SUBJECT: **PAYMENT PLANS**	EFFECTIVE: 10/01/2020
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DEPARTMENT: REVENUE CYCLE	
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POLICY:

Coquille Valley Hospital (CVH) patients who are unable to pay their expected healthcare costs in full or through use of available financing alternatives will be offered the opportunity to establish payment plans to pay their account balances in monthly installments. CVH will not charge interest on payment plans.

POLICY GUIDELINES

I. Routine co-payments and deductibles will be requested at the time of service. Co-payments related to emergency care will be requested of the patient post-assessment and after they are medically stable. This may occur prior to or at the time of discharge.

II. For patients with multiple outstanding patient liabilities, the total balance will be used to calculate the installment amount.

III. A matrix will be used to calculate the patient/guarantor's monthly payment amount (refer to Appendix A included with this policy).

IV. The patient and/or guarantor must make a deposit equal to the amount of one installment payment at the time that the installment arrangement is finalized and service is provided.

V. Patients/guarantors failing to make payments as arranged will be subject to collection agency referral when they fall two (2) payments behind their agreed upon installment schedule. Agency referral may be deferred for patients who are re-hospitalized.

VI. **Exceptions**

A. Any deviations from this standard schedule must be reviewed and approved by the Director of Revenue Cycle or a designee before confirming with the patient/guarantor. The reason for the exception and approval for granting such exception must be clearly documented in the patient's financial record.

B. Non - U.S. residents are not eligible for this payment option.

C. If the patient cannot meet the payment arrangement program, the patient should be evaluated for financial assistance in accordance with CVH's Financial Assistance Policy.

D. Payment plans on partial financial assistance (charity) accounts must be individually developed with the patient.

DEFINITIONS:

Bad Debt Expense: Uncollectible accounts receivable that were expected to result in cash inflows (i.e. the patient did not meet CVH's Financial Assistance eligibility criteria). They are defined as the provision for actual or expected un-collectibles resulting from the extension of credit. Payment plans are expected to be resolved within 36 months. Payment plans to extend beyond 1 year will be classified as bad debt expense and forwarded to the CVH Collections Unit (CU) for processing.

Financial Assistance: Financial Assistance (also known as charity care) is care that represents the uncompensated cost to a hospital of providing funding or otherwise financially supporting healthcare services on an inpatient or outpatient basis to a person classified as uninsured, under-insured or otherwise financially indigent. Financial Assistance services are those that may not initially have been expected to result in cash received. Financial Assistance results from a provider's policy to provide health care services free or at a discount to individuals who meet the established criteria. In this policy, the term "Financial Assistance" will be used rather than the term "Charity Care".

Family/Household: A group of two or more persons related by birth, marriage (including any legal common law spouse), or adoption who live together. All such related persons are considered as members of one family.

Liquid Assets: Money that can be accessed in a relatively short period of time, examples which may include, but is not an all inclusive list are, cash/bank accounts, certificates of deposit, bonds, stocks, cash value of life insurance policies, and pension benefits.

Living Expenses: A per-person allowance based on the Federal Poverty Guidelines for the 48 contiguous states and the District of Columbia. The allowance will be updated annually when guidelines are published in the Federal Register.

Payment Plan: When the patient is unable to pay his or her portion of healthcare costs all at one time, CVH will arrange to accept the amount due in regular installments over a defined period. Payment plans are expected to be resolved within 36 months according to payment plan guidelines (see Attachment A). Payment plans extending beyond one year will be classified as bad debt expenses and forwarded to the Internal Collections Unit for processing.

Under-insured: CVH considers a patient under-insured when a patient's primary, secondary, and/or other insurance will not cover a specific service or procedure at any hospital or healthcare facility.

Uninsured: CVH considers a patient uninsured when the patient has no insurance coverage.

Uninsured Allowance: A 30% uninsured allowance will be available to all patients who are without insurance and do not qualify for any financial assistance, for inpatient or outpatient services. The percentage of the allowance will be reviewed and updated annually and distributed by Administration to all CVH facilities and departments one month before the start of the new fiscal year, to be effective on the first day of the upcoming fiscal year.

PROCEDURE:

- Accounts with patient balances less than $500 shall be paid within 12 months from their first patient balance statement.
- Accounts with patient balances under $1,500 shall be paid in full within 18 months from their first patient balance statement.
- Accounts with patient balances of $1,501 - $3,000 shall be paid within 24 months of their first patient balance statement and balances of $3,001 or above shall be paid within 36 months. If the patient/guarantor requires a payment plan longer than that outlined, a referral to the outside Finance Program for extended payment arrangements will be offered. Payment amounts of $25 can be accepted if the term of the plan is for 6 months or less or if the

payment amount can be increased within 6 months (i.e. tax refund, completion of auto loan, etc.).

- If the patient cannot meet the payment arrangement program, the patient should be evaluated for financial assistance.

I. Elective Services (Prior Authorized/Schedule Services):

- Patient Account Services personnel may use different procedures depending on whether admissions are elective or urgent/emergent.
- Patient Access Services Financial Counselors
    1. Determine prior to admission that the patient/guarantor is unable to meet estimated financial responsibility through other means and that the payment plan program is suitable.
    2. Compute estimated patient liability.
    3. Determine the patient/guarantor's required deposit and estimated monthly payment in accordance with installment matrix (Attachment A).
    4. Notify patient/guarantor of the estimated liability; explain the payment plan program and inform the patient of the required deposit amount and monthly payments. Satisfy the patient/guarantor's questions and ensure understanding of the program.
    5. Obtain signed payment plan agreement and deposit (Attachment B).
    6. Scan signed payment plan agreement into the appropriate imaging system folder.
    7. Document the terms of the agreement in the comment section of the registration.
    8. For all patient liability balances:
        a) If sufficient time exists (7 calendar days prior to admission), mail the payment agreement to the patient/guarantor for signature.
        b) Ensure return of signed agreement.
        c) Scan the agreement into the document imaging system in the appropriate folder.
        d) If insufficient time exists (less than 7 days prior to admission), Inform registration staff that a signed agreement must be obtained at the time of admission.
- **Patient Access Services Representatives (Upon Check-In)**
    1. Document all comments relevant to the payment plan agreement and the patient's financial status not already noted in the patient account comments.
    2. Obtain patient signature and collect required deposit.
    3. If the patient is not willing to sign the agreement and/or make the required payments, refer the patient to the Financial Counselor.

- **Patient Access Services Financial Counselors**
    1. For those patients/guarantors who are unable or unwilling to complete an installment agreement and make the required deposit in advance of their admission or service, contact the patient's physician to determine if the admission can be deferred until the patient/guarantor can make suitable financial arrangements.
        a) If the physician agrees with the deferral, notify the patient/guarantor of the postponement. Enter standard comment "OK to Delay" in the system account comments.
        b) If the physician overrides the deferral recommendation, contact the patient/guarantor to further negotiate payment terms and
        c) Enter standard comment "Not Clinically Ok to Delay" in the system account comments.
        d) Move the account to the CVH Collections Unit.

II. **Emergent/Urgent Services:**

- Urgent or emergent services or those originating in the Emergency Department will not be denied or delayed for financial reasons. Due to the rapidity of these encounters, determination regarding payment plans will not be made prior to a medical screening examination or inpatient admission.
    1. **Patient Access Services Financial Counselors**
        a) Determine suitability of payment plan program for patient/guarantor.
        b) Compute estimated patient liability.
        c) Explain payment plan terms to patient/guarantor.
        d) Obtain signed payment plan agreement and deposit (Attachment B).
        e) Scan signed payment plan agreement into the appropriate imaging system folder.
        f) Document payment plan agreement in system notes.

III. **Availability of Policy**

- Every facility, upon request, must provide any member of the public or state governmental entity a copy of its financial assistance policies. This policy will also be available on the CVH Website.
    1. All CVH registration representatives will inform eligible patients/guarantors of the CVH payment plan policy.

IV. **Administration:**

In administering this policy, CVH will:

- Ensure the dignity of the patient

- Encourage up-front financial counseling
- Be patient-centric and patient friendly
- Be culturally appropriate (provided in prevalent languages used in communities)
- Serve the health care needs of everyone, regardless of ability to pay
- Communicate collection procedures.

V. **Uninsured Discount:** A flat discount percentage will be applied to gross charges for the uninsured.

- Exclusions: Medical expenses excluded from uninsured discounts:
    1. Elective cosmetic surgery services or other elective non-covered services for which a price has been negotiated.
    2. Any third parties who may be liable for services.
    3. Balances due (such as deductibles and co-pays) after payment is made by a primary insurer.

VI. **Revenue Cycle Supervisor**

- Performs periodic audits of this process to ensure compliance with this policy.
- Informs Revenue Cycle management of discrepancies or variances with established procedures or protocols. Requests management action plans to eliminate variances.
- Monitors and certifies the efficacy of Revenue Cycle management action plans.
- Works with stakeholders to resolve all issues that prevent the effective implementation of this policy.
- The Revenue Cycle management team will ensure that controls are in place to ensure compliance with this policy.

REFERENCES:

Related Policies and References	Policy Titles
	PAS – Financial Assistance
	PAS – Financial Practices
	PAS – Discharge Clearance
	PAS – Verification of Payer Coverage
	PAS – Cash Collection
	PFS – Payment Plans
	PAS – Waivers of Co-Payments and Deductibles
	PFS – Self Pay and Bad Debt Processing
	PAS – Processing Elective Scheduled Encounters

Related Policies and References	**Policy Titles**
	PAS – Financial Screening Quality Assurance
State Dept. of Health Reference	
TJC Standard(s) Accreditation Participation Requirements (APR) Environment of Care (EC) Emergency Management (EM) Human Resources (HR) Infection Prevention and Control (IC) Information Management (IM) Leadership (LD) Life Safety (LS) Medication Management (MM) Medical Staff (MS) National Patient Safety Goals (NPSG) Nursing (NR) Provision of Care, Treatment, and Services (PC) Performance Improvement (PI) Record of Care, Treatment, and Services (RC) Rights and Responsibilities of the Individual (RI) Transplant Safety (TS) Waived Testing (WT)	HR.01.07.01 – The hospital evaluates staff performance. IM.02.02.01 – The hospital effectively manages the collection of health information. LD.03.05.01 – Leaders implement changes in existing processes to improve the performance of the hospital. LD.04.01.01 – The hospital complies with law and regulation. LD.04.01.05 – The hospital effectively manages its programs, services, sites, or departments LD.04.01.07 – The hospital has policies and procedures that guide and support patient care, treatment, and services. LD.04.02.03 – Ethical principles guide the hospital's business practices. PI.01.01.01 – The collects data to monitor its performance. PI.02.01.01 – The hospital compiles and analyzes data. PI.03.01.01 – The hospital improves performance on an ongoing basis.
TJC - Other	
NFPA	
OSHA	

Related Policies and References	**Policy Titles**
NCQA	
HIPAA	
CMS	Section 300 of the Medicare Provider Reimbursement Manual
OIG	
Anti-Kickback Statutes	
Other	Title VI of the Consumer Credit Protection Act (Fair Credit Reporting Act)
	Title VIII of the Consumer Credit Protection Act (Fair Debt Collection Practices Act)
	Title I of the Consumer Credit Protection Act (Truth in Lending Act)
	Section 501(r) Requirements in Part V, Section B (Affordable Care Act)