ASSOCIATION OF COMMUNITY CANCER CENTERS

FINANCIAL ADVOCACY NETWORK

July 2020 Town Hall

Town Hall Objectives & Panelists

Financial advocacy experts discussed subjects that can benefit patients and financial navigation programs, including how to:

- Adapt your **financial navigation workflow** during COVID-19
- Develop resources to assist patients experiencing **loss of insurance**
- Access **financial assistance program updates**, funds, and resources
- Use **resources available from ACCC and partners** to support financial navigation

Panelists Included:

- **Lori Schneider,** ACCC Financial Advocacy Network Committee Chair; Oncology Operations Manager, Green Bay Oncology
- **Rifeta Kajdic,** Program Manager, Oncology Service Line, Saint Luke's Cancer Institute
- **Angie Santiago, CRCS**, Lead Financial Counselor, Oncology, Sidney Kimmel Cancer Center

Part I: Panelist Insights

Financial Navigation Workflow during COVID-19

Rifeta Kajdic

- Hurdles:
    - Tough decisions to limit exposure and risk to our patients, staff, and community
    - Equipment: is staff ready to work from home?
        - Computers (work-issued laptops or personal laptops that can be used?)
        - Internet Access
        - Fax
        - Calling patients / headphones
    - HIPAA compliance: policies and processes to protect patient PHI
    - Paperwork: FMLA/Disability forms, charity and drug assistance applications
- Solutions:
    - IT partnership
        - Remote access - allowing staff to utilize personal laptops from home
        - Apps - receiving faxes and making phones call securely
    - Patient awareness - calling patients and arranging assistance
    - On-site rotation - one on site person daily per site working as triage "switchboard"
    - Clinic partnership – working with clinic staff on site to assist with communication and paperwork
    - Training materials - keep your training tools up to date to adjust to COVID

Assisting Patients with Loss of Insurance

Angie Santiago, CRCS

- During the COVID-19 outbreak, we're all seeing patients being laid off and losing their medical coverage through their employer. When a patient is losing coverage, we want to move quickly to review options and assess what is best for the patient.
    - Need to assess:
        - is COBRA always the best option?
        - Does the patient have the means to pay their COBRA?
        - Are financial assistance programs open to assist with COBRA?
        - Does your hospital assist with COBRA payments?

        - How long will the assistance be able to help?
    - If a patient can only afford COBRA for only a few months, they may not have the option to just switch to an ACA plan. See HealthCare.gov for information about Marketplace options for patients who've enrolled in COBRA.
    - When COBRA is not an option:
        - Complete a financial assessment
        - Apply for Medicaid, if eligible
        - If ineligible, we direct patients to www.healthcare.gov
            - Remind them to calculate their adjusted income for the year – this makes a difference on tax credits
            - We help them make a grid to review ACA options
- Tips for Accessing Financial Assistance During COVID-19
    - Check daily – a closed fund today may open tomorrow
        - PAN Foundation's FundFinder is a good tool for this
    - Be proactive in conversations with patients. Questions can be asked by all staff (Care Team, Front Desk, Phone Room)
        - Do you anticipate any lapse in your current insurance coverage?
        - Are you currently in the process of applying for COBRA?
        - Do you have any concerns regarding your insurance coverage?
    - Use ACCC's COVID-19 Financial Advocacy Resources Hub for updates to programs, policies, and resources

Part II: Audience Q&A

Question: Are Unemployment benefits included in Adjusted Gross Income calculations?

Answer (Rifeta and Angie): This can vary by state.

Triage Cancer's COVID-19 resources explain the federal rules about how the new unemployment benefits and the economic impact payments can impact Medicaid, Marketplace financial assistance, and other government benefit programs like housing, SNAP, etc. Triage cancer also has a comprehensive resource for state laws.

Question: Is it important for patients who are on an ACA plan and receiving the additional $600 in unemployment benefits to report that to their plan?

Answer (Rifeta and Angie): We encourage patients to report this additional money to their plan up front in order to be transparent.

Question: Have you been successful in utilizing the COVID-19 funds that have become available? What has that enrollment experience been for you and have you found these programs valuable?

Answer (Angie): The foundations have made it a seamless process for advocates and for patients. When the funds close, we start looking at other options like assistance with premiums.

Question: Do you have an example or template of financial assessment questions?

Answer (ACCC): The assessment Angie highlighted during her presentation is an assessment of insurance options. This template is provided in the "Handouts" tab of the on-demand Town Hall.

For examples of financial distress screening assessment tools and processes, you can reference ACCC's Financial Advocacy Boot Camp Level II for an in-depth overview and practical examples. Some of the tools used include:

- Comprehensive Score for Financial Toxicity – Functional Assessment of Chronic Illness Therapy (COST-FACIT)

- AnMed Health Oncology Support Services Screening

Question: How do you choose which insurance programs to include on a comparison grid for patients?

Answer (Angie): Because we don't want to ever seem like we're advocating for one insurance over another, the comparison grid that I made was just an example version for three insurances. In practice, we will include all available plans. For example if there 14 Independence Blue Cross plans, we'll list all 14 because you never want a patient to feel like their health care system influenced patients to select a particular plan.

Question: When looking at insurance options, should we add up the annual premium and out-of-pocket maximum to get the annual maximum financial responsibility for the patient?

Answer (Angie): Yes, I do based on the insurance plan. If the plan says that chemo is covered at 100%, I'll tell the patient you might not necessarily meet your out-of-pocket maximum (OOPM). However, if they're in active treatment and have co-insurance, it's easier for them to meet that OOPM. It depends on the policy but we honestly don't see many that fully cover chemo.

Question: Do you financial advocates help find marketplace plans if the patients are over guidelines for the ACA, Medicaid, and the facility's charity plans?

Answer (Rifeta): Yes, absolutely. The financial advocates at our site are also enrollment counselors and attend yearly training. We will sit down with the patient and go through the Marketplace show them different options and kind of walk them through it because it can be confusing.

(Angie) I agree. We are not enrollment counselors but we still go to the ACA Marketplace website and those prices that we would show to the patient would be full price (no credit) because their income was over for any type of tax credit.

Question: How do you prep your team to be ready for open enrollment? How do you fit that into already busy schedule?

Answer (Angie): We do our own "advertising" for Medicaid and ACA open enrollment, including putting actual signage around the cancer center. "Call the Financial Advocacy team if you have any questions or concerns!"

We set up time with patients – it's not face-to-face right now, but I would email them a spreadsheet showing their plan options and walk them through it. We don't want patients to feel alone or have doubts about their decision. We want them to know we're still here to support them and we're still setting up time with them.

(Rifeta) The beauty of this role is that everyone really wants to help people. We even help with after-hours enrollment fairs to help the community. If we can help the community, it will help us down the line to find solutions for patients.

Question: Do you have a financial clearance process for patients that are starting treatment?

Answer (Angie): We don't do financial clearance ahead of time or collect money up-front – we don't want to scare our patients off.

On my financial navigation team, we work off our own referrals and who is newly scheduled at the infusion center. We use Epic - our doctors put in the orders and it hits a work queue for our billing and authorization team. That team reviews for medical necessity and obtains authorization. Once the Epic referral is authorized, it hits a work queue for our schedulers, who will place that patient on the infusion schedule. Once we see that there is a patient newly scheduled at the infusion center, we start looking at their medical insurance, out-of-pocket costs related to the treatment, and for any opportunities for

foundation support or manufacturer co-pay cards. We also take a peek at the back-end billing – maybe they've met their out-of-pocket maximum but it's due to hospital inpatient stays.

Then we go to the patient and introduce our role as part of the support team. We are going over their insurance benefits, letting them know if there's opportunities for financial assistance through foundations or co-pay cards, and we're assessing them for our hospital's compassionate care program. We also remind them that we aren't bill collectors and that we're here to be a resource to them. If there's no foundation grants open or co-pay cards available, we are working hand-in-hand with our social work team to find ways to help with rent/mortgage or other daily expenses.

So, we aren't doing financial clearance to indicate that they're able to pay or want to pay. We'll set them up on a payment plan and work closely with social work.

We want to support patients, and we also don't want them to share with their family and friends that we're more concerned about money than their treatment. We are more concerned with making sure you're able to come in for your treatment every time you need it.

Question: Do you have a set timeframe when you meet with patients for an initial consult? Do you meet with all patients or is it dependent upon need?

Answer (Rifeta): While we want to have the goal to meet with every patient, but we are outnumbered and can't handle that workload with our team. We rely on our teammates to refer patients to us, such as social workers, providers, and front-desk staff letting providers know the patient would benefit from seeing a financial advocate.

If we need to prioritize which patients we proactively meet with up-front, we can also go back and review other patients at a later point or find other ways to communicate our services, like sending a brochure in the mail.

We do initial meet-and-greets with the patients. They might not have questions at first, but they might later down the road. Financial health literacy is a real challenge, and patients may not understand their insurance. We give them a roadmap of what their treatment costs are going to look like so we can take away some of that stress and fear. We let them know they don't need an appointment to see us.

We also rely on treatment regiments as a back-up screening process. After the provider selects the treatment (e.g., radiation, oral chemo, etc.), it will go to the financial advocate's workflow where they can check if the patient is eligible for financial assistance / co-pay cards and it gives us another opportunity to screen that patient again. Similarly, if a patient's disease is progressing and they suddenly have a new treatment regimen, their financial situation may change. Perhaps they didn't need assistance two months ago, but now they need long-term disability. At that point, we can contact them again.

(Angie) We are a big cancer center with 46 physicians. Unfortunately, it's not realistic for our small team to see every patient. We try to meet them to introduce our role. Keep in mind that when we first meet patients, it's a lot for them. They're meeting their whole care team, starting treatment, maybe seeing a dietician and social worker. We never want a patient to feel overwhelmed, so we don't leave it at the patient saying, "I'm okay - Don't screen me for anything!". We might wait a month or two and come back to remind them that we are here for them and advocating for them. We might ask if we can reassess them for a financial assistance program or enroll them in a co-pay card.

Our cancer center does not have the same capabilities in Epic as Rifeta's, so I rely on our front-desk staff to put a three-letter word on the appointment: N-E-W. That's how I know it's a new treatment. Since we don't have the Epic workflow, our next best thing is to work with the front-desk to identify new treatments. Figure out what will work best in your cancer center and make the system work for you.

Question: How large is your cancer center and how many team members do you have to support your physicians?

Answer (Rifeta): We have five sites – four here, and one two hours away. We have about 17 full time employees (FTE) to support medical oncology, radiation, bone marrow transplant.

(Angie): We have 46 physicians in medical oncology, and three FTEs to support that group. We don't do any pre-authorization work. We see about 4,000 infusion patients yearly.

Question: Do you have any suggestions on how to begin developing co-pay assistance processes in an organization--especially now when a lot of healthcare institutions have suffered financial loss?

Answer (Rifeta): Now is the time to capitalize on anything you can do to financially support your patients and your health system. You have to really start tracking your work to arrive at a return-on-investment (ROI) on how these manufacturer co-pay cards, foundation programs, and different assistance channels can help both your patient and how your system cares for your patient. If the patient cannot afford their pills, they can't adhere to therapy. Tracking the impact of your work helps communicate an ROI to leadership on why these programs are important.

Question: How do you notify your billing department if a patient is on a manufacturer program?

Answer (Rifeta): In our referral regimens in Epic, which is where all treatments are dumped into the workflow, we created little flags on the referrals. For co-pay assistance, that allows us to evaluate the bill before the statement goes out to the patient. For IV infusions, we have a dedicated person who bills the patient, so the referral flags drive her workload. For oral drugs, we make sure that our oral chemo pharmacy screens all patients to let us know their co-pay. If we've enrolled the patient in foundation assistance or co-pay cards, we send that information back to the pharmacy to inform the billing process.

(Angie): We keep a spreadsheet – that's why I'm called the Excel Queen! We keep a spreadsheet of all of our patients on foundations and co-pay programs and once a week, what I call "billing day," we check the patients' back-end bills to see if there are any claims that can be submitted to a foundation or co-pay card.