

Patient Financial Communications Best Practices

These common-sense best practices bring consistency, clarity, and transparency to patient financial communications, and outline steps to help patients understand the cost of services they receive, their insurance coverage, and their individual responsibility.

For more information, go to hfma.org/communications.

1. Section 1—Emergency Department

NOTE: All practices must comply with EMTALA and all other Federal, State and Local regulations affecting the Emergency Department

- 1.1. Discussion participants:** The patient or guarantor will have these discussions with properly trained registration or discharge representative for routine scenarios; financial counselor or supervisor for non-routine / complex scenarios. Patient should be given the opportunity to request a patient advocate, designee or family member to assist them in these discussions.
- 1.2. Setting for discussions:** No patient financial discussions will occur before patient is screened and stabilized. Once a patient has been stabilized, in accordance with EMTALA, the following timings and locations are appropriate for financial discussions.
 - 1.2.1. Emergent Patients:** Discussions will occur during the discharge process. The discussion can also occur during the medical encounter as long as patient care is not interfered with and the patient consents to these conversations in order to expedite discharge.
 - 1.2.2. Patients who do not have an emergency medical condition:** Following the medical screening, provider representative will have a discussion with the patient during the registration or discharge process. The discussion can also occur during the medical encounter as long as patient care is not interfered with and the patient consents to these discussions in order to expedite discharge.
- 1.3. Registration, insurance verification, and financial counseling discussions:** No patient financial discussions will occur before patient is screened and stabilized, in accordance with EMTALA.
 - 1.3.1. Registration:** The provider organization will first gather basic registration information including demographics, insurance coverage, as well as determining the potential need for financial assistance.
 - 1.3.2. Provision of care:** Patient will be informed that their ability to pay will not interfere with treatment of any emergency medical conditions. Uninsured patients will be informed the goal of collecting information is to identify paying solutions or financial assistance options that may assist them with their obligations for this visit.
 - 1.3.3. Insurance verification:** Once screening has occurred and the patient is stabilized, the provider organization will review insurance eligibility information with the patient to ensure information accuracy.
 - 1.3.4. Financial counseling:** If appropriate, patient is referred to a financial counselor and/or offered information regarding the provider’s financial counseling services and assistance policies.

1.4. Patient share and prior balance discussions: These discussions will occur once the provider organization has fulfilled the previous best practice requirements. Interactions will not interfere with patient care, and will focus on patient education. During patient share and prior balance discussions, the provider representative will:

1.4.1. Patient share discussions:

- 1.4.1.1.** Provide a list of the types of service providers that typically participate in the service both verbally and if the patient requests, in writing.
- 1.4.1.2.** Inform patient that actual costs may vary from estimates depending on actual services performed or timing issues with other payments affecting the patient's deductible.
- 1.4.1.3.** If appropriate, ask the patient if they are interested in receiving information regarding payment options.
- 1.4.1.4.** If appropriate, ask the patient if they are interested in receiving information regarding the provider's financial assistance programs.

1.4.2. Prior balance discussions:

NOTE: Balance resolution discussion occurs on prior balances that are being pursued for collection by provider, collection agency or other organization. There will be many scenarios where patients will not have prior balances.

- 1.4.2.1.** Discuss with patient the services that led to the prior balance, including the dates of service and the resulting prior balance. Upon the patient's request, provide the patient a written list of the services provided, dates of service and the resulting prior balance.
- 1.4.2.2.** Ask the patient if they are interested in receiving information regarding payment options.
- 1.4.2.3.** Ask the patient if they are interested in receiving information regarding the provider's supportive financial assistance programs.
- 1.4.2.4.** Proactively attempt to resolve prior balances through insurance and financial assistance programs.

1.5. Balance resolution: Once the provider organization has fulfilled the best practice steps as outlined above, it is appropriate to inquire about how the patient would like to resolve the balance for the current service and any prior balance the patient may have, as well as informing the patient of the timing of collection activity.

1.6. Summary of care documentation: During the discharge process, the patient will receive, in writing, information regarding the provider's supportive financial assistance programs, and a summary of the potential financial implications for the services rendered, including a phone number to call with questions.

2. Section 2—Time of Service (Outside the ED)

- 2.1. **Discussion participants:** The patient or guarantor will have these discussions with properly trained registration or discharge representative for routine scenarios; financial counselor or supervisor for non-routine / complex scenarios. Patient should be given the opportunity to request a patient advocate, designee or family member to assist them in these discussions.
- 2.2. **Setting for discussion:** Provider organization will have discussion with patient during the registration or discharge process in a location that does not disrupt patient flow. The discussion can also occur during the medical encounter as long as patient care is not interfered with and the patient consents to these discussions in order to expedite discharge.
- 2.3. **Registration, insurance verification, and financial counseling discussions:** Provider organizations will maintain a thread of pre-registration discussions that occurred with the patient. If pre-registration discussions took place, these discussions will not occur again.
 - 2.3.1. **Registration:** The provider organization will first gather basic registration information including demographics, insurance coverage, as well as determining the potential need for financial assistance.
 - 2.3.2. **Insurance verification:** The provider organization will review insurance eligibility details with the patient to ensure information accuracy. Uninsured patients will be informed the goal of collecting information is to identify paying solutions or financial assistance options that may assist them with their obligations for this visit.
 - 2.3.3. **Financial counseling:** If appropriate, patient is referred to a financial counselor and /or offered information regarding the provider’s financial counseling services and assistance policies.
- 2.4. **Provision of care:** Provider organizations will have clear policies on how to interact with patients with prior balances choosing to have elective or non-elective procedures. They will also have clear definitions for elective and non-elective procedures. These policies will be made available to the public.
 - 2.4.1. **Elective services (As defined by the provider):**
 - 2.4.1.1. *Patient share discussions:* Patients have the obligation to make satisfactory payment arrangements before receiving care.
 - 2.4.1.2. *Prior balance discussions:* Patients with prior balances will be informed by the provider organization if the provider’s policies regarding prior balances mean the service will be deferred.
 - 2.4.2. **Non-elective services (As defined by the provider):**
 - 2.4.2.1. Patients will be informed that ability to resolve patient share or any prior balances will not affect provision of care.
- 2.5. **Patient share and prior balance discussions:** Discussions will not interfere with patient care, and will focus on patient education. During patient share and prior balance discussions, the provider representative will:

2.5.1. Patient share discussions:

- 2.5.1.1.** Provide a list of the types of service providers that typically participate in the service both verbally and if the patient requests, in writing.
- 2.5.1.2.** Inform patient that actual costs may vary from estimates depending on actual services performed or timing issues with other payments affecting the patient's deductible.
- 2.5.1.3.** If appropriate, ask the patient if they are interested in receiving information regarding payment options.
- 2.5.1.4.** If appropriate, ask the patient if they are interested in receiving information regarding the provider's financial assistance programs.

2.5.2. Prior balance discussions:

Note: Balance resolution discussion occurs on prior balances that are being pursued for collection by provider, collection agency or other organization. There will be many scenarios where patients will not have prior balances.

- 2.5.2.1.** Discuss with patient the services that led to the prior balance, including the dates of service and the resulting prior balance. Upon the patient's request, provide the patient a written list of the services provided, dates of service and the resulting prior balance.
- 2.5.2.2.** If appropriate, ask the patient if they are interested in receiving information regarding payment options.
- 2.5.2.3.** If appropriate, ask the patient if they are interested in receiving information regarding the provider's supportive financial assistance programs.
- 2.5.2.4.** Proactively attempt to resolve prior balances through insurance and financial assistance programs.

2.6. Balance resolution: Once the provider organization has fulfilled the best practice steps as outlined above, it is appropriate to inquire about how the patient would like to resolve the balance for the current service and any prior balance the patient may have, as well as informing the patient of the timing of collection activity.

2.7. Summary of care documentation: During the registration or discharge process, the patient will receive in writing, information regarding the provider's supportive financial assistance programs, and a summary of the potential financial implications for the services rendered, including a phone number to call with questions.

3. Section 3—Advance of Service

3.1. Discussion participants: Appropriately trained provider representatives will have these discussions with the patient or guarantor. Patient should be given the opportunity to request a patient advocate, designee or family member to assist them in these discussions.

- 3.2. Setting for discussion:** Discussions will occur using the most appropriate means of communication for the patient. These discussions may take place via:
- Outbound contact to patient in advance of a scheduled service.
 - Inbound contact from patient inquiring about their upcoming service.
 - Scheduling / Contact center when appointment is made.
- 3.3. Timing of discussion:** A reasonable attempt will be made for discussions with patients to occur as early as possible, taking place before a financial obligation is incurred up to the point at which care is provided. Timely discussions will ensure patients understand their financial obligation and providers are aware of the patient’s ability to pay and/or source of payment.
- 3.4. Registration, insurance verification, and financial counseling discussions:** Provider organizations will maintain a thread of pre-registration discussions that occurred with the patient. If pre-registration discussions took place, these discussions will not occur again.
- 3.4.1. Registration:** The provider organization will first gather basic registration information including demographics, insurance coverage, as well as determining the potential need for financial assistance.
- 3.4.2. Insurance verification:** The provider organization will review insurance eligibility with the patient to ensure information accuracy. Uninsured patients will be informed the goal of collecting information is to identify paying solutions or financial assistance options that may assist them with their obligations for this visit.
- 3.4.3. Financial counseling:** If appropriate, patient is referred to a financial counselor and /or offered information regarding the provider’s financial counseling services and assistance policies.
- 3.5. Provision of care:** Provider organizations will have clear policies on how to interact with patients with prior balances choosing to have elective or non-elective procedures. They will also have clear definitions for elective and non-elective procedures. These policies will be made available to the public.
- 3.5.1. Elective services (As defined by the provider):**
- 3.5.1.1. Patient share discussions:** Patients have the obligation to make satisfactory payment arrangements before receiving care.
- 3.5.1.2. Prior balance discussions:** Patients with prior balances will be informed by the provider organization if the provider’s policies regarding prior balances mean the service will be deferred.
- 3.5.2. Non-elective services (As defined by the provider):**
- 3.5.2.1.** Patients will be informed that ability to resolve patient share or any prior balances will not affect provision of care.
- 3.6. Patient share and prior balance discussions:** Interactions will not interfere with patient care, and will focus on patient education. During patient share and prior balance discussions, the provider representative will:

3.6.1. Patient share discussions:

- 3.6.1.1.** Provide a list of the types of service providers that typically participate in the service both verbally and if the patient requests, in writing.
- 3.6.1.2.** Inform patient that actual costs may vary from estimates depending on actual services performed or timing issues with other payments affecting the patient's deductible.
- 3.6.1.3.** If appropriate, ask the patient if they are interested in receiving information regarding payment options.
- 3.6.1.4.** If appropriate, ask the patient if they are interested in receiving information regarding the provider's financial assistance programs.

3.6.2. Prior balance interactions discussions:

Note: Balance resolution discussion occurs on prior balances that are being pursued for collection by provider, collection agency or other organization. There will be many scenarios where patients will not have prior balances.

- 3.6.2.1.** Discuss with patient the services that led to the prior balance, including the dates of service and the resulting prior balance. Upon the patient's request, provide the patient a written list of the services provided, dates of service and the resulting prior balance.
 - 3.6.2.2.** If appropriate, ask the patient if they are interested in receiving information regarding payment options.
 - 3.6.2.3.** If appropriate, ask the patient if they are interested in receiving information regarding the provider's supportive financial assistance programs.
 - 3.6.2.4.** Proactively attempt to resolve prior balances through insurance and financial assistance programs.
- 3.7. Balance resolution:** Once the provider organization has fulfilled the best practice steps as outlined above, it is appropriate to inquire about how the patient would like to resolve the balance for the current service and any prior balance the patient may have, as well as informing the patient of the timing of collection activity.

4. Section 4—All Settings

- 4.1.** Compassion, patient advocacy and education should be part of all patient discussions.
- 4.2.** Providers should have standard language to guide staff on the most common types of patient financial discussions.
- 4.3.** Where appropriate, provider organizations should utilize face-to-face discussions to facilitate one-time resolution.

- 4.4. Availability of supportive financial assistance should be communicated to patients. Provider organizations should communicate and make financially supportive policies available to the community.
- 4.5. Service provider should take initiative to communicate with patient.
- 4.6. All personnel engaging in patient financial discussions (e.g., registration staff, financial counselors, financial clearance representatives and customer service staff) will receive annual training on the following:
 - Patient Financial Communications Best Practices
 - Financial assistance policies
 - Common coverage solutions for the uninsured and underinsured
 - Customer service
- 4.7. Provider organizations should ensure broader education and awareness of the PFI Best Practices throughout their organization.
- 4.8. Provider organization should include the perspective of a patient when developing standard language used in patient financial discussions.
- 4.9. Providers should regularly survey their patients to assess performance against the PF Best Practices. Results should be shared with staff and leadership for continuous improvement opportunities.
- 4.10. Communication should be understandable by the patient.
- 4.11. Communication should include verification of patient information (mailing address, phone numbers, email, etc.) and the patients' preferred methods for future communication.
- 4.12. Providers should have technology that gives financial representatives up-to-date information about patient balances and financial obligations.
- 4.13. In all patient financial discussions, patient privacy should be respected and conversations should occur in a location and manner that are sensitive to the patient's needs.
- 4.14. Elective procedures should be defined by individual provider organizations to ensure patients are properly informed regarding their financial obligations.
- 4.15. Providers should have a toll-free number that is widely publicized that patients can call to receive assistance in financial matters and concerns they may have.
- 4.16. Provider organizations will have clear policies regarding the handling of patients with prior balances. These policies will be made available to the public.
- 4.17. Patient discussions will focus on steps toward amicable resolution of financial obligations.

Section 5—Measurement Criteria

Following are criteria for evaluating the effectiveness of patient financial communications in a healthcare organization. HFMA offers a [recognition program](#) so organizations can demonstrate their implementation of the practices.

1. Training program evaluation

- a. All staff, including Patient Access, Financial Counseling and Customer Service dealing with patient financial discussions should go through training on an annual basis.
- b. Evidence that training occurred is presented to the Executive Leadership Team on an annual basis.
- c. Training can be provided through a variety of forums (e.g. Web-based or in-person).
- d. Training can be provided by qualified resources (internal or external) as deemed appropriate by a designated quality officer (e.g. Compliance, Quality, or Human Resources).
- e. Training must cover:
 - i. Patient Financial Communications Best Practices specific to the staff role
 - ii. Financial assistance policies
 - iii. Available patient financing options
 - iv. Alternative solutions for the uninsured
 - v. Standard language to be used in patient discussions
 - vi. Laws and regulations (e.g. EMTALA, FDCPA, TCPA, etc.) specific to the staff role

2. Process compliance evaluation

- a. Ensure provider organization is compliant with the Best Practices through annual observation, monitoring and tracking of results.
- b. The evaluation will be comprehensive and cover all relevant parts of the Patient Financial Communications Best Practices:
 1. Best Practice Scenario 1 – Patient Financial Communications in the ED
 1. Registration
 2. Patient Share
 3. Prior Balance
 2. Best Practice Scenario 2 – Patient Financial Communications in Advance of Service
 1. Registration
 2. Patient Share
 3. Prior Balance
 3. Best Practice Scenario 3 – Patient Financial Communications at the Time of Service (Outside the ED)
 1. Registration
 2. Patient Share
 3. Prior Balance
 4. Best Practice Scenario 4 - Best Practices for all Patient Financial Interactions
- c. Process compliance evaluation can be performed by any organization independent of the department being audited (e.g. internal audit, compliance, quality or a 3rd party).
- d. A report containing the results of the process evaluation is presented to the Executive Leadership Team on an annual basis.

3. Technology evaluation

- a. Ensure technology is in place to support informing the patient of the following:
 - i. Verification of insurance eligibility for current services
 - ii. Verification of existing prior balance within organizational control

- iii. Estimated cost of the current services and the consumer responsibility portion
- a. A report containing the results of the technology evaluation is presented to the Executive Leadership Team on an annual basis.
- b. The technology evaluation can be performed by any qualified individual or organization (e.g. technology, compliance, quality or a 3rd party).

4. Feedback process and response evaluation

- a. Ensure process is in place to regularly solicit input and receive feedback from key stakeholders in compliance with Patient Financial Communications Best Practices (e.g. community, patient surveys, physicians)
- b. Ensure process is in place to measure and respond to input and feedback received
- c. Ensure provider organization has an escalation process for patient complaint resolution
- d. A report detailing the feedback and response process that is in place and a summary of the feedback and responses that have been exchanged is presented to the Executive Leadership Team on an annual basis.

5. Executive level metrics reporting evaluation

- a. Ensure process is in place to consolidate the reports from the 4 areas listed above into an overall Compliance Report and presented to the executive leadership team on an annual basis.