Cancer Patient

Financial Navigation

Helping Patients Manage Their Costs While Protecting Program Margins
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Over the past several years, the Oncology Roundtable has developed numerous resources to assist program leaders in enhancing the patient experience and addressing patients’ unmet needs. The most relevant resources are outlined here and are available in unlimited quantities through your membership.

**Addressing Patients' Financial Obligations**
*Best Practices for Optimizing Collections and Supporting Patients with Need*
- Increase access to financial counseling
- Improve patient understanding of financial responsibility
- Use specialists to reduce costs through opportunities such as drug replacement

**Delivering on the Promise of Patient-Centered Care**
*Designing Services to Support the Whole Patient*
- Establish a systematic approach to psychosocial screening and support
- Improve communication between patients and the care team
- Recognize the hallmarks of effective patient education and how to implement them
- Discover proven strategies for engaging patients as partners in their care

**Inside the Mind of the Cancer Patient**
*Uncovering Patient Preferences to Guide Cancer Program Investment*
- Position and promote quality
- Design patient services
- Prioritize program investment
- Elicit actionable feedback from patients

**Oncology Distress Screening and Management**
*Eight Lessons for Designing a Best-in-Class Program*
- Integrate distress screening into cancer center workflow
- Evaluate the benefits of automating distress screening
- Develop standardized algorithms to manage patients’ distress

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Advisors to Our Work

The Oncology Roundtable is sincerely grateful to the individuals and organizations who shared their insights, analysis, and time with us. We would especially like to recognize the following individuals for being particularly generous with their time and expertise.

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Source: Oncology Roundtable interviews and analysis.
Executive Summary

Cancer providers have a deep commitment to providing the best possible care regardless of patients’ ability to pay. However, programs are increasingly challenged to provide patients with access to care while maintaining the organization’s financial health. Although financial navigation has the potential to be instrumental for accomplishing these two goals, few cancer programs have committed sufficient resources to implementing robust financial navigation.

Three major pressures are expected to heighten the importance of comprehensive financial navigation across the next few years. The first pressure comes from coverage expansion through the Affordable Care Act. Although cancer patients will have more coverage options, these options are also more complex, increasing the likelihood that patients will not select the most appropriate plan for their needs. Second, health plans are increasingly shifting cost responsibility onto patients through higher deductibles, copays, and coinsurance. As a result, cancer patients face crippling out-of-pocket expenses, and cancer programs are finding a greater portion of their revenue at risk. Third, health care purchasers, including the government, payers, and patients, are demanding increased price transparency. As cost data become more readily available, providers must be prepared to engage patients in conversations about costs and out-of-pocket expenses.

In light of these pressures, cancer providers should implement financial navigation programs that meet the financial needs of their patients as well as improve program margins. To do so, programs must first develop processes that ensure that most—if not all—cancer patients receive financial counseling and basic education about their health benefits. Education helps prepare patients for their medical bills, alleviating financial anxiety and increasing the likelihood that patients will meet their financial responsibility.

Additionally, cancer programs should take advantage of every opportunity to mitigate the financial toxicity of a cancer diagnosis. The Affordable Care Act created new options to improve coverage for uninsured and underinsured patients. And, there are myriad patient assistance programs offered by pharmaceutical companies and nonprofit foundations available to cancer patients. Although evaluating insurance plans and identifying available assistance can be a painstaking process, they are well worth the effort for both patients and cancer programs.

Lastly, as provider revenue becomes increasingly dependent on patient payments, cancer programs need to improve patient collections. Although staff may be hesitant to request patient payment, point-of-service collections present the biggest opportunity to impact organizational bad debt.

This publication describes five goals for developing best-in-class financial navigation programs. The case studies presented here, along with the companion implementation tools housed online, aim to guide cancer program leaders as they work to implement these processes within their own organizations.
Introduction

The Need for Financial Navigation
The Financial Toxicity of Cancer

The financial impact of a cancer diagnosis can be devastating. On average, recently diagnosed, insured cancer patients face over $16,000 in direct and indirect costs per year due to their illness. Considering that, in 2012, the average American household earned just over $51,000 a year, the costs of cancer care can be crippling and have a long-lasting impact on patients and their families.

Increasingly, the oncology community is referring to this phenomenon as the “financial toxicity” of cancer care. And leaders in the field assert that, as with any side effect of treatment, providers have an obligation to help patients manage costs. Yet, this will require a major cultural shift for both patients and providers before it becomes a standard component of oncology practice.

In the meantime, cancer programs must prioritize the creation and implementation of comprehensive financial navigation programs that improve patient understanding of their financial responsibility and help them secure financial assistance.

Cancer Patients Face High Out-of-Pocket Costs

Cost of Cancer by Age

<table>
<thead>
<tr>
<th>Population</th>
<th>Median Annual Household Income</th>
<th>Average Annual Cost of Cancer¹</th>
<th>Cost of Cancer as Percentage of Average Household Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 65 years</td>
<td>$57,353</td>
<td>$16,213</td>
<td>28%</td>
</tr>
<tr>
<td>65 and older</td>
<td>$33,848</td>
<td>$16,441</td>
<td>49%</td>
</tr>
</tbody>
</table>

Not Addressing the Financial Toxicity

“A component of first-line therapy for [metastatic colorectal cancer] is bevacizumab…Patients receiving bevacizumab have a 2% increase in the risk of severe cardiovascular toxic effects. Over the course of a median of 10 months of therapy, bevacizumab costs $44,000…Most physicians insist on discussing the 2% risk of adverse cardiovascular effects associated with bevacizumab, but few would mention the drug’s potential financial toxicity.”

“Full Disclosure—Out-of-Pocket Costs as Side Effects”
New England Journal of Medicine


¹ Measured by comparing direct medical costs and indirect morbidity costs between cancer survivors and individuals without a history of cancer.
The Affordable Care Act has created new opportunities for individuals and families to gain health insurance. Earlier this year, the first phase of coverage expansion helped millions of adults gain access to coverage. A recent article in the *New England Journal of Medicine* estimates that 20 million Americans gained coverage as of May 1, 2014. Eight million individuals obtained coverage though the health insurance exchanges, and approximately six million gained Medicaid coverage. The law also makes private health insurance sold outside the marketplace more accessible by protecting individuals from exorbitant premiums or other barriers to coverage, such as preexisting health conditions. Recent estimates project that five million people gained coverage this year directly from insurers.

Interestingly, a RAND survey conducted in March of 2014 estimated that eight million people gained access through employer-sponsored coverage. There are two possible reasons for this. First, as the economy slowly improves, more people are finding jobs that offer health benefits. Second, individuals who had previously opted out of employer-sponsored coverage may have signed onto coverage in anticipation of the individual mandate.

![Graph showing estimated number of consumers who gained coverage under the ACA](image-url)

**Estimated Number of Consumers Who Gained Coverage Under the ACA**

*Ages 18-64, October 2013-May 2014*

<table>
<thead>
<tr>
<th>Coverage Under Parent’s Policy</th>
<th>Enrolled on Public Exchange Plan</th>
<th>Purchased Directly from Insurer</th>
<th>Enrolled in Medicaid or CHIP</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.0M</td>
<td>8.0M</td>
<td>5.0M</td>
<td>6.0M</td>
<td>20.0M</td>
</tr>
</tbody>
</table>

**Spiking Enrollment in Employer-Sponsored Insurance**

8.2M Increased enrollment in employer-sponsored insurance plans from September 2013–March 2014

---

1) May differ from actual enrollment because some surveys used for analysis concluded before April 1, 2014.
2) Children’s Health Insurance Program.

Launch of Health Insurance Exchanges

Exchange Plan Enrollees Creating New Risk

The public exchange plan enrollees represent a new and growing market segment for health care providers with the potential to boost volumes. But this population also presents a number of risks to providers.

The first risk is that there is no guarantee that exchange enrollees will continue paying their monthly premiums to remain insured. Individuals who stop paying their premiums will not lose coverage for three months. Unfortunately for providers, insurers do not have to reimburse for care provided in the last 60 days of those three months.

Another risk is that many exchange enrollees may experience fluctuations in income from month to month. Depending on how much their income changes, they may lose their eligibility for Medicaid or an exchange subsidy. As a result, provider reimbursement and network status may not be guaranteed.

Last, exchange enrollees tend to be low income. While they may be able to afford their monthly premium, they may not be able to afford their out-of-pocket expenses. Their inability to pay their copayments and deductibles is likely to contribute to hospitals’ rising bad debt.

Provider Reimbursement Not a Certainty

Three Key Questions

1. **Will Patients Continue to Pay Their Premiums?**
   - Exchange enrollees who pay one month’s premium are permitted to have an unpaid premium balance for 90 days before plan termination.
   - However, payers are not required to pay for claims received in the last 60 days of the 90-day period, threatening provider reimbursement for services within that window.

2. **Will Patients Experience a Change in Eligibility?**
   - Millions likely to undergo shift in eligibility across Medicaid and exchange market across one year.
   - Transitions in coverage may disrupt provider networks and create fluctuations in reimbursement.

3. **Will Patients Be Able to Pay Their Out-of-Pocket Costs?**
   - Most exchange enrollees opt for plans with lower premiums, higher out-of-pocket costs.
   - Inability to collect patient responsibility could add significantly to hospital bad debt.

In addition to the exchanges, Medicaid expansion has also had a significant impact on individuals’ ability to obtain coverage.

At the time of this writing, 26 states and the District of Columbia had decided to expand their Medicaid program. In these states, individuals with incomes between 100% and 133% of the federal poverty level (FPL) will not be allowed to purchase insurance on the exchanges, but they will be eligible for Medicaid.

In the 24 states that are not expanding Medicaid eligibility, exchange subsidies will be offered to individuals earning above 100% of the FPL. Therefore, there is a “doughnut hole” for residents of these states whose income is below 100% of the FPL and above the income cutoff for Medicaid eligibility. An estimated five million people across the country will fall into the “doughnut hole.” This population is likely to remain uninsured and continue relying upon hospital charity care.
While a growing number of individuals are enrolled on exchange plans and Medicaid, employers still remain the largest sponsor of health care in the US.

The employer mandate included within the Affordable Care Act requires all employers with more than 50 employees to provide health insurance or face a penalty, which, for many employers, will be less than the cost of insurance. As the provisions of the Affordable Care Act rolls out, a key question is whether employers will continue to provide health care coverage.

They have a range of options to consider. Employers may continue providing the same health plan options to their employees. On the other hand, they may discontinue employee health benefits and pay the associated penalty. Another option for employers is to provide a subsidy to their employees that allows them to purchase their own insurance on private exchanges.

Employers Choosing Between Abdication, Activation

Spectrum of Options for Controlling Health Benefits Expense

<table>
<thead>
<tr>
<th>“Abdication”</th>
<th>“Activation”</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>No Health Benefits</strong></td>
<td><strong>Defined Contribution/ Private Exchange</strong></td>
</tr>
<tr>
<td><strong>Self-Funded Benefits</strong></td>
<td></td>
</tr>
</tbody>
</table>

**Pros:**
- Full control over networks
- Exemption from minimum benefits requirements

**Cons:**
- Greater exposure to unexpected expenditures
- Complex network negotiations

**Pros:**
- Health benefits still part of compensation package
- Predictable, controllable cost growth

**Cons:**
- Fundamental disruption in benefit design
- Employees may underinsure

**Pros:**
- Total escape from cycle of rising premium costs

**Cons:**
- Fine for violating employer mandate
- Loss of important labor market differentiator

Source: Oncology Roundtable interviews and analysis.
The majority of employers indicate that they plan to continue providing coverage for their employees. Nevertheless, they are actively looking for ways to control their escalating health care costs.

Some of the most common strategies for employers to control costs are listed to the right. These include a restructuring of employee benefits and exploring alternative contracting strategies, such as narrow networks. Many employers are also focused on promoting employee health through the implementation of prevention and wellness programs.

However, one of the easiest ways for employers to reduce costs is to increase cost sharing, which places greater responsibility for health care costs onto employees.

### Levers for Employers to Address Health Care Costs

<table>
<thead>
<tr>
<th>Benefit Design</th>
<th>Contracting Strategy</th>
<th>Wellness</th>
</tr>
</thead>
</table>
| Evaluating and restructuring employee health plans to optimize utilization | Establishing relationships to control costs and ensure efficacy, for example:  
- Narrow networks  
- Specialty pharmacy | Promoting health and wellness among employees through voluntary awareness and preventative programs |

### Cost Sharing

Encouraging increased employee accountability of health care utilization by shifting an increased portion of costs to employees.

Source: Oncology Roundtable interviews and analysis.
Many employers are shifting costs to employees by offering consumer-directed health plans (CDHPs), such as high-deductible health plans (HDHPs).

As shown in the graph on the left, enrollment in HDHPs is rapidly increasing with a significant number of employees at large and small firms currently enrolled in health plans with a deductible of $1,000 or more.

Increased enrollment in CDHPs is troubling because consumers enrolled in these plans are more likely to postpone or forgo care. As shown in the data on the right, 23% of consumers report postponing care after enrolling in a CDHP. This is particularly concerning for cancer care as delayed diagnosis or treatment can negatively impact patient outcomes.

Both CMS and many health plans are working to increase health care pricing transparency by posting cost data online. The theory is that patients will use the data to compare providers. Early indicators show that patients are taking costs into account when selecting providers for health screening and low-acuity care.

In light of these pressures, there are three strategic imperatives for health care providers to support patients and maintain revenues:

The first is to preserve access to care. This has always been a priority for cancer providers, but with the increased complexity of available health plans and challenges securing financial assistance, organizations need to invest more heavily in financial counseling services.

Second, programs need to improve patient collections. As patients take on more responsibility for their health care costs, patient payments will make up a greater portion of potential hospital revenue.

The third imperative for health systems is to think critically about their payer strategy. As exchange plans and employer-sponsored health plans increasingly use narrow networks to control costs, health systems will need to decide whether they want to be in network and accept decreased reimbursement rates.

New Imperatives in Light of Increased Patient Cost Sharing, Reform

Three Imperatives for Providers

- Preserve patient access to care
- Improve patient collections
- Evaluate payer strategy

Source: Oncology Roundtable interviews and analysis.
There are three ways organizations are improving patient access in response to health care reform and increased patient cost sharing.

The first is by bolstering their financial counseling services to make sure eligible patients gain coverage, underinsured patients secure external assistance, and all patient better understand their health benefits and out-of-pocket expenses.

Organizations are also rethinking their charity care policies in light of coverage expansion. On the one hand, nonprofit hospitals need to continue to provide charity care to maintain their tax-exempt status. On the other hand, they are grappling with how they should manage uninsured patients who had an opportunity to purchase subsidized insurance on the exchanges but did not.

At the same time, organizations are trying to decipher unclear regulations about financial assistance for patients on exchange plans. For example, some hospitals are paying exchange premiums for patients who cannot afford them. Another concern is the legality of pharmaceutical-sponsored assistance for exchange enrollees. A handful of companies are not providing assistance to exchange enrollees, although many continue to do so.

Bolster Patient Assistance Through Financial Counseling, Charity Care

How Hospitals Are Responding

<table>
<thead>
<tr>
<th>Financial Counseling Services</th>
<th>Charity Care Policies</th>
<th>Assistance for Exchange Enrollees</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Building or expanding financial counseling resources</td>
<td>• Rethinking charity care policies in light of coverage expansion, individual mandate</td>
<td>• Deciding the legality of paying patients’ exchange plan premiums</td>
</tr>
<tr>
<td>• Ensuring high-risk patients, such as the uninsured and those with high deductibles, receive financial counseling</td>
<td>• Exploring ways to maintain tax-exempt status, including expanding charity care to insured patients</td>
<td>• Bolstering assistance for exchange enrollees as some pharmaceutical companies pull back assistance for high-priced specialty drugs</td>
</tr>
</tbody>
</table>

While providers’ first responsibility is preserving access to care, they should also commit to collecting copays, coinsurance, and deductibles from those patients who are able to pay.

Traditionally, hospitals have collected only a small portion of patient revenue. However, as enrollment in HDHPs grows, patient revenues will become a larger portion of cancer programs’ potential revenues. Consequently, providers must develop improved collection processes to safeguard margins and minimize bad debt.

According to Advisory Board analysis, as the size of a patient’s deductible increases, their propensity to pay decreases. This is likely because lower-income individuals are more likely to select lower-premium plans with higher deductibles and then are unable to afford the out-of-pocket costs.

To ensure that increased patient cost sharing does not hurt the organizations’ bottom line, hospitals and cancer programs will need to become more efficient and adept at collecting patient responsibility.

### As Patient Responsibility Increases, Likelihood of Collecting Decreases

<table>
<thead>
<tr>
<th>Year</th>
<th>7%</th>
<th>10%</th>
<th>18%</th>
<th>25%</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2005</td>
<td>7%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2010</td>
<td></td>
<td>10%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2012</td>
<td>18%</td>
<td></td>
<td></td>
<td>25%</td>
</tr>
</tbody>
</table>

#### High-Deductible Health Plan Enrollment

**Percentage of Commercially Insured with Deductible of $1,000 or More**

<table>
<thead>
<tr>
<th>Deductible Range</th>
<th>2003</th>
<th>2005</th>
<th>2010</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>$500-$999</td>
<td>68%</td>
<td>62%</td>
<td>61%</td>
<td>50%</td>
</tr>
<tr>
<td>$1,000-$2,000</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$2,001-$3,500</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$3,501-$5,000</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$5,001-$6,350</td>
<td></td>
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</table>

**Based on Analysis of 400K Patient Claims**

One of the best ways for insurers to reduce costs is to create narrow networks. Narrow networks effectively steer patients to a limited number of lower-cost providers by offering patients significantly reduced out-of-pocket expenses. They are a common characteristic of exchange plans, enabling insurers to reduce premiums by 26%.

Patients benefit from the lower monthly cost, but the trade-off is that they have a limited choice of providers. Narrow networks include about 40% fewer providers than PPO insurance networks.

For providers, being an in-network provider can result in increased market capture; however, in-network providers generally must accept reduced reimbursement rates.

### Degree of Hospital Exclusion Across Public Exchange Plans
20 Urban Markets, December 2013

- **Broad**: 30%
- **Narrow**: 32%
- **Ultra-Narrow**: 38%

Excludes 30% of 20 largest hospitals
Excludes 70% of 20 largest hospitals

### Average Percentage of PPO Network Specialists Included in Exchange Plan Networks
Anthem Blue Cross Blue Shield, 2014

- OB/GYNs: 62%
- Orthopedists: 59%
- Oncologists: 59%
- Cardiologists: 48%

100% PPO Network Breadth

Median premium reduction directly attributable to network narrowing:

- 26%

1) Comparing products by the same carrier of the same tier, across seven carriers.
2) “Pathway X” bronze plans compared to leading PPO plan offering across nine states.
Limiting Patient Access to Cancer Care

Notably, providers are not always given a choice of whether to participate in narrow networks. For the most part, payers are independently designing their provider network, and providers only learn of their network status when the health plan’s patients seek care.

In 2014, the Associated Press surveyed NCCN cancer centers about their inclusion in exchange plans’ networks. Thirteen of the 19 respondents indicated that they were excluded from a “significant” number of plans. In the event of a cancer diagnosis, patients will effectively be denied access to the expertise provided by these organizations due to high out-of-pocket expenses.

Despite these concerns, narrow networks are likely to become more common. In addition to the growing number of health insurance exchange enrollees, many employers consider narrow networks an effective lever to reduce health care spending.

Although cancer programs have limited control over their health system’s network participation, cancer program leaders should think through possible actions if they see increased numbers of plans in their market excluding them from their preferred provider network.

NCCN\(^1\) Cancer Centers Excluded from Many Exchange Plans

<table>
<thead>
<tr>
<th>Number</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>13</td>
<td>Number of NCCN organizations facing exclusion from a significant number of plans</td>
</tr>
<tr>
<td>4</td>
<td>Number of NCCN organizations indicating that every insurer included them as a network provider</td>
</tr>
<tr>
<td>2</td>
<td>Number of insurers (out of nine total) in New York City including Memorial Sloan-Kettering on exchange plans</td>
</tr>
</tbody>
</table>

But No One Buys Coverage Expecting to Get Cancer

“Patients who do not have a cancer diagnosis are not going to [worry about access to NCCN cancer centers] any more than they’ll ask, ‘What if I get a heart attack?’”

Deputy Chief Medical Officer, American Cancer Society


\(^1\) National Comprehensive Cancer Network.
Given these pressures, cancer programs should design and implement patient financial navigation programs that accomplish the dual goals of helping patients manage their costs and protecting their organization’s bottom line.

Drawing on an extensive review of literature, as well as conversations with experts in the field, we identified five goals and 17 tactics to serve as a framework for cancer service line leaders seeking to advance their efforts in patient financial navigation.

### A Road Map for Success

**1. Connect Patients to Financial Navigation**

1. Capture patients from multiple channels
2. Hardwire financial checkpoints

Make the case to expand financial navigation

**2. Educate Patients About Their Financial Responsibility**

3. Conduct comprehensive benefits review
4. Provide patients with out-of-pocket cost estimates
5. Script compassionate conversations

**3. Optimize Patient Coverage**

6. Screen patients for coverage eligibility
7. Enhance partnership with external Medicaid assistance agency
8. Coordinate treatment start with clinical team
9. Hardwire monthly insurance checks

**4. Maximize External Assistance**

10. Screen for assistance program eligibility up front
11. Automate patient eligibility screening
12. Assign billing point person for copay assistance
13. Foster best practice sharing among financial navigation staff

**5. Improve Patient Collections**

14. Increase patient awareness of point-of-service collections
15. Train staff for point-of-service collections
16. Develop staff incentive program for point-of-service collections
17. Build realistic payment plans

Source: Oncology Roundtable interviews and analysis.
Connect Patients to Financial Navigation

Tactic #1: Capture Patients from Multiple Channels
Tactic #2: Hardwire Financial Checkpoints
Special Report: Make the Case to Expand Financial Navigation
Many Patients Falling Through the Cracks

Because of the high cost of cancer care, the financial impact of treatment can be severe and long lasting. However, few cancer programs currently have a systematic process in place to identify patients in need of financial counseling. Rather, financial counseling services are typically fragmented, with responsibility for various aspects of the process divided among registration staff, social workers, navigators, and clinicians. As a result, many cancer programs miss opportunities to assist patients with their costs while simultaneously improving their program’s revenue capture.

Cancer Costs Impact Access to Care, Long-Term Financial Health

Common Breakdowns in Patient Access

- Program fails to identify underinsured patient
- Program fails to inform patient of financial obligation
- Program fails to educate patient on available assistance programs
- Program fails to develop realistic payment plan
- Program fails to tap into external sources of financial support

- 32% Percentage of cancer patients reporting cancer-related financial problems
- 23% Percentage of cancer patients reporting that they postponed recommended health care due to cost
- 2.65x Times more likely cancer patients are to go bankrupt than people without cancer

The first challenge for cancer programs is identifying all patients who would benefit from financial counseling. While most programs have systems in place to identify uninsured patients, it is much more difficult to consistently identify underinsured patients, which is a growing percentage of the population. Consequently, programs often do not learn about patients’ financial needs until the patient defaults on their bills.

Cancer programs can employ three approaches to improve identification of patients with financial need. The first is to increase patient awareness of available financial resources. Second, programs should provide patients with multiple access points to financial counseling along the continuum of care. Third, to ensure that all patients are exposed to financial counseling resources, best-in-class cancer programs standardize financial counseling appointments for all new patients.

**Three Approaches to Identify Patients with Need**

- **Educate Patients About Financial Resources**
  Drives increased use of financial counseling by educating patients on program offerings and destigmatizing financial assistance

- **Provide Multiple Access Points**
  Creates multiple opportunities spaced across the care continuum for patients to access financial counseling

- **Standardize New Patient Appointments**
  Ensures all cancer patients exposed to financial counseling through one-on-one meetings with staff

Source: Oncology Roundtable interviews and analysis.
To expand use of financial counseling, cancer programs should make sure that patients are aware of the support services available to them. While many programs provide new patient orientation, the effectiveness of these programs is often questioned due to patients’ anxiety and the volume of information they are expected to absorb immediately after diagnosis.

To try to improve patient awareness of support services, the Mayo Clinic developed an orientation DVD that provides an overview of the cancer center, its resources, and its physical layout. To gauge the impact of the DVD, researchers designed a randomized controlled trial testing different distribution channels, including mailing the DVD to patients’ homes. In contrast, a control group did not receive the orientation DVD.

Analysis of the data showed that patients who received the DVD at home reported increased use of the cancer program’s financial support resources, as well as higher levels of satisfaction with those resources. This channel is likely effective because patients are better able to absorb information when it is delivered to them in a more relaxed setting and when they can review the information at a time of their choosing.

**Mayo Orientation DVD Increases Patient Use of Financial Support**

<table>
<thead>
<tr>
<th>Patients Reporting Use of Financial Support Resources</th>
<th>Patients Reporting Satisfaction with Financial Support Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-Person Orientation Control n=18; DVD Mailed Home n=23</td>
<td>In-Person Orientation Control n=18; DVD Mailed Home n=23</td>
</tr>
<tr>
<td>Control Group: 80%</td>
<td>Control Group: 71%</td>
</tr>
<tr>
<td>DVD Mailed Home: 95%</td>
<td>DVD Mailed Home: 100%</td>
</tr>
</tbody>
</table>

**Orientation DVD Components**

- 12 minutes long
- Welcome to cancer center
- Introduction to philosophy of care
- Orientation to physical layout
- Encourages patient participation
- Patient testimonials
- Identifies sources for obtaining education and support information for specific patient needs, such as financial concerns

**Study in Brief: Assessing Patient Orientation Delivery at Mayo Clinic**

- Mayo Clinic conducted randomized controlled trial of 498 patients to assess methods for orientation, education
- Patients assigned to either the control group or one of three study groups, each providing a different orientation intervention delivery method: class, drop-in session, or education mailed home
- Participants completed pre-intervention and post-intervention questionnaires regarding anxiety, awareness, use, and satisfaction with available cancer center services and resources

Similarly, Lehigh Valley Health Network developed educational materials for cancer patients. But they realized that educating patients about their financial coordination program was not sufficient to identify all patients’ financial needs. To increase patient capture, they created multiple additional opportunities along the care continuum to connect patients to cancer financial coordinators.

For example, financial coordinators review the infusion schedule three days in advance to identify any patients that are “high risk” for financial problems. They then reach out to these patients prior to their infusion center visit to discuss the patient’s financial situation and the possibility of applying for financial assistance or charity care.

Patients also complete distress screening surveys at every visit in the medical and radiation oncology clinics. If financial concerns arise, the nurse refers the patient for financial counseling.

As a result, Lehigh Valley’s financial coordination program is highly valued by both patients and clinicians, successfully securing millions of dollars each year from pharmaceutical and patient assistance programs.

LVHN\(^1\) Engages Patients and Staff to Drive Use of Financial Coordinators

Five Channels Connect Patients to Financial Coordination Team

- **Self-Referral**: Patients receive brochure introducing them to financial coordination services, providing contact number for questions and concerns
- **Staff Referral**: All new cancer program staff educated about financial services, encouraged to refer any patient at any time
- **Multidisciplinary Conferences**: Financial coordinators review weekly multidisciplinary conference schedule, attend conference if patient indicates financial concerns
- **Infusion Schedule Review**: Financial coordinators review schedule three days in advance to identify and reach out to high-risk patients, including:
  - Self-pay
  - Medicaid
  - Medicare only
- **Distress Screening**: Patients screened at every visit, referred to financial coordinator if they indicate financial concern

Program Successes Across 2013

- **$1.3M**: Amount secured from drug replacement programs
- **$4.3M**: Amount of free or reduced self-administered medications secured via pharmaceutical assistance programs

Case in Brief: Lehigh Valley Health Network

- Health network based in Allentown, Pennsylvania; includes three hospitals, community health centers, a health plan, primary care and specialty physicians
- Created robust financial assistance program with goal of improving patient access to care while protecting cancer program’s revenues
- Financial coordinators recover significant assistance for patients through drug replacement, pharmaceutical assistance, internal and community programs


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1) Lehigh Valley Health Network.
Even with multiple access points, there are still times when patients with financial concerns do not receive help. The most common scenario is that patients simply do not know what their care will cost and therefore cannot predict that they will struggle to pay their medical bills. Consequently, they do not ask for help.

Other reasons that patients may not ask for financial help include embarrassment about financial problems, a lack of awareness that the cancer program can help, and fear that an inability to pay will lead to a delay in treatment.

All Cancer Patients Stand to Benefit from Financial Navigation

<table>
<thead>
<tr>
<th>Patient Barriers to Using Financial Resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>$ Unaware of their financial need</td>
</tr>
<tr>
<td>! Embarrassed to ask for help</td>
</tr>
<tr>
<td>? Unaware that cancer program has resources to help</td>
</tr>
<tr>
<td>☢ Scared that treatment will be interrupted or withheld</td>
</tr>
</tbody>
</table>

More Important Than Ever Before

“We realize that, in this day and age, every cancer patient is going to need a meeting with a financial counselor.”

Oncology Service Line Director, Hospital in the Midwest

Source: Oncology Roundtable interviews and analysis.
To make sure that all patients are exposed to financial counseling, Avera McKennan employs patient financial advocates that meet with every newly diagnosed patient. At the initial visit, patients meet with their oncologist, a patient financial advocate, and, if needed, an oncology social worker.

During their meeting, patient financial advocates provide an overview of the cancer program’s financial assistance resources and review the patient’s insurance benefits. Although a significant investment, the cancer program’s leadership believes it is worthwhile as patients are more likely to ask for help once they have established a relationship with their financial advocate.

### Case in Brief: Avera McKennan Hospital and University Health Center

- Network consisting of a hospital, primary care clinics, specialty care clinics, and long-term care facilities based in Sioux Falls, South Dakota, and the surrounding region
- Cancer program developed new patient meetings in which patients meet with their oncologist, patient financial advocate, and, if needed, social worker
- Patient financial advocate develops personal relationships with all patients, helps patients understand their financial responsibility, and encourages use available financial resources

Source: Avera McKennan Hospital and University Health Center, Sioux Falls, SD; Oncology Roundtable, Addressing Patients’ Financial Obligations, Washington, DC: The Advisory Board Company, 2009; Oncology Roundtable interviews and analysis.
While most cancer programs understandably focus the most intense financial counseling and education at the very beginning of treatment, there are a number of events that can jeopardize patients’ finances during and after treatment.

For instance, most cancer patients stop working either permanently or temporarily once their cancer treatment begins. Even following active treatment, cancer survivors are significantly more likely to be unemployed than people without cancer. As a result, patients’ income and insurance benefits may change significantly over the course of their care.

To ensure that patients’ financial concerns are met across the entire care continuum, cancer programs should have processes in place that anticipate patients’ needs and connect them with support.

Financial Pain Points Along the Patient Pathway

- **Diagnosis**: Patient meets with financial counselor
- **Treatment**: Unable to work, Treatment change, Insurance benefits change
- **Survivorship**: Insurance coverage lost, Receipt of first bill, Caregiver income change

Impacting Patients’ Ability to Earn a Living

- **40%-85%**: Percentage of cancer patients who stop working during initial treatment
- **1.37x**: Times more likely cancer survivors are to be unemployed compared to people without cancer

Oncology Hematology Care, an independent oncology practice, has implemented alerts into their EMR so that financial navigators can easily identify patients with financial need. Every day, the financial navigators generate a list of patients who have a balance of more than $750 or who have missed a scheduled payment. The financial navigators proactively contact each patient, asking them if they have any financial concerns. If needed, financial counselors use this as an opportunity to schedule an in-person meeting where they can review the patient’s insurance benefits and identify opportunities for financial assistance.

For Outreach Triggers:

**Identifying At-Risk Patients**
- Financial navigators use EMR to generate list of patients who may have financial concerns
- Patients considered at-risk for financial concerns include:
  - Balance over $750
  - Missed scheduled payment

**Patient Outreach**
- Financial navigators call each patient to touch base, ask if patient is experiencing any financial hardship
- If patient indicates concern, financial navigator works with patient to identify external assistance to help with living or treatment costs

**Case in Brief: Oncology Hematology Care**
- 50-physician oncology and hematology practice located in Cincinnati, Ohio
- To make sure cancer patients receive financial assistance across entire course of care, implemented triggers to prompt financial navigators to assess patient’s financial health
- Financial navigators run regular reports through the EMR to identify patients with balances over $750 and who have missed a scheduled payment; financial navigators then reach out to each patient to offer their assistance, if needed
In addition to high patient balances or missed payments, there are a number of other predictable points along the care continuum where patients are likely to experience financial distress. It is in the best interest of the patient as well as the cancer program to identify and triage those needs as quickly as possible.

To help cancer programs identify those crisis points, the Oncology Roundtable has developed a financial checkpoint worksheet that will assist programs by providing examples of major crisis points and how to hardwire follow-up.

### Sample Financial Checkpoint Worksheet

<table>
<thead>
<tr>
<th>Checkpoint</th>
<th>Point Person</th>
<th>Patient Identification</th>
<th>Action Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Post-Diagnosis</td>
<td>Financial counselor</td>
<td>Run EMR report for all new patients scheduled at beginning of each week</td>
<td>• Call patient before first appointment to introduce him/herself</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Schedule in-person appointment with patient</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Obtain or verify insurance information</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Notify patient of copay amount required at first and subsequent appointments</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Provide introductory education on cancer costs, such as Managing the Cost of Cancer</td>
</tr>
<tr>
<td>Beginning of Treatment</td>
<td>Financial counselor</td>
<td>From above checkpoint, financial counselor should meet with all new patients during first week of treatment</td>
<td>• Provide basic education on insurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Explain basics of patient insurance benefits</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Estimate patient cost responsibility</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Develop payment plan based on estimated cost</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• If necessary, connect patient to available financial resources</td>
</tr>
<tr>
<td>During Treatment</td>
<td>Social worker</td>
<td>Perform distress screening, refer patients to financial counselor if they indicate financial concern</td>
<td>• Assess cause and severity of patient need</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Provide necessary education to patient</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• If necessary, connect patient to available resources</td>
</tr>
<tr>
<td>Change in Treatment</td>
<td>Financial counselor</td>
<td>Run weekly EMR report of patients with change in treatment plan</td>
<td>• Provide revised patient cost estimate</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Call or schedule an appointment with patient to explain revised cost estimate</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Develop new payment plan based on estimated cost</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• If necessary, connect patient to available resources</td>
</tr>
<tr>
<td>End of Treatment</td>
<td>Financial counselor</td>
<td>Run EMR report based on estimated treatment end date, check with clinical team that patient ending treatment</td>
<td>• Call or schedule patient appointment</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Confirm insurance is paying as originally quoted</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Review remaining patient obligation and update payment plan, if necessary</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Confirm demographic and contact information</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Ensure patient knows whom to contact if questions arise</td>
</tr>
</tbody>
</table>

The complete financial checkpoint worksheet is available in the Appendix and online at: advisory.com/or/financialnavigation

Source: Oncology Roundtable interviews and analysis.
Alternatively, cancer programs may want to standardize follow-up for all patients at a specified point in time. 21st Century Oncology has identified the completion of active treatment as a critical point at which patients are likely to experience financial distress. As a result, their financial counselors have standardized in-person end-of-treatment meetings with all patients. During this meeting, the financial counselors review insurance- and cost-related information with patients, including a breakdown of the patient’s balance, confirming the details of the payment plan, and verifying the patient’s contact information. The goals of this meeting are to increase the likelihood that the cancer center will collect patients’ responsibility as well as to make sure patients with financial concerns are identified and given appropriate support.

21st Century Oncology’s financial counselors share responsibility for patient collections. Notably, other cancer programs deliberately assign collections to registration and billing staff so that financial counselors can focus exclusively on supporting patients.

**Case in Brief: 21st Century Oncology**
- Physician-led specialty provider operating 166 freestanding cancer treatment centers; headquartered in Fort Myers, Florida
- To improve patient transition following active treatment, standardized end-of-treatment meetings
- During meetings, financial counselors make sure patients understand their financial responsibility and know whom to contact when questions or concerns arise

**21st Century Oncology Standardizes End-of-Treatment Financial Meeting**

<table>
<thead>
<tr>
<th>Scheduling the End-of-Treatment Meeting</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Financial counselors receive biweekly reports listing patients finishing treatment that week</td>
</tr>
<tr>
<td>• Confirm with clinical team that patient is completing treatment</td>
</tr>
<tr>
<td>• Contact patient to schedule meeting</td>
</tr>
<tr>
<td>• Capture all relevant meeting details within patient record</td>
</tr>
</tbody>
</table>

**Components of the End-of-Treatment Meeting**
- Check patient balance
- Check charges to make sure insurance company is paying as quoted
- Confirm in-network provider status and patient cost-sharing rate
- Collect any outstanding balance
- Confirm payment plan details
- Verify patient demographics and contact information
- Introduce patient to customer service representative, who serves as main point of contact for financial questions after active treatment

**Percentage of 21st Century Oncology cancer patients who complete an end-of-treatment meeting**

95%
Many programs are unable to provide financial navigation to most of their cancer patients because of limited resources. According to data from the 2014 Oncology Roundtable Patient Financial Navigation Survey, approximately one-third of cancer programs do not have a financial counselor dedicated to working with cancer patients. Rather, financial counseling at these organizations is typically performed by navigators, social workers, and/or hospital financial counselors—all of whom have multiple responsibilities and cannot necessarily prioritize cancer patients’ financial needs.

Even programs with cancer-dedicated financial counselors struggle to meet all of their patients’ needs. Most cancer programs have only one or two financial counselors on staff. Because financial counseling is integral to continued financial stability, nearly all cancer programs would benefit from developing or expanding their financial navigation resources. However, it can be difficult to justify the investment in new or additional staff. To help these efforts, the Oncology Roundtable has identified three effective approaches.
The first approach to making the business case for oncology-dedicated financial navigation staff is to conduct a pilot. Pilots are instrumental in that they provide data on the potential benefits of hiring additional financial navigation staff.

At Memorial Healthcare System, administrators implemented a two-month pilot during which a social worker was dedicated part-time to assisting patients with drug replacement applications. Across the 60-day period, she secured approximately $40,000 in drug replacement.

The pilot’s results convinced oncology and hospital leadership that hiring a full-time pharmacy tech dedicated to drug replacement would allow them to increase revenue and provide a valuable service to patients.

### Case in Brief: Memorial Healthcare System

- Two-hospital health system located in Chattanooga, Tennessee
- Recognizing potential for increased revenue and improved patient service, piloted drug replacement position in July of 2007
- In the following two months, social worker recovered $40,000, helping the cancer program create a dedicated position and hire a full-time pharmacy technician to fill the role
Cancer program leaders can also strengthen their case by using retrospective financial analyses. The cancer director at Beneke Medical Center sought to demonstrate the need for additional staff by analyzing past billing records. She found that across a two-month period, the cancer center lost over $500,000 in reimbursement due to off-label drug use and a failure to secure preauthorizations. They also lost another $1 million due to unreimbursed care.

In response, the cancer director developed a business plan to add two FTEs. The first position was for a drug reimbursement specialist who would manage preauthorizations and secure reimbursement for off-label drug use. The second position was for a financial resource coordinator who would help patients sign up for coverage and secure external assistance.

Using these financial analyses, the cancer director successfully secured funding for both positions. To help program leaders develop similar business plans, the Oncology Roundtable has two sample business plans available for members to use as templates on advisory.com.

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**Beneke Collects Financial Data to Successfully Secure FTEs**

<table>
<thead>
<tr>
<th>FTEs Needed</th>
<th>The Business Case</th>
</tr>
</thead>
</table>
| **1** Drug Reimbursement Specialist | - Cancer leader collected two months’ worth of data to determine how much money was lost due to failure to secure preauthorizations and off-label drug use  
- AmOUNTED to over $500,000 during two-month period |
| **2** Financial Counselor       | - Cancer leader collected data from one month to determine how much money was lost from self-pay patients unable to pay for their treatment  
- AmOUNTED to over $1.1M during one month |

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**Talking the Talk…Walking the Walk**

“I told my executives that if they hired these positions and they didn’t recover their salary within six months, I would pay for these positions out of my own salary…They made their salaries back within one month.”

_Cancer Service Line Executive Director_

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**Case in Brief: Beneke Medical Center**

- Teaching hospital located in the Midwest
- To make the business case to hospital leaders to hire financial staff, oncology service line director collected data on money lost due to failure to secure preauthorizations and off-label drug use, as well as amount of uncompensated care provided to self-pay patients
- Cancer center secured two positions: (1) reimbursement specialist manages preauthorizations and documentation; (2) financial resource coordinator helps patients secure coverage and financial assistance from foundations, pharmaceutical assistance programs and drug replacement programs

---

1) Pseudonym.
In addition to financial data, most cancer programs have access to patient-reported outcomes that can also be used to demonstrate the need for cancer-dedicated financial counselors.

After implementing distress screening, Baptist Health Lexington started tracking the frequency and types of patient-reported concerns. They also recorded the number of patients who were referred to various hospital resources, including hospital-based financial counselors.

Their data revealed that a significant number of cancer patients were experiencing financial distress and were subsequently referred to the hospital’s financial counselors.

In response, the cancer director presented the distress screening data to her hospital executives to demonstrate the need for oncology-specific financial counseling resources. As a result, a hospital financial counselor was reassigned to work exclusively with cancer patients.

Justification for a Cancer Financial Counselor at Baptist Health Lexington

- Nurses screen patients regularly for distress at medical and radiation oncology visits
- Depending on patient need, nurses refer patients to hospital and cancer program resources
- Cancer program tracks number of patients being referred to social work, financial counseling, palliative care, and mental health specialists
- Cancer director realizes high number of patients report financial distress, referred to hospital financial counselor
- Cancer director lobbies executives for oncology-dedicated financial counselor
- Using data on number of patients referred to hospital financial counselor, hospital FTE transferred to cancer program

Case in Brief: Baptist Health Lexington

- 383-bed hospital in Lexington, Kentucky
- Set goal of achieving compliance with NCCN guidelines for distress management, launched three-month screening pilot in radiation oncology and medical oncology
- After reviewing patient data, cancer program director saw a high number of referrals to hospital financial services
- Cancer program director developed business case for cancer-dedicated financial counselor using the number of cancer patient referrals to hospital financial counselor as justification
- Ultimately secured approval to reassign hospital financial counselor to cancer center

Source: Baptist Health Lexington, Lexington, KY; Oncology Roundtable, Delivering on the Promise of Patient-Centered Care, Washington, DC: The Advisory Board Company, 2010; Oncology Roundtable interviews and analysis.
**Key Takeaways**

1. **Establish multiple mechanisms for connecting patients to financial assistance**
   
   Due to the high cost and financial complexity of cancer treatment, cancer programs should strive to increase patient access to and use of financial counseling services. There are three ways to improve patient capture: developing targeted education, hardwiring multiple access points, and standardizing financial counseling meetings for all patients.

2. **Cancer patients likely to experience financial distress at predictable points along the care continuum**
   
   Many cancer programs focus on providing the most intense financial support to patients at the beginning of treatment. However, there are a number of predictable points throughout the course of care when patients’ financial needs may change, such as when they receive their first bill or undergo a change in treatment. Best-in-class programs implement standardized triggers along the care continuum to make sure resources are available to patients during these crisis points so that they continue to receive necessary care without incurring unmanageable bills.

3. **Financial navigation presents significant opportunity to protect revenue and preserve patient access to care**
   
   To make the case for oncology-dedicated financial navigation, cancer leaders should support their argument using financial and/or patient-reported outcomes data obtained through data analyses or pilot programs. Importantly, cancer programs need to collect only a small sample of uncompensated care or track the number of patients with financial distress over a short period of time to demonstrate the need for financial navigation resources to hospital leaders.

Source: Oncology Roundtable interviews and analysis.
Chapter 2

Educate Patients About Their Financial Responsibility

Tactic #3: Conduct Comprehensive Benefits Review
Tactic #4: Provide Patients with Out-of-Pocket Cost Estimates
Tactic #5: Script Compassionate Conversations
As mentioned previously, the typical cancer patient incurs about $16,000 in direct and indirect costs over the course of a year due to their disease. Patients are rarely prepared for the financial impact of a cancer diagnosis so it is critical for programs to educate patients about their health benefits and financial responsibility.

Although these conversations are difficult, they are increasingly necessary. Without prior knowledge of what they will owe, patients are often shocked and overwhelmed when they start receiving bills. This lack of preparedness often leads to negative consequences, such as failing to adhere to treatment or spending less on food and clothing. Cancer patients are also significantly more likely to declare bankruptcy than individuals who have never had cancer.

By providing comprehensive financial education, programs can help to ensure that patients receive the care they need without sacrificing their financial well-being.

### Typical Cancer Patient Health Care Cost Responsibilities

- Deductible
- Copay
- Coinsurance
- Medication
- Premium
- Down Payment
- Transportation
- Lodging

### Potential Consequences When Cancer Patients Are Unprepared for Health Care Costs

- Fail to adhere to treatment
- Borrow money or use credit
- Use all or most of savings
- Sell possessions or property
- Work more hours
- Reduce spending on food and clothing
- Fail to pay medical bills
- File for bankruptcy

>60% Percentage of Americans filing for bankruptcy who claim medical debt as cause of bankruptcy

The first challenge when providing education to patients about the cost of their care is that the majority of Americans do not understand the basics of health insurance. In 2013, the American Institute of CPAs conducted a phone survey of over 1,000 adults. Respondents were asked to match the terms “premium,” “copay,” and “deductible” to their corresponding definitions. Over 50% of the participants could not correctly identify even one of these terms.

Startling Percentage of Americans Lack Basic Insurance Knowledge

<table>
<thead>
<tr>
<th>Percentage of Americans Unable to Correctly Define Basic Insurance Terms</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Premium</strong></td>
</tr>
<tr>
<td><strong>Copay</strong></td>
</tr>
</tbody>
</table>

Study in Brief: American Institute of CPAs

- Phone survey of 1,008 US adults aged 18 and older
- Participants asked to match three common insurance terms—premium, deductible, and copay—to the correct definition
- 51% of participants could not accurately identify at least one of the three terms

Therefore, a critical first step is ensuring that cancer patients understand the basics of health insurance as well as their own insurance benefits.

To that end, 21st Century Oncology’s financial counselors have one-on-one meetings with all patients at the beginning of treatment.

Financial counselors prepare for the meeting by researching the patient’s insurance benefits. During the meeting, they review the specifics of the patient’s coverage and explain relevant insurance terms.

### Tactic #3: Conduct Comprehensive Benefits Review

#### Providing Health Care 101

21st Century Oncology Explains Insurance Basics, Individual Benefits

<table>
<thead>
<tr>
<th>Financial Counseling Meeting</th>
<th>Benefits Review</th>
<th>Benefits Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial counselor schedules in-person meeting with every patient during first week of treatment</td>
<td>Financial counselor reviews each patient’s insurance benefits prior to meeting</td>
<td>• Financial counselor uses template to guide discussion during meeting • Explains basic insurance terms and individual coverage details</td>
</tr>
</tbody>
</table>

#### Case in Brief: 21st Century Oncology

- Physician-led specialty provider operating 166 freestanding cancer treatment centers; headquartered in Fort Myers, Florida
- Standardized meeting at beginning of treatment provides patients with basic insurance education and explanation of benefits
- Meeting serves as an educational resource to patients; no patients turned away from treatment due to financial reasons

Source: 21st Century Oncology, Fort Myers, FL; Oncology Roundtable interviews and analysis.
Patient-Friendly Insurance Information

To guide these conversations, 21st Century Oncology developed an educational form for patients, “Understanding Your Health Benefits.” The form is a simple but effective tool to improve patient comprehension. Financial counselors complete the form by filling in relevant plan details, including the patient’s deductible and copayment amount, and review the definitions provided on the handout with each patient.

At the end of the form, patients are asked to sign their name, indicating that they received and understood the information. Financial counselors also provide their contact information in case patients have additional questions.

Financial counselors fill in plan details, including the patient’s deductible, coinsurance, copay, OOP maximum, and the form includes definitions for basic insurance terms, including deductible, coinsurance, copay, and OOP maximum. The form also includes:

- Estimated patient financial responsibility
- Financial counselor contact information
- Line for patient signature

The complete form is available in the Appendix and online at: advisory.com/or/financialnavigation

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Source: 21st Century Oncology, Fort Myers, FL; Oncology Roundtable interviews and analysis.
The Push for Price Transparency

While helping patients understand the details of their insurance plan is a great starting point, cancer programs should strive to provide patients with an estimate of their total out-of-pocket costs.

The American public’s interest in their health care costs has grown with the rollout of health care reform and media coverage of health care spending. In fact, a recent survey demonstrated that the majority of Americans want to know their out-of-pocket costs before treatment and that they are inclined to choose providers who can produce that information.

Importantly, cancer patients are also interested in knowing their expected costs. Over two-thirds of cancer patients surveyed indicate that they want to know their out-of-pockets cost before treatment. Moreover, cancer patients need to have this information so that they can prepare for their financial responsibility or work with the cancer program to develop a payment plan, apply for external assistance, or apply for charity care.

Patients Want to Know Costs, Need to Know Costs

Growing Interest in Health Care Costs

84%
Percentage of Americans reporting that out-of-pocket cost estimates before treatment would have a positive impact on their decision to use a provider

68%
Percentage of cancer patients reporting that they wanted to know their total out-of-pocket costs before being treated

A Patient Caught Unaware

“Some of the most angry patients were not patients without the ability to pay but [those who] didn’t understand the enormity of the responsibility they would have. One patient bought a new car, for example. They said to me, ‘We never would have bought the car if we had known that our 20% would be $20,000.’”

Director of Oncology Services, Cancer Center in the Northwest

Tactic #4: Provide Patients with Out-of-Pocket Cost Estimates

Easier Said Than Done

Estimating cancer patients’ out-of-pocket expenses is difficult. Cancer treatment is complex, patients’ health benefits vary widely, and cost information may be hard to locate within billing systems. Also, because patients’ treatment plans are subject to change, many programs are hesitant to provide patients with a cost estimate which may change over time.

Yet the benefits of providing patients with an estimate of their costs far outweigh the risks. By providing out-of-pocket estimates, cancer programs can work with patients to determine whether they can manage their expenses before they are overwhelmed with medical bills. If they are unable to cover their costs, the cancer program can work with them early on to develop a plan, which may include applying for external patient assistance programs or generating a feasible payment plan.

Cancer Cost Estimates Particularly Challenging but Not Impossible

<table>
<thead>
<tr>
<th>Challenges to Developing Cancer Out-of-Pocket Cost Estimates</th>
<th>Three Methods to Develop Cancer Out-of-Pocket Cost Estimates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complexity of treatment</td>
<td>2. Homegrown Out-of-Pocket Estimate Tool</td>
</tr>
<tr>
<td>Lack of clear cost information</td>
<td>3. Automated Out-of-Pocket Estimate Tool</td>
</tr>
<tr>
<td>Inability to predict payer actions</td>
<td></td>
</tr>
<tr>
<td>Frequency of treatment change</td>
<td></td>
</tr>
</tbody>
</table>

Source: Oncology Roundtable interviews and analysis.
To assist patients in understanding their financial responsibility, the financial counselors at ProHealth create manual out-of-pocket estimates for select patients.

To generate the estimate, they review the patient’s orders for treatment and gather detailed benefit information from the insurer. The financial counselor uses this benefit information along with information from the pharmacy, which provides charge information for each drug in the patient’s regimen.

The financial counselors are then able to create a rough estimate that helps patients anticipate what their total out-of-pocket expense will be.

Because creating manual estimates is often time intensive, financial counselors provide cost estimates to uninsured patients, patients receiving off-label treatments, and patients who request a cost estimate.

**Case in Brief: ProHealth**

- Two-hospital health system located in Waukesha, Wisconsin
- Financial counselor creates estimate of financial responsibility if patient is uninsured, receiving an off-label treatment, or upon patient request

**Creation of Patient Cost Estimates**

- Financial counselor obtains patient’s treatment orders
- Pharmacy contact provides information regarding drug costs
- Financial counselor researches patient’s benefits
- Financial counselor uses cost, dosage, and frequency to estimate cost of care

**ProHealth Compiles Data from Chargemaster and Treatment Plan**

To reduce the time spent on developing out-of-pocket estimates for patients, 21st Century Oncology developed a homegrown spreadsheet that financial counselors use to provide all patients with a rough estimate of their costs.

One financial counselor was given responsibility for developing this tool. Over the course of two weeks, she researched the average costs of the most common cancer treatments provided by 21st Century Oncology physicians for Medicare and commercial payers and input the data into an Excel spreadsheet. For each treatment, the tool then breaks out the patient responsibility based on their level of cost sharing.

The tool requires regular updates as reimbursement changes, but it enables financial counselors to quickly produce rough estimates for all patients.

### Case in Brief: 21st Century Oncology

- Physician-led specialty provider operating 166 freestanding cancer treatment centers; headquartered in Fort Myers, Florida
- To provide patients with out-of-pocket estimates, financial counselor developed a resource sheet for common RT treatments
- Cost estimate sheet includes average cost for common radiation therapy treatments with dosage and intensity variations for Medicare and commercial payers, as well as estimated patient responsibility based on level of patient cost sharing

### Development of Cost Estimate Tool

- Financial counselor spent two weeks developing cost estimate tool
- Focused on cost estimates for most common radiation therapy treatments
- Researched average cost for Medicare and commercial payers
- Tool provides patient responsibility depending on payer and level of cost sharing

### Patient Out-of-Pocket Estimate Tool

<table>
<thead>
<tr>
<th>Treatment Plan</th>
<th>Average Cost</th>
<th>Estimated Patient Responsibility</th>
<th>Average Cost</th>
<th>Estimated Patient Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>17 IMRT no boost</td>
<td>$20,000</td>
<td>$4,000</td>
<td>$26,000</td>
<td>$2,600</td>
</tr>
<tr>
<td>28 IMRT w/3D boost (33 tx total)</td>
<td>Estimate</td>
<td>Estimate</td>
<td>Estimate</td>
<td>Estimate</td>
</tr>
<tr>
<td>28 IMRT w/ IMRT boost (33 tx total)</td>
<td>Estimate</td>
<td>Estimate</td>
<td>Estimate</td>
<td>Estimate</td>
</tr>
<tr>
<td>28 IMRT no boost</td>
<td>Estimate</td>
<td>Estimate</td>
<td>Estimate</td>
<td>Estimate</td>
</tr>
<tr>
<td>35 IMRT w/ boost (40 tx total)</td>
<td>Estimate</td>
<td>Estimate</td>
<td>Estimate</td>
<td>Estimate</td>
</tr>
</tbody>
</table>

1) The cost rates provided are not real values.
Method #3: Automated Out-of-Pocket Estimate Tool

Making It as Painless as Possible

Programs with high volumes of patients or wide variability in treatment plans may find that purchasing a vendor product is a more viable alternative. For instance, Gwinnett Cancer Center uses Ion Solutions’ Protocol Analyzer to rapidly estimate each cancer patient’s financial obligation. Cancer program staff update their fee schedule information in the tool regularly. The tool then incorporates the fee schedule with patient benefits and treatment information, both of which are pulled automatically from the EMR, to produce patient cost estimates.

Gwinnett Hospital Employs Automated Platform for Real-Time Estimates

- Patient medical record number
- Patient benefits
- Treatment plan

Rates for all commercial and government payers updated quarterly

Case in Brief: Gwinnett Medical Center

- 553-bed, not-for-profit health care network based in Lawrenceville, Georgia
- Uses IonSolutions Protocol Analyzer to automate out-of-pocket cost estimates for patients
- Software pulls patient information, including treatment plan, from EMR as well as up-to-date fee schedule rates to produce cost estimates for all cancer patients

Source: Gwinnett Medical Center; Lawrenceville, GA; Oncology Roundtable interviews and analysis.
An Array of Possible Vendors…

There are a number of vendors that sell software to facilitate out-of-pocket estimates. Unfortunately, because of the complexity of cancer care and billing, few guarantee that their software works for oncology.

Nevertheless, cancer program leaders should be aware if their organization has a relationship with any of these vendors and, if so, explore the potential for expanding use of the tool into the cancer program.

…but Many Cannot Provide Out-of-Pocket Estimates for Oncology

Characteristics of High-Quality Vendor Solutions

- Combines data from provider’s chargemaster, payer contract terms, and patient’s insurance benefits
- Identifies patients who need financial counseling
- Can be integrated with other revenue cycle solutions from same vendor
- Typically increases collection rates for high-deductible patient balances after insurance
- Provides scripting and role-playing to help staff improve communication with patients

Finding What Works for You

Given the array of options, the Oncology Roundtable has produced an assessment of three methods for producing out-of-pocket cost estimates.

In sum, manual estimates are time-consuming to produce, but do not require any upfront investment of resources. In contrast, homegrown tools require an upfront investment of time and ongoing maintenance but can greatly simplify the process of generating estimates for patients. While an automated tool is certainly the easiest and quickest way to produce out-of-pocket estimates, it is relatively difficult to find software that produces estimates for cancer patients.

Cancer programs should select the method that works best for their program depending on the volume of patients seen, the variety and complexity of treatment offered, the number of financial staff available, and the potential to use a software application.

<table>
<thead>
<tr>
<th>Comparison of Methods to Develop Out-of-Pocket Estimates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time Required to Create Tool</td>
</tr>
<tr>
<td>Time to Produce Estimate</td>
</tr>
<tr>
<td>Staff Training Required to Produce Estimate</td>
</tr>
<tr>
<td>Automation</td>
</tr>
</tbody>
</table>

Source: Oncology Roundtable interviews and analysis.
A Message Gone Wrong

The next challenge is to effectively and sensitively communicate the out-of-pocket estimate to patients. Large medical bills can be a significant source of anxiety. In extreme cases, patients who are overwhelmed with the cost of their care may decide to seek care from another provider, delay care, or even forgo care altogether.

To avoid these problems, cancer programs should make sure that cost estimates are communicated to patients with the utmost sensitivity. During these conversations, financial counselors should always provide practical advice about payment planning, the potential for applying for charity care, and the availability of assistance programs.

Out-of-Pocket Estimates Have Potential to Create Patient Distress

Worst Case Scenario

- Patient receives out-of-pocket cost estimate
- Patient concerned about ability to pay
- Patient refuses treatment

A Seemingly Insurmountable Expense

“There was a patient who had just learned she’d have to pay $800 a month for her chemotherapy treatment. She told me that she had decided to opt out of treatment and had started writing her funeral plans.”

Financial Counselor, Health System in the Midwest

At Schrader Health System, financial counselors undergo rigorous training to help patients understand their out-of-pocket cost estimates and tactfully address patient concerns. They learn scripts for navigating 15 potential patient reactions and then practice each situation through role playing exercises.

In every case, the financial counselor begins the conversation by explaining that they have prepared the out-of-pocket estimate as a service to the patient. They then walk patients through what their insurance covers, what it does not cover, and how the estimate was calculated.

If a patient expresses concern about their ability to pay, the financial counselor explores other payment options, such as developing a payment plan or applying for assistance programs or charity care.

### Training Helps Financial Counselors Navigate Hard Conversations

**Scripted Conversations at Schrader**

1. Receive 15 scripting examples to help them discuss out-of-pocket costs with sensitivity and manage range of patient reactions
2. Gain confidence and expertise through ongoing training, such as role-playing exercises

### Case in Brief: Schrader Health System

- Health system located in the Midwest
- Engaged MedAssets to develop CarePricer® tool to estimate cost of care prior to treatment
- Financial counselors meet with all patients with a single insurance provider or an estimated cost of care greater than $500 to provide them with an out-of-pocket cost estimate

1) Pseudonym.
Scripting can be instrumental in helping staff overcome their hesitance to initiate financial conversations. To help cancer programs develop their own scripting templates, the Oncology Roundtable developed scripting examples for several situations, including out-of-pocket estimates. The template also contains important tips for managing patients interactions and conversations about costs of care.

### Out-of-Pocket Estimate Scripting

**General Tips for Patient Interactions**
- Introduce yourself and your role within the cancer program
- Be prepared with all of the necessary patient information
- Communicate clearly and provide complete information
- Have the conversation in a private area
- Be compassionate and armed with possible solutions
- Be willing to reschedule if patient is visibly distressed

**Introduction**
Hello, my name is ___________ and I work as a financial counselor here at ___________. Given that finances are a concern for many of our patients, we try to meet with all patients as a service to you and your family to discuss the cost of your care.

Your financial situation will not affect your ability to receive care here. We’re committed to making sure you receive the best care available.

Our conversation today is meant to review what your health plan covers and what it does not cover, as well as any expenses you should expect. I’m here to answer any of your questions now and at any point during your care.

**Out-of-Pocket Estimate**
Your physician has recommended the following treatment

For a typical patient receiving this treatment with your benefits, we’d expect your total out-of-pocket costs to be ___________.

Remember, this is only an estimate. It is likely to change and, if you have a change in treatment, it will certainly change. But, we think it is important to provide all of our cancer patients with this estimate so that you are prepared for treatment costs. Do you have any concerns?

---

The complete out-of-pocket estimate scripting is available in the Appendix and online at: [advisory.com/or/financialnavigation](advisory.com/or/financialnavigation)

Source: Oncology Roundtable interviews and analysis.
Key Takeaways

1. **Most patients are poorly informed about their health benefits and underestimate their out-of-pocket costs**

   A significant number of Americans lack basic knowledge of health insurance as well as of their own health benefits. Consequently, few patients are able to confidently navigate their coverage when they receive a complex diagnosis like cancer. Cancer programs should dedicate time to educating patients about insurance and their policies.

2. **Providing out-of-pocket estimates ensures patients are better prepared for medical bills**

   Many cancer programs are reluctant to provide cost estimates to patients for fear of overwhelming them or giving an estimate that will not hold true over the course of treatment. However, without having an idea of treatment cost, patients are unable to plan for their out-of-pocket expenses and often surprised by the size of their bills. When programs provide patients with cost estimates, patients can prepare and secure external assistance or charity care, if necessary.

3. **Lead every financial conversation with compassion**

   While patients benefit from knowing their estimated cost of care, this discussion must be handled with sensitivity. To prepare staff for these conversations, programs should invest in staff education, provide scripting, and organize interactive training sessions. Additionally, each conversation should emphasize that patients with concerns about their ability to pay will still receive needed care and that the cancer program will help them find financial assistance.

Source: Oncology Roundtable interviews and analysis.
Chapter 3

Optimize Patient Coverage

Tactic #6: Screen Patients for Coverage Eligibility
Tactic #7: Enhance Partnership with Medicaid Assistance Agency
Tactic #8: Coordinate Treatment Start with Clinical Team
Tactic #9: Hardwire Monthly Insurance Checks
Cancer Patients Historically Struggle with Coverage

In the past, many cancer patients have struggled to sign up for or retain coverage following their diagnosis.

A primary reason for this is the cost of health care coverage. In a recent survey conducted by the American Cancer Society, almost half of respondents with a family member under 65 who had cancer indicated that they struggled to pay premiums and copays. As a result, over one-third of cancer patients indicated that they had postponed recommended care.

By expanding access to affordable coverage and eliminating obstacles to coverage, such as lifetime spending limits and pre-existing condition clauses, the Affordable Care Act will make it easier for cancer patients to gain coverage and remain insured for the duration of their care. However, they also face more confusing and complex options.

Because most Americans lack even a basic understanding of insurance, most patients will need help selecting the insurance plan that best meets their needs. Cancer programs should be prepared to help uninsured and underinsured patients select the most appropriate coverage options.

Lack of Insurance Has Dire Consequences

Insurance Status for People Under Age 65 Diagnosed with Cancer, 2010

n=1,011

- 66% Insured Entire Time Since Diagnosis
- 17% Currently Uninsured
- 17% Have Been Uninsured at Some Point Since Diagnosis

A Barrier to Care

- 49% Percentage of families with someone under 65 with cancer who said they had difficulty affording health care costs, such as premiums and copays
- 34% Percentage of cancer patients under 65 who said they had postponed recommended health care due to cost

Navigating Patient Health Plan Options

The Oncology Roundtable has uncovered four tactics to help cancer programs navigate, evaluate, and optimize patient coverage. Programs should implement processes to ensure that all uninsured and underinsured patients are identified and screened for eligible coverage options as quickly as possible.

Next, many hospitals currently contract with external agencies that specialize in signing patients onto Medicaid plans; however, these agencies rarely have the clinical expertise needed to appropriately manage cancer patients. Therefore, cancer programs should focus on partnering with and providing education to agency representatives.

Once patients have obtained coverage, cancer programs need to maximize opportunities for reimbursement by checking when patients’ insurance becomes effective and, if necessary, coordinating treatment start with insurance coverage.

Lastly, to make sure the cancer program will be reimbursed for care provided and patients are aware of their insurance benefits, programs should hardwire regular insurance re-verification, particularly for patients on exchange and Medicaid plans.

<table>
<thead>
<tr>
<th>Four Tactics to Bolster Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tactic #6:</strong> Screen Patients for Coverage Eligibility</td>
</tr>
<tr>
<td><strong>Tactic #7:</strong> Enhance Partnership with External Medicaid Assistance Agency</td>
</tr>
<tr>
<td><strong>Tactic #8:</strong> Coordinate Treatment Start with Clinical Team</td>
</tr>
<tr>
<td><strong>Tactic #9:</strong> Hardwire Monthly Insurance Checks</td>
</tr>
</tbody>
</table>

Source: Oncology Roundtable interviews and analysis.
The first step to optimize patients’ coverage is identifying patients who may benefit from new or improved insurance coverage. Identifying the underinsured is much more challenging than finding uninsured patients, and basic insurance verification will often fail to identify this population. However, best practice programs have trained registration staff to identify patients with gaps in coverage. Specifically, staff look for insurance “red flags,” such as patients with Medicare but no supplemental coverage or patients without an out-of-pocket maximum. The staff can then follow up with patients who face potentially significant out-of-pocket expenses and ensure they receive financial counseling.

To help program leaders implement this approach, the Oncology Roundtable has developed an insurance verification worksheet that staff can use to capture essential patient information and identify patients with potential gaps in coverage.

Evaluate Patient Benefits, Identify Gaps in Coverage

**Insurance Verification Worksheet**

<table>
<thead>
<tr>
<th>Patient Information</th>
<th>Verification Date</th>
<th>Verification Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Name</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient DOB</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient SSN</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient Phone Number</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient Address</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient MIB</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date of First Scheduled Appointment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insured Name (if different):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insured SSN (if different):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insured Address (if different):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff Information</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff Name</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Verification Method</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Primary Insurance Provider**

- **Insurance Provider**
- **Policy Number**
- **Effective Date of Coverage**
- **Termination Date of Coverage**

- **Annual Deductible:** __________
- **Deductible Met:** __________
- **Coinsurance:** __________

- **Copayment:** __________
- **Copayment Frequency:** __________
- **Does Copayment Change After First Visit?**
  - Yes
  - No

- **Out-of-Pocket Maximum:** __________
- **Out-of-Pocket Met:** __________
- **Out-of-Pocket Includes:**
  - Copayment
  - Deductible
  - Medication

**Structure of Payment Post Deductible**

- **Out-of-Network Benefits?**
  - Yes
  - No
- **Deductible:** __________
- **Copayment:** __________
- **Percent Reimbursed:** __________

**Reimbursements and Pre-Certification Needed:**

- **Specialist Visit:**
  - Yes
  - No
- **Outpatient Medical Testing (e.g., x-rays, MRI, CT scans):**
  - Yes
  - No
- **Chemotherapy:**
  - Yes
  - No
- **Radiation Therapy:**
  - Yes
  - No

The complete insurance verification worksheet is available in the Appendix and online at: advisory.com/or/financialnavigation

Source: Oncology Roundtable interviews and analysis.
When uninsured and underinsured patients are identified, best-in-class programs have trained staff to immediately evaluate each patient’s eligibility for new or supplemental coverage.

Starting with some basic personal and financial information, staff determine which health coverage options the patient may be eligible for. While this research may often be time consuming, programs can decrease the workload for staff by training them and providing them with easy-to-use guides that allow them to quickly assess patient eligibility for a variety of insurance plans.

The complete insurance eligibility reference guide is available in the Appendix and online at: advisory.com/or/financialnavigation

1) Consolidated Omnibus Budget Reconciliation Act.  
2) Family and Medical Leave Act.
One of the newest opportunities for patients to gain coverage is through the health exchanges. Unfortunately, because every market’s plans and every patient’s situation are unique, there is no “one-size-fits-all” approach to finding the right plan for each patient.

Instead, cancer programs should consider three categories of questions to help identify the most appropriate plan for any one individual. The first category is patient financial information. In particular, programs should determine patient eligibility for premium or out-of-pocket subsidies. And patients who signed onto silver-tier exchange plans and earn less than 250% of the federal poverty level were eligible for out-of-pocket subsidies.

Next, programs should evaluate the plan’s cost structure, including the amount patients will have to pay out of pocket in copayments and coinsurance. Finally, cancer programs should determine whether their program is included as a plan’s in-network provider or determine out-of-network benefits.

---

**Sample Questions to Evaluate Exchange Options**

**Patient Information**
- How many people are in the patient’s household?
- What is the patient’s total household income?
- Does the patient qualify for premium subsidies?
- Does the patient qualify for subsidies to help with out-of-pocket expenses?

**Plan Information**
- What is the monthly premium?
- What is the deductible?
- How much are copays for specialist visits and prescription drugs?
- How much is the coinsurance?
- What is the out-of-pocket maximum?

**Care Information**
- Is the hospital in network?
- Is the medical oncologist in network?
- Does the patient require a referral for specialty care?
- What drugs are covered?

Source: Oncology Roundtable interviews and analysis.
Although evaluating exchange plans is time consuming, exchange plans offer several benefits over other health plans available on the individual market. For example, the exchange plans must cover 10 categories of essential health benefits, such as prescription drugs and preventive and wellness services. In contrast, the average health plan on the individual market today covers only three-quarters of these benefits.

The financial navigator at Mercy Health St. Mary’s Hospital recognized the advantages of these plans and started making a list of patients who would benefit from an exchange plan months before the exchanges launched in October 2013. This list of patients included both uninsured patients and underinsured patients, including patients with Medicaid spend-down policies who often have extremely high out-of-pocket costs.

During the initial open enrollment period, the financial navigator helped almost 50 patients, about one-third of whom were previously uninsured, enroll onto exchange or Medicaid plans.

**Exchange Plans May Provide Superior Coverage**

**Identification of All Eligible Cancer Patients**

- Financial navigator maintains running list of patients who may benefit from coverage expansion
- Determines patient eligibility for Medicaid expansion or exchange plans
- During open enrollment, evaluates each patient’s exchange options

<table>
<thead>
<tr>
<th>Eligible Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Uninsured patients</td>
</tr>
<tr>
<td>2. Underinsured patients with high out-of-pocket costs, such as Medicaid spend-down policies</td>
</tr>
</tbody>
</table>

Number of cancer patients signed onto Medicaid expansion and exchange plans by April 1, 2014

47

**Case in Brief: Mercy Health Saint Mary’s Hospital**

- 344-bed, not-for-profit hospital member of Trinity Health; located in Grand Rapids, Michigan
- Financial navigator at the Lacks Cancer Center compiled list of all patients who could benefit from an exchange or Medicaid expansion plan, including those with insurance plans with high out-of-pocket costs or plans that do not offer robust coverage of essential health benefits

Source: Mercy Health Saint Mary’s Hospital; Grand Rapids, MI. Oncology Roundtable interviews and analysis.

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1) Federal poverty level.
Whereas finding the right exchange plans for patients can be resource intensive, it is often more straightforward to determine patients’ eligibility for Medicaid. However, enrolling patients in Medicaid can be a labor-intensive and confusing process.

Therefore, many hospitals contract with external Medicaid eligibility assistance agencies that help patients navigate the process. In fact, almost 40% of Oncology Roundtable members indicated that their organization contracts with an external Medicaid eligibility assistance agency. These agencies take on the tremendous workload associated with completing Medicaid applications.

While these agencies provide expertise that increases hospitals’ rate of Medicaid acceptance, they also present a number of challenges, particularly for cancer programs. Agency representatives often work across the entire organization and therefore lack an understanding of cancer care and the impact of insurance coverage on cancer patients.

### Agencies Improve Acceptance Rate but Lack Cancer Expertise

**Services Provided by Medicaid Eligibility Assistance Agencies**

- Identify eligible patients
- Explain benefits to patients
- Compile needed paperwork
- Complete patient applications
- Follow up on denied applications

**Challenges Presented by Medicaid Eligibility Assistance Agencies**

- Lack of coordination and communication between agency representatives and cancer financial staff
- Agency representatives not familiar with cancer continuum of care
- Agency representatives lack clinical knowledge, potentially leading to missed opportunities for coverage

Source: Oncology Roundtable interviews and analysis.
To overcome this problem at Lehigh Valley Health Network, cancer program leadership successfully lobbied for one agency representative to work exclusively within the cancer center. Initially, the representative did not understand the specific needs of cancer patients. For example, the representative had been trained to apply for Medicaid only after patients had incurred extensive medical bills because this increases the rate of approval. However, this caused significant anxiety for the program’s patients, who worried that they would ultimately be responsible for these bills. As a result, some patients were refusing necessary tests and procedures.

The cancer program identified the misunderstanding and explained to the agency representative that cancer patients needed to enroll in coverage as early as possible. They also emphasized the importance of tracking cancer patients throughout the entirety of their care as their treatment or financial circumstances may change.

The agency representative now serves as an invaluable extension of the cancer program’s financial coordination team, securing Medicaid coverage for about 20 cancer patients each month.

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Timing Is Everything

Signing patients onto coverage is an opportunity for cancer programs to secure reimbursement for services that otherwise would be written off as charity care or bad debt. However, signing patients onto coverage is not always enough to secure reimbursement.

Depending on the insurance plan, coverage might not be immediately effective, and it might not cover services retroactively.

In these instances, patients will owe money for treatment they thought would be covered by their new insurance plan. Their inability to pay their medical bills will likely add to the organization’s bad debt, in addition to causing significant patient anxiety.

Failure to Coordinate Coverage with Treatment Start Adds to Bad Debt

Uninsured and Underinsured Patient Process

Patient secures insurance coverage

Insurance coverage not effective immediately, not retroactive

Patient inability to pay adds to institution’s bad debt

Patient starts treatment immediately

Patient owes thousands of dollars for treatment not covered

Source: Oncology Roundtable interviews and analysis.
To make sure the cancer program is capitalizing on every opportunity for reimbursement, the financial navigator at Mercy Health St. Mary’s Hospital makes sure to check the effective coverage date and the policy for retroactive coverage when he signs patients onto new insurance plans.

If the patient is scheduled to begin treatment earlier than the effective coverage date, the financial navigator will meet with the patient’s clinical team to determine if treatment can safely be delayed until coverage begins.

Many cancer programs report that open dialogue between their financial and clinical teams significantly improves the financial well-being of both cancer patients and the program.

Financial Team Works with Clinicians to Maximize Reimbursement

Uninsured and Underinsured Patient Process at Mercy Health St. Mary’s Hospital

Patient secures new or improved insurance coverage

Financial navigator checks if insurance coverage not effective immediately, not retroactive

Depending on coverage, financial navigator asks physicians if treatment can safely be delayed until new or improved coverage starts

If physicians feel treatment can safely be delayed, financial navigator coordinates treatment start with patient and clinical team

~$3.4M Benefit to hospital in 2013 derived from obtaining or improving insurance coverage for cancer patients

Case in Brief: Mercy Health Saint Mary’s Hospital

• 344-bed, not-for-profit hospital member of Trinity Health; located in Grand Rapids, Michigan

• When cancer financial navigators secure coverage for patients, they immediately check the effective coverage date against patient’s treatment plan

• If coverage does not start immediately and is not retroactive, financial counselor asks physicians about the possibility of safely delaying patient treatment until new or improved coverage is effective

Source: Mercy Health Saint Mary’s Hospital, Grand Rapids, MI; Oncology Roundtable interviews and analysis.
Preparing for the Churn

Once patient coverage is secured, the cancer program’s work is not yet complete. It is critical that cancer programs continually reverify patients’ insurance, especially those enrolled on exchange and Medicaid expansion plans. Patient eligibility for those plans will change with fluctuations in their income, which may happen frequently.

A recent *Health Affairs* article estimates that as many as 50% of adults earning less than 200% of federal poverty level will churn between eligibility for Medicaid and exchange plans over the course of one year, which has serious implications for the cancer program’s revenue cycle. Patient churning between insurance plans will make it more difficult to determine and collect patients’ financial responsibility.

In response, cancer programs should hardwire regular insurance verification for all patients so that they have an up-to-date understanding of potential reimbursement challenges and patient benefits.

### Regular Insurance Verification Critical Due to Coverage Expansion

**Percentage of Future Enrollees with Change in Eligibility Between Medicaid and Exchange**

$n=19,248$

Over 50% of adults earning less than 200% of FPL will experience one or more changes in eligibility within one year.

<table>
<thead>
<tr>
<th></th>
<th>6 Months</th>
<th>12 Months</th>
<th>24 Months</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Change</td>
<td>8.6%</td>
<td>26.9%</td>
<td>23.6%</td>
</tr>
<tr>
<td>2 or More Changes</td>
<td>38.4%</td>
<td>19.9%</td>
<td>26.6%</td>
</tr>
</tbody>
</table>


1. Among adults aged 19 to 60 with family incomes below 200% of the federal poverty level.
2. Federal poverty level.
To ensure every patient’s insurance is verified on a regular basis, Schwartz Cancer Center created a non-billable code for insurance verification that is entered into the patient record every time it is performed. Using this code, financial counselors can easily track when patients’ benefits need to be re-verified. The practice manager also uses this code to measure and report financial counselor performance on a regular basis.

**Schwartz¹ Uses Non-billable Code to Track Insurance Verification**

Regular Insurance Verification at Schwartz Cancer Center

- Financial counselors verify patient insurance every 30 days
- Non-billable code for insurance verification entered into patient medical record
- Practice manager uses code to track financial counselor performance
- Updated plan information and patient benefits entered into practice management system

**Case in Brief: Schwartz Cancer Center¹**

- Community cancer program located in the South
- To ensure financial staff verify every patient’s insurance every 30 days, practice manager created non-billable code to be entered every time insurance was verified
- Using code, practice manager able to track insurance verification frequency and ownership

¹ Pseudonym.

Source: Oncology Roundtable interviews and analysis.
# Key Takeaways

1. **Exhaust all opportunities for insurance coverage**
   
   There are more opportunities for patients to obtain insurance than ever before; however, the majority of Americans do not know how to evaluate the range of options or how to identify a plan that best meets their needs. Cancer programs should be prepared to help patients evaluate their options, help patients obtain coverage, and follow up with patients to ensure their needs have been met.

2. **Collaborate with clinical team to maximize cancer center’s reimbursement**
   
   Cancer programs need to pay particular attention to the details of patient coverage. If coverage is not effective immediately and not retroactive, financial staff should ask clinicians about the feasibility of delaying care. If treatment can safely be delayed until coverage is effective, the cancer program benefits by being reimbursed, and patients will not be held accountable for the total cost of their care.

3. **Reverify patient coverage at least every 30 days**
   
   Cancer programs should hardwire regular insurance verification for all patients. Regular benefits verification improves program awareness of patients’ financial responsibilities and protects revenue if patients’ coverage changes.

Source: Oncology Roundtable interviews and analysis.
Maximize External Assistance

Tactic #10: Screen for Assistance Program Eligibility Up Front
Tactic #11: Automate Patient Eligibility Screening
Tactic #12: Assign Billing Point Person for Copay Assistance
Tactic #13: Foster Best Practice Sharing Among Financial Navigation Staff
Securing robust insurance coverage is an important step in lessening the financial toxicity of cancer; however, even patients with relatively comprehensive health benefits may experience financial distress.

As discussed earlier, patients with cancer accumulate an additional $16,000 in direct and indirect medical costs each year. Due to these costs, a significant number of insured cancer patients indicate concerns about the cost of their care and end up reducing their spending on necessities, such as food and clothing.

According to the 2014 Oncology Roundtable Patient Financial Navigation Survey, cancer programs around the country are seeing increased requests for financial assistance. Over three-quarters of survey respondents indicated that the number of insured cancer patients requesting financial assistance over the past year has increased. In contrast, only 6% of survey respondents indicated that the number of patients requesting assistance has decreased.

Struggling to Make Ends Meet

30% Percentage of insured cancer patients indicating concern about the cost of care

53% Percentage of cancer patients requesting copay assistance who reduce spending on basics, like food and clothing

Cancer Programs Reporting Change in the Number of Insured Patients Requesting Financial Assistance for Treatment-Related Expenses Over the Past 12 Months

2014 Oncology Roundtable Patient Financial Navigation Survey
n=83

Increased Slightly 42%
Stayed the Same 17%
Decreased Slightly 4%
Decreased Significantly 2%
Increased Significantly 35%

Many External Sources of Support…

There are a number of pharmaceutical companies, national and local foundations, and individual donors that offer financial assistance to cancer patients. Some of these programs are extremely generous and cover the entire cost of chemotherapy drugs, while others may provide patients with free transportation and lodging. However, it is difficult for cancer patients and programs to navigate these programs. Each assistance program maintains its own unique requirements and application processes which makes identifying eligible assistance programs and completing applications time intensive.

Understandably, cancer programs often focus their limited resources on patients with the most acute financial need, namely the uninsured and underinsured. As a result, many patients who could benefit from financial assistance miss the opportunity.

…But Most Cancer Programs Not Tapping into All Resources

**Major Sources of Patient Assistance**

**Pharmaceutical Companies**
- Drug replacement programs
- Copay assistance cards

**National Foundations**
- Copay assistance
- Assistance for non-treatment-related expenses (e.g., transportation and lodging)

**Local Foundations**
- Copay assistance
- Assistance for non-treatment-related expenses (e.g., transportation and lodging)

**Barriers to Maximizing Patient Assistance**

1. Time-intensive research and application process
2. Lack of knowledge about available resources
3. Unable to identify all patients eligible for financial assistance

Source: Oncology Roundtable interviews and analysis.
To assist cancer program leaders in identifying a greater number of patients who could benefit from financial assistance, the Oncology Roundtable has identified four tactics.

First, cancer programs can frontload the screening process for matching patient eligibility to available assistance programs to ensure that a larger number of patients, not just those who request assistance, are screened. As this process still requires significant time, programs may opt to invest in an automated system that decreases the manpower associated with identifying and applying for financial assistance. Because these assistance programs, particularly those offered by pharmaceutical companies, may have complex billing requirements, it is necessary for the cancer program to work closely with representatives in the billing department to capture all reimbursement opportunities. Finally, cancer leaders should develop initiatives to ensure ongoing support and education opportunities for their financial navigation staff.

### Four Tactics to Maximize Use of External Assistance

| Tactic #10: | Tactic #11: |
| Screen for Assistance | Automate Patient Eligibility Screening |
| Program Eligibility Up Front |

| Tactic #12: | Tactic #13: |
| Assign Billing Point Person for Copay Assistance | Foster Best Practice Sharing Among Financial Navigation Staff |

Source: Oncology Roundtable interviews and analysis.
Financial navigators at Oncology Hematology Care made significant changes to how they screen patients for available financial assistance to ensure that they identify all patients who are eligible. Rather than identifying patients based on their income or insurance status, they search for patients who have been prescribed specific chemotherapy agents that have generous pharmaceutical and foundation assistance programs.

Every day, the financial navigators produce an EMR report identifying any new patients prescribed one of 19 chemotherapy agents. They proactively research each patient’s eligibility for the corresponding assistance program and, if the patient qualifies, contact the patient to initiate the application process.

Although their financial navigation program is still new, they were able to secure over $1 million in pharmaceutical and foundation assistance across 2013.
The biggest barrier to providing financial assistance to a larger number of cancer patients is simply the time it takes to research assistance programs. Understandably, this task often falls to the wayside when financial counselors also have responsibility for many more urgent priorities, such as securing preauthorizations and verifying patient insurance benefits.

Given that it takes 30 minutes on average to research patient eligibility, most financial counselors do not have the ability to screen every cancer patient.

### Lack of Financial Counselor Time Biggest Barrier to Maximizing Assistance

#### Typical Priorities of Financial Counselor

- Secure preauthorizations
- Verify insurance
- Meet with patients
- Research patient eligibility for coverage

- Sign patients up for coverage
- Research eligibility for assistance programs
- Apply to assistance programs
- Track patient assistance applications

### Doing the Math: How Long Would It Take to Research Assistance Program Eligibility for All Cancer Patients?

**10 weeks**

Total amount of time required to research patient eligibility

- Average analytic case volume is 800 cancer patients per year
- Average time it takes to research patient eligibility for assistance programs is 30 minutes
- Average work week is 40 hours

Source: Oncology Roundtable interviews and analysis.
Resources to Help Make the Job a Little Easier

To help decrease the time associated with finding available assistance programs, there are a number of resources available to cancer programs and patients. The NCCN, the Patient Advocate Foundation, and Needy Meds all maintain free online databases to help connect patients with available assistance programs.

Free Online Tools to Identify Available Assistance

**Reimbursement Resource**
- Online website, mobile application
- Interfaces tailored for patients, payers, and providers
- Search for pharmaceutical programs by cancer type, drug name, assistance program

**My Resource Search**
- Online website, mobile application
- Search for local and national nonprofit, pharmaceutical programs
- Narrow search to specific resources, e.g., screening services, insurance policy options, medication assistance

**NeedyMeds**
- Online website
- Search for national nonprofit, pharmaceutical programs
- Find available programs, eligibility requirements by drug name, diagnosis, assistance program

Automatically Screening All Patients

To further streamline the process, Randolph Hospital subscribes to an online program, IndiCare, that provides instant access to eligibility requirements for pharmaceutical assistance programs.

The cancer financial counselor meets with every new cancer patient after his/her treatment plan is finalized. She inputs the patient’s financial, demographic, and treatment information into the software program, which then automatically matches the patient to available assistance programs. The software then pre-populates the application form with the patient’s data.

Since implementing IndiCare, Randolph Hospital has secured about $100,000 per month in patient assistance while paying a relatively nominal fee for their monthly subscription.

Randolph Hospital Uses IndiCare Software to Match Patient Eligibility

<table>
<thead>
<tr>
<th>Patient Information</th>
<th>Automated Screening</th>
<th>Completed Application</th>
</tr>
</thead>
<tbody>
<tr>
<td>Household size</td>
<td>• Automatically scans patient eligibility for over 1,500 patient assistance and copay programs</td>
<td>• Facilitates completion of online application</td>
</tr>
<tr>
<td>Annual income</td>
<td>• Provides real-time updates and changes in eligibility criteria</td>
<td>• Database stores patient, physician, and drug information to track claims, and provides automatic refill prompts</td>
</tr>
<tr>
<td>Treatment</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

An Outsized Return on Investment

- 28 hours: Average amount of time saved using IndiCare per month
- $100,000: Approximate amount recovered using IndiCare per month
- $400: Approximate cost of IndiCare subscription per month

Case in Brief: Randolph Hospital

- 145-bed hospital located in Asheboro, North Carolina
- Cancer financial counselor meets with all patients once treatment plan finalized, uses IndiCare, a web-based software assistance program, to automatically identify available assistance
- IndiCare facilitates completion of patient application, financial counselor can submit online or print for patient signature if needed

1) Oncology Roundtable estimate based on the following assumptions: cancer program sees 67 new patients per month and time to screen patients for assistance using IndiCare is five minutes per patient.

Source: Randolph Hospital, Asheboro, NC; IndiCare, https://www.indicare.com; Oncology Roundtable interviews and analysis.
Utilizing External Support

In addition to IndiCare, there are a number of other web-based platforms that offer a centralized and streamlined system to automatically screen and initiate applications for assistance. Many of these programs also automatically save patient, physician, and drug information for future use.

Some vendors provide staff as well as software to help cancer programs and their patients access assistance programs.

For cancer programs that cannot dedicate staff time to helping patients identify and apply for assistance, it may be worthwhile to explore the benefits of one of these options.

Options for Vendor-Managed Assistance Programs

<table>
<thead>
<tr>
<th><strong>Web-Based Platform</strong></th>
<th><strong>Outsourcing Service</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Description</strong></td>
<td><strong>Description</strong></td>
</tr>
<tr>
<td>• Centralized database of all patient assistance and copay assistance programs provides automated eligibility screening, applications, data storage</td>
<td>• Outside company manages pharmaceutical assistance and copay assistance programs, providing necessary staff and technology</td>
</tr>
<tr>
<td><strong>Pricing Structure</strong></td>
<td><strong>Pricing Structure</strong></td>
</tr>
<tr>
<td>• Monthly subscription fee, may depend upon number of patients signed up</td>
<td>• Company collects percentage of savings achieved, no up-front financial risk</td>
</tr>
<tr>
<td><strong>Sample Vendors</strong></td>
<td><strong>Sample Vendors</strong></td>
</tr>
<tr>
<td>• IndiCare</td>
<td>• RecoveRx</td>
</tr>
<tr>
<td>• NeedyMeds PAPTracker Software</td>
<td>• Pharmatek Systems</td>
</tr>
<tr>
<td>• Drug Assistant</td>
<td>• McKesson MedSource</td>
</tr>
<tr>
<td></td>
<td>• NeedyMeds Patient Assistance Program Administration</td>
</tr>
</tbody>
</table>

Source: Oncology Roundtable interviews and analysis.
Relying on Back-Office Staff

When a cancer program connects patients to assistance programs, it is critical to coordinate with the billing department to establish protocols for how each program should be managed. Working closely with billing staff is particularly important for copay cards, which are one type of assistance program sponsored by pharmaceutical companies. While copay cards can be extremely generous, they often require more detailed billing information, thus increasing the need for coordination between the cancer center and billing department.

Copay Programs Lucrative but Require Coordination with Billing Staff

Benefits of Copay Assistance Programs

- $: Tend to be very lucrative
- People: Offer assistance to wide range of patients, including those with high income
- Thumbs up: Provide relatively straightforward application process

Challenges with Copay Assistance Programs

- Document: Require specific billing procedures
- House: May require coordination between cancer program, billing department, and pharmaceutical company

Source: Oncology Roundtable interviews and analysis.
Tactic #12: Assign Billing Point Person for Copay Assistance

Looping in the Whole Team

The NaVectis Group, a consulting service that helps organizations develop financial navigation programs, has developed a training program aimed at maximizing the use and value of assistance programs.

One of the components of the training program is a 90-minute educational session for staff from across the organization, including the billing department. During this session, staff learn about copay assistance programs and the specific billing procedures they require.

The NaVectis Group also identifies two billing staff to serve as the experts for cancer copay program billing. These two staff members assume responsibility for the majority of copay assistance transactions and serve as the points of contact for the cancer program’s financial counselor. For cancer programs that rely on hospital-based billing staff, this training is especially critical to make sure billers have the oncology expertise needed to manage these programs smoothly.

The NaVectis Group Engages Billing Department Copay Leads

Financial Assistance Meeting

- Provides education on patient assistance programs for managers from across the organization, including:
  - Cancer center
  - Pharmacy
  - Patient access department
  - Social work department
  - Billing department
- Secures staff buy-in by emphasizing importance of copay assistance programs to patients and organization
- Explains billing basics of copay programs

Billing Department Leads

- Identifies two billing staff as owners of cancer copay programs
- Improves communication and coordination between cancer program and billing department

Developing Needed Expertise

“I would recommend having two billers become experts in this process rather than having 50 billers do this process one to two times a year.”

Dan Sherman,
Founder of The NaVectis Group

Case in Brief: The NaVectis Group

- Educational, two- to three-day program providing on-site training, ongoing support to cancer financial navigation staff, and a comprehensive approach to financial navigation services in oncology setting
- To ensure organization-wide knowledge of available assistance programs, provides 90-minute education session for managers across the organization, including the cancer center and billing department
- Two billing staff members take ownership for all billing for cancer copay assistance programs
- For more information on how The NaVectis Group can help your organization build a cancer financial navigation program, contact Dan Sherman at dsherman@navectis.com

Oncology Roundtable interviews and analysis.
As mentioned throughout this study, financial counselors play a unique dual role for cancer programs. They both secure revenue for the cancer program while simultaneously helping patients understand and manage the costs of their care.

It takes a talented individual to deliver successfully on these responsibilities as the role requires financial expertise as well as strong interpersonal skills. Financial counselors must also be detail oriented and persistent in order to successfully navigate patient assistance programs and complex insurance benefits.

Financial counselors who are consistently able to strike the balance of “head and heart” are an invaluable resource to cancer programs and need to receive ongoing support and education to maintain high performance.

Financial Counselors a Combination of “Head and Heart”

Desired Attributes in a Cancer Financial Counselor

- Strong interpersonal skills
- Persistent
- Financial literacy
- Ability to teach, communicate effectively
- Detail oriented
- Customer service oriented

A Delicate Balance

“They have an understanding of what insurance is and they meet the public well. They know how to balance the head and the heart. They know when to push and they’re not shy of asking for money. But they can also exercise some judgment to say, ‘This patient is not going to be able to pay.’”

CFO, Cancer Center in the South

Source: Oncology Roundtable interviews and analysis.
Schwartz Cancer Center\(^1\) supports their financial counselors by holding weekly team meetings. These meetings are an opportunity for financial counseling staff across the cancer center to learn from one another.

The agenda includes a training component, a review of each counselor's performance over the previous week, and a discussion of any new issues or challenges. While this is a very straightforward concept, the cancer program finds that it is essential for facilitating collaboration and maintaining morale.

### Financial Counselors at Schwartz\(^1\) Benefit from Regular Meetings

<table>
<thead>
<tr>
<th>Weekly Team Meeting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice manager holds weekly meetings with all financial counseling staff across the cancer center</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sample Meeting Agenda</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Provide education on specific topic, e.g., how and when to verify patient insurance</td>
</tr>
<tr>
<td>✓ Review financial counselors' performance, e.g., compliance with insurance verification standards</td>
</tr>
<tr>
<td>✓ Identify challenges, e.g., specific patient concerns</td>
</tr>
<tr>
<td>✓ Brainstorm solutions to common challenges or specific patient concerns</td>
</tr>
<tr>
<td>✓ Share stories, lessons learned</td>
</tr>
</tbody>
</table>

### Benefits of Regular Meetings

- Improve communication
- Provide ongoing education and training
- Foster collaboration and teamwork
- Decrease likelihood of "financial counselor fatigue"

### Case in Brief: Schwartz Cancer Center

- Community cancer program located in the South
- Practice manager instituted weekly meetings to provide ongoing education and training for financial counselors from radiation oncology and medical oncology departments
- Every week includes opportunities for education; past topics of education include how to process new patients and insurance verification policies

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1) Pseudonym.

Source: Oncology Roundtable interviews and analysis.
Financial counselors also stand to benefit from learning from their colleagues outside of the cancer center.

At Lehigh Valley, the financial counselors spent one day shadowing case managers within the hospital.

Through the experience, both teams realized that the other had valuable knowledge about patient assistance. The cancer financial coordinators learned that the case managers had a comprehensive guide to local nonprofits and foundations available for patients. In turn, the case managers learned that the financial coordinators had extensive knowledge of pharmaceutical assistance programs.

In addition to improving their use of financial resources, this project significantly improved communication between the two settings, helping smooth cancer patient transitions to and from the outpatient setting and increasing collaboration between the two teams.

Realizing Opportunities for Inpatient and Outpatient Financial Coordination

Shadowing Project at Lehigh Valley Health Network

- Cancer financial coordinators spent one day shadowing inpatient case managers to improve collaboration between settings
- Each team learned about new opportunities for financial assistance:
  - Financial coordinators learned about local resources that inpatient case managers rely on
  - Case managers realized financial coordinators have extensive knowledge of drug assistance programs
- Communication between the two settings improved greatly, smoothing patient transitions
- When cancer patients move from inpatient to outpatient setting, case managers proactively call financial coordinators to share pertinent patient demographic and financial information

Case in Brief: Lehigh Valley Health Network

- Health network based in Allentown, Pennsylvania; includes three hospitals, community health centers, a health plan, and primary care and specialty physicians
- To facilitate collaboration between care settings, cancer program financial coordinators shadowed inpatient case managers for a full day
- Financial coordinators and case managers learned about additional resources to help patients with financial needs
- Improved communication between inpatient and outpatient settings, allowing for smoother patient transitions

Key Takeaways

1. **Do not limit financial assistance to the uninsured and underinsured**
   Because it takes a significant amount of time to research patient eligibility for external assistance programs, cancer providers often concentrate their efforts on only a small percentage of their patients, such as the uninsured and those indicating significant financial concerns. However, most cancer patients would benefit from external assistance, and programs should aim to connect as many patients as possible to assistance programs. To make patient identification and screening more efficient, there are a number of strategies: screening for eligibility up front, automating patient eligibility screening using computer software, or contracting with a third-party vendor.

2. **Continue searching for untapped sources of financial assistance**
   Many cancer programs rely on tried and true resources for patient assistance, but cancer program leaders and financial navigation staff should continue to seek new avenues of assistance. For example, many local nonprofits and individual donors are motivated to help cancer patients; however, most programs do not take full advantage of these resources. Similarly, there are a number of pharmaceutical programs available to help patients with their out-of-pocket expenses that are not being leveraged to their full extent by cancer providers.

3. **Make sure cancer financial counselors receive ongoing support**
   Financial counselors play a unique role within the cancer program, both augmenting patient revenue and helping patients manage the cost of their care. It takes a talented individual to successfully fulfill both of these responsibilities, requiring a blend of financial knowledge and strong interpersonal skills. To avoid staff burnout and encourage high performance, cancer programs should do their best to support these staff members, offering ongoing training and education opportunities.

Source: Oncology Roundtable interviews and analysis.
Improve Patient Collections

Tactic #14: Increase Patient Awareness of Point-of-Service Collections
Tactic #15: Train Staff for Point-of-Service Collections
Tactic #16: Develop Staff Incentive Program for Point-of-Service Collections
Tactic #17: Build Realistic Payment Plans
Setting Realistic Expectations

One of the most important goals for organizations moving forward is improving patient collections. While cancer programs in particular are often hesitant to ask patients for their financial responsibility, successful patient collections are integral to continued financial success.

As the bar graph on the left shows, enrollment in high-deductible health plans is growing rapidly. At the same time, the bar chart on the right demonstrates that as patients’ deductibles increase, patients are less likely to pay any portion of that deductible.

The Financial Leadership Council at The Advisory Board Company recently conducted an analysis of patient claims to calculate the “tipping point” at which patients were unlikely to pay any of their responsibility. After analyzing over 400,000 patient claims, they found that as patients’ medical bills approached 5% of their annual income, patients were unlikely to pay any portion of their bill.

Altogether, these data suggest that organizations need to set realistic goals about what they will be able to collect from each patient.

As Patient Responsibility Increases, Ability to Collect Decreases

Average In-Network and Out-of-Network Deductibles for Group Plans

<table>
<thead>
<tr>
<th>Year</th>
<th>In Network</th>
<th>Out of Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>$680</td>
<td>$1,000</td>
</tr>
<tr>
<td>2010</td>
<td>$760</td>
<td>$1,380</td>
</tr>
<tr>
<td>2011</td>
<td>$1,010</td>
<td>$1,750</td>
</tr>
<tr>
<td>2012</td>
<td>$940</td>
<td>$1,570</td>
</tr>
<tr>
<td>2013</td>
<td>$1,230</td>
<td>$2,110</td>
</tr>
</tbody>
</table>

Patient Propensity to Pay by Deductible Size

Based on Analysis of 400K Patient Claims

<table>
<thead>
<tr>
<th>Deductible Size</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>$500-$999</td>
<td>68%</td>
<td>62%</td>
<td>61%</td>
<td>50%</td>
<td>36%</td>
</tr>
<tr>
<td>$1,000-$2,000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$2,001-$3,500</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$3,501-$5,000</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$5,001-$6,350</td>
<td></td>
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</tr>
</tbody>
</table>

The Tipping Point

Providers are unlikely to collect any portion of patient responsibility as total responsibility approaches 5% of patient income

While trying to collect the total amount owed by patients is often a poor use of resources, collecting just a small portion of patients’ responsibility can have a big impact on the organization’s bottom line.

In fact, modest point-of-service collections are one of the most effective ways for reducing a hospital’s bad debt. According to the Financial Leadership Council’s predictive model, asking patients for a $20 deposit reduces bad debt by 12%. Increasing the deposit to $50 reduces bad debt by 30%.

Organizations typically have the most success collecting patients’ payments at the point of service. However, point-of-service collections are a challenge for many organizations, particularly in cancer care. Only 35% of hospital finance leaders report that their cancer programs consistently collect point-of-service payments.

### Modest Pre-payment Requirements Can Significantly Reduce Bad Debt

#### Bad Debt at Walter Medical Center

Required Advanced Deposit Applied to Every Service for All Patients

- **No Pre-payment**: 5.28%
- **$20 Pre-payment**: 4.64%
- **$50 Pre-payment**: 3.67%

**Requirement of $20 deposit for all procedures reduces bad debt by 12%**

#### Cancer a Missed Opportunity

35% Percentage of hospital leaders reporting that their organization collects patient obligations at the point-of-service for cancer care

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1) Pseudonym.

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To help oncology service line leaders improve patient collections, the Oncology Roundtable has identified four tactics.

The first tactic centers on increasing patients’ awareness that the cancer program is collecting copays at the point-of-service. Most patients are willing to pay; however, they often do not know how much they owe prior to their appointment.

The next two strategies focus on improving staff comfort with asking for point-of-service collections. First, programs should provide training and scripting to help staff initiate financial conversations. Second, to further motivate staff, some programs implement point-of-service collections incentive programs.

Patients' financial responsibility extends beyond the copays collected at point of service and often is a large sum, especially for cancer patients. To increase the likelihood of collecting some, if not most, of patients’ responsibility, cancer programs should partner with patients to develop feasible payment plans.

**Four Tactics to Improve Collections**

- **Tactic #14:** Increase patient awareness of point-of-service collections
- **Tactic #15:** Train staff for point-of-service collections
- **Tactic #16:** Develop staff incentive program for point-of-service collections
- **Tactic #17:** Build realistic payment plans

Source: Oncology Roundtable interviews and analysis.
Point-of-service collections present an opportunity for organizations to reduce their bad debt; however, there are barriers that prevent organizations from consistently collecting patient payments.

Most patients arrive at the clinic with no prior knowledge about their responsibility and are therefore unprepared and even surprised if they are asked for payment.

The bigger challenge to point-of-service collections is obtaining buy-in from cancer center staff. Many feel uncomfortable asking cancer patients who have recurrent appointments for payment at each visit. They may also not know how much each patient owes or may feel that point-of-service collections are a lower priority.

Organizations Struggle to Implement Point-of-Service Collections

Common Barriers to Point-of-Service Collections

- Unaware of copay responsibility
- Unable to pay
- Uncomfortable asking for money
- Unsure of amount owed
- Lack of buy-in regarding importance of collections

Source: Oncology Roundtable interviews and analysis.
To prepare patients for point-of-service collections, Flynn Medical Center developed an awareness campaign. Two months before their new copay policy went into effect, they added a notice to patient bills, posted signs around the cancer center, and had staff mention it to patients during registration. As a result, patients were ready and willing to pay their copays when asked.

**Case in Brief: Flynn Medical Center**

- Four-hospital health system based in the South
- Realizing the need to start collecting copays from patients at point of service, cancer program began informing patients about new point-of-service collection policies two months in advance

> “We notified patients that we would be notifying them about point-of-service collections.”

*Director of Cancer Services, Flynn Medical Center*
Goodman Health\(^1\) also improved their patient collections by developing a four-step process to inform patients of their responsibility.

First, the cancer center’s business staff generate a list of scheduled patients several days in advance. They verify insurance status and determine the patients’ copays and deductibles.

The list is then delivered to financial counselors, who contact each patient to explain their financial responsibility and ask for payment over the phone. Registration staff are also prepared to follow up with patients to ask for their required copay when they arrive for treatment.

### Front-Loading Collections at Goodman Health\(^1\)

#### Pre-appointment Patient Notification

<table>
<thead>
<tr>
<th>List of Scheduled Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer center business office staff generate daily list of scheduled patients</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Benefits Verification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Business office staff verify patient insurance benefits, determining copay, deductible, and coinsurance</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient Notification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior to appointment, financial counselors call patients to discuss payment owed and request payment over phone</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Point-of-Service Collection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registration staff collect any outstanding payment at time of care</td>
</tr>
</tbody>
</table>

---

**Case in Brief: Goodman Health\(^1\)**

- Health system located in the Southwest
- Cancer business office determines patient responsibility prior to patient appointment, provides information to financial counselors
- Financial counselors call patients to notify them of their cost responsibility, offer to collect payment over the phone
- If needed, registration staff collect patient copays at time of service

---

\(^1\) Pseudonym.
To ensure staff members were ready to take on these new responsibilities, Goodman developed a rigorous training program. They regularly hold introductory training modules for staff that emphasize the importance of collections, and they offer ongoing educational sessions that cover a range of topics, such as new Medicare regulations. They also have developed several mechanisms to monitor staff performance, including daily quality audits and regular competency testing.

Goodman Health\(^1\) Reinforces Importance of Collections

### Continual Training

**Introductory Training**
- Two-week session for all registration employees
- Educates staff on registration processes

**Regulatory Sessions**
- Monthly sessions covering wide variety of issues
- Recent sessions include new Medicare regulations, private payer policies

**Service Quality Scripting**
- Mandatory customer service training every quarter
- Scripts provided to assist staff with patient interactions

### Formal Performance Monitoring

**Daily Quality Audits**
- Daily review of registration staff collections
- Problems identified, addressed in real time

**Quarterly Competency Tests**
- All staff subjected to skills test by manager
- Results used to inform targeted education efforts

### Case in Brief: Goodman Health\(^1\)

- Health system located in the Southwest
- Prepare staff for point-of-service collections by offering training sessions for all new employees, holding regular education courses for current staff, and providing point-of-service collections scripting
- Instill accountability for staff by performing daily reviews of point-of-service collections and holding regular competency testing

---

\(^1\) Pseudonym.
Scripting for Success

To help staff overcome their hesitancy to initiate financial discussions, cancer program leaders should provide them with scripting examples. The Oncology Roundtable has developed scripting to guide point-of-service collections that cancer programs can use as a template for their own staff.

Point-of-Service Collections Scripting

Hello ____________, it’s great to see you today. My name is __________________. As a service to you, I’ve contacted your insurance company regarding your benefits. Your copay amount due today is __________________.

How would you like to pay for that? We have several payment options, including cash, check, and credit card.

Most patients will be willing to pay their copay if they have been given prior notification. If patients express concern, anger, or inability to pay:

I completely understand. Given your concerns, there are some ways we can help. Let me set you up with a financial counselor who can help you gain a better understanding of your benefits and available options.

See the table below for more scripting examples to manage potential patient objections:

<table>
<thead>
<tr>
<th>Common Patient Pushback Scenarios</th>
<th>Respond with:</th>
</tr>
</thead>
<tbody>
<tr>
<td>If the patient says:</td>
<td>Respond with:</td>
</tr>
<tr>
<td>“That can’t be right. I have insurance that will pay.”</td>
<td>“We have verified your insurance coverage directly with the payer and have determined that a deductible/copay is your responsibility. Would you like to pay by cash, check, or credit card?”</td>
</tr>
<tr>
<td>“I didn’t bring my checkbook.”</td>
<td>“That’s okay. We also accept cash or credit cards.”</td>
</tr>
<tr>
<td>“I’m currently not working, just bill me.”</td>
<td>“We have a specialist who can work with you in locating financial assistance for you. Let me get someone to discuss this with you.”</td>
</tr>
<tr>
<td>“Just send me a bill.”</td>
<td>“Similar to when you visit a physician office, our policy is that you pay at the time of service. How would you like to take care of your payment today?”</td>
</tr>
</tbody>
</table>

Financial conversations scripting templates are available in the Appendix and online at: advisory.com/or/financialnavigation

Source: Oncology Roundtable interviews and analysis.
Tactic #16: Develop Staff Incentive Program for Point-of-Service Collections

Going Beyond Scripting

In addition to scripting, some organizations are further encouraging staff to improve point-of-service collections by developing focused incentive programs.

Staff incentives for point-of-service collections are an effective, but underutilized, practice. Only about one-quarter of hospitals report using this approach.

Organizations unable to provide financial incentives can also explore non-monetary incentive programs, such as providing extra time off or catered lunches to those who meet their goals.

Point-of-Service Collection Incentives an Underutilized Practice

Patient Access Departments Offering Staff Monetary Incentives for Collections

n=61

- Currently Offering Monetary Incentives
  - 24%
- Not Offering Monetary Incentives, but Planning To
  - 13%
- Not Offering Monetary Incentives and Not Planning To
  - 62%

Sample Staff Incentives for Point-of-Service Collections

Monetary Incentives

- Flat rate bonus
- Percentage of salary bonus
- Percentage of dollars collected

Non-monetary Incentives

- Casual social events
- Catered lunches or dinners
- Gift certificates
- Weekend trip
- Time off
- Recognition plaque or poster
- Parking spots


1) Answers do not sum to 100 due to rounding.
Motivating Staff Performance

Incentive Programs May Increase Point-of-Service Collections

Pinkman\(^1\) Cancer Staff Preparation for Point-of-Service Collections

- Education on importance of collections
- Scripting to help navigate patient interactions
- Incentive plan to encourage point-of-service collections

Gift card given to staff who meet monthly cash collection goal

112% Percentage increase in average monthly point-of-service collections after implementation of incentives program

Incentive Program Implementation Tips

- **Design Incentive Program**
  - Decide which employees are eligible
  - Determine if incentives will be based on individual or team performance
  - Determine what form the incentive will take (monetary versus non-monetary)
  - Create appropriate goals

- **Train Staff About Program**
  - Create training plan for staff
  - Educate staff on details, goals of program

- **Sustain Forward Momentum**
  - Create and display progress chart to track performance toward goals
  - Publicly acknowledge individuals and teams who meet goals

Case in Brief: Pinkman Medical Center\(^1\)

- Academic medical center located in the West
- Cancer program improved point-of-service collections by providing staff training, and scripting
- Provides incentive for staff to collect point-of-service payments by providing gift cards to staff members who meet their monthly collection goals

---

\(^1\) Pseudonym.
Point-of-service collections help ensure patients pay their copays, but patients' total financial responsibility encompasses much more than just the copay and is far harder to collect. To improve collection of total patient responsibility, cancer programs need to focus on developing realistic payment plans.

Financial counselors at 21st Century Oncology meet with every new cancer patient at the beginning of treatment to provide them with an estimate of their out-of-pocket costs and develop a payment plan to help them meet their obligation.

The financial counselors use a payment plan calculator in which they enter the out-of-pocket estimate, the patient’s annual income, and any down payment the patient was able to provide. The calculator then uses the cancer center’s standardized payment policies, including their suggested time frame for payment, to automatically generate a payment plan.

The financial counselors review the suggested payment plan with the patient to ensure that it is feasible for the patient. If the patient cannot meet their monthly responsibility, financial counselors will draw up an extended plan or search for new opportunities for financial assistance.

### 21st Century Oncology Provides Feasible Payment Options

<table>
<thead>
<tr>
<th>Payment Plan Inputs</th>
<th>Estimated treatment cost</th>
<th>Patient annual income</th>
<th>Down payment amount</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Payment Plan Calculator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Remaining Amount:</td>
</tr>
<tr>
<td>Months of Payment</td>
</tr>
<tr>
<td>Installments:</td>
</tr>
<tr>
<td>Monthly Payment</td>
</tr>
<tr>
<td>Plan Amount:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Payment Plan Grid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Estimate Balance</td>
</tr>
<tr>
<td>≤ $2,000</td>
</tr>
<tr>
<td>$2,001-$4,000</td>
</tr>
<tr>
<td>$4,001-$6,000</td>
</tr>
<tr>
<td>$6,001-$8,000</td>
</tr>
<tr>
<td>$8,001+</td>
</tr>
</tbody>
</table>

To incentivize patient payment in full, financial counselors can grant a 5%-10% prompt pay discount.

### Case in Brief: 21st Century Oncology

- Physician-led specialty provider operating 166 freestanding cancer treatment centers; headquartered in Fort Myers, Florida
- Payment plan calculator compiles estimated cost, patient’s annual gross income, and requested down payment to determine details of payment plan
- Financial counselors use payment plan guidelines, and patient conversations to develop realistic payments
- According to payment policies, patient down payment and monthly payments should not exceed 30% of the patient’s monthly income, unless patient requests otherwise

Percentage of cancer patient balances collected by financial counselors: 50%

Source: 21st Century Oncology, Fort Myers, FL; Oncology Roundtable interviews and analysis.
Developing Appropriate Next Steps

To help cancer programs develop realistic payment plans, the Oncology Roundtable has developed two tools. The first is a sample payment plan worksheet. Programs should augment or alter this worksheet as necessary to reflect their institution’s charity care and payment planning policies. The second tool is payment plan scripting. The key to successfully collecting from patients is having an open conversation with them about their financial responsibility and their ability to pay. For patients who are truly in need, this is also the right time to begin a conversation about available patient assistance programs or supplemental insurance coverage.

Scripting Even More Important Than Payment Plan Policies

Payment Plan Worksheet

<table>
<thead>
<tr>
<th>Option 1</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Name:</td>
<td>Account Number:</td>
</tr>
<tr>
<td>Financial Counselor:</td>
<td>Date:</td>
</tr>
<tr>
<td>Outstanding Balance</td>
<td>$</td>
</tr>
<tr>
<td>Payment Time Frame (90-360): 3 Months</td>
<td>Months</td>
</tr>
<tr>
<td>$700-$1400: 3 Months</td>
<td></td>
</tr>
<tr>
<td>$1500-$3000: 6 Months</td>
<td></td>
</tr>
<tr>
<td>$4000+: 12 Months</td>
<td></td>
</tr>
<tr>
<td>Payment per Month (1/2/3)+</td>
<td>$</td>
</tr>
<tr>
<td>$ exceeds patient’s ability to pay; proceed to</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Maximum Feasible Monthly Payment</td>
<td>$</td>
</tr>
<tr>
<td>Payment Time Frame (1/2/3)+</td>
<td>Months</td>
</tr>
<tr>
<td>$ exceeds 36 months; proceed to</td>
<td></td>
</tr>
<tr>
<td>Financing Options</td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>Bank Loan</td>
</tr>
</tbody>
</table>

Payment Plan Scripting

Payment Plan
Have you given any thought as to how you’ll pay for treatment?

If patients indicate they are able to pay for the entirety of their balance:
We have a variety of payment options, including cash, check, and credit card. How would you like to pay?

If patients indicate concern or inability to pay the entirety of their balance:
Don’t worry, our goal is to work with you to find a manageable way for you to pay for your care. Let’s discuss this some more to determine the best way to meet your needs.

Based on the patient’s situation, continue discussion with patient to determine the most appropriate next steps:
• Is the patient able to meet their responsibility over an extended timeframe by taking advantage of a payment plan? If so, use the Oncology Roundtable Payment Plan worksheet to determine a realistic time frame and monthly payment plan according to your organization’s payment plan policies as well as what is feasible for the patient.
• Is the patient eligible for insurance through programs, such as Medicare, an exchange plan, or COBRA? Determine if patient has applicable coverage and if they are likely eligible.
• Is the patient eligible for a discount based on the organizations charity care policies?
• Are there alternative avenues, such as drug replacement and patient assistance programs, that the patient is eligible for?

Based on our conversation today, let me walk you through the appropriate next steps:
Provide an overview of next steps. If needed, ask patients for relevant documents and a timeframe to solicit them, explaining that you need these documents to aid the patient in applying for assistance.

The payment plan worksheet and scripting template are available in the Appendix and online at: advisory.com/or/financialnavigation

Source: Oncology Roundtable interviews and analysis.

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advisory.com
Key Takeaways

1. **Staff hesitancy is the biggest barrier to point-of-service collections**
   While point-of-service collections represent a large opportunity for increased revenue, they are particularly challenging for cancer programs to implement. Staff often feel uncomfortable asking cancer patients for money. However, patients rarely have an issue with point-of-service collections if they have been informed of their responsibility ahead of time. Therefore, programs should focus their efforts on training staff to alert patients about payment owed and manage potential objections.

2. **To increase the likelihood of collecting and decrease patient financial distress, work with patients to develop realistic payment plans**
   When developing payment plans for cancer patients, programs need to remember that patients are unlikely to pay if their responsibility constitutes too much of their income. Programs should work with patients to identify feasible monthly payments and provide patients with access to assistance if those payments become unreasonable.

3. **Scripting is a key element of successfully collecting patient responsibility**
   Cost is a sensitive issue. Consequently, cancer programs need to develop scripting and training opportunities to help staff manage financial conversations and mitigate patient anxiety. When asking for point-of-service collections or developing payment plans, ensure that staff are prepared to connect patients to financial assistance if they express concern or inability to pay.
Appendix

- Financial Checkpoints Worksheet
- Financial Conversations Scripting
- Understanding Your Health Insurance Benefits
- Insurance Verification Worksheet
- Insurance Eligibility Reference Guide
- Payment Plan Worksheet
Financial Checkpoints Worksheet

**Page 1 of 2**

**Instructions:** Cancer programs should use this worksheet to identify points along the continuum of care where patients will likely experience financial distress and therefore stand to benefit from extra support. Refer to the following page for an example of a completed worksheet.

1. Pinpoint critical times along the patient pathway when financial issues may arise
2. Assign staff responsibility for each checkpoint
3. Specify how staff will identify which patients need support
4. List actions staff should take to address patient needs

<table>
<thead>
<tr>
<th>Checkpoint</th>
<th>Point Person</th>
<th>Patient Identification</th>
<th>Action Required</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
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</tr>
</tbody>
</table>
## Financial Checkpoints Worksheet (cont.)

**Page 2 of 2: Sample Worksheet**

<table>
<thead>
<tr>
<th>Checkpoint</th>
<th>Point Person</th>
<th>Patient Identification</th>
<th>Action Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Post-Diagnosis</td>
<td>Financial counselor</td>
<td>Run EMR report for all new patients scheduled at beginning of each week</td>
<td>• Call patient before first appointment to introduce him/herself</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Schedule in-person appointment with patient</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Obtain or verify insurance information</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Notify patient of copay amount required at first and subsequent appointments</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Provide introductory education on cancer costs, such as <em>Managing the Cost of Cancer</em></td>
</tr>
<tr>
<td>Beginning of Treatment</td>
<td>Financial counselor</td>
<td>From above checkpoint, financial counselor should meet with all new patients during first week of treatment</td>
<td>• Provide basic education on insurance, patient health benefits</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Estimate patient cost responsibility</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Develop payment plan based on estimated cost</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• If necessary, connect patient to available financial resources</td>
</tr>
<tr>
<td>During Treatment</td>
<td>Social worker</td>
<td>Perform distress screening, refer patients to financial counselor if they indicate financial concern</td>
<td>• Assess cause and severity of patient need</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Provide necessary education to patient</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• If necessary, connect patient to available resources</td>
</tr>
<tr>
<td>Change in Treatment</td>
<td>Financial counselor</td>
<td>Run weekly EMR report of patients with change in treatment plan</td>
<td>• Provide revised patient cost estimate</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Call or schedule an appointment with patient to explain revised cost estimate</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Develop new payment plan based on estimated cost</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• If necessary, connect patient to available resources</td>
</tr>
<tr>
<td>End of Treatment</td>
<td>Financial counselor</td>
<td>Run EMR report based on estimated treatment end date, check with clinical team that patient ending treatment</td>
<td>• Call or schedule patient appointment</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Review remaining patient obligation and update payment plan, if necessary</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Confirm demographic and contact information</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Ensure patient knows whom to contact if questions arise</td>
</tr>
<tr>
<td>Receipt of First Bill</td>
<td>Customer service representative</td>
<td>Trigger built into billing management system, run weekly report of patients receiving first bills</td>
<td>• Call patient to alert them that they will soon receive a bill</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Confirm payment plan with patient</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Provide contact information in case patient has concerns or questions</td>
</tr>
<tr>
<td>Missed Payment</td>
<td>Customer service representative</td>
<td>Trigger built into billing management system, run weekly report of patients missing planned payment</td>
<td>• Call patient to gently inform them they missed a payment</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Ask patient if they need financial assistance and connect them to appropriate resources</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Confirm payment plan with patient</td>
</tr>
</tbody>
</table>

Source: Oncology Roundtable research and analysis.
Financial Conversations Scripting

Page 1 of 3: Introduction and Benefits Explanation

Instructions: Talking with cancer patients about the cost of care is difficult. To assist cancer program staff with these conversations, this worksheet provides sample scripting.

General Tips for Patient Interactions

• Introduce yourself and your role within the cancer program
• Be prepared with all of the necessary patient information
• Communicate clearly and provide complete information
• Have the conversation in a private area
• Be compassionate and armed with possible solutions
• Be willing to reschedule if patient is visibly distressed

Introduction

Hello, my name is ____________, and I work as a financial counselor here at ________________. Given that finances are a concern for many of our patients, we try to meet with all patients as a service to you and your family to discuss the cost of your care.

Your financial situation will not affect your ability to receive care here. We’re committed to making sure you receive the best care available.

Our conversation today is meant to review what your health plan covers and what it does not cover, as well as any expenses you should expect. I’m here to answer any of your questions now and at any point during your care.

Benefits Explanation

Insurance coverage can be very confusing. To help you understand your benefits, I contacted your insurance carrier to determine your correct benefits information. As a reminder, this is not a formal guarantee of benefits as that depends on your insurance carrier. Instead, we want to provide you with a basic understanding of your plan.

Annual deductible: This is the annual amount that you are responsible for paying each policy year before your insurance company starts contributing to the cost of your care. Your annual deductible is ________________ and, to date, you have met ________________ of your deductible.

Copay: This is the amount that you pay for your office visits. You probably are used to paying for these when you visit your primary care physician. This is the same thing but since this is a specialist office, the amount might be higher than what you’re used to paying. Your copay responsibility is ________________ (if applicable, include if this is due at every visit and is collected at point of service).

Coinsurance: This is the percentage of the visit or treatment you are responsible for paying for, even after your deductible has been met. Your coinsurance is ________________.

Out-of-pocket maximum: This is the maximum amount that you are required to pay each year. Once you’ve reached this amount, your insurance company will pay 100% of all applicable charges. Your out-of-pocket maximum is ________________ (include if this covers copays, deductible, and/or coinsurance).

To date, you’ve met ________________ of your out-of-pocket maximum.
Out-of-Pocket Estimate

Your physician has recommended the following treatment ________________________________.

For a typical patient receiving this treatment with your benefits, we’d expect your total out-of-pocket costs to be ____________________.

Remember, this is only an estimate. It is likely to change and, if you have a change in treatment, it will certainly change. But, we think it is important to provide all of our cancer patients with this estimate so that you are prepared for treatment costs. Do you have any concerns?

Payment Plan

Have you given any thought as to how you’ll pay for treatment?

If patients indicate they are able to pay for the entirety of their balance:
We have a variety of payment options, including cash, check, and credit card. How would you like to pay?

If patients indicate concern or inability to pay the entirety of their balance:

Don’t worry, our goal is to work with you to find a manageable way for you to pay for your care. Let’s discuss this some more to determine the best way to meet your needs.

Based on the patient’s situation, continue discussion with patient to determine the most appropriate next steps:

• Is the patient able to meet their responsibility over an extended time frame by taking advantage of a payment plan? If so, use the Oncology Roundtable Payment Plan worksheet to determine a realistic time frame and monthly payment plan according to your organization’s payment plan policies as well as what is feasible for the patient.

• Is the patient eligible for insurance through programs, such as Medicaid, an exchange plan, or COBRA? Determine if patient has applied for coverage in the past and if they are newly eligible.

• Is the patient eligible for a discount based on the organization’s charity care policies?

• Are there alternate avenues, such as drug replacement and patient assistance programs, that the patient is eligible for?

Based on our conversation today, let me walk you through the appropriate next steps.

Provide an overview of the next steps. If needed, ask patients for relevant documents and a time frame to collect them, explaining that you need these documents to aid the patient in applying for assistance.

Thank you for taking the time to meet with me today. Here is my business card with my contact information. If I can be of any assistance to you at any time during your care, please feel free to reach out to me directly.
Financial Conversations Scripting (cont.)

Page 3 of 3: Point-of-Service Collections

**Point-of-Service Collections**
Hello ____________________, it’s great to see you today. My name is ___________________. As a service to you, I’ve contacted your insurance company regarding your benefits. Your copay amount due today is _______________.

How would you like to pay for that? We have several payment options, including cash, check, and credit card.

*Most patients will be willing to pay their copay if they have been given prior notification. If patients express concern, anger, or inability to pay:*
I completely understand. Given your concerns, there are some ways we can help. Let me set you up with a financial counselor who can help you gain a better understanding of your benefits and available options.

*See the table below for more scripting examples to manage potential patient objections:*

<table>
<thead>
<tr>
<th>If the patient says:</th>
<th>Respond with:</th>
</tr>
</thead>
<tbody>
<tr>
<td>“That can’t be right. I have insurance that will pay.”</td>
<td>“We have verified your insurance coverage directly with the payer and have determined that a deductible/copay is your responsibility. Would you like to pay by cash, check, or credit card?”</td>
</tr>
<tr>
<td>“I didn’t bring my checkbook.”</td>
<td>“That’s okay. We also accept cash or credit cards.”</td>
</tr>
<tr>
<td>“I’m currently not working, just bill me.”</td>
<td>“We have a specialist who can work with you in locating financial assistance for you. Let me get someone to discuss this with you.”</td>
</tr>
<tr>
<td>“Just send me a bill.”</td>
<td>“Similar to when you visit a physician office, our policy is that you pay at the time of service. How would you like to take care of your payment today?”</td>
</tr>
</tbody>
</table>

Source: Oncology Roundtable interviews and analysis.
# Understanding Your Health Insurance Benefits

21st Century Oncology

| Patient Name: ____________________ | Patient Number: ____________________ | Date: ____________________ |

## Understanding Your Health Insurance Benefits

People have differing amounts of health care expenses because insurance coverage is different. There are some common terms that apply to almost everyone. The following is prepared to assist you in understanding your health care benefits.

This is not a guarantee of benefits; we have made every effort to obtain correct benefit information from your insurance carrier. Final determination of your benefits will be dictated by your insurance company at the time the claims are processed. Therefore, your patient responsibility may be adjusted to reflect this.

- **Annual Deductible**: This is the amount of annual out-of-pocket expense for covered medical services that your insurance requires you to pay each policy year to a health care provider before the insurance pays for benefits.

- **Deductible** met to date.

- **Co-insurance**: This is the percentage of the visit or treatment that you are responsible for. Your deductible must be met before your insurance begins to pay their portion.

- **Out-of-Pocket Maximum**: This is the amount of co-insurance that you are required to pay annually. When you have paid this total amount for health care services your insurance then begins to pay all applicable charges at 100% of the allowed amount. Co-Pays and deductibles may or may not apply to this amount, this varies by insurance plan.

- **Out-of-Pocket Maximum** met to date.

- **Co-Pay**: This is the amount that you pay at your office visit today. As this is a specialist office, this amount may be higher than what you normally pay for your primary care physician visits. Co-payments are expected at the time of service. Some benefit plans require a co-payment due daily for radiation treatment.

Do my co-pays apply to my Out-of-Pocket maximum?  **YES or NO**

Does my deductible apply to my Out-of-Pocket maximum?  **YES or NO**

21C has a Financial Counselor assigned to each office to educate you on your insurance benefits and to assist you with any financial related questions during your course of treatment. If you have any questions regarding your benefits, please feel free to stop in or call the Financial Counselor, at any time during the course of your treatment. You will have the opportunity to speak with the Financial Counselor to discuss your insurance benefits in detail and determine your financial responsibility for your prescribed course of treatment. Based on the information provided by my insurance company, my estimated financial responsibility for treatment will be $______________

If you have any billing questions after completion of treatment please do not hesitate to contact our customer service department at 800-437-1618.

______________________________

Patient Signature

Source: 21st Century Oncology, Fort Myers, FL; Oncology Roundtable interviews and analysis.
Insurance Verification Worksheet

Instructions: Use this worksheet to collect the information required for insurance verification and to identify potential gaps in coverage.

<table>
<thead>
<tr>
<th>Patient Information</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Name:</td>
<td></td>
</tr>
<tr>
<td>Patient SSN:</td>
<td></td>
</tr>
<tr>
<td>Patient Address:</td>
<td></td>
</tr>
<tr>
<td>Patient MRN:</td>
<td></td>
</tr>
<tr>
<td>Insured Name (if different):</td>
<td></td>
</tr>
<tr>
<td>Insured Address (if different):</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Staff Information</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff Name:</td>
<td></td>
</tr>
<tr>
<td>Verification Date:</td>
<td></td>
</tr>
<tr>
<td>Verification Method:</td>
<td></td>
</tr>
<tr>
<td>□ Online</td>
<td></td>
</tr>
<tr>
<td>□ Phone/Spoke with:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Primary Insurance Provider</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Insurance Provider:</td>
<td></td>
</tr>
<tr>
<td>Policy Number:</td>
<td></td>
</tr>
<tr>
<td>Effective Date of Coverage:</td>
<td></td>
</tr>
<tr>
<td>Termination Date of Coverage:</td>
<td></td>
</tr>
<tr>
<td>Annual Deductible:</td>
<td></td>
</tr>
<tr>
<td>Deductible Met:</td>
<td></td>
</tr>
<tr>
<td>Coinsurance:</td>
<td></td>
</tr>
<tr>
<td>□ Individual □ Family</td>
<td></td>
</tr>
<tr>
<td>□ Yes □ No: Met to Date</td>
<td></td>
</tr>
<tr>
<td>Copayment:</td>
<td></td>
</tr>
<tr>
<td>Copayment Frequency:</td>
<td></td>
</tr>
<tr>
<td>□ Every Visit □ Other:</td>
<td></td>
</tr>
<tr>
<td>Does Copayment Change After First Visit?:</td>
<td></td>
</tr>
<tr>
<td>□ Yes □ No</td>
<td></td>
</tr>
<tr>
<td>Out-of-Pocket Maximum:</td>
<td></td>
</tr>
<tr>
<td>Out-of-Pocket Met:</td>
<td></td>
</tr>
<tr>
<td>Out-of-Pocket Includes:</td>
<td></td>
</tr>
<tr>
<td>□ Copayment □ Deductible □ Medication</td>
<td></td>
</tr>
<tr>
<td>Structure of Payment Post-deductible:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Referrals and Pre-certification Needed:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialist Visit</td>
<td></td>
</tr>
<tr>
<td>Outpatient Medical Testing (e.g., x-rays, MRIs, CT scans):</td>
<td></td>
</tr>
<tr>
<td>Chemotherapy</td>
<td></td>
</tr>
<tr>
<td>Radiation Therapy:</td>
<td></td>
</tr>
</tbody>
</table>

Source: Oncology Roundtable interviews and analysis.
Insurance Verification Worksheet (cont.)

Secondary Insurance Provider

<table>
<thead>
<tr>
<th>Insurance Provider:</th>
<th>Policy Number:</th>
<th>Effective Date of Coverage:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Termination Date of Coverage:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Annual Deductible:
- Individual
- Family

- Determined Met
- Yes
- No

Deductible: Met to Date

- Coinsurance:
  - Yes
  - No

Copayment:

- Copayment Frequency:
  - Every Visit
  - Other:

- Does Copayment Change After First Visit?:
  - Yes
  - No

Out-of-Pocket Maximum:

- Out-of-Pocket Met
- Yes
- No

- Met to Date

Structure of Payment Pre-deductible:

<table>
<thead>
<tr>
<th>Referrals and Pre-certification Needed:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialist Visit:</td>
</tr>
<tr>
<td>Outpatient Medical Testing (e.g., X-rays, MRI, CT scans):</td>
</tr>
<tr>
<td>Chemotherapy:</td>
</tr>
<tr>
<td>Radiation Therapy:</td>
</tr>
</tbody>
</table>

- Yes
- No

Out-of-Network Benefits?
- Yes
- No

If Yes:
- Deductible: _____________
- Copayment: _____________
- Percentage Reimbursed: _____________

Potential Red Flags

- Does the patient have a high-deductible plan ($1,000 or more)?
  - Yes
  - No

- Is the patient required to pay coinsurance or a copay on specialty drugs?
  - Yes
  - No

- Is the patient required to pay a copay at each visit?
  - Yes
  - No

- (For Medicare patients) Does the patient lack supplemental insurance?
  - Yes
  - No

- Is the patient likely to become too sick to work?
  - Yes
  - No

- Are there other reasons to think this patient may be underinsured and/or in danger of losing insurance?
  - Yes
  - No

Please explain:

If the answer is “Yes” to one or more of the above questions, refer patient to financial counselor

Financial Counselor’s Name: __________________________

Date: _____________

Notes:

Source: Oncology Roundtable interviews and analysis.
Insurance Eligibility Reference Guide

**Instructions:** Cancer programs should use this guide to assess patients’ insurance coverage eligibility. If patients are insured, use the Insurance Verification Worksheet to verify plan details. If patients do not have coverage or have significant gaps in coverage, staff should use the resources provided below to evaluate patients’ eligibility for new or alternate coverage.

<table>
<thead>
<tr>
<th>Category</th>
<th>Eligibility Resources</th>
</tr>
</thead>
</table>
| **Employer-Sponsored Coverage** | • If patient will need to take unpaid leave, find information on FMLA\(^1\) eligibility here: http://www.dol.gov/whd/fmla/  
  • If patient is recently unemployed, find information on COBRA\(^2\) eligibility here: http://www.dol.gov/ebsa/faqs/faq-consumer-cobra.html |
| **Medicare**              | • Find Medicare eligibility requirements here: http://www.cms.gov/Medicare/Eligibility-andEnrollment/OrigMedicarePartABEligEnrol/  
  • Find available Medicare supplemental policies here: http://www.medicare.gov/find-a-plan/questions/medigap-home.aspx |
| **Medicaid**              | • Find your state’s Medicaid eligibility requirements here: http://medicaid.gov/AffordableCareAct/Medicaid-Moving-Forward-2014/Medicaid-and-CHIP-Eligibility-Levels/medicaid-chip-eligibility-levels.html |
| **Veterans Benefits**     | • Find Veterans eligibility requirements here: http://www.va.gov/healthbenefits/apply/veterans.asp |
| **Health Insurance Exchange** | • Determine potential cost of premiums and maximum out-of-pocket cost using Kaiser Family Foundation’s subsidy calculator here: http://kff.org/interactive/subsidy-calculator/  
  • Find more information on health exchanges here: https://www.healthcare.gov/marketplace/b/welcome/ |
| **Self-Pay**              | Refer patient to financial counseling staff |

1) Family and Medical Leave Act.  
2) Consolidated Omnibus Budget Reconciliation Act.

Source: Oncology Roundtable research and analysis.
## Payment Plan Worksheet

**Instructions:** The purpose of this worksheet is to help financial counselors develop a realistic payment plan with patients.

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>Account Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial Counselor:</td>
<td>Date:</td>
</tr>
</tbody>
</table>

### Option 1

**Outstanding Balance**

**Payment Time Frame**
- $0-$500: 3 Months
- $501-$1,500: 6 Months
- $1,501-$3,000: 9 Months
- $3,001+: 12 Months

**Payment per Month**

If exceeds patient’s ability to pay, proceed to

### Option 2

**Maximum Feasible Monthly Payment**

**Payment Time Frame**

If exceeds 36 months, proceed to

### Option 3

**Financing Options**
- None
- Bank Loan
- Payroll Deduction
- Charity Care
- External Assistance
- Other:

<table>
<thead>
<tr>
<th>Patient Signature:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial Counselor Signature:</td>
<td>Date:</td>
</tr>
</tbody>
</table>