

## Including Collection-Friendly Payment Expectations in Patient Contracts

By Kristie Carlson, Paralegal

**M**edical debt is on the rise. According to a 2010 Commonwealth Fund Insurance Agency Survey, in 2010, 29 percent of adults ages 19 to 64 reported having medical debt or trouble paying medical bills, and 16 percent had been contacted by a collection agency for unpaid medical bills. Including patient-friendly payment expectations in patient contracts can help limit liability and improve the efficiency and effectiveness of your collection agency partners.

Collectors and providers can both benefit by including payment expectations in medical contracts signed by patients at the time of service.

“Consumer-friendly contracts laying out repayment expectations for the patient and the provider will improve their cash flow,” said Tom Gavinski, Vice President of IC System in St. Paul, Minn. “The collector will also have a clear understanding of repayment terms to discuss with the patient to eliminate any confusion.”

Ensuring patients have access to collection policies from the point of access throughout their encounter with the provider is important. A clearly stated collection policy can point patients in the right direction and help them pay or settle their accounts.

“This information is usually found on patient information forms they sign at the hospital or clinic and on individual brochures and signage at the health care provider,” said Gavinski.

When drafting consumer-friendly payment expectations providers should consider including the delinquency date, credit reporting terms, collection fees and termination of service provisions.

“Most important is the repayment expectations, such as the billing cycle and payment plan expectations,” Gavinski said. “Interest and fees are also important as well as the consequences of non-payment.”

Collectors and providers should be aware the Fair Debt Collection Practices Act (FDCPA) and state law may place restrictions on what can be included in the contract. The FDCPA prohibits the collection of any amount incidental to the principal debt unless the amount is expressly authorized in the agreement creating the debt or permitted by law. This applies to interest, service charges, collection charges and late fees. States may restrict the amount of interest or fees that can be applied to the principal or

lay out how fee provisions must be presented in the contract.

“Simply stating at the bottom of agreements ‘the patient is responsible for all collection fees,’ may not be sufficient,” said Christian Lehr, Chief Operating Officer of Healthcare Collections, LLC., in Phoenix, Ariz.

For example, Arizona state law provides the specific percentage of additional charge being added to the principal must be indicated in the contract creating the debt. Stating the patient is responsible for “all collection fees” is not permissible.

“The addition of fees is extremely contentious and it is imperative that the medical provider thoroughly vet their policy with their attorney,” said Lehr.

Collectors and providers should discuss including patient-friendly payment expectations in patient contracts to encourage settlement and payment of accounts.



## ACA Comments on HHS Proposed Changes to HIPAA Privacy Rule

**O**n May 31, 2011, the U.S. Department of Health and Human Services (HHS) released a Notice of Proposed Rulemaking for public comment concerning suggested changes to the Health Insurance Portability and Accountability Act (HIPAA). The proposed modifications provide individuals the right to an accounting of disclosures and the right to an access report. The accounting disclosure gives individuals information about the disclosure of health information to

persons outside the covered entity and business associate for certain purposes. The proposed changes also give individuals the right to obtain an access report outlining who has reviewed their protected health information, such as access for purposes of treatment, payment and health care operations.

ACA submitted comments on Aug. 1, 2011, seeking clarification regarding a possible conflict between the proposed HIPAA Privacy Rule changes and the Fair Debt Collection Practices Act

(FDCPA). Section 805(b) [15 U.S.C. §1692c(b)] of the FDCPA prohibits disclosing the existence of a consumer's debt to a third party. To ensure the final rules do not conflict with the FDCPA prohibition on disclosure to third parties, ACA suggests the rules make it clear the right to an accounting and the right to an access report apply only to patients seeking to access his or her own information; not third parties seeking disclosure of patient information.

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## After Health Reform, Safety Net Providers Still Play Crucial Health System Role

**N**early all leaders in health and health care policy recently surveyed (98%) believe traditional safety-net providers—including public hospitals, community health centers, and faith-based and mission-driven organizations—will continue to play crucial roles in the U.S. health system after the Affordable Care Act is implemented, according to a Commonwealth Fund/*Modern Healthcare* Health Care Opinion Leaders Survey.

A large majority of leaders (90%) feel the U.S. health system as a whole has been unsuccessful in achieving equity—defined as an absence in disparities among population groups in terms of health status, care and coverage. Approximately 80 percent feel the current health care system is unsuccessful in achieving equity in terms of access, quality, and outcomes for vulnerable populations.

The Affordable Care Act is projected to dramatically reduce the number of Americans without insurance coverage by expanding Medicaid eligibility, providing subsidized health insurance options, and

establishing a standard benefits package that limits costs to patients.

Nearly seven out of ten respondents believe health reform will effectively improve access (68%) and financial protection (67%) for vulnerable populations, and 70 percent support policies that would guarantee access to care for undocumented immigrants.

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In addition to enhancing access and affordability, the new law is designed to improve the quality of care. Preferred strategies for improving the quality of care vulnerable populations receive from safety-net providers include ensuring access to enabling services like transportation and translation (86%), facilitating the adoption and spread of patient-centered medical homes

(83%), moving toward integrated models of care delivery (82%), and using performance-based contracting with providers (74%). There was less support for the adoption and spread of accountable care organizations (47%).

More than eight out of 10 leaders support policies that would expand opportunities for scholarships and loan forgiveness for providers who practice in areas with shortages of health professionals and policies that would provide positive incentives—like enhanced payment rates—for providers to serve vulnerable populations.

The survey was conducted online by Harris Interactive on behalf of The Commonwealth Fund between June 14, 2011, and July 20, 2011, among 1,246 opinion leaders in health policy and innovators in health care delivery and finance.

For more information, visit The Commonwealth Fund website at: <http://www.commonwealthfund.org/Publications/Data-Briefs/2011/Aug/Opinion-Leaders-Vulnerable-Pops.aspx>.

## Bundled Payments for Care Improvement

**O**n Aug. 23, 2011, the U.S. Department of Health and Human Services (HHS) announced a new initiative to help improve care for patients while they are in the hospital and after they are discharged. Doctors, hospitals, and other health care providers can now apply to participate in a new program known as the Bundled Payments for Care Improvement initiative (Bundled Payments initiative). Made possible by the Affordable Care Act, it will align payments for services delivered across an episode of care, such as heart bypass or hip replacement, rather than paying for services separately. Bundled payments will give doctors and hospitals new incentives to coordinate care, improve the quality of care and save money for Medicare.

“Patients don’t get care from just one person – it takes a team, and this initiative will help ensure the team is working together,” said HHS Secretary Kathleen Sebelius. “The Bundled Payments initiative will encourage doctors, nurses and specialists to coordinate care. It is a key part of our efforts to give patients better health, better care, and lower costs.”

In Medicare currently, hospitals, physicians and other clinicians who provide care for beneficiaries bill and are paid separately for their services. This Centers for Medicare & Medicaid Services (CMS) initiative will bundle care for a package of services patients receive to treat a specific medical condition during a single hospital stay and/or recovery from that stay – this is known as an episode of care. By bundling payment across providers for multiple services, providers will have a greater incentive to coordinate and ensure continuity of care across settings, resulting in better care for patients. Better coordinated care can reduce

unnecessary duplication of services, reduce preventable medical errors, help patients heal without harm, and lower costs.

The Bundled Payments initiative is being launched by the new Center for Medicare and Medicaid Innovation (Innovation Center), which was created by the Affordable Care Act to carry out the critical task of finding new and better ways to provide and pay for health care to a growing population of Medicare and Medicaid beneficiaries.

The Innovation Center’s Request for Applications (RFA) outlines four

broad approaches to bundled payments. Providers will have flexibility to determine which episodes of care and which services will be bundled together. By giving providers the flexibility to determine which model of bundled payments works best for them, it will be easier for providers of different sizes and readiness to participate in this initiative.

For more information on the initiative, please visit: <http://www.innovations.cms.gov/areas-of-focus/patient-care-models/bundled-payments-for-care-improvement.html>.



## FTC Issues Staff Report on FCRA

**T**he Federal Trade Commission (FTC) recently released a staff report providing a summary of the agency’s interpretation of the Fair Credit Reporting Act (FCRA). The report notes the FTC has withdrawn its previous FCRA commentary from 1990, due to the initial report’s age and because updates to the Act have rendered the 1990 commentary partially obsolete. Accurate, timely,

and helpful information contained in the 1990 Commentary is provided in the 2011 report. In addition to FCRA analysis, the report provides an overview of the FTC’s role in enforcing and interpreting the FCRA.

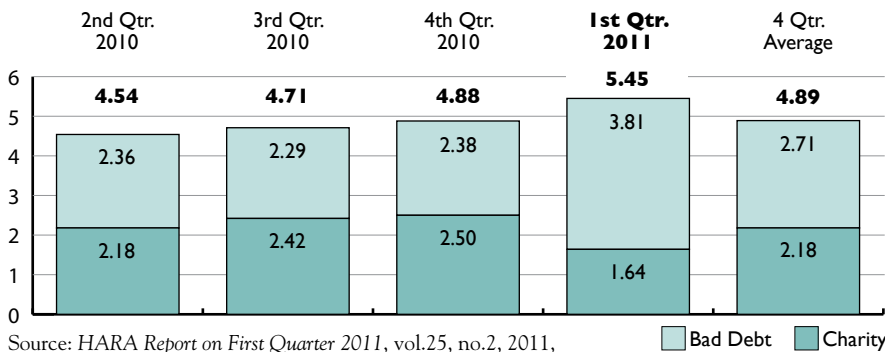
The staff report is available at: <http://www.ftc.gov/os/2011/07/110720fcrareport.pdf>.



# DATA WATCH

## Uncollectibles as a Percentage of Revenue

In the first quarter of 2011, U.S. hospitals failed to hold charity and bad debt write-offs to 5 percent or less of total gross revenue. Nationally, hospitals reported 5.45 percent of total first quarter gross revenue was written off as uncollectible, a spike from 4.88 percent in the fourth quarter 2010.



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