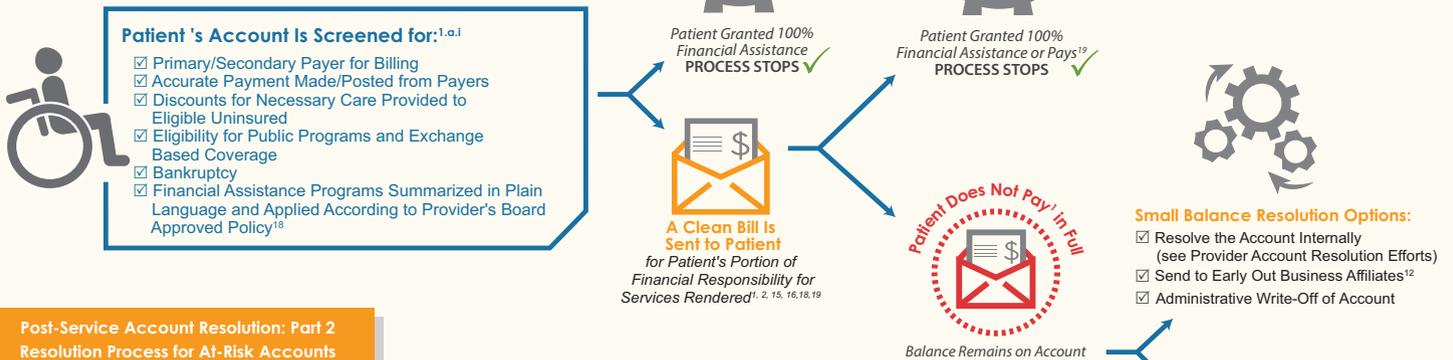


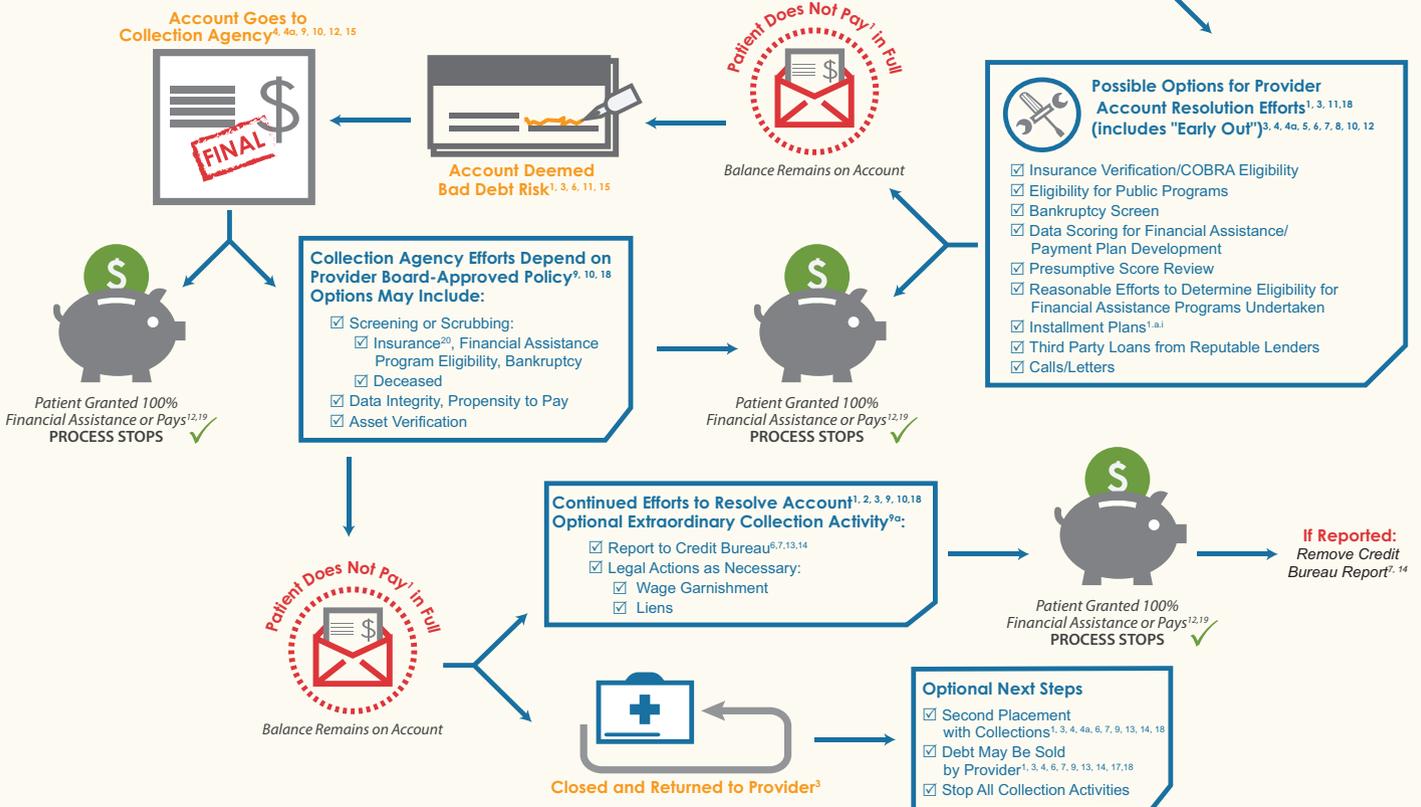
The Medical Account Resolution Process

Goal: We believe that most patients want to resolve their medical accounts in a responsible manner. However, one of the challenges facing them is the highly variable processes used to resolve accounts, which contributes to confusion. Therefore, our goal is to identify a common set of account resolution best practices that align with HFMA's Patient Friendly Billing Principles and emerging federal requirements to simplify the process for patients. These best practices should be consistent for widespread industry adoption, leading to improvement in the overall collection process, patient experience, and financial performance, ensuring a fair collection process for patients and providers. A key component of this is educating patients about the availability of financial assistance programs and the account resolution process, which begins prior to patient registration as prescribed by HFMA's Patient Financial Communications (PFC) Best Practices. This workflow begins with the initial statement and assumes all Patient Friendly Billing and Patient Financial Communications Best Practices have been observed.

Post-Service Account Resolution: Part 1 Medical Account Resolution Efforts Continued From Pre-Service/Time of Service



Post-Service Account Resolution: Part 2 Resolution Process for At-Risk Accounts



As recommended by the HFMA Medical Debt Task Force, the following suggestions are intended to provide best practices to support fair account resolution policies and procedures. This process does not require duplication of efforts at the front end of the revenue cycle where HFMA Best Practices for Patient Financial Communications have been adopted and consistently applied.

Explanation of Best Practices

- 1) Provider should make a reasonable effort to ensure accurate and complete patient financial responsibility for true patient balances by consistently taking the following actions:
 - Screening for financial assistance based on the organization's policy (FAP) (may include use of presumptive eligibility tools or other data scoring methods)
 - Attempting to enroll uninsured patients in any applicable public program(s), COBRA, or other insurance programs as suggested in HFMA's Patient Friendly Billing Report.
 - Widely publicizing the organization's financial assistance policies and offering help applying for public programs.
 - Ensuring correct balance after any insurance by verifying proper payment amount from insurance and provider application of contractual allowances prior to final patient billing
 - Ensuring that execution of processes outlined in this document adhere to HFMA's Patient Friendly Billing Principles and Patient Financial Communications Best Practices prior to and during the incident of care.
 - a. Providers should take responsibility for engaging patients in a constructive manner to help them understand the billing process and patient's responsibilities within it, as suggested in HFMA's Patient Friendly Billing report, *Consumerism in Health Care: Achieve a Consumer-Oriented Revenue Cycle*.
 - i. As discussed in Patient Financial Communications best practices, patient education should begin at scheduling for elective services and as soon as possible for emergent services once the Emergency Medical Treatment and Active Labor Act (EMTALA) has been satisfied. Patient education should occur at each touch point possible (e.g. pre-registration, registration, discharge, account resolution events). In order to help patients understand their financial obligation, education should include discussion of available financial assistance programs, public assistance programs, and available payment options, as well as what to expect during the account resolution process. Conversations prior to service should include an estimate of the patient's responsibility for services where possible. Education should include a discussion of the balance, what it includes, and how to resolve it.
 - ii. Patient education should be reinforced throughout the account resolution process to help patients understand their financial responsibility and the availability of financial assistance.
 - b. All parties involved (provider, patient, and payer) share responsibility to resolve any issues related to the patient bill.
 - c. These options are not exhaustive, but are examples of common practices that are frequently used to resolve an account. Further, taking all of these steps is not mandatory to adhere to the best practice. We encourage providers to use sound business judgment and knowledge of their patient population and the surrounding community when deciding which options to deploy and when.
- 2) The account resolution process clock starts at first statement date from provider's system. This bill date is essential information that must be provided to business affiliates.
- 3) Transfer of accounts between provider and business affiliate can occur at any time in the account resolution process.
- 4) All business affiliates must operate under contract with the provider. The contract should specify what types of account resolution activities are permissible.
- 4a) 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, and access to the billing system if the agency has the authority to file insurance claims. 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.
- 5) Early out efforts should be an extension of the business office, accountable to 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.
- 6) Reporting an account to a credit bureau should occur no earlier than 120 days from first provider (or early out agency acting on behalf of a provider) statement.
- 7) If a provider/business affiliate elects to report an outstanding debt to a credit bureau and the debt is subsequently satisfied (includes accepting 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. It is at the discretion of the hospital as to whether this requires removal of paid accounts from the report or to have them marked as paid but leave them on the report. In either scenario, 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.
- 8) Offer payment plans that consider the economic circumstances of the community.
- 9) Each provider should establish a formal policy regarding use of extraordinary collections actions (ECAs) (as defined by the IRS - i.e., liens, credit reporting, lawsuits, wage garnishments, or sale of debt). They must be board approved, communicated to, and contractually adhered to by business affiliates. 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.
- 9a) HFMA and ACA filed public comments on the definition of "extraordinary collections actions" as defined by the IRS 501(r) proposed rule. Both organizations strongly disagree with elements of the IRS's definition.
- 10) All business affiliates involved in account resolution actions are required to report patient complaints.
 - a. Reviews should consist of:
 - i. Reviewing billing/registration and other revenue cycle issues that result in inappropriate accounts sent to business affiliates
 - ii. Call audits and other quality assurance activities to ensure that policies are followed and provide process improvement
 - 11) If an account is delinquent, communicate to the patient the potential for all board-approved ECAs (including reporting to credit bureaus) prior to initial placement. Per the proposed 501(r) rule, this must occur 30 days prior to the use of ECAs.
 - 12) Regular reconciliations should occur between the provider system and business affiliates' 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 be such that it allows for a high degree of confidence that multiple parties are not pursuing the same account.
- 13) Acknowledgement should occur between the hospital/business affiliate and bureau (if reported) for account updates. Any paid debt or account dispute should be handled in accordance with ACA International Guidelines.
 - a. Reasonable timeframe
 - b. Detailed acknowledgement of data transmission that verifies receipt of information and completion of file update
 - c. Define the dataset between bureau and provider/business affiliate to assure consistent handling of accounts
- 14) Credit bureaus should provide an acknowledgement of accounts reported to the bureau vs. consumer files marked
- 15) All collection efforts (either internal or external) should adhere to formally documented and board approved provider collection policies, which include but are not limited to screening individuals for and granting financial assistance to those who are eligible, and any other permissible account resolution tactics.
- 16) If a provider has a financial assistance policy it should be easily accessible for patients. For not-for-profit hospitals, this is mandated by IRS section 501(r).
- 17) If the provider elects to sell outstanding accounts, it should require that the debt buyer (a) abide by ACA International's *Health Care Collection, Servicing and Debt Purchasing Practices Statement of Principles and Guidelines*, (b) adhere to ACA's International's *Code of Ethics*, and (c) be licensed as a debt buyer where required by state law.
- a. Please see the full report for a full discussion of contract provisions that should be incorporated in a debt sale contract.
- 18) Based on proposed 501(r) rule, not-for-profit hospitals must:
 - a. 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 that constitute more than 10% of the residents in the community served.
 - b. Make paper copies available upon request, in public locations and by mail.
 - c. Inform and notify visitors about the FAP through conspicuous public displays and other measures reasonably calculated to attract attention.
 - d. Inform and notify community residents about the FAP in a manner reasonably calculated to reach those who are most likely to require assistance.
 - e. Provide plain language FAP summary and offer an application prior to discharge.
 - f. Include plain language summary with all (at least three) billing statements and written communications.
 - g. Inform the patient about the FAP in all oral communications.
 - h. Provide at least one written, 30-day notice that ECAs may be initiated if a FAP application is not submitted or the bill is not paid within 120 days after the first billing statement or receiving an incomplete FAP application.
 - i. If an incomplete application is submitted within 240 days after the first billing statement, the hospital must suspend and not resume or initiate ECAs until it provides:
 1. A written notice that describes the information needed to complete the application along with a plain language summary of the FAP.
 2. 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.
 - j. When a complete application is submitted within 240 days after the first billing statement, the hospital/business partner must suspend and not resume or initiate ECAs until it:
 1. Makes and documents an eligibility determination in a timely manner.
 2. Notifies the individual in writing of the determination and the basis for the determination.
 3. Provides a billing statement that includes the amount the individual owes as a FAP-eligible individual, information regarding the AGB, and how it was determined.
- 19) If patients are granted partial financial assistance, the resolution process will continue until the remaining balance is resolved.
- 20) Unless specifically precluded by the provider's board-approved collection policy or provider's contract with a business affiliate, nothing in this best practice workflow should be construed to prevent business affiliates from directly contacting patients to attempt to establish third party coverage.

Presumptive Eligibility Criteria

Establish an objective and unbiased presumptive scoring for financial assistance programs (either full or partial discount) for both full balances or balances after insurance. These models should comply with IRS regulatory pronouncements as they become available. Until then, they should reflect the HFMA Principles and Practices sample, which can be found at www.hfma.org/FinancialAssistancePolicy/

- Use a presumptive eligibility model that relies on multiple data sources and providers believe has a high degree of predictive accuracy
- Use provider's financial assistance program policy
- Use income/family size calculations
- Use as a screening tool during registration, financial counseling, and back-end collections