



Financial Navigation for People Undergoing Cancer Treatment

02.2018

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TABLE OF CONTENTS

Introduction	3
Cancer Prevalence and the Cost of Treatment	3
Increased Insurance Cost-sharing Requirements	4
The High Out-of-pocket Burden of Cancer Treatment.....	5
The Risk of Bankruptcy.....	6
Employment Challenges.....	6
Financial toxicity	6
Effects on Treatment Adherence	7
Impact on Quality of Life	8
Potential Limitations of Financial Assistance Programs	8
Financial Navigation: A comprehensive Approach	9
Financial Navigation Services.....	9
Financial Navigators: The Program Lynchpin.....	10
Education and Background.....	11
Benefits for Health Systems and Patients	12
Implementation Considerations	13
Stakeholder Support	13
Financial Contributions	13
Proactive Patient Identification	14
Staff Training and Tools.....	14
Case Studies	14
Advocate Sherman Hospital	15
Aurora Health Care	15
Green Bay Oncology.....	15
Mercy Health Saint Mary’s	16
Munson Health Care	16
St. John Providence.....	17
Attachment A: Michigan Cancer Consortium Survivorship Workgroup Subcommittee Members	18
References	19

This report was supported by the Grant or Cooperative Agreement Number, DP15-1501, funded by the Centers for Disease Control and Prevention (CDC). Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the CDC or the Michigan Department of Health and Human Services.

INTRODUCTION

The impact of cancer goes far beyond its physical effects. Many cancer patients endure significant financial and personal hardships because of the high costs associated with cancer treatment. High cost-sharing requirements, especially for those who are uninsured or underinsured, as well as reduced income during and after treatment, can lead many to experience financial distress or toxicity—defined as the adverse impact on a patient’s well-being due to out-of-pocket healthcare costs related to cancer treatment.

In November 2016, the Michigan Cancer Consortium (MCC) held its annual meeting, during which the topics of financial toxicity and financial navigation were discussed. The discussion piqued the interest of health system representatives who asked for more information about the need for financial navigation programs and how to develop and implement such programs. The Michigan Department of Health and Human Services, with members of the MCC Survivorship Workgroup, formed the Financial Navigation Subcommittee to address these questions. The subcommittee comprises hospital administrators, financial navigators, and members of the MCC Survivorship Workgroup. A list of the members is available in Attachment A.

The following white paper, which describes the purpose and benefits of comprehensive financial navigation programs, is the result of the subcommittee’s work. This paper offers information on cancer prevalence and treatment costs, the effects of financial toxicity, current approaches to financial counseling, and comprehensive financial navigation as a promising practice that can provide benefits to patients and health systems. It also provides examples of successful financial navigation programs in cancer centers, hospitals, and health systems in and outside of Michigan to give those interested in implementing such programs a sense of the potential benefits for patients and health systems alike.

CANCER PREVALENCE AND THE COST OF TREATMENT

Cancer is extremely prevalent in Michigan and in the United States (U.S.). According to the American Cancer Society (ACS) (2017), nearly 1.7 million people in the U.S. and 57,600 in Michigan will be diagnosed with cancer in 2017. Due to advances in cancer detection and treatment, however, the survival rates of those diagnosed have increased significantly for many types of cancer (ACS 2017). In 1971, 3 million people, or about 1.4 percent of the population, had cancer at some time in their lives (CDC 2014). As of 2016, this number had grown to over 15.5 million, or about 4.8 percent of the population (ACS 2017; U.S. Census Bureau 2016). In Michigan in 2016, an estimated 7.0 percent of adults reported having ever been told by a doctor that they had some form of cancer other than noninvasive skin cancer (Fussman 2017).^A

^A Skin cancer does not have to be reported to the state and is not tracked nationally. When those who report being diagnosed with skin cancer and those who report being diagnosed with any other form of cancer are combined, about 11.8 percent of people report having been told they have cancer (Fussman 2016).

The cost of cancer treatment is staggering. New cancer treatments, targeted therapies, and specialized medicines all contribute to high treatment costs. Those with cancer may undergo surgery, radiation treatment, intravenous chemotherapy, in addition to numerous scans, bloodwork, and doctor visits. The cost of this care adds up quickly. The Cancer Action Network—the nonprofit, nonpartisan advocacy affiliate of the ACS—estimates that in the U.S. in 2014, employers, insurance companies, individuals, families, the U.S. government, and taxpayer-funded programs collectively spent \$87.8 billion on cancer-related healthcare costs (Singleterry 2017). Over half of these treatment costs come from doctor and outpatient hospital visits, and over a quarter of the costs come from inpatient hospital stays (ACS 2018).

INCREASED INSURANCE COST-SHARING REQUIREMENTS

For many, health insurance will cover a significant portion of the cost of cancer treatment. Most people in Michigan have some type of healthcare coverage, with only about 6 percent of all people and just under 8 percent of those 18–64 years of age being uninsured (U.S. Census Bureau 2015a).

Unfortunately, health insurance does not always cover as much of the cost as expected or needed, depending on the plan’s provider network, coverage of services, and cost-sharing requirements—including deductibles, copays, and coinsurance (all of which patients are required to pay until their out-of-pocket maximum is reached).

According to The Henry J. Kaiser Family Foundation (KFF) (2015, 2016), people with employer-sponsored health insurance, which includes most people in the U.S. and in Michigan, saw deductibles increase from an average of \$303 in 2006 to an average of \$1,077 in 2015. In fact, 51 percent of people with employer-sponsored health insurance had a deductible of \$1,000 or more in 2016, compared to only 10 percent in 2006, and a growing number of people have deductibles of \$3,000 or more (KFF 2016; Collins et al. 2015). Copayments for office visits have also increased: more than 25 percent of people with employer-sponsored insurance had copays of \$30 or more in 2015, compared to just 8 percent in 2006 (KFF September 2015).

Income and wages, however, have not kept up with the cost increases of healthcare, meaning those with health insurance pay significantly more for their coverage than in the past (KFF 2016; KFF September 2015). Even though less than 10 percent of Americans are uninsured, an estimated one-third of Americans report difficulty paying their medical bills (U.S. Census Bureau 2015b; Pollitz et al. 2014). The 2014 Commonwealth Fund Biennial Health Insurance Survey found that 23 percent of insured adults incurred out-of-pocket costs that were 10 percent or more of their annual household income. These findings indicate that many Americans are underinsured. A person who is underinsured has healthcare coverage with out-of-pocket cost-sharing (excluding the premiums) that is greater than 5 or 10 percent of their income, depending on their income level, or a deductible that is 5 percent or more of household income (Collins et al. 2015).

The use of multitiered cost-sharing prescription plans—plans with multiple levels of costs depending on the prescription being covered—has also increased in the last decade, going from 3 percent in 2004 to 25 percent of all prescription plans in 2013 (PDQ Adult Treatment Editorial Board 2017). This is due in part to the introduction of new, expensive pharmaceutical drugs, which insurers are often required to cover. To cover the medication, they pass some of the cost on to the patient. If, for example, someone is prescribed a drug that costs \$1,000 and they have a 10 percent coinsurance, they are required to cover \$100 of the cost.

THE HIGH OUT-OF-POCKET BURDEN OF CANCER TREATMENT

Cancer survivors, when compared to those without a history of cancer, are more likely to report having a high out-of-pocket burden. A 2014 review of the Medical Expenditure Panel Survey (MEPS) data from 2008 to 2012 shows that 4.3 percent of cancer survivors report high out-of-pocket burden compared to 3.4 percent of those without a cancer history.^B This report also found that those diagnosed recently (within the last year) had average yearly out-of-pocket costs of \$1,107; those diagnosed more than a year ago averaged \$747; and those without any cancer history averaged \$617 (Guy et al. 2013). Another study found that being treated for cancer increases the mean annual out-of-pocket medical expenditures by \$1,170 when compared to those who do not have cancer (Finkelstein et al. 2009). Cancer survivors who are on public insurance, are uninsured, or have low incomes are even more likely to report a high out-of-pocket burden (Guy et al. 2015).

Cancer survivors are also more likely than those without a history of cancer to face difficulties obtaining necessary medical care (19.2 percent compared to 12.5 percent), delay necessary medical care (21.6 percent compared to 13.8 percent), and have lower breast cancer screening rates (63.2 percent compared to 75.9 percent). (Guy et al. 2015).

Depending on a person's health insurance, oral cancer drugs may be covered under a plan's prescription drug benefit. More and more often, however, they are included in a specialty tier of drugs at the plan's highest level of cost sharing, often through coinsurance. The prices of new cancer drugs are regularly over \$100,000 and can be higher than \$150,000 per year (Zheng et al. 2017; Moninger 2017). While federal law caps annual out-of-pocket maximums^C at \$7,150 for an individual and \$14,300 for a family in 2017, these maximums increase each year. In 2017, the individual and family plans were raised by \$300 and \$600 over the 2016 maximums, respectively, and are expected to increase by \$200 and \$400 in 2018 (U.S. Centers for Medicare and Medicaid Services n.d.; U.S. Centers for Medicare and Medicaid Services 2016).

^B High out-of-pocket burden was defined as spending more than 20 percent of annual family income on healthcare costs.

^C The annual out-of-pocket maximum is the maximum amount an individual or family would be required to pay toward their healthcare in a given year, excluding their insurance premium.

Additionally, prescription benefits may not be included in this limit—depending on the plan (U.S. Centers for Medicare and Medicaid Services n.d.). Some Medicare prescription drug plans, for example, have no out-of-pocket maximums for prescriptions and require coinsurance toward each filled prescription. A five percent coinsurance on a drug that costs \$10,000 per month is over \$500 each month.

THE RISK OF BANKRUPTCY

In 2014, individuals and families collectively spent about \$4 billion in out-of-pocket costs for cancer treatment (Singleterry 2017). These costs can be a major financial burden for those undergoing treatment and can lead to mounting medical debt—often cited as a leading cause of bankruptcy—even for those with health insurance (Pollitz et al. 2014). People undergoing cancer treatment or have undergone treatment are at an increased risk for bankruptcy. A study in the state of Washington found that cancer patients within one year of diagnosis are about 3.5 times more likely to file for bankruptcy and 2.7 times more likely to file for bankruptcy within five years of diagnosis than control groups (Ramsey et al. 2013). Younger adult cancer patients had bankruptcy rates two to five times higher, depending on the type of cancer, and women and unmarried adults with cancer were also at higher risk of bankruptcy (Ramsey et al. 2013).

EMPLOYMENT CHALLENGES

A third of cancer survivors reported that the disease interferes with daily activities (de Boer et al. 2009). Many survivors are unable to work while undergoing treatment and may need to reduce their hours or leave their job altogether. Some struggle to rejoin the workforce even after treatment. Cancer survivors are more likely to report an inability to work, miss more work days, and spend more days in bed because of their poor health. Cancer survivors under 60 years of age in the U.S. are 1.5 times more likely to be unemployed than those who never had cancer (de Boer et al. 2009). Employed survivors missed 22.3 more workdays per year than individuals without any cancer treatment. Additionally, cancer survivors reported that cancer interfered with both physical (25 percent) and mental tasks (14 percent) required by their jobs (CDC 2014). When a person becomes unemployed due to the effects of cancer treatment, they may also lose their employer-sponsored health insurance plan—unless they use COBRA^D—which allows them to retain their plan, but leaves them responsible for the full cost of the plan premium.

FINANCIAL TOXICITY

Escalating treatment costs combined with increased cost-sharing requirements and reduced income leads many cancer patients and survivors to experience significant financial strain. People use many

^D Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) allows qualified workers and their families who lose their health benefits the right to continue those benefits for a period of time under specified circumstances. The qualified individual may have to pay up to 102 percent of the cost of the plan. Employers with 20 or more employees are required to offer COBRA (U.S. Department of Labor n.d.).

different words to describe the stress of one's financial situation, such as financial or economic hardship, financial or economic burden, financial distress, or even severe financial stress; however, these terms do not fully capture the effect or consequences that financial strain has on their lives.

Financial toxicity is a term coined to describe the adverse impact of out-of-pocket healthcare costs on the well-being of people undergoing cancer treatment. It refers to the patient's experience with the cost of treatment—a combination of the actual financial costs as well as the residual financial distress of those costs (Zafar and Abernethy 2013; Sherman 2014). Some people are more likely to experience financial toxicity than others based on certain risk factors, including personal income, preillness debts, assets, illness- and treatment-associated costs, ability to work during and after treatment, availability of health and disability insurance, and income(s) of others in their household (Shankaran et al. 2012). Financial toxicity can reduce treatment adherence, increase bankruptcy rates, and decrease overall quality of life.

EFFECTS ON TREATMENT ADHERENCE

Clinicians focus on ensuring their patients receive the best and most appropriate treatment regimens, but ignoring treatment costs may lead to treatment nonadherence. High treatment costs may prevent a person from fully participating in their treatment and may ultimately affect their outcomes.

Patients with high out-of-pocket responsibilities are at increased risk for not adhering or refusing recommended treatments (Zafar et al. 2013). In a survey of 300 adults at Duke Cancer Institute, 27 percent of respondents reported not adhering to their recommended prescriptions by skipping doses (55 percent), taking less than prescribed to make the prescription last longer (43 percent), or not filling a prescription because of the cost (86 percent) (Bestvina et al. 2014).

Several studies found that high copays are barriers to prescription drug adherence. One study stated that patients facing copays or coinsurance costs amounting to \$500 or more for a single prescription were four times more likely to not fill their prescription than those with costs of \$100 or less. Patients who had to fill five or more prescriptions were up to 50 percent more likely to stop taking their medications than those who had to fill fewer prescriptions (Blesser Streeter et al. 2011). A study of one cancer drug identified that those with the highest copayment amounts were 70 percent more likely to discontinue use of the drug within 180 days than those with the average or lowest copayment amounts (Dusetzina et al. 2014). Another study on a cancer inhibitor for women with early stage breast cancer found that women who had a copayment of \$90 or more for a 90-day medication supply were less likely to take their medication as prescribed, either by having a gap in their supply or by not taking it at least 80 percent of the days it was prescribed for (Neugut et al. 2011).

A 2017 study found that adults diagnosed with cancer were more likely to have a change in their prescription drug use—defined by skipping doses, delaying refilling prescriptions, taking less than

prescribed, requesting a lower-cost medication, purchasing medication from another country, or by using an alternative therapy—than those without a cancer history (Zheng et al. 2017).

IMPACT ON QUALITY OF LIFE

Several studies found that financial burden among those diagnosed with cancer affects their quality of life and well-being (PDQ Adult Treatment Editorial Board 2017; Chino et al. 2017). For example, people undergoing cancer treatment may reduce spending on necessities, such as food and clothing, or sell their possessions or property to cover treatment costs (Zafar et al. 2013; Meeker et al. 2016). Respondents to the 2010 National Health Interview Survey who reported that cancer caused many financial problems were much more likely to report poor mental health, poor satisfaction with social activities and relationships, and were less likely to describe their quality of life as good (Fenn et al. 2014). In a 2011 MEPS survey, those who reported having cancer-related financial burdens were also more likely to report a depressed mood and a greater likelihood of cancer-recurrence worry (Kale and Carroll 2016). Another study found that financial distress was inversely correlated with quality of life for those with advanced cancer, including rates of depression and anxiety, meaning that the higher the patient rated their financial distress, the lower they rated their quality of life (Delgado-Guay et al. 2015). Additionally, a study in Ireland found that the risk of depression was three times higher for those experiencing cancer-related financial stress (Sharp, Carsin, and Timmons 2012).

POTENTIAL LIMITATIONS OF FINANCIAL ASSISTANCE PROGRAMS

Though most cancer programs offer some form of financial counseling or assistance, they provide a limited scope of services to a limited population. Assistance may be focused on one specific episode of care rather than on the patient's overall planned treatment regimen. According to The Association of Community Cancer Centers (ACCC) (2014), though cancer programs may assist patients in obtaining health coverage, completing applications for hospital assistance or charity programs, and/or helping patients with insurance preauthorizations, they may focus solely on the uninsured—thus not adequately assisting those who are underinsured.

Frequently it is left to the patient to learn about and reach out to available assistance programs. Studies show that most patients avoid discussing the cost of their treatment with their physicians as it relates to their financial situation (Bestvina et al. 2014; Shankaran et al. 2012). Even if patients are aware of financial assistance options, they may not realize they need help until they begin receiving medical bills, by which time it may be more difficult to access available assistance programs.

By not taking a comprehensive view of a patient's needs, these programs may cause additional harm to patients by not offering appropriate options to the patient's unique situation. For example, if there is no comprehensive review of the insurance coverage options for patients and they are simply enrolled in Medicaid, the patients may find that they have a significant spend-down requirement—the amount of income a person must spend every month on medical expenses before they qualify for Medicaid

coverage—making the cost of care virtually unaffordable. But, because they are enrolled in coverage, they may not qualify for other supports.

The Advisory Board Company's Oncology Roundtable (2014) report states that most hospital financial counseling options are fragmented, with too many responsibilities divided up among registration staff, social workers, insurance navigators, and clinicians. As a result, cancer programs miss opportunities to assist patients with their costs, as well as opportunities to improve their own program's revenues.

FINANCIAL NAVIGATION: A COMPREHENSIVE APPROACH

One promising option for preventing or alleviating financial toxicity is the provision of comprehensive financial navigation services. Financial navigation programs differ from more limited financial counseling or assistance programs by proactively reaching out to all cancer patients to assess their needs for services and working closely with the patient, the care team, and administrative staff to develop and carry out a plan that alleviates the financial burdens of undergoing cancer treatment. These programs may also ease some of the psychological strain associated with paying for treatment and other costs of living—which can negatively affect treatment adherence and emotional well-being. Health systems and cancer programs that have implemented such programs, described later in this report, have found that offering comprehensive financial navigation saves the hospital money as well.

FINANCIAL NAVIGATION SERVICES

Financial navigation programs are generally staffed by financial navigators who support patients by ensuring they can afford their treatments and assisting them with obtaining resources to minimize financial stress (Tobias and Ring 2014; Sherman 2014; The Advisory Board Company 2014). Navigators take a proactive approach in reaching out and developing comprehensive plans to meet each patient's unique needs. They help patients understand their insurance options and determine what is best for their situation (often referred to as insurance optimization). When appropriate, financial navigation program staff can help patients apply for financial assistance that partially or completely covers the cost of medications and copays. If a patient has a medication with a copay they cannot afford, or their insurer is unwilling to cover it, financial navigation staff can connect them with drug replacement programs, which offer a free supply of the pharmaceutical drug. By working closely with the care team and administrative staff, the navigator ensures plans are carried out and adjusted as needed.

Financial navigation teams protect cancer program revenue by ensuring that insurance claims will be accepted by acquiring necessary preauthorization approvals, inspecting billing codes for accuracy, and including supporting documentation about medical necessity and recommended course of treatment, as needed. If a claim is denied, they quickly respond with additional information and recognized treatment guidelines, thereby increasing insurance reimbursement. They may also create individualized payment plans based on each patient's financial situation. This reduces the cost to the patient and increases the

likelihood they will be able to afford their portion of the treatment costs, which helps the cancer program avoid writing off the cost of the treatment.

Some cancer programs that provide this comprehensive array of services refer to their programs as financial assistance or counseling services. For the purposes of this paper, the Financial Navigation Subcommittee refers to this comprehensive approach as “financial navigation.” The subcommittee hopes that as the success and benefits of this approach become more widely recognized that the name, process, and role of financial navigators will undergo some level of standardization. Until such time, the subcommittee puts forth this information to promote what it considers best practice in financial navigation program delivery.

The information below describes and details the role of financial navigators, provides more information on the benefit of these programs for cancer programs *and* patients, and offers key considerations for implementing financial navigation programs—suggested by existing programs in the U.S.

FINANCIAL NAVIGATORS: THE PROGRAM LYNCHPIN

The following description of the role of a financial navigator is based on resources available through the Advisory Board Company’s Oncology Roundtable and the ACCC, documented examples of financial navigation programs, and a survey of existing programs conducted by the Financial Navigation Subcommittee for the purposes of this report.

Typical responsibilities of a navigator include:

- Seeking out patients to work with and assist, instead of exclusively working with uninsured patients or those who directly ask for assistance. This includes educating other cancer program staff and accounts receivable about financial navigation services, so they may refer patients they identify as needing financial support.
- Reviewing and verifying all new patients’ insurance status. This may need to happen on a regular basis, as insurance status may change over the course of treatment due to changes in employment status or other circumstances.
- Communicating with the patient about their insurance status, their benefit coverage (as it relates to their expected treatment plan), and the expected cost of the planned treatment. Studies find that patients are requesting this information more frequently from their providers (ACCC 2014).
- Using tools to assess a patient’s risk of financial toxicity or financial stress, such as the COmprehensive Score for financial Toxicity survey or The National Comprehensive Cancer Network’s (NCCN) distress management tool. These questionnaires measure patients’ distress levels related to cancer treatment and income (de Sousa et al. 2014; NCCN 2018).

- Completing insurance optimization to identify the best insurance for each patient's needs. This may include helping the patient apply for primary or secondary insurance, even if it is outside of typical open enrollment periods.
- Assisting patients in accessing financial resources to cover the cost of their treatment, if needed. These may include copay assistance programs, foundation support, drug replacement programs, or the cancer program, the hospital's charity, or financial assistance options.
- Completing paperwork for patients to apply for additional insurance, payment assistance, or drug replacement programs.
- Connecting patients to other available social or financial supports, such as counseling resources or assistance in covering basic living expenses, especially if they had to stop working or have a reduced income because of treatment.
- Creating payment plans with patients, based on their financial situation and expected treatment plan, to ensure they can pay for their portion of medical care.
- Sharing the payment plan with cancer program staff, such as clinic check-in staff, who may be responsible for collecting copays at the time of the visit.
- Monitoring for potential new patients by noting changes in insurance and working with accounts receivable to identify patients with missed payments or unpaid balances. An oncology program in Cincinnati, Ohio, for example, reviews all patient balances for those who have missed at least one payment and have a balance of \$750 or more (The Advisory Board 2014).

Navigators usually reach out to patients before treatment begins and then work with them for the duration of their treatment and, ideally, are viewed as a member of the care team, communicating with patients, the clinical team, the billing department, and office support staff. To help them work directly with the cancer team and patients, navigators are typically employed by the oncology program (rather than the billing department).

Other staff may be responsible for tasks that support a comprehensive financial navigation program but are not carried out by the financial navigator directly. These activities may include submitting and acquiring preauthorization approvals with documentation for medical necessity and appealing denials from insurers with research on documented treatment guidelines.

Education and Background

Education and background requirements for navigators can vary depending on the infrastructure and design of the financial navigation program. Although a specific person should be the main contact for an individual patient to build and maintain rapport and support service continuity, specific tasks may need to be spread across multiple roles. Financial navigators usually hold some type of postsecondary degree (associate's, bachelor's, or master's), but may have only a high-school diploma, depending on the specific needs or focus of the program. According to some survey respondents, it is rare that someone

with a high-school diploma would be fully prepared for this complex position, and those with a higher professional degree may be better suited to the work.

Because financial navigators are involved with many aspects of a patient's medical treatment, programs may emphasize the need for different skills. Some programs may look for someone with a medical billing background, as oncology billing can be detailed and complex. Having a firm understanding of these billing codes is essential to supporting successful claims submissions to insurers. Others may prefer someone with a medical background, so they understand the cancer treatment process. Another program may prefer staff who understand health insurance to support patients in accessing coverage. In other cases, a person with a background and connections in pharmaceuticals may help patients access drug replacement programs. A social work background could be helpful when working with families who need social services or assistance in connecting them with community resources, both financial and emotional, depending on their needs.

Representatives of existing financial navigation programs said it is essential for navigators to understand and have knowledge of all insurance and assistance programs available and how these programs work together. Navigators must also build rapport with patients, so patients will openly discuss their insurance and financial situations and come with any questions or concerns throughout their treatment.

BENEFITS FOR HEALTH SYSTEMS AND PATIENTS

Financial navigation programs do not typically generate revenue, which may leave some cancer program or hospital executives reluctant to invest in implementation. However, hospitals and health systems that have implemented comprehensive financial navigation programs have seen significant savings—well above the cost of employing a dedicated financial navigator because they are so effective at recovering and protecting revenue that may otherwise have been written off. Representatives of existing financial navigation programs who responded to the subcommittee's survey reported health system savings between \$760,000 and \$4 million annually. Other programs reported obtaining millions of dollars in free or reduced-cost prescriptions for their patients (Tobias and Ring 2014).

In addition to recovering and protecting revenue, financial navigators help patients meet their financial obligations, which reduces hospital charity care and makes the financial navigation programs more sustainable. Existing financial navigation programs report reducing out-of-pocket expenses for individual patients by a few hundred dollars to \$17,000, depending on the patient's needs. Many of the programs estimated saving each patient between \$2,500 and \$12,000 in out-of-pocket costs. The programs shared that their patients experience many emotional and psychological benefits as well. As one program representative said, "the gratitude and gratefulness patients share are indescribable."

IMPLEMENTATION CONSIDERATIONS

Several cancer program representatives described challenges they faced and lessons they learned when implementing a financial navigation program. These include considerations for building stakeholder support, documenting financial contributions, being proactive, and having adequate staff training and tools to support success.

Stakeholder Support

Several programs emphasized the importance of building support with all stakeholders before implementation. This can be done by explaining what financial toxicity is, how it affects treatment adherence, and how financial navigation can help patients and the cancer program. As one program representative reported, a health system or hospital may think that they are already providing support if they offer a financial assistance program, but there is often a difference between the level of assistance they are delivering and a comprehensive financial navigation program.

Survey respondents indicated that patients are unlikely to discuss their concerns about affording treatment costs with their care team, so physicians and others may be unaware of the financial distress patients experience. Strategies for increasing awareness and understanding of the issue include implementing a distress screening tool to identify the extent of need, review the extent to which treatment costs are written off or go through internal charity programs, and review patient accounts to identify whether patients are up to date on payments, what balances they carry, how many balances are sent to collections, and for what amount. This information can be used to build a case for program implementation and identify patients who need more assistance.

Hospitals may want to begin with a pilot program that allows cancer program executives to explore the potential benefits of financial navigation services before committing to a full program. One hospital that took this approach went on to save the cancer program over \$250,000 in less time than expected and, as a result, implemented the navigation services permanently (see Mercy Health Saint Mary's on page 14).

Financial Contributions

Once a financial navigation program is in place, program representatives recommend tracking as much data as possible, including detailed accounts of how much assistance is provided and by which organizations, companies, and foundations. This data can be used to calculate a return on investment to demonstrate the value of the financial navigation program, promoting sustainability or even expansion. Several program representatives indicated that they hired additional financial navigators over time due to programs' success.

Proactive Patient Identification

Program representatives recommend being as proactive as possible by identifying potential clients early on and even meeting with all new cancer patients to assess their likelihood for needing support. Programs report that this reduces larger financial issues in the long run, especially as financial distress can affect treatment adherence. Related to this, programs have found it necessary to regularly communicate with and educate the entire treatment team, including providers and the finance and billing departments, about the program to maintain consistent understanding and support and ensure patients are referred to financial navigation services appropriately.

Staff Training and Tools

Some programs stressed the importance of having staff who stay updated on insurance and financial assistance program information to effectively assist patients. Many existing programs highlighted the difficulties staff encounter in staying on top of constantly changing insurance options and prescription benefits. Some of these challenges include yearly fluctuations in insurers' offered plans; covered medications starting out on an insurer's approved list but moving off with little notice; and the variability in open enrollment periods. Additionally, assistance programs have differing eligibility criteria and time frames for accepting applications. One existing financial navigation program recommends using Vivor's PayRx Navigator (vivor.com), an online tool that identifies foundations from which patients may be eligible to receive assistance. The tool can also alert navigators when a foundation begins accepting new assistance applications, so they do not have to continuously monitor the program's status. Tailor Med (tailormed.com) and Assist Point (assistpoint.com) are other online tools that can help financial navigators identify sources of financial support for their patients.

Program representatives indicated that adequate training and support for the financial navigators is essential. Some recommend working with a qualified financial navigation trainer or learning from a successful program to support the staff in this complex role. Several organizations created tools to assist hospitals in developing this integral program and position. The ACCC and its Financial Advocacy Network have created (and made available online) a large array of resources to support individuals and programs in offering comprehensive and complete financial advocacy to their patients. More information and resources can be found at www.accc-cancer.org.

CASE STUDIES

The following are examples of financial navigation programs in Michigan and other states in the Midwestern U.S. Apart from Green Bay Oncology, the program descriptions come from information submitted through the survey conducted by the Financial Navigation Subcommittee.

Advocate Sherman Hospital

Advocate Sherman Hospital Cancer Center in Elgin, Illinois, implemented its financial navigation program in October 2015 and employs one full-time equivalent (FTE) oncology financial navigator. The hospital saw the need for this program because the stress screening tool it was using showed that many patients were struggling with financial or insurance distress, and nurses reported that patients were expressing concerns about their finances related to treatment.

The financial navigator meets with all new cancer patients to review their insurance status and out-of-pocket responsibilities. The program focuses on those who have Medicare, Medicaid, or no insurance, as well as those who have commercial insurance with a large out-of-pocket responsibility. They identify options to help mitigate patients' costs through insurance optimization, identifying copay assistance and medication assistance programs, and offering billing and financial assistance options. The financial navigator also monitors insurance claim denials. The level of assistance varies by patient, but the program has served over 650 patients since its inception.

Since January 2016, Advocate Sherman Hospital estimates the financial navigation program (housed in its cancer center) has saved the hospital \$1.5 million and its patients roughly \$2.5 million. While the level of financial help varies significantly, it has saved patients an average of \$3,900—with a savings range of a few hundred dollars to \$12,000. The program finds that, because of financial navigation support, cancer patients do not have to draw down their retirement savings or take other drastic financial measures to pay for treatment.

Aurora Health Care

Aurora Health Care, a nonprofit health system headquartered in Milwaukee, Wisconsin, has had a financial navigation program for about ten years, but formalized its processes over the past four. Instead of dedicated financial navigators, the program is composed of three departments that work closely together: the preservice, oncology social worker, and financial advocate teams. Preservice staff identify cancer patients at risk of financial distress by reviewing their out-of-pocket medical expenses, medical benefits, and treatment plan. Specially trained oncology social workers then work with referred patients to explore ways to reduce treatment costs and help with other nonfinancial needs. The financial advocate department is notified when a patient receives financial assistance, so their billing file can be appropriately monitored for insurance reimbursement, financial assistance opportunities, and payments made by patients according to the agreed-upon payment plan. These three departments work closely with the whole treatment team, including nurses and physicians, to receive referrals and provide comprehensive support to meet patients' financial assistance needs.

Green Bay Oncology

Green Bay Oncology in northeastern Wisconsin and the eastern Upper Peninsula in Michigan employs six financial counselors across six cancer centers with over 15 clinical staff, including oncologists, nurse

practitioners, and physician assistants. The financial counselors review insurance coverage; submit preauthorizations; review network providers; appeal insurance denials; submit all paperwork and apply for charity care, foundation assistance, pharmaceutical support, and hospital write off; order medications through the pharmacy, verify testing coverage, and work with social workers and nurses. They are the first point of contact for billing questions and discussing financial burden and payment options with patients (Green Bay Oncology 2017).

In 2015, Green Bay Oncology saved patients more than \$1 million in out-of-pocket expenses, and the hospital took in over \$436,000 from foundations and pharmaceutical copay cards. The amount of funding the hospital has taken in each year has increased since 2011, when it brought in about \$168,000 (Green Bay Oncology 2017).

Mercy Health Saint Mary's

The financial navigation program at Lacks Cancer Center at Mercy Health Saint Mary's in Grand Rapids, Michigan, started in 2008. The program has 1.6 FTE financial navigators who have served over 2,500 patients since the program's inception, which is about 30 percent of the cancer center's patient population. The program originated out of a recognition that cancer program staff responsible for addressing financial distress did not have the expertise to address the complex needs of patients. They identified a need to increase understanding of patients' financial challenges and train designated employees to work with patients on these issues.

The program's financial navigators identify patients in need and proactively assist them by optimizing their insurance and helping them apply for and receive support from external assistance programs. The navigators will work with any oncology patient, but they focus on those who are uninsured, underinsured, on Medicare, and those with stage IV cancer. The financial navigators focus on removing financial barriers for patients so that they can receive recommended treatment.

The Lacks Cancer Center saved the hospital over \$265,000 in its initial six-month pilot program and saved an estimated \$16 million since 2008 in costs that would have otherwise been written off or gone to their charity program (Sherman 2014). Additionally, out-of-pocket responsibilities were reduced by an average of \$5,000 per patient. According to program staff, patients reported that they have never seen a program like this before and say how helpful it is. The program has received national recognition for its proactive and creative approach to dealing with financial toxicity.

Munson Health Care

The Cowell Family Cancer Center at Munson Healthcare in Northwest Michigan has had a financial navigation program since September 2013 and employs two financial navigators. The cancer center started the program because they saw patients struggling with financial distress. Financial navigators assist uninsured and underinsured oncology and hematology patients as well as any patient undergoing infusion. They are the main point of contact for these patients and act as a liaison between the patients

and the physicians, social workers, nurses, the business office, and the pharmacy. The financial navigators conduct insurance optimization, help with necessary insurance and assistance program enrollments, and work to obtain financial assistance through foundations, pharmaceutical companies, as well as internal funding supports. They are a part of a multidisciplinary team and attend tumor board meetings and multidisciplinary clinics to identify potential clients. They serve about 20 percent of the cancer center's patient population, which is about 250 patients per year.

Since September 2013, the Cowell Family Cancer Center financial navigation program has saved an estimated \$4 million each year, with a total savings of approximately \$12 million since the program's inception. It estimates having saved patients an average of \$17,500 in out-of-pocket medical expenses. According to staff, their program receives high patient satisfaction scores and positive personal letters from patients expressing gratitude for the financial support they received.

St. John Providence

St. John Providence in Southeast Michigan has had a financial navigation program since May 2011 and employs two full-time oncology financial counselors to work with cancer patients with no insurance, on Medicaid, have Medicare only, or those with high out-of-pocket costs to advise and assist them with accessing available financial assistance programs. The counselors work with about 500 patients each year, which they estimate to be about 25 percent of the health system's cancer population. The counselors work with the medical team to ensure patients have access to and receive all necessary medications for their treatment. They have found that because of this support, patients are staying on their medications and adhering to their treatment plans, which they believe can potentially lead to a longer life.

The financial counseling program at St. John Providence saves the hospital an estimated \$2 million each year with a total of \$10 million saved since the program's inception in 2011. The program saves patients an average of \$2,500 in reduced drug and treatment costs. According to program staff, patients are very appreciative of this assistance, and some have said that they do not know how they would have been able to continue treatment if they did not receive assistance with costs, including prescriptions.

ATTACHMENT A: MICHIGAN CANCER CONSORTIUM SURVIVORSHIP WORKGROUP SUBCOMMITTEE MEMBERS

Louise Bedard, Michigan Oncology Quality Consortium

Shelley Corp, St. John Providence

Deb Doherty, Chairperson of Michigan Cancer Consortium Survivorship Workgroup

Pat Gavin, cancer survivor and advocate, Michigan Cancer Consortium Survivorship Workgroup member (Pat Gavin died December 18, 2017)

Kathy LaRaia, Munson Medical Center

Catherine Patterson, St. John Providence

Thomas Rich, American Cancer Society, Michigan Cancer Consortium Survivorship Workgroup member

Dan Sherman, Mercy Health Saint Mary's, Lacks Cancer Center

Julie Hammon, Oaklawn Hospital

Debbie Webster, Michigan Department of Health and Human Services

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