



Addressing Medical Debt

A Playbook for Hospitals and Clinicians

October 2026



Addressing Medical Debt: A Playbook for Hospitals and Clinicians

Authors

Marya Khan, M.P.H.; Taylor Dunlap; Kelsey Chalmers, Ph.D.; Eva Stahl, Ph.D.; Elizabeth Cope, Ph.D., M.P.H.

Suggested Citation

Khan M, Dunlap T, Chalmers K, Stahl E, Cope E. Addressing Medical Debt: A Playbook for Hospitals and Clinicians. Washington, DC: AcademyHealth; 2026 Oct.

Acknowledgements

We would like to thank the following individuals for their contributions to this playbook: Jessica Perlo, M.P.H., Executive Vice President; Timothy Lynch, J.D., Senior Director of Foundation Programs; and Jaime McClennen, M.S., Senior Communications Manager at the ABIM Foundation for their generous support, guidance, and review of this report; Fred Cerise, M.D., M.P.H., President and Chief Executive Officer; Jessica J. Hernandez, MHA, ECDHE, CCHW, Senior Vice President and Chief Health Equity Officer; and Kyle Cross, Senior Director, Revenue Cycle at Parkland Health; Kara Murphy, President and Brenda Chavez, Client Benefits Manager at DuPage Health Coalition; Ruth Landé, M.A., Vice President, Provider Relations and Eva Stahl, Ph.D., Vice President, Policy, Engagement, and Research at Undue Medical Debt; and Caroline Sloan, M.D., M.P.H., Internal Medicine Doctor at Duke Outpatient Clinic, Duke University Health System for sharing their work and serving as case examples; Rebekah Angove, Ph.D., Chief Science Officer at the Patient Advocate Foundation; Luke Messac, M.D., Ph.D., Attending Physician at Brigham and Women's Hospital and Assistant Professor, Emergency Medicine at Harvard Medical School; Nikita Singareddy, Co Founder and CEO of Fortuna Health; and Angela D. Thomas, Dr.P.H., M.P.H., M.B.A., Vice President, Healthcare Delivery Research at MedStar Health for their review of the plays. We would also like to express our appreciation to the anonymous focus group and interview participants who shared their insights and expertise to inform this playbook.

Contents

Introduction 4

 How to Use This Playbook 5

 Overview of Key Hospital Functions Affecting Patient Financial Experience 6

What Can Hospitals Do? 7

Play 1: Ensure that financial policies and practices promote organizational values and mission of improving health. 7

Play 2: Support fair and transparent hospital financial practices that reduce administrative burden for patients. 12

Play 3: Engage patient- and community-oriented organizations to strengthen financial navigation and improve hospital financial practices. 20

What Can Clinicians Do? 25

Play 1: Ensure that financial policies and practices promote organizational values and mission of improving health. 25

Play 2: Support fair and transparent hospital financial practices that reduce administrative burden for patients. 27

Play 3: Engage patient- and community-oriented organizations to strengthen financial navigation and improve hospital financial practices. 30

Conclusion 33

Appendix A-1

Case Example: Ensuring Patient-Centered Financial Practices:
 A Hospital Perspective (Parkland Health) A-1

Case Example: Partnering with Patients and Hospitals on Financial Navigation:
 A Community-Based Organization Perspective (DuPage Health Coalition) A-9

Case Example: Partnering with Hospitals to Relieve Patient Medical Debt:
 A National Nonprofit Perspective (Undue Medical Debt) A-14

Case Example: Addressing Health Care Costs with Patients:
 A Clinician Perspective (Caroline Sloan, M.D., M.P.H.) A-21

References 34

Introduction

Medical debt remains a significant challenge for patients and families across the United States, with approximately 40 percent of adults carrying health care or dental debt, including bills that are past due, being paid over time to providers, or owed to credit card companies, collection agencies, or family and friends.¹

Beyond the financial consequences, patients with medical debt often delay or skip care, have worse health outcomes, cut back on basic necessities, and lose trust in the health care system.^{2,3,4}

Hospitals are contending with their own financial sustainability amid pressures from the insurance industry, private equity ownership, and the broader health policy environment. At the same time, the policies and practices hospitals use to communicate costs, determine eligibility for financial assistance, collect payment, and connect patients with support affect patients' experience of care, either creating additional barriers or helping reduce the burden of medical debt. Clinicians also play an important role in helping patients navigate the high costs of care. Through conversations about costs and referrals to resources, they can help patients understand their options and connect with available support.

Evidence suggests that these approaches can make a meaningful difference. Hospital financial assistance, for example, has been associated with increased patient access to care, cost savings, and improved health outcomes.^{5,6} Among clinicians, exploring costs of care with patients has been associated with increased patient satisfaction and ability to navigate health care costs.^{7,8} Building on a recent environmental scan of hospital policies and practices related to financial assistance, billing, and collections, this playbook highlights key areas where hospitals and clinicians can support patients in addressing the costs of care.⁹ Drawing on expert interviews and other literature, this playbook presents three plays and four case examples that illustrate promising approaches for addressing patient health care costs.

The three plays focus on opportunities at multiple levels: organizational culture, policies and practices that shape the patient financial experience, and partnerships with organizations outside the hospital. Together, they encourage readers to consider opportunities for preventing medical debt, along with strategies for addressing debt after it has been incurred.

No single organization or intervention can address medical debt on its own. Rather than prescribing a single model, this playbook offers ideas and resources that organizations can adapt to their own circumstances. While the work is complex, meaningful change is possible; the approaches highlighted here reflect a range of ways hospitals, clinicians, and their partners can contribute to that change.

How to Use This Playbook

Each of the three plays provides practical recommendations, ready-to-use tools, questions to consider, highlights from case examples, and external resources for additional information. Detailed case examples can be found in the appendix to help readers translate these approaches into action. The playbook is designed to be flexible: readers can use it in its entirety to inform a broader strategy or turn to individual sections that address priorities within their own settings.

Start Where You Are

There is no single starting point for addressing medical debt. Hospitals and clinicians may be at different stages in assessing their current practices or implementing changes. Begin with the areas that are most relevant to your organization, whether that means examining existing financial assistance processes, improving how patients receive information and support, or strengthening partnerships with organizations that can assist patients.

The plays are organized around different opportunities to act and include recommendations for both hospitals and clinicians. While some actions require organizational-level changes, others can be incorporated into day-to-day clinical practice or build on work that is already underway.

Explore the Plays

Each play focuses on a specific goal or goals which include practical recommendations and tools to help translate ideas into action. You do not need to complete the plays in order. Instead, use the playbook to identify the actions that are most feasible and meaningful for your organization at a given point in time.

As you work through the plays, consider:

- **What are we already doing well?** Identify existing practices, programs, or partnerships that can be strengthened rather than starting from scratch.
- **Where are the gaps?** Consider where patients may encounter unnecessary barriers, confusion, or delays in accessing financial assistance or other support.
- **What is feasible now?** Look for opportunities that can be implemented within existing processes and resources, as well as longer-term changes that may require additional planning or investment.
- **Who needs to be involved?** Some changes will require collaboration across clinical, financial, operational, and other areas of the organization.
- **How will we know whether it is working?** Consider how you can monitor implementation and understand whether changes are improving patients' experiences and reducing the burden of medical debt.

Learn From the Case Examples

The case examples throughout the playbook illustrate how specific organizations and partners have approached medical debt. Examples highlight a range of approaches, organizational contexts, and lessons learned.

These examples are not intended to serve as models that can be exactly replicated. Instead, use them to consider what may be transferable to your own setting and what needs to be adapted first. The examples also illustrate that addressing medical debt can take different forms, from changes within a hospital to partnerships with outside organizations.

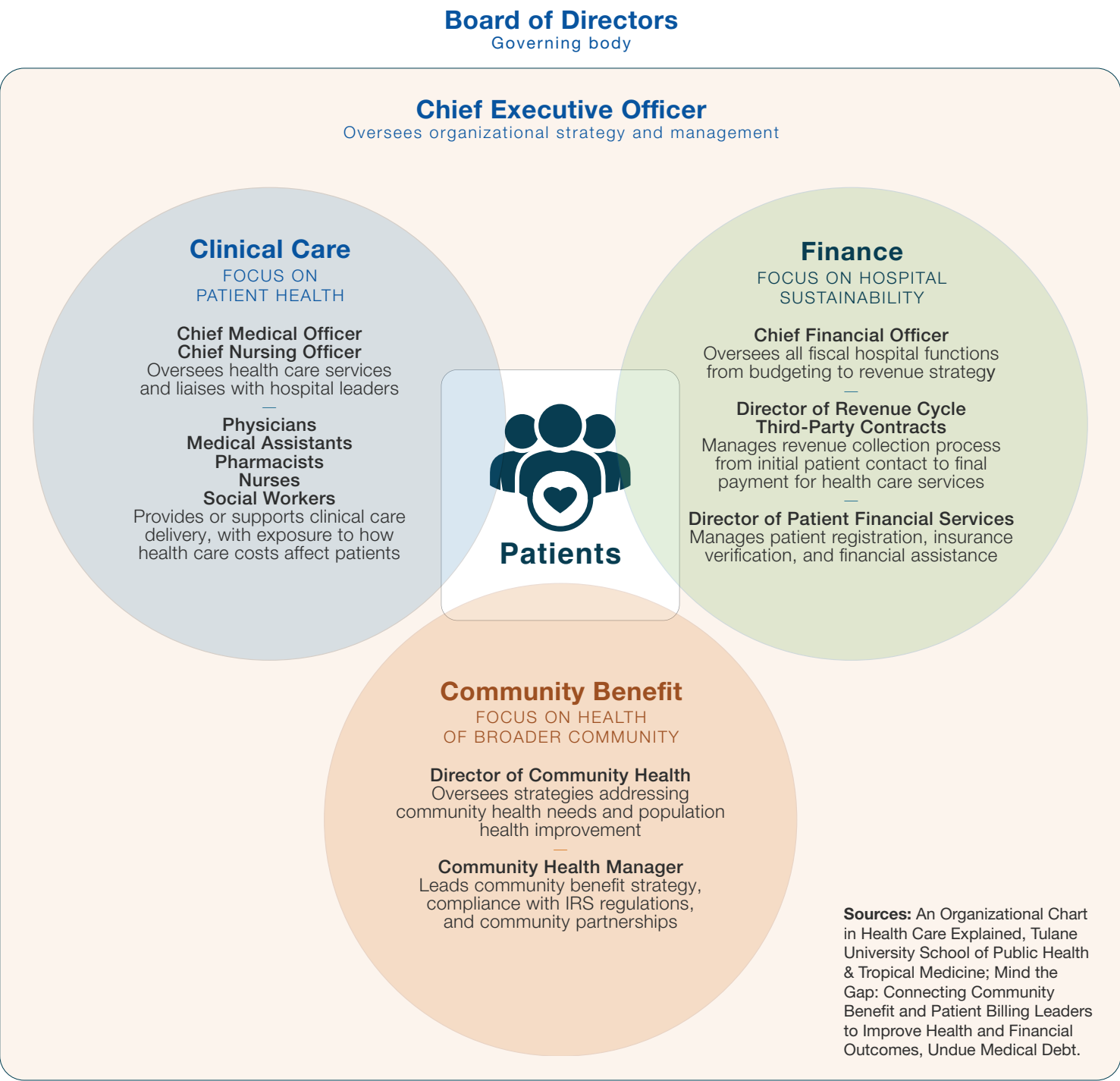
Use the Tools to Support Action

The tools included throughout the playbook are intended to make recommendations more actionable. Use them as starting points that can be adapted to your organization's needs, existing workflows, and available resources. Some tools may be useful for assessing current practices, while others can support implementation or help connect patients with additional resources.

Overview of Key Hospital Functions Affecting Patient Financial Experience

Various hospital departments either influence or are impacted by patient medical debt, and efforts to address debt need to consider these different groups and how their actions align with the organizational mission of improving patient health. **Figure 1** depicts the typical hospital roles that connect to the patient’s financial experience, which may vary across health systems. Achieving greater alignment across clinical, financial, and community functions can help streamline hospital processes and reduce patient debt. The Plays describe opportunities for increased alignment across these areas in a way that balances patient care and hospital sustainability.

Figure 1: Overview of Hospital Structure and Roles Interfacing with Patient Financial Experience



What Can Hospitals Do?



Play 1: Ensure that financial policies and practices promote organizational values and mission of improving health

Organizational culture sets the tone for how a hospital functions and how hospital leaders set priorities.

Achieving any organizational change requires fostering a supportive culture—and implementing new efforts to reduce medical debt is no exception.¹⁰

Goal: Support organizational culture change to align financial policies with the mission of improving patient health.

Why This Matters: When hospitals do not consider patients' financial well-being, they undermine their missions and patient trust. Patients will be less likely to return for care they need. This can harm the health of the communities hospitals serve.^{11, 12, 13, 14}

Reflection Questions for Hospital Leaders



- Are the hospital's financial policies and practices aligned with the mission of improving patient health?
- Who is included in setting financial policies and practices? What departments or individuals are involved? Who else could or should be involved?
- How do leaders and staff learn about the financial challenges patients face? How can the patient financial experience become visible to departments that do not routinely interact with patients?



Quick Preview: Highlights from This Play

- **Zoom out by engaging hospital leaders.** Hospital leaders have a unique overview of the big picture: how hospital functions fit together and impact each other. See Recommendation 1: *Engage hospital leaders who are responsible for the hospital's impact on the community* (page 8).
- **Get the right people in one room.** Financial policy is usually set without clinical, community benefit, or patient perspectives present. See Recommendation 2: *Develop a broad committee representing varied hospital functions for determining hospital policies related to financial assistance and medical billing and collection* (page 9).
- **Start with your own staff.** Employees frequently carry the same financial burdens as patients. Supporting them builds both capacity and empathy. See Recommendation 3: *Foster an internal environment of care and trust throughout the organization, starting with hospital employees* (page 10).
- **Run your own numbers.** Calculate what collections actually contribute as a share of total revenue before assuming the practice is financially necessary. See Recommendation 4: *Assess the return on investment of medical debt collection activities* (page 11).


Tool 1. Checklist to Assess Organizational Readiness

To assess readiness for implementing patient-centered financial policies and practices, complete the checklist below. If you answer No more often than Yes, the recommendations in this play may help identify where to begin.

Question	Y/N
Are hospital leaders aware of the hospital's patient financial policies and practices?	
Is providing financial assistance for patients facing financial barriers seen as a key component of your institutional mission?	
Do hospital leaders treat addressing patient medical debt as an organizational priority?	
Is there a standing working relationship between revenue cycle leaders and patient experience or community benefit leaders?	
Do you know what share of total revenue your collection activities generate?	
Do you educate staff at all levels about the financial assistance policy?	
Do hospital staff who may be facing financial barriers to care have access to financial assistance and support?	
Do you collect any data on patients' financial experience of care?	

Adapted from the reflection questions (page 7) and from the decision points described in the Parkland Health case example.

RECOMMENDATION 1
Engage hospital leaders who are responsible for the hospital's impact on the community.

Rationale: The CEO, Board, and other top leaders have an overall view of how the hospital is functioning and its impact in the community. Many hospitals serve as anchor institutions and are invested in the economic capacity and wellbeing of the community.^{15,16} Given their unique vantage point and influence in the organization, engaging hospital leaders on the issue of medical debt can be highly impactful.

Challenge: Hospital CEOs and other top leaders are confronting competing priorities and may be difficult to reach.

Taking Action: Many hospitals have executive rounds, where hospital leaders visit frontline and other department staff to gain an understanding of the issues that employees are confronting. This can provide an opportunity for staff to raise the issue of health care costs and medical debt with hospital leaders.¹⁷ See **Tool 2** on page 9 for talking points.


28%

About one in four adults
skipped or postponed care
in the past year due to cost


62%

About three out of five uninsured adults
skipped or postponed care
in the past year due to cost

**Tool 2. The Value of Addressing Medical Debt for Hospital Leaders**

These talking points are designed to help build support among hospital leaders to address medical debt.

Value Statement	Description
Financial practices are visible, and they shape community trust.	Many hospitals serve as anchor institutions and express explicit commitments to improve community health. ^{18,19} Collection practices that produce housing, employment, or credit consequences for patients undermine those commitments, and community members notice the gap between the hospital's stated mission and their experience.
Medical debt affects whether patients come back.	Patients delay or avoid care when they fear unaffordable bills. About one in four adults (28%) reported skipping or postponing care in the past year due to cost; among those who are uninsured, the number jumps to about three out of five (62%). ²⁰ Community members also describe how stories about unexpected bills travel through social networks and discourage others from seeking care. Financial policy is therefore an access question, not only a revenue question.
Reducing patient financial harm advances existing programs.	Nonprofit hospitals carry community benefit requirements, including financial assistance policies. ²¹ Framing this work as strengthening what the organization is already accountable for, rather than as a new initiative, lowers the barrier to engaging with hospital leaders. See Recommendation 3: Strengthen current hospital obligations regarding financial assistance as a part of hospital community benefit (Play 2, page 15).
The financial impact of collected debt may be smaller than you assume.	Organizations often treat aggressive collection activity as financially necessary without having recently measured the net revenue it generates. Although collections may not always be negligible, the costs (both administrative expenses and patient harm) and benefits of collecting debt should be measured, not assumed. See Recommendation 4: Assess the return on investment of medical debt collection activities (page 11).

RECOMMENDATION 2**Develop a broad committee representing varied hospital functions for determining hospital policies related to financial assistance and medical billing and collection.**

Rationale: Because medical debt has far-reaching consequences that extend beyond hospital revenue, bringing in varied perspectives can help in designing innovative solutions that incorporate a broader, systems-level view.

Challenge: Hospital operations are highly complex with specialized departments that are often siloed. For example, addressing financial assistance and medical debt usually falls within the purview of the finance department, and impacts on patients may not be well understood among financial leaders. Additionally, financial practices are often disconnected from clinical care teams, patient experience teams, or community benefit staff, which impedes a holistic approach to address patient financial issues.

Taking Action: Engage representatives, including leaders and frontline staff from financial teams, revenue cycle, clinical care, population health/community benefit, hospital social work, legal and regulatory, hospital board, and patient and community groups.



Key Point for Communicating with Patients and Staff

Patients and staff may have pre-conceived notions about financial assistance and who should receive it. Emphasize that eligibility for assistance is set by the health system as an objective assessment of patients' resources and ability to pay, and that it is a meaningful resource for eligible patients regardless of insurance status.

RECOMMENDATION 3

Foster an internal environment of care and trust throughout the organization, starting with hospital employees.

Rationale: Ensuring the wellbeing of one's own employees represents an important part of the solution toward culture change around medical debt.

Challenge: Hospital staff may be experiencing medical debt or other financial challenges themselves, affecting their own wellbeing, trust in the health system, and ability to be supportive of patients in a similar situation.

Taking Action: Prioritize medical debt relief and assistance to hospital staff to ensure their own wellbeing and that they are well-positioned to assist patients with financial support.



Case in Point: Parkland Health Supports Employees Facing the Same Barriers as Patients

As part of a broader effort to align financial practices with its mission, Parkland Health expanded support programs for its own workforce. This included childcare resources, on-site dental services, assistance in navigating health benefits, financial wellness programming, stress management seminars, and resources to reduce reliance on predatory lending. Leaders viewed these investments as reinforcing organizational values by recognizing that staff are themselves exposed to medical debt, while strengthening empathy for patients in similar circumstances and reducing stigma around financial hardship.

Lessons Learned

- Financial hardship is not solely a patient issue. Staff frequently face the same barriers and supporting them builds both capability and understanding.
- Parkland hires from the communities it serves, which tied employee experience and patient experience closely together and made the connection legible to hospital leaders.
- Parkland is a large public safety-net system. While a smaller organization may not be able to fund the same programs, organizations can still seek ways to prioritize staff financial wellbeing as part of their solution to medical debt in their communities.

See the full Parkland Health case example in the appendix for how this fit within a wider sequence of decisions (page A-1).



RECOMMENDATION 4

Assess the return on investment (ROI) of medical debt collection activities.

Rationale: Given the time, staffing, and resources needed to collect payments from patients, hospitals may find that pursuing such collection efforts is not worth the costs.²²

Challenge: Measuring the ROI of medical debt collections requires a holistic approach that considers a multitude of costs and benefits, including for the system, clinicians, other staff, patients, and the community.

Taking Action: Talk to the revenue cycle team to request this data. Also consider:

- Intangible costs, such as the impact on patient experience and trust, along with the organization's broader reputation and investment in the community.
- Whether any technology used in the collections process is helping or hindering, and in what ways.
- Potentially distinguishing the ROI of collection activities across different patient populations (e.g., high- vs low-income). Small ROIs for a hospital can have disproportionate impacts on patients' financial wellbeing.

RECOMMENDATION 5

Treat the financial experience as a part of the overall patient experience of care.

Rationale: By adopting a comprehensive perspective of what patient care entails, hospitals can gain a better understanding of how patients experience the full hospital encounter.

Challenge: Hospital departments are specialized to address siloed aspects of a patient's journey, from clinical care to financial billing.

Taking Action: Include questions about the patient's financial experience in hospital patient experience surveys to provide a complete picture of the hospital encounter, which can help to further inform hospital financial policies and practices.



Resources for Additional Information

- [An Organizational Chart in Health Care Explained](#), Tulane University School of Public Health & Tropical Medicine (2024): Provides an overview of how various hospital leadership, management, and staff roles are typically structured.
- [Mind the Gap: Connecting Community Benefit and Patient Billing Leaders to Improve Health and Financial Outcomes](#), Undue Medical Debt (2025): Provides an in-depth exploration for bringing revenue cycle and community benefit leaders together to collaboratively address the issue of patient medical debt.
- [Creating Economic Opportunity through Healthcare Career Pathways: An Impact Workforce Toolkit \(section on Institutional System Changes\)](#), Healthcare Anchor Network (2026): Provides information, tools, and resources for hospitals to implement workforce strategies focused on career development and staff support.

What Can Hospitals Do?



Play 2: Support fair and transparent hospital financial practices that reduce administrative burden for patients

Patients encounter numerous barriers as they navigate the financial aspects of care.

Information on insurance coverage, billing, and financial assistance can be difficult to find or interpret, which means patients may not be aware of or understand their options.^{23,24,25}

There are several opportunities to improve the patient financial experience – from improving the availability and administration of financial assistance to providing clear communications and support during the billing process. The following section explores how hospitals can improve support for patients as they navigate the complexity of hospital financial processes.

Goal 1: Prevent medical debt through patient-centered programs.

Why This Matters: Reducing medical debt can begin with prevention by providing financial assistance and other relevant support.

Reflection Questions for Hospital Leaders



- At what point do patients first learn about financial assistance?
- How do we establish our financial assistance eligibility criteria?
- What support options exist for patients who do not qualify for hospital financial assistance?
- Do we offer financial options that may be harmful to patients, such as high interest or deferred interest credit cards?
- Do clinical teams know what financial assistance is available and how to connect patients to it?



Quick Preview: Highlights from This Play

- **Screen at intake.** Screening for Hospital Presumptive Eligibility (HPE) for Medicaid can remove the financial assistance application entirely for patients who qualify. See Recommendation 1: *Participate in Hospital Presumptive Eligibility (HPE) programs to facilitate temporary Medicaid coverage for eligible patients* (page 13)
- **Some of this is subtraction.** Several items in this play are practices to stop rather than programs to start. They are the fastest to act on and the easiest to verify. See Tool 3: *Practice Audit: Which of these does your organization currently do?* (page 17)
- **Find out what is actually happening.** Map every collection activity across the organization, including those run by outside vendors. Leaders are often surprised. See Recommendation 2 (under Goal 2 in this play): *Align contracts with external vendors and partners to ensure ethical and patient-centered practices* (page 17).

**RECOMMENDATION 1****Participate in Hospital Presumptive Eligibility (HPE) programs to facilitate temporary Medicaid coverage for eligible patients.**

Rationale: HPE programs allow hospitals to provide coverage for up to two months to individuals whose income and household size are likely to make them eligible for Medicaid, with the potential for ongoing coverage.²⁶ They help patients afford care while reducing uncompensated costs for the hospital.^{27,28}

Challenge: Application processes and Medicaid requirements are complex, and only hospital employees who are properly trained and certified can make HPE determinations, although third-party contractors can help with application support.²⁹

Taking Action: Assign dedicated staff who are trained and certified in HPE determinations to submit applications, and to follow up with patients on filing a full Medicaid application for ongoing coverage.

Caution! Be transparent with patients about how Medicaid patient data may be used and shared.

RECOMMENDATION 2**Improve access to financial assistance.**

Rationale: By recognizing patient financial needs at the start of the patient encounter, hospitals can help prevent patient medical debt.³⁰ Nonprofit hospitals are required under federal law and the Affordable Care Act to adopt and publicize a financial assistance policy.³¹ Many states also set additional financial assistance requirements for hospitals.³²

Challenge: While IRS regulations set specific standards on sharing financial assistance policies and plain language summaries, they do not provide guidance on best practices for promoting and implementing financial assistance protocols. Additionally, federal financial assistance requirements do not apply to for-profit hospitals, and state regulations vary. However, many for-profit hospitals and hospitals in states without regulated minimums still provide access to financial assistance programs, so a lack of regulation is not justification to avoid action.

Taking Action: Both for-profit and nonprofit hospitals have a number of options for improving the accessibility of financial assistance:

- Expand awareness about the availability of financial assistance programs:
 - Provide information in easily accessible and understandable language, and in appropriate languages for the given location.^{33,34}
 - Convey that financial assistance is intended to provide equitable access to care and has no impact on care quality.
 - Post information in all patient areas of the hospital, on the hospital website's homepage, in patient portals, and on all billing materials, with a central number to speak with a representative regarding questions.^{35,36}
 - During registration and discharge, explain the availability of financial assistance and have patients sign acknowledgements about the availability of financial assistance for qualified patients.
- Simplify application procedures and requirements^{37,38,39}:
 - Use presumptive eligibility for financial assistance at intake to screen patients based on household income and size or participation in government programs, e.g., Supplemental Nutrition Assistance Program (SNAP) or Women, Infants and Children Nutrition Program (WIC).
 - Simplify any application forms, avoid ancillary requirements (e.g., related to area of residence, asset considerations, and insurance status), minimize documentation needs, and offer flexible documentation options (e.g., pay stubs, tax returns, or direct verification with employers).
 - Ensure financial assistance screening occurs before moving patients to a payment plan or taking any collection actions.



Case in Point: DuPage Health Coalition on Challenging Assumptions

The DuPage Health Coalition's financial counselors work with patients across multiple independent health systems in DuPage County, Illinois. As one leader observed, health systems often believed their financial assistance policies were generous but lacked understanding of the practical barriers that kept patients from using them, such as difficulty navigating applications, burdensome documentation requirements, and complex administrative processes.

Lessons Learned

- Generous policies and accessible policies are different things, and the gap between them is usually invisible from inside the organization.
- Health systems can make a meaningful difference by focusing on how patients access financial assistance and streamlining those processes.

See the full DuPage Health Coalition case example in the appendix (page A-9).



Case in Point: Parkland Health Moves Financial Screening Upstream

Parkland Health shifted from a reactive collections model to identifying financial need as early as possible in the patient journey. It simplified its financial assistance application to fewer than two pages, focused primarily on demographic and income information, and made that single form an entry point to several pathways at once, including hospital financial assistance, Medicaid enrollment, and grant-funded programs. Parkland also established an eligibility call center, trained registration staff to identify financial concerns at intake and connect patients to counselors, embedded standardized screening and referral workflows in its electronic health record (EHR), and offered self-pay discounts to eligible patients. Leaders reported that billing-related call volumes declined afterward, which they attributed in part to better patient education earlier in the process.

Lessons Learned

- The application itself is a barrier. Parkland's application was rewritten to under two pages, and one form opened several assistance pathways.
- Embedding processes in the EHR helped streamline and coordinate financial assistance across the organization, from registration to referrals and communication between financial counselors and clinicians. Parkland's leaders were explicit that manual workarounds would have added administrative burden and staffing needs.
- Documentation remains the hard part for patients with cash income, no fixed address, or limited paperwork. Parkland gave counselors latitude to accept alternative verification rather than apply rigid rules.

See the full Parkland Health case example in the appendix (page A-1).

**RECOMMENDATION 3****Strengthen current hospital obligations regarding financial assistance as a part of hospital community benefit.**

Rationale: Nonprofit hospital tax benefits are intended to be used for community support, including free or discounted care for eligible patients.⁴⁰

Challenge: Given budgetary concerns, hospitals may find it difficult to provide financial assistance, especially as federal guidance does not set standard eligibility thresholds or benefit amounts.

Taking Action: Align financial assistance spending with relevant benchmarks.

- For nonprofit hospitals that receive tax exemptions, consider whether your community investments and financial assistance spending meet the responsibility of these exemptions. As part of hospital community benefit, balance how funds are allocated across financial assistance and community programs in a way that is responsive to local needs and identified in community health needs assessments.
- Improve eligibility criteria for financial assistance, if possible. While hospitals must determine their own eligibility levels based on their financial situation, common eligibility thresholds can serve as guiding benchmarks (see box below).

**Common Eligibility Thresholds for Financial Assistance**

- Free care for families making 200% of federal poverty guidelines, or about \$54,000 for a family of three
- Discounted care for families making 400% of federal guidelines, or about \$109,000 for a family of three

Source: Saini V, Chalmers K, Smith P, Fu C, Back A, Talon V, Jean-Marie K, Serrato S. Hospital financial assistance and debt collection policies: a national dataset. Boston (MA): Lown Institute; 2025. (*dollar amounts revised based on 2026 federal poverty guidelines*)

RECOMMENDATION 4**Offer options for patients who do not qualify for financial assistance.**

Rationale: Given the high costs of health care, financial barriers to care remain present for many patients. Even those who have insurance are at increased risk, given the surge in high-deductible health plans and rising out-of-pocket costs.^{41,42}

Challenge: As hospitals are contending with their own revenue challenges, addressing the nuances of how patients understand hospital charges and pay their bills may not be top of mind for hospital leaders.

Taking Action: Provide transparent and flexible payment options.

- Provide good faith estimates for patients who are uninsured or self-pay, so they understand anticipated charges.
- Arranging for patients to pay over time is an important strategy for mitigating medical debt, as it facilitates payment for the hospital while providing needed flexibility to patients. To protect patients from accruing additional costs, such plans should be interest-free.

Caution!

- Educate/advise patients against using their credit cards for medical debt, as credit cards are considered financial debt not medical debt, with implications for any protections that may be available for medical debt.
- Do not store patients' credit card information in their electronic health record.
- Do not offer medical credit cards with fees or high interest rates, which can further trap patients in medical debt.

**RECOMMENDATION 5****Make guidance available to clinicians on how to address patient financial issues.**

Rationale: Seeing their patients struggle with affording health care and even going into medical debt, clinicians may experience a sense of moral injury⁴³ and often want to support patients in navigating the costs of care.

Challenge: Clinicians' primary role is focused on care delivery, and they have little control over whether patients can afford the care they need. Moreover, clinicians have limited time and resources to discuss financial aspects of care with patients.

Taking Action: Hospitals can support clinicians so they are well-equipped to assist their patients.

- Share a summary with clinicians of the hospital's financial assistance policies.
- Ensure clinicians are aware of where to direct patients who may need additional help with the financial aspects of their care.
- Provide clinicians with resources for addressing costs of care with patients, such as guidelines, tools, scripts, and EHR reminders.

Goal 2: Uphold patient-centered practices following care delivery.

Why This Matters: Prioritizing mission-aligned and patient-centered approaches remains significant even after care has been delivered so that financial operations reinforce the institution's core purpose of promoting patient health.

Reflection Questions for Hospital Leaders

- What kind of support do patients receive to help them understand their bills?
- Do patients know they can reach out if they are facing financial barriers to payment?
- Do you know what collection activities occur across your organization, including those managed by outside vendors?
- Do you know whether your hospital or partners are reporting patients' medical debt to credit agencies?

RECOMMENDATION 1**Adopt ethical billing and responsible debt collection practices.**

Rationale: Implementing and communicating clear and fair billing processes can help improve patient understanding of charges and their overall experience of care.⁴⁴

Challenge: Hospital billing and collection processes are highly complex with specialized departments, making it difficult for patients to easily understand and navigate. Debt collection practices might be routinized, with an automated process for unpaid bills.

Taking Action: Hospitals have a number of opportunities to streamline their billing processes and mitigate medical debt for patients.

- Provide timely and transparent billing notices so patients can understand the charges and their responsibility.⁴⁵
- Provide access to a billing representative to answer questions that patients may have throughout the billing process and the adjudication cycle of a claim.⁴⁶
- Charge self-pay patients rates that do not exceed insured rates, as patients are unlikely to be able to afford rates higher than reasonable charges negotiated by insurers.
- Do not engage in extraordinary collections actions (ECAs):
 - Avoid selling debt to third parties, especially without oversight and guarantee that other ECAs will not be used
 - Avoid reporting medical debt to credit agencies
 - Avoid delaying or denying non-emergent care
 - Avoid taking legal action, e.g., lawsuits, wage garnishment, property liens⁴⁷
- Advocate for state and federal laws to prohibit use of ECAs.



Why Aggressive Collection Actions Should NOT Be Pursued

- While extraordinary collections actions (ECAs) are generally legally allowed, this playbook recommends NOT engaging in ECAs due to the devastating impacts these actions can have on people's lives
- Even credit reporting can lead to disproportionately harmful consequences, affecting people's ability to obtain employment or housing—which only further jeopardizes their ability to pay

Tool 3. Practice Audit: Which of these does your organization currently do?

These are practices this play recommends avoiding. Each is a discrete action an organization may or may not take, making these practices a useful starting point and relatively easy to verify. Answer Yes, No, or Unknown.

Practices to Avoid!	We do this	A vendor does this for us
Storing patients' credit card information in the EHR to automatically charge them		
Offering or promoting medical credit cards		
Selling patient debt to third parties		
Reporting medical debt to credit agencies		
Denying non-emergent care to patients with outstanding balances		
Taking legal action, including lawsuits, wage garnishment, or property liens		

Answering "Unknown" to whether a vendor does this practice may be a red flag. Parkland Health's leaders found that although the hospital was not itself reporting patient debt, an outside vendor was doing so on its behalf, a practice they had not known was occurring. If you answered "Yes" to any of the statements, explore how you could halt that practice.

RECOMMENDATION 2

Align contracts with external vendors and partners to ensure ethical and patient-centered practices.

Rationale: While examining a hospital's internal financial policies is critical to protect patients from medical debt, it may be insufficient, given the many external relationships that affect patients' financial experiences.

Challenge: Hospitals often contract with third parties, such as physician groups or revenue cycle management companies, to support care delivery and hospital operations. These groups may have financial practices that conflict with those of the hospital.

Taking Action: Hospitals should require external vendors and partners to follow policies and practices that support patients.

- Require consistent billing ethics across all contracted entities, reviewing and revising any current contracts and issuing new requirements with new contracts.
- Explore the possibility of consolidating billing across all contracted entities to avoid multiple bills for the same visit, or provide white labeling (consistent bill formats) for streamlined and recognizable billing across contracted entities.
- Coordinate with insurers to provide patient education so patients have a clear understanding of their coverage.



Case in Point: DuPage Health Coalition on What Fragmented Billing Looks Like from Outside

DuPage staff described patients receiving separate bills from hospitals, physician groups, pathology laboratories, radiologists, anesthesiologists, and ambulance providers, often with no way to understand how the services were connected. Growing reliance on outsourced billing vendors compounded the problem; counselors reported long waits, dropped calls, and limited responsiveness even when experienced navigators called on a patient's behalf.

Lessons Learned

- If trained financial counselors cannot get answers from your billing vendor, patients will not either. Vendor responsiveness is a patient-facing quality.
- Consolidating billing across contracted entities addresses a problem patients experience constantly and hospitals rarely see.

See the full DuPage Health Coalition case example in the appendix (page A-9).

Goal 3: Assess the provision of hospital financial assistance and extent of patients' medical debt.

Why This Matters: Data collection and reporting help provide a more complete picture of hospital activities regarding financial assistance and debt collection, contributing to greater hospital transparency while also informing ethical financial approaches.

Reflection Questions for Hospital Leaders



- How will financial impacts be evaluated?
- What operational metrics should be monitored?
- How will we know whether patient financial harm has been reduced?

RECOMMENDATION 1

Collect and report data on financial assistance applications and medical debt collections.

Rationale: Given public concerns around the high costs of care and medical debt, hospitals can track their performance and share progress, so communities are aware of hospital actions to mitigate the financial burdens of care.

Challenge: Hospital processes may not be set up for tracking financial assistance applications and debt collections.

Taking Action: Hospitals can opt to collect, monitor, and report on a few key data points, some of which they may already be collecting:

- Number of patient financial assistance applications attempted, completed, approved, and denied, including amount of assistance, insurance status, and patient demographics (e.g., income, race/ethnicity).
- Number of patients with unpaid bills, including amount of debt, insurance status, any extraordinary collection actions, and patient demographics (e.g., income, race/ethnicity).

**Tool 4. Starter Tracker for Patient Financial Assistance Data**

Use/adjust the table below to collect data on patient financial assistance. While more detailed data tracking may be more informative, the table serves as a starting point.

Measures	[fiscal year] Number	[fiscal year] Number	[fiscal year] Number
Patient financial assistance applications attempted			
Patient financial assistance applications completed			
Patient financial assistance applications denied			
Patient financial assistance applications approved			
Number of patients receiving financial assistance through presumptive eligibility for financial assistance via participation in public benefit programs, such as SNAP or WIC			
Number of patients receiving financial assistance through presumptive eligibility for financial assistance via income estimation			
Number of patients receiving free care via financial assistance			
Number of patients receiving discounted care via financial assistance			
Number of patients on a payment plan			

Adapted from [Hospital Financial Assistance Data Reporting Requirements in Illinois](#).

**Resources for Additional Information**

- [Hospital Presumptive Eligibility: Opportunities to Connect Uninsured Individuals to Coverage](#), Center for Health Care Strategies, Inc. (2014): Factsheet with guidance for hospitals on participating in HPE programs, including hospital responsibilities, requirements, and an illustrative example.
- [Hospital Toolkit: Practical Guidance to Help Hospitals Make Financial Assistance Known, Easy, and Fair, Dollar For \(2025\)](#): Provides practical guidance for financial assistance, appeals processes, and debt collection protections.
- [Predictive Analytics in the Age of Un\(der\)insurance: A Primer](#), Undue Medical Debt (2026): Provides guidance on how to use predictive tools to identify patients who are eligible for financial assistance, including challenges and effective strategies.
- [Advancing Healthcare Access: Responsible Financial Assistance, Billing and Collection Policies for Hospitals](#), Healthcare Financial Management Association and Advocata Solutions (2025): Outlines guidance for strengthening hospital policies, practices, and staffing related to financial assistance and billing and collection.
- [Hospital Billing Ethics](#), The Leapfrog Group (2026): Factsheet detailing the Leapfrog Hospital Survey measure for ethical billing practice standards.
- [Workflow Requirements for Cost-of-Care Conversations in Outpatient Settings Providing Oncology or Primary Care: A Qualitative, Human-Centered Design Study](#), Annals of Internal Medicine (2019): Provides guidance for cost conversations, clinic-based workflows, and accessing financial support.
- [Patient-Provider Cost-of-Care Conversations to Prevent Financial Toxicity](#), Clinical Journal of Oncology Nursing (2025): Includes conversation protocol, workflow process map, and a template to document cost conversations.
- [Healthcare Transparency: Talking to Patients about the Cost of Their Health Care](#), American College of Physicians (2019): Provides tools for clinicians and patients to support cost of care conversations, including guides for identifying cost distress, inquiring about health care costs, and estimating costs of care, among other resources.

What Can Hospitals Do?



Play 3: Engage patient- and community-oriented organizations to strengthen financial navigation and improve hospital financial practices

Patients often need support navigating the financial aspects of health care, from understanding insurance coverage and applying for financial assistance to resolving billing concerns and avoiding medical debt.

The US health care system is complex, and navigating these processes can be difficult even for patients more familiar with the system; challenges are compounded when patients receive care from multiple providers, receive multiple bills, or are not told how to get help.

By partnering with patient- and community-oriented organizations, hospitals can strengthen financial navigation, reduce administrative burden on patients and clinicians, and identify opportunities to improve financial policies and practices.

Goal: Engage community-oriented organizations to expand financial support, strengthen patient navigation, and inform system improvements.

Why This Matters: Hospitals may recognize the importance of financial navigation but may not have the staffing, expertise, or infrastructure needed to provide individualized support to every patient. Community-oriented organizations, including patient advocacy organizations, nonprofit financial navigators, and medical debt relief organizations, can extend hospital capacity by providing trusted support to patients while helping hospitals identify opportunities to improve financial processes.

These partnerships can also provide hospitals with valuable insight into patient experiences. Because community-oriented organizations often work across multiple hospitals and interact with patients throughout the financial journey, they may identify barriers that are difficult for hospitals to see from within their own operations.



Quick Preview: Highlights from This Play

- **Identify existing expertise.** Many organizations already help patients understand coverage, apply for assistance, and resolve financial barriers. Community partnerships are most effective when organizations work together to connect patients with financial navigation services, not simply when hospitals provide patients with a phone number. Establish clear referral and follow-up processes. Community Health Needs Assessments (CHNAs) can help you understand how these organizations are serving patients outside the hospital walls. See Recommendation 1: *Build partnerships to help patients navigate financial challenges* (page 21).
- **Listen to what organizational partners are seeing.** Organizations that regularly work with patients can help identify gaps between hospital policies and patients' ability to access services. Start early in the patient journey to identify barriers that contribute to medical debt, then engage organizational partners to help address those gaps. See Recommendation 2: *Use partnerships to identify and fix system barriers* (page 22).
- **Use partnerships to address existing and prevent new debt.** Connect patients with organizations that can provide immediate debt relief, while also using those partnerships to identify barriers that may contribute to new debt. See Recommendation 3: *Partner to address existing debt while preventing new debt* (page 23).



Reflection Questions for Hospital Leaders

- Which organizations already help our patients navigate health care costs?
- Where do patients experience the greatest confusion or financial burden, and how do we ensure patients successfully connect with referred services?
- Do our clinicians and staff know what patient and community resources are available?
- How do we coordinate with community partners after making a referral?
- Are we investing in partnerships that improve patient outcomes rather than simply outsourcing financial functions? How do we measure this?
- How do we incorporate feedback from community-oriented partners into hospital improvements?

RECOMMENDATION 1

Build partnerships to help patients navigate financial challenges.

Rationale: Financial navigation requires specialized knowledge of insurance coverage, hospital financial assistance policies, billing processes, and available resources. While some hospitals have dedicated financial counselors, many do not have sufficient staffing capacity to provide individualized support to every patient experiencing financial challenges.

Community-oriented organizations can help fill this gap by helping patients navigate complex financial processes and connecting them with available resources. Organizations that support patients across multiple hospitals may also identify common barriers and opportunities for improvement that hospitals may not see internally.

Challenge: Effective partnerships require more than providing patients with a referral list. Hospitals must establish relationships with trusted organizations and create clear referral pathways.

Hospitals may also need to dedicate staff time to identifying partners, maintaining relationships, and ensuring referrals successfully connect patients with support.

Taking Action: Build relationships and referral systems that help connect patients with trusted sources of financial support.

- Identify nonprofit organizations, patient advocacy organizations, and other community-oriented partners with financial navigation expertise. Counties can also be a source of information for area resources to help patients address the financial aspects of care.
- Establish referral processes that are simple for patients, clinicians, and staff.
- Clarify roles and responsibilities between hospital staff and community-oriented partners, including how the hospital helps the community-oriented organizations sustain their work, whether through direct investment or by strengthening and informing broader funder networks locally.
- Create regular communication channels to discuss outcomes and patient barriers and opportunities for improvement.
- Review referral patterns and patient feedback to identify opportunities to strengthen navigation.

Caution!

- Do not rely on community-oriented organizations solely as referral outlets; establish mechanisms for communication, collaboration, and shared learning.
- Without strong partnerships, patients may experience fragmented support, additional challenges navigating services, or referrals to resources that do not fully address their needs.
- Ensure that community-oriented organizations are appropriately compensated for the services they are providing.

**Tool 5. Community Partnership Readiness Checklist**

Purpose: To help hospitals assess whether they have the infrastructure and staffing needed to build and sustain equitable partnerships with community-oriented organizations. If you answer mostly No, the recommendations in this play may help identify where to begin.

	Y/N
We have identified the patient financial challenges we want to address or are open to identifying patient challenges.	
We have identified existing community-oriented organizations with relevant expertise	
We have identified a hospital point person responsible for partnership coordination.	
We have established referral workflows that enable communication between departments that don't typically collaborate, e.g. community benefit leaders, revenue cycle, and financial assistance staff.	
We have a process for receiving and acting on partner feedback, e.g. through board representation, surveys, Patient and Family Advisory Councils (PFACs), one-on-one meetings, or other avenues for ongoing input and course correction.	
We have clarified data-sharing and privacy expectations.	

RECOMMENDATION 2**Use partnerships to identify and fix system barriers.**

Rationale: Community-oriented organizations often see the practical challenges that patients experience when attempting to understand bills, access financial assistance, resolve billing questions, or navigate health care costs. Because these organizations frequently work across multiple hospitals and support patients throughout their financial journey, they can provide valuable insight into gaps between hospital policies and patients' experiences in practice.

Partner feedback can help hospitals identify opportunities to improve financial assistance processes, billing practices, referral pathways, and other systems that contribute to patient confusion or burden.

Challenge: Sustaining meaningful partnerships requires dedicated staff time, resources, and organizational commitment. Establishing regular communication, clarifying roles, and integrating collaboration into existing workflows can help ensure both hospitals and community-oriented organizations have the capacity to participate meaningfully.

Taking Action: Create feedback loops with community partners to better understand patient needs and improve processes.

- Establish regular communication channels with organizational partners.
- Ask partners what barriers patients most frequently encounter when navigating financial processes.
- Review whether patients are successfully accessing available financial assistance and other resources.
- Share recurring themes identified by partner organizations with relevant internal teams.
- Incorporate partner feedback into reviews of financial assistance, billing, and navigation processes.
- Follow up with partners about actions taken in response to their feedback.

Caution!

Ensure that feedback from partner organizations leads to action and improvements in hospital processes and avoid collecting feedback without a clear plan for review, response, or follow-up.



Case in Point: DuPage Health Coalition Builds a Community-Based Navigation Network

Through Access DuPage, the DuPage Health Coalition connects uninsured and underinsured residents of DuPage County, IL with participating providers, care coordination services, and resources to address health care access and affordability challenges. The program creates a trusted pathway for patients who may otherwise struggle to navigate multiple systems independently, helping connect individuals with available support rather than relying on patients to identify resources and coordinate assistance on their own. By working across health systems and supporting patients throughout their care journeys, the coalition can help identify barriers that may not be visible from within any single health system.

Lessons Learned

- Financial navigation partnerships can extend health system capacity by connecting patients with community-oriented organizations that already have expertise supporting individuals through complex financial processes, from applying for financial assistance or health coverage to navigating medical billing.
- Effective partnerships require more than referrals. Clear roles, communication pathways, and shared expectations help ensure patients successfully connect with support.
- DuPage Health Coalition reflects a regional partnership model; smaller organizations may not be able to replicate the same structure, but the underlying approach (e.g. building relationships with trusted organizations already serving patients) can be adapted in many settings.

See the full DuPage Health Coalition case example in the appendix (page A–9).

RECOMMENDATION 3

Partner to address existing debt while preventing new debt.

Rationale: Some organizations specialize in medical debt relief and work with hospitals to eliminate qualifying debt for patients. These partnerships can provide immediate financial relief while also helping hospitals better understand patterns of unpaid bills and identify opportunities to strengthen upstream prevention strategies.

Debt relief partnerships can be one component of a broader strategy that includes accessible financial assistance, insurance navigation, transparent billing practices, and efforts to prevent avoidable medical debt.

Challenge: Hospitals must consider how debt relief fits within broader financial assistance policies and how patient information will be shared and protected.

In addition, relieving existing debt does not address the underlying systems that contribute to future medical debt. Hospitals should use lessons from these partnerships to identify opportunities for prevention.

Taking Action: Integrate debt relief partnerships into broader strategies to support patients and improve financial practices.

- Assess whether partnerships with medical debt relief organizations align with organizational goals and patient financial assistance strategies.
- Establish clear eligibility criteria for debt relief and clear processes for identifying and communicating with affected patients.
- Use insights from debt relief partnerships, including analyses of debt patterns and patient experiences, to identify opportunities to strengthen financial assistance and billing practices.

Caution!

- Debt relief does not replace the need for accessible financial assistance and patient-centered billing practices.
- Partnerships should be evaluated based on how they improve patient experiences and reduce financial burden.
- Ensure patients understand how their information will be used and protected.
- Avoid viewing debt relief as a standalone solution rather than part of a broader strategy to prevent medical debt.



Case in Point: Undue Medical Debt Partners with Health Systems to Address Existing Debt and Inform Future Prevention Efforts

Undue Medical Debt partners with health systems and other organizations to relieve qualifying medical debt and reduce the financial burden patients experience. Through these partnerships, organizations can identify eligible debt for relief and provide support to patients whose medical bills have become a source of ongoing financial hardship.

For health systems, partnerships with medical debt relief organizations can provide immediate support to patients while also creating opportunities to better understand patterns of financial hardship. Leaders should consider how debt relief fits within broader efforts to prevent future medical debt rather than viewing it as a standalone solution.

A health care provider can execute the legal and data-sharing agreements needed to securely transfer eligible account information, and Undue then identifies qualifying patients using income estimation tools and provides debt relief. Hospitals may choose to establish ongoing partnerships with Undue to review additional account cohorts, monitor trends over time, and evaluate the impact of workflow or policy changes.

Information gained through these efforts can help hospitals identify opportunities to strengthen upstream strategies, including financial assistance processes, insurance navigation, and billing practices.

Lessons Learned

- Medical debt relief can provide meaningful support for patients, but it should be paired with efforts to improve financial assistance, navigation, and billing practices.
- Successful partnerships require organizational readiness, including coordination across the departments that are responsible for financial operations, compliance, legal considerations, and patient communication.
- Debt relief partnerships can help health systems identify patterns in financial hardship and opportunities to address barriers before debt accumulates.
- Health systems should evaluate partnerships based on their impact on patients, including whether they reduce burden and improve access to support, rather than solely on operational outcomes.

See the full Undue Medical Debt case example in the appendix (page A-14).



Resources for Additional Information

- **Undue Medical Debt:** Partners with health systems to relieve qualifying medical debt and support broader efforts to understand and address medical debt.
- **Dollar For:** Supports patients in accessing hospital financial assistance and understanding charity care eligibility.
- **Patient Advocate Foundation:** Provides case management and financial navigation support for patients experiencing financial hardship.
- **Local community organizations:** Consider including local financial navigation, legal aid, and patient advocacy organizations relevant to your region.

What Can Clinicians Do?



Play 1: Ensure that financial policies and practices promote organizational values and mission of improving health

Clinicians form a key component of a hospital's organizational culture, given their medical expertise, direct role in care delivery, and commitment to ethics and improving patient health.

Drawing on their professional values and interactions with patients, clinicians can help inform and influence organizational policies and practices.

Goal: Raise awareness and connect with other clinicians in the hospital to promote shared understanding and collective action.

Why This Matters: While clinicians have many responsibilities and demands on their time, financial stress related to costs of care are increasingly affecting their relationships with patients. By developing a unified voice with other clinicians and sharing their insights with hospital leaders, clinicians can influence hospital policy and help align practices with organizational values.⁴⁸



Quick Preview: Highlights from This Play

- **Share your insights.** Next time you interact with a C-Suite leader, note how medical costs are impacting the patients you are seeing, e.g., in terms of care seeking, treatment decisions, adherence. See Recommendation 1: *Engage with hospital leaders to support stronger alignment between organizational ethics and hospital financial practices* (page 26).
- **Build peer support.** Ask fellow clinicians how they handle cost conversations and related issues with their patients. This can help inform effective approaches and start to coalesce clinician voices. See Recommendation 2: *Reach out to fellow clinicians for peer support, learning, and exchange* (page 26).

Reflection Questions for Clinicians



- Which hospital leaders influence hospital policies for patient financial assistance and billing and collections?
- Are there other clinicians in the hospital who may be struggling with how to engage with patients about the costs of care?



RECOMMENDATION 1

Engage with hospital leaders to support stronger alignment between organizational ethics and hospital financial practices.

Rationale: Clinicians often have direct insight into how medical debt affects their patients and can undermine the clinician-patient relationship and patient trust in the health care system. Raising awareness among hospital leaders can provide a valuable perspective about the unintended consequences of financial policies and practices.

Challenge: Given their patient-focused responsibilities, clinicians may not view themselves as champions for system change.

Taking Action: Share your insights with hospital leaders about how medical debt affects patients, community trust, and care-seeking behavior. Many hospitals have executive rounds, which can provide an opportunity to raise the issue of health care costs and medical debt with hospital leaders. Providing a deeper understanding of how health care costs play out for patients can be helpful for hospitals in designing effective solutions aligned with organizational ethics.

RECOMMENDATION 2

Reach out to fellow clinicians for peer support, learning, and exchange.

Rationale: As clinicians increasingly confront issues of health care affordability among their patients, having a trusted space to share challenges can offer a source of peer learning and support.

Challenge: Clinicians often lack formal avenues of support within hospitals for addressing cost issues and may experience a sense of moral injury⁴⁹ in confronting issues of health care affordability among their patients.

Taking Action: Connect with other clinicians to exchange experiences and strategies that have been effective in engaging with patients about the costs of care and explore opportunities to collectively carry your messages to hospital leaders.



Resources for Additional Information

[First Do No Harm: How Clinicians Can Champion the End of Medical Debt](#), Undue Medical Debt (2024):

Provides action-oriented guidance for physicians, nurses, community health workers, and other frontline clinicians on how to support patients who may be struggling with the costs of care, while also increasing the visibility of medical debt and its impacts on patients and their families.

What Can Clinicians Do?



Play 2: Support fair and transparent hospital financial practices that reduce administrative burden for patients

Clinicians are increasingly addressing patient concerns about health care costs.

Goal: Support patients as they navigate the financial costs of care.

Why This Matters: Health care financial operations are exceptionally complex, making it difficult for patients to navigate the various processes for managing their health care costs. Clinicians can play a role in helping their patients as they navigate the financial aspects of care.^{50,51}

Reflection Questions for Clinicians



- What kinds of financial issues are patients struggling with?
- What kinds of resources are available to patients facing financial barriers?
- How can financial conversations be integrated into care workflows?



Quick Preview: Highlights from This Play

- **Take stock.** Learn what hospital resources are available to patients facing financial barriers to care. See Recommendation 1: *Become familiar with the hospital's financial resources for patients* (page 27).
- **Pick one or two strategies.** Clinicians have several options for supporting patients in addressing financial challenges. Start with one or two that seem doable. See Recommendation 2: *Explore opportunities to engage with patients regarding the costs of care* (page 28).
- **Use available patient tools.** Patient-facing materials can provide needed information while saving time during the patient visit. See Resources for Additional Information: [*Healthcare Transparency: Talking to Patients about the Cost of Their Health Care*](#) from the American College of Physicians (page 29).

RECOMMENDATION 1

Become familiar with the hospital's financial resources for patients.

Rationale: As hospitals are working to support patients through their financial systems, clinicians can also be a trusted source of support by connecting patients to hospital resources.

Challenge: Clinicians have limited time with patients.

Taking Action: There are opportunities for clinicians to leverage hospital resources when assisting patients with managing care costs.

- Know where to access the hospital's financial assistance policy and gain a better understanding of how the policy and application process works.
- Find out where to refer patients for additional information on hospital financial resources, e.g., a hospital financial counselor, social work referral.
- Identify resources for patient medication discounts (see the clinician case example in the appendix).
- For contracted clinicians, ensure that you participate in the hospital's financial assistance policy.

**Tool 6. Checklist for Clinician Readiness**

Answer the below questions regarding engaging with patients on financial issues of care. If you answer No more often than Yes, the recommendations in this play may help identify where to begin.

Question	Y/N
Do you know where to find your hospital's financial assistance policy?	
Do you participate in/adhere to your hospital's financial assistance policy?	
If your physician group has its own financial assistance policy, is it aligned with your hospital's financial assistance policy?	
Do you feel comfortable engaging with patients about the costs of their care?	
Are you familiar with resources to help patients afford their medications?	

Adapted from the reflection questions in this play and from the clinician case example.

RECOMMENDATION 2**Explore opportunities to engage with patients regarding the costs of care.**

Rationale: Many patients who are facing financial barriers to care may not raise their concerns with clinicians, and some may be concerned that raising cost issues may affect the quality of their care.^{52,53}

Challenge: Clinicians may also be hesitant to raise the issue of costs or affordability with patients because they may be unsure of how to approach the issue.⁵⁴

Taking Action: Clinicians can help patients feel supported and informed regarding the financial aspects of their care:

- Ask patients if they have questions about the costs of their care, and use the two-measure screener below to assess risk for financial toxicity.
- Discuss overall costs, if known, and explore high-value care options with patients, when possible.
- Refer patients to hospital resources, e.g., a hospital financial counselor, social work referral, and/or financial assistance policies in case they might be eligible.
- Connect patients to more affordable medication options, e.g., using real-time benefit tools or other sources for discounts (see the clinician case example in the appendix).
- Point patients to community-oriented resources for further assistance with financial navigation, if needed (see Play 3 for Clinicians).
- For patients who may be uncomfortable discussing the costs of care, provide cost tools that they may use independently (see Resources for Additional Information: [Healthcare Transparency: Talking to Patients about the Cost of Their Health Care](#) from the American College of Physicians).

Tool 7. Two-Question Measure for Assessing Patient Financial Toxicity Risk

Ask patients to respond to the two statements below. If the answer to Question 1 is Yes, direct the patient to additional sources of support as described in the recommendations above and/or see Play 3 for Clinicians for referral options to community-based organizations.

Questions for Patients	Y/N
Question 1: "I worry about the financial problems I will have in the future as a result of my illness or treatment"	
Question 2: "I am satisfied with my current financial situation"	

Source: Thom B, Tin AL, Chino F, Vickers AJ, Aviki EM. Development and Validation of a Simplified Financial Toxicity Screening Tool for Use in Clinical Practice. *JCO Oncol Pract*. 2025 Jan;21(1):12-19. doi: 10.1200/OP-24-00598. Epub 2025 Jan 10. PMID: 39793553; PMCID: PMC12305446.



Case in Point: A Clinician Perspective on Engaging with Patients on Costs of Care

Dr. Caroline Sloan, a primary care physician at the Duke Outpatient Clinic, runs through a mental menu of options with her patients—from exploring lower-cost medications to estimating costs for labs and imaging to considering parking and transportation.

She highlights the importance of medication costs and uses the following options to address them: 1) real-time prescription benefit tools embedded in many EHRs for identifying lower-cost alternatives; 2) coupon and price comparison companies like GoodRx; and 3) direct-to-consumer pharmacies, like the Cost Plus Drug Company and Blueberry Pharmacy.

Lessons Learned

- Even patients who do not have catastrophic expenses may still struggle with affording their care, and clinicians can make a difference in helping them navigate costs.
- Engaging with patients on costs can serve to strengthen patient-clinician relationships and improve patient trust.

See the full Clinician case example in the appendix (page A-21).



Resources for Additional Information

- [**First Do No Harm: How Clinicians Can Champion the End of Medical Debt, Undue Medical Debt \(2024\):**](#) Provides action-oriented guidance for physicians, nurses, community health workers, and other frontline clinicians on how to support patients who may be struggling with the costs of care, while also increasing the visibility of medical debt and its impacts on patients and their families.
- [**Healthcare Transparency: Talking to Patients about the Cost of Their Health Care, American College of Physicians \(2019\):**](#) Provides tools for clinicians and patients to support cost of care conversations, including guides for identifying cost distress, inquiring about health care costs, and estimating costs of care, among other resources.
- [**The 7 Habits of Highly Effective Cost-of-Care Conversations, Annals of Internal Medicine \(2019\):**](#) Summarizes best practices for discussing costs of care with patients, from initiating conversations to anticipating costs to coordinating with the clinical team.
- [**Workflow Requirements for Cost-of-Care Conversations in Outpatient Settings Providing Oncology or Primary Care: A Qualitative, Human-Centered Design Study, Annals of Internal Medicine \(2019\):**](#) Provides guidance for cost-of-care conversations, clinic-based workflows, and accessing organization support.
- [**Patient-Provider Cost-of-Care Conversations to Prevent Financial Toxicity, Clinical Journal of Oncology Nursing \(2025\):**](#) Includes conversation protocol, workflow process map, and template to document cost conversations.
- [**The potential impact of introducing a cost tool to facilitate cost-of-care conversations in routine OB care: Lessons from the CONTINUE pilot study, PEC Innovation \(2023\):**](#) Discusses the value of providing paper-based tools to support patients in managing the nonmedical costs associated with care delivery, particularly among low-income patients, who may be uncomfortable with discussing cost issues.
- [**Choosing Wisely, ABIM Foundation \(2012-2023\):**](#) Although the Choosing Wisely campaign is no longer active, the website retains information about the initiative and addressing health care value.

What Can Clinicians Do?



Play 3: Engage patient- and community-oriented organizations to strengthen financial navigation and improve hospital financial practices

Clinicians and care teams are often among the first to hear when cost concerns affect a patient's ability to access or continue care, but they may not have the time, training, or resources to address complex financial challenges on their own.

By knowing what resources are available and how to connect patients with support, clinicians can help ensure financial concerns are addressed alongside clinical needs.

Clinicians also have an important role in identifying recurring challenges patients experience when navigating financial systems. Sharing these insights with health system teams can help them understand where policies and processes may create barriers and identify opportunities to improve financial support.

By connecting patients with trusted resources and sharing patient experiences, clinicians can help strengthen financial navigation, reduce burden on patients and care teams, and support improvements in hospital financial practices.

Goal: Connect patients with trusted partner organizations.

Why This Matters: Clinicians frequently learn when patients are experiencing financial concerns, but they may not have the time or expertise to help patients navigate insurance coverage, financial assistance applications, billing questions, or medical debt. Community-oriented organizations and other patient-focused partners can provide specialized support while allowing clinicians to focus on delivering care.

By understanding available resources and referral pathways, clinicians can help ensure that patients find support earlier, before financial challenges become overwhelming. Clinicians do not need to become financial navigators themselves; their role is to recognize when patients may need support and connect them with trusted resources.



Quick Preview: Highlights from This Play

- **Recognize financial concerns as part of patient care.** Patients may not always directly identify financial concerns, but clinicians and care teams may hear questions about affordability, bills, insurance coverage, or difficulty accessing recommended care. Clinicians do not need to become financial experts. Their role is to recognize when patients may need support and connect them with appropriate resources.
Become familiar with hospital financial assistance programs, financial navigators, and trusted community-oriented organizations that can support patients with different financial needs. See Recommendation 1: *Refer patients to trusted organizations that provide financial navigation support* (page 31).
- **Recognize patterns.** Clinicians often see where patients experience confusion or burden. Sharing these patterns can help organizations identify opportunities to improve financial processes. See Recommendation 2: *Share recurring barriers to help improve financial processes* (page 32).

Reflection Questions for Clinicians

- Do I know what financial navigation resources are available for my patients?
- How can I connect patients with support when they express concerns about affordability?
- Does my hospital have clear referral pathways for financial assistance and community resources?





RECOMMENDATION 1

Refer patients to trusted organizations that provide financial navigation support.

Rationale: Clinicians and care teams may not have the time or expertise to address all financial challenges patients face. Referring patients to trusted organizations helps ensure they receive specialized support to understand their options, access available resources, and navigate complex financial processes.

Challenge: Hospitals may not have established referral pathways for clinicians to readily connect patients with community-based organizations, and clinicians may not be aware of available community resources.

Taking Action: Help patients find and access available resources.

- Become familiar with available hospital and community-based financial resources, including organizations that help patients apply for financial assistance, understand billing, navigate insurance coverage, or address medical debt.
- Ask your hospital for a current list of local and national organizations that can assist patients with financial concerns.
- Where available, use established referral pathways to connect patients with financial navigators, patient advocates, or other support organizations.
- Consider incorporating financial resource information into routine workflows, particularly for patients who may face increased financial barriers.

Caution!

Clinicians should not be expected to become experts in financial navigation or independently resolve complex billing issues.

Tool 8: Community Resource Referral Guide

Purpose: To create a standardized referral resource that enables clinicians and staff to easily identify appropriate community partners, understand available services, and connect patients with support based on their individual needs.

Patient need	Potential community resource	Services provided	Example partnership activities
Applying for hospital financial assistance	Financial navigation organization (e.g. Dollar For)	Helps patients understand eligibility for hospital financial assistance and complete charity care applications	Provide patients with direct referral pathways for financial assistance application support, coordinate on eligibility documentation when appropriate, and review recurring application barriers identified by the organization to improve hospital financial assistance processes.
Understanding medical bills	Patient advocacy organization (e.g. Patient Advocate Foundation)	Provides case management, financial navigation, and support for patients experiencing financial hardship	Develop referral pathways for patients with complex financial needs, establish communication channels for appropriate follow-up, and use trends identified through case management to inform improvements to patient financial support.
Medical debt concerns	Medical debt relief organization (e.g. Undue Medical Debt)	Partners with health systems to relieve qualifying medical debt and support broader efforts to address medical debt	Assess whether a debt relief partnership aligns with organizational goals, establish processes for identifying eligible debt and communicating with patients, and use insights from debt portfolios to strengthen upstream financial assistance and billing practices.
Insurance enrollment or other support needs	Consumer assistance programs (CAPs), State Health Insurance Assistance Program (SHIPs) for Medicare, legal aid organizations, community resource networks, or other nonprofit organizations	Assists patients with insurance enrollment (e.g. Medicaid, Marketplace plans, or other coverage programs), financial counseling, legal or consumer advocacy, and connections to community resources based on individual needs	Build relationships with trusted local organizations, establish referral and communication pathways, and regularly review community resource availability and unmet patient needs.



RECOMMENDATION 2

Share recurring barriers to help improve financial processes.

Rationale: Clinicians and staff often see firsthand where patients encounter challenges with accessing financial assistance, understanding bills, or navigating hospital processes. These experiences can help hospitals identify patterns and opportunities to improve financial policies and practices.

Challenge: Without intentional processes for collecting and reviewing concerns, valuable insights from clinicians and patients may not translate into system improvements.

Clinicians also should not be expected to serve as the primary mechanism for identifying or resolving financial challenges.

Taking Action: Ensure patient and clinician perspectives inform how financial policies and processes are developed and improved.

- Share recurring patient concerns with appropriate health system teams to help identify barriers and improve financial practices.
- Participate in efforts to improve referral pathways, financial assistance processes, and patient financial support systems.
- Encourage hospitals to incorporate patient and clinician feedback when evaluating financial policies and practices.
- Communicate recurring challenges observed in clinical settings to teams responsible for billing, financial assistance, patient experience, and care coordination.

Caution!

- Recognize that individual patient experiences may reflect broader system challenges; use feedback to identify patterns while protecting patient privacy.
- Ensure feedback mechanisms lead to meaningful review and action rather than serving only as information-gathering exercises.
- Clinicians should not be expected to resolve systemic financial barriers through individual referrals alone.



Resources for Additional Information

- **Dollar For:** Supports patients in accessing hospital financial assistance and understanding charity care eligibility.
- **Patient Advocate Foundation:** Provides case management and financial navigation support for patients experiencing financial hardship.
- **Local community organizations:** Consider including local financial navigation, legal aid, and patient advocacy organizations relevant to your region.

Conclusion

While approaches to addressing patient health care costs will vary depending on a given hospital or clinician's unique context, this playbook is intended to provide guidance to help identify opportunities for improving financial assistance practices, supporting patients in navigating the costs of care, and mitigating medical debt. Beyond the recommendations and case examples illustrated in this playbook, the resources for additional information listed at the end of each section provide a host of materials that can further assist hospitals and clinicians in their efforts to support patients in addressing health care costs. As you make practice changes, we encourage you to track your progress and share your work and story with your local communities and with the public more broadly, enabling other hospitals, clinicians, and communities to learn from your example and experience.

If you have feedback or stories to share with us regarding your progress and what you are learning, please let us know by writing to this address: info@abimfoundation.org.

To share your stories more broadly, repost the social media graphics available in the marketing toolkit available here: academyhealth.org/MedDebtPlaybook, and add your own story!

Appendix

CASE EXAMPLE

Ensuring Patient-Centered Financial Practices: A Hospital Perspective (Parkland Health)

Core Problem: Are our financial practices causing harm?

Background

Parkland Health (Parkland) is one of the largest public safety-net health systems in the United States. Governed as a public hospital district with a [population health mission](#), Parkland serves Dallas County through a longstanding commitment to improving community health and reducing barriers to care. Prior to the work described in this case, the organization had already established strong community relationships through an extensive community engagement infrastructure, including Community Health Needs Assessments (CHNAs), patient and family advisory councils (PFACs), Community Health Workers (CHWs), and community relations staff embedded in primary care settings. As an [anchor institution](#), Parkland’s strategic plan also emphasizes hiring from the communities it serves and aligning organizational practices with its mission and values.

The work described in this case began when Parkland leaders questioned whether longstanding organizational practices fully reflected the health system’s mission as a public safety-net institution. Rather than assuming existing policies were achieving the intended balance between financial stewardship and patient well-being, they examined how those practices affected patients and whether alternative approaches could better support both organizational and community goals.

Health systems considering similar efforts should consider the context in which Parkland’s approach was developed, including its size, location, patient population, payer mix, leadership commitment, and capacity to implement change (**Table 1**).

Table 1. Contextual Factors Influencing Parkland’s Implementation Process

Contextual Factor	Parkland
Health system size	Large, integrated public health system with substantial operational capacity
Location and service area	Urban safety-net health system serving Dallas County
Patient population and payer mix	Large proportion of uninsured and Medicaid patients; self-pay collection represented very little revenue
Community context	Serves communities with significant financial and social needs, which shapes organizational priorities
Leadership commitment	CEO was already motivated to eliminate the practice and championed the change
Internal relationships	Strong collaboration across finance, operations, legal, health equity, and clinical teams enabled rapid implementation
Organizational mission and values	Patient-centered mission aligned closely with reducing medical debt burden
Change readiness	Existing systems and alignment allowed the organization to move quickly

In addition to these contextual factors, several organizational qualities enabled Parkland to move quickly once leadership decided to pursue the change. These included strong executive commitment, internal collaboration, and existing operational infrastructure to support change:

- **Strong Executive Leadership and Commitment to Mission:** Sustained executive support from CEO Fred Cerise, M.D., who signaled that reducing patient financial harm was an organizational priority rather than solely a revenue-cycle issue, along with governance and mission structures that prioritized community health, access, and public accountability.
- **Internal Collaboration and Communication:** Existing internal relationships among revenue cycle, patient experience, community health, and operational leaders.
- **Capacity to Drive Change:** Established financial assistance programs and internal capacity to redesign workflows and implement changes within the electronic health record.

This case illustrates how context can influence implementation strategy, timelines, and executive engagement. Organizations should consider how their own circumstances may require different sequencing, resources, or approaches to achieve similar outcomes. This case focuses on the decisions Parkland made, the challenges encountered, and the sequence of implementation (**Table 2**), while accompanying implementation tools provide more general guidance for adapting these lessons to other settings.

Table 2. Snapshot of Parkland's Implementation Process

Recognizing a Misalignment Between Mission and Practice	After reading <i>Your Money or Your Life</i> , CEO Dr. Fred Cerise leveraged his leadership role to initiate an organization-wide review of whether Parkland's financial practices reflected its mission and commitments to patients. The review examined billing and collection practices alongside CHNA findings and community feedback about patients' experiences with medical debt. Together, these findings highlighted concerns about the potential impact of financial practices and prompted leadership to engage revenue cycle leaders, frontline staff, clinicians, CHNA findings, and broader community feedback channels to identify opportunities to better align organizational practices with patient needs.
Decision Point 1: Should Parkland Continue Credit Reporting?	After learning that an external vendor was reporting unpaid medical debt to credit bureaus, Parkland leadership considered whether the practice should continue and whether the potential financial benefits justified its potential consequences for patients. As part of this broader assessment, Parkland analyzed approximately \$9 million in annual self-pay collections from patients who could have qualified for expanded financial assistance, including a potential increase in eligibility to 400% of the federal poverty level. For a health system with roughly \$3 billion in annual revenue, these collections represented less than one-half of one percent of total revenue. The analysis, together with feedback from patients, staff, and community members, helped leadership assess whether the financial benefit of its collection practices justified their potential impact on patients. Ultimately, leadership concluded that continuing to report medical debt to credit bureaus was inconsistent with Parkland's organizational values and that the potential financial benefit did not outweigh the potential for patient harm. Note: This type of analysis can be revisited periodically as financial assistance policies, collection practices, and patient needs evolve.
Decision Point 2: How Could We Operationalize Change?	Vendor contracts, policies, workflows, and EPIC rules were revised, with ongoing collaboration among revenue cycle, health equity, legal, compliance, and operational leaders. Staff programs were implemented to help address shared experiences with medical debt and promote empathy and culture change. Revenue cycle leaders reinforced the message that "health care is our primary goal, not collections" and worked to increase staff autonomy in addressing patient financial needs.
Decision Point 3: How Could Financial Harm Be Identified Earlier?	Parkland simplified financial assistance applications, established an eligibility call center, and offered self-pay discounts for eligible patients. Financial counselors and registration staff were trained to identify financial concerns early in the patient journey, connect patients with appropriate resources, and facilitate referrals through standardized EPIC-based screening and referral workflows.
Organizational Learning and Refinement	Ongoing feedback from patients, communities, clinicians, and employees was used to continually refine workflows and continue expanding awareness of available resources.

Recognizing a Misalignment Between Mission and Practice

The effort began when Parkland CEO Fred Cerise, M.D. read *Your Money or Your Life: Debt Collection in American Medicine* by Luke Messac, M.D., Ph.D., and was struck by a story describing a physician who routinely reassured patients that financial assistance was available, only to later learn that some of those same patients were being pursued through legal collection actions. This prompted Dr. Cerise to question whether Parkland's financial practices aligned with its mission.

Rather than assuming they were, leadership initiated a review of existing billing and collection practices, which revealed that although Parkland was not directly reporting debt to credit reporting agencies, an external vendor was reporting unpaid medical debt to credit bureaus on its behalf.

At the same time, CHNAs and community feedback showed that financial concerns were shaping care-seeking behavior:

- Patients delayed care due to fear of unaffordable bills
- Patients shared concerns about leaving debt to family members
- Community “word-of-mouth” discouraged care-seeking

Together, these findings reframed medical debt from a revenue-cycle issue to a barrier to access and trust, and ultimately, a question of mission alignment. Leadership began considering what changes to its financial assistance and collection practices might better align with Parkland's mission while also examining the financial implications of those changes.

DECISION POINT 1: SHOULD PARKLAND CONTINUE CREDIT REPORTING?

Once leadership understood that an external vendor was reporting patients' medical debt to credit agencies, they had to decide whether the practice should continue.

As part of this broader assessment, Parkland also considered whether they could expand eligibility for financial assistance, including potentially extending discounts to patients with incomes up to 400% of the federal poverty level (FPL).

Key Activities

Revenue-cycle and finance leaders analyzed collections from self-pay patients who would be affected by a potential expansion of Parkland's financial assistance criteria to 400% FPL. The analysis found that these collections generated approximately \$9 million annually. For Parkland, a large, safety-net health system with roughly \$3 billion in annual operations, this represented less than one-half of one percent of total organizational revenue. In a smaller system, or one with a different self-pay population, the same category could represent a meaningfully larger share of revenue. The relevant lesson is not that self-pay collections are financially negligible in general, but that their actual contribution should be measured in context and weighed directly against potential patient harm.

This analysis fundamentally changed the conversation about credit reporting. Rather than asking whether the organization could afford to discontinue the practice, leaders began asking whether the limited amount of money at stake justified using credit reporting as a collections tool, especially given the potential consequences for patients, including effects on housing, employment, financial stability, and trust in the health system. Ultimately, leadership concluded that allowing medical debt to be reported to credit agencies was inconsistent with Parkland's organizational values and that the potential financial benefit of using credit reporting to encourage repayment did not outweigh the potential for patient harm.

Interviewees emphasized that visible, early support from CEO Fred Cerise, M.D. was instrumental to implementation. Whereas efforts to modify billing and collections practices often require staff to build support among organizational leadership, Parkland's changes were championed from the highest levels of the organization. Combined with Parkland's longstanding mission-driven culture, this executive sponsorship facilitated implementation.

Because the changes aligned closely with organizational values related to access and patient care, relatively little will-building was required to gain support among leadership, clinicians, and staff. It was noted that while Parkland's Chief Financial Officer did not initiate the activity, his team was positively engaged once asked to address the concern. And while board approval was neither required nor formally sought, board members indicated they strongly supported the new policy.

Friction Points

Leaders faced operational and legal complexity given that credit reporting was embedded in longstanding workflows and vendor relationships, requiring cross-functional coordination to assess contractual and compliance implications of discontinuing the practice.



Leadership Insight

“When you attempt to change your financial assistance policies, you learn quickly that it is not simple and must involve legal and compliance early.

For example, we provide free mammography screening. There is a compliance concern that if we make services free, that is an inducement — even when most of the people involved are uninsured or on Medicaid. When someone has an abnormality that requires follow up, we don't want to charge them because we invited them in for free screening. We had to be cognizant of legal and compliance issues just to provide free care to our community.

We see the same thing when trying to apply our financial assistance programs to individuals who have poor insurance coverage. Someone who has tried to be responsible and obtain coverage through the ACA may have a \$10,000 deductible they cannot afford. We would like to apply our own financial assistance policy discounts to that deductible, but it gets complicated because of the contractual issues with the insurer.”

—Fred Cerise, CEO

DECISION POINT 2: HOW COULD WE OPERATIONALIZE CHANGE?

Having decided to discontinue credit reporting, Parkland shifted its focus to how the change would be operationalized across vendors, systems, and internal workflows. Perhaps the most notable aspect of this case is that most of the challenges were about implementation, not disagreement about the decision itself. There was little pushback on whether to make the change, and few examples of ongoing internal conflict. Instead, the work focused on practical steps like updating contracts, workflows, and documentation across systems. This was supported by early and visible executive leadership, existing relationships between revenue cycle and patient experience leaders, and alignment between the effort and the organization's mission. Parkland also invested in building shared understanding across departments by creating opportunities for two-way communication between revenue cycle and clinical teams, including during clinical grand rounds. These efforts helped strengthen trust, increase clinician awareness of financial assistance policies and patient financial experiences, and reinforce a shared commitment to supporting patients.

Key Activities

- Revised vendor contracts, policies, workflows, and EPIC rules through collaboration among revenue cycle, health equity, legal, compliance, and operational leaders.
- Established close, ongoing communication between revenue cycle leadership and Parkland's Chief Health Equity Officer, which leaders described as essential for aligning operational decisions with organizational goals related to access and reducing barriers to care.
- Expanded employee support programs to recognize and address staff experiences with medical debt, reinforce organizational values, and promote empathy for patients experiencing financial hardship.
- Created opportunities for ongoing communication and education between revenue cycle and clinical teams, including integrating revenue cycle into clinical grand rounds to strengthen two-way dialogue, increase clinician knowledge of financial assistance policies, and improve coordination in supporting patients.
- Revenue cycle leadership reinforced the message that “health care is our primary goal, not collections,” through ongoing staff training, workflow reinforcement, and engagement in departmental check-ins.

Building Clinician Awareness and Workflow Integration

Historically, financial counseling documentation was not easily visible to clinicians within EPIC. Leaders worked with internal teams to improve how financial assistance information was documented and accessed within the electronic health record. They also partnered with nurse navigators, referral coordinators, physicians, and advanced practice providers to increase awareness of available resources and how to locate them in the EHR (electronic health record) during patient care. Note: EHR systems like EPIC can serve as an important tool for improving transparency and access to financial assistance information. Health systems may consider working with EHR vendors to identify opportunities to improve visibility of available resources for clinicians and other patient-facing staff.

Revenue cycle leaders also participated in departmental meetings and clinical huddles to reinforce workflows and address implementation challenges, particularly within surgical and specialty care settings. Clinicians demonstrated strong awareness of patients' financial barriers, reflecting longstanding organizational emphasis on patient financial well-being.

Supporting Employees

Hospital employee support programs were expanded to include childcare resources, on-site dental services, assistance navigating health benefits, financial wellness programming, upfront tuition assistance, stress management seminars, and resources to reduce reliance on predatory lending.

These investments were viewed as reinforcing organizational values by recognizing clinicians' and staff's exposure to medical debt, while strengthening employee empathy for patients experiencing financial hardship and reducing stigma around medical debt.



Leadership Insight

“We intentionally hired from the communities we serve to create circumstances in which families can advance, experience economic stability, and thrive.”

These individuals brought invaluable lived experiences, and we quickly recognized that the employees were also experiencing barriers to transportation, housing, childcare, food, and other non-medical drivers of health. So beyond recruiting talent from the communities, we needed to create conditions for our employees to succeed.”

—Jessica Hernandez, Senior Vice President and Chief Health Equity

Building a Patient-Centered Culture

Interviewees emphasized that sustaining these changes required an intentional cultural shift within revenue cycle operations and the larger health system, which required explicit messaging from revenue cycle leadership. New employees, particularly those coming from more traditional collections environments, are consistently reminded that “health care is our primary goal, not collections.”

Friction Points

As implementation progressed, leaders encountered operational and policy questions, including eligibility for patients from outside Dallas County who initially presented through emergency care but required ongoing treatment.

Coordination across revenue cycle, legal, compliance, operations, and IT was essential. Vendor contracts required legal review and renegotiation, while financial assistance policies had to align with documentation requirements, annual eligibility reassessments, and outreach and incentive-related regulations.

Leaders also emphasized embedding changes in standardized EPIC workflows to avoid manual processes that could increase administrative burden or staffing needs.

DECISION POINT 3: HOW COULD FINANCIAL HARM BE IDENTIFIED EARLIER?

Leadership recognized that eliminating credit reporting addressed only one aspect of patient financial harm, which led to a shift from a reactive collections model to an upstream preventative approach focused on identifying and addressing financial needs as early as possible in the patient journey.

Key Activities

Parkland implemented several changes to identify and address financial needs earlier in the care process:

- Established an eligibility call center to help patients understand available resources, answer billing questions, develop payment plans, apply for financial assistance, enroll in Medicaid when eligible, and connect with grant-funded assistance programs.
- Simplified the financial assistance application to fewer than two pages, focusing primarily on demographic and income information. The application serves as an entry point for multiple assistance pathways, including hospital financial assistance, Medicaid enrollment, and grant-funded programs.
- Trained financial counselors on eligibility requirements across multiple programs so they could triage patients toward the most appropriate resources and identify when additional applications were needed.
- Trained registration staff to identify potential financial concerns and connect patients with financial counselors early in the care process.
- Embedded standardized financial screening and referral workflows within EPIC, allowing clinicians and staff to initiate referrals to financial counselors and facilitate follow-up.
- Offered self-pay discounts for eligible patients.
- Created various application pathways to help patients find the one that suited them best (e.g. through EPIC MyChart, online via the Parkland website, in-person on campus, through community health centers, by mail-in, etc.).

Leaders reported that call volumes subsequently declined, which they attributed in part to improved patient education regarding financial responsibility, good-faith estimates, available discounts, and financial assistance options.

Friction Points

Obtaining required documentation can present challenges for patients, particularly individuals experiencing homelessness, earning cash income, or those with limited documentation.

Financial counselors emphasized the importance of flexibility and creative problem-solving, including:

- Identifying alternative forms of documentation, including, when appropriate, contacting employers directly rather than requiring additional paperwork from patients.
- Empowering financial counselors and revenue cycle staff to work with patients to balance organizational requirements with individual circumstances, prioritizing affordability and problem-solving over a one-size-fits-all approach.



Leadership Insight

“When we talk directly to financial counselors, one of their biggest concerns is straying from strict policy and being exposed to discipline based on audit findings.

That’s why there’s an ongoing effort to increase autonomy: we want staff to feel empowered to navigate these situations rather than relying solely on rigid rules. We want to give front-line counselors the benefit of the doubt when they’re working with patients and families to get the necessary documentation to support eligibility for our assistance programs.”

—Fred Cerise, CEO

Organizational Learning and Refinement

Parkland used multiple ongoing mechanisms to understand patient experiences, build trust, and identify barriers to care.

Key sources of continuous feedback included:

- CHNAs
- Patient and family advisory councils
- Community conversations
- Press Ganey surveys
- Community Health Workers
- Community relations staff assigned to primary care clinics

Interviewees viewed Community Health Workers as particularly important because they conduct outreach and screening activities in nontraditional settings, often identifying barriers among individuals who have not yet entered the health system. Community relations staff embedded within clinics also provided ongoing insight into community concerns and patient experiences.

Measuring Progress

Because many consequences of medical debt, such as reduced trust, financial stress, or delayed care, are not routinely captured in health system data, Parkland relied on both operational measures and community feedback to understand whether changes were working.

Early indicators included:

- Elimination of credit-reporting activities
- Reduced administrative barriers to financial assistance
- Lower patient call volumes related to billing questions
- Faster connection to financial counseling and support services
- Increased staff, clinician, and community engagement with financial assistance resources
- Greater alignment between operational practices and organizational mission

Leaders also continued to monitor information gathered through CHNAs, community engagement activities, and patient feedback mechanisms to understand how patients, staff, and clinicians experienced these changes.

Additional quantitative measures, including changes in financial assistance utilization, application completion rates, navigation times, and other operational indicators may provide useful information for organizations pursuing similar efforts.

Lessons for Other Health Systems

“Take time to understand the impact of your financial assistance policies on individuals and their access to care (including talking to the physicians who are your strongest patient advocates). I suspect in many situations, more liberal financial assistance policies (particularly for uninsured individuals) will not have a significant effect on collections but will have a significant impact on individuals seeking care. A health system’s philosophy on care and access can be defined by your financial assistance policies and that needs to be driven by the board and executive leadership; don’t put the expectation and burden to define that philosophy and drive the changes needed to effect it all on revenue cycle staff.” – Fred Cerise, CEO

“As organizations pursue health equity, it is important to recognize that financial policies are health policies. I encourage leaders to engage and empower staff to work collaboratively with patients to solve problems rather than simply enforce policy. Placing patients first means creating a patient-centered approach that advances trust, the patient experience, access, and equity.” – Jessica Hernandez, Senior Vice President and Chief Health Equity Officer

Partnering with Patients and Hospitals on Financial Navigation: A Community-Based Organization Perspective (DuPage Health Coalition)

Core Problem: Why are patients who are qualified for financial assistance still accumulating medical debt?

Background

The DuPage Health Coalition (DHC) is a community-based health organization in DuPage County, Illinois that brings together hospitals, clinics, and local organizations to improve access to care for uninsured and underinsured residents. DHC functions as a systems coordinator and intermediary organization, aligning hospital financial assistance policies, supporting enrollment and navigation services, and helping patients move more seamlessly through insurance and billing systems. Over time, it has also played a role in identifying administrative barriers to care and working with health system partners to address them.

DHC's flagship program, [Access DuPage](#), has helped coordinate affordable health care services for more than 75,000 uninsured residents since it was established in 2001, including many who are ineligible for public insurance because of immigration status or other eligibility restrictions. Although DuPage County is an affluent community with high overall insurance coverage, Access DuPage continues to serve approximately 6,000 patients each year, reflecting persistent coverage gaps among lower-income residents and immigrant communities.

When developing Access DuPage, DHC leaders intentionally aligned program eligibility with participating hospitals' financial assistance policies so that eligible patients could access financial assistance and health care through a single, coordinated pathway. Although Illinois law [establishes](#) minimum financial assistance requirements for hospitals, individual hospitals may offer additional levels of assistance. DHC therefore works closely with hospital partners to maintain shared eligibility criteria and update them when hospital financial assistance policies change, keeping Access DuPage eligibility aligned with the assistance available through its hospital partners.

Because of these longstanding partnerships and aligned systems, DHC leaders initially assumed that relatively few enrolled patients would experience significant medical debt. A 2022 survey challenged that assumption, revealing that many households, including those already connected to Access DuPage services, continued to carry substantial medical debt from hospitals, physician practices, ambulance services, and other providers. Many families faced debts that exceeded what they could reasonably repay and were delaying or avoiding care.

Rather than viewing these findings as evidence that patients were not seeking financial assistance, DHC saw them as an indication that people were struggling to navigate an increasingly complex system of financial assistance programs, provider billing practices, and insurance rules. Instead of creating a new financial assistance program, DHC developed [Medical Debt Care DuPage](#), an initiative focused on helping patients access existing assistance programs while simultaneously working with health systems to identify and address barriers that prevented eligible patients from receiving financial relief.

Several contextual factors supported implementation of Medical Debt Care DuPage (**Table 3**). These conditions, including longstanding relationships with hospital partners and the state policy environment, shaped the strategies available to DHC and may influence how readily similar approaches can be implemented in other communities.

In addition to these contextual factors, DHC had developed organizational capabilities that supported implementation, including:

- Bilingual and bicultural certified financial counselors
- Expertise in insurance enrollment and financial assistance
- Established processes for coordinating care and patient navigation across multiple organizations

Table 3. Contextual Factors Influencing DuPage's Implementation Effort

Longstanding cross-sector relationships	DHC had worked with local hospitals and community organizations for more than two decades before launching Medical Debt Care DuPage. Hospital leaders participated in organizational governance, creating established channels for collaboration, trust, and problem-solving that facilitated later systems change efforts.
State policy environment	Illinois law supports presumptive eligibility for financial assistance through qualifying community organizations, allowing some hospitals to accept eligibility determinations made by trusted partners rather than requiring duplicative financial assistance applications. Interviewees noted that implementation still varied across health systems.
Community intermediary role	DHC already served as a trusted intermediary coordinating hospitals, clinics, and community organizations through programs such as Access DuPage. This existing role positioned the organization to identify recurring barriers across multiple organizations and convene partners to address them.
Aligned financial assistance structure	Access DuPage eligibility had intentionally been aligned with participating hospitals' financial assistance policies, creating a shared eligibility pathway that simplified enrollment and reduced administrative burden for many patients.
Community characteristics	Although DuPage County has relatively high overall insurance coverage and household income, DHC serves uninsured and underinsured residents, including many immigrant communities who continue to experience barriers to insurance, financial assistance, and affordable care.

Although every organization operates within a different context, this case highlights how local partnerships, organizational capacity, and available resources shaped DuPage's approach. Organizations seeking to implement similar strategies should consider how their own circumstances may require different sequencing, partnerships, or resource investments. This case describes DuPage's experience, the challenges encountered, and key implementation lessons (**Table 4**), while the accompanying implementation tools provide broader guidance for adapting these lessons to other settings.

Table 4. Snapshot of DHC's Implementation Process

Recognizing the Gap Between Eligibility and Access	DHC recognized that eligibility for financial assistance did not always translate into patients successfully receiving available support. A 2022 survey of Access DuPage participants revealed that many households continued to experience medical debt despite existing assistance programs, prompting DHC to examine barriers within financial assistance, billing, and insurance systems.
Implementation Strategy 1: Build Trusted Navigation and Advocacy Services	DHC developed Medical Debt Care DuPage to help patients navigate complex financial assistance and insurance systems. Bilingual and bicultural financial counselors and navigators provided individualized support, helping patients resolve billing issues, access available assistance, correct insurance errors, and address other barriers that contributed to medical debt.
Implementation Strategy 2: Build Partnerships That Reduce Administrative Burden	Leveraging longstanding relationships with local hospitals, DHC worked with health system partners to streamline access to financial assistance. Strategies included creating referral pathways, aligning eligibility criteria, encouraging use of presumptive eligibility for financial assistance, and reducing duplicative processes for patients seeking support.
Implementation Strategy 3: Use Individual Patient Cases to Improve Systems	DHC used patterns identified through patient navigation to inform broader conversations with health systems and other partners. By elevating recurring challenges, such as inconsistent financial assistance practices, billing barriers, and documentation requirements, DHC helped partners identify opportunities for operational and policy improvements.
Organizational Learning and Refinement	Over time, DHC's role expanded from helping individual patients access resources to serving as a trusted intermediary that helped organizations identify and address systemic barriers. The organization continued refining its approach by using patient experiences and partner feedback to strengthen navigation, coordination, and financial assistance processes.

Recognizing the Gap Between Eligibility and Access

DHC found that while many financial assistance programs already existed and many patients were eligible for them, patients were often unable to successfully access those resources.

Interviewees described multiple reasons why eligible patients continued to accumulate debt:

- Financial assistance applications were difficult to navigate.
- Patients often misunderstood insurance benefits or failed to realize additional coverage was available.
- Multiple bills from hospitals and independent providers created confusion.
- Fear surrounding financial assistance applications discouraged patients from seeking help.
- Administrative processes varied substantially across health systems and third-party billing vendors.

As one leader observed, health systems often believed their financial assistance policies were generous but had limited visibility into the practical barriers preventing patients from successfully using them. DHC therefore shifted its focus from creating new financial resources toward helping patients navigate the systems that already existed.

IMPLEMENTATION STRATEGY 1: BUILD TRUSTED NAVIGATION AND ADVOCACY SERVICES

Rather than focusing solely on debt relief, Medical Debt Care DuPage helps patients navigate the financial systems that determine whether debt occurs in the first place.

Key Activities

DHC assembled a bilingual, bicultural team of certified financial counselors and ACA navigators who work directly with patients to:

- Review medical bills from hospitals and other providers
- Determine eligibility for hospital financial assistance programs
- Identify insurance enrollment opportunities
- Resolve insurance billing errors
- Assist with financial assistance applications
- File appeals when appropriate
- Connect patients with transportation, medication assistance, and other supportive services

Beyond explaining available programs, staff frequently contact providers alongside patients, advocate during billing disputes, and help resolve issues that patients often find too challenging to navigate independently.

Interviewees emphasized that health insurance literacy frequently represents a larger barrier than eligibility itself. Many patients arrive with bills resulting from missing secondary insurance, incomplete claims, or misunderstandings about their coverage, not because they were truly responsible for the full cost of their care.

Friction Points

Staff described significant challenges helping patients navigate fragmented billing systems.

- Patients commonly receive separate bills from hospitals, physician groups, pathology laboratories, radiologists, anesthesiologists, and ambulance providers, often without understanding how these services are connected.
- Increasing reliance on outsourced billing vendors further complicated communication, with staff describing long wait times, dropped calls, and limited responsiveness even when experienced navigators contacted billing offices on patients' behalf.
- Interviewees noted that if trained financial counselors struggled to obtain answers, patients facing financial stress and unfamiliar terminology were even less likely to successfully navigate the process independently.

IMPLEMENTATION STRATEGY 2: BUILD PARTNERSHIPS THAT REDUCE ADMINISTRATIVE BURDEN

DHC viewed strong relationships with hospitals as essential to reducing patient burden.

Key Activities

Because DHC has partnered with local hospitals for more than two decades, and because hospital executives participate directly in DHC governance, the organization entered this work with an unusually high level of institutional trust. Interviewees viewed these longstanding relationships as a key enabling condition that allowed DHC to:

- Develop direct communication channels with hospital financial assistance staff
- Create expedited referral pathways
- Encourage hospitals to link DHC services on financial assistance webpages
- Align DHC eligibility criteria with hospital charity care policies
- Promote presumptive eligibility for financial assistance for patients already screened through DHC programs

Instead of requiring patients to submit the same financial information to multiple organizations, DHC leaders encouraged hospitals to accept eligibility determinations already made by trusted community partners whenever possible.

Interviewees described this approach as beneficial for both patients and providers by reducing duplicative administrative work while improving access to financial assistance.

Friction Points

Implementation varied across hospitals.

Although Illinois law supports presumptive eligibility for financial assistance through certain community organizations, interviewees reported inconsistent implementation across health systems. Organizational mergers, differing electronic health record workflows, and multistate health system policies sometimes limited hospitals' ability to recognize Access DuPage participants or apply financial assistance consistently.

As a result, patients who should have qualified for financial assistance occasionally continued receiving bills simply because existing eligibility information was not readily visible during registration or billing.

IMPLEMENTATION STRATEGY 3: USE INDIVIDUAL PATIENT CASES TO IMPROVE SYSTEMS

In their work with individual patients, DHC staff also identified recurring operational barriers affecting many others.

Key Activities

Interviewees described using patterns observed through patient navigation to inform broader conversations with health systems and community partners.

Examples included:

- Identifying a hospital financial assistance policy that did not align with Illinois law and working with leadership until the policy was revised
- Collaborating with EMS leaders to resolve recurring ambulance billing challenges that had previously been difficult for patients to address
- Highlighting problems associated with outsourced, third-party billing vendors
- Encouraging hospitals to reduce repeated documentation requirements through greater use of presumptive eligibility for financial assistance

Rather than approaching these issues as isolated patient complaints, DHC used them to identify opportunities for operational improvement across participating organizations.

Friction Points

Unlike organizations working within a single health system, DHC sought to improve policies and operations across multiple independent organizations over which it had no formal authority. Interviewees described relying on relationship-building, persistence, and repeated engagement rather than organizational mandates to advance change.

In some instances, resolving a recurring barrier required months or years of conversations with hospital leaders, EMS agencies, billing vendors, or funding partners before agreement could be reached. Organizational mergers, competing priorities, differing interpretations of policy, and concerns about administrative burden sometimes slowed implementation, even when participants generally agreed on the underlying goal of improving patient access to financial assistance.

Interviewees emphasized that lasting change often depended less on a single conversation than on sustained trust built over years of collaboration.

Organizational Learning and Refinement

Over time, DHC's role expanded beyond helping patients complete applications.

Interviewees increasingly viewed the organization as a trusted intermediary that could help hospitals understand barriers that were often invisible from within health system operations. Patients frequently disclosed concerns or confusion to DHC staff that they had not shared with providers, allowing staff to identify recurring challenges involving health literacy, administrative burden, communication, and changing financial circumstances.

Leaders also emphasized that financial assistance eligibility is not static. Patients whose circumstances worsen following illness or job loss may become eligible for additional assistance months after receiving care, underscoring the importance of ongoing financial reassessment rather than one-time screening.

Measuring Progress

DHC evaluates success through both operational outcomes and patient impact.

Indicators include:

- Approximately \$7–10 million in medical debt relief secured annually through successful financial assistance applications, insurance corrections, resolution of insurance billing errors before patients incur unnecessary financial responsibility, and other patient advocacy efforts.
 - *Note:* Debt relief data reflect best estimates because documentation confirming that individual bills were fully closed is not always available. In these cases, reasonable assumptions are used to estimate the amount of debt relieved. The reported figures therefore represent the best available estimates of debt relief rather than a verified count of every individual bill closed.
- DHC also expanded their program over time to include a team member with a special focus on older adults. In the last year, that advocate successfully navigated 213 unique patients who received just under \$1M in medical debt relief. This client population represented a blend of uninsured and Medicare or third-party insurance enrolled individuals age 60+.
- Hospital policy changes following DHC advocacy.
- Stronger partnerships between hospitals and community organizations.
- Improved patient confidence accessing needed health care.

Interviewees also pointed to growing trust between hospitals and DHC staff, noting that financial counselors increasingly accepted DHC eligibility assessments and referrals, helping patients move more efficiently through financial assistance processes.

Lessons for Other Community Organizations

When asked what advice they would offer other organizations considering how to better support clients experiencing medical debt, DHC emphasized the capacity for even small organizations to have a significant impact, and the need to take the time to ask the families they serve if they have unmet medical debt needs. “There is still so much stigma and shame about debt,” DHC noted. “Creating space and trust to have those conversations revealed a world of opportunity.” DHC also emphasized that collaborative and amicable relationships with provider partners proved incredibly helpful to their efforts. Oftentimes, patient financial services teams were very willing to help, but sincerely unaware of the ways the application process created barriers for patients. “Working together has proven far more helpful than a more contentious approach ever would have.”

Partnering with Hospitals to Relieve Patient Medical Debt: A National Nonprofit Perspective (Undue Medical Debt)

Core Problem: How can health systems partner with nonprofit organizations to relieve existing medical debt while identifying opportunities to prevent future financial harm?

Background

Undue Medical Debt (“Undue”) is a nonprofit organization focused on ending medical debt and allowing people to seek care without fear of financial ruin. The organization addresses medical debt through two complementary strategies: providing immediate relief to patients experiencing medical debt and working with health care organizations and other partners to identify opportunities to reduce the creation of future debt. Undue’s work is grounded in the recognition that medical debt affects patients beyond the balance owed. Leaders described fear as a central challenge: patients may delay or avoid care, hesitate to ask about affordability, or disengage from the health system because they are worried about financial consequences.

Through its debt acquisition model, Undue partners with hospitals, health systems, physician groups, ambulance providers, and other health care organizations to acquire and relieve eligible medical debt accounts. Undue acquires accounts directly from health care providers and, in some cases, from collection agencies that have previously purchased medical debt. Patients whose debt is relieved receive notification that their debt has been eliminated and are not required to take any additional action, though they’re invited to share their experiences after receiving relief.

Beyond providing direct relief, Undue works with health care organizations to better understand patterns among unpaid accounts and identify opportunities to strengthen financial assistance practices and the broader patient financial journey. These efforts may include improving identification of patients eligible for financial assistance, expanding use of presumptive eligibility for financial assistance, reducing administrative barriers, and strengthening communication about available resources.

Although Undue’s model offers opportunities to address existing medical debt and inform future improvements, health systems may differ in their readiness to pursue debt relief depending on organizational priorities, available resources, existing policies governing patient accounts, and leadership perspectives on how charitable debt relief aligns with broader financial and community benefit strategies.

For health systems, a partnership with Undue can serve as both an immediate intervention to support patients experiencing medical debt and an opportunity to gain insights into how existing financial practices may be improved. Undue recognizes that health systems are not the sole cause of medical debt; rather, they are operating within a complex health care financing environment where patients are increasingly responsible for significant portions of their health care costs. Several contextual factors shape the challenges health systems face in addressing medical debt, including rising patient financial responsibility, fragmented billing processes, and persistent barriers to identifying and connecting eligible patients with financial assistance. Undue works alongside organizations to address the impact of existing medical debt while supporting efforts to prevent future harm. **Table 5** summarizes key contextual factors that influence health systems’ approaches to medical debt and financial assistance and describes how partnership with Undue may help address persistent gaps and barriers.

Table 5. Contextual Factors Shaping Health System Partnership With Undue Medical Debt

Health System Perspective	Patient Perspective	Potential Role of Partnership
Accounts have completed the collection process and are financially written off.	Medical debt continues to affect financial stability, stress, and decisions about seeking care.	Debt relief addresses harms that persist long after organizational collection efforts have ended.
Revenue cycle focuses on recovering balances and complying with financial policies.	Patients often struggle to navigate insurance complexity and financial assistance while seeking care.	Partnership with Undue can help identify opportunities to improve the patient financial journey and reduce barriers to assistance.
Organizations operate within significant financial and operational constraints.	Patients increasingly bear a growing share of health care costs despite having insurance.	Debt relief complements, not replaces, broader affordability and financial assistance strategies.
Multiple departments and contracted entities manage different parts of billing.	Patients frequently receive separate bills from hospitals, physician groups, ambulance providers, and other entities involved in a single episode of care.	Undue can help identify fragmentation and opportunities to create a more coordinated financial experience.
Health systems may view bad debt as unavoidable.	Patients may continue avoiding care because of unresolved medical debt or fear of future bills.	Relieving debt and improving affordability practices can help strengthen trust and encourage patients to return for needed care.

Understanding these broader contextual factors helps explain why health systems may seek partnerships with organizations like Undue. **Table 6** describes the health system journey for partnering with Undue, including key decision points, implementation steps, and opportunities for organizational learning and refinement.

Table 6. Health System Journey for Partnering With Undue Medical Debt

Recognizing That Medical Debt's Impact Extends Beyond the Billing and Collection Processes	Recognize that medical debt often continues to affect patients long after health systems have classified accounts as bad debt or ceased collection efforts. Consider how relieving existing debt and improving financial assistance processes can strengthen patient trust, reduce barriers to care, and complement broader affordability strategies.
Decision Point 1: Determining Whether a Debt Relief Partnership Fits the Organization's Goals	Assess whether partnering with Undue aligns with organizational priorities related to mission, community benefit, patient experience, financial stewardship, and reducing the long-term impact of medical debt. Consider how debt relief could complement existing efforts to improve financial assistance and strengthen the patient financial journey.
Decision Point 2: Sharing Transaction Information Across Relevant Areas	Once a debt relief transaction occurs, Undue shares insights, opportunities, and patient stories with revenue cycle and other organizational leaders, including executive leadership and leaders of community benefit and other patient-facing departments.
Implementation: What Does a Partnership With Undue Look Like?	The health care provider executes the legal and data-sharing agreements and securely transfers eligible account information. Undue then identifies qualifying patients using income estimation tools and provides debt relief. Account analyses are used to identify opportunities to strengthen financial assistance, reduce fragmentation, and improve patient financial workflows. Organizations may choose to establish repeat partnerships with Undue to review additional account cohorts, monitor trends over time, and evaluate the impact of workflow or policy changes.
Organizational Learning and Refinement	Use patient stories, survey findings, and account-level analyses to identify opportunities for continuous improvement. Findings can inform financial assistance policies, strengthen presumptive eligibility for financial assistance, improve coordination across billing entities, and ensure clinicians, community partners, and other patient-facing staff consistently communicate available affordability resources. Partnerships may also strengthen organizational culture by reinforcing a shared commitment to reducing financial barriers to care and improving patient trust.

Recognizing That Medical Debt's Impact Extends Beyond the Billing and Collection Processes

From a health system's financial perspective, patient accounts that have gone through the collection process and are no longer actively pursued may appear resolved. However, for patients, the impact of medical debt often continues long after an account has left the organization's active financial operations.

This distinction is central to Undue's approach. The organization recognizes that debt relief can address an immediate burden for patients while also helping health systems better understand why accounts are entering bad debt in the first place. By reviewing patterns among unpaid accounts, health systems can identify opportunities to strengthen financial assistance processes, improve use of presumptive eligibility for financial assistance, reduce administrative barriers, and ensure that patients are connected with available resources earlier in the care journey.

Why Health Systems Partner With Undue

Undue's model begins from the premise that medical debt continues to affect patients long after health systems have classified accounts as bad debt or ended collection efforts. By partnering with health systems to retire eligible debt through a charitable third party, Undue addresses an ongoing burden for patients while creating an opportunity for organizations to better understand how those accounts entered bad debt and where future financial harm may be prevented. Health systems may consider partnering with Undue Medical Debt when they want to:

- Provide direct financial relief to patients experiencing medical debt
- Address older accounts that are unlikely to be collected
- Strengthen relationships with their communities
- Better understand why patients are entering bad debt
- Identify opportunities to improve financial assistance workflows

Leadership emphasizes that debt relief is not intended to replace broader affordability solutions. Rather, it provides one mechanism for addressing existing harm while generating information that can support longer-term improvements. The following case example describes Undue Medical Debt's partnership model, including how health care organizations can work with Undue to provide medical debt relief, better understand patient financial experiences, and identify opportunities to prevent future medical debt.

DECISION POINT 1: DETERMINING WHETHER A DEBT RELIEF PARTNERSHIP FITS THE ORGANIZATION'S GOALS

For health system leaders considering a partnership, an early question is how debt relief aligns with organizational priorities. Potential considerations include:

- **Mission and community benefit goals:** Many nonprofit and public health systems view medical debt relief as aligned with their mission to improve community health and reduce barriers to care.
- **Patient trust and experience:** Providing relief can demonstrate responsiveness to patient concerns and communicate that the organization recognizes the burden medical costs create.
- **Financial and operational considerations:** Health systems may have significant volumes of patient accounts that are unlikely to generate revenue and partnering with Undue provides an opportunity to redirect those accounts toward patient benefit.
- **Broader affordability strategies:** Debt relief can complement other efforts, including:
 - improving financial assistance enrollment
 - implementing presumptive eligibility for financial assistance
 - strengthening affordability conversations
 - reducing fragmentation across billing entities
- **Organizational readiness and competing priorities:** Charitable debt relief partnerships are a relatively new and unfamiliar model for many health care organizations. Because Undue's work is unique, organizations may not have encountered this type of partnership before and may have questions about legal considerations, data sharing, or how it fits within existing revenue cycle and board policies. Undue offers guidance on these points, and once questions are answered, organizations can determine whether a partnership fits their needs.

DECISION POINT 2: SHARING TRANSACTION INFORMATION ACROSS RELEVANT AREAS

Some health care providers partner with Undue with involvement solely from the revenue cycle team. While this keeps the process simple, it can mean the organization isn't taking full advantage of the work, for example, by missing opportunities to connect debt relief with community benefit reporting or broader financial assistance efforts.

Areas where the work may connect include:

- **Revenue cycle and finance leaders:** Revenue cycle teams are often the primary operational partners because they manage patient accounts and understand existing billing processes.
- **Executive leaders:** CEO and senior leadership support can help address questions related to mission alignment and organizational priorities.
- **Community benefit and population health teams:** These teams can help connect debt relief efforts to broader community needs and organizational goals.

Patient-Facing Staff as Trusted Messengers

Health systems can strengthen the impact of debt relief efforts by ensuring that clinicians, care teams, registration staff, social workers, community health workers, and other patient-facing staff understand available financial assistance resources and know how to connect patients with support. Financial concerns often emerge throughout the care journey, not only during billing or collections, so responsibility for communicating resources cannot rest solely with revenue cycle teams.

Undue also noted that clinicians and community partners can serve as trusted messengers who help patients understand that debt relief programs are legitimate and that support is available. This is particularly important because some patients may initially question whether debt relief notifications are real or may feel hesitant to seek assistance due to stigma or uncertainty.

Building stronger connections across revenue cycle, clinical, and community-facing teams can help health systems move from viewing financial assistance as a separate administrative function to integrating affordability support into the broader patient experience.

Implementation: What Does a Partnership With Undue Look Like?

Step 1: Establishing the Partnership and Data-Sharing Process

Once a health system decides to move forward with a partnership, the health system works with Undue to establish the legal, operational, and data-sharing processes needed to securely share eligible accounts and provide debt relief. Because many health systems have not previously partnered with a charitable organization to acquire and eliminate medical debt, the initial phase often involves addressing questions related to compliance, cybersecurity, and internal roles.

Key Activities

- Establishing legal agreements, including a Business Associate Agreement (BAA), to allow secure sharing of protected health information;
- Confirming cybersecurity requirements and data protections, and;
- Sharing files of bad debt accounts with Undue for analysis and qualification.

Undue notes that many health systems already produce similar account files for collection agencies, allowing organizations to build on existing reporting processes rather than creating entirely new workflows. The information needed to assess eligible accounts typically includes basic account details, such as patient information needed for income estimation, outstanding balance, and date of service. By leveraging existing reporting processes, health systems can often provide the necessary information without creating an entirely new workflow.

Some electronic health record (EHR) companies have already developed ways for organizations to generate the specific report needed to share eligible accounts with Undue, so many health systems may already have documentation or reporting resources available that can simplify the data extraction process. The availability of these resources varies across organizations, and some health systems may need to develop or adapt reporting workflows to support implementation.

Friction Points

Some organizations have existing policies that prohibit selling patient accounts because those policies were created with traditional debt collection in mind. In these cases, health systems may need to review or adapt governance processes to account for a charitable debt relief model. Undue works with organizations to address these concerns based on experience partnering with a range of health care organizations.

Step 2: Identifying Eligible Accounts

After establishing the partnership and data-sharing process, health systems provide Undue with information about eligible patient accounts. These are typically accounts that have already gone through the organization's collection process and are no longer actively pursued. While the health system may consider these accounts uncollectible, they can continue to create significant financial and emotional burdens for patients.

Undue reviews the accounts using third-party income estimation tools to identify patients who meet program eligibility criteria, generally individuals with incomes at or below 400% FPL. These tools allow Undue to assess eligibility without requiring patients to complete additional financial assistance applications. Undue noted that a large proportion of unpaid accounts reviewed through this process meet eligibility criteria, reflecting that patients who are unable to pay medical bills are often experiencing financial hardship.

Health systems may provide accounts to Undue through a purchase arrangement or donate accounts directly. Some organizations choose to donate accounts because it simplifies the administrative process. When accounts are purchased, pricing is based primarily on the age of the debt, with older accounts generally costing less. Undue accepts accounts up to seven years old. For health systems, this may provide some financial return on accounts that have already been reserved as unlikely to be collected while allowing those accounts to be converted into direct patient relief.

Undue can also analyze account data to help health systems better understand patterns among unpaid accounts. For example, organizations may examine differences across locations, changes following billing system transitions, or whether patients who may have qualified for financial assistance were missed earlier in the financial assistance process.

Step 3: Providing Medical Debt Relief to Patients

Once Undue acquires eligible accounts, the organization notifies patients that their medical debt has been eliminated. The notification informs patients that their debt has been cleared and that they do not need to complete an application, make a payment, or take any additional action. Because Undue provides relief as a charitable organization and disinterested third party, patients do not have tax obligations associated with the relieved debt.

The simplicity of this process is intentional. Many patients experiencing medical debt are already navigating significant stress and may face barriers to completing additional paperwork or requesting assistance. By eliminating the need for an application or verification process, Undue's model reduces administrative burden for patients while providing immediate relief.

Undue also recognizes that communication and trust are critical components of debt relief. Patients may initially question whether the notification is legitimate, particularly in a low-trust environment where people are accustomed to receiving bills, collection notices, and requests for payment. Undue works to build awareness of the program so patients understand that the debt relief is real and can feel confident accepting the support.

Patients are invited, but not required, to share their experiences after receiving relief. Through surveys, interviews, and patient stories, Undue gathers information about how medical debt has affected individuals and families, including impacts on stress, financial stability, and willingness to seek future care. These insights help health systems better understand the impact of medical debt within their communities and reinforce the importance of addressing financial barriers as part of patient care.

Organizational Learning and Refinement

Beyond providing medical debt relief, Undue works with health systems to analyze patterns among unpaid accounts and identify opportunities to strengthen financial assistance practices and the broader patient financial journey. These confidential conversations are intended to be collaborative rather than evaluative. Undue does not serve as an auditor; instead, the organization works with health systems to understand what their account data may reveal about where patients are experiencing barriers and where processes can be improved. Even within a collaborative partnership, reviewing account-level data may surface findings that are difficult for organizations to address. Analyses may identify patients who appeared eligible for financial assistance but were not connected to available resources, variation in medical debt across facilities or service lines, or workflow changes associated with increases in unpaid accounts. Addressing these findings often requires organizations to revisit established operational processes, coordinate across departments, and consider changes that extend beyond the initial debt relief partnership.

Depending on an organization's goals, Undue can provide customized analyses to help health systems answer questions such as:

- **Are certain locations, service lines, or patient populations generating higher volumes of unpaid accounts?** Health systems may use account-level insights to understand variation across facilities or departments and identify areas where additional support or process improvements may be needed.
- **Are patients who may qualify for financial assistance being identified and connected to resources?** Undue frequently sees accounts that may have qualified for financial assistance but were not identified before entering bad debt. Reviewing these patterns can help organizations assess whether presumptive eligibility for financial assistance and screening processes are functioning effectively
- **Did changes to billing systems, workflows, or organizational processes affect patient financial outcomes?** Some health systems use repeated partnerships with Undue to compare trends over time, such as changes before and after implementing new billing systems or financial assistance processes.
- **Are physician or contracted provider accounts included in financial assistance efforts?** Undue highlighted fragmentation across health care organizations as a recurring challenge. Patients may receive care in a hospital setting but receive separate bills from clinicians who are not included in the hospital's financial assistance policy. Reviewing account data can help organizations identify where patients may be receiving inconsistent support.

These analyses can help health systems better understand why patients are entering medical debt, identify opportunities to improve the patient financial journey, and strengthen how financial assistance resources are communicated and delivered across the organization.

Translating Insights Into Patient-Facing Improvements

Findings from account analyses may also highlight opportunities to strengthen how affordability resources are communicated throughout the patient experience. As discussed earlier, improving access to financial assistance requires engagement beyond revenue cycle teams alone. Organizations may use these insights to strengthen referral pathways and ensure patients are connected with available resources earlier in the care journey.

Establishing an Ongoing Partnership

While some organizations partner with Undue to address a single batch of accounts, others establish ongoing relationships that allow them to evaluate trends over time and assess whether changes to financial assistance processes or billing workflows influence patterns of medical debt. Because legal agreements and operational processes are often already established, subsequent partnerships may require less administrative coordination than the initial implementation.

Measuring Impact

Health systems may evaluate partnership impact through multiple measures.

- Patient-level outcomes
 - Undue collects patient feedback through surveys, interviews, and stories, which describe reduced stress associated with medical debt, increased willingness to return for needed care, and a greater sense of dignity, relief, and support following debt relief.
- Operational insights
 - Health systems may use partnership analyses to refine financial assistance processes, identify missed opportunities for presumptive eligibility for financial assistance, and better understand patient accounts entering bad debt.
- Community impact
 - Debt relief can also serve as a tangible demonstration of a health system's commitment to supporting patients, strengthening community relationships, and addressing the financial barriers that can affect access to care.
 - Health systems may also assess whether debt relief efforts improve awareness of available resources and strengthen trust by communicating clearly with patients and community partners about affordability support.

Although debt relief can address the burden of existing medical debt for eligible patients, leaders emphasized that charitable debt relief alone cannot resolve the broader structural factors contributing to medical debt. Partnerships are intended to complement, not replace, ongoing efforts to improve affordability, financial assistance, and the patient financial experience.

Lessons for Other Nonprofits or Health Systems

Undue emphasized, “Medical debt relief is not the end of the story; rather, it is a window into the patient financial experience. The accounts themselves often reveal important opportunities to reduce financial barriers, strengthen assistance programs, and prevent future debt before it occurs.

Debt relief is a simple entry point to addressing patients' financial stress. Organizations often assume medical debt relief requires a major operational undertaking, but in many cases the process builds on workflows and data that already exist. The most successful partnerships are those that view debt relief not only as a way to address existing harm, but also as an opportunity to better understand where patients are struggling and how the patient financial experience can be improved.”



Resources for Additional Information

[Advisory Opinion 20-04](#): Guidance on the legality of charitable organizations purchasing and forgiving qualifying patients' unpaid medical debt.

CASE EXAMPLE

Addressing Health Care Costs with Patients: A Clinician Perspective (Caroline Sloan, M.D., M.P.H.)

Core Problem: How can clinicians address costs of care with their patients?

Background

Dr. Caroline Sloan is a general internist with the Duke University Hospital system. She works in primary care at the Duke Outpatient Clinic, with a focus on vulnerable populations and patients with multiple chronic conditions. She is also a researcher, studying financial barriers to care and the role of costs in medical decision-making.

In both her clinical work and her research, Dr. Sloan has focused on the use of real-time prescription benefit tools for lowering patients’ medication costs and improving adherence. These tools are designed to be integrated into electronic health records (EHRs) so that clinicians can view estimated out-of-pocket medication costs, along with any lower-cost alternatives. While the tools address medication costs specifically, Dr. Sloan emphasizes the value of leveraging these tools to help initiate cost-of-care conversations with patients more broadly.

After providing a brief overview of real-time prescription benefit tools below, this case example explores how Dr. Sloan addresses the costs of care with her patients by: 1) estimating out-of-pocket costs, including but not limited to the use of real-time prescription benefit tools, and 2) finding ways to lower out-of-pocket costs.

Starting in 2021, Medicare Part D plans were required to provide out-of-pocket medication cost estimates via a real-time prescription benefit tool that could be integrated into an EHR prescribing system. Many EHR vendors already have these tools, but starting in 2028, all EHRs will be required to include one in their base product. While health systems are not required to turn on the tools, about two-thirds have done so. These tools are not limited to Medicare Part D enrollees, as commercial insurers are also opting to deploy these tools. Dr. Sloan mentioned that at her institution, about 90 percent of all prescriptions have real-time prescription benefit data. While she finds the estimated costs to be very helpful, she also cautions that the tools are not 100 percent accurate, and there is room for improving the quality of the data.

As clinicians in other settings explore how best to address health care costs with their own patients, it is important to consider the contextual factors surrounding Dr. Sloan’s work. See **Table 7** below.

Table 7. Contextual Factors Surrounding Dr. Sloan’s Approach

Contextual Factor	Description
Clinician Background	Practicing clinician and researcher with a focus on addressing patient health care costs with in-depth knowledge of real-time prescription benefit tools
Care Delivery Setting	Outpatient primary care clinic that is part of a large academic health system
Access to Cost Estimates	Health system adoption and optimization of clinician-facing real-time prescription benefit tool; patient portal with estimated costs for other health system services
Patient Population	Adults with chronic disease and acute medical needs; more than half enrolled in Medicaid alone, almost 30 percent enrolled in Medicare alone or dually enrolled in Medicare/Medicaid, more than 10 percent enrolled in commercial insurance, and 2 percent uninsured

The following sequence outlines one strategy for raising the issue of health care costs with patients, regardless of clinicians’ setting, workflows, patient populations or their out-of-pocket costs. Note that not all clinicians have access to real-time prescription benefit tools in their EHR, and not all patients have access to estimated costs for health care services in their patient portal. In cases where a health system is not employing these tools, clinicians can advocate for their adoption with health system leadership.

Table 8. Snapshot of Dr. Sloan’s Strategy for Addressing Costs of Care

Recognizing a Gap in Information on Medication Costs	When Dr. Sloan first started working at an outpatient clinic with vulnerable populations experiencing chronic conditions, she found that concerns about costs of care often limited her ability to provide up-to-date, evidence-based care. This led her to learn about approaches to estimating and lowering out-of-pocket costs in real time, during the clinic visit.
Workflow Step 1: Exploring Lower Cost Medication Options	Part 1: When ordering a prescription during a patient visit, Dr. Sloan uses her EHR’s real-time prescription benefit tool to find out the cost of the medication she wants to prescribe and to see what lower cost medication options might be available. She then discusses the options with her patient. Part 2: If none of the options are affordable, she explores other low-cost sources with the patient, such as coupons or direct to consumer pharmacies.
Workflow Step 2: Estimating Costs of Other Health Services	If she is prescribing other services, such as labs or imaging, she asks patients to look up their estimated costs, which are available in the patient portal to help inform the course of care delivery.
Workflow Step 3: Considering Non-Medical Costs	Dr. Sloan also considers other related costs that patients may be concerned about, such as transportation, which she considers when ordering services or consultations.
Learning and Refinement	Dr. Sloan recognizes that none of this is perfect, and she doesn’t always have complete information, but she keeps cost issues top of mind as she meets with her patients to help them save money where they can—and she says her relationships with her patients are better for it.

Recognizing a Gap in Information on Medication Costs

Dr. Sloan was first exposed to issues of medication costs when she was a resident at the Duke Outpatient Clinic. Many of the clinic’s patients were on Medicaid or Medicare and faced financial barriers related to their care. When prescribing diabetes medications for her patients, she was struck by how few options she could consider—namely metformin or insulin. By contrast, her colleagues working at other clinics with patients who had employer-sponsored insurance could prescribe newer drugs. Meanwhile, she did not even know the cost of other diabetes medications or if they would be covered.

Around that time, real-time prescription benefit tools were being developed and adopted, and Dr. Sloan started studying them in her research. She thought if clinicians could figure out how much medications cost, they could talk to their patients and decide together what the best medication for the patient would be, taking into consideration both clinical and financial aspects.

Noting that clinicians are not really taught how to talk about costs with their patients, Dr. Sloan underscores that real-time prescription benefit tools provide a seamless entry into that conversation. She also pointed to guides put out by the American College of Physicians in 2019 on cost conversations, while acknowledging the need for more resources in this area.

WORKFLOW STEP 1: EXPLORING LOWER COST MEDICATION OPTIONS

Part 1: Using the Real-Time Prescription Benefit Tool

When Dr. Sloan is prescribing a medication for a patient during a visit, she will enter the medication into the EHR and see what the estimated out-of-pocket cost is for the medication at the patient's preferred pharmacy, along with other less expensive options that may be available. These options might include:

- Same medication available for a lower cost at another pharmacy
- Same medication in a different quantity at the same pharmacy
- Alternative medications at the same pharmacy

She uses the information on her screen as a conversation starter about costs. Turning the screen to the patient, she shows them the cost of the medication and asks if that is affordable or not. Sometimes patients say, "Yes, that's okay," and sometimes they say, "No, that's too expensive, can we find something else?"

Using the tool jumpstarts that conversation, which might otherwise be difficult to have, as it can be harder to generally ask if a patient is having trouble affording their medications.

Real-time prescription benefit tools exemplify how price transparency can be translated in a practical and understandable way for patients. Because the tool interacts in real-time with an insurer, it provides out-of-pocket cost estimates, which is what clinicians and patients need to make informed decisions. To be useful, price transparency must rely on communication across the health system, insurer, clinician, and patient, which is complicated, but these real-time prescription benefit tools are showing that it is possible.

Configuration and Usage of Real-Time Prescription Benefit Tools

Health systems can configure these tools to be either:

- User-directed: Clinicians must click on a button to see the cost estimates
- Automatic display: Cost estimates pop up automatically if there is a potential for savings for the patient

Dr. Sloan explained that her institution originally had a user-directed format to avoid alert fatigue among clinicians and required clinicians to click on the tool to see the costs. While she regularly accessed the tool because it was related to her research, the tool was not widely utilized across the health system. Given this underutilization, the tool was modified to show an automatic pop-up whenever a clinician enters a prescription where there are a few dollars or more in potential savings.

Many more clinicians at the health system now know about the tool, although they still may not use it. Dr. Sloan does not recall any formal training on the tool, aside from possible email guidance. However, she indicated that the tool is easy to use. A clinician only has to look at the displayed costs with the patient and decide if they want to select another option.

Friction Points

As of 2022, about one-third of health systems had not adopted a real-time prescription benefit tool. Among systems that have adopted the tool, clinicians may not know it exists if the configuration is user-directed. Even when the tool is configured for automatic display, clinicians may disregard it from a lack of familiarity or trust.

Health systems are challenged with figuring out the appropriate balance between providing easy access to information about lower-cost medications versus risking alert fatigue among clinicians. There is also no set standard or best practice for the appropriate threshold in savings to trigger an automatic display—\$5, \$100, or no threshold at all?

Importantly, the tool is not always perfectly accurate, so additional work is needed to make these tools more trustworthy. In the meantime, Dr. Sloan believes the tools can offer valuable guidance and, at a minimum, start a conversation regarding costs. Broader education on the tool would help clinicians better understand the tool and how to use it in conversations with their patients.

Part 2 (if needed): Exploring Other Low-Cost Medication Options

If the real-time prescription benefit tool does not offer any appropriate lower-cost medication options, Dr. Sloan will look for other ways to lower costs. Referring to this as her “medication toolkit that she keeps in her head”, she points to options such as:

- Coupon and price comparison companies like GoodRx, to find out how much a medication costs without insurance and/or with a coupon
- Direct-to-consumer pharmacies, like the Cost Plus Drug Company and Blueberry Pharmacy, which offer transparent, low-cost drug pricing
- Local nonprofits in her area that provide assistance for medications
- If available, a clinic financial care counselor, who can look up whether the patient qualifies for a pharmaceutical assistance program, which are often income-based and can offer up to a year’s worth of medication at no cost

WORKFLOW STEP 2: ESTIMATING COSTS FOR OTHER HEALTH SERVICES

For services such as labs, imaging, and specialists, Dr. Sloan’s health system provides cost estimates in the patient portal, although they are only available for facilities within the health system. During the visit, she encourages her patients to look up their estimated costs. She then looks at the costs with them to see if the services are affordable for the patient. If the patient has concerns, Dr. Sloan will try to work with them to see what may be most urgently needed and what could possibly wait.

Dr. Sloan acknowledges that some may push back on this as rationing care, but she finds that people are already rationing their own care and may not be telling their clinicians about it. So, having the cost information examined in the visit allows her to at least help the patient decide what is most clinically important. Unfortunately, there is not always a low-cost option, especially if the services are urgently needed.

Friction Points

While Dr. Sloan’s institution provides estimates for labs, imaging, and specialists in the patient portal, not all health systems do. Moreover, unlike the real-time prescription benefit tool, which provides comparative cost estimates, the patient portal only provides estimates for facilities within a given health system. The lack of comparative costs can leave patients and clinicians in the precarious situation of having to potentially postpone or even forego certain services. In some cases, patients may, however, be able to look up in their insurance portal what labs and imaging may cost at centers outside of their health system.

If real-time benefit tools could provide out-of-pocket cost estimates for services like labs, imaging, and specialists in the same way they provide comparative medication estimates, the tools would be incredibly informative for patients and clinicians in navigating the course of care. The scope of real-time benefit tools will be expanding in 2028 to include vaccines and supplies, and Dr. Sloan hopes it will broaden even further down the road. However, she recognizes there may not be a business case for health systems to provide comparative price estimates for similar services at other systems.

WORKFLOW STEP 3: CONSIDERING NON-MEDICAL COSTS

Finally, other areas of costs that Dr. Sloan considers are health-related non-medical costs, primarily transportation, parking, and facility fees. When she is making a referral, she thinks about the following factors:

- Transportation: Are there service or appointment options close to the patient’s home, or on the bus line? Does she need to schedule far enough in advance so the patient can arrange for transportation that is available through their insurance?
- Parking: There are some clinics that are based at the hospital, which has a parking fee, and there are outlying clinics that do not have a parking fee, so she opts to refer patients to those outlying clinics when possible. She also considers whether clinics are on the bus line, for patients who do not have a car.
- Facility fees: Hospital-based clinics have facility fees, so she tries to refer patients to outlying clinics that are less likely to have a facility fee and again are accessible by bus.

Learning and Refinement

Dr. Sloan highlights that even patients who do not have catastrophic expenses may still struggle with affording their care, so working with them to address costs can make a difference.

Measuring Progress

Dr. Sloan sees the tangible benefits of helping her patients save money where she can while also improving adherence. She has found that her relationships with her patients improve when she addresses issues of cost because it demonstrates that she understands their situations. She emphasized the value of real-time prescription benefit tools, which are embedded in the EHR, free for clinicians to use, and do not require a behavioral intervention for patients.

Even though they are not perfect, real-time prescription benefit tools are bringing price transparency into the clinic in a way that didn't exist a few years ago. The industry is generally supportive of these tools, including EHR vendors, commercial insurers, and health systems, because it makes sense financially for everyone. Of course, Dr. Sloan acknowledges there is room for improvement in terms of their accuracy and reach, along with education for clinicians about their use.

Lessons for Other Clinicians

Having studied costs of care, real-time prescription benefit tools, and medical decision-making, including putting that learning into practice, Dr. Sloan serves as a model case rather than a typical case. Understandably, clinicians may feel uncomfortable talking to their patients about costs, and they have limited time with their patients, so some clinicians may prefer to send their patients to speak with a financial counselor after the visit. However, Dr. Sloan feels that engaging with patients directly about costs during the visit is more efficient because she can make any necessary decisions right there and then versus hearing from a financial counselor afterwards. She would rather handle everything during the visit, which is why she has found the real-time prescription benefit tools to be so helpful.

She acknowledges that, "It feels unfair to have to deal with cost issues in the clinic when affordability and medical debt issues are systemic problems. But while others are trying to solve these systemic issues, clinicians can help patients afford their care and avoid going into debt."

References

- ¹ Lopes L, Kearney A, Montero A, Hamel L, Brodie M. Health care debt in the U.S.: the broad consequences of medical and dental bills. San Francisco (CA): KFF; 2022.
- ² Lopes L, Kearney A, Montero A, Hamel L, Brodie M. Health care debt in the U.S.: the broad consequences of medical and dental bills. San Francisco (CA): KFF; 2022.
- ³ Sparks G, Lopes L, Montero A, Presiado M, and Hamel L. Americans' Challenges with Health Care Costs. San Francisco (CA): KFF; 2026.
- ⁴ Levitt L. Medical Debt-The Canary in the Coal Mine for Health Care Affordability. JAMA Health Forum. 2024 Sep 6;5(9):e243368. doi: 10.1001/jamahealthforum.2024.3368. PMID: 39235806.
- ⁵ Nodora JN, Gilbert JA, Martinez ME, Arslan W, Reyes T, Dover JA, Ramos GM, Komenaka IG, Hitchon HD, Komenaka IK. An innovative approach to the multidisciplinary treatment of uninsured breast cancer patients. Cancer Causes Control. 2025 Mar;36(3):309-319. doi: 10.1007/s10552-024-01935-8. Epub 2024 Nov 26. PMID: 39589718.
- ⁶ Adams A, Kluender R, Mahoney N, Wang J, Wong F, Yin W. The Impact of Financial Assistance Programs on Health Care Utilization: Evidence from Kaiser Permanente. Am Econ Rev Insights. 2022 Sep;4(3):389-407. doi: 10.1257/aeri.20210515. PMID: 36338144; PMCID: PMC9634821.
- ⁷ Hettler DF, Moreland S, Underhill-Blazey M, Patel A. Patient-Provider Cost-of-Care Conversations to Prevent Financial Toxicity. Clin J Oncol Nurs. 2025 Mar 14;29(2):135-143. doi: 10.1188/25.CJON.135-143. PMID: 40096558; PMCID: PMC12056851.
- ⁸ Fitzpatrick V, Erwin K, Rivelli A, Shields M, Delfinado L, Cabiya M, Wennerberg K. The potential impact of introducing a cost tool to facilitate cost-of-care conversations in routine OB care: Lessons from the CONTINUE pilot study. PEC Innov. 2023 Feb 15;2:100136. doi: 10.1016/j.pecinn.2023.100136. PMID: 37214536; PMCID: PMC10194338.
- ⁹ Khan M, Dunlap T, Chalmers K, Stahl E, Cope E. Hospitals and Medical Debt: A Report on Policies and Practices. Washington, DC: AcademyHealth; 2026 Mar.
- ¹⁰ Foster-Smith, Rhonda. "Why culture determines the success of change initiatives." Nursing Management, vol. 57, no. 1, Jan. 2026, p. 56, doi:10.1097/nmg.0000000000000326.
- ¹¹ Lopes L, Kearney A, Montero A, Hamel L, Brodie M. Health care debt in the U.S.: the broad consequences of medical and dental bills. San Francisco (CA): KFF; 2022. Available from: <https://www.kff.org/health-costs/kff-health-care-debt-survey/>
- ¹² Han X, Hu X, Zheng Z, Shi KS, Yabroff KR. Associations of medical debt with health status, premature death, and mortality in the US. JAMA Netw Open. 2024 Mar 4;7(3):e2354766. doi:10.1001/jamanetworkopen.2023.54766. PMID: 38436960; PMCID: PMC10912961.
- ¹³ Levitt L. Medical Debt-The Canary in the Coal Mine for Health Care Affordability. JAMA Health Forum. 2024 Sep 6;5(9):e243368. doi: 10.1001/jamahealthforum.2024.3368. PMID: 39235806.
- ¹⁴ Nandyal S, Strawhun D, Stephen H, Banks A, Skinner D. Building trust in American hospital-community development projects: a scoping review. J Community Hosp Intern Med Perspect. 2021 Jun 21;11(4):439-445. doi: 10.1080/20009666.2021.1929048. PMID: 34211645; PMCID: PMC8221161.
- ¹⁵ Koh HK, Bantham A, Geller AC, Rukavina MA, Emmons KM, Yatsko P, Restuccia R. Anchor Institutions: Best Practices to Address Social Needs and Social Determinants of Health. Am J Public Health. 2020 Mar;110(3):309-316. doi: 10.2105/AJPH.2019.305472. Epub 2020 Jan 16. PMID: 31944837; PMCID: PMC7002960.
- ¹⁶ Brown EM, Frazee TK, Gottlieb LM, Fichtenberg C. "I would love to see these big institutions... throwing their weight around": qualitative findings regarding health and social sector collaborations to address community-level socioeconomic adversity. BMC Public Health. 2024 Jul 29;24(1):2020. doi: 10.1186/s12889-024-19465-y. PMID: 39075415; PMCID: PMC11285253.
- ¹⁷ Senior leader rounding builds crucial connections with staff, through humble inquiry. Mount Sinai Reports. 2022 Mar. Available from: <https://reports.mountsinai.org/article/px2022-03-leader-rounding>
- ¹⁸ Koh HK, Bantham A, Geller AC, Rukavina MA, Emmons KM, Yatsko P, Restuccia R. Anchor Institutions: Best Practices to Address Social Needs and Social Determinants of Health. Am J Public Health. 2020 Mar;110(3):309-316. doi: 10.2105/AJPH.2019.305472. Epub 2020 Jan 16. PMID: 31944837; PMCID: PMC7002960.
- ¹⁹ Brown EM, Frazee TK, Gottlieb LM, Fichtenberg C. "I would love to see these big institutions... throwing their weight around": qualitative findings regarding health and social sector collaborations to address community-level socioeconomic adversity. BMC Public Health. 2024 Jul 29;24(1):2020. doi: 10.1186/s12889-024-19465-y. PMID: 39075415; PMCID: PMC11285253.
- ²⁰ Sparks G, Lopes L, Montero A, Presiado M, and Hamel L. Americans' Challenges with Health Care Costs. San Francisco (CA): KFF; 2026. Available from: <https://www.kff.org/health-costs/americans-challenges-with-health-care-costs/>
- ²¹ Internal Revenue Service. Requirements for 501(c)(3) hospitals under the Affordable Care Act—Section 501(r). Washington (DC): Internal Revenue Service; 2025 Jul 1. Available from: <https://www.irs.gov/charities-non-profits/charitable-organizations/requirements-for-501c3-hospitals-under-the-affordable-care-act-section-501r>
- ²² Bruhn WE, Rutkow L, Wang P, Tinker SE, Fahim C, Overton HN, Makary MA. Prevalence and Characteristics of Virginia Hospitals Suing Patients and Garnishing Wages for Unpaid Medical Bills. JAMA. 2019 Aug 20;322(7):691-692. doi: 10.1001/jama.2019.9144. PMID: 31237609; PMCID: PMC6593627.
- ²³ Randall S, Rohrer J, Wong N, Nguyen NL, Trish E, Duffy EL. Financial assistance and payment plans for underinsured patients shopping for "shoppable" hospital services. Health Aff Sch. 2024 May 10;2(5):qxae062. doi: 10.1093/haschl/qxae062. PMID: 38808329; PMCID: PMC11132125.
- ²⁴ Duffy EL, Frasco MA, Trish E. Disparate Patient Advocacy When Facing Unaffordable and Problematic Medical Bills. JAMA Health Forum. 2024 Aug 2;5(8):e242744. doi: 10.1001/jamahealthforum.2024.2744. PMID: 39212978; PMCID: PMC11364993.
- ²⁵ Navigating the maze: a look at health insurance complexities and consumer protections. KFF. Available from: <https://www.kff.org/private-insurance/navigating-the-maze-a-look-at-health-insurance-complexities-and-consumer-protections/>
- ²⁶ Center for Health Care Strategies, Inc. Hospital presumptive eligibility: factsheet. Hamilton (NJ): CHCS; 2014 Feb. Available from: <https://www.chcs.org/resource/hospital-presumptive-eligibility-opportunities-to-connect-uninsured-individuals-to-coverage/>
- ²⁷ Knowlton LM, Logan DS, Arnow K, Hendricks WD, Gibson AB, Tran LD, Wagner TH, Morris AM. Do hospital-based emergency Medicaid programs benefit trauma centers? A mixed-methods analysis. J Trauma Acute Care Surg. 2024 Jan 1;96(1):44-53. doi: 10.1097/TA.00000000000004162. Epub 2023 Oct 13. PMID: 37828656; PMCID: PMC10841404.

- 28 Tran LD, Knowlton LM, Wagner TH. Emergency Medicaid Acquisition Through the Affordable Care Act: The Association Between Hospital Enrollment in California and Hospital Revenue. *Med Care*. 2020 Aug;58(8):727-733. doi: 10.1097/MLR.0000000000001352. PMID: 32692139
- 29 Center for Health Care Strategies, Inc. Hospital presumptive eligibility: factsheet. Hamilton (NJ): CHCS; 2014 Feb. Available from: <https://www.chcs.org/resource/hospital-presumptive-eligibility-opportunities-to-connect-uninsured-individuals-to-coverage/>
- 30 Santos T, Lindrooth RC, Young GJ, Lee SY. Financial Assistance Policy, Hospital Charity Care, and Medical Debt in Collections. *JAMA Netw Open*. 2026 Jan 2;9(1):e2555698. doi: 10.1001/jamanetworkopen.2025.55698. PMID: 41591774; PMCID: PMC12848624.
- 31 Internal Revenue Service. Requirements for 501(c)(3) hospitals under the Affordable Care Act—Section 501(r). Washington (DC): Internal Revenue Service; 2025 Jul 1. Available from: <https://www.irs.gov/charities-non-profits/charitable-organizations/requirements-for-501c3-hospitals-under-the-affordable-care-act-section-501r>
- 32 Kona M, Raimugia V. State protections against medical debt: a look at policies across the U.S. in 2025. New York (NY): Commonwealth Fund; 2025 Jul. doi:10.26099/7m6v-ve80.
- 33 Walker J, Rushbanks E, Snodgrass C, and Rivera R. Hospital Toolkit: Practical guidance to help hospitals make financial assistance known, easy, and fair. Vancouver (WA): Dollar For; 2025 Nov. Available from: <https://dollarfor.org/wp-content/uploads/2025/11/Toolkit20251110.pdf>
- 34 Healthcare Financial Management Association and Advocata Solutions. Advancing Healthcare Access Responsible Financial Assistance, Billing and Collection Policies for Hospitals. Downers Grove (IL): HFMA; 2025. Available from: https://www.hfma.org/wp-content/uploads/2025/05/WP_Advancing-Healthcare-Access_0525_final.pdf
- 35 Walker J, Rushbanks E, Snodgrass C, and Rivera R. Hospital Toolkit: Practical guidance to help hospitals make financial assistance known, easy, and fair. Vancouver (WA): Dollar For; 2025 Nov.
- 36 Healthcare Financial Management Association and Advocata Solutions. Advancing Healthcare Access Responsible Financial Assistance, Billing and Collection Policies for Hospitals. Downers Grove (IL): HFMA; 2025. Available from: https://www.hfma.org/wp-content/uploads/2025/05/WP_Advancing-Healthcare-Access_0525_final.pdf
- 37 Walker J, Rushbanks E, Snodgrass C, and Rivera R. Hospital Toolkit: Practical guidance to help hospitals make financial assistance known, easy, and fair. Vancouver (WA): Dollar For; 2025 Nov.
- 38 ABIM Foundation. Addressing medical debt: rebuilding trust in health care. Philadelphia (PA): ABIM Foundation; 2024 Jun. Available from: <https://abim-foundation.org/what-we-do/rebuilding-trust-in-health-care/addressing-medical-debt-2>
- 39 Messac L, Janke AT, Rogers LH, Fonfield I, Walker J, Rushbanks E, Becker NV, Bai G. US Nonprofit Hospitals Have Widely Varying Criteria To Decide Who Qualifies For Free And Discounted Charity Care. *Health Aff (Millwood)*. 2024 Nov;43(11):1569-1577. doi: 10.1377/hlthaff.2023.01615. PMID: 39496092; PMCID: PMC12230784.
- 40 Internal Revenue Service. Requirements for 501(c)(3) hospitals under the Affordable Care Act—Section 501(r). Washington (DC): Internal Revenue Service; 2025 Jul 1. Available from: <https://www.irs.gov/charities-non-profits/charitable-organizations/requirements-for-501c3-hospitals-under-the-affordable-care-act-section-501r>
- 41 Collins SR, Roy S, Masitha R. Paying for it: how health care costs and medical debt are making Americans sicker and poorer—findings from the 2023 Commonwealth Fund Health Care Affordability Survey. New York (NY): Commonwealth Fund; 2023 Oct. doi:10.26099/bf08-3735.
- 42 Collins SR, Richards C, Gupta A, Roy S. How Medical Bills and Debt Impact Americans with Private Insurance: Findings from the Commonwealth Fund 2025 Affordability Survey and Focus Groups. New York (NY): Commonwealth Fund; 2026 Sept.
- 43 von Ungern-Sternberg BS, Sommerfield A, Becke-Jakob K. Moral injury in clinical and academic medicine-it is time to act. *BJA Open*. 2026 Jan 20;17:100525. doi: 10.1016/j.bjao.2025.100525. PMID: 41623685; PMCID: PMC12859220.
- 44 Meyer MA. A Patient's Journey to Pay a Healthcare Bill: It's Way Too Complicated. *J Patient Exp*. 2023 Jun 7;10:23743735231174759. doi: 10.1177/23743735231174759. PMID: 37323758; PMCID: PMC10262600.
- 45 The Leapfrog Group. Factsheet: billing ethics. Washington (DC): The Leapfrog Group; 2026 Apr 1. Available from <https://ratings.leapfroggroup.org/sites/default/files/2025-03/2025%20ASC%20Billing%20Ethics%20Fact%20Sheet.pdf>
- 46 The Leapfrog Group. Factsheet: billing ethics. Washington (DC): The Leapfrog Group; 2026 Apr 1. Available from <https://ratings.leapfroggroup.org/sites/default/files/2025-03/2025%20ASC%20Billing%20Ethics%20Fact%20Sheet.pdf>
- 47 ABIM Foundation. Addressing medical debt: rebuilding trust in health care. Philadelphia (PA): ABIM Foundation; 2024 Jun. Available from: <https://abim-foundation.org/what-we-do/rebuilding-trust-in-health-care/addressing-medical-debt-2>
- 48 Undue Medical Debt. First Do No Harm: How Clinicians Can Champion the End of Medical Debt, Undue Medical Debt; 2024. Available from: https://unduemedicaldebt.org/wp-content/uploads/2024/12/DO_NO_HARM_GUIDE.pdf
- 49 von Ungern-Sternberg BS, Sommerfield A, Becke-Jakob K. Moral injury in clinical and academic medicine-it is time to act. *BJA Open*. 2026 Jan 20;17:100525. doi: 10.1016/j.bjao.2025.100525. PMID: 41623685; PMCID: PMC12859220.
- 50 Hettler DF, Moreland S, Underhill-Blazey M, Patel A. Patient-Provider Cost-of-Care Conversations to Prevent Financial Toxicity. *Clin J Oncol Nurs*. 2025 Mar 14;29(2):135-143. doi: 10.1188/25.CJON.135-143. PMID: 40096558; PMCID: PMC12056851.
- 51 Fitzpatrick V, Erwin K, Rivelli A, Shields M, Delfinado L, Cabiya M, Wennerberg K. The potential impact of introducing a cost tool to facilitate cost-of-care conversations in routine OB care: Lessons from the CONTINUE pilot study. *PEC Innov*. 2023 Feb 15;2:100136. doi: 10.1016/j.pecinn.2023.100136. PMID: 37214536; PMCID: PMC10194338.
- 52 Perez SL, Weissman A, Read S, Smith CD, Colello L, Peter D, Nickel W. U.S. Internists' Perspectives on Discussing Cost of Care With Patients: Structured Interviews and a Survey. *Ann Intern Med*. 2019 May 7;170(9_Suppl):S39-S45. doi: 10.7326/M18-2136. PMID: 31060057.
- 53 Doherty M, Jacoby J, Gany F. "I wish I knew about these programs before!" A brief report exploring barriers to financial assistance reported by gynecological oncology patients. *J Psychosoc Oncol*. 2023;41(5):493- 501. doi: 10.1080/07347332.2022.2149374. Epub 2022 Dec 14. PMID: 36514954; PMCID: PMC10322634.
- 54 Perez SL, Weissman A, Read S, Smith CD, Colello L, Peter D, Nickel W. U.S. Internists' Perspectives on Discussing Cost of Care With Patients: Structured Interviews and a Survey. *Ann Intern Med*. 2019 May 7;170(9_Suppl):S39-S45. doi: 10.7326/M18-2136. PMID: 31060057.