Payment Plans and Collections

Hospital Discounted Care

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Objectives

- 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 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

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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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Payment Plans

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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

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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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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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Question 1

- If a facility also bills for their physicians, what is the maximum allowable payment plan for the bill?
  - A. 2%
  - B. 4%
  - C. 6%

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Answer 1

- If a facility also bills for their physicians, what is the maximum allowable payment plan for the bill?
  - A. 2%
  - B. 4%
  - C. 6%
- Bills from a facility have a payment plan maximum of 4% of the household's monthly gross income even if the bill includes charges from a health care professional

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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 indicates that they want to pay $175 per month towards their bill in order to pay it off faster. Is the facility allowed to set the payment plan at $175 per month?
  - A. Yes
  - B. No

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Answer 2

- Is the facility allowed to set the payment plan at $175 per month?
  - A. Yes
  - B. No
- The patient is certainly allowed to pay more than their set monthly payment amount, but the facility is not allowed to set the monthly amount due to more than the 4% max.

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Setting up a Plan

- Patients should be contacted within 30 days of their determination to settle 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
- Patients have no less than 181 days past their date of service (DOS) or date of discharge (DOD), whichever is later, to make a payment

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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 190. 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

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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 3

- 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. $121 per month for 36 months
  - C. $185 per month for 24 months
  - D. $245 per month for 12 months
  - E. All are acceptable

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Answer 3

- Which of the following would not be an acceptable payment plan?
  - A. $250 per month for 36 months
  - B. $121 per month for 36 months
  - C. $185 per month for 24 months
  - D. $245 per month for 12 months
  - E. All are acceptable
- The first payment plan is far more than the set rate for the procedure

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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 1

- 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 4

- 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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Answer 4

- 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
- Since the established payment plan is for $150 per month which is still lower than their 4% max, nothing needs to be changed

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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 5

- 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

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Answer 5

- What is the remaining balance on the patient's account?
  - A. $0
  - B. $2,140
  - C. $3,280
  - D. $5,420
- The patient is not responsible for any payments to the facility on this bill, as the full allowed rate (plus some) has been received from the insurance company.

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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 x 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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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 25.5-3-503;
  - 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.

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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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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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Additional Training

- Screening and Application Processes
  - August 9, 10:00 a.m. to 1:00 p.m.
  - August 11, 1:00 to 4:00 p.m.
- Payment Plans and Collections
  - August 16, 1:00 to 4:00 p.m.
  - August 18, 10:00 a.m. to 1:00 p.m.
- Uniform Application
  - August 23, 10:00 a.m. to 1:00 p.m.
  - August 25, 1:00 to 4:00 p.m.

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Office Hours

- Every Wednesday starting at 9:00
  - Through the end of September
  - May extend into October if appears to be a need/want for continuing
- Meeting link and call-in information available on the Hospital Discounted Care website
- Come with any and all questions about HDC or CICP

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HDC Go Live

- Hospital Discounted Care begins on September 1
- Applies to any service provided on or after September 1
  - Services provided prior to September 1 can be discounted under HDC but not mandatory
  - For patients who are hospitalize before September 1 and discharged on or after that date, hospital would only be mandated to apply HDC to charges on or after September 1

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Contact Info

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Thank you!

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