



# Strategy 1: Design Effective Enrollment Procedures and Practices



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Interviewed hospitals identified a wide range of information and ideas on health coverage eligibility screening, verification and enrollment of the uninsured. What became abundantly clear is that a key component to successfully enrolling eligible individuals is designing a process that is transparent, consistent and supported by effective tools.

## TRANSPARENT PROCEDURES

Hospitals must have thorough written procedures that address the various steps and processes used to enroll uninsured patients in appropriate programs. These written procedures serve as a guide for staff activities and create a framework for accountability. They are most effective when jointly developed and maintained by the patient access/ registration department, the patient financial services department, and other appropriate departments that interface with patients.

The most effective procedures:

- Reflect the organizational mission, vision and values to meet care needs in the community.
- Harmonize and reflect compliance with current law or regulation, including the Charity Care and Discount Payment Law of 2006 (Assembly Bill 774; Chapter 755, Statutes of 2006).
- Include any technical aspects required to implement new processes, procedures or tools, as well as any technology or software used for various functions.
- Describe in detail the process' operational aspects and include cross references to staffing roles and responsibilities required to implement and operate the process. Detail additional requirements or persons involved and how to access supplemental support resources (e.g., training, certification, vendors).
- Include the sequence of transactions necessary, including those related to accounting and reporting.
- Provide for routine and periodic evaluation and revisions as needed.
- Provide a clear description of key terms.

Additionally, it is important for hospitals to ensure that their processes are consistent with the criteria outlined in CHA's guidebook, *Hospital Financial Assistance Policies and Community Benefit Laws*. Visit [www.calhospital.org/financial-assistance-guidebook](http://www.calhospital.org/financial-assistance-guidebook) to learn more about this publication.

## CONSISTENT PROCESSES AND PRACTICES

Organizations interviewed reinforced that the goal of current processes and practices is to ensure every single patient who accesses the organization's facilities is appropriately screened, interviewed, educated and provided with coverage enrollment information at the appropriate time. This goal is optimized by having consistent processes and practices in place.

### Defining Roles and Responsibilities

Ensuring consistent processes and practices requires clearly defined roles and responsibilities. This is particularly important because many individuals — including employees, independent contractors and nonemployees, and others such as county Medi-Cal eligibility personnel and third-party eligibility vendors — may be involved in helping a patient access health coverage while at the hospital.

Clearly defined roles are critical, given they will likely differ by organization. For example, some hospitals utilize employed staff to complete the eligibility screening, secure the application and necessary verifications from the patient, and then forward the information to county Medi-Cal eligibility personnel to complete enrollment. Typically, county Medi-Cal eligibility personnel are assigned to the hospitals and either come to the campus or offer a specific meeting location for patients who need to meet with them. A limited number of hospitals perform the entire screening and eligibility process for uninsured individuals; many others choose to use staff employed by eligibility and enrollment services vendors.

With this level of variability, clearly defining roles and responsibilities is integral to successful eligibility and enrollment processes.

### Ensuring Enrollment Processes are Sensitive to Each Individual Patient's Condition

Most hospitals interviewed generally described using one of two different paths to help a patient access health care coverage. Choice of pathway depends on the patient's condition and the entry point through which the individual accessed hospital services.



**Many** individuals may be **involved** in **helping a patient** access health coverage

## Patients Who Enter Through the Emergency Department

Patients who present in the emergency department must first receive appropriate medical screening and care. Only after the patient receives a medical screening exam and is determined to be stable can the eligibility screening process begin. Given the dynamic and unique environment in the hospital emergency department, the enrollment screening process must be designed to occur quickly and without disruption to the environment or patient care needs. The process must also be sensitive to a patient's emotional needs to ensure that the patient is ready to have the conversation required for the eligibility screening process.



Once cleared by the qualified health care professional, patients generally leave the emergency department quickly, posing a challenge when attempting to follow up with individual patients for appropriate screening and enrollment. Therefore, the process used in the emergency department must be designed so that screening and enrollment staff provide each patient with a Covered California Single Streamlined Application, information on and applications for financial assistance available through the hospital's charity care and discount program(s), and other health care program information.

Once released, the hospital process should include telephone follow up — either by hospital staff, contractors or vendors — to assist the patient through the process of collecting the necessary documentation required to apply for Medi-Cal.

Even patients seeking urgent or routine care in a hospital emergency department must follow this process. However, the process for patients seeking urgent care in locations other than a dedicated emergency department can generally allow additional time to go through the screening, verification and follow-up process.

## Patients Who Access Care by Direct Admission, Outpatient Departments or Clinics

For patients admitted to the hospital or those scheduled to be seen in outpatient departments or clinics, organizations typically use a detailed, multi-stage process.

Typically, registration staff have already determined the coverage status of uninsured patients by telephone or mail before they come into the facility. If this is not the case, staff may talk with the patient at registration, at the bedside or elsewhere, to determine whether he or she requires enrollment assistance.

Since hospital census reports typically capture coverage status, a vendor hired by the hospital may assume eligibility and enrollment responsibility for specific programs when the patient's financial need is identified.

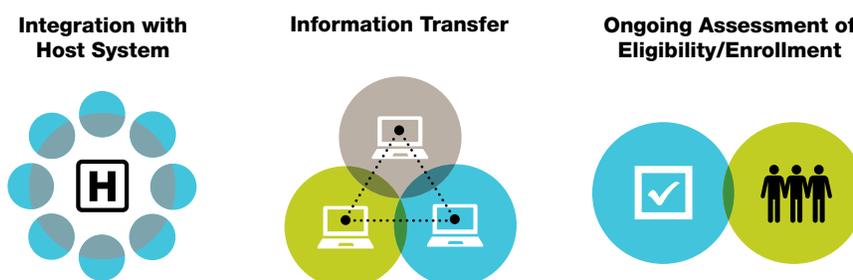
The processes evaluated were designed to emphasize identifying and making contact with uninsured patients within 24 hours of inpatient admission.

Many hospitals have integrated into their processes Covered California Certified Application Counselor activities and use of the online Covered California Single Streamlined Application.

## EFFECTIVE TOOLS

Hospitals widely utilize electronic systems and software for eligibility screening and enrollment purposes. Hospital processes often include electronic access to public databases (federal, state and county) to remain current on specific program eligibility requirements and benefits. These tools also help identify patients who could not recall whether they are already enrolled in specific programs. Consequently, some hospitals routinely check a variety of programs and systems. Hospitals also report using commercially available software tools for real-time payer verification to validate coverage in Medi-Cal and other programs. The online Covered California Single Streamlined Application provides similar capabilities, thereby greatly streamlining the enrollment process.

Many organizations report using registration software to capture eligibility information throughout the admission interview. The software can help identify potentially eligible individuals, and can link to sources of coverage.



### Integration with Host System

Numerous organizations have fully integrated their eligibility processes into the hospital's information systems, building in expanded capabilities for:

- Using the census as the starting point for identifying patients in the self-pay category who require follow-up
- Communicating with potentially eligible Medi-Cal patients to determine whether patients or their families need assistance with completing the application
- Engaging in regular communications about program enrollment with discharged patients who are eligible for coverage

### Information Transfer

Hospitals indicate that their systems and software support easy sharing of eligibility and enrollment information both internally with the hospital's staff and externally with vendors, in accordance with existing business associate agreements.

A system-based mechanism to identify uninsured patients typically enables data sharing with vendors requiring the information to perform the agreed-upon steps in the eligibility and enrollment process.

Information is typically transmitted seamlessly, and in compliance with federal and state patient confidentiality laws. For example, when a patient registers in one participating hospital, his or her record is given a code that identifies the patient as “pending,” or potentially eligible for some type of coverage.

Regardless of whether the hospital’s vendor is on-site, the vendor has electronic access to needed information. Today, vendors can use advanced technology to run pre-approved real-time reports from the hospital’s host system, identifying uninsured patients and screening for those whose coverage status is still pending.

In another hospital, vendors interview the patients at entry points. If this does not occur, the vendor can still access that information through the hospital’s host system and follow up with the patient after discharge.

### **Ongoing Assessment of Eligibility and Enrollment Status**

Building in an ongoing assessment system that tracks eligibility data over time increases the probability that eligible patients will gain access to available coverage. Such tracking provides increased opportunity to communicate with the patient, and furthers the ability to have a more informed conversation when that patient accesses hospital services at some point in the future.

Hospitals also have robust practices to encourage patient re-enrollment in coverage programs. Reminder letters are a common approach, particularly with programs that require annual re-enrollment.

New information systems already in use may also prove to be valuable tools. For example, one hospital cites a new cloud-based database system that helps organizations maintain regular communication with patients to encourage them to re-enroll.



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