Closing the Gap: The Journey to Connect Community Benefit and Patient Billing

Over the last year Healthcare Anchor Network (HAN) and Undue Medical Debt collaborated to engage health system revenue cycle, community benefit and population health leaders to align strategies in helping patients avoid medical debt. Through the learning cohort, **Mind the Gap: Connecting Community Benefit and Patient Billing,** participants worked to forge new connections, better understand roles and data access and develop shared strategies and language to drive change. The "Mind the Gap" cohort takes its name from the disconnect between hospital revenue cycle and community benefit teams—two departments that are often siloed despite working toward the shared goal of patient wellbeing. **When these teams bridge this gap and work together, hospitals can achieve better health outcomes for patients while significantly reducing the burden of medical debt.**

This resource highlights the key steps and insights from the cohort to support continued change and improve patient outcomes.

PROBLEM
Introduction to the Issue of Medical Debt

TRUST
Relationship Building

DATA ALIGNMENT
Data Sharing to Support and Monitor Progress

RIGHT SIZING SOLUTIONS
Financial Assistance Policies are a Barometer

BUILDING THE CASE
Leveraging Allies

LONGEVITY
Reflection

The Problem - Introduction to the Issue of Medical Debt

Affecting over 100 million people, medical debt is a critical issue for hospitals, patients, and communities. Patients with medical debt avoid and delay care, experience acute stress and anxiety and struggle with financial stability. Health systems work to get patients to the right financial and health outcome and can do more to maximize patient experience and reduce their own administrative burden.

Learn more about medical debt

Medical Debt 101

Medical Debt Dictionary

Trust - Relationship Building

Trust and relationships are the foundation to cross departmental collaboration and organizational culture building. Revenue cycle or medical billing teams and community benefit leaders may not interact often. Teams across and within different health systems have a lot to learn from one another.

What is Revenue Cycle?

Revenue cycle is the process of converting healthcare into financials. It includes coding the clinical care (diagnosis & procedure codes), getting the patient insurance information, getting authorization for care, sending claims for care, fighting claim denials, billing patients and helping patients find coverage and financial assistance and understand their bills.

Common Revenue Cycle Roles

Revenue Cycle Vice President, Manager, Director

- Sometimes top leader has the title Chief Revenue Officer
- Oversees entire revenue cycle operations, sets strategic direction, manages budgets, ensures compliance, reports to executive leadership on financial performance

Patient Access Vice President, Manager, Director

- Patient Access is a part of revenue cycle, typically focusing on the early stages of patient registration, scheduling and prior authorization.
- Manages registration, insurance verification, pre-authorization, scheduling, and front-end revenue cycle processes

Patient Financial Services Vice President, Manager, Director

- Patient Financial Services is synonymous with revenue cycle
- Manages registration, insurance verification, pre-authorization, scheduling, and front-end revenue cycle processes

Self-Pay Collections Manager, Director

- This title is not used as often but would indicate a focus on patient collections
- Manages uninsured patient accounts, screens for Medicaid eligibility, coordinates charity care applications

*These employees will report to the Chief Financial Officer.

What is Community Benefit?

Community benefit refers to the programs, services, and activities hospitals provide to improve the health and well-being of the communities they serve — especially for people who are low-income, uninsured, or face barriers to care. These activities must address identified community health needs, expand access to essential services, advance public health, educate the community, or reduce the burden on government. Community benefit includes charity care, community health programs, subsidies for essential but unprofitable services, health education, and public research. It does not include activities primarily for marketing, profit, or the benefit of internal staff.

Common Community Benefit Roles

Role	Description
Director of Community Health	• Variations could include references to population health or community health improvement • Implements population health strategies, manages care coordination programs, analyzes population health data, ensures program effectiveness
Community Health Manager	• Often manages Community Health Workers (CHWs) and health educators, and maintains data related to community health and hospital initiatives • Leads community benefit strategy, ensures IRS compliance, manages community health needs assessments, oversees community partnerships
Community Outreach Specialist/ Coordinator	• Generally supports public-facing program activities • Develops relationships with community organizations, coordinates health fairs and screening events, promotes hospital programs in community
Community Relations Manager	• Note: This role may take on more of a public relations bent within some health systems; hospitals without a more formal community health department often utilize this role for most community benefit activities • Develops and maintains relationships with community organizations, coordinates collaborative health initiatives, manages partnership agreements
Health Educator	• Often a nurse, and generally tied to the clinical part of hospital operations • Develops and delivers health education programs for community members, creates educational materials, coordinates prevention programs
Community Health Worker (CHW)	• Provides culturally appropriate health education, connects community members to healthcare resources, conducts outreach in underserved areas
Program Manager/Coordinator	• Focused on specific initiatives like wellness, nutrition, or housing

*These employees typically report to the Chief Strategy Officer or the Chief Medical Officer.

Setting up the Meeting

To support strong collaboration, community benefit and revenue cycle teams should introduce their partnership by setting clear, shared goals around reducing barriers to care and improving the patient's financial experience. From there, they can structure ongoing meetings—ideally monthly or bi-monthly—that bring together leaders and frontline staff from both sides to review community health needs assessment (CHNA) insights, community health trends, financial-assistance data, and patient feedback. Each meeting should include time to identify emerging access issues, refine referral pathways between financial counselors and community programs, and co-develop patient-friendly materials or outreach strategies. By consistently revisiting metrics, sharing successes, and jointly planning next steps, these meetings become a reliable forum for aligned decision-making and continuous improvement.

Data Alignment- Data Sharing to Support and Monitor Progress

Data is a powerful tool to drive decision making and investment. What data do community benefit staff track? What data do revenue cycle staff rely on? How are they shared or gated? Review existing revenue cycle and community health data points for areas of potential synergy.

What is a community health needs assessment?

A community health needs assessment (CHNA) is a process that the IRS requires nonprofit hospitals to complete every three years to understand the health strengths and challenges of the communities they serve. It involves listening to residents, reviewing data, and partnering with local organizations to identify the most pressing health issues, including chronic disease and mental health needs, as well as barriers to transportation and access to care. The goal is to create a clear, shared picture of what the community truly needs to be healthier. Hospitals then use these findings to guide their community benefit programs, including financial assistance, and invest in solutions that make a meaningful impact.

What data points matter to Revenue Cycle?

Community health data is increasingly important for nonprofit hospital revenue cycle leaders because it helps them understand the barriers patients face long before a bill is ever generated. Data points that matter most include social determinants of health, such as insurance coverage rates, income levels, housing stability, transportation access, and language needs, all of which influence a patient's ability to seek care, complete care, and resolve bills. They also pay close attention to community rates of chronic disease, emergency department use for avoidable conditions, and uninsured or underinsured populations, since these directly affect charity care, bad debt, and financial-assistance demands. Ultimately, revenue cycle leaders can use these insights to design more patient-centered billing processes, strengthen financial-assistance programs, and reduce financial barriers to care.

Use this data worksheet

Effective data sharing between revenue cycle and community benefit teams helps nonprofit hospitals connect internal financial trends with the economic realities their patients face. When revenue cycle shares information on financial-assistance use, bad debt, and common affordability barriers, and community benefit adds CHNA findings, poverty indicators, and SDOH data, both teams gain a clearer understanding of who is struggling and why. Together, these insights guide smarter policies and targeted outreach that improve equitable access to care while strengthening the hospital's financial stability.

Right Sizing Solutions - Financial Assistance Policies are a Barometer

Financial assistance is a critical pathway for patients and is under increasing pressure as patients lose access to health coverage under recent policy shifts. Community benefit and revenue cycle leaders should familiarize themselves with the value and operability of their health system's financial assistance policies. This includes understanding current state laws and new innovative approaches to financial assistance.

Financial assistance resources

- **EXAMPLE**: Inova Presentation/Case Study
- Presumptive Eligibility
- State Laws map/Credit bans map

Building the Case- Leveraging Allies

Identify key allies outside of the community benefit and revenue cycle teams that are positioned to champion a project and help move it to the finishline. Change can happen.

Develop your messengers

- Physician leaders may be key allies. Guide: "How Clinicians Can Champion the End of Medical Debt"
- Lown Institute Medical Debt Panel (featuring Dr. Fred Cerise from Parkland Health and Dr. Deepak Manmohan Goyal from Monument Health)

Longevity - Reflection

Collaboration is not a drop-in solution; it requires culture change. Maintaining practices that prioritize collaboration across revenue cycle and community benefit will help build a culture of shared practice and innovation in the service of both hospital and patient financial wellness.

Conclusion - Sustaining the Journey Forward

The journey from medical billing to mission alignment is not a single destination but an ongoing commitment. Throughout this journey, you've explored how bridging revenue cycle and community benefit teams can transform medical debt from a shared challenge into a shared opportunity for impact.

The tools, data, and relationships shared from this cohort are starting points. Real change happens when these connections become embedded in an organization's daily operations.

The gap between medical billing and community benefit is a space waiting to be filled with collaboration, innovation, and a shared commitment to both organizational sustainability and community health.

Resource: For quick reference, see the Key Learnings from the cohort to jump start your collaboration.

What's Next:

- Identify and reach out to your revenue cycle or community benefit counterparts
- Schedule regular touchpoints between revenue cycle and community benefit teams
- Identify one pilot project to work on collaboratively
- Share your learnings and challenges
- Revisit this journey map as your collaboration evolves

Appendix

Community Benefit and Revenue Cycle | Internal Data Sharing

Below is a table with common data held by Community Benefit and by Revenue Cycle respectively. Sharing this data between the teams can identify potential projects and track needed improvements.

Revenue Cycle

Financial assistance:

- Total number of patient encounters for those that received financial assistance
- Unique number of patients who received financial assistance
- Racial or ethnic group breakdown
- Age group (i.e., 17 and under, 18 to 64, 65 and older)
- Gender
- Top ten patient origin ZIP code for those having received financial assistance
- If known, percentage of financial assistance determined by presumptive eligibility
- Number of denials + percentage of denials of overall applications

Medicaid:

- Total number of patient encounters for those are covered through Medicaid
- Unique number of patients who received financial assistance
- Racial or ethnic group breakdown, by total unique patients
- Age group (i.e., 17 and under, 18 to 64, 65 and older), by total unique patients
- Gender, by total unique patients
- Top ten patient origin ZIP code for those having received financial assistance

Community Benefit and/or Population Health

Inpatients:

- Total inpatients
- Total unique inpatients
- Racial or ethnic group breakdown, by total unique patients
- Age group (i.e., 17 and under, 18 to 64, 65 and older), by total unique patients
- Gender, by total unique patients
- Top ten inpatient origin ZIP codes, by total visits
- Payor mix: private insurance, Medicaid, Medicare, Medicare Advantage, TRICARE, self-pay, other, by total visits and total unique patients

Number of outpatients:

- Total outpatients
- Unique outpatients
- Racial or ethnic group, by total unique patients
- Age group (i.e., 17 and under, 18 to 64, 65 and older), by total unique patients
- Gender, by total unique patients
- Top ten outpatient origin ZIP codes
- Payor mix: private insurance, Medicaid, Medicare, Medicare Advantage, TRICARE, self-pay, other, by total visits and total unique patients

Emergency care:

- Total number of emergency room visits
- Unique number of patients seen in the emergency room
- Top ten emergency room visits patient origin
- Top ten primary diagnoses for patients presenting at the emergency room
- Ambulatory care sensitive conditions presenting at the emergency department, total unique patient visits by condition (see chart below), by primary diagnosis
- Ambulatory care sensitive conditions presenting at the emergency department, total visits by condition (see chart below)
- Payor mix: private insurance, Medicaid, Medicare, Medicare Advantage, TRICARE, self-pay, other

Top 10 languages requested for translation or interpretation services

A list of relevant community-based contracted partnerships, such as charitable clinics and FQHCs

Ambulatory care sensitive conditions presenting at the Emergency Department.

Condition	ICD-10 codes
Angina	I20.0-I20.9, I24.0, I24.8–24.9
Aspiration	J69.0, J69.8
Asthma	J45–46
Cellulitis	L03–04, L08, L88, L98.0, L98.3
Congestive heart failure	I11.0, I50, J81
Constipation	K59.0
Convulsions/epilepsy	G40–41, R56, O15
COPD	J41–44, J47
Dehydration and gastroenteritis	E86, K52.2, K52.8, K52.9
Dental conditions	A69.0, K02–06, K08, K09.8, K09.9, K12–13
Diabetes complications	E10.0–10.8, E11.0–11.8, E12.0–12.8, E13.0–13.8, E14.0–14.8
Ear, nose, and throat infections	H66–67, J02–03, J06, J31.2
Gangrene	R02
Gastro-esophageal reflux, gastroenteritis	K21, K529
Hypertension	I10, I11.9, I16
Iron deficiency anemia	D50.1, D50.8–50.9
Influenza	J10–11
Nutritional deficiencies	E40–43, E55, E64.3
Pelvic inflammatory disease	N70, N73–74
Perforated/bleeding ulcers	K25.0–25.2, K25.4–25.6, K26.0–26.2, K26.4–26.6, K27.0–27.2, K27.4–27.6, K28.0–28.2, K28.4–28.6
Pneumonia and other acute LRTI	J13–14, J15.3–15.4, J15.7, J15.9, J16.8, J18.1, J18.8, J20–20.2, J20.8, J20.9, J22
Tuberculosis and other vaccine preventable	A15–16, A19, A35–37, A80, B05–06, B16.1, B16.9, B18.0–18.1, B26, G00.0, M01.4
UTI/pyelonephritis	N10–12, N13.6, N39.0