

Medical Debt Case Study

USING MEDICAID COVERAGE TO PREVENT MEDICAL DEBT

TENNESSEE JUSTICE CENTER

Table of Contents

Introduction	1
Background: Barriers to Coverage	1
Enlisting Hospitals	2
Findings and Outcomes.....	3
Medical Debt Eliminated.....	3
Specific Hospital Challenges	4
Technology Solutions	5
Education and Training	6
Medical Legal Partnership	6
Conclusion.....	7
Questions & Requests for Additional Information	7

Introduction

In 2019, the [Tennessee Justice Center](#) (TJC) received a generous grant from the Annie E Casey Foundation to participate in the Southern Partnership to Reduce Debt (SPRD) project with fellow non-profit entities in the southern United States. While the SPRD project covers a wide variety of debt adversely impacting communities of color, our focus was exclusively on medical debt. Specifically, our work was designed to support efforts to improve Tennessee hospital practices to reduce medical debt and improve health care coverage for the eligible but uninsured populations. The scope of our work included:

- Partnering with two hospital systems outside of Nashville, Tennessee, including one children’s hospital to examine ways to increase public health coverage and prevent the accumulation of medical debt;
- Collaborating with both hospital systems and their revenue cycle departments and vendors to identify barriers to finding coverage who may be eligible under the Tennessee’s Medicaid program, called TennCare, or its Children’s Health Insurance Program, known as CoverKids; and
- Collaborating with both hospital systems to create strategies and develop processes to alleviate the barriers to enrolling into coverage.

The fruit of this work includes this case study as well as a resource titled, *TennCare Enrollment Strategies for 2020: Best Practices Guide for Hospitals (Best Practices Guide)*.

The grant enabled TJC to:

- Relieve individual patients of medical debt and afford them coverage for ongoing care;
- Identify and correct systemic defects in state eligibility rules and processes that had been erroneously denying coverage to numerous eligible families;
- Learn valuable lessons about how to effectively collaborate with health care providers and state entities to advocate on behalf of low-income families.

Background: Barriers to Coverage

Lack of adequate health insurance coverage is a social problem with serious consequences for families and hospitals. Uninsured medical debt is the leading cause of personal bankruptcy in Tennessee for patients. The other side of the same coin is unreimbursed costs for providers. While many hospitals are highly profitable, small rural hospitals are struggling throughout the country under the burden of uncompensated care. The problem is more prevalent in states that have refused to allow the expansion of Medicaid coverage authorized by the Affordable Care Act. [Tennessee is one of those states](#), and it has large rural areas where uninsured rates remain high. That is a primary factor accounting for [Tennessee’s status as the state with the nation’s highest rate per capita of rural hospital closings](#). When a community’s sole hospital closes, the devastating effects on health access and the local economy affect everyone, insured and uninsured alike.

Even without access to expanded Medicaid, [almost half of uninsured Tennesseans are potentially eligible for publicly subsidized health coverage but are not enrolled](#). The purpose of this AECF-

funded project was to pilot advocacy collaborations between the Tennessee Justice Center and hospitals to enable the hospitals to connect their uninsured patients to coverage. The project's purpose is to prevent or reduce patients' medical debt and enable hospitals to get reimbursed for costs that would otherwise become bad debt. Recognizing that [the sickest five percent of the population incur over half of all medical expense](#), the project focused on obtaining Medicaid or Children's Health Insurance Program (CHIP) coverage for high cost patients for whom insurance is the most critically needed.

There are two major barriers that hospitals and patients encounter in Tennessee. First, Tennesseans must satisfy categorical eligibility by belonging to a category that Medicaid covers (children, pregnant women, caretaker relatives, disabled or elderly). They must also be financially eligible to qualify for Medicaid. With over 20 different pathways to coverage, the laws and regulations governing eligibility are very complex. To further complicate matters, each program has its own specific set of income and household composition requirements to determine eligibility. Unfortunately, mastering all the eligibility rules can elude even the most seasoned healthcare professionals.

The inherent complexity of Medicaid eligibility and enrollment is compounded in Tennessee by the state's difficulties administering the program. The ACA required all states to upgrade their automated eligibility systems by 2013, but Tennessee lagged far behind the rest of the nation. The TennCare Eligibility Determination System (TEDS) did [not come online until March 2019](#), and only after what was supposed to have been a \$37 million project had incurred \$400 million in cost overruns. The state [terminated coverage for over 200,000 children](#) and low-income Medicare beneficiaries, most of whom were still eligible. State administrative deficiencies affect children and adults with severe chronic conditions the most, because the lesser known eligibility categories for which they qualify are so complicated that the state often fails to screen them accurately.

2

Enlisting Hospitals

TJC has worked for many years to connect uninsured children to coverage, organizing an enrollment campaign called Insure Our Kids. The campaign has enlisted large insurers, nonprofits and hospitals in conducting outreach and enrollment activities. Still, many eligible children remain uninsured, and their numbers actually increased as a result of the state's mass purge of the TennCare and CoverKids rolls.

This project was developed on the premise that hospitals can play a bigger role in connecting uninsured patients to coverage, especially those chronically ill patients for whom coverage is the most important. Hospitals are on the front lines and interact with uninsured patients regularly, and the hospitals have a self-interest in helping those patients enroll.

All hospitals have staff or contractors, known as revenue cycle vendors, whose job is to pursue payment from patients' potential insurance coverage. Unfortunately, most hospitals and their revenue cycle vendors focus simply on helping patients apply for coverage without pursuing a true enrollment strategy. In the absence of such a strategy, many eligible but not enrolled patients remain uninsured, and they are mired in medical debt.

The premise of this project is that, by investing in special efforts to enroll their sickest uninsured patients, hospitals can “do well by doing good.” To test this premise, we partnered with two very different Tennessee hospitals. One partner was a rural hospital system, [Maury Regional Medical Center](#), in Columbia. The other was [Le Bonheur Children's Hospital \(LBCH\)](#), part of the large [Methodist Healthcare](#) system in Memphis. LBCH joined forces with University of Memphis Cecil C. Humphreys School of Law, Memphis Area Legal Services to create a medical legal partnership (MLP) called the [Memphis Children's Health Law Directive](#) (Memphis CHiLD). Memphis CHiLD consists of an on-site Legal Clinic located at LBCH, where Memphis Law students and faculty, and attorneys assist patients with a variety of legal issues including problems enrolling into public health benefits.

Our goal was to establish “proof of concept” by demonstrating to providers and their revenue cycle vendors that there is more to be gained by connecting uninsured patients to coverage than by treating them as debtors and making them the targets of collection efforts. Specifically, we have sought to show that it is worth modifying current practices to invest in technically sophisticated efforts to find coverage for chronically ill, uninsured patients. During the grant period, we focused on the often-overlooked categories of Medicaid where vulnerable patients stood the greatest chance of incurring medical debt. We provided Medicaid eligibility education and technical assistance including the use of our benefits screening tool called [AskJane!](#). For difficult eligibility and enrollment cases, we accepted individual patient referrals for legal representation. This work included filing eligibility appeals, negotiating with TennCare counsel and participating in administrative hearings.

3

In addition to establishing proof of concept and assisting individual patients, the project's goals were to learn:

- how to best structure the collaboration between patient advocates and hospitals;
- what types of technical support hospitals need from professional advocates to enable them to connect their eligible but uninsured patients to coverage;
- about existing hospital industry and revenue cycle arrangements as they affect the treatment of medical debt and uninsured patients; and
- about state coverage policies and enrollment processes that prevent eligible patients from enrolling in public coverage programs

Findings and Outcomes

Medical Debt Eliminated

During the SPRD project, we eliminated medical debt for individual patients and gained valuable insight into problems that were later identified as systemic in nature. Of the patients who were referred to TJC for representation, we eliminated \$847,506 in medical debt. In addition, we were able to bring systemic problems to the attention of the Division of TennCare that have since been rectified. Specifically, we convinced the Division of TennCare to make changes to a flawed policy regarding Institutional Status Medicaid that was in violation of state and federal law. We

conservatively estimate this will prevent the accumulation of over \$31.5 million in medical debt annually by low income patients who are hospitalized for more than 30 days.

Specific Hospital Challenges

We learned about the challenges specific to hospitals as well as the strategies currently being used by administrators to manage uncompensated care risk. Generally, hospitals and revenue cycle vendors focus on strategies to help people apply for benefits without monitoring the application process or scrutinizing the accuracy of the state's eligibility determination. While this approach identifies eligibility for the most popular categories of Medicaid, we discovered three critical problem areas that remain.

First, the lesser-known categories of Medicaid are typically overlooked. These categories include Medically Needy Spend Down for Pregnant Women and Children and the disability-related categories for Social Security beneficiaries who formerly received Supplemental Security Income (SSI). Accurately screening patients for eligibility is particularly challenging for providers, as well as Division of TennCare, which compounds the likelihood of an erroneous decision. Unfortunately, patients who qualify for coverage under one of these categories already has very high medical needs, and if uninsured, are prone to incur substantial medical debt. For hospitals, these patients are expensive to treat so failure to identify and secure coverage for these patients increases a hospital's uncompensated care risk.

Second, hospitals and revenue cycle vendors struggle with patients who are in the Medicaid Coverage Gap (aka Coverage Gap, or The Gap). This population is not categorically eligible for Medicaid and their income is too low to qualify for premium tax credits and cost sharing reductions under the Affordable Care Act. There are approximately 280,000 Tennesseans in the Coverage Gap.

4

A popular approach to secure coverage for patients in the Coverage Gap is applying for Social Security Disability, but the process can be long and arduous. For the uninsured patients, the wait for a disability determination is often an expensive proposition leading to substantial medical debt for those who fail to qualify.

We also learned that hospital staff often failed to consider how the eligibility status for people in the Coverage Gap could change, due to a change of circumstance or the length of their stay in the hospital. This is especially true for patients who become incapacitated and/or extremely deconditioned due to a lengthy stay in a hospital or nursing facility. We discovered that hospitals may need a protocol to identify when to rescreen an uninsured patient for eligibility.

Third, uninsured and underinsured individuals awaiting hospital discharge can find themselves in a predicament that exposes them to still greater medical debt. Usually these people have health care needs that require specialized or nursing care after being discharged from the hospital. Usually, the patient needs to be admitted to a nursing care or rehabilitation facility, but (s)he lacks sufficient health coverage or is uninsured. Since the patient cannot be safely discharged, (s)he remains in the hospital incurring further debt until another funding source becomes available.

Long term services and supports coverage is available to Tennessee residents through the [CHOICES program](#). It provides Medicaid coverage along with other benefits for people over 21 years of age who need help with activities of daily living whether in their own home or a skilled nursing facility. While applying for the CHOICES program should be a part of the hospital discharge team's plan, qualifying for CHOICES can be tricky, and unfortunately, some patients will fail to meet the stringent eligibility requirements. These patients become trapped at the hospital because they are unable to go home or to another facility without specialized care covered by health insurance. To maximize these patients' opportunities, a hospital's discharge team must have a thorough understanding of how the CHOICES program operates.

Improving coverage for uninsured patients in these three areas will reduce the risk that eligible, but uninsured patients will incur unnecessary medical debt. We have taken what we have learned about these challenges and combined it with our knowledge and experience working with individual clients to create a resource specifically for providers. It is TJC's *TennCare Enrollment Strategies for 2020: Best Practices Guide for Hospitals*. It outlines the latest strategies that reflect recent changes to Medicaid eligibility rules and coverage policies in Tennessee. In addition, we added a section to walk frontline staff step-by-step through the application process including how to monitor and correct common enrollment problems patients may encounter.

Technology Solutions

Given the complexity of eligibility and the daunting learning curve for new revenue cycle personnel, turnover in frontline staff poses a difficult and ongoing challenge for hospitals and their revenue cycle vendors. This problem can have serious consequences for high-cost patients for whom the lesser-known categories of Medicaid provide essential health benefits. To reduce the likelihood Medicaid coverage will be overlooked, maintaining a heightened level of consistency across the enterprise when making Medicaid and CHIP eligibility determinations is the key to success.

Working with financial counselors with varying degrees of Medicaid knowledge, we realized using a technology tool was one way to ensure a level of competency and consistency across the enterprise. However, in a fast-paced environment, conducting a thorough screening proved to be problematic, and we have learned that screening should be reserved for cases that can justify the time and staff resources it requires. Based on our work, the better approach seemed to be using a comprehensive screening tool like AskJane! after an application had been submitted and the patient's eligibility had been denied. A tool like AskJane! could be used to check the accuracy of an initial state eligibility decision or later when the patient's circumstances affecting eligibility may have changed.

Our Memphis partner found AskJane! helpful when assisting patients who were referred by LBCH hospital personnel for representation. For Memphis CHiLD, identifying the Medicaid category and establishing proof of eligibility for the patient was vital to securing healthcare coverage. The staff at MRMC did not use AskJane! as much, and instead referred patients directly to us for representation. Based on this experience, we discovered more work needs to be done to

determine when to incorporate a comprehensive screening tool like AskJane! into a hospital's workflow.

Education and Training

We also learned simply having a screening tool was not enough. Education and training for frontline staff, discharge teams and social workers were also needed. Both of our partners received training and educational materials, and as a result, we were able to increase their knowledge about the lesser-known Medicaid categories. This enabled advocates to secure Medicaid coverage for several previously uninsured patients who would have otherwise incurred devastating medical debt.

During our trainings, we also sought to change hospital thought process from "if eligible" to "how to become eligible" when working with uninsured patients. This proved valuable because enrollment staff were able to identify potential areas of coverage for complicated cases, and then seek assistance from the TJC, if needed or a systemic problem was encountered. This process also enabled us to address systemic problems, stemming from the state's new TEDS computer system for determining eligibility, that ordinarily could not be fixed through the appeal process. Had the enrollment staff relied solely on the state's eligibility determination, Medicaid coverage for these patients would have been overlooked resulting in substantial medical debt.

Medical Legal Partnership

While having a technology solution and training reduced medical debt for eligible but uninsured population, some patients still needed legal assistance beyond what the hospital could provide. We found a Medical Legal Partnership (MLP) to be a useful mechanism for assisting those patients.

6

The MLP concept is not new. In fact, it has been widely accepted within the healthcare and legal fields since the mid-1990s. In addition to serving clients, the structure of the MLP enables legal advocates to help patients as clients without the burdens associated with the Health Insurance Portability and Accountability Act (HIPAA). Since the legal work is provided on the behalf of the patient and not the health care provider, a thoughtfully designed MLP removes the need to satisfy stringent rules for HIPAA compliance, which can be cost-prohibitive for small organizations. For this reason, the MLP became the preferred model for delivering legal assistance that some uninsured patients desperately needed in order to secure coverage and prevent medical debt.

For this project, we created or joined an existing MLP so we could file appeals and represent patients at administrative hearings and collaborate on case strategy with other legal advocates and enrollment staff. This was particularly beneficial to patients who were entangled in bureaucratic red tape resulting from systemic problems associated with TEDS.

In Memphis, we joined the existing MLP, Memphis CHiLD, and provided TennCare training, access to AskJane!, and technical assistance and support to the MLP. During 2019, Memphis CHiLD served 74 individuals and their families who were experiencing a wide range of problems enrolling in Medicaid.

For our collaboration with Maury Regional Medical Center we established a new MLP. For both the Memphis and Maury County MLPs, TJC provided training and technical assistance. We also accepted 14 individual patient referrals for legal representation to secure coverage that the patient was eligible. Although these cases were complex, we resolved 13 successfully and eliminated \$847,506 of medical debt. Not only did this help patients and their families financially, but it also provided health coverage for their future medical needs.

Conclusion

The barriers to coverage combined with the challenges that are unique to hospitals have resulted in preventable medical debt for many Tennesseans. Since very few people have the financial ability to pay for their medical care out of pocket, securing health coverage is vital. This is especially true for hospital patients who are likely to encounter expenses in the thousands of dollars.

The results of this case study demonstrate the hospital industry's approach to increase coverage and reduce patient medical debt should be revisited. In addition, continuing education, training and collaboration with legal services entities should become part of an overall strategy to reduce the medical debt burdens on patients and the uncompensated care risk for hospitals.

Whether the results from this project are enough to influence hospital behavior to pursue Medicaid coverage over patent collections remains an open question. For this reason, we encourage hospital administrators to review this case study in tandem with the *Best Practices Guide* to assess current processes and implement practical changes. We believe hospital administrators who do will see a reduction in their hospital's uncompensated care as well as better health outcomes for their patients. We hope our project and the *Best Practices Guide* will enable hospitals to "do well by doing good".

Questions & Requests for Additional Information

Questions about this case study, the *TennCare Enrollment Strategies for 2020: Best Practices Guide for Hospitals*, or requests for more information about TJC services should be directed to:

Rob Watkins
Staff Attorney
Tennessee Justice Center
211 7th Avenue North, Suite 100
Nashville, TN 37219
615.846.4712 (direct)
rwatkins@tnjustice.org