

The State of the Market for Medicaid Reimbursement Process Automation

Research Objective

The main objective of this research was to determine the needs and interests related to Medicaid reimbursement automation processes in smaller hospital facilities.

Who Should Read This Report

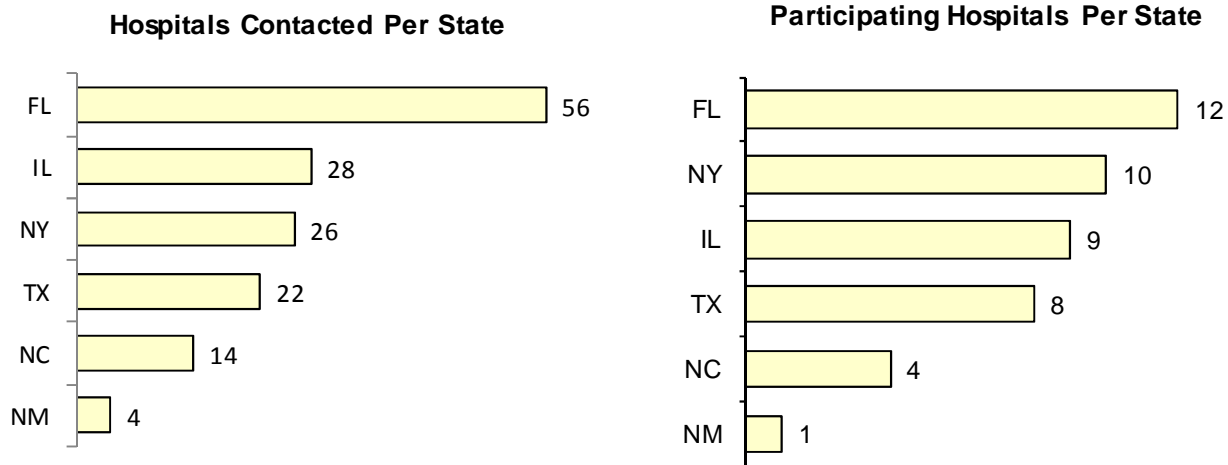
This report is beneficial to those interested in the current processes and/or procedures in the emergency department and other outpatient areas that patient advocates use to screen and assist patients to obtain Medicaid benefits. It is also beneficial to those with an interest in revenue cycle improvements associated with the Medicaid reimbursement process.

Methodology

The research was conducted from Oct. 8-23, 2009 and Nov. 12-20, 2009. A total of seven questions were asked.

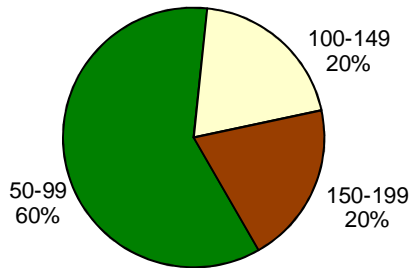
The targeted markets for this research included emergency departments and outpatient areas of smaller hospitals. The facility types were either short-term acute care or pediatric.

Pegasus Research Group interviewed representatives of 44 hospitals (one representative of each hospital) located in FL, IL, NC, NM, NY and TX with an average daily census of 50-99 beds, 100-149 beds and 150-199 beds.

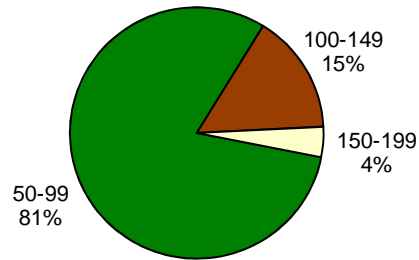


Amongst the hospitals that responded, 81% had an average daily census of 50–99 beds, 15% had an average daily census of 100-149 beds, and 4% had 150-199 beds.

Average Daily Census Breakdown of Hospitals Contacted for Study

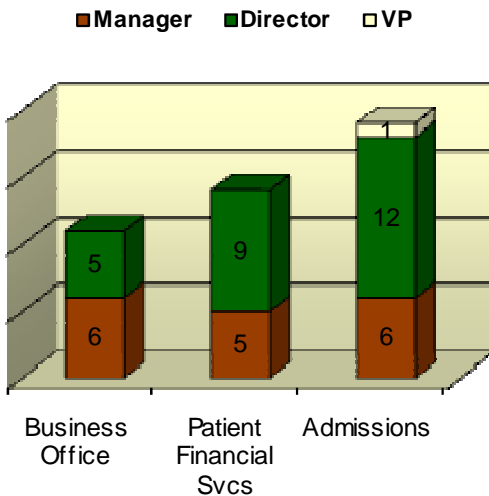


Average Daily Census Breakdown of Hospitals Participating in Study

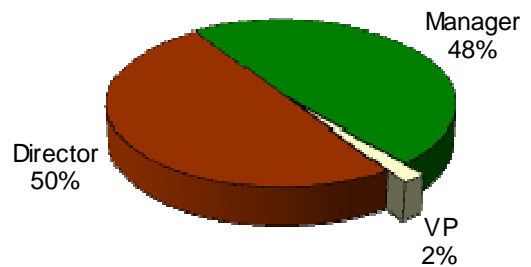


The representatives were within the business office, patient financial services or admitting departments. Fifty percent of the respondents were directors, 48% were managers and two percent were vice presidents.

Research Respondants by Department



Research Respondants by Title



The Margin of Error (MoE) is a statistic expressing the amount of random sampling error in a survey's results. In other words, it is a measurement of the accuracy of the results of the research. The larger the MoE the less faith one should have that the reported results of the research are close to the "true" figures; that is, the figures for the whole population. For this research project, the MoE of plus or minus 13% means that there is an 87% (i.e., 100% minus 13%) chance that the responses of the target population as a whole would fall somewhere between 13% more or 13% less (+/- 13%) than the responses of the sample (a 26% spread).

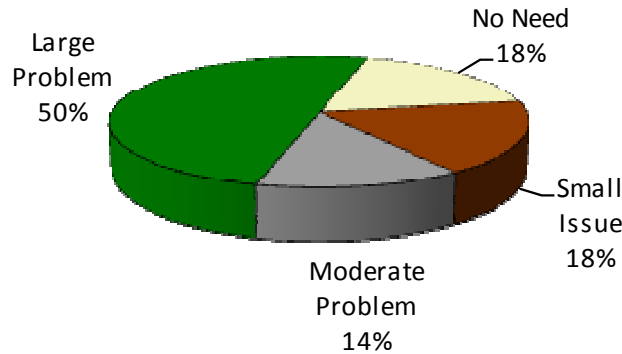
Contact Information

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Establishment of Need

How much of a need is there at your hospital to get more uninsured on Medicaid — especially those who visit the emergency department or other outpatient areas?

Based on 44 Responses



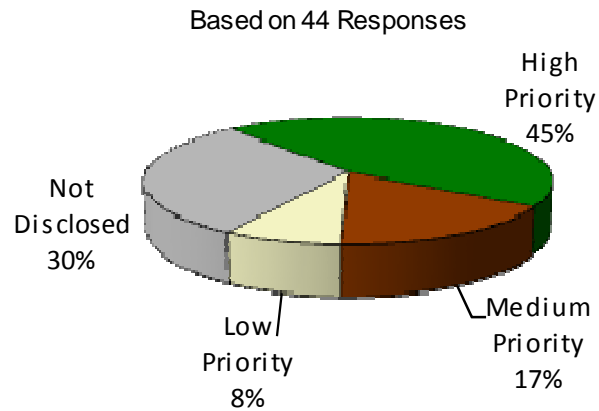
Fifty percent of respondents stated the need to get more uninsured on Medicaid is a pressing issue, claiming economic drivers as the reason for the increased need. Some hospitals are seeing increased lay-offs by local employers thus contributing to fewer people with family physicians.

Fourteen percent of the respondents contacted stated that the need to get more uninsured on Medicaid was a moderate problem for their hospital. This is mostly due to a self-pay population that just isn't high enough to make the need a large problem. Granted, it is still an issue, just not one that rated, "large problem".

Amongst the respondents who claimed the need to get more uninsured on Medicaid was a small issue (28%) or no issue at all (18%), one of the reasons mentioned was a lower self-pay population. This oftentimes occurs when a smaller hospital is part of a healthcare conglomerate and pushes the indigent population to a larger, more funded location nearby. Another reason mentioned by those who did not have a large need to get more uninsured on Medicaid was satisfaction with their current processes or vendor.

Revenue Cycle Priority

You have lots of priorities within the revenue cycle. How pressing is this need compared to others?



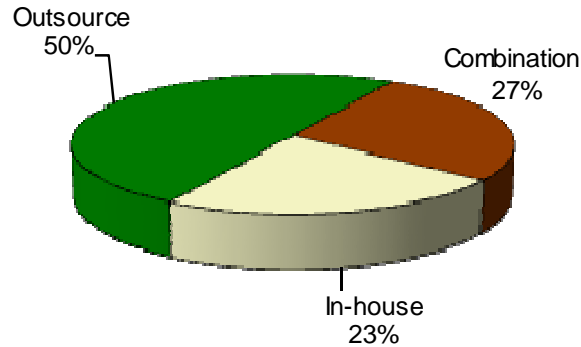
Many hospitals agreed that they have multiple priorities within their revenue cycles, especially at the front end. These priorities include point of service, getting more cash upfront, and trying to obtain patients with a payer source. Forty-five percent of the respondents commented that the need to get more uninsured on Medicaid is a high priority within their revenue cycle. In fact, many stated it was their highest priority.

Amongst the 17% of respondents that claimed it was a medium priority and the eight percent that claimed it was a low priority, the most common reason was a self-pay population that was too low.

Medicaid Model

Overall, hospitals tend to handle their Medicaid eligibility (getting uninsured on Medicaid) in-house, outsource the service, or have a combination of the two. What is your current model?

Based on 44 Responses



The majority of the hospitals contacted (50%) outsource the Medicaid eligibility function and most of the outsourced vendors mentioned were local contracted agencies with no regional presence.

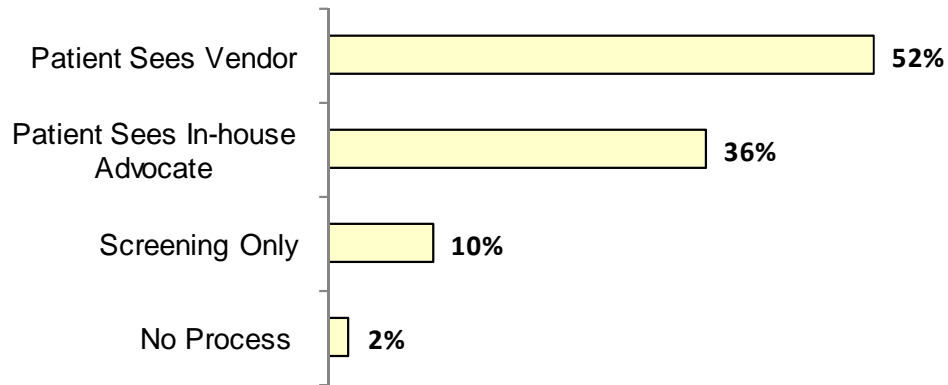
Amongst the 27% of hospitals that employ a combination of in-house processes and outsourced services to handle Medicaid eligibility, the most common model is the use of insurance verification tools augmented with an outsourced vendor to handle the patient interviews and assessment. However, even though there are multiple processes in place, hospitals are still experiencing challenges obtaining all documentation once a patient has completed the applications. Additionally, the reason hospitals have multiple processes in place is because not all patient advocacy systems have a complete, streamlined process. Hospitals have to patch a process from one system with another piece from a different system and then 'tweak' it to fit their individual needs.

The 23% of hospitals that managed their eligibility screening processes in-house either did not have a sufficient self-pay population for it to be a problem, or they were implementing a process that was not working for them. The in-house processes consist primarily of registrars who perform the insurance verification checks of the patient up-front and then have financial counselors or patient advocates perform the assessments.

Patient Assist Process

What process do you use today in the emergency department and outpatient areas to screen and assist patients to obtain Medicaid benefits?

Based on 44 Responses



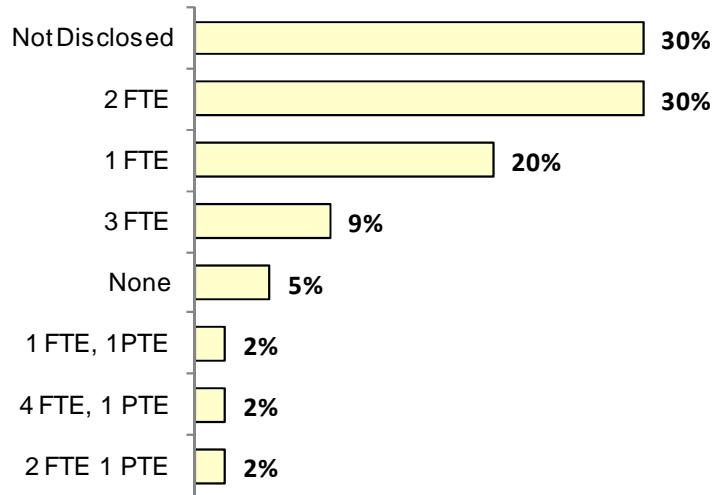
The first step in the process involves the patient seeing a registrar. From there the process changes depending on the hospital and the area of intake. In the ED the processes are fairly similar across the board; the patient comes in and the insurance verification check takes place by the registrar. If at that point a patient is deemed indigent, then a patient advocate will be summoned to see them bedside. The patient advocate is either an in-house employee or a contracted employee working with an outsourced firm. Within the in-patient and observation areas, there are processes in place but in out-patient there is less coverage, if at all.

Due to staffing levels, hospitals aren't able to provide assistance in this area. Indeed, the staff assigned to or engaged in screening is very minimal at these smaller hospitals. Regardless of the process – whether in-house or outsourced – there are gaps in the coverage. Most of these smaller hospitals have one to two staff members assigned to the eligibility process and few hospitals can cover all shifts.

Dedicated Staff Resources

How many staff are assigned to or engaged in screening for Medicaid in the emergency department and outpatient areas?

Based on 44 Responses

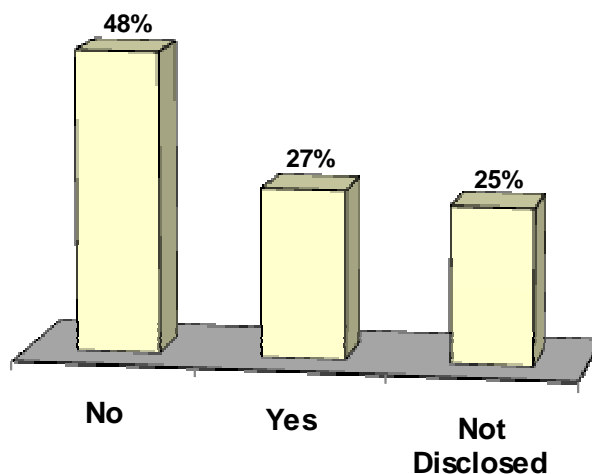


Amongst the hospitals that disclosed the number of staff members dedicated to Medicaid eligibility, the greatest populations had minimal staff coverage. Thirty percent of hospitals had two full-time employees and 20% only had one full-time employee, further demonstrating the lack of round-the-clock coverage.

Challenges with Resolution

Have you experienced any problems with application completion and resolution/follow-up to approval?

Based on 44 Responses



Forty-eight percent of respondents stated that they were not experiencing any challenges with application follow-up or resolution at their hospital. However, many said that this statement was in regards to their established processes and not as it relates to Medicaid. Oftentimes, the challenges arise once the process has gone to the state—Medicaid delays resolution.

Thirty-seven percent claim that there are challenges with their current processes, and many stated that the challenges they experience are with applications not being completed properly, but the resolution/ follow-up is good.

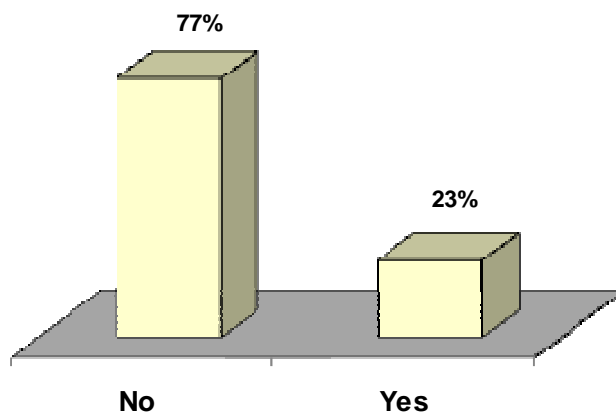
Twenty-five percent of respondents did not disclose whether or not they were experiencing any challenges.

Most of the respondents we spoke with stated that they are diligent in patient follow-up to get them qualified for public-aid or charity.

Technology Solution Evaluation

Have you looked at technology solutions to improve the screening and application process?

Based on 44 Responses



The majority (77%) of the respondents contacted for this study have not looked at a technology solution to improve the Medicaid eligibility screening process. Some hospitals did look at various tools, but did not find anything they liked. It appears that they do not want to have to increase their registration times, as they are already checking eligibility, scanning cards, and now there are red flag rules (i.e., they don't appear to want to incorporate additional processes into their registration workflow).

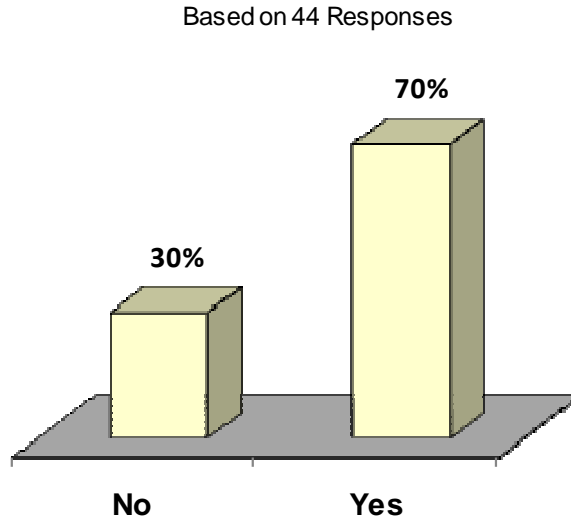
One hospital stated that the reason they've never looked at a technology to improve the process is because it is something that they've decided is better suited to manual processes. The respondent expressed that this is because it involves having to interview the patient, and a revenue cycle tool should not be given to registrars because they have enough to do as it is without also serving as Medicaid eligibility specialists.

One hospital developed their own tool to try to improve the process. However, this tool does not integrate with their system. The Admissions Director at this hospital helped develop this screening tool, but stated the need for a complete end-to-end process still exists. She would like the process to be automated so it will actually make it past the registration. She would like to see a tool where the registrars could enter the payer code at the information screen and it would automatically populate the self-pay screen where all the questions would reside/display and the registrars would simply need to populate the responses.

Most of the products that hospitals have reviewed/considered are add-on's to current systems already in use. They are indicating interest in a solution that will make the entire process easier and more streamlined. They want the ability to view the applications throughout the entire process, especially when dealing with state regulations. Respondents mentioned wanting something that would prevent patients from having to go through a long process at the end of treatment or during treatment, and make it easy enough so that care isn't delayed.

Technology Interest Level

If marketed to your hospital, would you be interested in a technology solution that would make eligibility screening processes easier with better returns?



At 70%, the population of hospitals that would be interested in a new revenue cycle product is a positive indicator of potential need. The need to get more uninsured on Medicaid is a pressing issue for most of the hospitals in this study and a tool to improve that process and deliver better returns appealed to many of the respondents. There were some, however, who did not have any interest in this product. At 30%, the contacts who did not see a benefit for their hospital either claimed there were not that many self-pay patients to make it an issue or their current processes could not be improved upon.