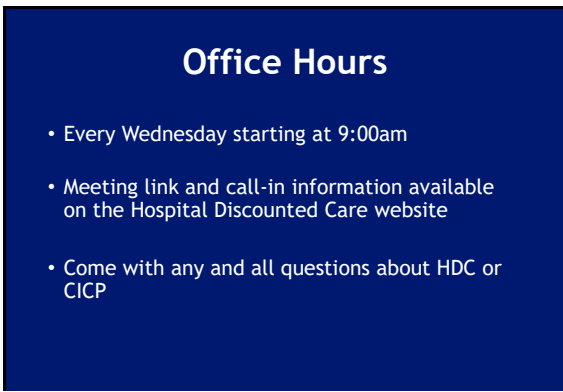
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## Contact Info

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[https://hcpf.colorado.gov/hospital\\_discounted\\_care](https://hcpf.colorado.gov/hospital_discounted_care)

Thank you!



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