

Predictive Analytics in the Age of Un(der)insurance: A Primer

Potential, Pitfalls, and Emerging Strategies

EXECUTIVE SUMMARY

Introduction

Hospitals are in a tough spot. [Drastic changes to the healthcare landscape](#), coupled with big increases in patient cost-sharing and the rippling effects of inflation on basic needs like housing and groceries,ⁱ have created additional pressure on hospitals and households. Hospitals face rising costs, increases in claim denials,ⁱⁱ ongoing staffing shortages and tariff uncertainties — not to mention absorbing the fallout from recent cuts to Medicaid and Affordable Care Act coverage programs. ⁱⁱⁱ This places providers in the unenviable position of needing to collect more from patients who, in many cases, are already struggling at the end of their financial ropes.

But the status quo has not been working well for patients, either. In a 2023 national survey, nearly four in ten respondents — including almost 30% of respondents with employer-based coverage—reported delaying care due to costs.^{iv} For many people, having health insurance no longer means they can afford to use healthcare. Employer-sponsored insurance (ESI) premiums are outpacing wage increases^v and continue to grow.^{vi} Over half of people with ESI are enrolled in high-deductible health plans (HDHPs), leaving them exposed to high out-of-pocket costs.^{vii} The impact is that even insured patients are struggling to pay their medical bills, and providers are increasingly struggling to collect from them. One 2022 analysis of patient accounts showed that between 2018 and 2021, bad debt attributable to insured patients soared from 11.1% to 57.6%. ¹ All of this contributes to higher amounts of [uncompensated care](#). Unfortunately, these trends will likely only be exacerbated^{viii} by care safety net.

These harsh realities will require hospitals to think more holistically about [revenue cycle management](#) as a safety net strategy for connecting patients to care. Quickly and efficiently connecting patients to financial assistance can help prevent patients from accruing medical debt, potentially improving health outcomes. For example, one study of a large health system found that access to financial assistance — including for insured patients with relatively high incomes (350% of the federal poverty level or FPL) — increased healthcare utilization, including ambulatory care, and “increases the detection and management of treatment-sensitive conditions,” such as diabetes.^{ix} Early analysis of medical debt and mortality rates in 2,943 counties has found a correlation between medical debt and reduced mortality for all causes of death.^x Yet research suggests that many patients remain unaware of financial assistance.^{xi} Making it easier for patients to qualify for financial assistance can connect them to the right treatments faster, build trust and foster loyalty while also improving the long-term health of communities.

Using predictive analytics to presumptively screen and qualify patients for financial assistance may be a vital strategy to navigating an increasingly challenging environment. Many hospitals and health systems have already begun incorporating predictive modeling offerings from third-party vendors to better manage caseloads and avoid overtaxing their teams. The universe of hospitals using predictive analytics will likely grow as self-pay patient volumes increase and demand for financial assistance grows. ^{xii}

But best practices for using predictive analytics in this context are still evolving. This paper explores how and when predictive analytics can be deployed to maximize patient access to financial assistance and reduce administrative burdens for hospital staff. It provides an overview of emerging issues and a framework for addressing them in ways that benefit patients and providers alike. In it, we discuss:






¹ Collection rates for patient out-of-pocket amounts fell by 22% from 2020 to 2021, mostly attributable to increases in bad debt from these insured patients. [“Hospital Collection Rates for Self-Pay Patient Accounts.”](#) Crowe, August 2022. Accessed June 3, 2025. See the [executive summary](#) for topline.

- How hospitals and their vendors are **currently using predictive analytics** to make decisions about financial assistance and collection
- **Opportunities and known challenges** in deploying predictive modeling to [presumptively screen](#) people for financial assistance, including ethical considerations
- A set of **emerging strategies** for maximizing the benefits — while also minimizing the potential risks — of predictive analytics as a screening tool for hospital financial assistance

Methodology

We conducted desk research and held structured interviews with revenue cycle vendors; hospital finance and community benefit leaders from academic medical centers, large national health systems and small regional systems; patient and legal services advocates; and industry thought leaders, including policymakers and community leaders. We refer to this group collectively as “stakeholders” in this paper, since each person we interviewed represents a critical segment of the healthcare ecosystem. In our interviews, we asked them to identify challenges, opportunities and lessons learned from implementing presumptive eligibility approaches. We are grateful to everyone who took the time to share their observations, experiences and ideas with us in our efforts to chart a clearer path for integrating predictive modeling tools into financial assistance workflows. **We invite feedback and discussion on this paper as this field develops and matures.**

Emerging Strategies

-  **Strategy 1: Workflow** Bolster existing financial assistance policies and procedures to include a robust presumptive eligibility screening and determination approach.
-  **Strategy 2: Technology** Adjust current financial assistance policies and procedures to fully leverage predictive analytic tools.
-  **Strategy 3: Evaluation** Conduct routine data and landscape scans to understand how best to target, tweak, and scale financial assistance policies and presumptive eligibility initiatives.
-  **Strategy 4: Communication** Proactively share data and trends with patients, partners and policymakers.
-  **Strategy 5: Leadership** Develop champions among senior leaders and board members who will invest in the technology, workforce and infrastructure to upgrade financial assistance policies and procedures as an integral part of delivering quality care.

Conclusion

Hospitals — and patients — face unprecedented strain in 2025. Using predictive analytics to presumptively screen uninsured and underinsured patients for eligibility for financial assistance or public coverage programs, like Medicaid or CHIP, are critical steps in connecting patients to timely care, increasing revenue and (for tax-exempt hospitals) meeting community benefit obligations. These functions are already part of many hospitals’ revenue cycle workflows. But increasing demand stemming from uninsured and underinsured patients will require hospitals to streamline these processes and scale the work. Predictive analytics can help hospitals shift more patient [bad debt](#) accounts to [charity care](#) and convert uninsured patients to insured status, helping revenue cycle teams protect critical revenue streams. This would allow leadership to redirect staff time to collection efforts that are more likely to succeed, speeding up the timeframe for communicating the financial assistance determinations or more affordable coverage options to patients and giving them peace of mind in a fraught time. **More efficiently helping patients get to needed resources is possible with planning, collaboration and upfront investment.**

Without a doubt, we are in a moment of tremendous uncertainty and disinvestment in healthcare programs and related supports. [Financial assistance](#), a bedrock of the safety net, will be critical for patients everywhere in accessing needed and timely care. Hospitals will need tools to manage an inevitable growth in the uninsured and underinsured. Predictive analytics is one tool that can alleviate workload and get patients to resources. However, it is not a panacea, or without implementation hurdles. While there is a clear case for leveraging these emerging technologies, the data they provide us highlight a deeper issue — the unaffordability of health insurance. Far and away the largest issue stakeholders raised were out-of-pocket costs, particularly for insured patients, coupled with hurdles imposed by complex insurance design such as prior authorizations and claims denials. Several shared concerns that hospital financial assistance will soon be pushed to the breaking point. **We need larger-scale public policy interventions that shore up the safety net to fully address the challenges healthcare providers and patients are facing today — but in the meantime, we owe it to patients to find ways to preserve access to care.**

About Us

Undue Medical Debt (formerly RIP Medical Debt) is a national 501(c)(3) nonprofit whose purpose is to strengthen communities by erasing financially burdensome medical debt. Founded in 2014 by former debt collection executives, Undue Medical Debt is one of the leading charitable organizations that help pay medical bills. We work tirelessly to end medical debt and ensure a future where everyone can access healthcare without fear.

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THE PROBLEM: TRADITIONAL APPROACHES TO FINANCIAL ASSISTANCE ARE NOT MEETING COMMUNITY NEEDS

Hospital financial assistance policies (FAPs) are an increasing lifeline for uninsured and underinsured patients — though it's clear that not all patients who qualify for financial assistance are getting it. Most hospitals offer some form of financial assistance to patients who cannot afford all of their out-of-pocket payment, with the average income threshold for eligibility hovering around 200% of the federal poverty level (FPL) (about \$64,000 for a family of four).^{xiii} Current federal law, enacted as part of the Affordable Care Act (ACA), requires nonprofit hospitals to have these policies and “widely publicize” them to patients and the public and some states have expanded the requirement to include for-profit hospitals.^{xiv} The ACA's changes focused heavily on making it easier for patients to find out about and apply for financial assistance before accruing debt or avoiding care.² Since then, however, investigative journalists, advocates and lawmakers have documented examples of patients who should have qualified for Medicaid or financial assistance, but whose accounts wound up in collections.^{xv} For example, one report in Maryland found that 60% of bad debt attributable to patients under 200% FPL should have been classified as charity care.^{xvi} Accounts like these have prompted regulators to raise questions about the adequacy of hospitals' financial assistance notifications to patients and spurred interest in requiring more proactive strategies.

Many uninsured and underinsured patients are not accessing financial assistance, often because the burden of finding the policy and applying for help falls to them. In a typical workflow, patients must ask about financial help, and research suggests many patients overlook information about financial assistance and miss opportunities to apply. There are several reasons why patients who ought to qualify for financial help may not be getting it — even when health systems are fully compliant with the ACA's notice and billing requirements. The first is lack of awareness or knowledge of financial assistance — even when billing statements contain notices about financial help. Take cancer patients as an example. Cancer care is particularly expensive, and delaying treatment can have dire consequences.³ But in a 2024 poll of cancer patients and survivors, 25% of respondents were completely unaware of financial assistance.^{xvii} Just over a third of respondents reported either being offered financial assistance or applying for it, and the majority either learned about financial assistance on their own or from a third party — not their provider.^{xviii}

The fact that the typical methods of providing information about financial assistance aren't breaking through to a significant section of cancer patients — a cohort that is highly motivated to proactively find ways to afford ongoing care — is cause for concern. Other patient surveys highlight similar gaps in patient knowledge and ability to access financial assistance.⁴ These data suggest that standard notification and outreach strategies of the type required by the ACA are inadequate on their own.

2 [“Requirements for 501\(c\)\(3\) Hospitals under the Affordable Care Act – Section 501\(r\).”](#) Internal Revenue Service. Accessed June 3, 2025. Note that “financial assistance” and “charity care” are used interchangeably throughout this paper. Financial assistance is the term used in the ACA requirements and is generally preferred by patients and advocates. Charity care is the term of art used particularly in accounting and legal circles. For a broad overview of financial assistance—or, charity care—rules and regulations, including the Affordable Care Act requirements, see Levinson, Zachary, et al. [“Hospital Charity Care and Why It Matters.”](#) KFF, November 3, 2022.

3 In fact, cancer care is so expensive researchers have coined the term “financial toxicity” to describe how cancer patients make treatment choices based on the financial costs associated with care. See [“Financial Toxicity and Cancer Treatment \(PDQ\)—Health Professional Version.”](#) National Cancer Institute, May 29, 2024. Accessed June 3, 2025.

4 Dollar For, a national organization that helps people apply for financial assistance, estimates that just under 30% of people who qualify for financial assistance actually receive it. Patient awareness and knowledge of financial assistance is a huge hurdle: only 48% of survey respondents reported receiving information about financial assistance from the hospital. [“The Path to Charity Care: Exploring the Journey & Roadblocks to Financial Assistance for Medical Bills.”](#) Dollar For. Accessed June 3, 2025.

Second, completing an application for financial assistance can be a daunting task for patients.

Traditionally, patients apply for financial assistance by submitting an application form that provides their household income, with supporting documentation such as pay stubs, tax

returns, or employer letters of attestation. Applications also commonly ask detailed questions about household size, available assets, other expenses, and individual circumstances that might indicate a higher level of need.^{xx} Gathering these documents can be overwhelming and, at times, invasive. Most application forms do not explain how hospitals will use this data, particularly data about assets. In our interviews, stakeholders shared instances of patients who did not complete financial assistance applications because they struggled to gather all the documents required, grew frustrated with the process or feared that the data they provided would be used against them.

Third, as out-of-pocket costs soar, hospitals' financial assistance eligibility levels and financial counseling practices may not be keeping pace with demand from underinsured patients.

While more hospitals have begun extending their FAPs to include underinsured patients, eligibility thresholds may still fall short of what is needed to close the affordability gap in a local community.^{xx} Underinsured patients may be unaccustomed to asking for financial help or navigating the charity care application process and may not initiate discussions about financial assistance unless it is offered to them.

The proliferation of high-deductible health plans (HDHPs) has proved particularly challenging to patients and providers.^{xxi} HDHPs are often initially appealing to employers and patients because they can come with a lower monthly premium. They may work well for well-resourced families that can bear the financial shock of a healthcare crisis, but they are risky for low-to moderate-income families — especially those without substantial savings.^{xxii} These plans pose a particular challenge for hospitals that have extended financial assistance to insured patients, since they may not realize any revenue from claims to HDHPs.

“In general, we’re seeing higher out-of-pocket costs over the past few years from patients with full coverage or not very good coverage. I’m typically trying to get money from the insurance companies, but when we’re contracted for a certain payment and it’s a deductible and we’re writing that deductible off to charity, we’re not getting paid anything. At the end of the day, it’s a cash problem.”

– Hospital finance leader

Fourth, hospitals may operationalize their revenue cycle workflows — including traditional forms of outreach, such as financial counseling, and presumptive eligibility (PE) screening — in ways that leave FAP-eligible patients behind.

In the complex environment of a hospital revenue cycle team, staff may lack the bandwidth, resources or charge from their employers to presumptively screen patients into financial assistance or coverage options prior to sending a bill, relying instead on the patient to raise their hand and ask for help. “There is so much chaos in that world that adding a PE screening tool [early on in the billing process] isn’t on anybody’s priority list,” one former revenue cycle manager stated. Instead of happening early in the patient encounter or billing cycle, screening may occur as a last-ditch attempt to keep the bill from being classified as bad debt, once routine billing strategies have proven to be unsuccessful and an account is already past due. Complicating matters further, some hospitals and vendors use “[propensity-to-pay](#)” tools in ways that can lead to patients who qualify for financial assistance receiving billing statements instead, rather than the assistance they ought to qualify for. (See below for a longer discussion of this.)

“There are still a lot of people who can’t get through the [FAP application] process. And some of the documentation requests, I haven’t been able to fill in for myself when I’ve tried!”

– Revenue cycle management vendor

Charity Care Versus Bad Debt Workflow

Once patients qualify for financial assistance, they do not need to worry about making unaffordable payments and are often eligible to receive care for free or at a discount for a set period of time. By contrast, patients who do not apply for financial assistance will continue to receive bills and may have their debts referred to third-party vendors that attempt to collect on the debt or get the patient to set up a payment plan. If those efforts are unsuccessful, the accounts are typically classified as “bad debt” and written off as losses to the hospital. For the patient, however, the debt may continue to haunt them as they field calls from collection agencies. Some may put off seeking further care to avoid further financial hardship.

Potential and Pitfalls: Using Predictive Analytics in Presumptive Screening To Fill Gaps in the Safety Net

All of the factors discussed so far — rising out-of-pocket costs, complex revenue cycles, and underutilization of financial assistance — make predictive modeling tools an attractive option for many hospitals. **Hospitals can use predictive modeling to presumptively qualify patients for financial assistance with fairly high levels of accuracy without requiring an application, theoretically increasing the number of patients getting financial assistance while reducing administrative overhead.** This is a huge boon to patients, as well as providers. When used judiciously, these tools can complement traditional application methods to financial assistance by allowing hospitals to bypass the paper trail and screen patient accounts through bulk data processing. This can create new efficiencies in the revenue cycle workflow and make more relief available to patients sooner. Predictive analytics can offer another pathway for connecting patients to financial assistance, allowing staff to focus on more complex cases. And for some hospitals, using predictive analytics may be necessary to counter shortages in financial counseling and revenue cycle staff.⁵

How Predictive Modeling for Financial Assistance Eligibility Works: The 30,000-Foot View

As medical billing has become more complex and cumbersome, more hospitals and health systems have come to rely on tools from third-party [revenue cycle management](#) (RCM) vendors to manage front-end billing tasks and lift administrative burden.^{xxiii} These vendors offer suites of tools that range in scope from prior authorizations and eligibility or benefits determinations to sending patient scheduling reminders.^{xxiv} Predictive modeling tools that screen patient financial data for potential eligibility for financial assistance are often in the mix alongside tools that can help screen for Medicaid or other coverage, as well as estimate the likelihood that a patient will pay an overdue bill (i.e., their “[propensity to pay](#)”). Depending on their resources and capacity, hospitals may use several of these tools for various subsets of patient accounts.

5 As one hospital revenue cycle leader put it, “I would really rather do the full charity care application process for each patient. But we don’t have endless financial counselors.”

In the financial assistance context, predictive analytics tools rely on technology that automates either verifying or estimating patient income. Approaches and tool specifications differ, but most PE tools rely on three types of data: 1) actual income data; 2) credit data, such as credit scores⁶ and payment histories⁷; or, more recently, 3) a combination of individual patient data, including consumer spending data, and community rating based on the patient's zip code or Census tract. Depending on how the tool is structured and the data used, hospitals can use the data to verify or estimate income for purposes of financial assistance eligibility.

Accessing verified actual incomes represents the “holy grail” of data sets in terms of accuracy. However, pulling these data can be pricier and more time-consuming than other options.^{xxv} Sourcing incomes from state income tax returns, for example, results in highly accurate income data, but it costs more and comes with significant privacy and security considerations — and requires individual approval from the patient, negating some of the “presumptive” benefits of PE. While these trade-offs may make sense when verifying individual incomes for eligibility in public programs like Medicaid, using this approach for a financial assistance PE determination may not be feasible for many hospitals — or for the state agencies that would need to provide this data.^{xxvi}

In the absence of actual income data, many PE tools use predictive modeling based on a patient's credit history and patterns of consumption (e.g., retail, utility and grocery store purchases) to estimate a patient's income, household size and capacity to pay their bill. Increasingly, vendors are marketing approaches that combine a patient's individual data with community-level data, such as the cost of living in a geographic area and other factors (e.g., how many individuals receive mail at a household to deduce the number of household members).^{xxvii}

Practical Challenges to Using Predictive Modeling Tools for PE

Predictive modeling PE tools are imperfect. Understanding the limitations of the predictive modeling tools on the market today — and structuring workflows that account for their shortcomings — should allow hospitals to maximize their benefit and connect more patients to care. This next section describes the challenges stakeholders raised most frequently in interviews.

Working with imperfect data

Predictive models have data limitations that are helpful to understand when building a screening workflow. Take, for example, PE tools that rely on community factors identified by zip code or even zip-9 codes. As sophisticated as they are, today's community data-driven models cannot keep up with the speed of change in local economies, such as gentrification. These will only show data for the last group in a community who completed the U.S. Census, which happens every ten years. If a neighborhood gentrifies in between Census counts, for example, PE tools that rely on community rating may incorrectly qualify that neighborhood's higher-income residents for financial assistance.^{xxviii} Conversely, a predictive model could inaccurately disqualify a low-income person living in assisted living or public housing in an otherwise high-income area.

6 Factors evaluated in a credit score include a person's payment history, amounts they owe, length of credit history, new credit and credit mix. Black, Michelle. [“What Makes Up Your Credit Score.”](#) *Forbes*, July 1, 2024. Accessed June 3, 2025. Importantly, “soft” inquiries into a patient's credit history — the type that providers or vendors may conduct while prescreening a patient for presumptive eligibility for financial assistance — do not impact a person's credit score. They will, however, show up on certain credit reports the patient can access themselves. It may be advisable for providers using PE tools that pull credit histories to include a brief statement to patients about this.

7 A person's payment history — their history of making payments on credit accounts (loans, mortgages, retail accounts and credit cards) — makes up 35% of their credit score. Treece, Kiah; and Traver, Jordan. [“Focus on Payment History—It's the Most Important Credit Factor.”](#) *Forbes*, March 26, 2022. Accessed June 3, 2025.

Predictive models can also inaccurately estimate household size, which is critical to determining whether a patient’s income is low enough to qualify them for financial help or Medicaid. In Oregon, which introduced PE screening for all patients with bills over \$500 earlier this year, the state identified scenarios where high-income patients who were financially supported by family members but had no employment or credit history qualified for financial assistance when the tools inaccurately ascribed them to a household of one.^{xxx} By contrast, a patient advocate working in Massachusetts and Missouri experienced problems with PE screens denying eligibility for low-income people living in blended households, especially where more than one family lived in a housing unit. In these instances, the PE tool estimated the joint incomes of everyone living in the apartment – incorrectly attributing a greater income to the patient’s household, leading to a denial of financial assistance even though the patient should have qualified.

Predictive models also do not have perfect credit data. An estimated 6% of U.S. adults are “unbanked”^{xxx} or have slim credit files, meaning patients who do not participate in the credit economy may be missed entirely.⁸ Additionally, many of the credit-based tools hospitals use today are based on financial models developed to help creditors assess lending risks. In a sense, their application as income estimators is an “off-label” use. Regulatory frameworks have not yet caught up with the application of these tools for determining when patients are eligible for financial assistance.⁹

These examples show the limitations of relying solely on predictive modeling tools for financial assistance. One approach would be to view a screening result as providing helpful guidelines, rather than making a cut-and-dry “eligible/not eligible” decision.^{xxxi} Hospitals that use these tools will still want to enact fail-safes to ensure low-income patients do not fall through the cracks.

Streamlining complex, misaligned workflows

Many stakeholders named the disjointed, unrelentingly complex and fast-paced nature of the work conducted by revenue cycle staff as a limitation to implementing PE — and an opportunity for improvement.

Revenue cycle teams often involve “front-end” and “back-end” staff and third-party vendors who help with everything from Medicaid eligibility determinations to financial counseling.¹⁰ Miscommunication, siloes and overwork across these teams can be implementation challenges. Even when hospitals use PE for financial assistance screening, financial counselors may be limited, under-resourced or simply not well-integrated into the overall revenue cycle workflow to follow up with patients whose PE screens are inconclusive or borderline.

“We do have a typical financial assistance application process, but our PE processes are so separate that I doubt our financial counselors who run FAP [applications] are even aware that we do PE screens. The financial counseling team is really focused on the patients who apply.”

– Hospital revenue cycle leader

8 While this data gap can present issues for hospitals that screen higher-income unbanked patients, it is more of a concern for very low-income households. According to [the Federal Reserve](#), 23% of people making less than \$25,000 per year are unbanked. That number drops precipitously for higher income people, with only 1% of people making over \$100,000 per year. Young adults, Black and Hispanic adults and adults with disabilities are more likely to be unbanked.

9 There are, however, cautionary tales from other sectors when predictive modeling has been used to determine benefits eligibility without appropriate safeguards. See, e.g., [“What Happened When AI Went after Welfare Fraud.”](#) *On Point*, WBUR, March 13, 2025.

10 Where the front-end teams tend to be more focused on processing insurance claims, back-end team members focus more on collections.

A second challenge for revenue cycle teams is deciding when in the billing cycle to run PE screens, particularly for insured patients. Most of the stakeholders we interviewed reported that they screened uninsured patients for Medicaid eligibility right away, and conducted PE screens for financial assistance if the patients were ineligible for Medicaid or did not respond to information requests. By contrast, most waited to screen insured patients for financial assistance until fairly late in the billing process after multiple bills and collection attempts, unless the patient proactively reached out for financial counseling or submitted a financial assistance application.

Part of the rationale stakeholders offered for delaying the screen for insured patients is that many of those patients will pay some amount if billed, giving hospitals the opportunity to capture some revenue. However, several — including veteran users of predictive analytics software — acknowledged their ambivalence about the timing of their PE screens, noting downsides and the need to better understand the impact on patients and risk of regulatory exposure as more states address billing practices.

Notably, one hospital leader shared that her system uses PE screening retroactively at the end of the year as a check to make sure they have qualified as many people for financial assistance as possible. This approach can provide added “quality control” for any patient accounts that may have been missed. The table below shows the range of approaches described by stakeholder interviews.

“I’m not sure we have the most optimal process. [A competing health system] scores patients before they even run the bill. The timing our system uses, and implications [for changing] it, are things we don’t fully understand.”

– Hospital leader

Timings of PE screens

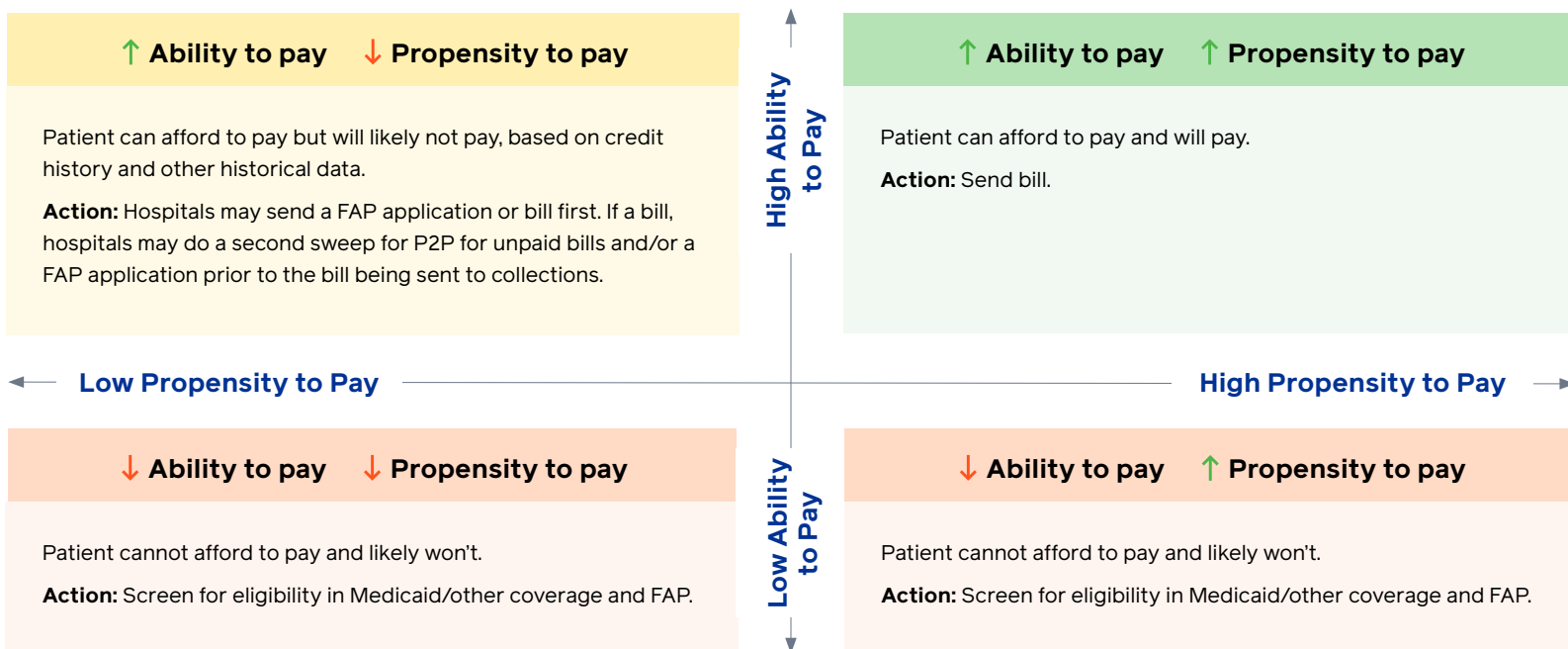
Source: Stakeholder interviews

	When do your hospitals presumptively screen uninsured patients for financial assistance?	When do your hospitals presumptively screen insured patients for financial assistance?
Health System A	Upfront	Once the patient is behind on payments, or if patient asks for help
Health System B	Upfront	When patient faces catastrophic costs (costs greatly exceed income and assets, as defined in financial assistance policy)
Health System C	Upfront, if unable to connect an uninsured patient with financial counselor	After 120 days, if the patient has not paid and the account is at risk of being classified as bad debt
Health System D	After 120 days, if the patient is ineligible for Medicaid and has not yet completed a full financial assistance application	After 120 days, if the patient has not paid and the account is at risk of being classified as bad debt

Noise in the machine: Getting clear about propensity to pay versus presumptive charity

A third issue arises when revenue cycle teams improperly conflate results from tools that estimate a patient's "propensity to pay" — which look at credit factors beyond a patient's ability to pay, such as their payment history — with their ability to pay.¹¹ Where presumptive charity tools look at patient income and household size to estimate ability to pay, propensity-to-pay tools also incorporate data that estimates how likely a patient is to pay the bill based on previous payment history and credit data and recommend various collection strategies based on patients' ratings.¹² Used appropriately, propensity-to-pay tools can help hospitals avoid spending resources trying to collect from patients who are unlikely to pay their bills. **But issues can arise when revenue cycle teams rely on propensity-to-pay tools screen for financial assistance eligibility, and/or decide to send bills to low-income patients with strong payment histories instead of offering them financial assistance upfront.**

In our interviews, stakeholders shared examples of low-income patients paying some portion of a bill they owed, even if it was beyond their financial means. This effectively penalizes some low-income patients for paying bills on time. Several stakeholders raised concerns about propensity-to-pay tools being used interchangeably with "presumptive charity" tools. They pointed to the conflicting incentives and messages many revenue cycle teams receive from leadership, vendors and industry, which can lead to pursuing low-income patients with strong payment histories for payment, rather than qualifying them for free or reduced-cost care. While this strategy may result in additional revenue for hospitals, it does so by creating financial hardship, potentially leading to interruptions in their care and eroding community trust. It also risks wasting resources on collection efforts that will ultimately prove fruitless. The best approach for patients--as shown in the visual below--is to screen and process low-income patients for financial assistance regardless of their propensity to pay.



11 While neither term has a legal definition in this context, "ability to pay" is generally understood to refer to whether the patient can afford to pay the bill based on income and household size. In the consumer credit industry, "ability to pay" is more broadly defined in the [Truth in Lending Act Regulation Z](#). And in other settings — such as the rules that govern credit offered to college students — the credit card issuers must consider a consumer's ability to make required minimum payments before opening a new account or increasing a credit limit. 12 CFR § 1026.51(a)(1)(i).

12 While the formulas and data RCM vendors use to estimate income and propensity to pay are proprietary, several have descriptions of their models online. For an example, see ["Payment Predictor for Healthcare."](#) Equifax, 2006. Accessed June 18, 2025.

EMERGING STRATEGIES FOR EFFECTIVE USE OF PRESUMPTIVE ELIGIBILITY

Despite these imperfections, using predictive analytics for PE can add capacity to beleaguered revenue cycle teams, greatly expand the number of patients who receive financial assistance and increase the speed at which they receive help. Adopting and integrating the right tool requires cross-departmental collaboration to understand where there are opportunities for improvement, what data is collected by a particular predictive modeling tool and how results are calculated, and what supporting strategies hospitals or third-party vendors will need to implement to ensure all patients who are eligible for financial assistance receive it.

Simply put, hospitals will need policies, strategies and systems in place that support the effective use and ongoing evaluation of these tools. We offer the following framework as a starting point to maximize the opportunities of predictive analytics tools to presumptively screen for financial assistance while minimizing the risks.



STRATEGY 1: WORKFLOW

Bolster existing financial assistance policies and procedures to include a robust presumptive eligibility screening and determination approach.

1. Make sure financial assistance policies (FAPs) adequately meet the community's current needs.

To maximize the impact of an investment in predictive analytics tools, hospitals should ensure they have laid a good foundation. Hospitals should take stock of their existing patient-facing registration and FAP-related materials — policies and plain language summaries; application forms; stock language included in billing statements, scheduling calls, and text communications; and financial counselor or billing scripts — and identify opportunities for improvement. Specifically:

- **Evaluate current eligibility thresholds.** Look at the health system's current bad debt and charity care data and talk with the community benefit team, which is tasked with conducting routine community health needs assessments (CHNA) that can pinpoint access problems. Compare data and discuss: Is the current FAP adequate to meet the need?
- **Expand FAPs to include low- and moderate-income insured patients.** While the Affordable Care Act expanded health insurance coverage, out-of-pocket costs for patients have continued to grow.^{xxxii} Increasingly, insured patients are struggling to afford deductibles, coinsurance and copayments. Many hospitals have expanded their financial assistance policies to cover low- and moderate-income insured patients.^{xxxiii}
- **Use patient income — not assets — to determine eligibility for financial assistance.** Hospitals should remove most FAP application questions that ask about patients' assets.¹³ Data shows that most people living under 400% — currently a common upper limit for financial assistance eligibility — have limited assets.^{xxxiv} These are often modest, like a car or home, or a small savings account that allows people to cover

¹³ Health savings accounts (HSAs) are the possible exception to this general rule. HSAs are savings accounts that allow people to set money aside on a pre-tax basis for certain qualified medical expenses, including deductibles, copays, and other forms of patient cost-sharing. HSAs are commonly paired with high-deductible health plans. "Health Savings Accounts," FDIC Consumer News (September 2024). Accessed June 18, 2025.

contingencies or save for retirement.¹⁴ Evidence suggests that requiring asset testing as part of eligibility determinations for low-income people disincentivizes savings, causes harm and increases administrative burden.^{xxxv} By contrast, evidence from public means-tested programs that have eliminated asset tests have shown them to reduce administrative burden without significantly increasing program costs.^{xxxvi} Yet many hospital FAPs indicate that they use assets to determine FAP eligibility, with some including language that suggests patients might need to “spend down” assets in order to qualify.^{xxxvii} For most people whose incomes qualify them for financial assistance, answering questions about their assets on an application form can create a barrier to completing the form — especially since it is not always clear how asset information will be used^{xxxviii} — without yielding any useful information to inform an eligibility determination. For financial assistance purposes, asking about income and household size should suffice.¹⁵

2. Expand PE screening to include insured patients, not just self-pay patients, and run screens for insured patients earlier in the billing cycle.

Patients often receive bills weeks or months after their initial date of service. Currently, many organizations that deploy PE screening tools for insured patients do so late in the billing cycle, once an account is past due and has been flagged as bad debt. Multiple bills may have been sent; multiple calls may have been made, and the account may have been referred to a third-party vendor for collections. The problem with this approach in the age of underinsurance is that insured patients may not be aware of financial assistance or think it applies to them. Waiting for these patients to affirmatively apply for financial assistance means some of them fall through the cracks.

A proactive screening of insured patients could save time and resources, ultimately freeing staff and vendors to focus on accounts where patients can and will pay.^{xxxix} Instead of taking the reactive approach of sending multiple billing statements to patients who can't afford them (and putting the burden on the patient to provide documentation), hospitals should screen patients earlier in the billing cycle — i.e., during scheduling, at the point of service or before the first bill is sent. Predictive analytics can help make this possible, while also decreasing unnecessary communications with patients who are unable to pay. This allows billing teams to focus their first collection efforts on younger, more collectible patient debt while narrowing the pool of patients who need direct support from financial counselors to apply for financial assistance.¹⁶

3. Align front-end and back-end revenue cycle teams on financial assistance goals and PE approaches.

One challenge flagged by several stakeholders was the need to align front-end teams performing patient registration, insurance claims and financial counseling functions with back-end teams that focus more on collections. To get the most out of any PE approach, hospitals will likely need to invest in strengthening communication channels and data-sharing between front-end and back-end staff. This includes patient registration, financial counseling staff and revenue cycle teams, including third party vendors.

14 Furthermore, the majority of the nation's households have less in savings and other liquid assets than the annual limits on out-of-pocket cost-sharing for private insurance plans. Young, G., et al. “How Many People Have Enough Money to Afford Private Insurance Cost Sharing?” Peterson-KFF Health System Tracker (March 10, 2022). Accessed June 18, 2025.

15 Many hospital FAPs have “catastrophic” eligibility levels for higher-income patients whose medical expenses far exceed their annual income. In these situations, it may be sensible to ask patients to provide more detail about their assets and expenses to gain a fuller picture of what levels of relief are needed.

16 Depending on the hospital's FAP, it may still be beneficial to both hospital and patient to have the patient submit a full application. Some hospitals only use PE screens to find patients eligible for charity care for an episode of care, whereas eligibility periods after a full application is submitted and approved can last for several months or longer. This also gives the hospital access to verified data and limits transaction fees associated with running a patient's account multiple times after repeat encounters.

It is particularly important to build a culture of financial assistance first, making patients aware of this pathway before introducing payment plan options. As part of a PE integration, provide registration and patient billing staff with scripts and training that highlight financial assistance policies first, especially if those policies have expanded recently to include new populations like underinsured individuals. Make sure that vendor contracts address and pay for vendors to enroll eligible patients in financial assistance. Many low- and moderate-income patients with insurance, including Medicare beneficiaries, may not realize they qualify for financial help and will not think to ask. Taking proactive steps to share information and ask questions could help increase the accuracy of any PE determination, and make sure patients are getting upfront information about financial assistance.

4. Use multiple pathways to presumptively screen and qualify patients for financial assistance.

Predictive analytics software is not the only tool hospitals have at their disposal to identify patients who should qualify for financial assistance. For some hospitals, it may not even be feasible. Even if a hospital is using predictive analytics software, using the software in combination with some of the below approaches may help to improve accuracy.

First, hospitals can integrate presumptive screening for financial assistance into patient registration for scheduled visits. Hospitals can look for opportunities to collect or harness existing data that can augment, or even supersede, eligibility determinations from predictive modeling tools. This can include adding questions about household size and family income into patient registration intakes or social determinants of health screenings. Staff can explain that the data will be used solely to identify patients who may be eligible for financial assistance.

Second, hospitals can accept proof of enrollment in means-tested programs as sufficient documentation for financial assistance eligibility. Many local and state-based programs rely on means-testing for eligibility. Participants in these programs have already been vetted and their incomes verified. Hospitals can accept proof or attestation of a patient's enrollment or eligibility for another means-tested programs, such as WIC or SNAP, as sufficient verification of financial need.^{XL} It can be helpful to have working agreements with local and state agencies to build consensus on what constitutes sufficient documentation, and to develop limited data-sharing agreements for these purposes.

Third, hospitals can deploy their electronic health records (EHRs) to streamline PE for patients. Hospitals have long been encouraged by trade associations to shortcut their financial assistance eligibility determinations by mining their own data to identify patients who likely qualify based on individual life circumstances, such as homelessness and participation or eligibility for public means-tested programs. Now, there are several ways hospitals can use EHRs to streamline financial assistance.

"I would love to see a standard FAP application that has a checklist for patients that captures SNAP, WIC, etc., and states, 'If you already have these, don't fill out the rest.' These may be even more accurate than predictive analytics software. It means you've already been means-tested, submitted documentation. My sense is hospitals should be accepting this much more readily than they already do. Why go through another round of [income] verification? It just makes sense."

– Health care consultant

Hospitals can use EHRs to document prior FAP eligibility findings and to flag individual life circumstances, such as homelessness, that negate the need for a formal application.¹⁷ Similarly, they can establish protocols for deeming that a patient is eligible for financial assistance without the need for further verification if they are currently unhoused, bankrupt or died without an estate. Second, hospitals can automatically qualify people who demonstrate, through referral or shared EHR, that their medical home is a free clinic, federally qualified health center (FQHC), or charitable community access program, since most patients from these facilities have household incomes under 200% FPL.

¹⁸ In these cases, integrating a PE approach would mean establishing referral networks with these providers and including information about income and eligibility for free or sliding-scale services in data-sharing agreements, in addition to clinical data-sharing, so that patients do not need to jump through hoops twice.¹⁹

Hospitals can also maintain active lists of addresses that tend to correspond with low- to no-income patients. These can include churches or other faith-based organizations, which will sometimes serve as mail stops for homeless people in their communities, shelters and short-stay hotels. If these addresses are flagged within the system as known resources for low-income people, the hospital can create a flag that indicates a patient with that address may have had a significant income change warranting further outreach.

5. Communicate PE practices and outcomes directly to patients.

For tax-exempt hospitals with 501(c)(3) status, federal law mandates that hospitals using PE must provide some basic information in their financial assistance policies, including a high-level overview of the PE data and approaches they use.^{XLi} Yet most descriptions in current FAPs are extremely generic. Hospitals must also share the outcome of results with patients who do not qualify for full financial assistance after a screening, so that patients have an opportunity to submit a full application. Ironically, due to the wording in these federal requirements, few hospitals or vendors notify patients who have received a full write-off from a PE screen that their bill has been zeroed out.^{XLii}

We recommend that hospitals review PE results with all patients who have received financial assistance through a PE screen — including a full write-off, or full free care — to ensure patients are fully informed. This is particularly important for low-income patients with chronic or serious illness who may otherwise delay follow-up treatment or care due to cost concerns.^{XLiii} Hospitals that use PE screening should review PE results with patients and allow them the opportunity to apply for additional assistance or to provide additional documentation. Hospitals should also proactively educate patients about what PE means for them. For example, many patients do not know that a “soft hit” on patient credit, a common data point for PE tools (not to mention many marketing firms), does not impact their credit score. Sharing this information may allay patients’ concerns. Patients should also be informed when they are found eligible for financial assistance through PE screening. **Notification is an important part of closing the loop with the patient and building trust.**

17 This includes prior FAP application results; patient registration or electronic health record (EHR) data pertaining to relevant life circumstances, such as homelessness or catastrophic illness; and evidence of eligibility or participation in other means-tested programs, such as Medicaid. HFMA’s non-exhaustive list of other categories for “individual life circumstances” include: “1. State-funded prescription programs; 2. Homeless or received care from a homeless clinic; 3. Participation in Women, Infants and Children programs (WIC); 4. Food stamp eligibility; 5. Subsidized school lunch program eligibility; 6. Eligibility for other state or local assistance programs that are unfunded (e.g., Medicaid spend-down); 7. Low income/subsidized housing is provided as a valid address; and 8. Patient is deceased with no known estate.” See [“Principles and Practices Board Sample 501\(c\)\(3\) Hospital Charity Care and Financial Assistance Policy and Procedure.” HFMA](#). Accessed June 3, 2025.

18 Alternatively, hospitals could presumptively qualify FQHC patients who receive free care (mandated for anyone under 100% FPL) or sliding scale rates (mandated for anyone under 200% FPL) at the FQHC. Health centers must document income and family size, but have flexibility in how they do so. [“Chapter 9: Sliding Fee Discount Program.” HRSA, Health Center Compliance Manual](#). Accessed June 3, 2025.

19 Illinois’ longstanding law also includes a category of eligibility for patients who are enrolled in an “organized community-based program providing access to medical care that assesses and documents low-income financial status as criteria. See [“Presumptive Eligibility Criteria.” Illinois Hospital Association](#). Accessed September 15, 2025.

As these tools become more common, it will be helpful for hospitals to provide more detail about how and when in the billing cycle predictive analytic models are being used, what data they use, and additional safeguards hospitals have in place to ensure all patients have the ability to apply for financial assistance and “correct the record” in cases where predictive analytic tools have found they are ineligible for full financial assistance.



STRATEGY 2: TECHNOLOGY

When using predictive analytic tools, understand their limits and develop strategies that adjust for inaccuracies while holding patients harmless.

1. Do not allow propensity-to-pay scores to trump estimated FPL information.

Several stakeholders raised concerns about vendors and revenue cycle teams using presumptive charity screenings interchangeably with propensity to pay. To avoid scenarios in which patients who should qualify based on income are instead receiving bills or targeted by collection actions, hospitals should run presumptive charity screenings first. Using this kind of targeted approach can preemptively qualify people for financial assistance, freeing up staff time to focus on triaging those who can and are likely to pay. Staff

and third-party vendors should be trained to understand all financial assistance-related policies and procedures, including how “ability to pay” is determined under the hospital’s FAP. **If propensity-to-pay tools are used, they should only inform collection strategies for patients who are deemed able to pay.** This helps avoid delays in collections, eases friction with patients, and enhances trust for future services. This also ensures staff are investing efforts and energy where they are most likely to capture revenue.

“I can’t overstate that people are interchangeably using terms like ‘ability to pay’ with ‘propensity to pay’ without acknowledging or maybe understanding the distinction and its impact. As a field we need to better define the terms and also provide guardrails around how to segment patients”

– Revenue cycle vendor

2. Establish routine quality controls to ensure consistent results and effective support for all patients who are eligible for Medicaid or financial assistance.

Some stakeholders reported that propensity-to-pay scoring can be attractive because it increases accuracy of presumptive charity scoring, weeding out higher-income patients who might erroneously receive financial assistance.^{XLIV} Given the current environment, this desire to wisely steward hospital resources is understandable. But there are better, more patient-friendly ways to reconcile differences between presumptive charity scores and patient records. These include:

- Increasing communication with patients (for example, asking for confirmation of PE results or asking patients to voluntarily provide income and household size information at registration or check-in)
- Reviewing potential financial assistance awards over a certain dollar amount
- Conducting routine spot-checks of PE awards and comparing them to patient-provided data
- Requiring additional documentation for patients to qualify for financial assistance for an extended period of time (up to 12 months), or for patients in higher income thresholds (over 200% FPL)

Systems that use propensity-to-pay scoring should put guardrails in place to ensure that low- and

moderate-income patients are always vetted for financial assistance. Hospitals should consider using propensity-to-pay scoring at the end of the billing cycle solely to inform collections strategies for patients whose income estimates make them ineligible for financial assistance. This may help avoid instances of patients being billed who should have qualified for help. It ensures staff are investing efforts and energy on accounts where payment is likely, keeping financially vulnerable patients connected to care, and avoids scenarios that draw negative publicity and invite regulatory scrutiny.



STRATEGY 3: EVALUATION

Conduct routine data and landscape scans to understand how best to target, tweak, and scale financial assistance policies and PE initiatives.

Understand the baseline: where are patients who qualify for Medicaid, financial assistance or other state or local programs falling through the cracks?

Revenue cycle, patient access and community benefit teams can collaborate to collect data on key indicators related to bad debt and charity care and monitor these indicators over time.

Examples include:

- Tracking bad debt, charity care and Medicaid enrollment data
- Tracking conversion of patient accounts from bad debt to either charity care or Medicaid
- Tracking income levels and insurance status for patients who qualify for financial assistance, either through PE or traditional applications
- Tracking the numbers of patients who qualify for financial assistance based on PE screening versus full applications
- Tracking incomplete versus completed financial assistance and Medicaid applications
- Scrubbing bad debt data annually to monitor community need
- Running PE screens retrospectively at the end of the year to take a second look at eligible patient files that may have been missed feedback on where the traditional process breaks down for patients — and soliciting solutions — can result in process improvements that benefit everyone.

Addressing “Moral Hazard”

Several stakeholders raised concerns about potential moral hazard if hospitals adopt more patient-friendly billing practices. They worried that more expansive FAPs — coupled with limits on collections tactics — would lead to fewer patients paying their bills, even when they can afford to. But while a handful of patients may skip out on bills they can pay, studies have shown the opposite to be true: most patients with dental and medical debt attempt to pay their bills, even when they cannot afford to. Indeed, research shows that most people with medical debt are living below 400% of the federal poverty level and have limited financial resources.

Exploring data on the numbers of low-income people served by the hospital and the financial challenges they face can offer a helpful reframe and encourage leaders to craft financial assistance and collections policies that respond to the needs of the majority of patients, rather than reacting to the potential bad behaviors of a few.

Sources: See Winger, A., et al. “How Financially Vulnerable Are People with Medical Debt?” Peterson-KFF Health System Tracker (February 12, 2024). Also see Lopes, L., et al. “Health Care Debt in the U.S.: The Broad Consequences of Medical and Dental Bills.” Peterson-KFF Health System Tracker (June 16, 2022). Accessed June 18, 2024.

These baselines can be helpful for building in evaluation metrics and processes to understand what is working, what is not working and why. All of this can be presented to internal workgroups as part of ongoing FAP implementation and evaluation. It can also be helpful to raise accuracy issues and challenges with vendors so they can improve their offerings.

Review FAP written materials and procedures and simplify processes for patients. Even with predictive modeling tools, hospitals will need to fall back on traditional applications for some patients. It can be helpful to ask patients, staff, and community partners to review existing application forms and do “practice” attempts to submit a financial assistance application. Getting feedback on where the traditional process breaks down for patients — and soliciting solutions — can result in process improvements that benefit everyone.

Hospitals should also share success stories from their PE efforts. Sharing the steps an organization has taken to improve the billing process for patients with community partners and other stakeholders can build goodwill and provide opportunities for partnership and shared learning around trouble spots — for example, proliferation of HDHPs — that may be affecting access in a community. Taking proactive steps to respond to patient and community critiques of what is not working are critical activities for all healthcare providers to undertake, particularly as regulators look to hospital billing and collections as an intervention point for addressing medical debt.



STRATEGY 4: COMMUNICATION

Proactively share data and trends with patients, partners and policymakers.

Keep community partners in the loop. Providers should share what their systems are doing to actively monitor and respond to community trends in affordability and medical debt with their community partners. Many hospitals partner with government and community organizations in a wide variety of ways. These partners can include local business associations and employers; clinical and public health partners, such as charitable clinics, rehab facilities, FQHCs and public health departments; social and human services organizations working on issues ranging from food access to homelessness; schools; and neighborhood, volunteer and faith-based organizations or groups with deep connections to particular pockets of a given community.²⁰

The list is potentially endless. Billing teams can work with community benefit and clinical staff to identify existing relationships and plug into existing community meetings. Asking for third-party feedback on what is working well, and what can be improved, from organizations who know and understand the community allows hospitals to avoid delays in patient care, streamline patient eligibility in coverage and financial assistance programs and build alliances with local stakeholders to develop additional solutions to support families. Alternatively, billing teams can present to patient-family advisory councils (PFACs), comprised of hospital patients and their caregivers, or hold their own community meetings. Holding regular meetings to ask for feedback on financial assistance policies and billing procedures, and sharing improvements as they are made, makes it more likely that patients get the right outcome.

²⁰ For detailed examples of hospital-community partnerships, see [“Hospital-Community Partnerships to Build a Culture of Health: A Compendium of Case Studies.”](#) American Hospital Association. Accessed August 11, 2025.



STRATEGY 5: LEADERSHIP

Develop champions among senior leaders and board members who will invest in the technology, workforce and infrastructure to upgrade financial assistance policies and procedures as an integral part of delivering quality care.

1. Use data and internal partnerships across finance, population health and community benefit functions to get buy-in from senior leaders and staff.

To understand the impact of using predictive analytics to presumptively screen patients for financial assistance, it helps to have a sense of the economic value they can bring to a hospital.

Hospital leaders can work with revenue cycle staff and third-party vendors to evaluate existing internal data about current levels of bad debt, charity care and Medicaid enrollment. It is also helpful to gather data about complete applications versus incomplete applications and Medicaid or coverage enrollments from financial counselors and enrollment assisters to understand where patients are struggling to finalize their applications. These data points can help hospitals estimate the number, types and value of patient bad debt accounts that could be reclassified as charity care — or, better still, connected to Medicaid or other coverage — with more robust PE screening. This can help leaders understand where patients are getting tripped up by documentation requirements and identify the tools they need to remove these barriers.^{XLV} These metrics can be tracked over time to evaluate the effectiveness of PE strategies and predictive analytic models the hospital chooses.

Moving beyond the economic rationale for using PE, healthcare leaders can deepen their own understanding of the impacts of charity care on patient outcomes and experience. One way to achieve this is to create a workgroup of community benefit (or community health) and finance teams for the purposes of reviewing and upgrading financial assistance policies and implementation to address community need. By involving community benefit and clinical leaders in conversations about financial assistance, finance teams are more likely to surface useful feedback from community partners and patients about where the FAP, application form or financial counseling process are breaking down for patients. Multi-state systems and recently consolidated systems can consider gathering cross-disciplinary teams for each geographic region to ensure local community needs and trends do not get lost in the shuffle.

“[In our system] there is strong integration between the community health team and the revenue cycle team. [I’m] the operational leader who owns the charity care policy and work. The CFO signs off on it, and the board approves it, but it’s me and my team who are constantly evaluating and tweaking it. I facilitate at least two monthly meetings that involve finance and community health team members. We go line by line to evaluate spending in our entire community health portfolio. One meeting is a program management meeting for our community health strategies, and the other also involves finance and revenue cycle. We look at the FAP in these meetings as well and keep a “tick list” of things we want to change and problems throughout the year. We use these to update our FAP every May.”

– Hospital community benefit leader

2. Share expertise and data to inform policymaking.

Historically, state and federal lawmakers have had relatively little to say about PE for financial assistance. That may be changing. (See Appendix A for a table of states that now require hospitals to presumptively screen patients for financial assistance.) Moving forward, it is critical that hospitals work with other stakeholders to identify barriers and opportunities for strengthening PE frameworks in ways that are reasonable, effective, and scalable. Areas that stakeholders flagged as ripe for improvement — including public policy intervention or investment — include the following:

- **Setting guidelines for predictive modeling tools.** Although hospitals are highly regulated, predictive modeling tools themselves are generally not. Some stakeholders saw value in having standardized definitions of key terms, like “ability to pay” versus “propensity to pay,” and defined limits for when to use propensity-to-pay strategies. Others raised the need for more transparency from vendors about how the “black box” of their predictive models make decisions.
- **Expanding data-sharing agreements between public agencies and hospitals to verify incomes or enrollment in means-tested programs.** Access to verified income data is one of the biggest limitations in current PE systems, and part of what has sparked reliance on third-party predictive modeling tools. Public agencies can play a larger role in making data available to hospitals and health systems for the limited purposes of expediting more accurate PE screening, either by establishing data-sharing agreements with state departments of revenue or agencies that run means-tested programs for public benefits, such as Medicaid, SNAP or WIC.²¹
- **Supporting rural hospitals in using PE strategies that work for their communities.** Rural hospitals face unique challenges in using PE. High start-up costs and limited economic benefits, especially for hospitals reliant on Medicare and Medicaid reimbursement rates and critical access hospitals, make adoption more difficult. Policymakers could provide technological or financial support to help rural hospitals integrate PE and develop workgroups to study which PE strategies and predictive modeling tools are best suited to the unique challenges of small communities.²²

Other issues — such as allowing hospitals to rely on PE determinations when claiming Medicare bad debt reimbursement,^{XLVI} and creating fair financial assistance standards for for-profit hospitals^{XLVII} as for-profit healthcare expands^{XLVIII} — also require public policy fixes.

21 Medicaid, SNAP, WIC, the Low-Income Home Energy Assistance Program (LIHEAP), and unemployment compensation programs have been identified as particularly rich opportunities for data-sharing agreements since many of the eligibility requirements overlap. For a helpful guide and comprehensive list of issues to be addressed (pre-One Big Beautiful Bill Act), see Saffold, Jeneé Y., et al. [“Data Sharing to Build Effective and Efficient Benefit Systems: A Playbook for State and Local Agencies.”](#) Benefits Data Trust, January 2023. Accessed September 15, 2025. There is room to improve data sharing between federal and state agencies as well. See [“Federal Low-Income Programs: Use of Data to Verify Eligibility Varies among Selected Programs and Opportunities Exist to Promote Additional Use.”](#) GAO, February 25, 2021. Accessed September 15, 2025. Table 12 has a list of the verification methods various Medicaid agencies use to verify income; notably, Medicaid prohibits assets from being considered.

22 Rural communities face privacy concerns that elide larger urban centers. As one former revenue cycle leader noted, “Everybody knows everybody... that can be good or bad.” An RCM developer added, “Inevitably we’d approve somebody, and the financial counselor would say, ‘I know that person, and they own X thing and shouldn’t qualify for charity care.’” To reduce bias, lower costs and ensure accuracy, rural hospitals might use PE tools less frequently, such as through annual reclassification of patient accounts, and focus instead on qualifying people enrolled in means-tested programs and other client-specific factors.

CONCLUSION

The healthcare safety net is, once again, in need of repair. Unless state and federal governments act to protect Medicaid and address rising out-of-pocket costs, hospitals will soon be treating even more insured patients that need financial assistance to afford care, and more uninsured patients who are no longer eligible for Medicaid or public programs. For uninsured and underinsured patients, hospital financial assistance programs will be a critical lifeline to access care. While some fundamental drivers and economic pressures — rising healthcare premiums; price inflation for essential goods and services^{XLIX} and labor,^L and policy decisions that expand or contract public coverage options^{LI} — lie squarely beyond individual patients' or providers' capacity to solve, one thing is clear: patients and providers are both living with the consequences.

We need larger-scale public policy interventions to fully address the challenges healthcare providers and patients are facing today. Far and away the largest issue stakeholders raised was the need to address out-of-pocket costs, particularly for insured patients, and to address prior authorizations and denials, which add to hospitals' administrative burdens, create massive complexities within the billing system and harm patients. Stakeholders raised the need for public policymakers to shore up the healthcare safety net, coupled with concerns that hospital financial assistance will soon be pushed to the breaking point. Multiple stakeholders discussed the need to increase Medicaid payment rates to physicians as a necessary corollary to addressing these issues, especially for hospitals that cannot offset costs with commercial insurance.

These changes seem unlikely now, [given passage of H.R.1 and its massive cuts to Medicaid](#). That makes stakeholders' concerns that generous financial assistance policies will soon be incompatible with community need all the more poignant: "I feel a bit of panic from the hospital end of things about who will pay," shared one former revenue cycle leader. "Most people are under the 400% federal poverty level threshold for financial assistance. It's the right threshold to have, but it's still not dealing with the core problem, which is where hospitals despair."

We know hospitals are in the business of taking care of people. While addressing the affordability crisis in our broken insurance markets will require policymakers to act, hospitals need solutions now. As more patients struggle to pay their out-of-pocket costs, forward-thinking hospitals are taking proactive steps to triage patients' financial needs along with their clinical ones. By effectively harnessing data and community relationships, reworking patient workflows, and establishing strong organizational norms that promote patient-friendly billing practices, hospitals can replace outmoded approaches to self-pay collections with practices that save them time and treasure.

Providers aim to do right by their patients. They need actionable strategies to rebuild patient trust in a system that often fails them and their patients. Adopting the approaches in this paper will allow revenue cycle leaders to position their organizations to meet patients' needs more effectively while stewarding scarce resources. It's a tall order, but patients can't afford to wait years for policy solutions to emerge — and neither can hospitals.

Appendix A: Table of State Laws

STATE	REQUIREMENTS	NOTES
<p>California (passed October 2025, effective July 2027)</p>	<p>Applies to all hospitals. Has a number of mandatory categories (listed below) and allows the Department of Health Care Access and Information and hospitals to determine any other appropriate programs they may want to include.</p> <p>Mandatory categories</p> <ul style="list-style-type: none"> Enrollment in means-tested programs such as Calfresh, CalWORKs, TANF, WIC, California Alternate Rates for Energy (CARE), LIHEAP, Housing Choice Voucher Determined eligible for financial assistance during the past six months Experiencing homelessness Uninsured Enrolled in or eligible for Medi-Cal with cost sharing Enrolled in a Covered California health plan <p>Details</p> <p>Provides patients the ability to appeal a determination or apply directly for charity care</p> <p>For patients found eligible, discounts must be reflected in the first bill</p> <p>Patients must be notified of eligibility determination in writing</p>	<p>Similar in scope and design to Illinois' PE law</p> <p>The state sets eligibility levels for charity care and discounted payments at 400% FPL — however, rural hospitals can set lower thresholds</p> <p>Patients not found presumptively eligible must be provided with a copy of the hospital's charity care and discount payment policies.</p> <p>Allows hospitals to use third-party software tools or services to conduct screening. They're not required to do so, but they must document the methods they use for screening.</p>
<p>Illinois (passed and effective in 2014)</p>	<p>Applies to all hospitals, although at various tiers for rural versus urban.</p> <p>Mandatory categories</p> <ul style="list-style-type: none"> Homeless Deceased with no estate Deemed mentally incapacitated and without a guardian Medicaid eligible but not enrolled on date of service <p>Mandatory for Urban Hospitals</p> <ul style="list-style-type: none"> Enrollment in means-tested programs with criteria at or below 200% FPL: WIC SNAP Illinois Free Lunch and Breakfast program LIHEAP Enrollment in community-based program providing access to medical care Recipient of grant assistance for medical services <p>Optional</p> <ul style="list-style-type: none"> Recent personal bankruptcy Incarceration Affiliation with a religious order and a vow of poverty Enrollment in TANF or the Illinois Housing Development Authority's Rental Housing Support program 	<p>The oldest state-level PE law on the books</p> <p>Hospitals must submit an annual report on compliance to the Office of the Attorney General, to include:</p> <p>Applications submitted (complete and incomplete)</p> <p>Applications approved (including the number approved using PE)</p> <p>Applications denied</p> <p>Dollar amount of financial assistance provided at cost</p> <p>Description of electronic and information technology used</p>
<p>Maryland (enacted 2020)</p>	<p>Applies to all hospitals.</p> <p>Eligibility Details</p> <p>Requires PE for medically necessary care for patients who do not qualify for Medicaid/CHIP and who:</p> <ul style="list-style-type: none"> Live in a household with kids enrolled in free/reduced cost meal programs Receive SNAP Receive benefits through the Maryland energy assistance program Are enrolled in WIC Receive benefits from "any other social service program" as determined by the Maryland Department of Health and the Department of Human Services 	<p>The Health Services Cost Review Commission and DHHS were to collaborate in evaluating the impact of adding other PE categories but it is unclear where that is in the process (the charge came from 2021). Categories included:</p> <p>Unhoused people,</p> <p>People enrolled in Medicaid, Medicare QIM-B and SLIME</p>

<p>Minnesota (passed and effective in 2023)</p>	<p>Applies to private nonprofit and municipal hospitals. Some sites state Minnesota has two for-profit hospitals, but according to KFF they have zero.</p> <p>Details</p> <p>Not explicitly PE for financial assistance, but is tied into a broader Medicaid PE law:</p> <p>Participating hospitals must determine if a patient who is uninsured (or of unknown status) is eligible for Medicaid PE, connecting them to a Certified Application Counselor (CAC) for an appointment</p> <p>Requires the hospital to screen any uninsured patient (including those eligible for Medicaid PE) for charity care:</p> <p>First screening must be completed in person or by phone within 30 days of receiving services</p> <p>Hospitals can only request asset or income information “reasonably necessary and readily available to determine eligibility” and “facts that are relevant to determine eligibility”</p> <p>If the patient is “not ineligible” the hospital must help them apply for charity care (in house). Specifies this must not constitute an “unreasonable burden” for the patient—including not requiring a patient to apply for a state or federal program they are “obviously or categorically ineligible for” or have been found ineligible for in the previous 12 months</p>	<p>While financial assistance PE determinations are pending, a hospital cannot:</p> <p>Initiate payment plans or change the terms of a payment plan</p> <p>Offer a line of credit or loan, or refer to collections (including in-house)</p> <p>Deny services to anyone in the patient's household, including elective procedures</p> <p>Accept a credit card payment of over \$500 for the medical debt owed</p>
<p>Oregon (enacted in 2023, effective July 2024)</p>	<p>Applies to all nonprofit hospitals. Oregon has three for-profit hospitals.</p> <p>Eligibility Categories</p> <ul style="list-style-type: none"> • Uninsured • Enrolled in Medicaid • Owes the hospital more than \$500 (after insurance adjustments are made) <p>Other notes</p> <ul style="list-style-type: none"> • Hospitals are prohibited from requesting any documentation from patients for presumptive screening • Screening cannot have a negative impact on the patient's credit (no hard credit pulls) • Provides for nine months of continuous eligibility 	<p>Arguably the most comprehensive of the existing state-level PE laws</p> <p>Prohibits hospitals from using propensity-to-pay tools as part of the PE screen</p> <p>Patients must be notified they've been screened</p> <p>Patients must be given information on how to apply for financial assistance if screening is negative</p> <p>No collection activities can be undertaken during the appeal</p>

Maryland and Illinois require hospitals to recognize patients who are already enrolled in other needs-based programs, such as WIC and SNAP, as presumptively eligible for financial assistance.^{LII} Oregon has gone the furthest: [H.B. 3320](#), enacted in 2023, requires nonprofit hospitals to presumptively screen and apply financial assistance for every patient who is uninsured, enrolled in Medicaid, or who owes the hospital over \$500 prior to sending a bill. It prohibits hospitals from using propensity-to-pay tools as part of the presumptive charity screen. California recently passed similar legislation (see Table). These laws, like all PE strategies and tools, have not been without their implementation challenges.^{LIII}

Appendix B: Checklist for Busy Hospital Leaders

1. Understand what “presumptive charity/financial assistance” is and how it works.²³
2. Develop internal partnerships between finance and community benefit leaders to understand the opportunities and challenges for implementing PE strategies.
 - Identify which data are needed to create a baseline and measure success.
 - Work with staff, community partners and vendors to understand how predictive analytics might fill gaps in existing processes.
3. Adjust financial assistance policies and procedures to realize the full benefits of PE tools.
 - Base eligibility on incomes (not assets).
 - Disclose how PE tools are being used to make eligibility decisions and add other PE characteristics to policies and applications.
 - Train staff on policies, procedures and how PE tools are used.
 - Ask for feedback on your financial assistance application forms, outreach methods and implementation. Does your FAP meet the principles of “Early, Easy and Engaged”?
 - Explore opportunities to determine whether patients are presumptively eligible based on individual life circumstances, such as housing status, FQHC patient or beneficiary of other means-tested government programs.
4. If the hospital does not use PE strategies today, start! If predictive analytic tools are used, put safeguards in place.
 - Don't let propensity-to-pay scores trump estimated FPL information.
 - Apply them to all patients with a self-pay balance, not only uninsured people.
 - Apply them early in the billing process, before the first patient bill is sent.
 - Review PE results with all patients and allow/encourage them to apply for additional assistance as warranted. Assure that people receiving free care on a presumptive basis are informed.
5. Communicate all PE results to patients, including full financial assistance determinations. (This gives patients the opportunity to apply for a full eligibility period, instead of one episode of care.)
6. Monitor and evaluate the effectiveness of the financial assistance process.
 - Track metrics. Include both outcome (financial analyses, such as accounts converted from bad debt to charity care status) and process measures (such as number of people approved based on PE versus hard-copy applications).
 - Ask community partners for input and feedback.
7. Encourage vendors to improve their offerings and share data with policymakers to strengthen PE frameworks and infrastructure.
 - Share success stories and challenges with vendors, particularly around accuracy
 - Encourage policymakers to accept PE results, build infrastructure to support PE strategies at small and rural hospitals, and to implement broader-scale reforms that address the root causes of medical debt and lack of affordability
8. Reach out to hospital associations to work together on the issue and make clear to policymakers that these analytic tools are costly.

23 When referring to “presumptive charity,” this paper uses the term mostly to refer to predictive analytics software that estimates patient income and household size — or ability to pay — in order to “presumptively” screen and qualify a patient for financial assistance without making them complete a paper application.

Endnotes

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- VII "[Employee Benefits: High Deductible Health Plans and Savings Accounts](#)." *U.S. Bureau of Labor Statistics*, April 11, 2025. Accessed June 3, 2025.
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- XXVI For a sense of the complexities involved, see the flowchart at the end of this letter showing the steps required to issue refunds to people who should have qualified for financial assistance, but were billed instead. "[Letter to Chair Peña-Melnyk, House Health and Government Operations Committee, Re: House Bill 333-Hospitals-Financial Assistance – Medical Bill Reimbursement Process – Letter of Information](#)." *Maryland Health Services Cost Review Commission*, February 28, 2023. Accessed June 3, 2025. https://mgaleg.maryland.gov/cmte_testimony/2023/app/1CMIImEtYy_JxtEUHMnl-6D_JRPIYGpZj2.pdf
- XXVII Stakeholder interview. See also Waystar's description of the limitations of credit-only models, particularly for low-income people, and its use of socioeconomic data. "[4 Do's and Don'ts of Uncompensated Care: Improving Charity Care for Providers and Patients](#)." *Waystar*, June 22, 2024. Accessed June 3, 2025.
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- XXXI Perhaps recognizing the promise and pitfalls of PE tools, the IRS requires tax-exempt hospitals to disclose when they use PE tools and inform patients who do not qualify for full financial assistance after a PE screening. This gives the patient another opportunity to “correct the record” and apply for more help. Treas. Reg. § 1.501(r)-6(c)(2).
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- XXXVIII Ibid. The authors found “it was difficult to compare asset requirements across hospitals because FAPs do not necessarily specify eligible assets or how they were used to determine eligibility.”
- XXXIX One study of 150 hospitals between 2019 and 2021 found that one-third of hospitals in the cohort expanded FAP eligibility to include moderate-income patients and underinsured patients, and increased the use of presumptive eligibility. Goodman, Christopher, et al. [“Comparison of US Hospital Charity Care Policies Before vs After Onset of the COVID-19 Pandemic.”](#) *JAMA*, September 27, 2022. Accessed June 3, 2025.
- XL At least two states, Illinois and Maryland, have codified categories for presumptive eligibility of this nature in state statute
- XLI The IRS requires tax-exempt hospitals to disclose when they use PE tools and inform patients who do not qualify for full financial assistance after a PE screening. This gives the patient another opportunity to “correct the record” and apply for more help. Treas. Reg. § 1.501(r)-6(c)(2).
- XLII Where a PE tool finds that the patient is ineligible for full financial assistance, hospitals must notify the patient of the outcome, inform the patient about how to apply for more generous help, and give them a reasonable time to do so before engaging in extraordinary collection actions. Anecdotal reports from stakeholders and others suggest that many hospitals do not inform patients who receive full financial assistance from PE screens about their awards.
- XLIII Shinkman, Ron. [“Bad Debt Reclassified As Charity Care, But Many Patients Remain in the Dark.”](#) *Fierce Healthcare*, September 20, 2016. Accessed June 3, 2025.
- XLIV Stakeholder interviews.
- XLV Hut, Nick. [“Reimagining charity care: How Monument Health puts patients first with an innovative financial assistance program.”](#) *HFMA*, April 29, 2024. For example, when Monument Health’s Executive Director for Revenue Cycle and Supply Chain realized patients who should qualify for financial assistance were not completing the application, he worked with internal stakeholders and existing vendors to develop a PE process that led to an increase in charity care allocations without decreasing the hospital’s collections. This “eased trepidation among the organization’s finance leaders about a possible revenue drop from the initiative, and it also confirmed that the patients who were being helped truly lacked the ability to pay.”
- XLVI While several stakeholders mentioned that CMS’s current policies create extra documentation burdens that may chill hospital interest in using PE, they were split on how to resolve this. One argued to just eliminate Medicare bad debt entirely and increase the Medicare rate structure across the board. Others felt CMS could also recognize that PE was “mostly” accurate and put some bumpers up for how to deploy it.
- XLVII Although any provider can offer financial assistance, it has historically been most strongly associated with nonprofit hospitals, particularly hospitals with tax-exempt status under Section 501(c)(3) of the Internal Revenue Code. This is due in part to the historical role many of these hospitals played in offering care to poor and medically underserved communities, and to federal requirements that hospitals with tax-exempt status under Section 501(c)(3) of the Internal Revenue Code provide a “benefit to the community” beyond the provision of medical care to individual patients. For many tax-exempt hospitals, extending charity care is a critical part of how they fulfill this obligation to provide “community benefit.” See [“Requirements for 501\(c\)\(3\) hospitals under the Affordable Care Act – Section 501\(r\).”](#) *Internal Revenue Service*. Accessed September 15, 2025.
- XLVIII In 2022, 58.2 percent of U.S. hospitals were privately owned nonprofit hospitals; 18 percent were owned by state and local governments; and the remaining 23.8 percent are privately owned for-profit hospitals. These numbers don’t tell the whole story, however. A handful of states (Hawai’i, Minnesota, New York, Rhode Island, and Vermont) had no for-profit hospitals in 2022, while both Texas and Nevada had more for-profit hospitals than public and private nonprofit hospitals combined. [“Hospitals by Ownership Type.”](#) *KFF*. Accessed September 15, 2025.
- XLIX For example, two-thirds of working adults responded that the increased costs of goods and services that were non-healthcare related contributed to their difficulties affording health care in 2023. Collins et al, “Paying For It.”
- L See Hudson, Caroline.
- LI [“Status of State Medicaid Expansion Decisions.”](#) *KFF*, May 9, 2025. Accessed June 3, 2025.
- LII Kona, Manaasa. [“State Options for Making Hospital Financial Assistance Programs More Accessible.”](#) *Commonwealth Fund Blog*, January 11, 2024. Accessed June 4, 2025.
- LIII There have been implementation issues. See [“Hospital Feedback on the First Quarter Implementation of HB 3320 Financial Assistance Prescreening.”](#) *Oregon Health Authority Health Policy & Analytics Division*, January 2025. Accessed April 2, 2025.