



# Best Practices for Resolution of Medical Accounts

A Report from the Medical Debt Collection Task Force

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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. Realizing that documenting industrywide consistent post-service account resolution practices would help resolve many of these challenges, the Healthcare Financial Management Association (HFMA) has 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 include a diverse group of providers, consumer advocates, collections agencies, and credit bureaus.

This document is based on the deliberations of the Medical Debt Collection Task Force. It 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.

The primary audiences for this work include healthcare providers, business affiliates, and credit bureaus.<sup>1</sup> 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 patients about the account resolution process.

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 these key stakeholders about voluntary best practices for resolving the patient's portion of medical bills. 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, all parties must collaborate, including the patient.

All recommendations in this report are designed to be used in conjunction with applicable state and federal laws.

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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. Examples include, but are not limited to, accounts receivable management companies, collection agencies, and debt buyers.

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## Framework for the Best Practices

The task force recognizes 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, the task force's goal was 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. Key components of this process include 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 Best Practices; educating patients about what to expect from the account resolution process; and recognizing that patients and providers share responsibilities for account resolution.

*Patient-Friendly Billing.* Providers and others involved in the medical debt resolution process should ensure that healthcare financial communications follow guidelines from HFMA's *Patient Friendly Billing*<sup>®</sup> Project ([hfma.org/patientfriendlybilling](http://hfma.org/patientfriendlybilling)). Specifically, written communications should be:

- *Clear.* All financial communications should be easy to understand and written in clear language. Patients should be able to quickly determine what they need to do with the communication.
- *Concise.* Bills should contain just the right amount of detail necessary to communicate the message.
- *Correct.* Bill items should correctly reflect the financial aspects of the episode of care.
- *Patient friendly.* The needs of patients and family members should be paramount when designing administrative processes and communications.

*Patient Financial Communications.* The scope of the Medical Debt Task Force was limited to processes related to post-service events. However, we strongly believe the groundwork for successful account resolution (from both the patient and provider perspective) occurs prior to service and patient discharge. Best practices for this key phase are addressed in the work of the Patient Financial Communications Task Force, which provides best practices for financial communications with patients prior to discharge. (For more information and a complete list of the best practices, see [hfma.org/communications](http://hfma.org/communications).)

The Medical Debt Collection Task Force follows this earlier work with the expectation that these recommendations are a foundation and that adherence to these best practices will eliminate the need for redundant efforts. Nothing in this report is intended to suggest that hospitals should duplicate efforts if they are already following those best practices.

*Patient education.* Providing a clear understanding of what to expect at every stage in the process helps patients engage in their health care and become active participants in resolving outstanding accounts. Therefore, it is important for healthcare providers to assume responsibility for educating consumers early (prior to service and/or at the time of service where possible) in the account resolution process. Efforts to educate and engage the patient should continue throughout the process. The final IRS 501(r) rule pertaining to new requirements for not-for-profit hospitals, added to the Internal Revenue Code by the Affordable Care Act, will likely make some steps mandatory.<sup>2</sup>

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. Explaining the account resolution

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2. IRS. "New Requirements for 501(c)(3) Hospitals Under the Affordable Care Act." [www.irs.gov/Charities-%26-Non-Profits/Charitable-Organizations/New-Requirements-for-501\(c\)\(3\)-Hospitals-Under-the-Affordable-Care-Act](http://www.irs.gov/Charities-%26-Non-Profits/Charitable-Organizations/New-Requirements-for-501(c)(3)-Hospitals-Under-the-Affordable-Care-Act)

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, reviewing payment options, and discussing the provider's financial assistance programs (FAPs), which may provide either free or discounted care, depending on the provider's policy and the patient's eligibility. The account should also be screened for bankruptcy. For compliance with the IRS 501(r) rule, FAPs should be summarized in plain language and available to patients throughout the resolution process. (For more information about the IRS 501(r) rule, see the Resource List on p. 13.)

*Shared responsibilities.* Gathering the information required for the programs referenced above is a shared responsibility. As established in 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.

*Framework for the process workflow.* Along with an emphasis on patient education and shared responsibilities, the tenets embodied in HFMA's Patient-Friendly Billing and Patient Financial Communications Best Practices constitute the framework for the medical account resolution process workflow presented on pages 7 and 8.



## Explanation of Best Practices

- 1) Provider should make a reasonable effort to ensure accurate and complete patient 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, *Hospitals Share Insights to Improve Financial Policies for the Uninsured and Underinsured Patient*
  - 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.
  - a. 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.
  - a. 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 501(r) rule, this must occur 30 days prior to use of ECAs.
- 12) Regular reconciliations should occur between the provider's 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 the 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. 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.
  - 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. 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.
  - 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 an 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/business partner 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 practices 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/](http://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

## Additional Discussion

Selected topics related to the medical account resolution process are addressed in more detail in this section of the report. (For an index of topics, see p. 14.)

*Patient balance.* The process to resolve the patient balance from the first statement begins 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 financial assistance policies must be communicated verbally and in a written policy, and notices posted prominently in locations in the provider facility.

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

All hospital billing statements 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 for the FAP documents may be obtained.

*Timing.* 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 timeframe as a reasonable period before extraordinary collection actions (ECAs) begin. Given the significance of the first statement date in account resolution activities, the task force believes that it is essential information that must be shared with business affiliates who are engaged in account resolution efforts.

*Verification of information.* 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 modern forms of communication permissible.

*Governance by policy.* 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 of directors 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.

*Small balance resolution.* 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 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.

*Assignment of accounts.* The practice of assigning accounts to business affiliates for resolution does not imply a delinquent obligation. The term “early out,” sometimes referred to as pre-collection, 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.

*Account reconciliation.* 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.

*Information sharing.* 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 account resolution efforts to effectively resolve the account in a patient-friendly manner. The provider should receive account status (which

includes disputes, current balance, last payment date, and amount) when the primary agency returns the account to the provider.

*Disputed item(s)/amount(s).* Provider policies should include guidelines for responding to consumers who dispute all or part of the item(s) or amount(s) billed. Such policy 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 item(s) or amount(s) have been verified. In this way, an account will be considered resolved or the charge or charges will be removed if the item(s) or amount(s) cannot be verified within a reasonable amount of time.

*Complaint tracking.* 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 reoccurring 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*.

*Account resolution efforts.* Providers must undertake reasonable efforts in a consistent manner to resolve accounts. These may include solutions mentioned previously, or by further means such as phone calls, letters, 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.<sup>3</sup> These options are not exhaustive, but are examples of common prac-

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3. 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 PRM §312 and provide sufficient documentation to support the determination. How this will be achieved should be incorporated into the provider’s financial assistance policy.

tices that can be used to work with patients to resolve an account. Further, 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.

*Determination of delinquency status.* 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 as discussed previously.

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

*Rescreening.* 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 may want to rescreen accounts to ensure fair, patient-friendly account resolution. Further, it is important to make appropriate efforts to provide adequate 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.

*Extraordinary collection actions.* Extraordinary collection actions (ECAs) as defined by the IRS, should be pursued only after reasonable efforts to resolve a patient's account using the methods discussed above have occurred.<sup>4</sup> 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. This task force does not endorse any specific strategies, but reiterates the importance of compliance with provider policies and governing state and federal regulations. While the use of ECAs will vary based on the provider's policy, such actions are defined by the IRS in the IRS 501(r) rule to include reporting to credit bureaus and legal actions such as lawsuits, wage garnishment, or property liens.

The task force recommends waiting 120 days from the date of the first billing statement before commencing ECAs. However, there are

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4. HFMA and ACA International strongly disagree with some aspects of the IRS's definition of "extraordinary collection activities." Both organizations stated their positions to the IRS in comment letters on the IRS 501(r) proposed rule. HFMA's comment letter is available at: [www.hfma.org/Content.aspx?id=1139](http://www.hfma.org/Content.aspx?id=1139)

circumstances allowed by the 501(r) rule where ECAs may occur prior to 120 days. 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.

*Reporting to credit bureaus.* 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 or reported as resolved on a consumer's credit report within 45 days of account resolution. In this way, the consumer is not penalized beyond resolution of the account.

*Application of payments.* 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.

*Disposition of unresolved accounts.* 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.<sup>5</sup> 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*.

*Requirements for debt buyers.* 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. 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

This task force realizes this framework does not resolve all issues related to post-service medical account resolution. Therefore, 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.

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5. ACA International. *Health Care Collection, Servicing, and Debt Purchasing Practices: Statement of Principles and Guidelines*. [www.acainternational.org/healthcaremarket-health-care-collection-servicing-and-debt-purchasing-practices-statement-of-principles-and-guidelines-10281.aspx](http://www.acainternational.org/healthcaremarket-health-care-collection-servicing-and-debt-purchasing-practices-statement-of-principles-and-guidelines-10281.aspx)

Therefore, any timeframes 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 timeframe to help educate patients and provide benchmarks for the industry.

## Resources

ACA International, *Code of Ethics and Code of Operations of ACA International*, 2010, [www.acainternational.org/coe](http://www.acainternational.org/coe)

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## Appendix 1: Legal Provisions for Collections 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 collections activities and debt buyers. These provisions include but are not limited to the following.

<b>Statute</b>	<b>Citation (statute or regs)</b>	<b>Key Provisions</b>
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.
Various state laws		Consumer protections; licensing and bonding of collection agencies; unfair trade practices, etc.

## Appendix 2: 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 the likelihood that a debt will be paid. 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.

*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 co-payment, co-insurance, or deductible, as well as a balance for non-covered services or uninsured patients.

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

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

*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, workman's compensation plans, Medicaid, or other state or local programs.