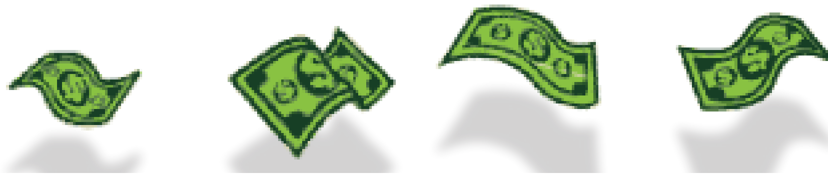
Medicaid Eligibility Vendors:

Are they leaving (your) money on the table?

Little-known secrets your vendor may not want you to know about.



The Midland Group

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In 2008, Medicaid alone provided health coverage and services for approximately 49 million low-income children, pregnant women, elderly persons, and disabled individuals in the U.S., totaling an estimated $204 billon. A survey released in February by the Kaiser Family Foundation found total Medicaid enrollment jumped 7.5 percent from June 2008 to June 2009, and 13 states had double-digit increases. With virtually every state making or considering substantial budget cuts in 2010, there is even more pressure on hospitals to squeeze every cent out of what little money is left to fund Medicaid. But along with cuts in Medicaid, hospitals can expect increases in regulations, decreases in state employees needed to process Medicaid applications, and a long line of newly unemployed people seeking their entitled benefits. If you've retained an eligibility vendor to process Medicaid applications for your self-pay patients, you may want to pose a few questions they may have never been asked before. The money you save may be your own.

When evaluating your current eligibility vendor or considering a new one, hospitals need to ask three simple but very important questions:

Skimming off the cream is fine for milk but does it work for patient accounts?

How do you define success and does your eligibility partner (or potential partner) define it the same way? When comparing two vendors, are you measuring them based on the same criteria? Do you receive sales calls from vendors touting their impressive accept rates, success rates, or conversion rates? It might go something like this:

You: "This is Chris Smith, St. Somewhere General Hospital, Patient Financial Services, how may I help you?"

Vendor: "Hi Chris, how are you doing old buddy?"

You: "Fine...but, who is this?"

Vendor: "Vinnie Vendor. Hey, I know you're busy but I have some valuable information for you..."

You: "But, I..."

Vendor: "I'm with Acme Eligibility Company, the nation's leading provider of public benefits eligibility services. Did you know we convert 90% of self-pay patients to a public benefit?"

You: "No, I didn't know that. What is your accept rate?"

Vendor: "Oh, buddy...it's fabulous. We accept 95% of patients we screen."

You: "So I guess your success rate is real high."

Vendor: "Yep, almost 100% and what's more impressive is the number of applications we throw

at those Medicaid workers. Ya know, we leave them speechless almost every day."

You: "Well, our vendor is only converting 40% of the patients they screen. And their success rate is only about 90%. Gee, your company must really have a special secret. Let's talk..."

Now...let's activate the ***Truth Detector***.

You: "This is Chris Smith, St. Somewhere General Hospital, Patient Financial Services, how may I help you?"

Vendor: "Hi Chris, how are you doing old buddy?" (I've never talked to you before but I'm going to use my naturally smooth style to fool you into thinking we know each other.)

You: "Fine...but, who is this?" (Am I supposed to know this person? Is it that new member from the Rotary meeting last night?)

Vendor: "Vinnie Vendor. Hey, I know you're busy but I have some valuable information for you..." (I don't really care if you're busy right now. I've got to make my quota this month.)

You: "But, I..." (Oh, no. It is end of month and the system has already crashed once today. I have no time for this.)

Vendor: "I'm with Acme Eligibility Company, the nation's leading provider of public benefits eligibility services. Did you know we convert 90% of self-pay patients to a public benefit?" (Well, 90% of all self-pay accounts over $50,000 in charges. We don't even mess with anything less unless they're labor and delivery or NICU charges.)

You: "No, I didn't know that. What is your accept rate?" (Hmmm. Maybe I should hear what he has to say.)

Vendor: "Oh, buddy...it's fabulous. We accept 95% of patients we screen." (We'd accept more but the other 5% slip through the cracks somewhere, we just don't know where. IT has been working on it...or so they tell me.)

You: "So I guess your success rate is real high." (Okay, I'll bite.)

Vendor: "Yep, almost 100% and what's more impressive is the number of applications we throw at those Medicaid workers. Ya know, we leave them speechless almost every day." (They complain and we pretend to care.)

You: "Well, according to our current vendor's reports, they are only converting 40% of the patients they screen. And their success rate is only about 90%. Gee, your company must really have a special secret. Let's talk..." (Hmmm. We're really cash poor. We need all the help we can get... and I could use a free lunch.)

The ***Truth Detector*** has uncovered a few discomforting facts:

- Acme Eligibility Company obviously isn't screening every self-pay patient. They are screening patients based on (high) charges and case type.
- Because they are cherry-picking which patients they will screen, they are also cherry-picking the cases they accept to process, leaving many good cases behind.

- They’re also submitting applications on cases that don’t qualify, burdening the state’s already overburdened case workers.

The current partner does it right

The current partner is screening all self-pay patients regardless of charges (or with a very low minimum), taking the time to carefully evaluate their financial circumstances and verify their reported income and employment. They are accepting cases for processing based on the merit of the case, and not overwhelming the state with cases that are doomed to fail.

The preferred method to gauge success is to evaluate cases based on the total number of self-pay patients registered. Using the total number as the baseline for success ensures that the conversion rate your partner provides is accurate based on all of the accounts you ask them to screen. Hospitals should keep in mind that statistics can easily be skewed. If vendors can cherry pick the type of cases that are often accepted or report data only on cases they accept, it will lead to a falsely high rate of converted accounts since cases can be prescreened for potential eligibility. Case mix can also influence success rates. For example, neonatal intensive care unit (NICU) and labor and delivery cases tend to be more straightforward than psychiatric cases. Supplemental Security Income (SSI) cases are especially time-consuming and complex. The bottom line, remember these three criteria: baseline referrals, no pre-screens, and a fair case mix when evaluating the conversion rate of a potential eligibility partner.

Why are these accounts under the proverbial rug...and how long have they been there?

A public benefits partner with expertise in state programs should make an initial determination within 48 hours of the patient's registration, pending verification of income and assets. If an account is accepted for processing, the hospital should be notified within 30 days and absolutely no later than 45 days that the account status is "Medicaid pending" or whatever code is used in the system to indicate it is in the hands of the vendor. If the vendor determines that a patient is not a candidate for a government program, the hospital can follow their normal course of action with the account before it becomes too old, e.g., pursue charity benefits or offer extended payment options. Be quick! The value of the services received in the patient's mind diminishes, making it more difficult to garner cooperation from the patient to pay their bill.

The last thing a hospital should be looking at is their self-pay A/R with no understanding of the status of accounts older than 30 or 45 days and with a competent eligibility vendor, you shouldn't have to. Why would a vendor let accounts sit?

- A lack of depth in personnel. A vendor struggling with turnover may be asking inexperienced staff to "fill in" until a knowledgeable person can be found.

- Inefficient processes may cause fluctuations in self-pay census to overwhelm a vendor and let those accounts accumulate without appropriate contact. Patients are transient. Eligibility partners must establish effective contact protocols to ensure they are successfully locating patients. How far is your vendor willing to go to speak with a patient? Will they visit patients in their homes, in hospitals, in shelters, under bridges? Will they assist with patients' transportation challenges? How far is your vendor willing to go to find patients? Do they simply run a skip trace or will they engage a private investigator? How far a vendor is willing to go in finding patients may tell you a lot about their commitment to you as a customer.

- Poor supervision could also result in accounts floundering in the patient accounting system. Is the person assigned by the vendor to your hospital held accountable by management? If the vendor has an employee on-site at the hospital, does management make regular and frequent visits? Even the best employees require supervision.

A case review system is one way to ensure that accounts get the attention they deserve. This involves a review by a vendor supervisor periodically to verify that decisions on accounts are being made promptly and that any exceptions are justified and documented in the patient accounting system. What kind of management strategies does your vendor have in place to assure that accounts are considered and returned in a timely manner?

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In short, as a true partner, the vendor should take joint ownership of your self-pay A/R and assume accountability for the eligibility status of every self-pay account.

Do patients turn into pumpkins at midnight, too?

Nearly all hospitals are facing increases in emergency department visits and outpatient services and they have to be ready to treat patients with any variety of afflictions regardless of the time of day, day of the week—holiday, or not. In most hospitals, the conventional eight to five work schedule will not suffice to screen all self-pay patients for public programs. Eligibility vendors who offer staff to work evening and weekend hours will help make sure the hospital is putting itself in a position to uncover all potential benefit options for patients no matter when they are admitted. And, as business office professionals everywhere can attest, patients are most cooperative and motivated to pay as close to the time of actual treatment as possible. However, that doesn't mean that all patients can or must be screened in person. Stratification of patient accounts can keep costs down and still effectively reach patients who need to be screened for benefits. And, because there are times when a one-to-one, in-person screening is simply not possible, a service center is a sensible alternative.

Vendors are finding service centers are very effective at contacting patients who were not screened in person or patients who are pre-registered and have yet to receive services. Still, service centers must

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operate during hours when people are available. By contacting people during nontraditional hours, working patients feel respected by not interrupting their daytime schedules, which may translate to better cooperation. Patients appreciate the opportunity to discuss payment options when they are comfortable in a familiar environment and can focus on their financial circumstances rather than their medical condition. Patients are often more willing to share information with a vendor as opposed to the hospital and if they feel they have an advocate, it will contribute to the overall positive patient experience and improved community relations for the hospital.

How does an eligibility vendor accommodate unpredictable case volumes in terms of scheduling? Do they offer staff that carry pagers or can be available at short notice on an as needed basis? Is their phone answered by a person, or by a "robo voice?" Have you received complaints by your patients about getting garbled voicemail messages or never-ending automated telephone options when they try to call the vendor? You should expect your eligibility specialist to have enough staff to handle fluctuationing patient volumes and employees with exceptional customer service skills to ensure each patient is treated respectfully.

Conclusion

There are many factors that separate a garden-variety vendor from a true partner. A partner is an advocate for your patients and a problem-solver for your staff. Expertise in public benefits is the "cost of entry" for an eligibility firm; you should expect it. That is why you hire them. Navigating through the intricacies of the various state and federal rules and regulations requires specialized knowledge and experience. But, the ideal partner must go further—beyond the rules and regulations—to consistently deliver and report high quality results regardless of the case mix, hours of operation, or census fluctuations.

Founded in 1989, The Midland Group is an acknowledged leader in providing revenue cycle assistance to medical facilities of all sizes and specialties nationwide. Its expertise includes public benefits eligibility, financial counseling, Social Security disability appeals, third-party billing and liens, and extended payment options for hospital and clinic patients. Midland's growing client list exceeds 130 healthcare facilities ranging from short-term acute care hospitals, psychiatric hospitals, and outpatient mental health facilities, to specialty and rehabilitation hospitals, outpatient surgery centers, and both general practice and specialty physician groups.

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