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patient advocacy data

	Patients	Charges
Public Assistance Plans	32,897	\$638,332,228
Third Party Liability for Injury	3,458	\$20,242,884
Insurance Facilitation	3,316	\$40,021,532
CMS 1011 Funding	632	\$3,964,052
Indian Health Services	444	\$3,702,388
Crime Victim Coverage	194	\$2,207,422
Workers Comp. Coverage	69	\$518,382
COBRA Facilitation	163	\$3,681,893

Total	41,208	\$713,063,312
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Presidents Message

Greg Moga, President



Call us! As the national and world economy deteriorates, Outreach Services continues to add critically needed dollars to

your bottom line. Whether outsourcing or backstopping your internal team, we have the flexibility to adapt our process to your priorities and to help bridge the coverage gap for your most at-risk patients.

We have always had hospital clients who were on the razor's edge of financial disaster, particularly older inner-city hospitals which primarily served an immigrant and indigent population. But now they are not alone- virtually all our hospital clients are seeing the impact of declining coverage, higher deductibles, reduced coverage, higher unemployment, and lengthening payment cycles for Medicaid reimbursement. It is a perfect storm!

When I began this company in 1987, Outreach Services' niche- Medicaid and SSI advocacy- was almost an afterthought for many of our hospital clients. Our results were noticed by few, and our financial impact, while appreciated, was taken for granted. This outlook has undergone an amazing change. Our liquidations have become the bottom-line margin for many of our hospitals. Instead of being of interest

only to the business office, our efforts have become a critical component noticed by the entire senior management team.

I should be pleased by all of this attention- who doesn't want their work to be noticed and appreciated? But frankly, these worldwide economic trends are a bit scary, and where they are leading us, is hard to imagine. So, call us! We have solutions ready, and a first-rate team ready to complement your efforts.

COBRA Facilitation and Appeals

Josie Sackmann, Regional Director
Shawn Mimnaugh, Director of Third Party Liability

With the economy in crisis and rampant layoffs across the country, hospitals will see more and more patients with lapsed commercial insurance coverage seeking medical services. Employees facing a job loss often make an initial decision to forego COBRA benefits due to premium costs, the bureaucratic application process, or lack of information from their former employers. However, COBRA regulations state that employees may elect coverage for a significant period of time following receipt of a post-termination COBRA notice. As such, where medical care is sought following a termination of employment, COBRA coverage should be pursued before Medicaid or charity is

considered. COBRA provides continued health coverage for the individual (and possibly spouse and dependents) and better reimbursement to providers for services rendered.

A consistent process for identifying and pursuing COBRA coverage is important, and relatively simple to establish. Questions at registration regarding employment, former employment, and current or past insurance coverage should easily identify patients to whom COBRA benefits may be available. From there, hospital or outsourced financial counseling staff should work with the patient, former employer and COBRA benefits administrator to ensure necessary applications are completed and submitted, and premium costs are paid.

...In many cases, it may be more cost effective to front the COBRA premium amount...

As COBRA premiums are expensive, many patients may be unable to meet the cost. Hospitals, or their outsourcing agency, may determine it's cost effective to front the premium amount in order to secure the patient's coverage and the subsequent insurance reimbursement. Ultimately, the premium cost is considerably less for the patient to pay than the medical bill, and considerably

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less for the provider than the loss of writing off the bill.

A solid approach to appealing COBRA denials is also necessary. In one of our recent cases, the COBRA payer denied payment of a claim due to untimely authorization. At the time of admission the patient was technically uninsured, having not yet pursued COBRA eligibility, so no authorization was completed or possible.

The case was further complicated because the patient received care in one state after previously residing in a second state and being employed in a third state. The health insurer was from a fourth state. In the appeals process, we not only had to consider COBRA laws, but also the health insurer's contractual agreements, employer health insurance extension prerequisites, and state-to-state guidelines. Our team contacted each entity to confirm the technical, statutory compliance requirements were met and establish what was required to complete the reimbursement process. Upon review and consideration of our formulated appeal, the insurer met its obligation to pay the claim, and the facility received its due reimbursement.

Though not all COBRA cases are this complicated, with health insurers feeling the hit of a failing economy, technical and subjective claim denials will likely become more common. By assisting patients in understanding and navigating the COBRA process, and appealing inappropriate denials, hospitals can better protect their own financial health and that of their patients.



Financial Responsibility for Nursing Home Patients

Meaghan Dorsey, Regional Director

We in the health care industry have a responsibility to explain clearly to our patients and their families the financial process of placement in a nursing home. There is a breakdown in explaining this process between discharge from the hospital and admission to the nursing home, and it is during this interim that patients and families are often left in a state of confusion. As the number of aged adults needing placement services continues to climb, the need to clarify the process and answer questions becomes more pressing.

Having worked both in the hospital and nursing home settings, I've seen first hand the need to move patients quickly from the hospital to the nursing home. In my experience, however, the Medicare benefit period is rarely explained well. Patients and families are notified of their "100 days of Medicare", but they frequently don't understand the breakdown of that timeframe. So, to clarify, for a person with 100 Medicare days, his or her first 20 days in a skilled setting are covered completely. In days 21 through 100, however, the patient is responsible for a daily co-payment. If the patient has co-insurance that has been verified to cover skilled nursing, then that co-payment should be covered. But if the co-insurance has not been verified, or if it does not cover skilled-nursing needs, the patient is financially responsible for that daily co-payment, which is approximately \$128.00 a day, but varies by facility and state. After the 100th day, Medicare stops covering the cost of skilled care, and only if a patient has been out of a

skilled setting for 60 days will a new Medicare benefit period begin. Without that 60 days hiatus, the benefit period for skilled nursing does not renew, and the financial responsibility falls entirely to the patient.

Medicaid, however, can provide a payer source for the patient, as long as income and resource eligibility requirements, which vary by state, have been met. Many questions arise when applying for Medicaid, including those relating to spousal impoverishment, transfer of assets, and contribution of income. Someone with extensive knowledge of long-term care Medicaid eligibility can usually answer all them. The eligibility process is not so complex that an attorney must be involved, although oftentimes these questions are directed to an attorney. Offering direction to patients and their families as they navigate this process, and advocating on their behalf, can make all the difference to a family struggling with the transition of moving a loved one into a nursing home.

Featured Employee Leticia Carrasco

Patient Advocate, Washington Region



Leticia has been a part of Outreach Services for 4 years and has shown great compassion towards the patients that she assists.

One of Leticia's most memorable experiences was getting an account covered under Medicaid after a 3-year process. The patient was extremely appreciative that she didn't give up on him and the hospital was pleased that all of the private pay accounts were being covered. There is nothing more rewarding to her than knowing that she provided an important social service while preventing write-offs for the hospital.



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