

# Medical Debt: Overview of New IRS Regulations and Industry Best Practices

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National Consumer Law Center

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**March 4, 2015**

**National Elder Rights Training Project for the National Legal Resource Center.  
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- <http://nlrc.acl.gov/index.aspx>
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- See upcoming trainings, conferences, and webinars
- Request a training
- Request consulting
- Request technical assistance
- Access articles and resources





## Presenter – Jessica Curtis

- Jessica Curtis is Senior Advisor to Community Catalyst's Hospital Accountability Project. She served as Project Director between 2009 and 2014, during which time Community Catalyst led the consumer advocacy effort to improve reporting and legal requirements for non-profit hospitals' community benefit practices.
- She has provided a broad range of policy-based, legal and strategic assistance to community organizers, advocates and policymakers spanning a range of issues related to hospital community benefit programs.
- Her organization, Community Catalyst, works to ensure consumer interests are represented wherever important decisions about health and the health system are made.





## Presenter – Mark Rukavina

- Mark Rukavina is Principal of Community Health Advisors, LLC. Community Health Advisors provides customized service to non-profit hospitals enabling them to improve community health while complying with federal and state regulatory requirements.
- Mark is an active member of the Healthcare Financial Management Association. He has served on their Medical Debt Task Force and Price Transparency Task Force.
- Mark has extensive experience advising hospitals, healthcare providers, community organizations, and policymakers on access expansion and community health improvement efforts. He's a recognized expert on financial barriers to healthcare and medical debt.





## Presenter – Chad Mulvany

- Chad Mulvany is a healthcare finance policy director for the Healthcare Financial Management Association. Based out of Washington, DC he is responsible for analyzing the implications of legislative and regulatory developments on healthcare providers and is also a contributor to HFMA's Value Project research. Chad is a regular columnist in HFM, the HFMA magazine and speaks frequently on issues related to health reform.
- Chad holds a Masters of Business Administration from the University of Maryland. He is active with the Virginia Chapter of HFMA where he has served as a past board member.





## Moderator – Chi Chi Wu

- Chi Chi has been a staff attorney at NCLC for over a decade. Chi Chi focuses on consumer credit issues at NCLC, including legislative, administrative, and other advocacy.
- Chi Chi's specialties include fair credit reporting, credit cards, refund anticipation loans, and medical debt.
- Before joining NCLC, Chi Chi worked in the Consumer Protection Division at the Massachusetts Attorney General's office and the Asian Outreach Unit of Greater Boston Legal Services.



# New IRS Regulations on Financial Assistance and Charges



Jessica L. Curtis, JD

Senior Advisor, Hospital Accountability Project (HAP)

*Medical Debt: Overview of New IRS Regulations and Industry Practice*

National Consumer Law Center

March 4, 2015

# ROADMAP

1. Overview
2. Financial Assistance Policies (FAP)
3. Limitation on Charges



# Poll #1: What position best describes you?

1. Attorney in private practice
2. Legal services or nonprofit attorney
3. Social services or elder care
4. Government agency
5. Other

# Regulatory Framework

- **Tax exemption - source of the federal legal standard**
  - IRS and Treasury Department develop guidance and handle oversight
  - Does the hospital “promote the health of a class of persons broad enough to benefit the community”? – Federal standard (1969)
- **Section 9007 of the Patient Protection and Affordable Care Act amends Internal Revenue Code**
  - Adds Section 501(r), “Additional Requirements for Charitable Hospitals”
  - Mandates:
    - Financial assistance policies
    - Reasonable billing & collections
    - End overcharging
    - Conduct regular community health needs assessments (CHNA) & develop implementation strategies
- **IRS Form 990, Schedule H**
  - Tax-exempt hospitals report community benefit annually
  - Quantitative data – how much money spent? Where did it go?
  - Qualitative data, including financial assistance, collections, charges

# Scope of Applicability

- **Tax-exempt hospitals** under Internal Revenue Code Section 501(c)(3)
  - Includes “dual status” hospitals, e.g. publicly owned hospitals that also have 501(c)(3) designation
  - These hospitals must comply with substantive requirements but are exempted from public reporting
- In most cases, does **not** apply to medical providers who are not hospital employees (physicians, ambulance services, etc.)
- Financial provisions apply to **debt buyers and other third parties hospital uses for collection**

# What Services Must FAP Cover?

- **Emergency care**
  - As defined by EMTALA
- **Medically necessary care**
  - Hospitals may choose definition
  - Examples: state Medicaid definition, generally accepted practice standard's, attending physician's judgment

# Pause!

# Financial Assistance Policy (FAP)

- Develop and implement a written **financial assistance policy (FAP)**
  - Hospital leadership (board, board committee or designee) must formally adopt the policy
  - Fully implement the policy = “consistently carried out”
  - Hospitals must also develop an emergency medical care policy that “prohibits the hospital from engaging in actions that discourage individuals from seeking emergency medical care” (e.g. demanding upfront payments before treatment for emergency care or debt collection activities that interfere with the provision of emergency care)
- **Widely publicize the FAP**

What has to be in the FAP?	The FAP or application form must include...
All levels of financial assistance available under FAP and eligibility criteria	Description of all the information and documentation an applicant will be asked to provide
Basis for calculating patient charges (i.e., the method hospital uses – see Charges discussion)	Contact information, including phone number and physical location, for hospital department or office that can provide more information
How to apply	
Steps the hospital may take to collect, including time frames and process (unless hospital has separate billing and collections policy)	
Any third-party sources the hospital uses to determine presumptive eligibility for FAP	
Complete list of providers covered by the FAP/not covered	

# Widely Publicizing the FAP

- **Online**
  - Full policy, application form, and plain language summary must be available; direct URL must be provided
- **Free hard copies onsite and by request**
  - By mail upon request and “conspicuously displayed” in public areas, at least ER and admissions areas
- **Notify and inform members of the public**
  - Hospital to choose method “reasonably calculated” to reach those most likely to need financial help
- **Notify and inform patients**
  - Offer plain language summary at discharge or intake
  - Every billing statement (URL to full info, contact information)
  - Conspicuous display in public areas (ER, admissions)



# Translation Requirements

- **Key documents must be translated** into the language spoken by populations reaching threshold
  - Full policy, application form and plain language summary
- **Threshold = lesser of 1,000 individuals or 5 percent of the community** served or likely to be affected/encountered by hospital
- Hospitals may use “any reasonable method” for determining translation needs

# Questions?

# Limitation on Charges

- **ACA prohibition on “gross charges”**
  - Better known as the list price, or chargemaster rates
  - Interpreted to apply only to patients eligible for financial assistance under FAP
- **Patients eligible for FAP may be charged, at most, only “amounts generally billed” (AGB) to insured patients**
  - Hospitals can use one of two methods for determining AGB
    - Look-back method – uses past claims data (Medicare, Medicare + all private insurers, Medicaid alone or with some combination)
    - Prospective method – estimates Medicare and/or Medicaid payment based on billing codes
  - Includes insurer AND patient out-of-pocket obligation

# Safe Harbor

**Hospitals don't always know whether a patient qualifies for FAP eligibility when they send a bill, even when they make good faith efforts to find out (for example, they send the first bill before the patient has submitted an application for financial assistance). How can they be protected when they unintentionally don't comply with the law?**

- The charge was not made or requested as a precondition for receiving medically necessary care
- At the time of the charge, either the patient had yet to submit a complete FAP application or the hospital had yet to make an eligibility determination; AND
- Once the patient is found eligible for FAP, the hospital refunds any amount the patient has paid for care that exceeds what the patient would have owed under FAP.

# Takeaways for Practitioners

- 1. Transparency is the name of the game**
- 2. Many protections are tied to eligibility (and FAP content, including eligibility, is largely at hospitals' discretion)**
- 3. State laws may set higher standards**
- 4. Opportunities to engage hospital staff and boards**
  - Board has ultimate authority to set and adopt policy
  - Rules imply investment in staff training (“consistently carried out”) - staff education, troubleshooting?
  - Rules allow hospitals to designate third party government or nonprofit agencies that can assist in application process
  - CHNA process encourages hospitals to consider financial barriers to care

# Federal Dates and References

- **March 23, 2010** – ACA becomes law
- **Proposed Rules**
  - 2012 – Financial Assistance, Charges, and Collections  
<http://www.irs.gov/pub/irs-drop/reg-130266-11.pdf>
  - 2013 – CHNAs and Sanctions  
<http://www.gpo.gov/fdsys/pkg/FR-2013-04-05/pdf/2013-07959.pdf>
  - 2014 – Sanctions <http://www.irs.gov/pub/irs-drop/n-14-03.pdf>
- **December 31, 2014** – Final Rules  
<http://www.regulations.gov/#!documentDetail;D=IRS-2012-0036-0229>
- **December 29, 2015** – Transition relief for hospitals ends
  - Final Rules in effect for tax years starting after this date
  - For tax years starting before this date, standard is a “reasonable, good faith interpretation” of Section 501(r) (compliance with Proposed Rules deemed a good faith interpretation)



# State Law References

## **Free Care Compendium, Community Catalyst**

<http://www.communitycatalyst.org/initiatives-and-issues/initiatives/hospital-accountability-project/free-care>

## **Community Benefit State Law Profiles, Hilltop Institute at the University of Maryland**

[http://www.hilltopinstitute.org/HCBP\\_CBL\\_state\\_table.cfm](http://www.hilltopinstitute.org/HCBP_CBL_state_table.cfm)

“Effectiveness will ultimately depend on hospitals making a good faith effort to comply with the spirit of the law, not just the letter.”

- [Something for the Rest of Us: Finally, Federal Rules on Hospital Bills Are Here](#) (Health Policy Hub, 1/20/15)



# Questions?

# Thank You



Jessica Curtis

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# Medical Debt: Overview of New IRS Regulations and Industry Best Practices

*March 4, 2015*

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# About the Presenter

**Mark Rukavina**, principal of Community Health Advisors, LLC, has more than 25 years of experience working on health policy issues. Community Health Advisors, LLC offers customized service to hospitals to ensure compliance with regulatory mandates and protection of federal tax exempt status.

He is recognized for his policy expertise on healthcare affordability, community benefits, & community health improvement. Mark recently testified before the Consumer Financial Protection Bureau and has testified before House & Senate Congressional committees.

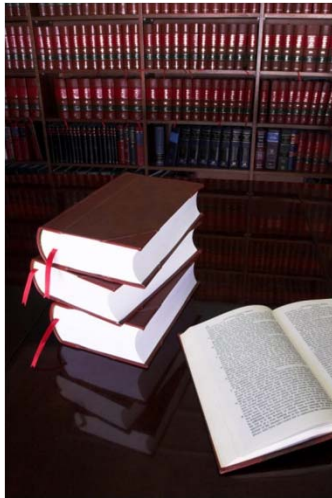
He recently served on the Healthcare Financial Management Association/ACA International Medical Debt Task Force and HFMA's Price Transparency Task Force. He currently advises HFMA on their Dollars and Sense Initiative.

Prior to founding CHA, he served as executive director of The Access Project, a national non-profit and also served as Program Director for a partnership under a national demonstration program sponsored by AHA's Health Research and Educational Trust.

He holds an MBA from Babson College & a BS from of the University of Massachusetts in Amherst.



# Disclosure



The following information is not intended as legal advice and may not be used as legal advice. Legal advice must be tailored to the specific facts and circumstances of each case or inquiry. Every effort has been made to assure that the information contained in this presentation is up-to-date as of the date of publication. It is not intended to be a full and exhaustive explanation of the law in any area, nor should it be used to replace the advice of your own legal counsel.

# Recent Media Attention

The screenshot shows a Mozilla Firefox browser window displaying a ProPublica article. The browser's address bar shows the URL [www.propublica.org/article/senator-to-hospitals-stop-suing-poor-patients](http://www.propublica.org/article/senator-to-hospitals-stop-suing-poor-patients). The ProPublica logo and tagline "Journalism in the Public Interest" are visible at the top. The article title is "Senator to Hospitals: Stop Suing Poor Patients". The sub-headline is "Unforgiven: The Long Life of Debt". The article text begins with "Prompted by an investigation by ProPublica and NPR, Sen. Charles Grassley asks a Missouri nonprofit hospital to explain why it seizes the wages of thousands of its patients." The byline is "by Paul Kiel, ProPublica, and Chris Arnold, NPR, Jan. 22, 2015, 5 a.m." There are 34 comments and a print icon. A large photo of Sen. Charles Grassley is featured. A sidebar on the left contains social media sharing icons for Twitter (327), Facebook, Email, Google+, LinkedIn, Reddit, Print, Creative Commons, and Dollar. A right sidebar contains a section titled "This is part of an ongoing investigation: Unforgiven" with a small photo of a man and text describing the investigation. Below this is a "Connect with Facebook" section with an "Enable Social Reading" button. At the bottom right is a promotional banner for "FAMILIAR" with "WORLD PREMIERE JAN 30". The Windows taskbar at the bottom shows the time as 2:17 PM.

Sen. Charles Grassley to Nonprofit Hospitals: Stop Suing Poor Patients - ProPublica - Mozilla Firefox

www.propublica.org/article/senator-to-hospitals-stop-suing-poor-patients

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Unforgiven  
The Long Life of Debt

## Senator to Hospitals: Stop Suing Poor Patients

327

Prompted by an investigation by ProPublica and NPR, Sen. Charles Grassley asks a Missouri nonprofit hospital to explain why it seizes the wages of thousands of its patients.

by Paul Kiel, ProPublica, and Chris Arnold, NPR, Jan. 22, 2015, 5 a.m.

34 Comments | Print



This is part of an ongoing investigation:

### Unforgiven

The way lenders and collectors pursue consumer debt has undergone an aggressive transformation in America. Collectors today don't give up easy, often pursuing debts for years. For many people, these changes have profoundly affected their lives.

Connect with Facebook to share articles you read on ProPublica. [Learn more](#)

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WORLD PREMIERE JAN 30

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# Transparency



Regulations make reference to the statute's objective of promoting transparency of a hospital's CHNA, FAP, and of providing protections to FAP-eligible patients with respect to charges and collections.

Be accountable – clarity and consistency



# Billing and Collection Policy

- Describe collection actions that may be utilized in the event of nonpayment including extraordinary collection actions (ECAs) and also:
  - Process and time frame
  - Reasonable efforts made to determine whether someone is FAP-eligible before engaging in ECAs
  - All other required information to ensure that reasonable efforts were made prior to initiating ECAs.



# Extraordinary Collection Actions

- Stipulate which collection actions hospital has been authorized to utilize in event of no-payment.
  - Reporting adverse information to credit bureaus
  - Selling debt to another party (with some exceptions)
  - Actions requiring legal or a judicial process, including but not limited to:
    - foreclosing on real property
    - attaching or seizing a bank account or any other personal property
    - commencing a civil action
    - causing an individual's arrest
    - subjecting an individual to a writ of body attachment
    - garnishing wages
    - liens on property (with certain exception)

# Responsible Parties - ECAs

- The final regulations hold a hospital accountable for the ECAs of all third parties collecting debt on its behalf and to which it sells debt.

# Deferring or Denying Care

- Final regulations include deferring or denying care as an ECA if hospital delays care or requires payment before providing care to an individual with outstanding balance, unless hospital can demonstrate that it is based on other factors, not nonpayment of past bills.

# What's the most common reason that your client's debt from a nonprofit hospital is sent to collections?

- A. Uninformed of financial assistance
- B. Did not meet eligibility requirements
- C. Documentation too burdensome, could not meet
- D. Confused by billing statement or communication
- E. I don't have clients with medical debt

# Notification

- Final regulations significantly change what was included in the notice of proposed rulemaking under application and notification periods.
- Waiting period of 120 days from date of first post-discharge billing statement.
- Written notice must be provided at least 30 days in advance of initiating specific ECAs and meet informational requirements.

# Application Period

- Hospital must accept and process an application for financial assistance for 240 days after the first post-discharge billing statement.
- If hospital chooses, it may extend this period.

# Determining Medicaid Eligibility

- If hospital believes has received a complete application from an individual from whom it believes may qualify for Medicaid, it may postpone making FA determination until Medicaid application is completed, submitted, and a Medicaid eligibility determination made.

# Medical Account Resolution Best Practices

Medical Account Resolution Best Practices Jan 2014.pdf - Adobe Reader

File Edit View Window Help

7 / 16 75%

Tools Sign Comment

## The Medical Account Resolution Process

*Goal: We believe that most patients want to resolve their medical accounts in a respectful manner. However, one of the challenges facing them is the highly variable process in order to resolve accounts, which contributes to confusion. Therefore, we regard it as timely common and efficient resolution best practices that align with IMA's Patient Friendly Billing Practices and emerging federal requirements to simplify the process for patients. These best practices should be consistent for addressing industry variation, 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 with patient registration as prescribed by IMA's Patient Financial Communications (PFC) Best Practices. This workflow begins with the color 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 the Service/Time of Service

**Patient's Account is Screened for:**

- Primary Payer/Secondary Payer for Billing
- Accounts for Necessary Care Provided to Eligible Uninsured
- Eligibility for Public Programs and Exchange Based Coverage
- Financial Assistance Programs Summarized in Plain Language and Applied According to Provider's Board Approved Policy

**Patient Control 100% Financial Assistance** PROCESS STOPS ✓

**Patient Control 100% Financial Assistance/Other** PROCESS STOPS ✓

**A Clean Bill is Sent to Patient for Patient's Portion of Financial Responsibility for Services Rendered** ✓

**Small Balance Resolution Options:**

- Review the Account Identity (Use Provider Account Resolution Efforts)
- Send to Early On Business Address
- Acceptable Waiver of Account

**Balance Remains on Account**

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

**Account Goes to Collection Agency** ✓

**Account Deemed Bad Debt** ✓

**Account Does Not Pay for the Balance Remains on Account**

**Collection Agency Efforts Depend on Provider Board Approved Policy** ✓

Options May Include:

- Forfeiting or Forfeiting
- Financial/Financial Assistance Program Eligibility, Bankruptcy
- Deceased
- Data Integrity Priority to Pay
- Asset Verification

**Patient Control 100% Financial Assistance or Other** PROCESS STOPS ✓

**Patient Control 100% Financial Assistance or Other** PROCESS STOPS ✓

**Account Does Not Pay for the Balance Remains on Account**

**Possible Options for Provider Account Resolution Efforts** ✓

- Insurance Verification/COBRA Eligibility
- Eligibility for Public Programs
- Bankruptcy Review
- Data Scrubbing for Financial Assistance/Payment Plan Development
- Presumptive Status Review
- Reasonable Efforts to Determine Eligibility for Financial Assistance Programs/Understand Insurance Plans
- Third Party Claims from Republics/Lenders
- Call Letters

**Continued Efforts to Resolve Account** ✓

- Report to Credit Bureaus
- Legal Actions as Necessary
- Wage Garnishment
- Suits

**Patient Control 100% Financial Assistance or Other** PROCESS STOPS ✓

**Reported Review Credit Bureau Report** ✓

**Optional Next Steps:**

- Second Placement with Collections
- Debt May Be Sold by Provider
- Stop All Collection Activities

**Account Closed and Returned to Provider** ✓

**As recommended by the IMA Medical Debt Task Force, the following suggestions are intended to provide best practices to support the account resolution goals for end providers. This process does not require duplication of effort at the best end of the revenue cycle where IMA's Best Practices for Patient Financial Communications have been adopted and consistently applied.**



# Presumptive FAP-Eligibility

- Hospital will have made reasonable effort to determine eligibility if it utilizes information other than that provided by individual or based on prior FAP-eligibility determination.
- Presumptive eligibility must be described in FAP

# Ineligibility Based on PE

- The final regulations do NOT treat as a reasonable effort a presumptive determination that an individual is not FAP-eligible.
- You can't use the presumptive method to deny financial assistance!

# Anti-Abuse Rule

- Hospital will NOT have made reasonable effort if makes determination based on information hospital facility has reason to believe is unreliable or incorrect or on information obtained under duress or thru coercive practices
- Delaying or denying emergency medical care until individual provides requested info is considered a coercive practice

# Waiver NOT a Reasonable Effort

A signed waiver stating that an individual does not wish to apply for, or receive information on, assistance, will not constitute a determination that the individual is not FAP-eligibility and will not satisfy the requirement of reasonable efforts to determine whether a patient is FAP-eligible before engaging in ECAs.



# Establishing Policies

Financial assistance and billing & collection policies are established only after adopted by authorized body.



# Financial Barriers to Care

- Final regulations note that the health needs of a community may include the need to address financial and other barriers to access to care.
- Though hospitals are not required to make the link between a hospital's Community Health Needs Assessment and its Financial Assistance Policy, it may be beneficial to community and hospital to do so.

# Failure to Satisfy Section 501 r

- A hospital failing to meet one or more of the Section 501 requirement may have its 501 (c )(3) status revoked as of first day of the taxable year in which failure occurs.
- Facts and circumstances approach

# Failure to Meet CHNA Requirements

- \$50,000 excise tax on a hospital that fails to meet the CHNA requirements with respect to any taxable year.
- Excise tax applies on a facility-by-facility basis and may be imposed on a hospital for each taxable year that a hospital facility fails to meet the CHNA requirements.



# Minor Errors and Omissions

- Not considered failure if following satisfied:
  - Due to inadvertent or reasonable cause
  - Hospital corrects as promptly after discovery as is reasonable, given nature
  - If multiple omissions or errors, only if minor in aggregate

# Questions?

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# Healthcare Dollars and Sense: Fostering Communication, Compassion, Advocacy, and Education

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**Chad Mulvany**

Director, Healthcare Finance Policy, Strategy and  
Development



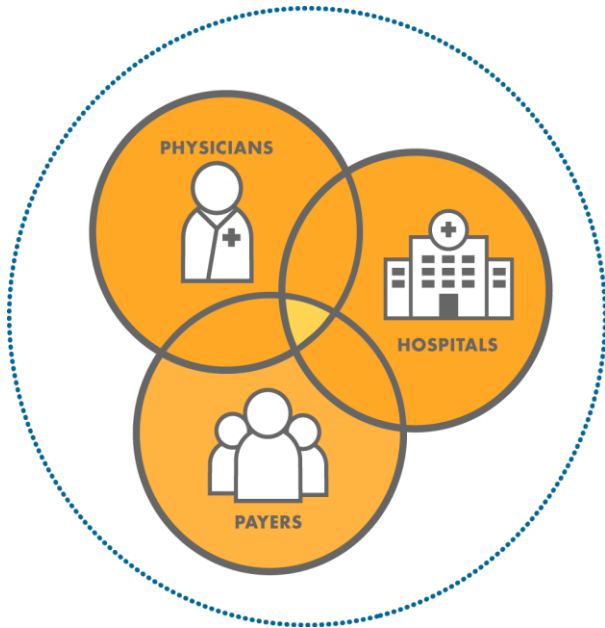
**hfma**

healthcare financial management association

# About HFMA

Our core membership of 40,000 financial professionals comes together with other healthcare leaders through the wide array of services HFMA offers.

## AUDIENCES



## SERVICES

- MEMBERSHIP
- CAREER DEVELOPMENT AND CERTIFICATION
- CONTINUING EDUCATION
- SMALL GROUP-FOCUSED INTERACTIONS
- INFORMATION ANALYSIS AND PERSPECTIVE
- STANDARD SETTING/ GUIDANCE DEVELOPMENT
- ORGANIZATIONAL PERFORMANCE IMPROVEMENT
- VIRTUAL AND FACE-TO-FACE NETWORKING

## THOUGHT LEADERSHIP

- Share finance perspectives to drive improvement
- Convene healthcare groups to build consensus
- Develop strategic frameworks to guide action
- Establish principles and guidance to advance capabilities
- Foster measurement and accountability for outcomes

# Agenda

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- Why Now?
- Overview of HFMA's Healthcare Dollars and Sense:
  - Price Transparency Recommendations
  - Patient Financial Communications
  - Medical Account Resolution

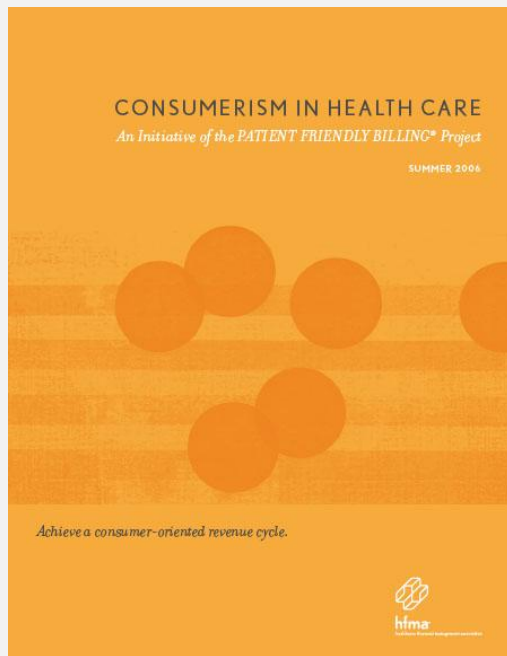
# Factors Driving the Need for a Patient Friendly Approach to Outstanding Balances

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- Rising deductibles and out-of-pocket payments
  - Continued growth in employer-sponsored high-deductible health plans (HDHPs)
  - High exposure to HDHPs in Affordable Care Act plans
- Employer pressure on private payers and providers
- Even with ACA there are still many uninsured
- Empowers patients to become more engaged in their

# Patient Friendly Billing

## Consumerism in Health Care



## Insights to Improve Financial Policies for the Uninsured



Reports are available at

<http://www.hfma.org/patientfriendlybilling/>

# HFMA Resources to Help You Improve the Billing and Payment Experience for Patients

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[hfma.org/dollars](https://hfma.org/dollars)



# HFMA Price Transparency Task Force



America's Health Insurance Plans

equityhealthcare



CATALYST FOR PAYMENT REFORM

Florida Blue



GEISINGER



# HFMA Price Transparency Task Force Report

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- Clarifies basic definitions that are often misused
- Sets forth guiding principles
- Establishes roles for payers, providers, others
- Reflects consensus of key stakeholders

[hfma.org/dollars](https://hfma.org/dollars)

# An Actionable Definition of Price Transparency

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Readily available information on the price of healthcare services, that, together with other information, helps define the value of those services and enables patients and other care purchasers to identify, compare, and choose providers that offer the desired level of value.

# Guiding Principles

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Price transparency information should:

- Empower patients and other care purchasers to make meaningful price comparisons
- Be easy to use and easy to communicate
- Be paired with other information that defines the value of services for the care purchaser
- Enable patients to understand the total price of their care and what is included in that price

**And price transparency will require the commitment and active participation of all stakeholders.**



# Health Plan Role

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- Health plans should serve as the principal source of price information for their members.
- Tools for insured patients should include:
  - The total estimated price of the service
  - A clear indication of whether a particular provider is in the health plan's network
  - A clear statement of the patient's estimated out-of-pocket payment responsibility
  - Other relevant information on the provider or service sought

**HEALTHCARE  
DOLLARS & SENSE™**

**Price  
Transparency**



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healthcare financial management association

# Provider Role

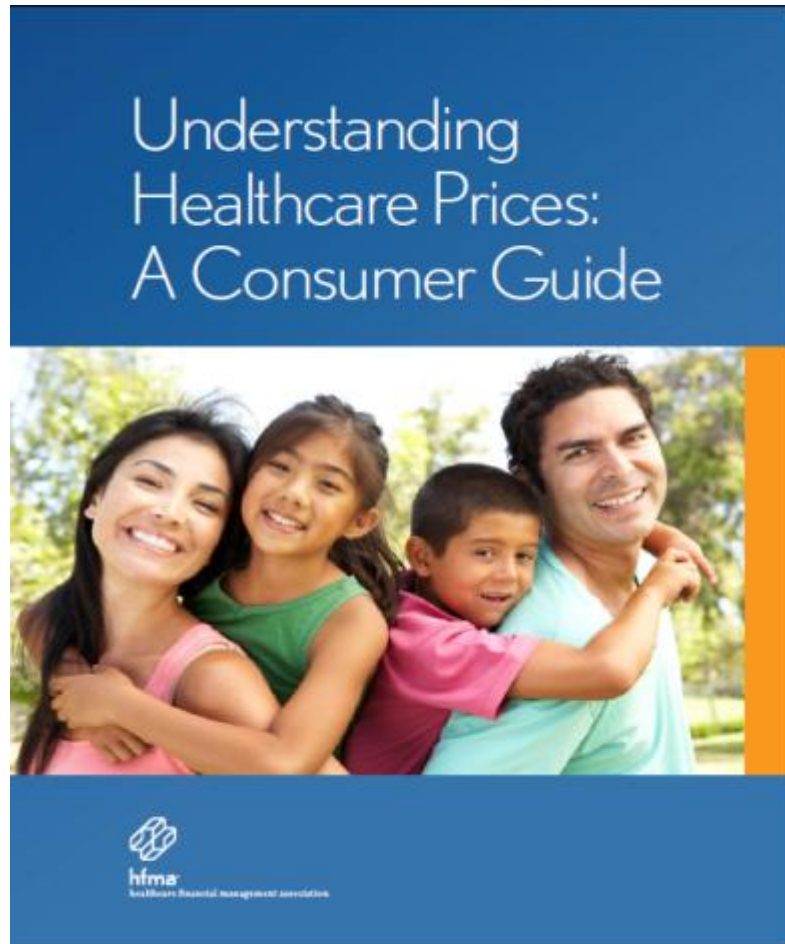
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For uninsured patients and out-of-network care, providers should:

- Offer an estimated price for a standard procedure and make clear how complications may increase the price.
- Clearly communicate pre-service estimates of prices.
- Clearly state what services are included in an estimate.
- Give patients other relevant information, where available.

# All Stakeholders Can Offer a Pricing Resource to Consumers

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[hfma.org/tconsumer](http://hfma.org/tconsumer) guide  
[ahaonlinestore.org](http://ahaonlinestore.org)

- Describes how to request price estimates, step by step
- Clarifies what estimates may or may not include
- Explains in-network and out-of-network care
- Defines key terms
- *Available for posting on your website at no charge*
- *Hardcopies available for purchase in bulk at a nominal price through AHA's online store*



# Example: Provide Simple, Clear Estimates for Self-Pay Patients



**MARICOPA**  
HEALTH SERVICES  
CHARTERED HEALTHCARE ORGANIZATION

2525 E Roosevelt St  
Phoenix, AZ 85008  
602-344-1015

## COPA CARE ESTIMATE

Creation Date: 4/3/2014  
Completed On: 4/3/2014  
Estimate Valid Until: 5/18/2014

Thank you for choosing Maricopa for your healthcare needs. As requested, this letter summarizes the deposit that will be required prior to the requested service being provided. The following anticipated charges are only an estimate for the requested procedure(s) or service(s) outlined below and does not include charges due to complications or any additional procedures.

Patient Information	
Patient Name:	[REDACTED]
Patient Address:	[REDACTED]
Patient Phone:	[REDACTED]
Medical Record Number:	[REDACTED]
Account Number:	[REDACTED]
Estimated Date of Service:	4/3/2014
Estimated Discharge Date:	4/3/2014
Estimate Details	
Services	
PF BX BREAST 1ST LESION STRTCTC	
Description	Service Amount
0960-PF BX BREAST 1ST LESION STRTCTC	\$1,641.00
Estimated Charges:	\$1,641.00
Discount:	-\$923.50
Adjusted Estimated Charges:	\$717.50
<b>Total Estimated Charges:</b>	<b>\$1,641.00</b>
Self Pay Discount:	-\$923.50
Prompt Pay Discount:	-\$0.00
Prior Unpaid Balance:	\$0.00
<b>Your Estimate:</b>	<b>\$717.50</b>

Important Notice about direct payment for your healthcare services. The Arizona Constitution permits you to pay a healthcare provider directly for healthcare services. Before you make any agreement to do so, please read the following important information:

If you are enrolled in a health plan and your healthcare provider is contracted with the health insurance plan, the following apply:

- 1) You may be required to pay the healthcare provider directly for the services covered by your plan, except for cost share amounts that you are obligated to pay under your plan, such as copayments,



# Price Transparency Is Just One Element of a Patient-Centered Approach

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[hfma.org/dollars](http://hfma.org/dollars)

# Communication Is Critical Throughout the Process

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**Every day, healthcare professionals conduct sensitive financial discussions with patients. But there have been no accepted, consistent best practices to guide them in these discussions—until now**



[hfma.org/dollars](http://hfma.org/dollars)

# What the Best Practices Cover

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Provision of  
Care

Registration  
and Insurance  
Verification

Financial  
Counseling

Patient Share

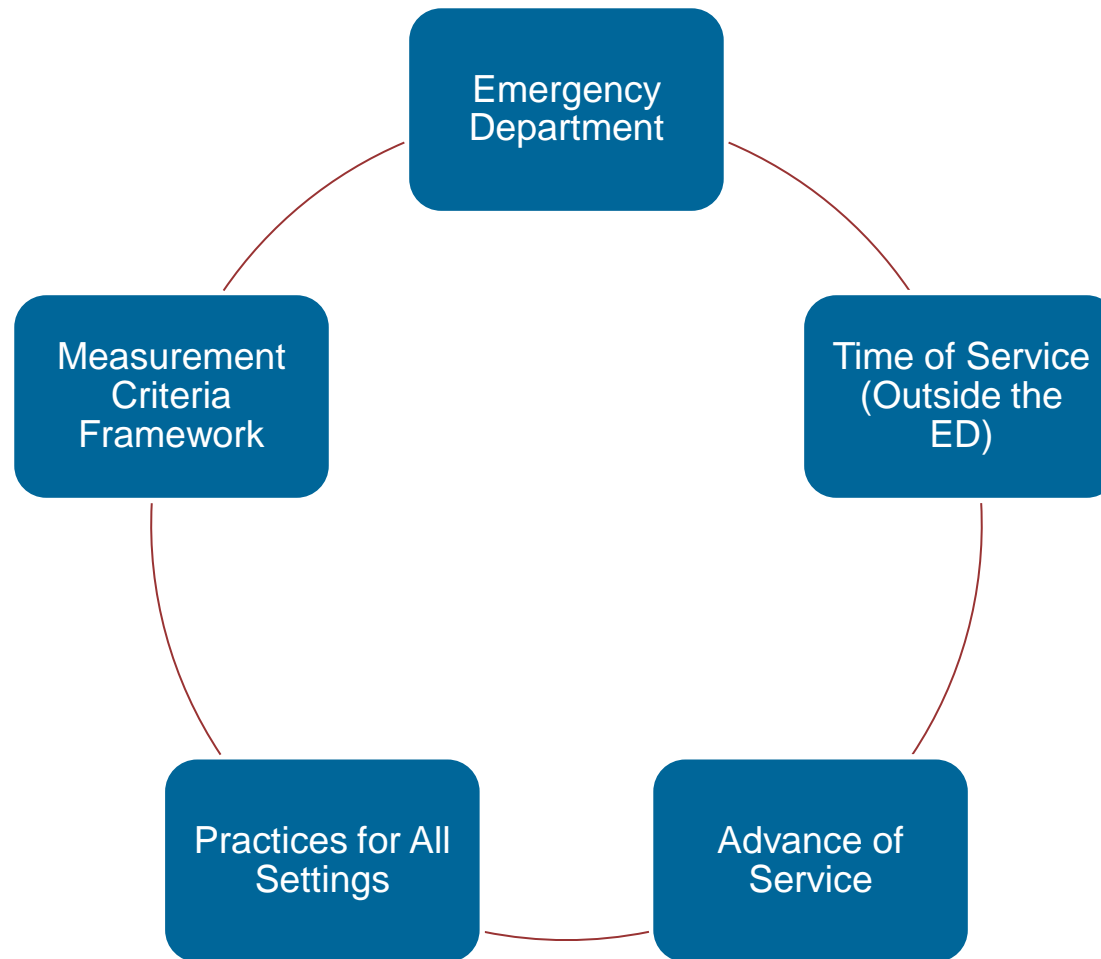
Prior  
Balances  
(if applicable)

Balance  
Resolution

# Designed for the Most Needed Settings & Purposes

HEALTHCARE  
DOLLARS & SENSE™

Patient  
Financial  
Communications



# Benefit Patients *and* Providers

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- Encourage patients to talk with a financial counselor about any financial concerns
- Identify opportunities to locate additional or alternative insurance coverage
- Determine how accounts will be resolved through conversation
- Identify patients who fall under the 501(r) regulations
- Benefit from the public relations value of a satisfied consumer vs. an unhappy consumer

# Achieve Recognition as an Adopter

HEALTHCARE  
DOLLARS & SENSE™

Patient  
Financial  
Communications

- Recognition demonstrates commitment to best practices
- Based on HFMA review of an application and supporting documentation
- All provider organizations may apply
- Recognition valid for two years
- Adopters may use the phrase “Supporter of the Patient Financial Communications Best Practices” in their marketing materials



# Price Transparency Is Just One Element of a Patient-Centered Approach

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# Best Practices for Medical Debt

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*By following the HFMA Best Practices for Medical Account Resolution, your organization is affirming that. . .*

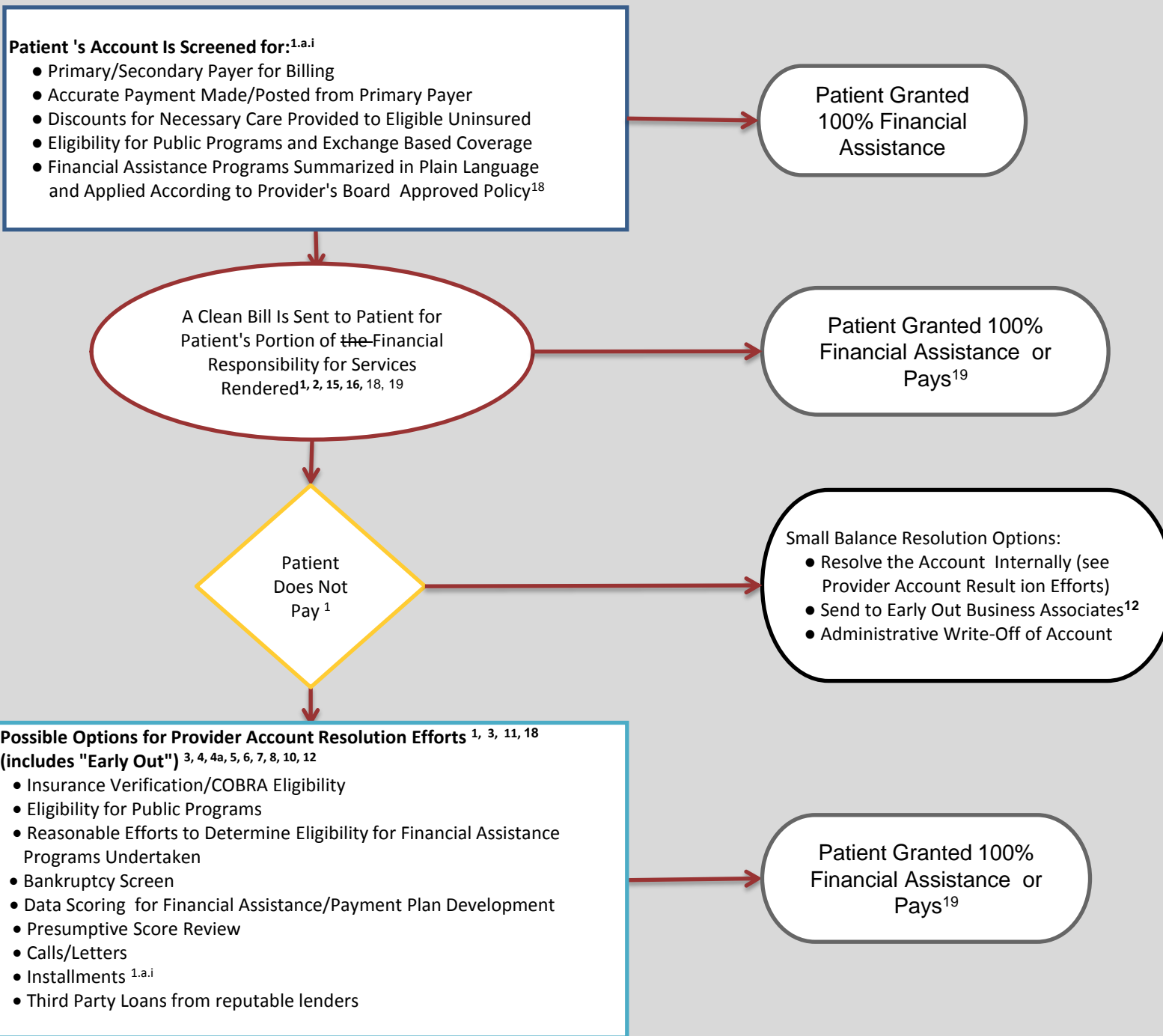
- We want to find solutions that are balanced, fair, and reasonable.
- We keep patients informed about payment expectations and time frames.
- The business practices that we—and our business affiliates use—have been approved at the Board level.

**HEALTHCARE  
DOLLARS & SENSE<sup>SM</sup>**

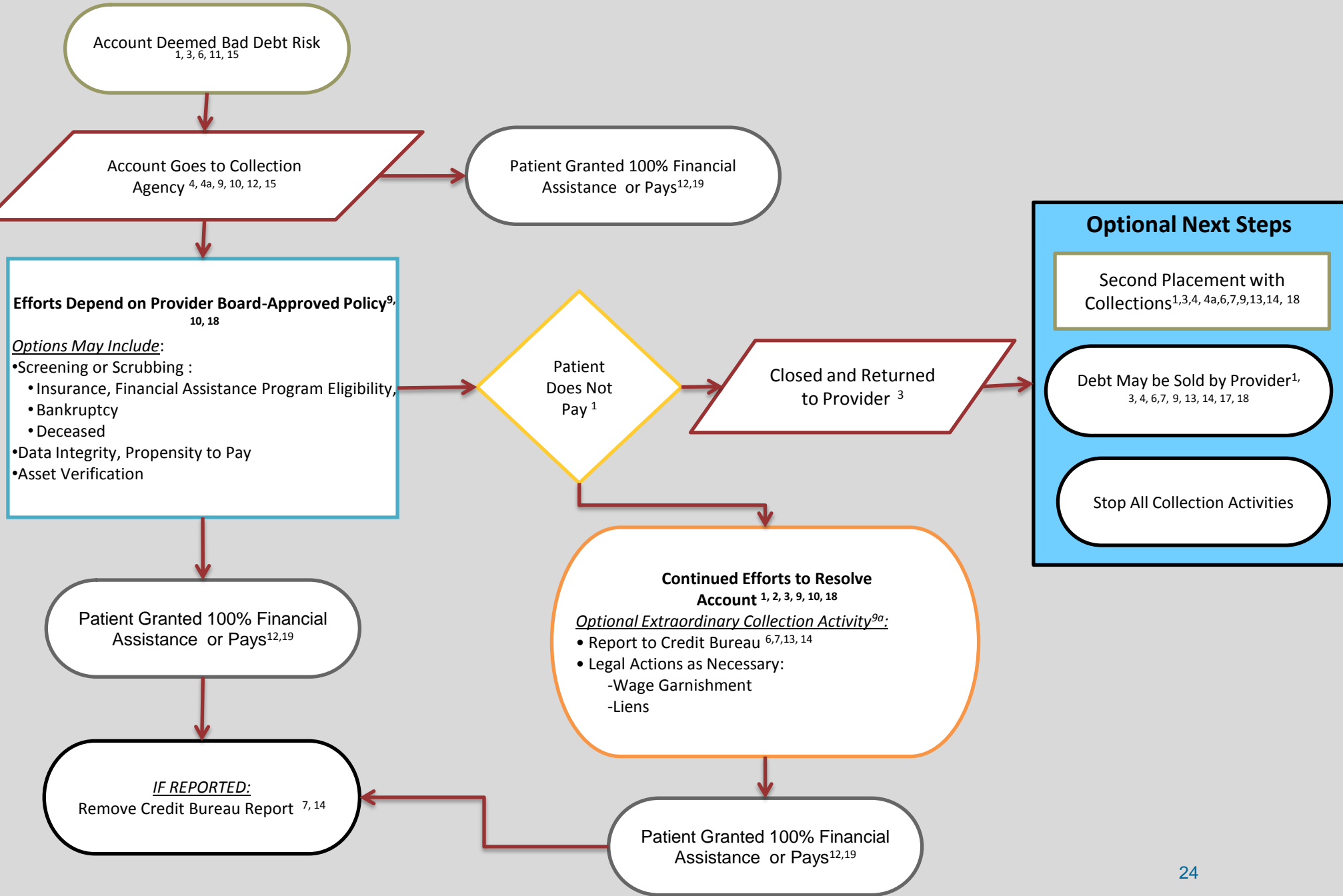
**Medical Account  
Resolution**



# Draft Post Discharge Resolution Process



# Draft Post Discharge Resolution Process (cont.)



# Selected Best Practices

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- Educate patients and follow best practices for communication
- Make all bills and other communications clear, concise, correct, and patient-friendly
- Establish policies and make sure they are followed internally and by business affiliates
- Be consistent in key aspects of account resolution—from billing disputes to payment application
- Coordinate with business affiliates to avoid duplicative patient contacts



# Selected Best Practices

(cont.)

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- Exercise good judgment about the best ways to communicate with patients about bills
- Start the account resolution clock when the first statement is sent to the patient
- Report back to credit bureaus when an account is resolved (in the event that an account is reported to a credit bureau)
- Track all consumer complaints.
- Draw on best practices, principles, and guidelines to inform your organization's approach



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