

## **Symposia Title: Integrating and Sustaining Financial Capability Services in Rural Healthcare Delivery: Consumers, Healthcare Providers, and Systems Perspectives**

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The session addressed the integration of financial capability services into rural healthcare systems. Studies of patient adherence to medical therapies show that household financial constraints are a major reason patients fail to obtain care. The National Financial Capability Study shows that as many as one-in-six American households skipped prescription medications in the prior year due to cost. The percentages of people who failed to get care or skipped other forms of medical treatment due to cost are even higher. For rural communities, which tend to have higher rates of unemployment, more uninsured residents, and lower average incomes than non-rural areas, ongoing out-of-pocket costs can prove to be an especially acute financial burden. As copays and deductibles rise at double-digit rates annually, even families with health insurance coverage are struggling to manage out-of-pocket medical expenses. In effect, cost-sharing can reduce access to necessary treatments, resulting in worse health outcomes and increased costs for the patient, insurer, and healthcare system.

Although financial capability support services are available in many rural communities, programs are not well integrated into healthcare systems. As the prevalence of cost-sharing between the consumer and health provider (e.g., copayments and coinsurance) expands in the U.S. healthcare system, household finances play an increasingly important role in reducing healthcare access. Identifying ways to better integrate financial capability services can help support patients' abilities to cover ongoing medical expenses, thereby improving financial and health outcomes. In turn, better mental and physical health are critical to sustaining a productive workforce needed for economic development.

In this session, we highlighted our investigations into opportunities that strengthen partnerships between rural health systems and financial capability resources and services. First, we described consumers' experiences with their health plans, their understanding of the healthcare system, their perceived and actual out-of-pocket costs, and their levels of financial hardship. Next, the symposia addressed the team's investigation of rural healthcare providers' perspectives on the financial security of their patients and the viability of financial capability service integration to help patients access and pay for healthcare. Lastly, we presented a promising model of integration based on a feasibility study that explores the sustainability of financial capability services through insurance reimbursement. The symposia papers utilized recently acquired data from surveys and focus groups. The symposia addressed a timely topic with three perspectives of the healthcare puzzle: consumers, healthcare providers, and systems perspectives. Findings underscored a recognized need for financial capability resources and services for patients and provide valuable information about the capacity requirements and supports necessary for integrated, sustained partnerships that support rural community health.

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**Paper 1: Managing Out-of-Pocket Medical Expenses: How Well are Families Prepared for a World of High Deductibles? Presenter: J. Michael Collins**

In 2019, 2000 public employees in the state of Wisconsin completed a Healthcare Out-of-Pocket Costs Survey. The survey included questions about employees' experiences with their health plans, their understanding of the healthcare system, their perceived and actual out-of-pocket costs, and their levels of financial hardship. The survey shows even among an employee population with higher levels of education, stable income and access to high-quality health care plans, out-of-pocket costs are a major concern for families. Many people reported being confused about deductibles and out-of-pocket costs, and the majority over-estimate what their actual deductible is. Importantly, about one-third of respondents reported they did not get needed healthcare due to costs, including both those in high-deductible insurance plans and those in more traditional plans. A lack of savings and the inability to pay for emergency expenses are common problems related to people not being able to manage out-of-pocket costs. Among those with health saving accounts, the majority say they are not comfortable with how to use health savings accounts, and not sure where to get information about out-of-pocket costs. While survey respondents report they want more education about managing out-of-pocket costs, they are not interested in formal counseling, education or other forms of help provided through their employer or health care provider. These results document some of the challenges consumers face in a market with increased cost-sharing burdens.

**Paper 2: The Integration of Financial Capability Services into Rural Health Systems: Survey Findings from Healthcare Providers. Presenter: D. Elizabeth Kiss**

There is a recognized need for financial capability services for patients, however, little is known about the capacity requirements and supports necessary to integrate this type of service. This investigation centered on three core topics: 1) providers' observations of the influence of financial capability on patients' healthcare access, 2) providers' knowledge of current resources (or lack thereof) to support patients' financial capability, and 3) providers' attitudes and suggestions for integrating financial capability services into healthcare systems. A 13-question online survey was completed by 116 health care providers from Wisconsin (n=81), Kansas (n=35), and Oklahoma (n=1). Participants represented all segments of the healthcare provider population and a range of practice areas (e.g., general practitioners, mental health professionals, patient advocate, pharmacist, etc.), the majority of whom serve primarily rural populations. Overwhelmingly, providers expressed concern about patients' financial security and the negative impacts of costs on access to healthcare. Nearly 3-out-of-4 survey respondents (74 percent) said they are very or extremely concerned about their patients' out-of-pocket costs. Similarly, 97 percent of survey respondents said, within the past month, they had a patient skip a recommended treatment because of the costs. Additionally, 97 percent of survey respondents said a patient within the past month did not fill a prescription because of the costs and 88 percent said a patient within the past month did not get mental healthcare because of the costs. These provider perspectives aligned with previous consumer-focused studies related to financial constraints and medical adherence. Together, findings highlighted that out-of-pocket expenses could create or exacerbate financial hardships, which force patients to recalibrate their financial decisions, delay, or skip medical treatment. Nearly three-quarters (73 percent) of survey respondents said they are surprised very often or extremely often at patients' out-of-pocket costs. The majority of providers believed low premiums and low out-of-pocket costs were the most important features in people's decisions of health insurance plans. Interestingly, a previous patient survey conducted by the University of Wisconsin-Madison found that only 7 percent of patients think their provider is very or extremely concerned about their out-of-pocket costs. This comparison reveals a very large disconnect between patient and provider perceptions, something important to consider when developing any financial education resources for healthcare settings. About half of surveyed providers (52 percent) believed a health savings account (HSA) is very or extremely beneficial to patients; just 3 percent of survey respondents believe an HSA was not at all beneficial. Providers also unanimously recognized a need for more resources to support patients' financial security. Most providers relied on their personal education about available community resources and it was evident that healthcare providers do not have integrated, systematic financial support services in their healthcare establishments. These findings indicated a need to support both providers and patients with more accessible resources.

**Paper 3: Patient Financial Security and the Availability and Integration of Financial Capability Services and Resources: Focus Group Findings from Nurses and Healthcare Providers Presenter: Suzanne Bartholomae**

The purpose of the study was to learn how healthcare professional's role as a provider interacts with or can affect a patient's access to financial capability resources. Four focus groups were conducted in Iowa and North Dakota with nurses (n=14) and other healthcare professionals (n=3) to gather their perspectives regarding the financial security of their patient population, the knowledge of available financial capability resources and the feasibility of directing patients to financial capability resources and services. Recruitment from email invitations sent to statewide professional listservs resulted in a sample of 14 nursing professionals and 3 healthcare providers. Focus group participants came from a range of practice areas such as Emergency, Obstetrics, Surgery, Geriatrics, Wound Care, Oncology, and Intensive Care. During focus groups, providers discussed the prevalence of financial insecurity in their communities, describing lack of job opportunities, low wages, and low financial management skills as the most common contributors to this financial insecurity. Focus group participants highlighted the often overly complex and overwhelming process consumers face when trying to access and pay for care. One focus group participant said "they're not coming back in to get some of those treatments because of their high, high deductible. So even people who are covered, their deductible might be \$5000 to \$8000 and so they're just delaying their care." Related to current resources for patients, focus group participants identified a range of resources that addressed basic needs, such as food pantries, rent assistance, low-cost and free clinics, and free transportation for appointments. One focus group most often described referring patients to public assistance benefits, whereas other focus groups responses identified WIC, Medicaid, and other public benefits. The hospital admission process and discharge plan were touchpoints during which a patient's current financial stressors were asked about directly or emerge in the planning process. Hospital resources in the area of financial issues include financial counselors and case workers, yet they tend to be underutilized. Providers identified community resources such as food pantries and Legal Aid, but did not identify any community resources directly related to financial capability. The healthcare professionals acknowledged that there is a need for support in financial capability resources. The study identified several barriers preventing healthcare providers from addressing their patients' financial needs. First, providers themselves were not comfortable with providing financial support to their patients. Part of this was due to the healthcare providers' lack of confidence in their own financial management. Focus group participants mentioned the issue of time constraints. Many providers were unaware of resources; however, providers recognized this as an area of stress and concern and were very interested in ways to refer patients to financial support resources.

**Paper 4: A Systems Approach to Integrating Financial Capability Services with Health Care Service: A Feasibility Study of Reimbursement. Presenter: Carol A. Janney**

Current procedures for Medicaid billable services present an opportunity for an insurance reimbursement model for sustaining financial education services. This investigation tested the feasibility of billing Medicaid within a partner organization, Community Mental Health (CMH), for financial education services provided by MSU Extension. Financial education for adults with severe mental illness or cognitive impairments are eligible for Medicaid billable services using Healthcare Common Procedure Coding System (HCPCS) categories and 2016 Current Procedural Terminology (CPT®) codes. With Medicaid, only services provided by one provider can be billed. The CPT/HCPCS codes determine the hourly rate for these services and services can be billed in 15-minute intervals for individuals or groups (n=15-20/group) with a billing rate of \$16.80/person in 2016. The investigators explored current procedures for Medicaid billable services for other medical procedures, determined procedural requirements for financial capability billable services, and determined feasibility of implementation within Medicaid patient services for one CMH. In its feasibility study, the research team also discovered contractual and referral process regulations for billing Medicaid for financial education services. For example, organizations such as Extension, who provide financial capability services, would need to have a contract with the organization and apply for provider status. The financial capability program would also need to be incorporated into the health goals of the patient under their CMH case manager (i.e., the case

manager would authorize and refer the patient to MSU financial education program). Given providers' positive response to questions regarding referral, this seems like a feasible structure. Billing Medicaid would also require the financial capability educator to have the following credentials: high school diploma and educational transcripts, criminal background check, W-9 form, and U.S. citizenship. Depending on the services provided, the educator may be classified as an aide or qualified mental health provider, requiring additional credentials. Organizations, such as Extension, could define additional financial education credentials for the educators. Despite these structural opportunities, the attempt to set up the Medicaid billing system using CMH was not well-received in the selected Michigan county. Although the community foundation and CMH supported financial education services for adults with severe mental illness, they preferred not to use their allocated and limited Medicaid funds for this purpose; they preferred to use their Medicaid funds for behavioral health services rather than on financial education services. This finding aligned with focus group and survey findings mentioned above regarding healthcare providers' primary focus on medical recovery.

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