

## Identifying Patient Eligibility for Medicaid Programs Can Put a Big Dent in Hospitals' Uncompensated Care Costs

Written by Ankeny Minoux, Chief Operating Officer, PointCare | January 30, 2013

While implementation of the Patient Protection and Affordable Care Act is now in play, hospitals will continue to struggle with a basic challenge: how to secure reimbursement from millions of still uninsured and private pay patients that present to their emergency rooms on a daily basis.

Unfortunately, even under the PPACA, finding adequate solutions to the challenge won't be easy. It will require new operational procedures, the incorporation of point-of-care technologies and, most importantly, a change in mindset at all levels of the hospital team. If done correctly, the result will be improved relationships with patients, increased revenues and a changing dynamic that benefits all communities served.

### Changing the tone of the conversation

A [report](#) by the National Association of Public Hospitals and Health Systems projects hospitals will see \$53.3 billion more in uncompensated care costs by 2019 than originally estimated when lawmakers approved the PPACA. According to the American Hospital Association, 87 percent of hospitals expect bad medical debt to continue to grow.

Already, analysts are predicting that millions of Americans will opt to pay the \$95 penalty in 2014; \$325 in 2015 and up to \$695 in 2016, (or 2.5 percent of income, whichever is greater) rather than obtain coverage, and some states are still vowing to fight the mandate to expand Medicaid.

Tired of the battle, hospitals are left with few options: continue to write off millions in uncompensated care, turn patients who can't pay bills over to collection agencies or hope the government does a better job than it has at convincing patients to enroll in available coverages.

But there is another alternative. A growing number of hospitals nationwide are looking to improve the system by positioning themselves as a resource for self-pay patients and by changing the tone of conversation with their patients.

Each year hospitals lose money by not recognizing or not fully exploiting available avenues to secure reimbursements from responsible parties, these include:

- Lesser-known public coverage programs (not just Medicaid), including CHIP, health care reform's PCIP, and cancer-assistance options
- Private guarantee issue programs
- Hospital charity care programs
- Unidentified third-party coverage
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### Uninsured or uninformed?

Research has documented that millions of Americans are currently eligible for free or low-cost public health insurance, but are not aware or just not signed-up. For hospitals, this represents significant dollars that responsible parties, both public and private, should be paying, but aren't. The non-profit Foundation for Health Coverage Education conducted a multi-year online survey that concludes that well-over 60 percent of visitors to their website

seeking coverage end up qualifying for one or more free or low-cost government programs they weren't previously aware of as an option.

Curiously, hospitals typically don't make significant efforts to follow-up with responsible parties to secure retroactive reimbursements. However, most will target patients — either by asking for a credit card or by requesting a co-pay or deposit — often of up to \$350 or more — or by turning patients over to a collection agency. According to the Commonwealth Fund, 30 million Americans were contacted by collection agencies in 2010, an increase of over 25 percent from 2005.

The problem is most of these efforts don't work well either. Last year, about 80,000 ER patients at the nation's largest for-profit hospital chain left without treatment after being told they would have to first pay \$150 because they did not have a "true" emergency. (That statistic brings up yet another interesting point as a [2012 study](#) found that most Medicaid patients presenting to the ER did have an acute emergency. )

When hospitals become debt collectors, it changes the tone of conversation with patients and their community. In short, many self-pay processes today create an awkward patient experience that results in lack of coverage for the patient and little to no compensation for the hospital.

Even hospitals that think they are "doing the right thing" by writing off charges for patients who can't pay may be inadvertently exacerbating the problem. Delaying providing patients with information on available resources could put patients at financial risk. Consider the patient with a chronic disease or injury: should it worsen and ongoing care is needed, the patient is put into an even greater financial "hole" than they would have been if a hospital took steps to alert them early on about their coverage options.

Unfortunately, current efforts to enroll patients in available programs are scattered and filled with bureaucratic challenges. Despite the initial development of the PPACA's health insurance exchanges in several states, including California, Indiana, Illinois and Wisconsin — there have been no widespread successful public program enrollment efforts to date.

And efforts to enroll patients in existing Medicaid programs today are more complicated than ever, causing many to simply quit. In an informal survey conducted by FHCE with a local Medi-Cal agency in southern California, out of 50 calls placed to the agency, only 15 were answered, and the average wait time was 22 minutes. It's no wonder so many people exclaim, "never mind" and are then forced to go to ERs for care.

## **Pushing for coverage at point-of-care**

To meet their charters, regulation mandates and the needs of their communities, hospitals must develop a better way to work with their uninsured patients. There is a significant correlation between billing satisfaction and patient perception; hospitals seeking to improve their perception in their target markets should not forget to look at all of the issues related to billing.

To develop a better system, hospitals will have to work in an empathetic and compassionate manner to improve the self-pay patient process, increase patient satisfaction and streamline administration.

## **What hospitals can do**

Hospital financial teams and patient advocates believe the best approach is to position the hospital as a resource and facilitator. The focus should be on providing prompt and reliable information at the point-of-care, enabling quick enrollment to protect patients retroactively and in the future.

In the past year, new software technology solutions have emerged to help hospitals connect patients with available government insurance. Newer approaches are reversing the paradigm further by qualifying each patient at the point-of-care in the emergency room. The programs also include quick access to information on available coverage programs and assistance for patients for hospital billing staff.

## Steps any hospital can take today

While it is important to explore current software solutions, there are other steps that hospitals can take to begin to change their tone and effectively position themselves as a patient advocate helping patients secure coverage. Basic steps include:

- Commit to patient-friendly billing. Encourage your staff to talk about resources (e.g., asking "how we can help?") .
- Leverage available technology to ensure first-touch success.
- Ensure there are adequate materials available and that your staff is educated on program options. Online solutions can help provide this resource.
- Help patients understand their responsibility in the process (i.e., providing follow-through), while simplifying the process as much as possible.
- Provide a clear decision tree for hospital billing representatives with the necessary tools to ensure consistency.

If patients don't qualify for Medicaid or other public programs, look for other ways to assist:

- Expand payment options to include a low-cost loan program at reasonable monthly rates .
- Offer to loan the premium on individual guarantee issue plans for children or COBRA.
- Adult business owners may be able to get future claims covered if they sign up for a small group guarantee plan.
- Share expectations, goals, reward and recognition.

The key is remembering to keep updated on all new public and private options, and to note that new programs are added every year.

Hospitals might also benefit from developing a position of "financial navigator" to help champion and spearhead the program, while working closely with the finance and accounts receivable teams. And, as you build the program, ensure you provide the right tools for admissions and internal accounts receivable team and reports for your administration.

Lastly, once an enrollment program is in place, make sure to keep in contact with patients and encourage them to follow-through with their application process.

## Helping patients in need and the bottom line

While the PPACA is moving forward, some proponents acknowledge there may be delays and changes in the current legislation in the coming years. That doesn't mean hospitals should take a wait and see attitude — millions of dollars and community reputations are at stake.

Taking steps to find ways to ensure patients are aware of available coverage options — and changing the overall process related to accounts receivable — will help patients and hospitals today and in the future.

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