April 2025 – Vol. 41 No. 4
Published for Health Care Providers by ACA International
www.acainternational.org

PULSE

Mayo Clinic and Minnesota AG Reach Settlement Over Charity Care Policies

The nonprofit system agreed to change its charity care and debt collection practices, though it did not admit wrongdoing.

The Minnesota attorney general's office announced a settlement with Mayo Clinic on March 14, addressing concerns over the nonprofit system's charity care and debt collection practices. The agreement requires Mayo Clinic to overhaul its policies, ensuring that eligible patients receive necessary financial assistance. It also prohibits Mayo from suing patients to collect debt other than in extraordinary circumstances.

"In exchange for their tax exemption, nonprofit hospitals are supposed to give back to their communities by providing free or reduced-cost health care to folks with low incomes," Attorney General Keith Ellison said in a release. "My office investigated Mayo Clinic and discovered that they were actively dissuading certain patients from seeking charity care. While this is disappointing, I am heartened by the substantial improvements Mayo Clinic has made to their charity care program, and I am grateful for their cooperation with our investigation."

The investigation, launched in 2022, was prompted by allegations reported in the *Rochester Post-Bulletin* that Mayo Clinic had sued patients who may have qualified for charity care to collect medical debt. The Minnesota attorney general's office found that Mayo Clinic's policies included barriers to patients' access to charity care and that the organization engaged in "aggressive" debt collection practices, contrary to the Minnesota Hospital Agreement.

The Hospital Agreement, which was renewed in August 2022 for a period of five years, covers all 128 nonprofit hospitals in Minnesota, including Mayo Clinic.

The settlement requires significant changes to Mayo Clinic's charity care and debt collection practices. Key provisions include:

- Providing charity care to patients with incomes up to 200% of the federal poverty guidelines, and offering discounts of 40% to 50% for patients with incomes up to 400% of the federal poverty guidelines.
- Screening certain patients to determine presumptive eligibility

Continued on pg 2

Trump Issues Executive Order cont. from page 1

for charity care, and providing discounts without requiring an application for those who qualify.
- Implementing a streamlined application process for patients who are not presumptively eligible.
- Prohibiting lawsuits to collect debt, except in exceptional circumstances, and requiring approval from Mayo's CFO before filing any lawsuit.

Yahoo! Finance noted that "Minnesota has been particularly bullish on attempting to hold hospitals to charity care obligations."

In 2023, Ellison investigated Minnesota-based Allina Health following reports the system was denying care to patients carrying high loads of medical debt. The system has since ended that policy. Minnesota also bolstered its charity care laws in 2023 to require hospitals to check whether patients are eligible for financial assistance before referring medical debt for collections."

Patient Collection Rates Declined in 2024

The collection rate from commercially insured patients dropped 3 percentage points between 2023 and 2024, according to recent findings.

A recent study from Kodiak Solutions revealed the collection rate for providers from commercially insured patients dropped by more than 3 percentage points, from 37.6% in 2023 to 34.4% in 2024. The decline is creating substantial revenue cycle management challenges.

Kodiak researchers attribute the decline to patients assuming greater financial responsibility through high-deductible health plans and other cost-sharing arrangements. While providers have attempted to offset these losses by improving point-of-service collections and bad debt recovery, they simultaneously face increasing resistance from insurance companies.

Initial claim denial rates climbed to 11.8% in 2024, marking the fourth consecutive year of increases. Commercial health plans and Medicare Advantage plans were the primary drivers of this trend, with both showing increased rates of initial request for information denials. Final claim denials held steady at 2.8%, though this rate remains 16.7% higher than in 2020.

What's Next?

To combat these challenges, health care providers are implementing innovative strategies.

"While our data suggest that these headwinds continue to gather strength, I am encouraged by the conversations that my colleagues and I are having with revenue cycle leaders across the country," Matt Szaflarski, vice president of Revenue Cycle Intelligence for Kodiak, said in a statement. "These leaders are using revenue cycle data to pinpoint problem areas and then developing creative solutions that will drive their revenue cycle performance in 2025."

A few of the initiatives Kodiak researchers suggested include:

- Enhanced patient education about health plan benefits and financial responsibilities
- Implementation of digital payment solutions and online billing systems
- Integration of clinical departments with revenue cycle operations
- Stronger payer contract language to reduce pre-payment denials

Health care organizations are focused on improving the patient financial experience through better communication and technology-driven solutions. These include offering payment plans, digital customer service options, and clearer explanations of benefits and costs before services are rendered. Read the study here.

NEWS & NOTES

HHS Workforce Reduction Plan Sparks Mixed Reactions from Health Care Organizations

The Department of Health and Human Services' plan to reduce its workforce by 20,000 employees and consolidate its divisions from 28 to 15 has drawn sharp criticism from health care organizations focused on senior care and Medicare. Leaders from Caring Across Generations and the Medicare Rights Center expressed deep concern about the impact on older adults, disabled individuals, and caregivers, warning that the restructuring could damage critical services and exacerbate existing challenges in the healthcare system. However, the National Association of Community Health Centers took a more collaborative stance, pledging to work with the Trump administration and new HHS Secretary Robert F. Kennedy Jr. on the proposed changes.

The restructuring plan includes closing half of HHS's regional offices and creating a new Administration for a Healthy America, which will combine several existing divisions into a single entity. The total workforce reduction will bring HHS staff numbers down from 82,000 to 62,000 full-time employees through various measures, including early retirement programs.

Read more here.

Proposed Medicaid and SNAP Cuts Could Cost Over 1 Million Jobs

A recent report from the Commonwealth Fund and George Washington University's Milken Institute School of Public Health reveals that proposed cuts to Medicaid and SNAP could have far-reaching economic consequences across the U.S. The analysis projects more than 1 million job losses nationwide, with state GDPs potentially shrinking by over $110 billion in 2026 alone. The cuts, proposed in the U.S. House of Representatives' budget resolution, would reduce federal funding by approximately $880 billion for Medicaid and $230 billion for SNAP over the next decade.

The impact would extend well beyond health care and food sectors, with nearly half of the job losses affecting other industries such as retail, construction, and services. The health care sector alone could lose 477,000 jobs, while SNAP reductions would eliminate 143,000 positions nationwide, according to the report. State and local governments would face an estimated $8.8 billion reduction in tax revenues, forcing difficult decisions about raising taxes or cutting services.

Medicare Advantage Growth Slows But Remains Strong in 2024

Medicare enrollment reached a record high last year, with a total of 34.5 million enrollees.

Medicare Advantage (MA) enrollment continued its upward trajectory during the 2024 annual enrollment period, according to a new analysis from Chartis and HealthScape Advisors.

The program reached a milestone with 34.5 million enrollees, representing 51% of the total Medicare population, despite growing at a more modest 3.9% compared to the 7-10% growth rates seen in the early 2020s.

The analysis revealed that MA plans added 1.3 million new beneficiaries, while Traditional Medicare gained approximately 200,000 beneficiaries, marking the highest overall Medicare program growth on record with 1.5 million new members. Special Needs Plans (SNPs) demonstrated particularly strong performance, growing by 10.1% and adding 665,000 members.

"Even with slowed growth, Medicare Advantage enrollment continues to show signs of strength, and it should for the foreseeable future," said Nick Herro, Chartis senior partner in strategic transformation. "Special Needs Plan popularity, anticipated regulatory support by the new administration, and consistent growth in the aging population present future growth opportunities and instill confidence in this market segment."

Health plan executives displayed increased confidence in the market, with 91% anticipating similar or improved performance in 2026, up from 74% the previous year. Additionally, 59% expressed a positive or extremely positive growth outlook, compared to 47% last year.

The total number of available plans declined by 1.6% to 5,581 plans in 2025, breaking from the five-year trend of 5.4% growth, according to the analysis. Health maintenance organizations remained dominant, representing 56% of the non-SNP MA market, while PPO plans maintained growth but showed signs of slowing expansion.

For-profit insurers continued their market dominance, controlling nearly three-quarters of the MA market. Meanwhile, nonprofit and provider-sponsored health plans experienced slight market share decreases, despite the overall growth in MA enrollment.

Read the full analysis here.

DATAWATCH

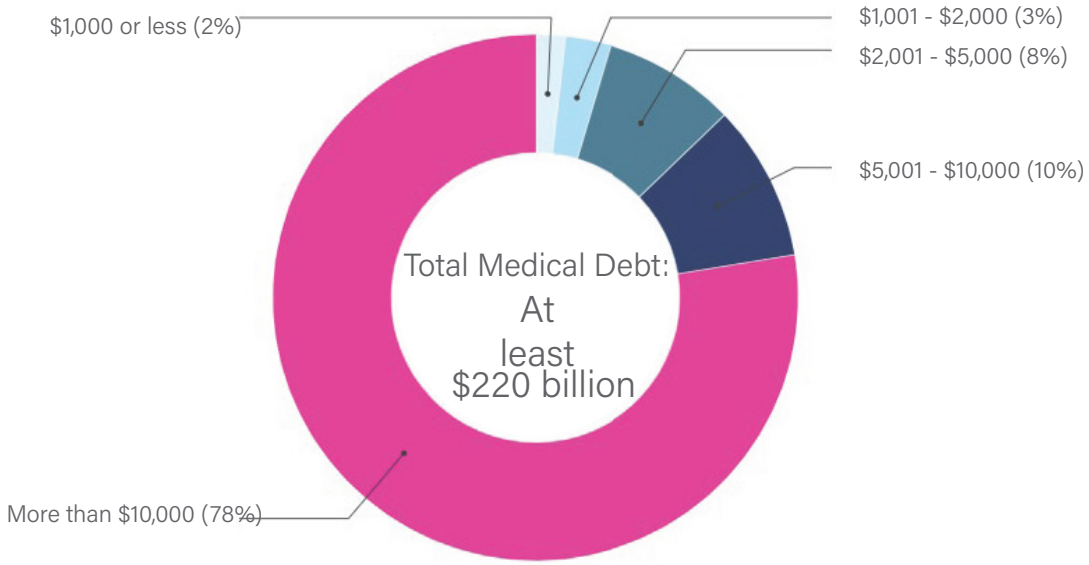
Medical Debt Crisis Persists in America Despite High Insurance Coverage Rates

Despite over 90% of Americans having health insurance, medical debt remains a significant burden, affecting nearly one in 12 adults— approximately 20 million people who collectively owe at least $220 billion, according to a study from KFF.

Many Americans with medical debt report making difficult financial sacrifices, including reducing essential spending and borrowing money from family members. The Survey of Income and Program Participation (SIPP) data reveals that about 14 million people owe over $1,000 in medical debt, while 3 million owe more than $10,000.

Notably, the prevalence of medical debt increases with age until people reach Medicare eligibility, with 10% of adults aged 50-64 reporting medical debt compared to 6% of those aged 65-79, highlighting the protective effect of Medicare coverage.

Share of Aggregate Total Medical Debt in the U.S., by the Amount of Debt Individuals Owe, 2021



Source: KFF analysis of the Survey of Income and Program Participation (SIPP)

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

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