RESEARCH REPORT

Advisory Board

Uncompensated care in the high-deductible era

Revisiting policies to meet rising patient obligations

PUBLISHED BY

Revenue Cycle Advancement Center

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Introduction

Revisiting policies to meet rising patient obligations

Difficulties with patient collections and uncompensated care continue, leaving providers scrambling for ways to collect on unpaid bills. In this era of high deductible health plans, patients are on the hook for a greater portion of their care costs. Even median income patients struggle to afford health care, reflected by the popularity of websites such as GoFundMe,[1] which has normalized crowdsourcing for health care costs, fundamentally shifting the perception of who should qualify for "charity."

As patient obligations change, so must health systems' approach to financial assistance and charity care. Health care costs have become so burdensome that financial assistance must extend to the middle

As a result, we have seen an uptick in member questions regarding charity care across the past several months. How can charity care policies be more transparent? Is there an industry standard for charity care? How can populations be segmented to identify need for charity care? What are best-in-class, not-for-profits doing to update their charity care policies?

In response to these market forces and resulting questions, Advisory Board has identified key challenges in charity care along with resources to address these struggles in the pages to follow.

Calculating uncompensated care

> Uncompensated care is care or services delivered by a health care provider that is not reimbursed. **It is equal to bad debt plus charity care.**

Accurately calculating uncompensated care is essential for non-for-profit hospitals to achieve tax-exempt status. To acquire this status, hospitals must file with the Internal Revenue Service (IRS) and submit a community health needs assessment every three years. While the IRS does require hospitals to offer seven community benefits (**charity care, participation in government programs like Medicaid, medical education, health services research, subsidized health services, community health improvement activities, and cash-in kind contributions**), the degree to which hospitals offer these benefits is highly variable.

> "More than a quarter of 5,534 U.S. hospitals surveyed in 2016 did not have any community partnerships, according to the American Hospital Association…Overall, there's very little collaboration, which is 'not all that surprising because **hospitals candidly are not a public health department**…**their business model is still one that requires them to fill up beds. They often don't have the resources, infrastructure or capacity to focus on broader community health issues**.'"
>
> Gary Young, Director of the Center of Health Policy and Healthcare Research
> NORTHEASTERN UNIVERSITY

Source: Internal Revenue Service, "Requirements for 501(c)(3) Hospitals under the Affordable Care Act – Section 501(r)," https://www.irs.gov/charities-non-profits/charitable-organizations/requirements-for-501c3-hospitals-under-the-affordable-care-act-section-501r; Kaiser Health News, "GoFundMe CEO: 'Gigantic Gaps' In Health System Showing Up in Crowdfunding," https://khn.org/news/gofundme-ceo-gigantic-gaps-in-health-system-showing-up-in-crowdfunding/; Modern Healthcare, "In Depth: Flaws in hospital community benefit reporting create knowledge vacuum," https://www.modernhealthcare.com/article/20181201/NEWS/181119965/indepth-flaws-in-hospital-community-benefit-reporting-create-knowledge-vacuum; Revenue Cycle Advancement Center research and analysis.

1) According to Kaiser Health News, of the $5 billion dollars raised on GoFundMe, about one third has been for medical expenses (January 2019)

1

Uncompensated care and Medicaid's impact

Medicaid expansion continues to impact bad debt

Changes in bad debt reporting standards also impact landscape

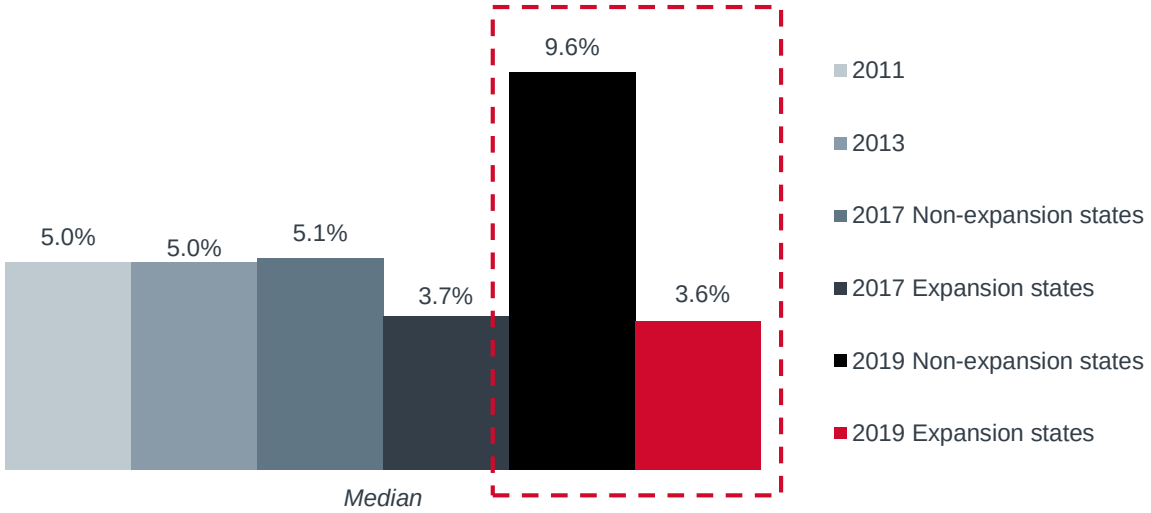
In March 2018, the IRS created a new accounting standard, Topic 606, for measuring bad debt. Prior to the new standard, hospitals could report bad debt as the difference between the amount billed and what was paid by the patient. Under the new—now current—standard, hospitals can only report bad debt if an adverse event, such as a patient losing their job, prevents them from paying what the hospital expected to receive.

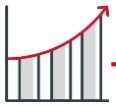
Beyond this new definition, Medicaid expansion has also changed the bad debt landscape, a trend first noticed in 2017, and which held in our 2019 Hospital Revenue Cycle Benchmarking Survey. Bad debt at the median hospital in states with expanded Medicaid eligibility declined by 2.7%, while it increased by 88% for the median hospital in states without expanded Medicaid. Given that Medicaid expansion was only in certain states, we saw **considerable bad debt variation across the country**.

Health system bad debt

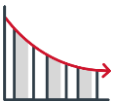
Percentage of net patient revenue

n= 79 (2011), 43 (2013), 67 (2017), 87 (2019)





+88% Change in bad debt for median hospital in states with no Medicaid coverage expansion since 2017



-2.7% Change in bad debt for median hospital in states with Medicaid coverage expansion since 2017

Source: Modern Healthcare, "New bad debt accounting standard likely to remake community benefit reporting." https://www.modernhealthcare.com/article/20180317/NEWS/180319904/new-bad-debt-accounting-standards-likely-to-remake-community-benefit-reporting; Hospital Revenue Cycle Benchmarking Survey; Revenue Cycle Advancement Center research and analysis.

Charity care performance diverges across cohort

Strong cash collectors provide more in patient financial assistance

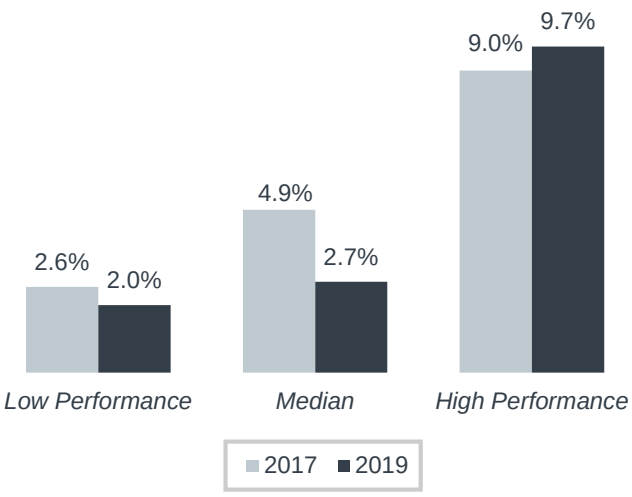
Overall, Advisory Board's 2019 Hospital Revenue Cycle Benchmarks showed a decrease in charity care among median and low performers, while the top performers saw an increase in the percentage of net patient revenue dedicated to charity care. Further analysis revealed that **organizations with cash collection rates above the 75th percentile report higher charity care provision than those with weaker cash collection performance.**

While the obvious conclusion is that organizations with rates of cash collection are in a better financial position, and can therefore distribute more charity care, there is a more critical inference. A well-run revenue cycle, one that provides a positive patient financial experience resulting in higher collections, and that mitigates and prevents denials, is in a much better position to support the organization's mission of providing affordable care to patients.[1]

Charity care

Percentage of net patient revenue

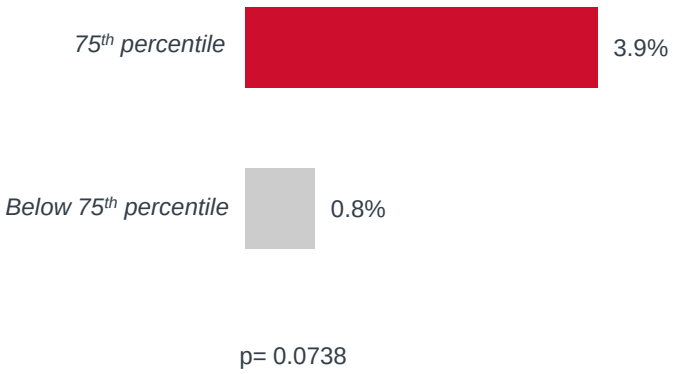
n= 68 (2017), 87 (2019)



Strong collectors provide more charity care[3,4]

Average charity care as a percentage of NPR

n=26 (2019)



1) For further resources on these issues, see The Patient Financial Experience Toolkit, Financial Experience Consumer Profiles and Denials Crash Course
2) Strong collectors" defined as respondents reporting a cash collection rate greater or equal to the 75th percentile.
3) Findings statistically significant at a 90% confidence level, confirmed via Student's T-test.

Source: Hospital Revenue Cycle Benchmarking Survey; Revenue Cycle Advancement Center research and analysis.

Medicaid expansion also impacts charity care

Expansion provides opportunity to provide assistance to other types of patients

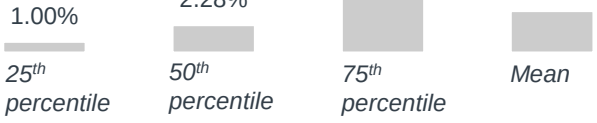
Besides its impact on bad debt, Medicaid expansion also changed charity care distribution. Expansion states report considerably lower usage of charity care compared to non-expansion states, a natural result of more patients receiving Medicaid coverage.

Rather than providing less charity care overall, health systems in expansion states may wish to rethink who qualifies for financial assistance, taking size of deductible into account along with other patient demographics such as income.

Charity care in expansion states, 2019

Percentage of net patient revenue

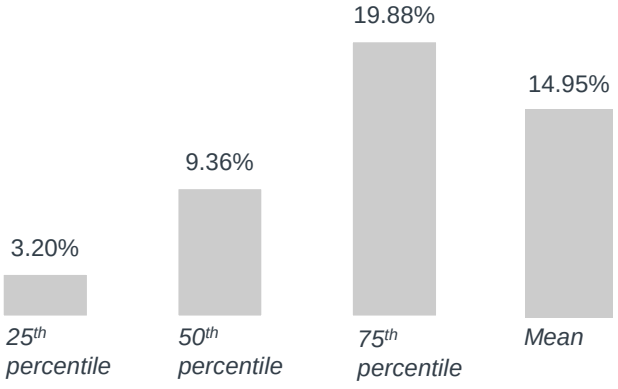
n=21



Charity care in non-expansion states, 2019

Percentage of net patient revenue

n=16



Continuing to watch Medicaid's evolution

Following the 2012 Supreme Court ruling that states could opt out of Medicaid expansion[1] coupled with waivers that allow states to experiment how they set up their Medicaid programs,[2] we've seen sizeable variation in Medicaid structure and outcomes from state to state. After the November 2019 gubernatorial and legislative elections, Medicaid changes could be coming in Kentucky, Mississippi, and Virginia.

Kentucky

Under Governor Matt Bevin (R), Kentucky required Medicaid recipients to work to maintain their coverage which would have left 95,000 of the 400,000 Kentuckians on Medicaid without coverage.[3] However, a federal judge recently overturned the requirement on technical grounds. Attorney General Andy Beshear (D)'s victory over current Governor Bevin means Medicaid work requirements will continue to be kept at bay, given his campaign promise to eliminate them.

Mississippi

In Mississippi's gubernatorial election, voters chose Tate Reeves (R) over Jim Hood (D). Given Reeves' stated opposition to Medicaid expansion on "philosophical grounds," it is unlikely the state's approach to expansion will change.[4] This is concerning for Medicaid populations as Mississippi has one of the highest uninsured rates and the lowest median household income in the country at $42,009[5] (2017).

Virginia

Governor Ralph Northam (D) expanded Medicaid in 2017, but the expansion was met with work requirements similar to Kentucky's given the state's Republican controlled Legislature at the time. However, Democrats took control of both houses of the Virginia legislature in November, with one of their anticipated first initiatives to lift the work requirements

1) Kaiser Family Foundation
2) Medicaid.gov
3) The Hill
4) Clarion Ledger
5) United States Census Bureau

Source: Advisory Board Daily Briefing, "What yesterday's elections mean for health care," https://www.advisory.com/daily-briefing/2019/11/06/elections-Kentucky; The Hill, "Beshear vows to rescind Kentucky's Medicaid work requirements after claiming victory in governor's race," https://thehill.com/policy/healthcare/469173-beshear-vows-to-rescind-kentuckys-medicaid-work-requirements-during-first; Kaiser Family Foundation, "A Guide to the Supreme Court's Decision on the ACA's Medicaid Expansion," https://www.kff.org/health-reform/issue-brief/a-guide-to-the-supreme-courts-decision/; Medicaid.gov, "State Waivers List," https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/index.html; Hospital Revenue Cycle Benchmarking Survey; Revenue Cycle Advancement Center research and analysis.

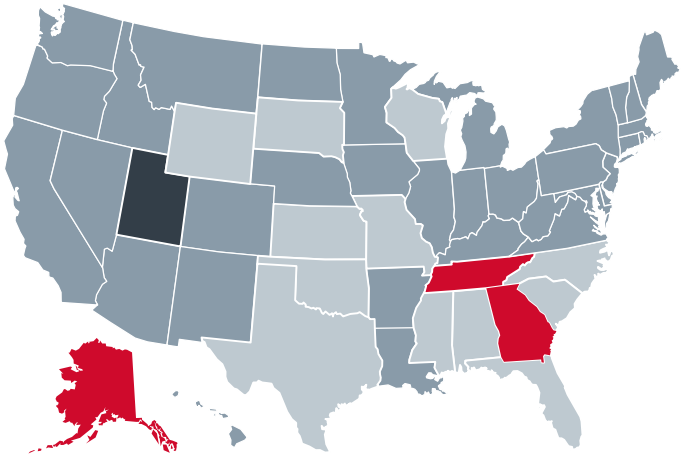
Block grants for Medicaid back on the table

Funding caps could limit enrollment and reimbursement prospects

Beyond the impact of the November 2019 elections, we are continuing to monitor the impact of Medicaid block grants. Block grants would alter how reimbursement is disbursed by providing states with a lump sum of federal government money, leaving states to decide on how manage and distribute the funds. The argument behind the block grants is to make the program more efficient. However, critics argue that because federal funding would not increase alongside state spending under a block grant system, care will be less available to low-income populations in the long-term.[1]

In July 2019, Utah requested partial expansion of their program using a block grant-like funding cap, though their request was denied by the Centers for Medicare and Medicaid Services. Alaska and Georgia are currently debating block grant status while Tennessee is the first state to formally file with the Health and Human Services Department to convert its program to block grant status.

Medicaid program status



Expanded Medicaid[3] | Per capita cap | Have not expanded Medicaid | Block grant debated by state officials

Tennessee submits alternative Medicaid financing structure proposal

Proposal submitted to Health and Human Services Department on November 20

Block grant amount calculated based on projected costs and serves as the floor for federal funding, inflated annually

Per capita adjustments to block grant amount account for enrollment increases that may occur in future years

Shared savings mechanism by which savings to the federal government are shared equitably with the state

Source: Bloomberg Law, Kaiser Family Foundation, "Status of State Action on the Medicaid Expansion Decision," https://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/?activeTab=map&currentTimeframe=0&selectedDistributions=status-of-medicaid-expansion-decision&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D; Wall Street Journal, Tennessee Unveils Draft Plan to Convert Medicaid to Block Grants," https://www.wsj.com/articles/tennessee-unveils-draft-plan-to-convert-medicaid-to-block-grants-11568732400; Health Care Advisory Board research and analysis.

1) The Wall Street Journal
2) Bloomberg Law
3) Federal poverty level; estimated 40K fewer people covered compared to full expansion.

2

Current trends in charity care

Health care unaffordability requires charity care rework

Financial assistance required in environment of high costs, stagnant wages

The increase in patient obligations, slow wage growth, and the continued overall rise in health care costs has created an underinsured middle class worried about meeting their obligations. While charity care has long been limited to low income patients, such policies leave a cohort of middle income consumers who may struggle to afford services and procedures that can rival the cost of a new car.

As such, charity care and financial assistance policies must evolve. Many health systems have begun to tweak their programs, extending coverage to eliminate surprise billing, spending more resources on communicating policies to patients, and automating the process of enrollment. The remainder of this publication shares observations on the current state of financial assistance in health care, and how health systems should respond.

OBSERVATION 1

The rise of HDHPs[2] has created a solidly middle class, underinsured population

> "What I'm seeing is that Medicaid expansion goes up to 138% of the poverty limit and then most hospital charity care will only go up to 200% of the poverty limit—so my argument has always been, '**what small group of people are you helping?**'"
>
> Financial Navigator
>
> MEDICAL CENTER IN VIRGINIA

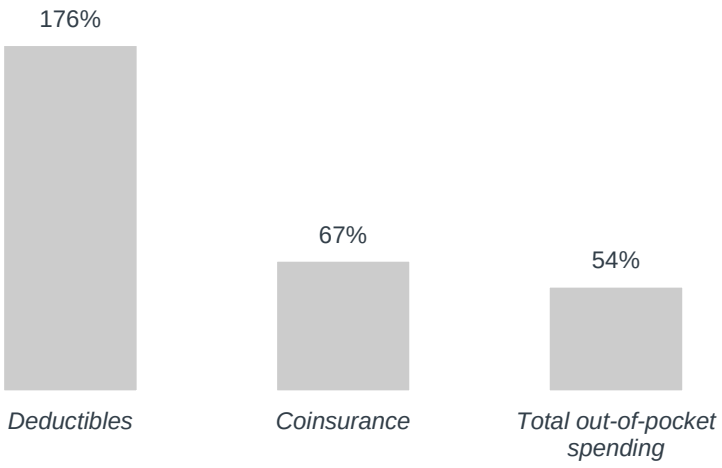
The growth[3] in out-of-pocket costs (deductibles, copayments, coinsurance) has led to a population of patients that struggle to meet their obligations. From 2007 to 2017, enrollment in HDHPs with a health savings account went up from 4.2% to 18.9%. HDHPs without a health savings account grew from 10.6% to 24.5% in the same time period.[5]

In 2019, the average cost of employer-provided coverage for a family of four surpassed $20,000.[6] What compounds the issue even further is the growth in health care costs, compared to growth in wages.

Enrollee spending steadily increases despite relatively stagnant wages[7,8]

Compound annual growth rate increase by category, 2006-2016

n=1.05 million-15.3 million



DATA SPOTLIGHT

29%

Increase in enrollee wages, 2006-2016

1) Federal poverty limit
2) High Deductible Health Plans
3) Compound annual growth rates
4) Kaiser Family Foundation
5) CDC'S National Center for Health Statistics
6) Wall Street Journal
7) Preston-Kaiser Health System Tracker
8) Copays declined 38%, 2006-2016

Source: National Center for Health Statistics, "High-deductible Health Plan Enrollment Among Adults Aged 18-64 with Employment-based Insurance Coverage," https://www.cdc.gov/nchs/products/databriefs/db317.htm; Preston-Kaiser Health System Tracker, "Increases in cost-sharing payments continues to outpace wage growth;" https://www.healthsystemtracker.org/brief/increases-in-cost-sharing-payments-have-far-outpaced-wage-growth/; Preston-Kaiser Health System Tracker, "Tracking the rise in premium contributions and cost-sharing for families with large employer coverage;" https://www.healthsystemtracker.org/brief/tracking-the-rise-in-premium-contributions-and-cost-sharing-for-families-with-large-employer-coverage/;Wall Street Journal, "Cost of Employer-Provided Health Coverage Passes $20,000 a Year;" https://www.wsj.com/articles/cost-of-employer-provided-health-coverage-passes-20-000-a-year-11569429000; Revenue Cycle Advancement Center research and analysis.

Extending financial assistance to mitigate balance billing

Zuckerberg updates financial policy, eliminating surprise bills

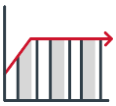
How can health systems respond?

Zuckerberg San Francisco General Hospital and Trauma Center updated their financial assistance policy to protect patients from balance billing. In April 2019, the organization unveiled their new billing policies to better shield patients financially through a partnership with San Francisco Department of Public Health. (The hospital is part of the San Francisco Health Network, the city's public health care system).

Zuckerberg San Francisco General Hospital and Trauma Center's new billing policies

End balance billing, while continuing to seek payment from insurance companies

Create an income-based out-of-pocket maximum for all income levels



Modify patient financial assistance programs to increase patient eligibility

Ensure patients using out-of-network services will not pay more for them than for in-network services

CASE EXAMPLE

Zuckerberg San Francisco General Hospital and Trauma Center
1-hospital health system • San Francisco, CA

Billing Policy

- Due to high levels of Medi-Cal, Medicare and uninsured patients (only 6% of the patient population are commercially insured), the organization wanted to address the rise of HDHPs and balance billing through updated policy
- As of February 1, 2019, all balance billing was halted and will not resume

Source: National Center for Health Statistics, "High-deductible Health Plan Enrollment Among Adults Aged 18-64 with Employment-based Insurance Coverage," https://www.cdc.gov/nchs/products/databriefs/db317.htm; Zuckerberg San Francisco General, "New Billing Policies at ZSFG (April 16, 2019)," https://zuckerbergsanfranciscogeneral.org/news/new-billing-policies-zsfg-april-16-2019/; Revenue Cycle Advancement Center research and analysis.

Communication lag limits charity care utilization

OBSERVATION 2

Despite IRS requirements, hospitals lag in communicating their charity care policies

According to IRS requirements, charity care must be widely publicized in plain language, online and on paper, across the hospital facility. It must also be communicated to patients in a reasonable manner.[1]

Currently, many hospitals identify eligible patients and notify them of charity care processes in an ad hoc manner. As a result of insufficient and confusing communication methods, eligible patients miss out on charity care, which can ultimately leads to a poor patient financial experience and additional costs for the health system.

Hospitals that offer retroactive charity care spend more time on the back-end assisting patients, while hospitals without retroactive charity care may have to write these eligible patients, who were unaware of charity care, off as bad debt.

What should health systems do?

Health systems must enhance their communication methods to guarantee that patients are consistently and adequately educated about charity care and financial assistance policies. Bellin Health created the below checklist to ensure all printed communication was effective. Following the checklist's five areas—**organization and sequence, content and language, readability, graphic design and layout, and visuals**—will improve hospitals' current lag in communication.

Create easy-to-read resources for effective communication

Organization and sequence

- Is the intended audience obvious?
- Is the purpose of the piece clear and stated up front?
- Are the benefits and relevance to readers obvious right away?
- Is the scope limited to 3 to 5 key points average readers *will want to know* at the time they are reading the piece?
- Is the information in the order readers will expect to find it?

Content and language

- Does it focus on behaviors and "how to" information?
- Does it mostly use 2 syllable words and sentences of 10-15 words?
- Is the amount of jargon limited?
- Are new concepts explained in common words?
- Are acronyms explained or avoided?
- Are the sentences straightforward, simple, and clear?
- Did the writer use the conversational language of the readers, active voice, and a friendly tone?
- Are key points emphasized and reviewed?
- Does the piece invite interaction, e.g., with checklists or quizzes?

Source: Internal Revenue Service, "Requirements for 501(c)(3) Hospitals under the Affordable Care Act – Section 501(r)," https://www.irs.gov/charities-non-profits/charitable-organizations/requirements-for-501c3-hospitals-under-the-affordable-care-act-section-501r; Health Care Advisory Board, "The Patient Experience Toolkit," https://www.advisory.com/research/health-care-advisory-board/white-papers/2015/patient-education-toolkit; Revenue Cycle Advancement Center research and analysis.

1) Requirements for 501(c)(3) Hospitals Under the Affordable Care Act – Section 501(r)

Easy-to-read resources for effective communication

Readability

- Is the text written at a 4th or 5th grade reading level?

Graphic design and layout

- Is the amount of text limited to <50% of the space on each page?
- Does the piece *look* easy to read?
- Is the text in upper and lower case letters vs. ALL CAPITALS?
- Are key points emphasized with bolding, different typeface and/or larger type, color, boxes, or rule lines vs. underlining and italics?
- Is the text left justified?
- Is the length between 3-5 inches or 30-50 characters (and spaces)?
- Is color used?
- Is there a sharp contrast between ink color and paper?
- Are headings simple, clear, and near the left?

Visuals

- Do visuals help readers understand the topic?
- Do visuals show the action readers should take?
- Are illustrations/photos realistic, uncluttered, and related to the messaged?

Results

- Consistent documentation of patient and family education through archived materials
- All patient care areas have access to a database of patient and family education materials

CASE EXAMPLE

Bellin Health
1-hospital system • Green Bay, WI

Patient Education

- Bellin Health created a centralized Patient Education Council, comprised of members from different clinical areas and staff at all levels of seniority
- The Council examines educational materials and distributes them across the system to ensure easy access by patients to information around financial assistance and charity care policies.

Source: Health Care Advisory Board, "The Patient Experience Toolkit," https://www.advisory.com/research/health-care-advisory-board/white-papers/2015/patient-education-toolkit; Revenue Cycle Advancement Center research and analysis.

Look to cancer centers for excellence in financial assistance

OBSERVATION 3

Cancer centers lead the way in best practices around charity care

The cost of cancer treatment in the United States is growing, with patients receiving more expensive chemotherapy, immunotherapy, and other types of treatment in the last decade.[1] As a result, cancer is considered one of the most expensive conditions to treat, with patients seeing prices higher than $10,000 a month for individual cancer drugs and biological agents.[1]

The stress of paying for treatment (financial toxicity) also often endangers patient outcomes—compared to their counterpart, **cancer patients with financial distress report poorer physical health, poorer mental health and higher non-adherence to therapy.**[2] Additionally, financial toxicity follows cancer survivors post-treatment who typically report high out-of-pocket spending than those without cancer, some even spending 20% of their income on medical care.[1]

Cancer centers have worked to get ahead of this problem by having financial counselors proactively meet with patients. During these meetings, counselors review insurance benefits and out-of-pocket maximums. If patients qualify for charity care, applications are processed during treatment so patients see lower bills post-discharge.

> "Patients are **appreciative**. Patients are **glad to know that somebody is there looking at finances**. I have not had one patient upset about a in-person visit from a financial counselor."
>
> Oncology Patient Financial Navigator
> CANCER CENTER IN MISSOURI

What should health systems do?

The model of having in-person visits with a financial counselor is logical for cancer centers given the financial toxicity of the condition, but it should be applied more widely—our 2018 Consumer Financial Experience Survey revealed that **patients want financial counselors at the first point of access.** This is a key, given that the majority of patients did not have access to a financial counselor at all.

Majority of patients did not have access to a financial counselor

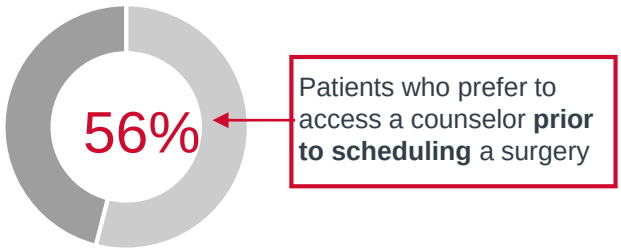
In your most recent non-emergency survey, did you have access to a patient financial counselor?

n=1,000

Majority of patients prefer early access to a financial counselor

In the future, when would you most prefer a financial counselor be made available to you?

n=1,000



1) National Cancer Institute
2) Advisory Board's Oncology Roundtable

Source: National Cancer Institute, "Financial Toxicity (Financial Distress) and Cancer Treatment (PDQ)—Health Professional Version," https://www.cancer.gov/about-cancer/managing-care/track-care-costs/financial-toxicity-hp-pdq; Oncology Roundtable, "The financial toxicity of cancer is harming patients. How can your program help?, https://www.advisory.com/research/oncology-roundtable/oncology-rounds/2017/09/cost-of-cancer?WT.ac=GrayBoxNM_CR_Blog_x_x_x_CarRd_2019Apr24_Eloqua-RMKTG+Blog ; 2018 Consumer Financial Experience Survey; Revenue Cycle Advancement Center research and analysis.

Investing in front end staff to improve financial experience

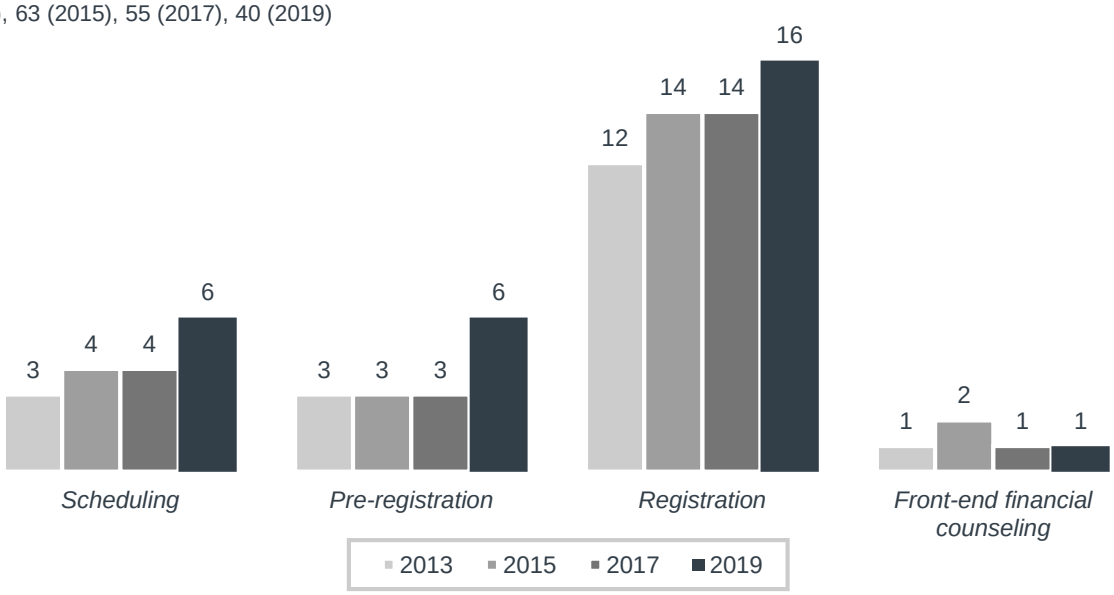
OBSERVATION 4

Providers continue to invest in the financial experience

Integral to giving patients access to patient financial counselors at the first point of access is investment in patient access overall. Our 2019 Hospital Revenue Cycle Benchmarking Survey revealed that hospitals are continuing to invest and add staff in front end functions, compared to other areas of the revenue cycle. However, most investment is seen in pre-registration and registration, with much lower growth in front-end financial counseling. To unlock the full potential of front-end financial counseling, further investment is needed.

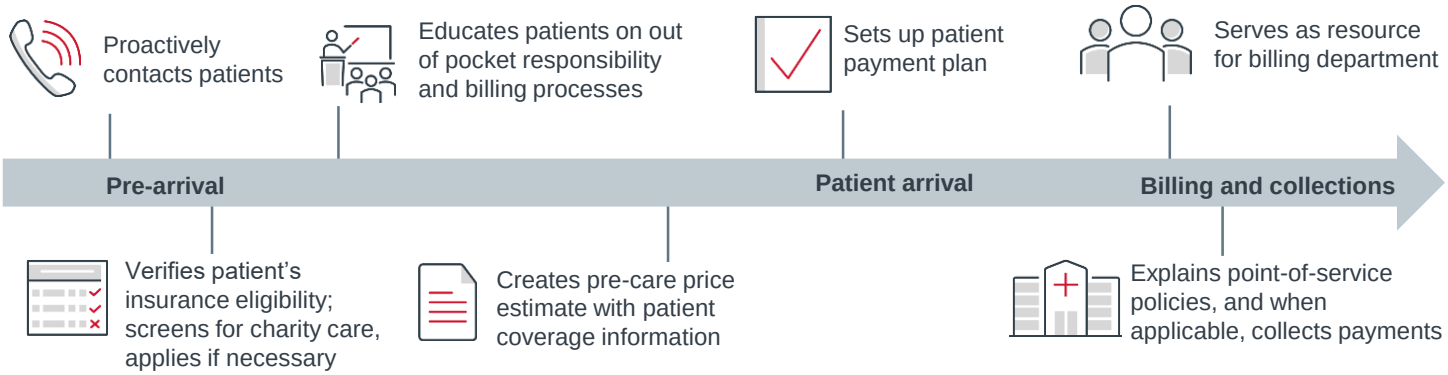
Median number of FTEs per 100 beds by revenue cycle function

n= 41 (2013), 63 (2015), 55 (2017), 40 (2019)



Financial counselors provide the most value when their involvement is frontloaded. Deploying the following will ensure patients have assess to resources early in their treatment:

The role of a financial counselor



1) For more information, see The Patient Financial Experience Toolkit,

Source: Hospital Revenue Cycle Benchmarking Survey; Revenue Cycle Advancement Center research and analysis.

Improve staff performance with patient impact forums

Beyond improvements in financial counseling, patient impact forums, where non-clinical staff have organized opportunities to hear from patients firsthand, will also improve the problems with staff performance related to charity care.

> “I went down to the registration desk and asked for a copy of the hospital charity application. Some of them gave me a Medicare application while some of them didn’t know what I was talking about.”
>
> Financial Navigator
>
> MEDICAL CENTER IN VIRGINIA

Patient Impact Forums

Patient impact forums can solve problems with registration staff’s lack of knowledge around charity care and financial assistance. By actively engaging with patients through forums, staff feel more connected to the patient experience and their work, which will also make them perform better when it comes to important tasks like offering charity care applications. Below are two examples from health systems showing how these forums operate.

1 Invite former patients to share their experience with frontline staff

Patient access leaders can invite former patients who received charity care to return to the office and share their experience with frontline staff. Leaders can then facilitate a conversation between the patient and frontline staff about the importance and impact of offering charity care. The patient can also offer in-person feedback about their experience receiving charity care and suggestions for future interactions.

CASE EXAMPLE

Toledo Hospital
794-bed facility • Toledo, OH

Patient Feedback

Manager invites staff to the unit where they or their family member received care to provide feedback and insights on their experience

2 Facilitate bedside visits for frontline staff

Similar to financial counselors’ bedside visits at cancer centers, patient access leaders can take frontline staff to meet with patients, helping them to learn how to interact with patients at the bedside and discuss their financial options. Following the meetings, the leader and the staff member should debrief on lessons learned.

CASE EXAMPLE

Stevens Hospital[1]
Academic center • Midwest

Patient Interactions

- In response to low scores for food quality, kitchen staff round to clinical units to deliver food
- Leaders report patient contact improved staff’s understanding of their work’s impact

Source: Human Resources Advancement Center, “Hardwiring Accountability at the Front Line,” https://www.advisory.com/-/media/Advisory-com/Research/HRIC/Research-Study/2012/Hardwiring-Accountability-at-the-Front-Line/25808_HRIC.pdf; Revenue Cycle Advancement Center research and analysis.

1) Pseudonym

Simplify and speed the application process

OBSERVATION 5

Applying for charity care is onerous for patients

Determining patient eligibility for assistance may take several days to process due to organizations use of a manual and paper processes.

For example, one organization requires patients to submit the following as documentation: monthly sources of income for the last three months, notice of ineligibility from other assistance programs, a complete copy of the previous year's state and federal tax returns, the last three months of bank statements for both checking and savings, and a letter detailing need for financial assistance.

While these requirements are standard across many organizations, they can be arduous for both the patient and the provider without an electronic submission option.

What should health systems do?

Similar to the inefficient and confusing communication methods, having a slower manual process to determine charity care eligibility will cost both the patient and the organization valuable time. **Investing in an automated financial clearance solution will save valuable time and give patients more peace of mind.**

> "If I had unlimited resources, **I would make the process faster**…**our turnaround times aren't as quick as I'd like to see them**. They're about four to six weeks. I would shorten that to within five to seven business days."
>
> Financial Counselor
> CLINIC IN MONTANA

Source: Revenue Cycle Advancement Center research and analysis.

Simplify and speed the application process (continued)

Meeting the rise of HDHPs and manual applications

Investing in an automated financial clearance software tool will address the **new self-pay population** while also **speeding up the approval process for *all* eligible patients.** And financial clearance software is not for charity care eligibility alone—the software checks eligibility for public insurance and helps organizations identify which patients are likely to pay and which patients need assistance, making investment in this area all the more important.

From Advisory Board's review of financial clearance software tools on the market, we have identified common capabilities across the board with the most important listed below.

Automated financial clearance screening process

Automated screening

Software screens patients prior to point-of-service and determines eligibility for Medicare, Medicaid, charity care and other assistance programs.

Instant enrollment

After screening, the patient is immediately enrolled in the appropriate program.

Provide educational resources

Patient access and financial assistance staff can use information from tool to educate their patients on the assigned programs.

Other key features

- Compliance with IRS' 501(r)
- Ability to store data for price transparency post-screening
- Fully loaded with all possible discounts, payment terms, and loans

Case Study

Advocate Aurora Health Care decided to focus on patient collections after noticing that **self-pay patients received 30% of all bills** but the organization was only collecting about one third of patient balances over $200 among their entire patient population. These data points encouraged the organization to focus on their self-pay population and invest in a financial clearance software tool with improved propensity-to-pay models to predict which patients would need further assistance before sending them to collections agencies. With the tool, Advocate Aurora has also **dramatically reduced the number collection agencies they contract.**

20 **Number of collection agencies needed before software**

4 **Number of collection agencies needed after software**

CASE EXAMPLE

Advocate Aurora Health Care
27-hospital system • Milwaukee, WI

Financial Clearance Software

- After noticing an uptick in self-pay patients and bad debt, Advocate Aurora invested in a financial clearance software tool
- This tool help them reduce the number of collection agencies they worked with from 20 to 4, and improved the patient financial experience

Source: Experian, "Patient Financial Clearance," https://www.experian.com/content/dam/marketing/na/healthcare/brochures/patient-financial-clearance.pdf; Experian, "Advocate Aurora Health Care," https://www.experian.com/content/dam/marketing/na/healthcare/case-studies/eh-advocate-aurora-healthcare-client-success-story-collections-optimization-manager.pdf; AccuReg, "Automate Financial Assistance," https://www.accuregsoftware.com/outcomes/revenue-cycle-impact/automate-financial-assistance/; Revenue Cycle Advancement Center research and analysis;

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