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Oct. 12, 2022

The Honorable Patty Murray
United States Senate
154 Russell Senate Office Building
Washington, D.C. 20510

Dear Senator Murray:

Caring for those who are poor and vulnerable is the heart of the Providence mission. Thank you for the opportunity to provide additional information about this enduring commitment, which we have held sacred for more than 165 years.

As one of the oldest institutions in the state of Washington, Providence was founded by a group of courageous women who braved the Western frontier to build the region's first hospitals. Today, thanks to the dedication of our 120,000 caregivers, the legacy of our founding Sisters continues to touch lives in diverse communities across seven Western states. Each year, Providence delivers high-quality, affordable care to more than 5 million people from all walks of life.

Our commitment to those in need has never been stronger – even as we sustain significant operating losses from the pandemic. This includes nearly $1 billion in operating losses so far this year. **Despite these financial challenges, in 2021, we provided $1.9 billion in community benefit, which is $366 million higher than before the pandemic. Our community benefit in 2021 included providing charity care to 266,000 individuals in need and $1.2 billion in uncompensated Medicaid costs.**

Thanks to your leadership, the Affordable Care Act and Medicaid expansion are largely working as intended. More people in our communities who would have previously qualified for charity care are now covered by Medicaid. **As a leading advocate for these policies, Providence is proud that six of the seven states we serve are Medicaid expansion states. While this has caused our charity care numbers to decrease slightly over the years, we have seen an increase in unpaid Medicaid costs, which as you know was an expected outcome of Medicaid expansion.** Other large nonprofit health systems serve in states that have not expanded Medicaid, which may explain why their charity care levels may be slightly higher.

The process of billing and helping patients navigate their insurance coverage is one of the most complex aspects of health care in the U.S. It has become even more challenging in recent years as insurers and employers shift more of the burden onto patients, requiring individuals to pay higher out-of-pocket costs. This puts providers like Providence in the position of having to help patients figure out what is due and carry out the collection of payment, which is required by law and per our insurance contracts. As a physician of 43 years, I would much rather keep the focus on clinical care and healing, instead of seeing our caregivers spend so much time on the billing and payment process.

Still, we absolutely understand how stressful it can be to deal with medical bills. **We don't want financial hardship to ever get in the way of access to care or the healing process, and we are proud that our charity care policies implement, and in many cases exceed, federal and state requirements.** We communicate about the availability of financial assistance multiple times throughout a patient's journey with us and have compassionate and knowledgeable financial counselors available to assist patients with the application process.

Health care is a uniquely human endeavor, and we are by no means perfect. We are continuously working to improve on behalf of our patients and have been on a journey for the last two years to ensure our billing and collections practices are fully aligned with our values as a Catholic health care ministry.

Specifically, in responding to the Office of the Attorney General in Washington state, we came to understand an error that caused some Medicaid enrollees to receive collections notices and make payments to collection agencies. That is not consistent with Providence policy, and we fixed it as of December 2021. Based on an initial review, we are currently issuing refunds with interest to patients who made payments after being sent to collections and are continuing to do further evaluation of every patient account affected by this error.

We have also reviewed and improved our practices around the use of third-party agencies for collections. In recent years, we have gone from having 17 agencies to two, and have provided clear instructions to these agencies that they are not to engage in any aggressive tactics, such as reporting to credit bureaus, garnishing of wages, charging interest or initiating lawsuits or liens.

Thank you again for the opportunity to respond to your questions. We take these matters seriously and appreciate the offer to engage with you on these important issues. We look forward to a continued partnership as we provide care to 1.6 million patients in Washington state and serve as one of the state's largest employers. Our patients and caregivers are at the heart of everything we do, and we are committed to continuous improvement to ensure we are supporting them and easing their way. If your office has any questions or needs additional information please contact, Jacquelyn Bombard, Executive Director of Federal Relations, at Jacquelyn.Bombard@providence.org or 512.569.3105.

Sincerely,

Rod Hochman, M.D.
President and CEO
Providence

PROVIDENCE RESPONSES

Q1. For each year from 2017 to 2022, please provide the following information: How many patients qualified for free or discounted care? How many patients listed Medicaid as their primary or secondary insurer? How many patients were on a payment plan with Providence or third-party contractors? How many patients did Providence refer to debt collection services? How much, in total, did Providence receive from those patients? How much, in total, did Providence pay to debt collectors for pursuing those patients?

Over the last five years, Providence proudly served an average of 226,000 individuals per year who qualified for free or discounted care and an average of 620,000 individuals per year who listed Medicaid as their primary or secondary insurer. Regarding our payment plans, these are interest-free plans available to patients who are not eligible for complete financial assistance or who choose not to take advantage of assistance. Many patients who choose this option have told us they appreciate the ability to pay their balance over time without interest as opposed to paying the entire balance at once or utilizing credit cards to finance their health care. Regarding the use of third-party collections agencies, this is a common practice used by a majority of all health systems nationwide as a more efficient way to resolve hard-to-collect balances from those who have the ability to pay. By engaging a third-party who specializes in collections, it frees up our caregivers to focus on communicating with patients upfront and building relationships with them. It is also a more cost-effective option, and the amount we spend to engage these agencies is consistent with, if not lower than, national benchmarks. Per Providence policy, patients who are identified as charity care or Medicaid eligible are *not* to be sent to collections. Providence utilizes a presumptive screening tool for specific populations to identify those who may be of highest need. This measure is above the requirements of the law. If the screening indicates the patient likely qualifies, we apply presumptive charity and write off the balance as charity care. As noted earlier, we are continuously improving our practices around the use of third-party agencies. In recent years, we have gone from having 17 agencies to two and provided clear instructions to these agencies that aggressive tactics are not to be used. We are also continuing to improve our upstream communications and interactions with patients, which will help to increase understanding of their financial situation and decrease the use for third-party collection agencies downstream.

Q2. How much total charity care has Providence provided in each year from 2017 to the present? Please include: Providence's methodology for calculating charity care; the services included in that calculation; and the amount of charity care provided for each service included in the calculation.

Over the past five years, Providence has provided a total of $1.4 billion in charity care. This includes $260 million in 2017, $303 million in 2018, $303 million in 2019, $276 million in 2020 and $271 million in 2021. This is calculated based on a cost to charge ratio methodology. Providence follows the Internal Revenue Service Form 990, Schedule H guidance in calculating its cost to charge ratio. This ratio is then applied to all charges for patients identified as eligible under the financial assistance policy to determine the total cost of charity care.

Q3. What policies determine whether to refer a patient to debt collection services? Do those policies include income thresholds and determinations of need? Please provide a copy of any such policies and procedures.

The Providence policies regarding financial assistance and bad debt assignment determine whether to refer an individual to a third-party agency. Individuals determined eligible for charity care or Medicaid are not to be referred to collections. The income threshold for charity care eligibility varies by state. In Washington state, for example, our policy is more generous than Washington state law requires. Per our policy, patients in Washington with household incomes of up to 300% of federal poverty level qualify for a 100% discount while patients with incomes of between 301% and 400% qualify for a 75% discount. Prior to sending any account to a third-party agency, the policy requires Providence to make reasonable efforts to inform patients of the availability of financial assistance. Providence utilizes a presumptive screening tool for specific populations to identify those who may be of highest need. This measure is above the requirements of the law. If eligibility is likely, those identified are not sent to collections and their balance is written off as charity care. The bad debt assignment policy also makes clear that aggressive tactics, such as credit reporting, garnishing or liens, are not to be used with any patient regardless of income level. In addition, Providence championed recent laws in Oregon and Washington that increased charity care eligibility and will continue these advocacy efforts across our states and at the federal level. This is in line with our historic advocacy to guarantee access to health care for every individual. We fundamentally support more individuals having access to Medicaid and/or charity care relief.

Q4. ***What policies determine how Providence or any third-party contractor determines the terms of payment plans for Providence services? Do those policies include income thresholds and determinations of need? Please provide a copy of any related policies and procedures.***

Providence payment plans are interest free and are available to those who are not eligible for full charity care or choose not to use charity care. Terms are based on the unique circumstances of each individual and depending on how much is owed. For example, balances of less than $200 are typically placed on a four-month interest-free payment plan while balances of greater than $3,000 are typically placed on an 18-month interest-free plan. However, our financial counselors are available to work with patients to design terms that best meet their unique needs.

Q5. ***What is the application process for patients to receive financial assistance or charity care? What policies and practices are in place to ensure patients are aware of financial assistance programs? At what point during patients' visits do Providence employees make patients aware of those programs? Please provide a copy of any such policies and the procedures for providing patients with information about those financial assistance programs.***

All patients can apply for financial assistance at any time by submitting a completed application and providing the required documents to confirm income for the family members in their household. A written determination is provided to applicants following completion of the application. Our Financial Counselors are available to assist patients through the entire application process from start to finish.

Providence widely communicates about the availability of financial assistance and has a team of financial counselors available to assist patients with the process. We recognize that navigating the health care system can be overwhelming and that people may be afraid to ask for help with medical bills. That is why we make every effort to make patients aware of the opportunity for free or discounted care, including: *at the time of admission and discharge, on all billing statements from Providence and our third-party agencies, our web sites, signage in inpatient and outpatient areas, discussions with patients, and information translated into multiple languages.* In addition, all our hospitals have dedicated personnel available to assist patients in completing the financial assistance application and determining eligibility for assistance from Providence or a government-sponsored insurance program.

Q6. How does Providence ensure that all patients eligible for free or discounted care are informed of their eligibility and ability to request financial assistance? What processes are in place to ensure that Providence does not improperly bill such patients for their care? Does Providence conduct audits to specifically ensure these patients receive the full financial assistance for which they are eligible, and that patients are not improperly billed? Please provide any related policies, procedures, and information on related audits.

As referenced in Q5, Providence proactively communicates the availability of financial assistance in numerous ways and strives to engage with patients early to determine the need for assistance. However, it is not always possible to have these conversations in the moment given the urgency of some medical situations. In such cases, we prioritize getting patients the care they need and follow-up with them after the fact regarding their bill and the options for financial assistance. Unfortunately, for any number of reasons, we may not always hear back from the individual. If patients do not respond to tell us they need financial help, we proceed with the normal billing process, which includes a reminder on every statement about the availability of financial assistance and to contact us to apply. When patients do respond, we work with them to get them approved for assistance and adjust their balance and forgive the debt accordingly. If an uninsured patient has not applied for financial assistance and a balance is outstanding at 120 days, Providence voluntarily screens the individual for financial aid eligibility. This screening is a service Providence chooses to provide, above and beyond what is required by state law. If the screening indicates the individual is likely eligible, the balance will be written off as presumptive charity.

Q7. Please provide a description of any policy and training changes, if any, Providence has implemented or intends to implement to ensure low-income patients are promptly informed of their eligibility for free or discounted care and that they receive the full discount for which they are eligible

As noted in Q5, Providence communicates widely about the availability of financial assistance throughout the patient journey, and we continue to improve the billing process to make the notification of financial assistance prominent and clear. In addition, we have been actively raising awareness about how individuals in our communities can access free or discounted care at Providence through social media, blogs and other channels.

The Rev Up program referenced in recent New York Times coverage and by the Office of the Attorney General in Washington state was a short-lived, limited program that no longer exists. The intent was not

to target those in financial distress. Rather, it focused on helping those who are commercially insured and have the means to pay, better understand their out-of-pocket costs. We acknowledge that the original training materials, and even the name Rev Up, were not consistent with our values. The training was modified over time to ensure the availability of financial assistance and our values of compassion and respect are prominent and clear. The original training materials are not in use today.

Q8. What processes are in places for Providence to write-off, forgive, refund the debt, or otherwise ameliorate the harm inflicted on patients who are eligible for financial assistance who were not properly informed of their eligibility?

As described above, we began issuing refunds with interest, after resolving an error that resulted in some Medicaid patients receiving collections notices and making payments to a third-party collection agency. According to Providence policy, this error should not have occurred, and we fixed it as of December 2021. We are currently issuing refunds with interest to the impacted patients. We are validating that, per Providence policy, this error did not negatively impact credit. However, in the event a credit impact did occur, we will work with the third-party agencies to reverse the negative impact.

Q9. ***How much did Providence pay to McKinsey & Company for producing the materials related to the creation, adoption, and implementation of the Rev-Up program? Which materials were distributed and used by staff and what changes, if any, were made to the materials?***

Like other not-for-profit health systems and organizations, Providence uses consulting services for a variety of reasons. Today, Providence has significantly scaled back the use of all consultants. One of the issues we were addressing at the time had to do with Revenue Cycle inefficiencies, which account for $400 billion of all U.S. health care costs. That's nearly a half a trillion dollars, or 15 cents of every dollar spent on health care. With insurance companies denying claims at astonishingly high rates, our caregivers are required to work even harder to get claims approved on behalf of our patients. Providence works with nearly 1,000 different health plans, each with different out-of-pocket costs and requirements. When we sought consulting services, many of our caregivers were still using faxes to communicate with the insurance companies or would be stuck on hold for hours trying to get authorizations for care. Because navigating insurance is complex, it can be challenging for patients to know what their portion of the bill will be, and we are continuously seeking to better support patients by improving transparency around costs. As noted earlier, the Rev Up program developed by McKinsey & Company was a short-lived, limited program that no longer exists.