

Health Care Recovery Dollars: A Sustainable Strategy for Medical-Legal Partnerships?

White Paper – Capacity & Sustainability Working Group
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“We are creating win-win-win situations here.”

*Woody Thorne, Director
Community Benefits Department
Southern Illinois Healthcare*

Summary

This white paper is a survey of four innovative medical-legal partnership programs that capture some level of health care dollars to support their program activities. Our goal is to identify some of the key components of this strategy, and offer guidance to sites looking to explore this strategy. Obviously, the staff at each program is the very best resource for concise information about individual program specifics. We are grateful to the highlighted programs and their committed, passionate leadership and staff for sharing their experiences and insights in this report.

Health care recovery dollars are funds reimbursed to hospitals as a result of a successful appeal of improperly denied Medicaid or Social Security Disability application. Normally, when a hospital has treated an uninsured individual whose application for public health insurance has been denied, the hospital will remain unpaid for those services provided. Yet if a legal service organization can help that individual successfully appeal his or her Medicaid denial, the hospital can then re-bill Medicaid for the services rendered since the initial date of application (and oftentimes before) and be reimbursed for the healthcare provided to that now-insured patient. In this way, the legal services provided have a direct financial impact on the hospital; legal aid organizations become money-making partners with their medical counterpart.

This paper explores this exciting model and highlights four programs that are successfully tracking and leveraging “health care recovery dollars” generated by their legal assistance. The paper concludes with recommendations for how existing and new medical-legal partnership programs can incorporate this paradigm into their projects. The four highlighted programs are:

1. **The Law and Health Project**, a collaboration of Land of Lincoln Legal Assistance Foundation, Inc., Southern Illinois University School of Law, and Southern Illinois Healthcare,
2. **The Medicaid Appeals Project**, a collaboration between Legal Aid of Missouri and Truman Medical Center,
3. **The San Diego Benefits Advocacy Project**, a collaboration between Scripps Mercy Hospital (SMH) and the Legal Aid Society of San Diego, Inc., and
4. **LegalHealth**, a project of the New York Legal Assistance Group that contracts with fourteen New York City hospitals and community-based health organizations.

The paper concludes that this strategy has powerful potential to transform the character of medical-legal partnership programs' relationships with their host medical center by proving to hospitals that the legal advocacy provided financially benefits hospitals as well as the hospitals' patients. It may be easily integrated into already-existing programs as well as used persuasively to expand and replicate the program model in hospitals that do not already have medical-legal partnership programs. Furthermore, by tracking health care recovery dollars and securing full or partial on-going financial support from hospitals, legal services organizations may be able to step outside of the standard grant/foundation funding cycles and insure program sustainability.

Health Care Recovery Dollars Model

Medical-legal partnership programs that have a "health care recovery dollar" component function essentially in the same way as other medical-legal programs do: hospitals and legal services organizations establish a medical-legal partnership program, identify a medical champion, create a memorandum of understanding, train medical providers to spot legal issues that adversely impact their patients' health, provide direct advocacy services to patients on site, and jointly work towards policy change. However, what is different about these programs is that at their inception, the projects' focus and goals are the successful appeal of patients' Medicaid and SSI denials, usually at the exclusion of the full range of legal services. They also closely track not only the legal outcomes for their clients, but also the gross financial outcomes for their partner medical institution.

Within this program model, hospitals identify which of their patients have applied for and been denied Medicaid or other public health insurance and benefits programs. They use various referral systems to direct those patients to the legal organization, which has an office or set office hours within the hospital. The legal services organization processes high numbers of appeals cases, carefully tracking which clients' appeals have been granted and the amount of medical debt that each client is considered to owe to the hospital. As part of any medical debt case, the advocate's job is to contact the hospital billing department, alert them that the client is now insured, and demand that the billing department stop billing the client and instead re-bill Medicaid. In this way, as usual, the legal advocate's obligation is first and foremost to his or her client; the goal is to relieve the client of medical debt and get the client and his or her family insured.

However, in so doing, the legal advocate is (and always has been, in the usual course of advocacy) inadvertently providing a large financial boon to the hospital; for every successfully resolved medical billing or benefits denial case, the hospital may now seek coverage for the costs of services rendered. In a well-functioning medical-legal partnership within a safety-net hospital, this can amount to millions of dollars flowing from Medicaid to the hospital that otherwise would have been lost. Diane Goffinet, Legal Director of the Law and Health Project, explains that:

I had been doing Medicaid cases since 1994, and I had been clear that my work was benefiting the hospital on the back end, above and beyond my client getting their medical debt relieved. Before this project, I couldn't care less if the hospital got paid, all that mattered to me was that the client got on Medicaid, and had their debt relieved. But now, when a client gets enrolled, I write a letter to every doctor that we sought medical records from in order to prove the case. I say, "This person has now been approved, here is their Medicaid number, and here is how you can bill outside the 12 month period time limit."

In other words, while the advocates' goal is to benefit the client, his or her advocacy work directly enriches the medical center "on the back end." Health care recovery dollars projects capitalize on that "back end" benefit to create a business partnership with the hospital. This business partnership may only function to fully or partially fund the operating costs of the program; most legal aids are non-profit organizations and are not engaging in this partnership to make a profit (and the same might be said of

the safety net hospitals). However, in this way the legal services are able to proactively ensure that their work continues outside of the limitations of a grant- or donation-driven funding model.

An “Embedded” Business Model that Grows...

The Law and Health Project, the Medicaid Appeals Project, and the San Diego Benefits Advocacy Project all began with external funding. Only once they had proved their value to the hospital did they begin to be wholly or partially funded by the medical center. Making this change was not complicated; according to Gregg Lombardi, Legal Aid of Missouri’s Deputy Executive Director. When shifting the relationship, “All it took was a few minor changes in the contract; it was similar to the original MOU we drafted when we had been externally funded.”

Furthermore, these programs all began as projects that focused on appealing denials of Medicaid, SSI and other public benefits. They firmly established their projects as money-making ventures for their partner medical institution and proved their significant financial worth. Then, once these programs had solidified the public benefits components of their work within the hospital and created strong referral networks and systems, they expanded slowly to provide a diverse range of legal advocacy to hospital patients. Goffinet explained that, after three years:

Now our focus is not just Medicaid and Social Security anymore; we do wills, guardianship, housing, consumer law, family law. I have learned how to do wills, powers of attorney, divorces, etc. Our goal is to improve health outcomes by alleviating legal stressors. But I personally do not do every single case – I funnel most of the cases that are not SSI and Medicaid to my colleagues who are experts in those areas, and try to get *pro bono* help from the community.

This expansion of legal services has only further delighted the partner hospitals, who were pleased to not only be improving their bottom line and insuring a greater number of patients, but also to be critically improving their patients’ quality of life and resolving the full spectrum of legal obstacles to patient health and wellness.

It is important to note that the model could work backwards as well: medical-legal partnership programs that focus on other areas of law could begin to incorporate a large number of Medicaid and SSI appeals cases into their repertoire, track the benefit to their partner medical institutions, and then use that financial data to argue for a shift in the character of their relationship with their partner medical institution. Lombardi explained that: “For a program that already exists, there is little need to change forms, etcetera, because telling the hospital that the client is [now insured] is part of representing the client; it’s necessary to get the bills re-sent to Medicaid. All that is different in this model is that you are claiming credit for the money coming in, having the hospital track the benefits you have been getting for them all along.”

When establishing these programs, the projects presented the program as a financial support to the hospital and explicitly discussed the potential financial benefit with their hospital counterparts. All of the individuals interviewed emphasized the need to “talk numbers” with the hospital. According to Lombardi:

If you can go in and say “We estimate that a large percentage of Medicaid terminations and denials would be reversed if the individual was represented by competent counsel,” and then tell them your estimate for how much Medicaid dollars would be recouped through your work, then that’s a very powerful argument. For our program, we estimate that every Medicaid denial reversal brings in \$5,000-\$7,000 per case, and also reduces rates of Emergency Room use. For example, a client with high blood pressure who is on Medicaid can get treatment for the high blood pressure and be able

to control the problem. The same patient, without Medicaid, may show up at the Emergency Room three months later, with a stroke that will cost the hospital tens of thousands of dollars to treat and will, obviously, greatly reduce the client's quality of life. We can't quantify the dollar value of avoided emergency room visits, but I am hoping that we can find a way to do that in the future.

Oftentimes, medical centers are already working hard to enroll their patients in medical coverage programs. Hospitals increasingly have entire departments whose job it is to enroll uninsured patients in the appropriate health coverage program. Lewis Popper, General Counsel of Truman Medical Center, explained that:

Truman Medical Center is a safety net institution. We now have full time state employees who have the power to admit people to Medicaid right in our hospital. However, [until we started the Medicaid Appeals Project] we had no capability to *appeal* denials of Medicaid, which of course came all too often. What we tried to do was to tell them to go down to Legal Aid....We had realized that most of our patients didn't necessarily [know about or feel comfortable] getting to Legal Aid, so we decided to put an appeals legal office right in the hospital, right in the office where we were doing the initial applications for Medicaid. The money started coming in, and it was "found" money – money that [we otherwise would never have been reimbursed]... It was an amazing success, and that was the bottom line.

In addition, for-profit corporations often approach hospitals to do this kind of work for a high price. So for a Legal Services organization to offer to do it for merely operating costs, or a portion of operating costs, creates a large incentive for the hospitals to choose the legal services organization as the best possible partner for their patients and for their administration.

Hospital Debt Paradigms

In order to fully comprehend the potential for this program model and the financial power of legal services, it is helpful to have some understanding of hospitals' fiscal calculations. Essentially, while public health insurance programs help finance services for the uninsured, these subsidies do not cover the full cost of care. For this reason, hospitals must absorb the cost involved in caring for the uninsured. The financial burden placed on hospitals and physicians is significant.

Hospitals have three kinds of losses, each with a different financial impact:

- 1. Medicaid Payments:** Medicaid only pays a small percentage of the costs of care. Hospitals have different contributions rates from Medicaid; depending on the kind of hospital and the percentage of Medicaid patients they see, they are reimbursed at different rates. These rates range from roughly 25% to 35% of the full cost of providing the service. The difference between the costs of providing the medical service and the amount that Medicaid reimburses the hospital is called "uncompensated care" or "uncompensated services." However, "uncompensated services" can later be claimed by the hospital as charitable contributions, and do not become "bad debt."
- 2. Charity Care:** Charity Care functions differently depending on how each hospital wants to run its individual Charity Care program. Yet it usually works in this way: when a patient comes into a hospital and does not qualify for Medicaid, but is still very low income, the hospital helps the patient apply for Charity Care, and then submits that patient's bills to their Charity Care program. For example, while Medicaid coverage is usually reserved for families living at up to 200% of the Federal Poverty Level, a family who is living at 400% of the Federal Poverty Level may be eligible to receive help from a hospital's Charity Care program. Because "Charity

Care” can be written off as a charitable contribution, (while meanwhile helping to avoid “bad debt”) some hospitals very aggressively promote their charity care programs and help patients complete all of the required paperwork.

- 3. Bad Debt:** “Bad debt” is accrued by a hospital when patients do not participate in trying to qualify for insurance at all, and just say, “Send me the bill.” Then, when the patient does not pay, and the hospital - even with the help of collections agencies - cannot collect the money owed by the patient for services, the debt owed becomes “bad debt.” Bad debt is a serious concern to hospitals, because if a medical center has too much “bad debt” then it starts to be a liability on the hospital’s income statement, and the hospital’s bond rating suffers. This makes it much harder for the hospital to borrow money. Like an individual with bad credit who has to borrow money at a higher rate, a hospital with too much “bad debt” must borrow money at a higher rate of interest. As a result, the whole community suffers, because the hospital has less money to invest in patient care. The hospital therefore has an incentive to do all that it can to reduce its accrual of “bad debt.”

A successfully appealed Medicaid denial results in Medicaid enrollment that will cover services provided during the three months prior to the initial application (if the applicant requests retroactive benefits within an appropriate time-frame, and only if the applicant was eligible during those three prior months). It also results in *future* payments; once patients are insured they are more likely to see preventative care, which gives the hospital a chance of preventing any future medical emergencies that will likely also be uncovered by insurance. Finally, according to Popper, certain “safety net” hospitals also receive “supplemental payments” for every dollar billed to Medicaid. In other words, even though a hospital is only reimbursed a certain percentage of every bill, for those hospitals that see a very high number of low-income patients, they are further reimbursed another few cents on each dollar, for some services.

The financial benefits to hospitals from this work cannot be understated. Carol Neidenberg, Program Manager for the Benefits Advocacy Project, explained how, as a result of the successful resolution of *one* case resolved by the San Diego Benefits Advocacy Project, the hospital was reimbursed for services worth one million dollars. Popper explained that in Missouri, Truman Medical Center has even contemplated giving its medical providers a *financial incentive* to make referrals to the Medicaid Appeals Project. The financial benefits are so lucrative that one hospital administrator explained that, at one point, “We worried that the state would accuse us of setting up a system to get more Medicaid dollars, but no one said anything – for we are only getting what we deserve!” Indeed, the beauty of this model is that the Legal Services organization inadvertently becomes not only an advocate for the financial wellbeing of the client, but also for the financial wellbeing of the hospital; the patient is eligible for (but erroneously not receiving) Medicaid, while the hospital is eligible for (but erroneously not receiving) payments for services rendered to low-income patients.

The Motivation for Legal Services Organizations

It is important to note that on their part, the legal services organizations involved are not providing this service to the hospital for financial incentives. They are doing it because, as Lombardi declared, “Our incentive was that it was our mission to do this!” The legal service providers interviewed clearly expressed that they started this program simply because they recognized that they were not reaching the vast amount of individuals whose Medicaid applications were being denied, and wanted to find an effective way to do so. With the exception of LegalHealth, the programs came out of the public benefits/consumer centers of their legal services organizations; *these departments/units are specifically charged with insuring that low-income people receive the public benefits they are eligible to receive.* As advocates, their duty is to their clients, and, as expressed by Goffinet, getting the hospital reimbursed is, and never has been, the priority. Rather, the priority is relieving clients of thousands of dollars of medical debt while simultaneously getting them insured so that they can seek preventative care and find a medical home.

That said, these programs have tremendous potential to support the work of legal services organizations, which must rely on year-by-year foundation support and/or funds from the Legal Services Corporation, which strictly curtails the kinds of work that legal services organizations receiving its funding can do. Such restrictions forbid, among other things, the provision of legal services to undocumented immigrants. By being partially or fully funded by hospital support – to undertake advocacy that they would otherwise do and to strive for results that it is their mission to achieve – each of the programs highlighted have ensured the financial feasibility of their work for the long term, outside the fluctuations of grant cycles. This funding model may even create an opportunity for legal service organizations to refuse Legal Services Corporation funding, thus allowing them to expand the depth and reach of their services.

To fully understand this model, it is useful to get a picture of exactly how the four programs in the United States that track and leverage the financial impacts of their work function. What follow are summaries of the four highlighted programs, including how they got started, how they are staffed, how they are funded, how they manage their referral processes and client/patient confidentiality responsibilities, how they track and report data, and the financial impact of their work for their medical partners.

Program Summaries

The Medicaid Appeals Project: Legal Aid of Missouri and Truman Medical Center

The **Medicaid Appeals Project** is a collaboration between Legal Aid of Missouri and Truman Medical Center. The program is also in the process of expanding to Children's Mercy Hospital.

Legal Aid of Missouri (LAWMO) has been providing high-quality, legal services to low-income Missourians for more than 40 years. With 49 attorneys and 19 paralegals on staff, LAWMO is the seventeenth largest private law firm in the Kansas City area and the only private, not-for-profit law firm in Western Missouri to provide a wide-range of legal services to low income clients. Attorney Effie Day runs the Medicaid Appeals Project within LAWMO. Project staffing includes an intake paralegal located at the TMC's main campus, who spends one day per week at TMC's satellite hospital in Eastern Jackson County. 6 attorneys and 3 paralegals work on the project, although the team also handles Medicaid appeals for clients who do not receive treatment at TMC.

Truman Medical Centers, Incorporated (TMC) is a non-profit, tax-exempt corporation that functions as the "safety net" hospital system for uninsured, under-insured, and government-assisted patients in Jackson County and Kansas City, Missouri. TMC is the primary teaching site for the University of Missouri-Kansas City Schools of Medicine, Nursing, Dentistry, and Pharmacy. Each year, the hospital treats nearly 100,000 unduplicated individuals, including approximately 12% of all Jackson County residents. At TMC, 13% of patients have private insurance, 31% are uninsured, 53% have Medicaid or Medicare and the remaining 3% have some other payment source. Lewis Popper, TMC's General Counsel, manages the relationship with LAWMO. As a member of TMC's Leadership Team, he acts as the liaison between the project and TMC's top-level administrators.

Project Inception and Organization

In 2004, LAWMO approached TMC with the idea of starting a medical-legal partnership program designed around appealing Medicaid denials. According to Gregg Lombardi, LAWMO's Deputy Executive Director, "TMC, as Kansas City's public hospital, treats a very large percentage of the people who have their Medicaid denied. So four years ago we approached them and asked them to refer to us those individuals they were treating who had had their Medicaid denied. It took a lot of calls to a lot of people within the organization before we could find anyone who had the time to devote to a project of this magnitude. We ended up going to the Board President of TMC, who introduced us to Lewis. When we talked with Lewis about the potential benefits of the project, not only to Truman but also to its patients, he was immediately excited about the idea."

According to Lewis Popper, "One day, Gregg called me – after having put this whole thing together himself – and said, 'I have a great idea; we have a terrific office that appeals Medicaid denials and we could set up an office hooked in with TMC to handle all of your appeals - and we should even approach a healthcare foundation to fund it.'"

Together, Popper and Lombardi strategized that their separate efforts to ensure that low-income individuals were being appropriately covered by Medicaid might be more successful if they created a LAWMO branch on-site at TMC. In July 2005 LAWMO and TMC together applied for and received a \$146,985 start-up grant from the Health Care Foundation of Greater Kansas

City. The primary goal for that first year was to obtain Medicaid benefits for 45 TMC patients; LAWMO staff estimated that the work would lead to TMC receiving \$1,000,000 in Medicaid payments within 15 months after the project's inception.

Since creating the Medicaid Appeals Project, LAWMO has expanded its Medicaid appeals team significantly to handle the work generated by the project. According to Lombardi, "We have added three new attorneys and one paralegal. This paralegal is on site at TMC during normal business hours every day, doing intake and outreach at the hospital. And then the cases come back to our office and we assign them to attorneys on the project."

Project Funding

In its first year, the Medicaid Appeals Project netted TMC \$1,200,000. The financial successes of the first year led LAWMO and TMC to announce that from 2006 onward, the project would be entirely self-funded for the foreseeable future; they would seek no further grant money from the Health Care Foundation of Greater Kansas City. "We were very pleased that the project was successful enough that Truman Medical Center was willing to fund it," explained Lombardi. "And I can tell you that the Foundation was pretty happy when we went back to them and told them that they could keep their money."

Today, TMC fully funds the costs of the project, provides office space and overhead, and pays LAWMO a percentage of the returns. According to Popper, at the end of the first year, LAWMO and TMC agreed that TMC would pay LAWMO 30% of the money that comes into the hospital as a result of the LAWMO's appeals work. Popper explained, "We thought about it and thought "Why not? It's found money, and to give them 30% of it was a good deal for us. Moreover, when they started bringing in so much money to us that their percentage got above a certain amount of money, they actually offered to reduce their percentage, because they were fully covering their costs."

Referral Process and Patient/Client Confidentiality

As noted above, TMC has state employees out-stationed within the hospital to enroll eligible low-income individuals in the appropriate health insurance program. When one of those applications is denied, TMC Financial Counseling Center staff escort the denied Medicaid applicants to the LAWMO office, obtain patient authorizations for release of medical records from TMC, and make sure that LAWMO promptly receives the medical records needed for appeals. On its end, when LAWMO has successfully appealed a denial, it gets the client's permission to disclose to the hospital that he or she has been retroactively enrolled in Medicaid. LAWMO then informs the hospital of the patient's coverage and tells the hospital that it can now re-bill for the time period covered by the appeal.

Case Tracking and Reporting

LAWMO tracks client outcomes for each of the 11,000 clients it represents each year. It uses this same internal tracking and evaluation system for the Medicaid Appeals Project. LAWMO tracks those clients that come in through the project and records the debt burden relieved for each client. The hospital also tracks which patients have been referred through the project to LAWMO. When LAWMO successfully appeals a denial (after receiving client permission to do so) they inform TMC that that patient is now covered by Medicaid and asks that the hospital re-bill Medicaid for the medical services provided to the client. The hospital puts a notation in the patient's file within its own computer system, and tracks the amount of debt TMC is reimbursed as a result of LAWMO's advocacy. Because it can take as much as three months or more for Medicaid to make payments on approved claims, the total final financial benefit of the project are not known for some time after the end of each annual cycle.

By the end of the project's second year, LAWMO had pursued Medicaid appeals for 443 of TMC's patients and obtained Medicaid benefits for 422 of them, obtaining benefits for TMC patients who had been denied in 95% of their cases. **In the first two years combined, TMC received \$2,995,088 (\$1,282,895 for the first year and \$1,712,193 for the second) in Medicaid payments for services that it has provided to the 422 patients represented by LAWMO.** This amounts to \$6,776 per successful representation and \$3,430 per referral that TMC's staff has made to the project.

The Law and Health Project: Land of Lincoln and Southern Illinois Healthcare

The Law and Health Project is a collaboration of Land of Lincoln Legal Assistance Foundation, Inc., Southern Illinois University School of Law, and Southern Illinois Healthcare.

Land of Lincoln Legal Assistance Foundation, Inc. is a nonprofit organization providing free civil legal assistance to low-income persons in 65 counties in rural central and southern Illinois. It has five branch offices and three satellite offices. Its mission is to pursue civil justice for low-income persons through representation and education. At Land of Lincoln, Diane Goffinet is the Legal Director for the Law and Health Project. Ms. Goffinet has over fourteen years of legal services experience and specializes in health and public benefits issues. She provides direct supervision for the fulltime project paralegal, who is also a social worker. Ms. Goffinet originally devoted 10% of her time to the project, then 25%, and now spends 50% of her time on the project. The project coordinator does all intakes and represents clients at the Social Security and Medicaid hearings that came in through the project. Ms. Goffinet assumes responsibility for any cases that must be filed in court.

Southern Illinois Healthcare is the largest health care provider in southern Illinois. SIH owns and operates three hospitals: Memorial Hospital of Carbondale, Herrin Hospital, and St. Joseph Memorial Hospital of Murphysboro. SIH promotes strong, effective community outreach through its Community Benefits Department (CBD). The Department is charged with fostering productive, collaborative relationships with individuals and organizations in the service area, as well as implementing innovative, contemporary programs designed to fulfill the unmet needs of the underserved. Woody Thorne, Director of the CBD, serves as the primary coordinator of medical-clinical activities related to the Law and Health Project and coordinates SIH medical providers' participation in the project. Mr. Thorne. In this role, he coordinates the referral process from SIH to Land of Lincoln. Mr. Thorne has consistently devoted approximately 8% of his yearly work hours to the Project.

The Project receives referrals from all three of SIH's hospitals and its various free clinics, mental health clinics and community clinics. In collaboration with local schools, the project has recently expanded to serve School-Based Health Centers (SBHC). Also, while the project started out doing only Medicaid and SSI denials, it has now branched out into providing a wide range of legal services to SIH's patients.

Project Inception

In the spring of 2002, Diane Goffinet and Woody Thorne met at a community meeting on health issues. By chance, they sat at the same table during lunch and began brainstorming about the possibility of creating a medical-legal partnership program. Having read about the Boston program, Thorne contemplated how legal services could be engaged to work on such a project to assist patients in their service area. They discussed possible logistics of the project, and Goffinet returned to Land of Lincoln to talk over the idea with her colleagues. During this meeting, Goffinet recalls, "We decided that they didn't need to hire an attorney, they needed to hire *us*." A collaborative model was constructed and a site was selected to pilot the program.

Thorne and Goffinet initially launched a 12 week pilot project at one of SIH's free clinics to assess need in the community. They arranged that SIH would provide enough funding to pay one law student ten dollars an hour for 20 hours a week for 12 weeks; the hospital first put forward roughly \$1,600. During the pilot project, Land of Lincoln took in 10 clients and opened a total of

13 cases. By the end of the twelve-week period, Land of Lincoln had successfully resolved a case in which the client needed assistance accessing public medical benefits. This client had an outstanding obligation of \$10,000 to SIH. As a result of the legal advocacy provided, the client was enrolled in the appropriate benefits program and relieved of \$10,000 in medical debt. Meanwhile, the hospital was reimbursed approximately \$3,300 for the services provided to the client, nearly twice what it had spent to fund the pilot project. Such data was strong proof of the potential benefits of a long-term medical-legal collaboration, and convinced SIH of the need to continue investing in the project. Land of Lincoln applied to hire a Vista volunteer to coordinate the project for the following year and SIH paid for Land of Lincoln's portion of the Vista salary, roughly \$5,000 a year for the first two years..

Project Funding

The total annual cost of the project is \$129,000. This pays for 50% of the attorney's salary and benefits, and 100% of the project coordinator's salary and benefits, as well as travel costs. At the end of the first two-year period, SIH agreed to fund the program at roughly \$30,000 a year. According to Goffinet, there is an application process within the SIH Community Benefits department which Land of Lincoln completes to request funding from the health system. Land of Lincoln presents the costs of running the project to SIH, and SIH pays a portion of those costs. Hospital funding has fluctuated slightly as the project has attracted other funders.

Referral Process and Patient/Client Confidentiality

The Law and Health program receives the majority of its referrals from social workers and case managers at SIH's various hospitals and clinics. When the referral is received, a Land of Lincoln staff member goes to the client either bedside in the hospital or by appointment at the clinic. A one-page referral form is completed by the referring provider, signed by the patient, and faxed to Land of Lincoln, who then calls the referring provider and either triages the client's needs on the spot, or arranges an intake with the client/patient. Because the project operates in large, rural area, it is important for Land of Lincoln to coordinate with SIH to do an intake while the individual being referred is, if possible, still present in the area. Upon receiving services, patients provide a waiver that enables project staff to communicate and exchange information regarding issues specifically pertaining to the financial obligations of each patient for the specific timeframe at issue. This waiver allows SIH to document the costs of services provided to patients, and to estimate how much it was eventually reimbursed for those services.

Case Tracking and Reporting

From the program's inception, Land of Lincoln tracked the financial outcomes of every case resolved through the Land and Health Project, beginning with the 13 cases from the pilot project. The Law and Health Project provides a quarterly report to SIH, that details the number of clients referred to the Project for the reporting quarter, the referral source, the general problem the patient was referred for, and the status of the referral, keeping the client's identities confidential. It also reports how many cases were closed in that quarter and the result of each case, including an estimate of any financial reimbursement to the health system from Medicaid due to Land of Lincoln's representation of the client. Each quarter the report begins with a narrative describing two or three success stories exemplifying the work that has been done over the past three months. To preserve client confidentiality, the Law and Health Project keeps a separate chart with this limited information separate from Land of Lincoln's case management system. Thorne and Goffinet regularly review the project status relative to process and outcome goals and discuss how to improve upon the current project design. They meet at least quarterly in person to evaluate the effectiveness of the project, to identify any changes that may need to be made, and to review training issues or needs.

Land of Lincoln keeps track of the amount of the financial obligations relieved or back-benefits

paid to their clients after the successful conclusion of a case and informs SIH of this information. The hospital separately works with the Center for Rural Health and Social Service Development, an arm of the local research university, to evaluate the project using process, outcome, and financial indicators. According to this research and the records maintained by Land of Lincoln, in the first four years of the project, **between 2002 and 2006, the hospital invested a total of \$115,438 in the Law and Health Program. During this time, the project saw 372 clients, and successfully relieved those clients of \$1,132,431 in financial obligations. Of this amount, Medicaid and other insurance sources reimbursed SIH \$287,573, more than twice the hospital's investment.** Furthermore, in 2007 alone, the project resolved more than a million dollar's in clients' medical debt. **From October 2007 through December 2007, the financial obligations relieved totaled \$253,362.58. The estimated reimbursement SIH for that quarter totaled \$83,609.**

**The San Diego Benefits Advocacy Project:
The Legal Aid Society of San Diego County and Scripps Mercy Hospital**

The **San Diego Benefits Advocacy Project** is a medical-legal partnership between Scripps Mercy Hospital (SMH) and the Legal Aid Society of San Diego, Inc. (LASSD).

LASSD has over 50 years of experience providing legal, advocacy and education services to low-income individuals and families in San Diego County. Its mission is to provide equal access to justice for poor people through quality legal services. In March 1999, LASSD established the Consumer Center for Health Education and Advocacy (Consumer Center), an advocate-attorney team dedicated to helping clients access care and obtain and maintain their eligibility for government benefit health programs and access care. Carol Neidenberg, MS, is the Program Manager for the Benefits Advocacy Project. She coordinates a staff of two bilingual (English/Spanish) outreach workers and the part-time commitment of two lawyers.

Scripps Mercy Hospital (SMH), part of the Scripps Health network, is a not-for-profit health care delivery organization with two hospital campuses located in the Central and South Regions of San Diego County. SMH provides a continuum of health care to San Diego residents, many of whom are low-income women, children and families. As the largest disproportionate-share hospital in San Diego, SMH is a critical safety net provider; since San Diego does not have a county hospital or an integrated community clinic system to care for its uninsured and/or medically fragile population, the county relies heavily on the private not-for-profit health system to provide this care. While a physician at each of SMH's hospitals serves as the project's medical champion, the primary contact at SMH is Margaret Beltran-Espinoza, Manager of the Public Resource Department. This department is responsible for screening patients for health care coverage and enrolling them in the appropriate public health insurance or charity care programs. It is through this department that the Benefits Advocacy Project receives referrals.

Project Inception

LASSD had heard about the medical-legal partnership model, and had been interested in establishing such a program. In 2004, when the hospital's Community Benefit Administrator discussed with Carol Neidenberg the scope and objectives of the Scripps Community Benefit Fund (established by SMH to make charitable contributions to the community), LASSD decided to submit a proposal to the Fund for support for a medical-legal partnership program. LASSD was awarded a one-year \$25,000 grant. LASSD matched this amount, provided in-kind support, and in March 2005 launched the San Diego Benefits Advocacy Project at the SMH Central campus. The Project works with low income adults, many of whom are homeless and/or have mental illnesses.

At the end of the first year, as that funding was running out, LASSD arranged a meeting with the CEO of SMH, during which Gregory E. Knoll, Esq., Executive Director of LASSD, presented the financial and legal results of the first year's advocacy. This data showed that the project had more than paid for itself after the first six months. As a result, the Scripps Community Benefit Fund granted a second year award of \$50,000 that allowed the Project to reach beyond the acute care setting to serve ambulatory care patients at Mercy Clinic. By the second year, legal and advocacy services were extended to Scripps Mercy Chula Vista Hospital, along with South Bay community clinic sites affiliated with the Scripps Family Practice Residency Program.

While initially the hospital benefit staff were leery of working with outside legal professionals, by

the second year a more efficient referral system and closer working relationships had evolved.

Project Funding

According to Neidenberg, in preparation for asking for doubled funding for the second year's operation from the Fund, the Consumer Center "had to take a serious look at our records and prove that we had really recouped a great deal of money. We had to go through [our records system] and read every case. We tracked how many cases we were referred and how many were successfully resolved. We also had some SSI cases we had resolved, which was even better, as all of those individuals had been enrolled in Medi-Cal as a result of being found eligible for SSI."

In its first year, LASSD helped SMH patients obtain approvals for previously denied health care services that resulted in hospital reimbursements of more than two and a half times the return on the original investment. The Consumer Center used these calculations in its second year grant application to argue for increasing funding, a more effective referral system, and an on-site Mercy Clinic presence. According to Neidenberg, "The first year the costs of running the program were supplemented by LASSD. The second year, we got the \$50,000 grant because we were able to clearly demonstrate the financial benefit of our work to the hospital. But now, in the third year, we crunch the numbers from the moment the referral hits our desks. This year's funding is \$100,000. Half is from the Fund and the other half is the hospital's contribution." Today, Project staff is 100% funded by Scripps, with continued in-kind management and attorney support from LASSD. Neidenberg explained how both the Scripps Community Benefit Fund and SMH were anxious to guarantee that the project continued: going into the fourth year, the Fund Fed-Ex'd the grant application to Knoll to ensure that LASSD submitted an application, and SMH's CEO personally called to request that LASSD to submit an application.

Referral Process and Patient/Client Confidentiality

SMH has an internal department whose function is to enroll patients in Medi-Cal, County Medical Services and other government insurance programs. Uninsured patients first go through the hospital's internal Public Resource Department, run by Beltran-Espinoza, which leads them through the enrollment process and secures the individuals' permission to refer their case, if denied, to LASSD. Initially, because the staff of this department felt that their role was being usurped by the project, there was some difficulty creating a smooth and functional referral system. However, as the appropriate division of responsibilities became clear, the hospital's Public Resource Department now regularly refers the Benefits Advocacy Project close to 50 potential clients a week.

SMH receives notice when an application for public benefits for those individuals helped by the department is denied, and refers those cases to LASSD. Project staff receive weekly referrals either via fax or at the virtual on-site clinic and facilitate advocacy services within the Consumer Center and LASSD accordingly. According to Beltran-Espinoza, "We fax the referrals, we have a drop box, and [project staff] come into the office twice a week to collect all of our referrals. Then we go over the denials and let them know the details of that person's application, talking to them about each particular case, providing all the information about what we did, and then [LASSD] helps that patient to go through an appeal or works it out between the county and the patient." By the time the Benefits Advocacy Project staff receives the referral, the patient has already signed a release of information, authorizing the hospital to forward their information to LASSD.

However, because of the particular patient population that SMH serves, not all of the patients referred turn into cases. Haydee Quintanilla, one of the project's health advocates, explained: "From November 2007 through February 2008, we were referred 396 patients. Out of those referrals, we sent contact letters to those with mailing addresses; about 5% don't receive letters because they are homeless. Or

we called and left messages and tried to get people to call us back. We [usually] get three to four calls back from every 25 letters or so. [As a result] we might only open five cases out of those 25 referrals. Generally, of those five cases, four get resolved and one goes to hearing.”

LASSD is currently working to create a system through which it can contact Medi-Cal applicants *before* they leave the hospital and disappear into the wider world, where they may then be unreachable. Neidenberg explained that, “What I would like to do is get in touch with these patients before they are discharged and meet them face-to-face. After leaving the hospital, we would collaborate with other community agencies to find these individuals and make sure that their applications are completed and processed before we lose them. As a county, we fail the homeless population, as so many are uninsured and without a medical home.”

Case Tracking and Reporting

Both LASSD and SMH each have their own systems of case tracking and record keeping. LASSD provides SMH with semi-annual reports that detail the cases referred by SMH, and the outcomes achieved as a result of LASSD’s advocacy. LASSD keeps track of the medical service provided to the client, the amount of the bill, how much debt was relieved as a result of the successful appeal of the Medi-Cal or SSI/Medi-Cal denial, and how much debt was recouped by the hospital. LASSD also works with doctors to teach them how they can re-bill for services that preceded the retroactive coverage period.

While LASSD did not always receive the patient-level data on finances reimbursed for the first two years, it now receives this regularly from hospital and rigorously tracks each case. **During the first half of the project’s third year, for the period between June 2007 and October 2007, it successfully relieved clients of \$3,131,413 in medical debt.** According to Medi-Cal’s financial paradigms, the hospital gets a portion of every dollar back. It is the hospital’s responsibility to determine the exact amount of funding it is reimbursed as a result of LASSD’s work successfully appealing Medi-Cal denials.

LegalHealth: New York Legal Assistance Group and Assorted Hospitals

LegalHealth is a division of the citywide **New York Legal Assistance Group** (NYLAG). NYLAG was founded in 1990 on the premise that low-income individuals and families could improve their lives significantly if given access to quality legal services. NYLAG does not limit its services by strict income guidelines or immigration status. LegalHealth's work brings legal services to medical clinics at fourteen New York City hospitals and community-based health organizations. These legal clinics are conducted by staff attorneys who receive referrals from physicians, social workers and other medical professionals. LegalHealth also provides training to medical professionals on legal matters that directly affect the healthcare needs of patients and provides technical assistance to other medical-legal partnerships.

Project Inception/Program Funding

LegalHealth was founded by attorneys Randy Retkin (Executive Director) and Julie Brandfield (Associate Director). Both had read the New York Times article about the Boston Medical Center Family Advocacy Program and had immediately understood the urgent need to bring this program model to New York City's urban poor. Since 2001, LegalHealth has grown from two lawyers to a team of twelve attorneys, two paralegals and a data coordinator and evaluator, and has provided free legal assistance to 6,300 low-income people with serious health problems. The program model has, from its start, required that hospital partners underwrite a portion of the cost of operating the onsite legal clinics; hospitals provide a \$25,000 annual contract fee. The request covers approximately thirty percent of LegalHealth's cost of running a medical-legal partnership program at the hospital.

When initiating a partnership with a hospital or clinic, LegalHealth holds a meeting with the hospital administration or physician champion. At the table is often the hospital's CEO or Vice President, as well as a department head and the General Counsel. During this meeting, Retkin and Brandfield introduce LegalHealth, explain what LegalHealth does, and detail how the program's legal advocacy will benefit the hospital, its patients, and its healthcare professionals. Retkin and Brandfield explicitly describe how LegalHealth's successful advocacy will generate revenue for the hospital through various funding streams. They provide copies of program reports and the results of their pilot study to demonstrate the successes that LegalHealth has had to date. They then make the funding request. In this way they make clear from the start: the hospital must play a part in supporting the provision of advocacy services to its patients.

LegalHealth does not begin a program within a hospital without first securing this financial commitment upfront. According to Retkin, "The concerns about funding have often focused on the hospitals' own financial situation because of the tough times for hospitals. We often have to come prepared with examples showing how the investment is well worth it financially." The hospitals must re-invest \$25,000 every year, and after the first year LegalHealth comes to these meetings equipped with case examples from their work at that particular hospital, showing how the hospital and patients benefited from on-site legal advocacy. Such case examples successfully convince the hospital to continue funding.

Referral Process and Patient/Client Confidentiality

LegalHealth has two sets of releases for its clients to sign: one consent signed by the client allowing LegalHealth to release confidential info to the hospital, and a HIPAA release signed by client allowing the hospital to release information to LegalHealth. This exchange of information is part of the terms of the contract that LegalHealth has with each hospital.

Case Tracking and Reporting

Because LegalHealth's medical-legal partnerships started out by providing a wide range of legal services, LegalHealth did not immediately start tracking the financial benefits of cases that might generate revenue such as Medicaid Appeals. Instead, they commissioned two independent consultants to examine the costs and benefits to the hospitals of the services LegalHealth provides to their patients. Impetus to formally analyze the benefits to hospitals came from several of LegalHealth's funders who believed that a formal study would strengthen LegalHealth's ability to secure hospital funding in the future.

The two consultants collected data about cases handled at two major hospitals during 2004 and 2005. Of the 381 cases LegalHealth handled for patients at these hospitals during the study period, 13% generated new revenue, averaging \$11,904 per patient. The study found that the cases that generated revenue were those involving insurance and benefits matters. **The study showed that LegalHealth's services resulted in \$345,221 in collections and \$1.3 million in billings (in the aggregate for both hospitals).** It concluded that for every dollar spent by the hospital in support of LegalHealth's onsite clinic, it received \$16.00 in revenue. Retkin believes these results to be extremely significant: "It shows that the cost of our services is outweighed by the benefits. Anecdotally, we have always known this was true, but now we have the data to justify the hospitals' contributions to LegalHealth.

http://legalhealth.org/docs/lgh_financial_impact_study.pdf)

Because LegalHealth and the hospitals had not previously devised tracking systems for this data, to determine whether a financial benefit resulted to the hospitals the team requested that each hospital provide information relating to medical diagnosis, billing and collection amounts, insurance, and the dates of all inpatient, outpatient and clinic service for each client. Because many of LegalHealth's clients do not have Social Security numbers or working phone numbers, the research team was not able to find data on all of the cases; it was able to evaluate roughly 60% - 77% of the cases. LegalHealth is now working to expand this pilot study to all of its sites, and anticipates completing annual reports for each of its hospitals, beginning in 2008, which track the financial benefit to each hospital more closely.

Potential Problems: Conflict with Programs that Enroll Patients in Medicaid

The Medicaid Appeals Project and the San Diego Benefits Advocacy Project described varying levels of conflict with the departments or for-profit companies whose responsibility it was to enroll eligible individuals in publicly-funded health insurance programs. As the advocates were establishing their medical-legal partnership programs, turf issues surfaced, until a series of meetings and interventions from hospital administration (admonishing the internal department/for-profit company for refusing to make referrals to the medical-legal partnership program) clearly established the division of work. Goffinet explained that in her work with SIH, the *only* problem she ran into in the administration of the Medicaid Appeals Project was that “The hospital has a company that comes in and help clients apply for Medicaid...I had to get records and show cases to SIH to prove that the other contractor was claiming credit for getting money that I had gotten as a result of legal advocacy. I solved this by using my contacts in the hospital administration, who resolved the problem.” Experience and results eventually proved to the hospital department/company that they had not lost any power or jurisdiction, but rather gained an important partner whose efforts actually supported and furthered their own work.

The Law and Health Project, while it did not face these problems at TMC, is grappling with similar issues as it works to expand into other hospitals. As Lombardi explained:

This [one particular] hospital pays a company \$500,000 a year to sign people up for Medicaid. That organization handles about 10-15 appeals per year for them. There are probably about 50-75 appeals a year that they should be doing. So we propose we can reduce the hospital's costs by about \$400,000 (if they had their own internal staff help people sign up for Medicaid) as our costs would be about \$100,000, and for that they would increase their Medicaid payments by about \$250,000 to \$500,000. So by contracting with us we would net them between \$600,000 to \$900,000 a year in savings. But there are a lot of for-profit corporations that have been in these hospitals for years, doing this work. And they have relationships with the hospitals. And any change seems at first like a bad idea. Also, hospitals sometimes have long term contracts with the organizations that they can't get out of. We may have to be patient and wait for the contract to expire and then start to work with them.

The Implications for Pediatric Programs

The consensus among the individuals interviewed was that while this program model would not be nearly as financially lucrative in a pediatric setting, it is very possible to make it work, though at a much lower “profit” to the partner medical center. This is because most states have much better health insurance coverage for children; it is rare to find a low-income child whose medical services have not been covered by the appropriate federal, state or county program. However, there *are* families who have not completed their paperwork and whose coverage has lapsed, who are struggling with administrative errors on the part of the county system, or who have not enrolled their children in Medicaid due to immigration-based fears, etc. There are also families who are referred to pediatric medical-legal partnership programs by their child's pediatrician for one legal difficulty, and are then found, on intake, to be struggling with large amounts of the parents' medical debt, sometimes recent enough to take action to resolve. In addition, Lombardi suggests that while most low-income children are indeed covered through a patchwork of public health insurance programs, there may be advocacy opportunities in those cases where the public or private insurer has deemed a procedure or medication “not medically necessary” and refused to cover it. In those cases where the pediatrician can adequately document that it is indeed medically necessary, the medical-legal partnership program can work with the doctor to overcome the denial and have the bills covered.

Moreover, in pediatric hospitals with obstetrics-gynecology services and maternity wards, there may be medical debts related to the uninsured mother's care. Finally, for those programs that operate within the pediatric departments of large safety-net hospitals, there may be an opportunity to expand the reach of

the medical-legal partnership to include and encompass some of the hospital's adult Medicaid appeals cases.

According to Neidenberg, in 2007, 23% of the cases handled by the San Diego Benefits Advocacy Project concerned children's benefits (ages 0-18), while 77% if the client population were adults (Ages 18 and over). From the pediatric advocacy perspective, this is actually a very encouraging figure, considering that the project was not specifically geared towards helping children.

It is worth noting that even if the hospital *only breaks even* as a result of the advocacy work of a medical-legal partnership project, this would still benefit the hospital greatly. The funding for the program could be written off as a charitable contribution, while meanwhile the money recouped from successful appeals of erroneous Medicaid denials would have become "uncompensated services" and therefore would not fall into the category of "bad debt." Meanwhile, as explained by Lombardi, if it was somehow possible to track the *future benefit* of properly-enrolled children/families in Medicaid, there would be a potentially powerful argument that the work of the medical-legal partnership program effectively reduces expensive future Emergency Department visits, often relied upon by uninsured families for medical care.

Interestingly, Ewen Wang, Associate Director of Pediatric Emergency Medicine at Stanford University Hospital, in association with Charles Dibble, Assistant Director of Patient Admitting Services, provided a public health benefits registration service within Stanford's pediatric emergency department. Children without insurance were asked by Emergency Department registration staff if they would like to fill out a one-page form that would be faxed to the San Mateo Children's Health Initiative. San Mateo County's Children's Health Advocates then worked to enroll uninsured children in the appropriate public health insurance program. In evaluating the program, it was found that in the fiscal year 2006, 417 of the 1,231 children who were initially self-payors were referred to the project as eligible for benefits. **Of those 417 children, 250 children were successfully enrolled in a medical benefits program (60%). From those cases, the hospital was able to recover over \$180,000 that would have otherwise been characterized as "bad debt."** (Publication pending) While these figures do not track the finances reimbursed to the hospital as a result of successful Medicaid denial appeals, it is likely that a proportional financial benefit could be found in the pediatric emergency room setting as a result of appeals work.

In sum, this model has very positive potential for replication in a pediatric setting. However, in order to establish the highest rate of returns for a hospital, a medical-legal partnership program hoping to become fully funded by its partner medical center may want to branch out to include some degree of adult advocacy services.

Recommendations for Creating Health Care Recovery Dollars-Funded Programs

1. When beginning negotiations with the hospital, make sure that the hospitals' Chief Financial Officer, in addition to the General Counsel and other top administrators, is at the table.
2. The report commissioned by LegalHealth concludes by recommending that in preparation for meetings with the hospital, legal services organizations draft a "value proposition" for use when pitching a health care recovery dollars project to the hospital. The report defines "value proposition" as a clear statement of the tangible results the hospital can expect as the product of partnering with the legal services organization. The legal services organization should bring a copy of this proposition with them to the meeting and present it to the CFO and CEO of the hospital.
3. Begin with a pilot study that can prove the program's financial benefit to the hospital.
4. As the programs reviewed make clear, it is not always necessary to have a medical champion

when pioneering a medical-legal partnership program that will bring financial benefit to the partner hospital; if the medical center has a financial incentive for its staff to refer clients to the medical-legal partnership project, then its administration will itself “champion” the project.

5. The programs highlighted do not rely heavily on the work of attorneys to process Medicaid cases. Public benefits denials that go to an appeals process do not necessarily need the representation of attorneys; anyone can act as an appointed representative at some administrative hearings. The projects are staffed and run by paralegals, social workers, and community advocates who liaise with the hospital, conduct intake, discuss cases with county representatives, and (in some programs) oftentimes argue for the client at hearing. In these programs, the lawyer only steps in when the case is at a point where attorney representation is necessary. As a result, not all of these projects include the full-time salary of an attorney, which can help to reduce costs and maximize attorney time.
6. Create clear and appropriate confidentiality waiver/release forms that will allow the necessary flow of financial and billing information back and forth between the client, legal organization and medical center.
7. Implement a data collection system that tracks both the debt relieved to the patient and the funds reimbursed to the hospital. Track this data from the very first case.
8. Make sure to track the full range of cases that will ultimately lead to medical coverage; every individual enrolled in SSI is automatically enrolled, retroactively, in Medicaid. Such retroactive coverage can result in very large financial reimbursements for hospitals. Similarly, families who have been wrongly denied TANF are also retroactively linked to Medicaid back to the date of the initial application (that was wrongly denied). As alluded to by Goffinet, in some situations there are ways to bill Medicaid for services provided before the usual three month period of retroactivity.

Finally, it bears repeating that this program model can easily be adopted by medical-legal partnerships already in operation. For those existing programs, it may be helpful to review closed case files and calculate the Medicaid benefits recouped by the partner medical institution as a result of past advocacy. In some ways, one could argue that it may be even easier for those programs with years of experience working in a hospital or clinic to make a convincing case for on-going financial support from the medical partner: the legal team need only go back through their case records and track the total amount of medical debt relieved as a result of those cases in which the legal advocacy provided resulted in a client or client’s family being enrolled or re-enrolled in the appropriate public healthcare benefits program. Only those debts to the partner institution should be tracked for this purpose, though it might be useful to calculate the full amount of reimbursement to other medical institutions in the area, so as to have data when considering program expansion to other hospitals.