September 2023 – Vol. 39 No. 9
Published for Health Care Providers by ACA International
www.acainternational.org

# PULSE



# Health Care, Finance Industries Embrace Real-Time Payments

The convergence of digital transformation and real-time payments is revolutionizing the health care and finance sectors, as 92% of health care companies commit to adopting this swift and efficient transaction method.

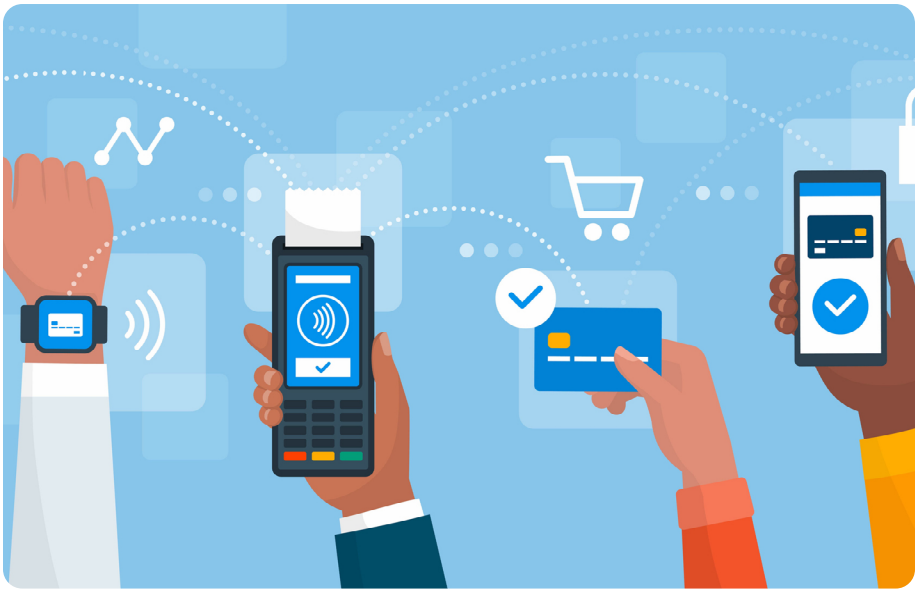
In an era where speed and efficiency are paramount, the health care and finance industries are poised for a monumental shift, according to a recent article from PYMNTS.

In collaboration with Corcentric, a new PYMNTS report titled "Digital Payments: Expanding the Payments Palette," highlights the resounding enthusiasm of health care and finance companies toward embracing real-time payments. This shift marks a pivotal moment as trillion-dollar industries, traditionally relying on paper-based processes, make a determined leap into the digital realm.

The report found that a remarkable 92% of health care companies have expressed their intent to embrace real-time payments, mirroring the sentiments of finance and insurance companies.

The impact of this transition extends beyond just convenience. While credit card transactions are supported by 93% of finance and insurance businesses, and debit card transactions by 88%, there lies a significant opportunity to integrate digital options more comprehensively. Surprisingly, only 37% of these businesses currently support ePayables.

Additionally, a remarkable 96% of health care companies have embraced credit card payments, with 84% supporting debit card payments, according to the study. And 67% of health care companies now support eChecks, bringing traditional payment methods into the digital age.



Among the 250 surveyed professionals from health care and finance sectors, 86% of finance and investment professionals have already charted real-time payments on their investment roadmaps. The enthusiasm is even higher among health care companies, with 92% planning to invest in new payment initiatives.

Moreover, a significant percentage of businesses have already embraced real-time payments, with 53% of health care companies and finance and insurance businesses leading the charge. Notably, 81% of health care companies and 67% of finance and insurance businesses already integrated with real-time payments have committed to further investments in this transformative technology.

Read the report here.

# The Surprising Reality of Medical Debt Among Middle-Class Americans

Roughly 25% of medical debt belongs to middle-class Americans, in contrast to 22% of lower-class people and 13% of higher-class people.

Middle-class Americans are grappling with an overwhelming burden of medical debt, surpassing both lower and higher income groups, according to a recent report by the think tank organization Third Way.

The study, which drew on data from the Census's Survey of Income and Program Participation (SIPP), scrutinized the prevalence of medical debt within families of varying income levels.

Contrary to general assumptions, nearly a quarter of middle-class families, accounting for 17 million households, found themselves unable to fully settle their medical bills in 2020. Notably, this rate surpassed that of lower-income families by 1.5 percentage points and higher-income families by 9 points. Even with a higher proportion of middle-class individuals possessing sufficient insurance coverage, the financial strain of medical debt persisted, often outweighing the hesitations of lower-income families to seek care due to cost concerns.

The study debunked the notion that higher income equates to better financial resilience against medical expenses. Middle-class families, grappling with the range of $50,000 to $100,000 for a typical family of three in 2023, encountered difficulties in covering high deductibles and out-of-pocket costs, thus succumbing to the weight of medical debt. This financial strain transcended various educational backgrounds, impacting those without high school diplomas as well as individuals holding Bachelor's degrees, according to the study.

Racial disparities also emerged, with Black and Hispanic middle-class individuals experiencing disproportionately higher rates of medical debt compared to their White and Asian counterparts. Additionally, Black middle-class individuals faced medical debt rates exceeding even those of Black individuals with lower incomes, signaling a complex interplay between race and financial challenges.

Age-wise, the study spotlighted middle-class individuals as the most vulnerable across age groups, except for seniors above 65 years old who were safeguarded by Medicare coverage. Surprisingly, middle-class families without children, often assumed to have more financial flexibility, were not exempt from this struggle, outpacing both lower and higher-income counterparts in medical debt.


Read the report here.

# Hospital Price Transparency Compliance Lags Two Years After Rule Introduced

A recent report finds that 64% of hospitals fall short in complying with the federal Hospital Price Transparency Rule.

Two and a half years after the introduction of the federal Hospital Price Transparency Rule, the compliance landscape remains challenging, with only 36% of hospitals adhering to the regulations, according to a recent report from PatientRightsAdvocate.org.

Despite repeated calls from the Centers for Medicare & Medicaid Services (CMS), a mere 721 out of 2,000 U.S. hospitals are fully complying with the Hospital Price Transparency Rule.

The rule mandates hospitals to publish standardized charges, discounted cash prices, and consumer-friendly displays for the most sought-after services. However, a staggering 64% of hospitals still lag behind, failing to provide the

*Continued on pg 3*

# NEWS & NOTES

## Medicare Shared Savings Program ACOs Save $1.8B in 2022

In 2022, the Medicare Shared Savings Program (MSSP) achieved remarkable success, saving Medicare $1.8 billion and demonstrating improved quality measures, according to a report from the Centers for Medicare and Medicaid Services (CMS).

Notably, 63% of accountable care organizations (ACOs) received payments for their performance, marking the program's sixth consecutive year of generating savings. This achievement also represents the second-highest annual savings since the program's inception in 2012.

ACOs excelled in various quality benchmarks, including diabetes and blood pressure control, tobacco cessation, cancer screenings, and depression follow-up. Low-revenue ACOs, often composed of primary care clinicians or small hospitals serving rural areas, demonstrated greater per capita net savings compared to high-revenue counterparts.

In response to the positive outcomes, CMS proposed changes to the MSSP to encourage broader health care provider participation, promote equity in underserved regions, and accommodate high-cost, complex health needs of beneficiaries.

Read more here.

## AHA Urges Easier Adoption of Episode-Based Payments and Enhanced Resources

The American Hospital Association (AHA) has called on the CMS to simplify the implementation of episode-based payment models, like bundled payments, across hospitals in a recent letter.

In response to a CMS request for information, AHA outlined crucial guidelines for evolving payment models and emphasized the need for a flexible model design that allows voluntary participation, selection of clinical episodes, and the addition of components or waivers.

AHA also stressed the importance of risk adjustment to account for treating complex patients, while advocating for balanced risk and reward mechanisms. Transparent methodology, preventing hospitals from competing against their own performance, adequate model duration, and accessible participant data were other key recommendations.

Read AHA's letter here.

## Hospital Price Transparency cont. from page 3

necessary transparency.

Although the compliance rates remain subpar, there is some improvement. A previous report indicated that less than 25% of hospitals were compliant in early 2023. This number has now risen to 36%, indicating that efforts are being made to meet the transparency requirements.

The latest findings reveal that many hospitals struggle with compliance due to incomplete or unclear pricing information. Around 64% of hospitals had files with inadequately associated prices, and 69 hospitals had no usable standard charges files at all. Moreover, several hospitals that were compliant in earlier reports were found to be non-compliant in the most recent assessment.

Surprisingly, even major health networks like HCA Healthcare, Tenet Healthcare and others have not achieved full compliance. Conversely, some improvements have been observed in hospitals owned by CommonSpirit Health, Community Health Systems and Kaiser Permanente.

To address the persisting compliance issues, CMS plans to intensify enforcement through the Outpatient Prospective Payment (OPPS) rule. This includes requiring high-ranking hospital officials to certify the accuracy of machine-readable files. Penalties for incorrect or misleading information could reach up to $2 million, incentivizing hospitals to enhance their reporting accuracy.

PatientRightsAdvocate.org suggests that CMS should reform enforcement strategies, share the compliance process publicly, and use payer disclosures to validate hospital price data. These steps aim to bolster transparency, allowing patients to make informed decisions about their health care.

Read the report here.

# DATAWATCH

# Rural Americans Struggle with Health Care Costs

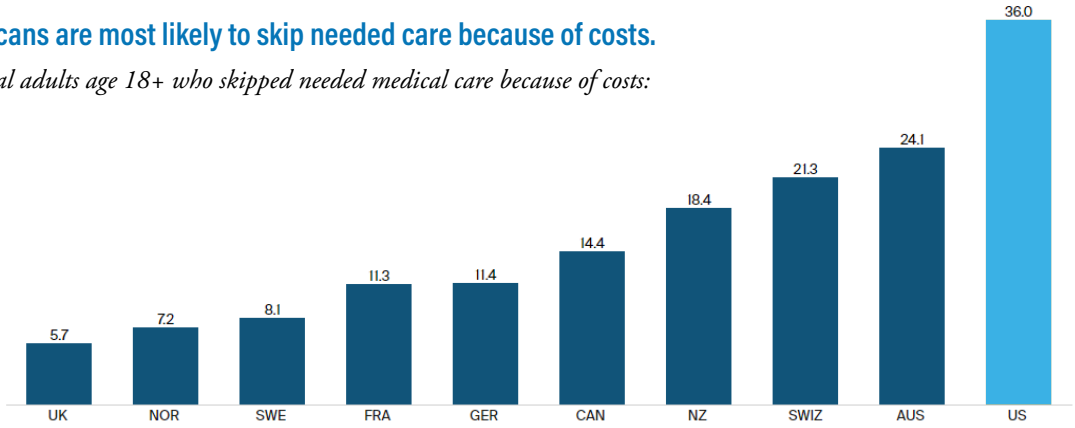
Recent research from The Commonwealth Fund's 2020 International Health Policy Survey reveals the stark disparities in health access and affordability across rural America. The survey, comparing the situation in the U.S. with 10 other high-income countries, paints a grim picture.

Approximately 15% of the U.S. population resides in rural areas, where higher rates of chronic diseases, limited access to care and elevated suicide rates are prevalent. Perhaps most concerning is the number of rural Americans struggling with medical bills and health care affordability. Compared to residents in the analyzed countries, rural Americans are more than twice as likely to skip necessary medical care due to financial concerns. In countries like the UK, Norway and Sweden, this rate is significantly lower.

This is compounded by the lack of universal health care coverage in the U.S. Unlike its peers in the analysis, the U.S. lacks a comprehensive health care system, leaving a considerable portion of the rural population uninsured or underinsured. Access to health care is vital, but merely possessing insurance falls short if rural communities lack a well-established health care infrastructure.

## Rural Americans are most likely to skip needed care because of costs.

*Percent of rural adults age 18+ who skipped needed medical care because of costs:*




***Source:*** Munira Z. Gunja, "Rural Americans Struggle with Medical Bills and Health Care Affordability," To the Point (blog), Commonwealth Fund, July 24, 2023. https://doi.org/10.26099/pq3a-k123


PULSE

is a monthly bulletin that contains information important to health care credit and collection personnel. Readers are invited to send comments and contributions to:

**Communications Department**
**ACA International**
**3200 Courthouse Lane**
**Eagan, MN 55121**
comm@acainternational.org

ACA® INTERNATIONAL
The Association of Credit and Collection Professionals