



Best Practices for Resolution of Medical Accounts

A REPORT FROM THE HFMA MEDICAL ACCOUNTS
RECEIVABLE RESOLUTION TASK FORCE

WITH SUPPORT FROM



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About this report

The appropriate resolution of the patient portion of bills related to medical services continues to present challenges to both patients and healthcare providers. The goal of this report is to document industrywide consistent patient education and engagement strategies – preservice or postservice as the Emergency Medical Treatment and Active Labor Act (EMTALA) and circumstances dictate – and post-discharge account resolution practices to help resolve these challenges.

HOW THIS REPORT WAS DEVELOPED

In 2014, the Healthcare Financial Management Association (HFMA) partnered with the ACA International (Association of Credit and Collection Professionals) and gathered a task force of stakeholders to establish best practices for the fair resolution of patients' medical bills. The stakeholders represented on the HFMA Medical Debt Collection Task Force include a diverse group of providers, consumer advocates, collection agencies and credit bureaus.

The task force reconvened in 2020 to update the best practices and add best practices for modifying financial assistance policies (FAPs) in response to the COVID-19 pandemic and potential future public health emergencies. This document reflects the task force's consensus on the current state of best practices related to the equitable resolution of the patient portion of medical bills.

WHO SHOULD READ THIS REPORT

The primary audiences for this work include healthcare providers, providers' business affiliates (e.g., collection agencies) and credit bureaus.¹ For these audiences, the work is intended to identify a standardized process for resolving the patient portion of medical bills and to provide a framework for educating, informing and engaging patients about the account resolution process. The best practices include a discussion of steps to be taken prior to using "extraordinary collection actions," or ECAs. While this term of art applies in a regulatory context only to not-for-profit hospitals, in the

¹ For purposes of this document, business affiliates are organizations that contract with healthcare providers to work directly with patients on behalf of healthcare providers to resolve outstanding medical accounts receivable. Examples include, but are not limited to, accounts receivable management companies, collection agencies and debt buyers.

standardized processes captured in this document it is intended to apply to both for-profit and not-for-profit hospitals.

The secondary audiences for this work include patients, through the providers who work with them directly, and the policy community. This work is intended to help educate, inform and engage these key stakeholders about voluntary best practices for resolving the patient's portion of medical bills.

CONTEXT FOR THIS REPORT

The task force believes the practices endorsed in this report are balanced, fair and reasonable for all stakeholders, including the patients whose interest these best practices seek to protect. For the best practices to be effective, patients, providers and their respective representatives / business partners must collaborate.

These best practices are intended to guide account resolution activities under normal operating circumstances. However, localized natural disasters or national public health emergencies, such as the COVID-19 pandemic, may require health systems to modify FAPs and account resolution practices to support their communities during a time of crisis. These modifications could include, among other things, ceasing outbound collections activity for a period of time, ceasing ECAs for a period of time, modifying FAPs to take into account the specific nature of the public health emergency and/or modifying point-of-service collections. (See appendix 1 for a sample public health emergency FAP.)

All recommendations in this report are designed to be used in conjunction with applicable state and federal laws. Selected relevant laws are listed in appendix 2.

A glossary of terms is provided in appendix 3. Sample wording for consent to contact patients about their bills is in appendix 4.

Framework for the best practices

The task force recognizes that most patients want to resolve their medical accounts in a responsible manner and that providers seek to engage their patients in these efforts by treating them with dignity and respect. These best practices are built on a framework that includes elements of HFMA's other consumerism-related best practices, including Patient Friendly Billing, Patient Financial Communications Best Practices and a report from HFMA's Price Transparency Task Force.

THE PATIENT FRIENDLY BILLING ELEMENT

One of the challenges facing providers is the highly variable processes used to resolve accounts, which contributes to confusion. Therefore, the task force's goal was to identify a common set of account resolution best practices that align with federal requirements and with HFMA's [Patient Friendly Billing](#) principles, to simplify the process for patients. Specifically, providers and others involved in the medical account resolution process will ensure that healthcare financial communications are:

- **Clear.** All financial communications will be easy to understand and written in clear language. Patients will be able to quickly determine what they need to do with the communication.
- **Concise.** Bills will contain just the right amount of detail necessary to communicate the message.
- **Correct.** Bill items will correctly reflect the patient's responsibility after the claim has been adjudicated and/or financial assistance or other discounts have been applied, as appropriate.
- **Patient-friendly.** The needs of patients and family members will be paramount when designing administrative processes and communications.

THE COMMUNICATIONS ELEMENT

Providing a clear understanding of what to expect at every stage in the process helps patients engage in their healthcare and become active participants in resolving outstanding accounts. Therefore, it is important for providers to assume responsibility for engaging and educating consumers long before the post-discharge account resolution process, as prescribed by HFMA's [Patient Financial Communications Best Practices](#).

The scope of HFMA's 2014 Medical Debt Task Force was limited to processes related to post-discharge events. However, in recognition of the role that preservice/discharge patient engagement plays, this update incorporates summarized versions of the Patient Financial Communications Best Practices, including the guidance for conversations with patients shown in the sidebars, to provide a framework for beginning the patient education and engagement process.

Providers and others involved in the medical account resolution process recognize that patients and providers share responsibilities for account resolution.

Patient education content

Education should be designed to engage patients and help them understand their financial responsibility with regard to their account balance, including what it is made up of, and how to resolve it.

CONVERSATIONS WITH PATIENTS

who

Who participates in financial conversations?

— The patient or guarantor will have financial discussions with a properly trained registration or discharge representative for routine scenarios; financial counselor or supervisor for nonroutine/complex scenarios.

— Patients should be given the opportunity to request a patient advocate, designee or family member to assist them in these discussions.

Recommendations for productive conversations about financial matters with patients are shown in the sidebars on the previous page, this page, and the following page. Explaining the account resolution process, proactively describing available options and detailing the steps necessary for patients to avail themselves of the best existing options will improve patient financial communication.

A discussion of options should include attempting to qualify patients for coverage by third party payers, discussing the provider's FAPs and self-pay discount programs, which may provide either free or discounted care, depending on the provider's policies and the patient's eligibility, and reviewing payment options. The account should also be screened for bankruptcy. For compliance with the IRS 501(r) rule pertaining to requirements for not-for-profit hospitals, which was added to the Internal Revenue Code by the Affordable Care Act, FAPs should be summarized in plain language and made available to patients throughout the resolution process. Other mandatory steps apply.²

Timing and methods of education and engagement efforts

A reasonable attempt will be made for discussions with patients to occur as early as possible, taking place before a financial obligation is incurred up to the point at which care is provided. Timely discussions will ensure patients understand their financial obligation and providers are aware of the patient's ability to pay and/or source of payment.

Efforts to educate, inform and engage the patient should begin prior to service (for nonemergent services) or prior to discharge (for nonemergent services, in accordance with EMTALA) and continue through the account resolution process's multiple touchpoints. The final IRS 501(r) rule pertaining to requirements for not-for-profit hospitals, added to the Internal Revenue Code by the Affordable Care Act, requires some mandatory steps, like disclosure of FAPs.

To ensure patient engagement, education should be provided through multiple vehicles. In addition to traditional vehicles like discussions with revenue cycle staff, signs posted prominently in patient registration areas, pamphlets, preregistration/registration packet inserts and billing statement inserts, providers are encouraged to develop more contemporary vehicles like YouTube videos and chatbots linked to their websites. This can provide an efficient and

engaging mechanism to help patients find the specific information they need in a convenient manner.

This report emphasizes the importance of patient education early in the account resolution process but educational efforts should not stop then. The best practice is for the provider or business associate

CONVERSATIONS WITH PATIENTS

when

When do patient financial conversations take place?

Depending on the setting, the provider representative will have a discussion with the patient during the preregistration, registration or discharge process.

For services provided in the emergency department, all practices must comply with EMTALA and all other federal, state and local regulations affecting the emergency department.

- ▶ Discussions with emergent patients may occur during the discharge process.
- ▶ The discussion also may occur during the medical encounter as long as it does not interfere with patient care and the patient consents to these discussions in order to expedite discharge.
- ▶ No patient financial discussions will occur before the patient is medically screened and stabilized.

For discussions that occur at the time of service, the provider organization will have the conversations with patients during the registration or discharge process in a private location that does not disrupt patient flow.

Discussions that occur in advance of service will use the most appropriate means of communication for the patient. These discussions may take place via:

- ▶ Outbound contact to patients in advance of a scheduled service
- ▶ Inbound contact from patients inquiring about their upcoming service
- ▶ Scheduling/Contact center when appointment is made

² Internal Revenue Service. "Requirements for 501(c)(3) Hospitals Under the Affordable Care Act – Section 501(r)." [https://www.irs.gov/charities-non-profits/charitable-requirements-for-501\(c\)\(3\)-hospitals-under-the-affordable-care-act-section-501\(r\)](#)

to offer ongoing education to reinforce the opportunities (e.g., financial assistance, payment plans, other sources of coverage) patients have for positive account resolution. Therefore, providers and business associates must use every patient communication to engage and educate the patient about their account resolution options.

For templated written communications provided to patients (e.g., FAPs, explanations of billing process, patient bills or account statements) the best practices recommend that hospitals have these communications reviewed by their internal communications staff and/or patients who participate on advisory councils.³ This will

³ HFMA, [Patient Friendly Billing Project](#).

help eliminate industry jargon and other language that might confuse patients.

THE PRICE TRANSPARENCY ELEMENT

Providing patients with access to price estimates is a core part of the education and engagement process. The price estimate allows for tangible discussion of the patient's obligation and facilitates discussion of potential sources of coverage, financial assistance and payment plans, as necessary. When hospitals have highly reliable price estimates for scheduled services, these estimates should be provided to patients proactively. In situations where price estimates are less

CONVERSATIONS WITH PATIENTS

what

What should be addressed during patient financial conversations?

During the discussion, the provider organization will first gather basic registration information, including demographics and insurance coverage, and determine the potential need for financial assistance.

Patients will be informed that their ability to pay will not interfere with treatment of any emergency medical conditions.

Uninsured patients will be informed that the goal of collecting information is to identify payment solutions or financial assistance options that may assist them with their obligations for this visit.

If the setting is an emergent situation, once screening has occurred and the patient is stabilized, the provider organization will review insurance eligibility information with the patient to ensure the information is accurate. In nonemergent situations, this will occur prior to service.

In either situation, if appropriate, the patient is referred to a financial counselor and/or offered information regarding the provider's financial counseling services and assistance policies to help identify sources of coverage, apply for financial assistance or set up payment plans.

The conversation will include a discussion of the patient's share of the costs for services. These discussions will occur once the provider organization has met EMTALA requirements and completed the previous steps. Interactions will not interfere with patient care and will focus on patient education. During patient share and prior balance discussions, the provider representative will take the following actions.

- ▶ Provide a list of the types of service providers that typically participate in the service, both verbally, and if the patient requests, in writing.
- ▶ Inform the patient that actual out-of-pocket expenses may vary from estimates, depending on the actual services performed or timing issues with other payments affecting the patient's deductible.
- ▶ If appropriate:
 - Ask if the patient is interested in receiving information regarding the provider's financial assistance programs.
 - Ask if the patient is interested in receiving information regarding payment options.
 - Discuss prior balances.
- ▶ If the patient is admitted to observation, the patient should be informed about the administrative difference between an inpatient stay and an observation stay, and the implications this may have on coverage for postacute services. For Medicare, this is required through the Medicare Outpatient Observation Notice.⁴
- ▶ After all relevant topics have been discussed, inquire about how the patient would like to resolve the balance for the current service and any prior balance.
- ▶ Inform the patient of the timing of collection activity as outlined in the provider's account resolution policies.

⁴ CMS, [Medicare Outpatient Observation Notice](#).

reliable, hospitals should follow the recommendations of HFMA's [Price Transparency Task Force](#). These recommendations include:

- **Refer insured patients to their health plans.** For insured patients, health plans are in the best position to help their members find the total estimated price of a service. The estimate should include the member's expected out-of-pocket expenses, based on their current deductible status along with copayment and coinsurance information.
- **Partner with health plans.** When hospitals are providing estimates to insured patients, they should partner with plans to exchange up-to-date benefit information and member spending data (accumulation of cost sharing relative to annual deductibles and out-of-pocket maximums) to improve the accuracy of patient share estimates.
- **Work directly with uninsured patients.** Hospitals should serve as a price information resource for uninsured persons. This includes helping uninsured patients identify alternatives for sharing their healthcare expenses, including insurance options of which they may not be aware, and access financial assistance, if eligible.
- **Share the responsibility with patients.** Gathering the information required for the programs referenced above is a shared responsibility. As established by HFMA's Patient Friendly Billing project, the provider has the responsibility to streamline information requirements and information-gathering processes, while the patient has the responsibility to provide requested information in a timely manner.

Building on the framework provided by HFMA's [consumerism best practices](#), the foundation for the medical account resolution process encompasses attitude and culture, enabling education and tools, and supportive policies. Compassion, respect, patient advocacy and education should be part of all patient discussions.

ATTITUDE AND CULTURE

The HFMA Patient Friendly Billing report, [Strategies for a High-Performance Revenue Cycle](#), identified culture as a key performance differentiator between high-performing and low-performing revenue cycles. An organization's culture is made up of the shared attitudes, values and goals that it puts into practice. How well an organization develops a sense of mission and vision surrounding the revenue cycle

can dramatically affect performance. Without the right culture in place, the organization's efforts around people, processes, technology, metrics and communication will be less than effective.

Organizations with high-performance revenue cycles generally employ several strategies as part of their efforts to address culture. One of these is finding purpose through the patient. High performers recognize that positive patient financial experiences are a key contributor to patient satisfaction. Consumer-focused processes and communications are just a start. At these organizations, employees understand how their interactions with patients directly contribute to the quality of the patient's care. The task force believes that this emphasis on a culture that finds purpose in serving patients must extend to all business partners with whom a provider organization works. One expression of this culture is a commitment from business partners to adhere to ACA International's [Collector's Pledge](#), which states:

- I believe every person has worth as an individual.
- I believe every person should be treated with dignity and respect.
- I will make it my responsibility to help consumers find ways to pay their just debts.
- I will be professional and ethical.
- I will commit to honoring this pledge.

With regard to patient conversations, patient privacy must be respected. Conversations about financial matters should occur in a location and manner that are sensitive to the patient's needs. These conversations will focus on steps toward amicable resolution of financial obligations. The service provider will take the initiative to communicate with the patient. Where appropriate, provider organizations will use face-to-face discussions to facilitate efficient account resolution.

In this context, patient advocacy refers to hospital staff and their business partners working with, and on behalf of, patients to help them identify sources of coverage and enroll in any applicable coverage; identify opportunities for financial assistance or other discounts for which a patient may qualify; and structuring payment plans that meet the needs of both patient and providers.

An understanding of the organization's mission and culture and their own roles within the organization is essential for staff in revenue cycle roles.

ENABLING EDUCATION AND TOOLS

Providers will have standard language to guide staff on the most common types of patient financial discussions. Also, all personnel engaging in patient financial discussions will receive annual training on the following:

- HFMA [Patient Financial Communications Best Practices](#)
- Financial assistance policies
- Common coverage solutions for the uninsured and underinsured
- Customer service
- Provider account resolution policies

Revenue cycle professionals should work to ensure broad education and awareness of communications best practices throughout their organizations.

Additionally, providers will have technology that gives financial representatives up-to-date information about insurance coverage, patient balances and financial obligations.

SUPPORTIVE POLICIES

Organizations will communicate and make supportive FAPs available to the community and communicate their availability to patients. A provider's FAP should be easily accessible for patients. For not-for-profit hospitals, this is mandated by IRS section 501(r).

Providers should regularly survey their patients to assess performance against HFMA's Patient Financial Communications Best Practices. Results should be shared with staff and leadership for continuous improvement opportunities.

If patients are granted partial financial assistance, the resolution process will continue until the remaining balance is resolved.

The medical accounts receivable resolution process

The components of the medical accounts receivable resolution process are described in this section of the report:

- Preservice/discharge patient education and engagement
- Post-discharge resolution process for all accounts
- Post-discharge resolution process for accounts that are sent to a collection agency

PRESERVICE/DISCHARGE PATIENT EDUCATION AND ENGAGEMENT

Specific recommendations for patient education and engagement – the what, how, when and where – are provided in this section.

What to discuss

Regardless of timing, core goals of patient engagement and education should include a discussion of the following:

- ▶ The account resolution process, including the steps from preregistration to appeals, estimated timing and who to contact with questions about the patient's account
- ▶ The provider's account resolution policies, including policies about prior balances
- ▶ The potential for surprise bills and how to avoid them
- ▶ Registration/demographic data and information necessary from an insured patient and referring provider, if applicable, to file a clean claim
- ▶ Sources of potential coverage, including public assistance programs, workers compensation/work-related injury, and coverage enrollment process for uninsured patients
- ▶ Availability of financial counseling
- ▶ Provider's FAP and how to apply
- ▶ The process for obtaining an out-of-pocket estimate of the patient's responsibility

What to discuss

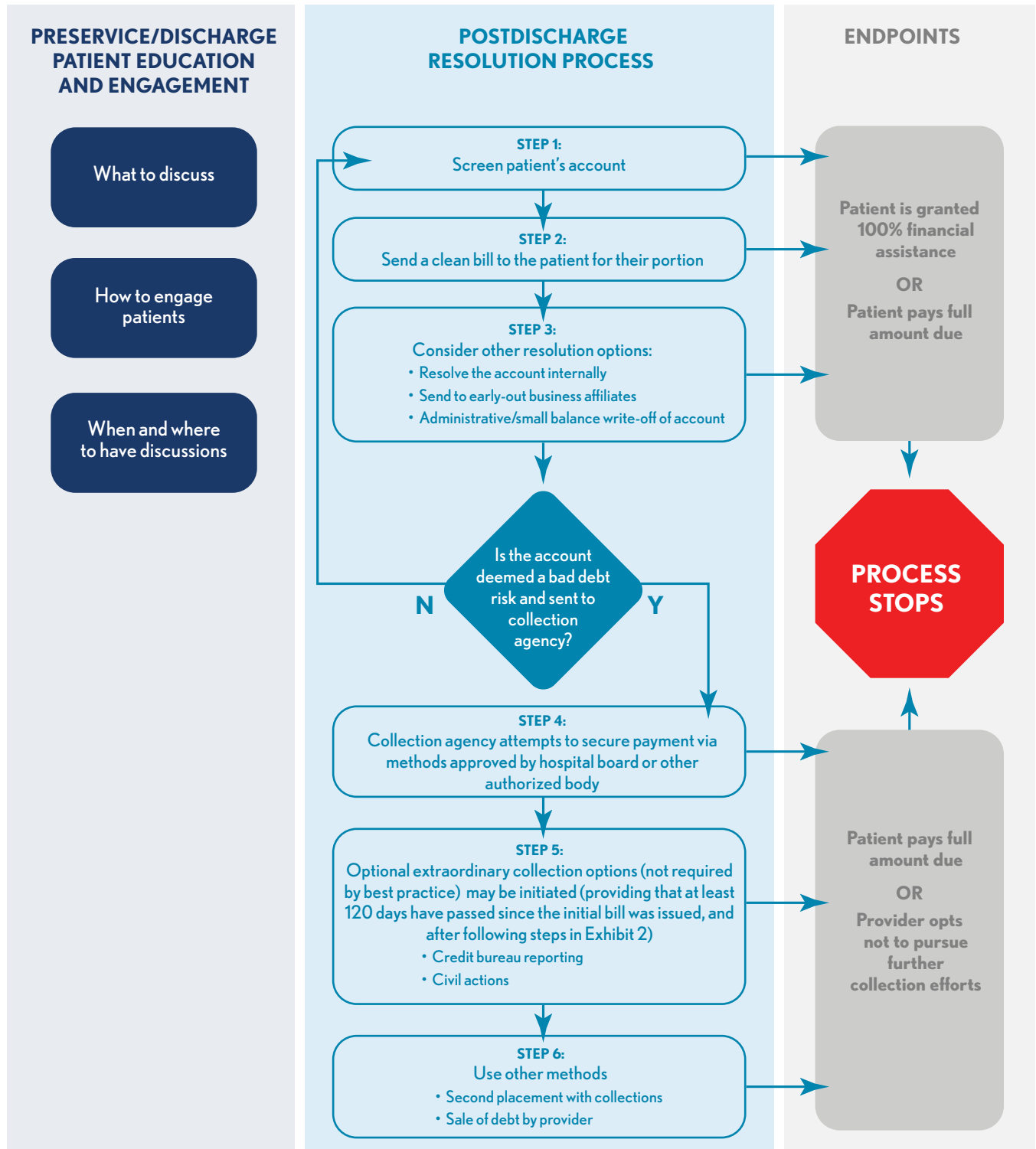
How to engage patients

When and where to have discussions

- For nonemergent services, price estimates should be made available to the patient when the service is scheduled.
 - For emergent services, price estimates should be made available as soon as it's practical to do so, based on EMTALA.
 - In accordance with HFMA's Price Transparency Task Force recommendations, the health plan is the best source of price estimates for insured patients. For uninsured patients, the provider is best positioned to provide the estimate.
- ▶ How patients can direct questions about their bill and resolve disputes regarding their balances
 - ▶ Options for payment plans and the process for establishing a plan
 - ▶ Obtaining patients' consent for contacting them and identifying their preferred communications mechanisms. (See appendix 4 for sample consent language.)
 - ▶ How patients can select and update communications preferences, including contact information

Exhibit 1. The medical accounts receivable resolution process

Each item in this graphic is described in detail in this report. The graphic has been simplified for illustration purposes.



How to engage patients on financial matters

Providers should take responsibility for engaging patients in a constructive manner to help them understand the billing process and the patient's responsibilities within it. Compassion, patient advocacy and education should be part of all patient discussions.

Providers and business affiliates should use a variety of communications methodologies as allowed by law that include, but not limited to, face-to-face conversations, letters, text messages, emails and phone calls/voice mails. When selecting a communication method, providers and business partners should take into account patients' preferred communication method(s).

All parties involved (provider, patient and payer) share responsibility to resolve any issues related to the patient bill.

These options are not comprehensive but are examples of common practices that are frequently used to resolve an account. However, taking all of these steps is not mandatory to adhere to the best practice. Providers are encouraged to use sound business judgment and knowledge of their patient population and the surrounding community when deciding which options to deploy and when.

When and where to have discussions

As discussed in HFMA's [Patient Financial Communications Best Practices](#), patient education should begin at scheduling for elective services and as soon as possible for emergent services once EMTALA requirements have been satisfied. Patient education should occur at each touch point possible (e.g., preregistration, registration, discharge and account resolution events).

Patient education should be reinforced throughout the account resolution process to help patients understand their financial responsibility and the availability of financial assistance.

- **Emergent services.** Financial discussions must comply with EMTALA and regulations that apply to the emergency department. They will occur during the discharge process.
- **Nonemergent care at the time of service.** It's preferable for these financial discussions to take place during the registration process. Alternatively, these conversations may take place during the discharge process in a location that does not disrupt patient flow.

- **In advance of a nonemergent service.** Financial discussions should use the appropriate communication method for the patient. They may take place via outbound contact, inbound contact or during scheduling.

POST-DISCHARGE RESOLUTION PROCESS FOR ALL ACCOUNTS

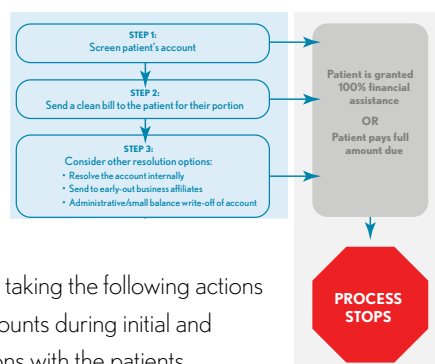
All account resolution efforts (either conducted internally by the provider or externally by a business affiliate) should adhere to formally documented and board-approved provider collection policies, which include, but are not limited to, screening individuals for financial assistance and granting it to those who are eligible, and any other permissible account resolution tactics. If patients are granted partial financial assistance, the resolution process will continue until the remaining balance is resolved.

The post-discharge resolution process begins with a thorough screening of the patient's account. Subsequently, a clean bill is sent to the patient for the patient's portion. If the patient is granted 100% financial assistance or pays the full amount due, the process stops. Other resolution efforts are considered if a balance remains, including resolving the account internally, sending to early-out business affiliates, and administrative write-off of the account.

Screen the patient's account

Providers should make a reasonable effort to ensure accurate and complete patient responsibility for true patient bal-

ances by consistently taking the following actions to screen patient accounts during initial and subsequent interactions with the patients.



- **Primary and secondary payers for billing.** Screen the account to ensure that information collected from the patient is accurate/still accurate.
- **Accurate payment(s) from payers made and posted.** Ensure correct balance after any insurance by verifying proper

payment amount from insurance and provider application of contractual allowances prior to final patient billing.

- **Eligibility for public programs and exchange-based coverage.** Attempt to enroll uninsured patients in any applicable public programs, COBRA, worker's compensation/ work-related injury or other insurance programs.

- **Financial assistance programs summarized in plain language and applied according to the provider's board-approved policy.** See the sidebar for a description of IRS 501(r) requirements for not-for-profit hospitals.
- **Discounts for necessary care provided to uninsured patients who are eligible.** Screening for financial assistance

Financial assistance policy requirements for not-for-profit hospitals based on the IRS 501(r) rule

Although the 501(r) rule applies only to not-for-profit hospitals, for purposes of these best practices, the task force believes that all providers, regardless of tax exempt status, should adhere to the 501(r) requirements related to account resolution.

- Make current and complete versions of the organization's financial assistance policy (FAP), FAP application, and a plain-language summary available on a website. Languages must include English and the primary language of any populations with limited English proficiency. The final 501(r) rule stated that FAPs should be translated into the languages spoken by 1,000 or more individuals in the community served or spoken by greater than 5% of the population of the community served.
- Make paper copies available upon request, in public locations and by mail.
- Inform and notify visitors about the FAP through conspicuous public displays and other measures reasonably calculated to attract attention.
- Inform and notify community residents about the FAP in a manner reasonably calculated to reach those who are most likely to require assistance.
- Provide a plain language FAP summary and offer an application prior to discharge.
- A hospital billing statement must include a conspicuous written notice that notifies and informs the recipient about the availability of financial assistance under the hospital's policy. The notice must include the telephone number of the office or department that can provide information about the FAP and FAP application process including the URL where copies of the FAP documents may be obtained.
- Inform the patient/guarantor about the FAP in all oral communications.
- Provide at least one written, 30-day notice that extraordinary collection actions (ECAs) may be initiated if an FAP application is not submitted or the bill is not paid within 120 days after the first billing statement or receipt of an incomplete FAP application.
- If an incomplete financial assistance application is submitted within 240 days after the first billing statement, the hospital/ business affiliate must suspend and not resume or initiate ECAs until it provides:
 - ▶ A written notice that describes the information needed to complete the application along with a plain language summary of the FAP.
 - ▶ A written notice, at least 30 days before the completion deadline, about potential ECAs if the individual does not submit a complete FAP application or pay the amount due by the completion deadline.
- When a complete financial assistance application is submitted within 240 days after the first billing statement, the hospital/business affiliate must suspend and not resume or initiate ECAs until it:
 - ▶ Makes and documents an eligibility determination in a timely manner.
 - ▶ Notifies the individual in writing of the determination and the basis for the determination.
 - ▶ Provides a billing statement that includes the amount the individual owes as an FAP-eligible individual, information regarding the amounts generally billed and how the amounts generally billed was determined.

based on the organization's FAP may include taking applications from patients and using presumptive eligibility tools or other data scoring methods. (If, at any point in the process, the patient is granted financial assistance – full or partial – the provider should communicate the amount of financial assistance provided and clearly describe the next steps in the account resolution process.) These tools and methods should establish an objective and unbiased presumptive scoring for FAPs (either full or partial discount) for full balances or remaining balances after insurance.

- These models should comply with IRS regulatory pronouncements.
- Use a presumptive eligibility model that relies on multiple data sources and that providers believe has a high degree of predictive accuracy. Beyond credit scores and other indicators of income and outstanding liabilities, items in a presumptive model might include indicators the patient is homeless (or has recently received care from a homeless clinic; patient is deceased with no known estate; patient has been approved for Chapter 7 bankruptcy; and the patient/family qualifies for the federal Supplemental Nutrition Assistance Program (SNAP).
- Ensure that the use of these models conforms to the provider's board-approved policy.
- Use income/family size calculations.
- In addition to using these methods as a screening tool, they may be used during registration, financial counseling and back-end collections.

• Bankruptcy

Send a clean bill to the patient for the patient's portion

As stated previously, HFMA's Patient Friendly Billing initiative offers guidance for designing bills that are readily understandable by patients.

- **Bills should be easy to understand and written in clear language, free of jargon.** Patients should be able to quickly determine what they owe and confirm, at a glance, that their health plan has paid its portion and how much it has paid (if applicable).

- Bills should contain just the right amount of detail necessary to communicate the message.
- Bill items should correctly reflect the financial aspects of the episode(s) of care.
- The needs of patients and family members should be paramount when designing patient-facing bills.
- Bills should include information for who to contact in case of questions related to items and amounts included on the bill.

Continuously consider other resolution options

These options include repeating some actions that were taken at an earlier date, given that circumstances may have changed:

- Insurance verification/COBRA eligibility
- Eligibility for public programs
- Bankruptcy screen
- Data scoring for financial assistance/payment plan development
- Presumptive score review
- Reasonable efforts to determine eligibility for financial assistance programs
- Payment plans that consider the economic circumstances of the community
- Third-party loans from reputable lenders
- Calls/letters/emails/texts
- Transfer of accounts between the provider and a business affiliate

Additional business affiliate efforts, depending on provider board-approved policy, may include the following:

- Screening or scrubbing for insurance, FAP eligibility, bankruptcy and death of patient.
- Asset verification

Unless specifically precluded by the provider's board-approved collection policy or the provider's contract with a business affiliate, nothing in these best practices should be construed to prevent business affiliates from directly contacting patients to attempt to establish third party coverage. Best practices for working with account resolution business affiliates are shown in the sidebar.

Best practices for working with account resolution business affiliates

TIMING Transfer of accounts between the provider and a business affiliate can occur at any time in the account resolution process. Early-out efforts should be considered an extension of the business office, accountable to the provider’s policies and procedures related to self-pay accounts. Accounts in early out should not be considered delinquent but are in the process of resolution actions that occur before delinquency.

CONTRACT REQUIREMENTS All business affiliates must operate under contract with the provider. The contract should specify what types of account resolution policies are permissible in accordance with the hospital’s board-sanctioned collections policy. Business affiliates must comply with the Fair Debt Collections Practices Act for these accounts.

ACCESS TO DATA All business affiliates need access to relevant data to service accounts. This includes, but is not limited to, the date of first statement, payments made, subsequent statements, access to the billing system (if the agency has the authority to file insurance claims) and the patient’s preferred/consented communications method(s). It should be noted that the account resolution process clock starts at first statement date from the provider’s system. This bill date is essential information that must be provided to business affiliates.

- ▶ Obtaining consent to use a communications methodology is required both to avoid legal action and to engage the patient via their preferred medium. Sample consent language is included in appendix 4.

- ▶ If communications method preferences change, or the patient updates the methods of communication to which they consent, this information should be shared among business partners, i.e., between the hospital and business affiliate(s).
- ▶ If claims are placed with a secondary agency, they should receive information from the first placement that is necessary to pursue the account. This should include any information related to account disputes.

COMPLAINT REPORTING All business affiliates involved in account resolution actions are required to report patient complaints.

- ▶ Complaint reviews and quality assurance activities should consist of:
 - Reviewing billing/registration and other revenue cycle issues that result in inappropriate accounts sent to business affiliates
 - Call audits and other quality assurance activities to ensure that policies are followed and to identify and act on process improvement opportunities

RECONCILIATIONS Regular reconciliations should occur between the provider’s system and a business affiliate’s system to ensure balances are in sync (i.e., take backs) for accounts in bad debt.

- ▶ Providers should also ensure through the reconciliation process that only one entity (business affiliate(s) or the provider) is working on an account to avoid duplication of patient contact.
- ▶ The frequency of these reconciliations should allow for a high degree of confidence that multiple parties are not pursuing the same account.

POST-DISCHARGE RESOLUTION PROCESS FOR ACCOUNTS THAT ARE SENT TO A COLLECTION AGENCY

When accounts are deemed a bad debt risk and sent to a collection agency, the agency must use collection methods that have been approved by the provider’s board or other authorized body. Each provider should establish a board-approved formal policy regarding use of ECAs as defined by the IRS—i.e., liens, credit reporting, lawsuits, wage garnishments or sale of debt. (Per 501(r), [debt sales](#) are not considered an ECA if the purchase agreement includes provisions prohibiting ECAs, limiting interest charged, requiring debt to be returnable if the individual is FAP eligible, and limiting what FAP-eligible individuals are required to pay if debt is not returned.) The formal policy must be communicated to, and contractually adhered to by, business affiliates.

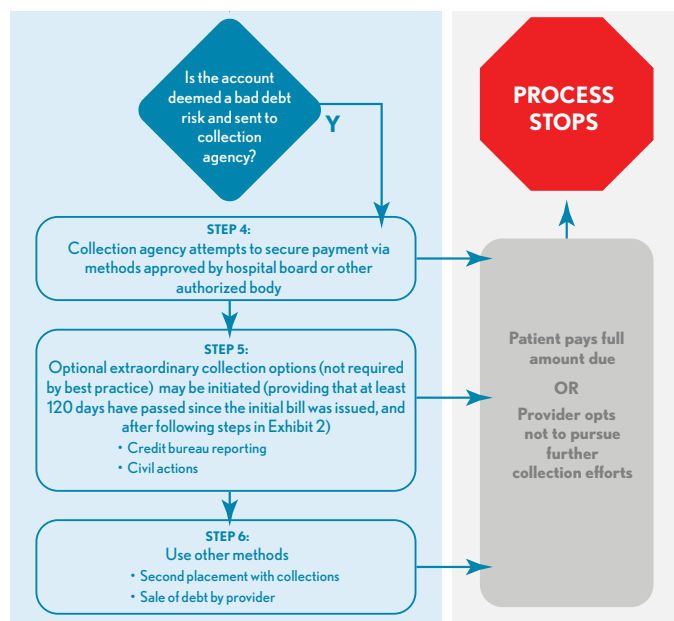


Exhibit 2. Recommended steps prior to initiating an extraordinary collection action (ECA)

	Credit Reporting	Debt Sale	Legal Action ⁵
501(r) requirements met.	✓	✓	✓
Screening to obtain correct address/phone number, and other contact information (e.g., skip tracing) completed.	✓	✓	✓
Screening for primary/secondary payer for billing. This includes eligibility for public programs, COBRA and exchange-based coverage.	✓	✓	✓
Accurate payment made and payment posted by provider (if balance is after insurance) verified.	✓	✓	✓
Reasonable communications efforts attempted to provide information to patients regarding the availability of: <ul style="list-style-type: none"> • Financial assistance/other potential discounts • Financing options/payment plans 	✓	✓	✓
Financial assistance (charity care, uninsured/self-pay discounts) determination attempted using any available information collected from the patient and/or via presumptive screening tools or presumptive eligibility categories.	✓	✓	✓
Screening for adherence to negotiated payment plan (if one exists) completed.	✓	✓	✓
Bankruptcy status verified.	✓	✓	✓
Screening for other indicators of indigence completed. Examples may include: patient/family qualifies for free school lunch program, family is eligible for SNAP, patient/responsible party lives in subsidized housing, patient/responsible party is homeless.	✓	✓	✓
Screening for balance materiality threshold completed.	✓	✓	✓
Screening for appropriate account aging/prior resolution attempts. ⁶	✓	✓	✓
Review of credit report completed. Includes overall score, existing liability balances, current liability statuses) across all open loans and credit accounts to ascertain the patient's ability to pay.			✓
Confirmed the patient's/responsible party's current estimated income above provider threshold for legal action?			✓
Patient/responsible party likely to sustain current earnings based on job type and tenure in current role?			✓
File sent or made available by business affiliate to provider documenting due diligence steps (if actions completed by business affiliate).	✓	✓	✓
ECA approved by hospital revenue cycle leader ⁷ after determining that all applicable steps in the checklist have been taken. This is determined by reviewing either internal records or a file sent by the business affiliate working the account. The ECA review and approval process is intended to provide a crucial pause point that ensures the use of an ECA is the appropriate next step based on the hospital's board-approved account resolution policy.	✓	✓	✓
Once ECA is approved, final notice giving patient/responsible party 30 days to respond ⁸ is sent. ⁹	✓	✓	✓

⁵ Includes civil actions and garnishments.

⁶ Assumes provider/business affiliate has some verified contact information and is able to send statements/texts/emails and/or make calls based on contact information.

⁷ Individual who is a manager or above.

⁸ If the patient responds via phone, call scripting should include discussion of available financial assistance.

⁹ Notice includes potential options for financial assistance and payment plans.

Procedures for optional credit bureau reporting

TIMING Reporting an account to a credit bureau should occur no earlier than 120 days from the date of the first provider (or early-out agency acting on behalf of a provider) statement. Prior to initiating any ECA, the appropriate steps outlined in Exhibit 2 should be completed.

REPORTING ACCOUNT RESOLUTION If a provider/business affiliate elects to report an outstanding debt to a credit bureau and the debt is subsequently satisfied (including acceptance of a settlement for less than full value as paid in full), the hospital should establish a policy stating the patient's credit report should be updated to reflect the account's resolution.*

- ▶ The task force suggests that a negative listing for medical debt be removed from a consumer's credit report within

45 days of account resolution. In this way, the consumer is not penalized beyond resolution of the account.

- ▶ It is the responsibility of the provider/agency to report the satisfaction of an account to credit bureaus.
- ▶ Providers/agencies that choose not to report to credit bureaus are exempt from this step.
- ▶ Acknowledgment should occur between the hospital/business affiliate and credit bureau (if reported) for account updates. Any paid debt or account dispute should be handled in accordance with ACA International guidelines:
 - Reasonable timeframe
 - Detailed acknowledgment of data transmission that verifies receipt of information and completion of file update
 - Define the dataset between bureau and provider/business affiliate to assure consistent handling of accounts

* [The New York Attorney General's settlement](#) with the credit reporting agencies requires the agencies to remove all medical debts from a consumer's credit report after the debt is paid by insurance.

Ongoing provider efforts to educate patients about the account resolution process should include informing patients of board-sanctioned ECAs and patient notification should occur prior to undertaking these activities. Per the IRS 501(r) rule, this must occur 30 days prior to use of ECAs. Based on HFMA's best practices, the specific steps listed in Exhibit 2 must be taken before initiating ECAs.

Procedures for optional credit bureau reporting are shown in the sidebar above.

Additional methods

Additional methods that may be used include a second placement with collections, the sale of the debt by the provider, or cessation of all collection activities. In the event of a second placement with collections, all best practices and procedures applicable to the first agency placement remain in effect.

If the provider elects to sell outstanding accounts, it should require that the debt buyer:

- Abide by ACA International's *Health Care Collection, Servicing and Debt Purchasing Practices Statement of Principles and Guidelines*
- Adhere to [ACA International's Code of Ethics](#)
- Be licensed as a debt buyer, where required by state law

Please see the full report, [Statement of Principles and Guidelines for the Sale and Purchase of Consumer Debt](#), for a full discussion of contract provisions that should be incorporated in a debt sale contract.

Frequently asked questions

These FAQs are related to various phases of the medical account resolution process.

BASICS OF THE ACCOUNT RESOLUTION PROCESS

What steps can hospital finance leaders take to be confident they are handling patient financial responsibility in accordance with best practices?

Post-discharge account resolution efforts begin with diligence to assure that the balance (also known as patient responsibility) is correct and complete. Once efforts to identify and bill third party payers or governmental programs have been pursued to their fullest and financial assistance programs applied as required by IRS 501(r), there may be a balance for which the patient is responsible. Per the 501(r) rule, patient education regarding FAPs must be communicated verbally and in a written policy, and notices posted prominently in locations in the provider facility. Although the 501(r) rule applies only to not-for-profit hospitals, for purposes of these best practices, the task force believes that all providers, regardless of tax-exempt status, should adhere to the 501(r) requirement for FAP communication and posting.

While a remaining patient balance assumes the prior steps have been taken, it does not preclude continuing efforts to educate the patient, repeat screenings for financial assistance program eligibility or other attempts to qualify the patient for third party coverage, offer payment arrangements or other solutions on an ongoing basis.

All hospital billing statements must include a conspicuous written notice informing the recipient about the availability of financial assistance under the hospital's policy. The notice must include the telephone number of the office or department that can provide information about the FAP and FAP application process, including the URL where copies of the FAP documents may be obtained. The best practices encourage providers to make certain these links are easily accessible (requiring less than three clicks to access) and recommend that providers check the links not less frequently than annually to ensure that the links are not broken.

Links that are broken or not easily accessible may trigger an IRS next-level review for not-for-profit providers.

Is it necessary to get a patient's permission to call or text them about their bill?

As specified in HFMA's Patient Financial Communications Best Practices, communication with the patient should include verification of patient information (mailing address, phone numbers, email, etc.) and the patient's preferred methods for future communication, which should include all contemporary forms of communication permissible. If the patient changes their preferences related to how they would like to be contacted, this information must be updated and shared with all partners. Given Telephone Consumer Protection Act requirements, this is particularly time sensitive if the patient or responsible party withdraws their consent to be contacted via cell phone using an automatic telephone dialing system.

How should disputed bills be handled?

Provider policies should include guidelines for responding to consumers who dispute all or part of the items or amounts billed. Such policies should include assurance that the patient has received a full list of all charges, including interest and late fees, and suspension of collection activities until the items or amounts have been verified. In this way, an account will be considered resolved or the charge or charges will be removed if the items or amounts cannot be verified within a reasonable amount of time.

Is "small balance" defined as a certain dollar amount?

The definition of small balance is subject to the provider's discretion and internal policies. A provider may choose to pursue account resolution in a number of ways. Resolution may occur as a result of an early transfer to a business affiliate, internal resolution or small balance write-off. This workflow does not favor one method of small balance resolution over another but seeks to illustrate the options

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that may be pursued in accordance with provider policy and governing laws. This step could take place prior to extensive account resolution efforts, after receipt of payment from a third party payer, or following partial payment from a patient.

How should payments be applied when a patient has multiple accounts with a balance?

Payments should be applied to accounts in a consistent manner. For patients with multiple open accounts, unless there are specific payment application instructions provided by the patient, the payment should be applied to the balance on the statement that accompanies the payment. If there are funds in excess of the balance related to the statement and no accompanying instructions for applying the remaining funds, they should be posted to the oldest account first. Lacking any direction whatsoever (e.g., a payment sent without instructions or an accompanying statement or a payment sent with statements from multiple accounts and no instructions) from the patient as to how to apply payments to multiple accounts, providers should systematically apply payments to older accounts first to assure a fair and constant methodology of account.

What issues should be covered by account resolution policies?

All activities in pursuit of account resolution should be governed by the provider organization's financial assistance program, account resolution and collections policies. These policies should be approved by the provider's board or other authorized body and followed by all parties, including business affiliates representing the provider. Providers should have a clear written policy regarding the provision of financial assistance, which describes how to apply, what supporting documentation should be submitted, eligibility criteria and any measures providers may take to resolve accounts. This policy should be readily available to all patients.

What is considered a reasonable effort to resolve an account?

Providers must undertake reasonable efforts in a consistent manner to resolve accounts. These may include solutions mentioned previously, or by further means, subject to patient consent where applicable, such as phone calls, text messages, email, letters and other contemporary means to communicate with the patient, screening (including, but not limited to, bankruptcy, eligibility for

financial assistance programs or third party payers); data scoring for the purpose of financial assistance or payment plan development; and third party loans from reputable providers.¹⁰

Where appropriate, messages sent to patients/responsible party (or scripting used) should emphasize the benefits of engaging with providers or business affiliates to resolve accounts. As discussed in the concluding section on areas for further refinement, the task force believes that in the future, these messages could be tailored to patients based on their economic profile to help demonstrate the value proposition of engaging with providers in account resolution efforts.

These options are not comprehensive but are examples of common practices that can be used to work with patients to resolve an account. Furthermore, taking all of these steps is not mandatory to adhere to the best practice. The task force strongly encourages providers to use sound business judgment and knowledge of their patient populations and the surrounding community when deciding which options to deploy and when.

The use of electronic communications to engage and educate patients about their options for resolving an outstanding balance poses a unique opportunity for providers to deploy adaptive outreach strategies. Analytics based on patient/responsible party responses to electronic communications (e.g., open rates, response rates) can be used to tailor content and timing of engagement messages, leverage patient/responsible party preferences to increase effectiveness and facilitate account resolution.

When is account rescreening recommended?

While the task force firmly believes that early screening of accounts for third party payers, bankruptcy, financial assistance programs and other means of resolution is preferred for both the patient and provider, we understand that no system is perfect. Therefore, business affiliates should rescreen accounts to ensure fair, patient-friendly account resolution. And, as discussed below, accounts should be rescreened prior to initiation of any ECA. Furthermore, it is important to make appropriate efforts to provide adequate

10 If a provider uses data scoring tools to screen and qualify individuals for financial assistance or charity care, their use should be documented in the organization's financial assistance policy. If the provider claims any charity care granted to Medicare beneficiaries using data scoring tools as allowable reimbursement on the cost report, the presumptive tool needs to satisfy the requirements of Provider Reimbursement Manual §312 and provide sufficient documentation to support the determination. How this will be achieved should be incorporated into the provider's financial assistance policy.

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information to consumers regarding their obligation and the possible consequences of failure to resolve an account.

A formal board-approved policy from providers should specify what actions may be taken and the circumstances under which each may be employed. Business affiliates acting on behalf of a provider (ranging from early-out to account recovery affiliates) must offer the patient/responsible party the provider's FAP and options for a payment plan based on the provider's policy during communications/interactions in accordance with section 501(r) requirements.

When can an account be considered delinquent?

When accounts cannot be resolved (or a pathway for resolution established) an account may be considered delinquent by the provider. While an account's age (based on the date of first billing of patient responsibility from a provider or early-out business affiliate) is a reasonable factor used to determine whether or not an account is delinquent, it is not the only factor that could be considered. Ultimately, this determination should be grounded in the organization's board-approved account resolution policy and sound business judgment about the collectability of an account.

At the provider's discretion, accounts deemed at risk for nonpayment may be outsourced to a business affiliate for advanced efforts to obtain resolution. Similar to the process for early-out accounts, if a provider chooses to use external business affiliates to pursue at-risk account resolution, then reconciliation must occur.

WORKING WITH ACCOUNT RESOLUTION BUSINESS AFFILIATES

What are best practices for working with account resolution business affiliates?

If an account is assigned to a business affiliate who acts on behalf of a provider, the business affiliate must offer the patient/responsible party the provider's FAP and options for a payment plan based on the provider's policy during communications/interactions in accordance with section 501(r) requirements. The business affiliate must adhere to the hospital's board-approved account resolution policy.

HFMA believes it is important for hospitals to ensure that their business affiliates' approach to account resolution is aligned with the

provider's brand and mission to the community. To that end, the best practice recommendation is that hospitals use the ECA checklist in Exhibit 2. This provides a pause point prior to initiating an ECA to review the account, make sure it has been properly handled, and provide one last outreach to the patient prior to initiation of the ECA. Additionally, hospitals should review scripting the business affiliate typically uses during account resolution activities with patients during their evaluation of potential business affiliates. This will also help ensure the business affiliate's approach to account resolution is aligned with the hospital's mission and brand.

Are early-out accounts assigned to business affiliates automatically considered delinquent?

The practice of assigning accounts to business affiliates for resolution does not imply a delinquent obligation. The term "early out," sometimes referred to as precollection, simply means that the provider has chosen to outsource some or all of its open accounts to a business affiliate to service the accounts as an extension of the provider's patient accounting department. In this sense, early out may refer to any account resolution activities handled by a business affiliate that occur before an account is deemed delinquent.

What account information should a hospital share with business affiliates?

If an account is outsourced to a business affiliate for resolution, the business affiliate must have access to all necessary information to assist the patient in resolving the account. In the event an account is placed with a secondary business affiliate, the secondary affiliate should have access through the provider to the necessary account information from the primary affiliate's efforts in order to effectively resolve the account in a patient-friendly manner. The provider should receive account status (which includes disputes, current balance and last payment date and amount) when the primary agency returns the account to the provider. Hospitals must take reasonable steps to ensure that business affiliates who are handling protected health information related to patients' accounts are compliant with HIPAA privacy and security requirements.

What collection methods are permissible for business affiliates to use?

A board-approved policy must specify and govern the steps permissible for business affiliates to use as they attempt to resolve

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accounts. These steps should be included in the provider's contract with the business affiliate. Compliance with established account resolution policies is mandated and should be assured by regular audits and account reconciliation between the provider and business affiliate. Disputed balances must be reviewed in a timely manner as specified by ACA International and the IRS 501(r) rule to rectify errors and update accounts.

What is involved in account reconciliation with business affiliates?

When a provider chooses to use external business affiliates to pursue account resolution (either as part of an early-out strategy or if the account becomes delinquent and is transferred to a business affiliate), account reconciliation must occur. This will ensure multiple entities are not pursuing resolution of the same account simultaneously and protect patients from duplicative contacts. This step must occur with sufficient frequency to provide a high level of confidence that the patient is not experiencing duplicative contacts regarding the same account. If the patient updates information on their account (including changes in contact information or consent to contact) this information must be updated in both business affiliate and hospital records.

How should hospitals monitor complaints about business affiliates?

All consumer complaints should be tracked and shared between the business affiliate and the provider in order to improve customer service, hasten account resolution and avoid recurring grievances. As referenced earlier, account servicing parties must abide by the provider's board-approved financial assistance program, account resolution and collection policies. Regularly occurring audits should be performed to assure compliance with policies for both early-out providers and accounts that are in collections. Business affiliates' internal policies should comply with established ethical standards as outlined in ACA International's [Code of Ethics](#) and [Code of Operations](#).

EXTRAORDINARY COLLECTION ACTIONS

How should hospitals approach the decision about whether to use ECAs?

As defined by the IRS in section 501(r), ECAs include taking legal action, selling an individual's debt to another party and/or credit

bureau reporting. While the 501(r) rule only applies to not-for-profit hospitals, for purposes of this best practice, we use the term to refer to these account resolution activities regardless of whether the provider taking them is for-profit or not-for-profit.

Adhering to this best practice does not require hospitals to use ECAs; they are optional, to be used at a hospital's discretion and in accordance with the board-approved account resolution policy. This task force does not endorse any specific strategies but reiterates the importance of compliance with provider policies and governing state and federal regulations.

Hospitals are encouraged to weigh the risk of using an ECA (e.g., potential to negatively impact patients or injure the hospital's standing in the community) against anticipated increased yield resulting from the ECA's usage.

The discussion of ECAs in the context of this best practice is intended to provide guidance on the steps an organization should take prior to using a particular ECA if a hospital believes the risks are justified by the benefits.

ECAs should be pursued only after reasonable efforts to resolve a patient's account have occurred. Exhibit 2 offers a checklist of steps hospitals should take prior to using an ECA. The task force believes the checklist in Exhibit 2 can be used as the basis for internal controls to ensure ECAs are not used on patient accounts if all reasonable efforts to resolve a patient's account have not been exhausted. Prior to the initiation of any ECA, the best practice process assumes the following steps have been taken related to the patient/responsible party's account:

- Screening for correct contact information
- Screening for possible insurance coverage and accuracy of existing insurance information
- Reviewing accuracy of payments made by health plans and balance posting by providers
- Patient or responsible party has been contacted regarding opportunities for financial assistance and payment plans
- Determination of presumptive eligibility for financial assistance
- Adherence to existing payment plans (if one exists)
- Reviewing patient/responsible party bankruptcy status or other factors that would deem a person eligible for FAP or other support (e.g., victims of violent crimes)

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Regardless of the number of times an account has been screened for the items listed above, an account must be screened based on the checklist in Exhibit 2 prior to initiation of an ECA.

Hospitals should set a balance materiality threshold prior to initiation of a legal action. This can be based on market conditions and other provider-specific factors (e.g., not-for-profit status, affiliation with religious or governmental organizations, safety net status, mission-related services, community supported activities, endowments, etc.).

Providers need to determine an appropriate duration of account resolution effort prior to initiation of an ECA.¹¹ At a minimum, this must comply with the 501(r) requirements which require patients should be given at least one written 30-day notice that ECAs may be initiated if a financial assistance application is not submitted, the bill is not paid, or an arrangement to repay the bill has not been agreed to by both patient and provider within 120 days after the first billing statement or receipt of an incomplete financial assistance application. However, this can vary based on the severity of the ECA and the provider's business practices. The task force recommends waiting 120 days from the date of the first billing statement before commencing ECAs. It should be noted that the 501(r) rule allows ECAs to occur prior to 120 days in certain circumstances. The task force's use of 120 days as a general guideline serves to protect patients from undue haste in use of ECAs, apart from the IRS ruling.

When does the clock start for ECAs and other time-bound account resolution activity?

The initial billing to the patient for a patient balance (either true self pay or balance after insurance) is the starting date for the process to resolve the account. All time-bound activity should be driven by this date.

For example, if the provider allows reporting to a credit agency, according to the IRS 501(r) rule, it should occur no sooner than 120 days from the date of the provider's first bill to the patient. While the rule does not require the 120-day waiting period in situations where certain conditions have been satisfied, this group recommends this time frame as a reasonable period before ECAs begin. Given the significance of the first statement date in account resolution activities, the task force believes that it is essential information that should

be shared with business affiliates who are engaged in account resolution efforts.

Does a hospital or business affiliate that reported a past due account to a credit bureau need to report back to the bureau when an account is resolved?

Providers may choose not to report past due accounts to credit bureaus. However, it is the position of this task force that if reporting has occurred, it is the responsibility of the reporting entity (either provider or business affiliate) to also report back to the bureau if the account is resolved. The task force suggests that a negative listing for medical debt be removed from a consumer's credit report within 45 days of account resolution. In this way, the consumer is not penalized beyond resolution of the account.

To what extent should a hospital board or other authorized body be involved in ECA-related and other medical account resolution policies?

For not-for-profit hospitals, the final IRS 501(r) rule requires an authorized body of the hospital to adopt the provider's financial assistance and billing and collections policies (e.g., accounts receivable resolution policy). Beyond being a requirement for not-for-profit providers, this is a best practice for all hospitals, regardless of tax-exempt status. As part of this best practice, if the account resolution policy undergoes a material revision, it should be reviewed and approved by the authorized body.¹²

To further the authorized body's understanding of how the account resolution policy is impacting patients and the community, a finance leader should provide, on an annual basis, a high-level review of the ECAs allowed and the circumstances in which they are allowed under the current account resolution policy. The review also should include reporting of the percentage of patients/guarantors, by race and ethnicity, who are written off to bad debt. Additionally, this review should include the rate at which the permissible ECAs are used and the financial results of their use. As discussed in the section on areas for further refinement, as the data becomes available, providers should report to the authorized body the rate at which permissible ECAs are used, by patient/guarantor race and ethnicity.

¹¹ The New York Attorney General's [settlement](#) with the credit reporting agencies requires them to wait 180 days before medical debt will be reported on a consumer's credit report.

¹² This is a requirement for not-for-profit providers under IRS 501(r).

FINAL DISPOSITION OF UNRESOLVED ACCOUNTS

What happens when all efforts to resolve an account are unsuccessful?

Following the exhaustion of all reasonable efforts to resolve the debt, providers should have written, board-approved policies regarding the disposition of remaining unresolved accounts. Some options to consider might include placing the debt with a secondary business affiliate for further efforts, selling the debt to a certified debt buyer who adheres to the ACA International's Code of Ethics or discontinuing efforts and writing the account off to bad debt. If the provider intends to claim Medicare charity care and bad debt as reimbursable on the cost report, all resolution activity must also comply with the *Medicare Provider Reimbursement Manual*.

How does a hospital go about selling outstanding accounts?

If the provider elects to sell outstanding accounts, it should require that the debt buyer abide by ACA International's *Health Care Collection, Servicing and Debt Purchasing Practices Statement of Principles and Guidelines*, adhere to ACA International's Code of Ethics, and be licensed as a debt buyer, where required by state law. In addition, the provider should prohibit the resale of accounts by the debt buyer without the provider's prior approval. The purchase and sale agreement between the provider and the debt buyer should also include a representation from the debt buyer that it will only engage collection agencies for the collection of sold accounts that agree to maintain collection agency licenses where required by state law; comply with federal, state and local laws; and adhere to ACA International's Code of Ethics.

Areas for Further Refinement

The task force realizes this framework does not resolve all issues related to post-discharge medical account resolution. We will continue to work with stakeholders to improve the framework for the benefit of patients and providers. Specifically, still in question is how to assign an average time to the various steps in the process. We realize that providers' internal revenue cycle operations will vary to a degree within this framework based on organizational operational requirements and board-approved policy. Therefore, any time frames developed would have to balance the flexibility to allow providers to manage their organizations in a manner they see appropriate against the need for a standardized time frame to help educate patients and provide benchmarks for the industry.

Additionally, we believe there are areas for improvement in the best practices that will present themselves as increased data source integration facilitates improved data aggregation and analysis.

PATIENT-SPECIFIC ACCOUNT RESOLUTION MESSAGING

The best practices stress the need to convey the benefits to the patient of engaging with providers and business affiliates to resolve accounts. Providers and business affiliates should look for opportunities to collect the data necessary to create targeted

communications to specific segments of patients that “proves the value proposition” of engaging in account resolution efforts. For example, this messaging could relate the percentage of individuals with similar economic profiles (e.g., 150% - 200% of federal poverty level) and balances who had their balances reduced or were connected with a source of coverage by engaging with the provider.

AUTHORIZED BODY ECA REPORTING

The best practices stress the need to periodically report to the hospital board or authorized body on the rate at which certain ECAs are used and their financial impact to the organization. Currently, providers have access to patient race and ethnicity data in their electronic medical records. However, data on authorized ECA usage typically resides only with business affiliates, as they typically take the ECA. Providers and business affiliates need to develop ways to integrate these data sources so statistics on the percentage of each type of authorized ECA used by race and ethnicity can be presented to the authorized body. This will help the hospital perform root cause analysis in its patient education and account resolution efforts to identify and address issues related to racial and ethnic disparities.

Resources

ACA International. [Code of Ethics and Code of Operations of ACA International](#), 2010.

ACA International, *Health Care Collection, Servicing and Debt Purchasing Practices Statement of Principles and Guidelines*.

HFMA. [Avoiding Surprises in Your Medical Bills](#), 2018.

HFMA. [Patient Financial Communications Best Practices](#), 2013.

HFMA. [Price Transparency in Healthcare: Report from the HFMA Price Transparency Task Force](#), 2014.

HFMA. [Consumerism in Health Care: An Initiative of the HFMA Patient Friendly Billing Project](#), 2006.

HFMA. [Comment Letter on IRS's Proposed Rule: Additional Requirements for Charitable Hospitals, Section 501\(c\)\(3\)](#), September 24, 2012.

Internal Revenue Service. "[Requirements for 501\(c\)\(3\) Hospitals Under the Affordable Care Act - Section 501\(r\)](#)."

Appendixes

APPENDIX 1: SAMPLE PUBLIC HEALTH EMERGENCY FINANCIAL ASSISTANCE POLICY

On (INSERT DATE), the (INSERT NAME/TITLE of GOVERNMENT OFFICIAL) declared a public health emergency (PHE) in the (INSERT LOCATION). The subject of this PHE is (INSERT CAUSE). In conjunction with the date of the PHE declaration, (INSERT HOSPITAL/HEALTH SYSTEM) leadership and Board of Directors has granted approval of an additional presumptive Financial Assistance category to provide financial assistance for patients impacted by (INSERT CAUSE). (INSERT HOSPITAL/HEALTH SYSTEM) has granted (INSERT HOSPITAL/HEALTH SYSTEM) leadership the authority to utilize this presumptive category to assist with patient liabilities resulting from testing and/or treatment of (INSERT CAUSE) or related symptoms. (INSERT HOSPITAL/ HEALTH SYSTEM) leadership has also been granted the authority to extend financial assistance on a case-by-case basis to patients who have experienced financial hardships resulting from (INSERT CAUSE), irrespective of whether they are or have been tested and treated for (INSERT CAUSE). This presumptive category will remain in effect from the date of declaration of the PHE, (INSERT DATE), until such time as the (INSERT HOSPITAL/HEALTH SYSTEM) leadership and Board of Directors deems appropriate and amends this policy.

APPENDIX 2: LEGAL PROVISIONS FOR COLLECTION ACTIVITIES AND/OR DEBT BUYERS

Healthcare organizations should seek to use only those collection agencies that are fully committed to compliance with the wide range of laws and regulations that apply to collection activities and debt buyers. These provisions include but are not limited to the following.

Statute	Citation (statute or regs)	Key Provisions
Federal Trade Commission Act	15 U.S.C. §§ 41-58	Prohibits unfair or deceptive practices; enforcement and oversight are by Federal Trade Commission
Health Insurance Portability and Accountability Act (HIPAA)	45 C.F.R. Parts 160 and 164	Collection agencies may be “covered entities” or “business associates” and thus subject to HIPAA privacy/ security rules
Fair Debt Collection Practices Act	15 U.S.C. §§ 1692-1692o	Prohibits deceptive and abusive collection practices
Fair Credit Reporting Act	15 U.S.C. §§ 1681-1681u	Privacy protections regarding credit reports, etc.
Gramm-Leach- Bliley Act	15 U.S.C. §§ 6801-6809	Requirements to protect consumers’ financial information
Telephone Consumer Protection Act	47 U.S.C. § 227	Rules concerning telemarketing, robocalls, the Do Not Call list, etc.
Requirements for 501(c)(3) hospitals	26 U.S. Code § 501r	Requirements for financial assistance policies and billing and collection efforts
Various state laws		Consumer protections; licensing and bonding of collection agencies; unfair trade practices, etc.

APPENDIX 3: GLOSSARY OF TERMS

Account resolution process

The steps a provider may take to help patients resolve the patient portion of a hospital bill.

Business affiliate

Organizations that contract with healthcare providers to work directly with patients on behalf of healthcare providers to resolve outstanding medical accounts. Examples include, but are not limited to, accounts receivable management companies, collection agencies and debt buyers.

Data scoring

The use of existing information, or data, to predict whether the patient/guarantor is eligible for financial assistance and/or has the ability to satisfy an outstanding balance. The data is filtered through a model and given a score which indicates the propensity of a consumer to pay a debt. This tool is used to determine if an individual is eligible for financial assistance programs or for the development of a payment plan.

EMTALA

The Emergency Medical Treatment and Active Labor Act requires hospital emergency departments that accept payments from Medicare to provide an appropriate medical screening examination to anyone seeking treatment for a medical condition, regardless of citizenship, legal status or ability to pay. Participating hospitals may not transfer or discharge patients needing emergency treatment except with the informed consent or stabilization of the patient or when their condition requires transfer to a hospital better equipped to administer the treatment.

Patient portion

The balance due from the patient after all other forms of payment have been applied to the account, including insurance payments, contractual allowances, discounts or financial assistance programs. This balance is the patient's responsibility and includes copayment, coinsurance or deductible, as well as a balance for noncovered services.

Payment options

These may include payment plans, loans and other avenues for resolving the balance in incremental payments.

Postservice

All activities undertaken in the resolution of a patient account that occur after the patient is discharged from the hospital.

Preservice

All activities undertaken in the resolution that occur before services are rendered to the patient.

Reconciliation

The comparing of account details such as servicing organization, balance, payments and complaint resolution between providers and business affiliates.

Third party payers

Parties to an insurance or prepayment agreement; usually an insurance company, prepayment plan or government agency responsible for paying to the provider designated expenses incurred on behalf of the insured. Examples include commercial insurance, workers' compensation plans, Medicaid or other state or local programs.

APPENDIX 4: SAMPLE WORDING FOR CONSENT TO CONTACT

I grant permission and consent to [healthcare facility name] and its agents, assignees, and contractors (which may include third party debt collectors for past due obligations): (1) to contact me by phone at any number associated with me, if provided by me or another person on my behalf; (2) to leave messages for me and include in any such messages amounts owed by me; (3) to send me text message or emails using any email address I provided or any phone number associated with me, if provided by me or another person on my behalf; and (4) to use prerecorded/artificial voice messages and/or an automated telephone dialing system (an auto dialer) as defined by the Telephone Consumer Protection Act in connection with any communications made to me as provided herein or any related scheduled services and my account. I further agree to provide updated contact information in an effort to avoid unintended disclosures of my information and I accept and acknowledge that [healthcare facility name] and its agents, assignees and contractors (which may include third party debt collectors for past due obligations) will treat any email address or phone number I provide as my private email or phone number that is not accessible by unauthorized third parties. I understand that communication attempts will be made to my cellular phone during permitted calling hours based upon the time zone affiliated with the cellular phone number provided, unless notified otherwise. I understand that my refusal to provide the information described in this paragraph will not affect, directly or indirectly, my right to receive healthcare services.



healthcare financial management association

The Healthcare Financial Management Association (HFMA) equips its more than 56,000 members nationwide to navigate a complex healthcare landscape. Finance professionals in the full range of work settings, including hospitals, health systems, physician practices and health plans, trust HFMA to provide the guidance and tools to help them lead their organizations, and the industry, forward. HFMA is a not-for-profit, nonpartisan organization that advances healthcare by collaborating with other key stakeholders to address industry challenges and providing guidance, education, practical tools and solutions, and thought leadership. We lead the financial management of healthcare.

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