Revenue Cycle Impact on Medicare Cost Reports
May 14, 2015

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Mike Nichols, CPA, FHFMA

- 32 years of health care experience
  - Cost reporting (auditing, preparing, reviewing)
  - Contractual allowance and settlement analysis determinations
  - Reimbursement opportunities and strategies

- McGladrey LLP
  - Healthcare Advisory Services
  - Partner (health care consulting)

- HFMA
  - First Illinois Chapter
  - Past President
  - 2013-2014 Regional Executive Region 7
Explore the key drivers of Medicare reimbursement that are directly connected to information developed through a hospital’s revenue cycle function, and learn how and where this information is used within the cost report.
Describe the importance of collaboration between a hospital’s revenue cycle and reimbursement functions.

Recognize the importance of collaboration necessary to produce a compliant and accurate Medicare cost report.

Identify best practices to link the revenue cycle and reimbursement functions.
Tools and Takeaways

- Uncompensated care definitions
- Charity care log data elements
- National cost/charge ratio information based on FY15 rule
- DSH data elements
- Medicare bad debt documentation
- Revenue cycle KPIs reflected in the cost report data
Revenue Cycle and Cost Report Connections
Hospital Revenue Cycle Definition

- The entire process completed by a hospital to ensure that Revenue is:
  - Recognized;
  - Recorded;
  - REALIZED
Medicare Cost Report Purpose

- The entire process completed by a hospital to ensure that all the net Revenue attributed to a hospital’s Medicare “book of business” is:
  - Recognized;
  - Recorded;
  - **REALIZED**
Cost Report Uses

- **External (CMS)**
  - Standardized data gathering tool
  - Determination of program liability on annual basis by hospital
  - Reconcile interim payments
  - Comparison of Medicare cost vs. reimbursement
  - Develop future payment amounts and methodology
  - Benchmarking across providers
  - Investigative tool (establish patterns)

- **Internal (provider)**
  - Same as CMS (individual/local/competitive basis)
  - Operational assessments and management tool
  - Advocacy and education
Revenue Cycle

**Front End**
- Patient Access
  - Scheduling
  - Processes
  - Pre-registration
  - Processes
  - Registration
  - Processes
  - Point-of-Service
  - Collections
  - Bad Debt Flags
  - Financial
  - Counseling/Prior
  - Balance
  - Adjudication
  - Staffing Deployment

- Denial Management
  - Dental
  - Quantification
  - Denial Tracking
  - Denial Mgmt.
  - Program
  - Insurance
  - Verification
  - Pre-certification / Authorization

**Middle**
- Charge Capture & Pricing
  - Managed Care Pricing/Contracting
  - Charge Capture/Reconciliation
  - Late Charges
  - Resource-based Pricing
  - Formula-based Pricing
  - CDM Review
  - Pricing
  - Rationalization
  - CDM Standardization / Consolidation

- HIM Clinical Documentation
  - Clinical Documentation
  - Outpatient Documentation
  - Medical Records Assembly Process

- Coding & 3rd Party Reimbursement
  - ICD-9 & 10 Coding
  - HCPCS Coding
  - APC Process Improvement
  - Cost Report Optimization:
    - DSH
    - IME/GME
    - Medicare Bad Debt
    - Excluded Units
    - Wage Index
    - Transfer DRG
  - Physician Coding
  - Observation Status Review
  - Fee Screen Review

**Back End**
- Claims Processing & Denial Management
  - Late Charge Analysis
  - EDI Editing and Billing
  - Denials and Appeals Tracking
  - Staffing Model
  - Billing System
  - Backlog (DNFB Reduction)
  - Electronic Billing
  - Validation
  - Unit Billing
  - DNFB Reduction

- Cash Collection & AR Management
  - Receivables Strategy and Work Tools
  - Bad Debt Management, Including Medicare
  - Denial Management
  - Self-Pay Collections Management
  - Agency/Vendor Management
  - Payment Appeal/Dispute Resolution
  - Mg'd. Care Prompt Pay
  - Penalties & Underpayment Recoveries
  - Cash Acceleration
  - Third Party Follow-up
  - Electronic Remittance / Payment Postings

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**Value**
- Efficient processes to control financial risk
- Improved accuracy of collected data
- Improved POS collections
- Reduction in denials due to registration issues

**Value**
- Improved net revenue from pricing based on market, payer mix, service level and objective charge structure & formulas
- Improved charge capture processes

**Value**
- Improved days in AR (Cash flow)
- Reduced cost to collect
- Reduced bad debts
- Reduced denials

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McGladrey
# High Impact Focus Areas

<table>
<thead>
<tr>
<th>Focus Areas</th>
<th>CR Ref</th>
<th>Topics</th>
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</thead>
<tbody>
<tr>
<td>Patient Statistics</td>
<td>S-3</td>
<td>Counting days impacts DSH, GME and cost-based reimbursement</td>
</tr>
<tr>
<td>Uncompensated Care</td>
<td>S-10</td>
<td>Defining elements and implications for DSH and HIT incentives, as well as importance to external users of cost report information</td>
</tr>
<tr>
<td>Charges</td>
<td>C</td>
<td>Calculated cost-to-charge ratios</td>
</tr>
<tr>
<td>Settlement Data</td>
<td>D-E</td>
<td>Payment methodologies Internal records vs. PSR (automated crosswalk/PSR interface) Interim payment considerations</td>
</tr>
<tr>
<td>Medicare Bad Debts</td>
<td>E series</td>
<td>Reporting process and audit issues</td>
</tr>
<tr>
<td>Financial Statements</td>
<td>G Series</td>
<td>Source and external uses</td>
</tr>
</tbody>
</table>
Patient Statistics
Available Beds — S-3 (Patient Access)

- Medicare term of art that impacts payment calculations
  - Indirect medical education (PPS)
  - Disproportionate share
  - Critical access hospitals
  - Other special payment situations

- Patient registration may be responsible for
  - Bed management
  - Reporting closed units

- Understand differences between licensed, operating, staffed and available beds
  - Licensed: As reported to the state licensure authority (most likely maximum)
  - Operating or staffed: Actual beds in service impacting staffing decisions and ability to admit more patients (most likely minimum)
  - Occupied: Actual inpatient census (most likely lowest number)
  - Available: Medicare term of art applied to all inpatient payment provisions
Counting Patient Days (Revenue Capture)

- Source of patient days
  - Census
  - HIM
  - Revenue & Usage Reports

- Count patients in an *inpatient* bed at midnight

*Two Midnight Rule*

- Exclude patients in an ancillary area at midnight (L&D, ER, X-Ray, etc.)

- Exclude L&D patients at midnight unless they have already occupied an IP routine bed

- Medicare days should be filed by discharge date
  - “Since Medicare days are based on discharge date, then so should Total, Medicaid, etc.”
Patient Days: Observation Days

- **Non-distinct part (scattered site)**
  - Need to accumulate time units (hours; minutes, etc.) based on charging (based on UB04 codes) methodology and convert to equivalent patient days
  - Observation time in subproviders or ICU should be calculated and reclassified to adults and pediatrics
  - Post surgical recovery time should be reclassified to where charge is generated (OR; Recovery; ER, etc.)
  - Use separate mechanism to track compared to distinct part observation

- **Distinct part (defined area)**
  - Will be apportioned based on charges, rather than cost calculated on a per diem
  - Maintain cost center specific expenses; revenues, program revenues and cost allocation statistics
  - Ensure not included in adults and pediatrics patient statistics, expenses, revenues and cost allocation statistics
  - Observation time in subproviders or ICU should be calculated and reclassified to adults and pediatrics
  - Post surgical recovery time should be reclassified to where charge is generated (OR; Recovery; ER, etc.) but may be billed out of this cost center if this is where cost is incurred
  - Use separate mechanism to track compared to distinct part observation
Uncompensated Care
Uncompensated Care Cost Calculation (Charge Capture and Patient Accounting)

- Overall cost-to-charge ratio applied to various uncompensated care program changes to impute costs (based on Medicare defined costs)
- Sum of all elements represents Medicare defined uncompensated care costs
- Medicaid and other state indigent care payment systems and charity care programs (per collection reports and other sources)
- Charity reported at charges
  - Currently used for HIT payment (Both PPS and CAH)
  - May be used for future DSH calculation
  - Total patient charges, which include bad debts (i.e., before any write-offs)
- Bad debt information is for the entire complex (excludes professional component)
Medicare Definitions Uncompensated Care

- **Uncompensated care** – Charity care and bad debt which includes non-Medicare bad debt and non-reimbursable Medicare bad debt; uncompensated care does not include courtesy allowances or discounts given to patients.
**Medicare Definition: Charity Care**

- **Charity care** – Health services for which a hospital demonstrates that the *patient is unable to pay*; charity care results from a hospital’s policy to provide all or a portion of services free of charge to patients who meet certain financial criteria; for Medicare purposes, charity care is not reimbursable, and unpaid amounts associated with charity care are not considered as an allowable Medicare bad debt.
Medicare Cost Report Definitions Bad Debts

- **Non-Medicare bad debt** – Health services for which a hospital determines the non-Medicare patient has the financial capacity to pay, but the *non-Medicare patient is unwilling to settle the claims*

- **Non-reimbursable Medicare bad debt** – The amount of allowable Medicare coinsurance and deductibles considered to be uncollectible but are not reimbursed by Medicare under the requirements of §413.89 of the regulations and of Chapter 3 of the Provider Reimbursement Manual Part 1
## Timing/Recognition Issues: When do we know, FOR SURE?

<table>
<thead>
<tr>
<th>Net Revenue</th>
<th>Charity Care</th>
<th>Bad Debts</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Actual payments received or expected</strong> for services delivered during this cost reporting period.</td>
<td><strong>Total initial payment obligation of patients who are given a full or partial discount based on the hospital’s charity care criteria (measured at full charges)</strong> for care delivered during this cost reporting period for the entire facility</td>
<td><strong>Total facility charges for bad debts written off or expected to be written off on balances owed by patients</strong> for services delivered during this cost reporting period</td>
</tr>
</tbody>
</table>
Charity Care Log

- Essential components for documenting charity care write-offs
  - Patient name
  - Hospital identification number
  - Charity application status
  - Service from-to dates
  - Patient days
  - Primary/secondary payer
  - Total gross charges
  - Contractual adjustments
  - Denied days/changes
  - Payments
  - Full or partial charity
  - Charity write-off amount
  - Patient amount due after charity discount
  - Patient payment plan: Yes or no
CMS Charity Care Definition

- Provider may have established before discharge, or within a reasonable time before the current admission, that the beneficiary is either indigent or medically indigent
- Providers can deem Medicare beneficiaries indigent or medically indigent when such individuals have also been determined eligible for Medicaid as either categorically needy individuals or medically needy individuals, respectively
- Otherwise, the provider should apply its customary methods for determining the indigence of patients to the case of the Medicare beneficiary under the following guidelines
IRS Charity Care Definition: Agrees to Provider’s Policy

- Free or discounted health services provided to individuals who meet the organization’s criteria for financial assistance and are thereby deemed unable to pay for all or a portion of the services.

- Charity care does not include:
  - Bad debts or uncollectible charges written off due to the patient’s failure to pay.
  - The cost of providing such care.
  - The difference between the cost and revenue for Medicaid (and other means tested programs).
  - The difference between cost and revenue for Medicare.
  - Any contractual adjustments for any third party payer.
FASB (GAAP) Definition: Financial Reporting

- Management’s policy for providing charity care, as well as the level of charity care provided shall be disclosed in the financial statements.
- Such disclosure shall be measured based on the direct and indirect costs of providing charity care services.
- Providers may use:
  - Cost accounting system (patient specific analysis)
  - [Financial statement] cost/charge ratio, applied to charges for charity care
  - Other methods may be used
- Separate disclosure for any funds received to offset or subsidize charity services provided by the organization.
Charity Care Reporting Land Mines

- Financial statement audit typically done three to four months after year-end
- Medicare cost report typically due five months after year-end
- IRS 990 completed and filed up to 11 months after year-end
- Prepare a reconciliation between the three – accrual/IRS/CMS cost report
Action Items for Uncompensated Care

- Develop worksheet to model S-10 and include formulas, comments and other information regarding the sources and methodology related to the reported data.
- Review and update all hospital policies relating to uncompensated care, charity care, compassionate care, uninsured or underinsured – do internal audit.
- Understand how regulatory or internal operational changes may impact reported results.
- Differentiate non-covered services from C/A for Medicaid, SCHIP and state/local indigent care programs.
- Segregate SCHIP/state only claims from Medicaid.
- Update S-10 reported values on a periodic basis and file amended WS S-10 immediately prior to audit.
WS C – Revenue Capture Strategies
• Provider CCRs will vary from national
• National average CCRs from FFY 2015 Final Rule
• Values:
  - Mark-up formula
  - Cost center groupings
• CMS groupings
• Can this information be used to evaluate pricing strategy beyond Medicare?

<table>
<thead>
<tr>
<th>Group</th>
<th>FY 2015 CCRs</th>
</tr>
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<tbody>
<tr>
<td>Routine Days</td>
<td>0.489</td>
</tr>
<tr>
<td>Intensive Days</td>
<td>0.407</td>
</tr>
<tr>
<td>Drugs</td>
<td>0.192</td>
</tr>
<tr>
<td>Supplies &amp; Equipment</td>
<td>0.292</td>
</tr>
<tr>
<td>Implantable Devices</td>
<td>0.349</td>
</tr>
<tr>
<td>Therapy Services</td>
<td>0.344</td>
</tr>
<tr>
<td>Laboratory</td>
<td>0.128</td>
</tr>
<tr>
<td>Operating Room</td>
<td>0.212</td>
</tr>
<tr>
<td>Cardiology</td>
<td>0.123</td>
</tr>
<tr>
<td>Cardiac Catheterization</td>
<td>0.133</td>
</tr>
<tr>
<td>Radiology</td>
<td>0.165</td>
</tr>
<tr>
<td>MRI</td>
<td>0.087</td>
</tr>
<tr>
<td>CT Scans</td>
<td>0.043</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>0.195</td>
</tr>
<tr>
<td>Blood</td>
<td>0.360</td>
</tr>
<tr>
<td>Other Services</td>
<td>0.405</td>
</tr>
<tr>
<td>Labor &amp; Delivery</td>
<td>0.398</td>
</tr>
<tr>
<td>Inhalation Therapy</td>
<td>0.181</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>0.114</td>
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</tbody>
</table>
Pricing Strategy (Charge Integrity and PFS)
Rational pricing strategy – Evaluate Hospital’s existing cost, market position and managed care contract terms to develop a pricing strategy that identifies opportunities to adjust service prices to optimize net revenue while being competitive in market
  - Market assessment – Market/competitor pricing data to identify market opportunities
  - Contract/payer environment assessment – Understand managed care payer matrix
  - Financial model – Utilize cost/Medicare rate data and market data to project future gross and net revenue impact
    • Cost surrogate option – Understand existing prices compared to internal cost accounting data and/or Medicare rates
    • Reimbursement-based option – Calculate service level price sensitivity for each CDM service code based on payer contract rates
    • Market-based option – Use market data to calculate competitor average prices and develop market average data pricing adjustments into financial model
  - Medicare cost report impact analysis
Coding compliance/reporting --- CMS requires all providers to appropriately code and report all services and procedures performed within their organization; it allows them (CMS) and providers to effectively manage patient utilization, health care trends, future payment/rate settings and current financial reimbursement obligations; the following should be addressed to mitigate coding compliance/reporting concerns:

- Outdated CPT/HCPCS/modifier/revenue code and description assignments
- Outdated pharmacy national drug codes and minimum units charging
- Missed facility and/or professional services and procedures charges
Lost gross and net revenue --- Because recorded revenues are based on procedure/service level charges and contractual reimbursement methodologies, if a CDM is not updated or does not fully reflect the services and procedures being performed, providers are, in fact, experiencing lost revenues; the results of not having an updated CDM on revenues include

- Impact to the cost-to-charge ratio for critical access hospitals as a result of the cost-based reimbursement methodology
- Missed gross and net revenues for services performed but not reported, e.g., missed facility and procedure charges, reference lab charges, etc.
- Pharmaceuticals and supplies may have lost additional net revenues if inappropriately reported without a higher level revenue code, e.g., 636 high cost drugs and 278 implantable supply
- If bundling of procedures, equipment and other codes is not appropriately re-priced, will lead to lost gross and net revenues
Worksheet C: “The Bridge” (Charge Integrity and PFS)

- Worksheet C – Revenues – Cost-to-charge ratios:
  - Fully allocated departmental costs
  - Total department charges
  - = Cost-to-charge ratio for each ancillary department

  Hint: Set up grouping workpapers to include both costs and charges to eliminate matching errors
Worksheet C Issues

- Objective is to improve how hospitals categorize Medicare charges, total charges and total costs into departments
  - Mismatch with the CCR
  - Mismatch between how hospitals categorize on the cost report and how CMS categorizes on MedPAR file
Implantable Devices

- Did this facility incur and report costs for high cost implantable devices charged to patients?
  - Charge capture
  - CDM update
  - Billing
  - Documentation
  - Follow-up
Medical Supplies vs. Implantable Devices

- Medical supplies (UB 270-274; 621-623) (line 71)
- Implantable devices (UB 275-278; 624) (line 72)
  - Classify all billable supply costs and charges based on UB codes
  - Accommodate through general ledger or through an A-6 reclassification based on volume or charges in the revenue usage report

*Applies to all hospitals*
Settlement Data
Settlement Data – Internal Sources (Patient Access, Charge Integrity and PFS)

- **Internal data**
  - Census data (patient days and discharges)
    - Total facility
    - Financial class
  - Revenue and usage reports
    - Departmental charge distribution
    - Procedure
    - UB04 revenue codes (matching)
  - Case mix reports
    - Verification of reasonableness of reported volumes
Revenue Center Cross Walk

UB04 Codes

CMS Lines
GL Dept #
GL Dept Name
Revenues by
UB Code

Percentage Allocation of
Each UB Code for Each
Department
Applied to Paid Data
Using PSR Import
Settlement Data – External Sources

- PSR – Provider statistical and reimbursement report (how often obtained)
  - Service dates (splits) vs. run dates (update when cost reports are amended or settled)
  - Provider components
  - Managed care reports
  - Included and excluded reports

- Intermediary correspondence (where are these maintained)
  - Interim payments (bad debts; GME; organ acquisition)
  - Rate letters
    - DRG base rates
  - Per resident amount updates
  - Cost report due dates and acceptance
Disproportionate Share (DSH)
Disproportionate Share (DSH) – (Patient Access, Charge Capture, Patient Accounting)

- Hospitals may qualify for an additional payment per discharge for serving a disproportionate share of low income patients
- DSH adjustment based on two fractions: Medicare fraction (SSI percentage) and Medicaid fraction
  - Medicare fraction – Days of patients entitled to both Medicare Part A and SSI/total days of patients entitled to Medicare Part A; obtained from CMS
  - Medicaid percentage – Days of patients eligible for Title XIX Medicaid, but not entitled to Medicare Part A/total patient days
    - Sum >= 15% to qualify (>20.2% higher adjustment factors)
- 340B Drug pricing program
  - Eligible with DSH adjustment percentage of 11.75%
  - SCHs and RRCs eligible at 8%
- Similar calculation for rehab units (LIP)
### DSH Information Days Categories

<table>
<thead>
<tr>
<th></th>
<th>In-State Paid</th>
<th>In-State Eligible</th>
<th>Out-of-State Paid</th>
<th>Out-of-State Eligible</th>
<th>Mcaid HMO</th>
<th>Other</th>
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<tbody>
<tr>
<td><strong>24 PS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>25 IRF</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
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</table>

Is there a mechanism to capture the days in these categories?
### Required Data Fields
- Account Number
- Medical Record Number
- Name
- Social Security Number
- Sex
- Admit Date
- Discharge Date
- Length of Stay
- Patient Type
- Date of Birth
- Financial Class
- Insurance Plan Codes (3 fields)
- Insurance Plan Policy Numbers (3 fields)
- Medicaid Recipient # (if not in Policy #)

### Suggested Additional Fields
- Discharge Status Indicator
- Discharge Location
- DRG
- Room Number
- Total Charges
- For Babies - Mother's Account Number
- Medicare HIC # (if not in policy #)
# DSH Key Drivers

<table>
<thead>
<tr>
<th>Key Drivers</th>
<th>Action Items</th>
</tr>
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<tbody>
<tr>
<td>DSH/LIP</td>
<td></td>
</tr>
<tr>
<td>▪ DRG payments</td>
<td>▪ Case management/payment accuracy/transfers?</td>
</tr>
<tr>
<td>▪ Medicaid eligible days</td>
<td>▪ Process to identify, verify and report ALL eligible days?</td>
</tr>
<tr>
<td>▪ SSI %</td>
<td>▪ Validate reported SSI data</td>
</tr>
<tr>
<td></td>
<td>▪ Impact of Medicare Part C days in SSI</td>
</tr>
<tr>
<td></td>
<td>▪ Is the reported information correct?</td>
</tr>
</tbody>
</table>
Medicare Bad Debts
Medicare Bad Debts (PFS)

- Unpaid deductible and coinsurance amounts related to covered hospital services
  - Excludes pro fees and fee screen amounts
  - Excludes MCO amounts
- Reimbursed @ 65% of the amount (phased to 65% for CAH)
- Reasonable collection efforts consistent among all payers
- Debt actually uncollectible when claimed as worthless
  - Cannot be claimed as bad debt until returned from collection agency
Medicare Bad Debts

- May 2, 2008 CMS memorandum
- Contractors to disallow bad debts if not returned from collection agency
- Settlements issued after May 2, 2008
Medicare Bad Debts
Reasonable collection efforts

- Collection effort must be documented in patient file
- Collection may include use of a collection agency in addition to or in lieu of subsequent billings
- Traditional accounts turned over to collection cannot be claimed until returned from agency
- 120-day rule – beginning on the date of the first bill sent to the patient (indicating deductible or coinsurance owed by the beneficiary)
  - “Presumed uncollectible” after 120 days

Who owns bad debt process? Reimbursement or PFS?
Medicare Bad Debts
Crossovers/Other Categories

- Medicare/Medicaid crossover patients (must bill requirement) (actual voucher vs. notice)
  - Prove that no other insurance exists
- Indigent or medically indigent patients (hospital must establish and document indigence)
- Charity accounts for Medicare beneficiaries
- Deceased patients (must document lack of estate)
- Bankrupt patients (must document court filings, etc.)
- May all be claimed without collection effort (no 120-day rule) (varies with contractor)
Medicare Bad Debts
Recoveries

- Recoveries must be netted against bad debt expense claimed, even if the claim was originally included in a prior year bad debt submission
  - Caution: Re-starts 120-day counting period
- Prorate recoveries not specifically identified as payment for covered/non-covered services
### Required Fields per 339 Exhibit 5

<table>
<thead>
<tr>
<th>Field</th>
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<tbody>
<tr>
<td>Last Name</td>
</tr>
<tr>
<td>First Name</td>
</tr>
<tr>
<td>M.I.</td>
</tr>
<tr>
<td>HIC. NO.</td>
</tr>
<tr>
<td>DOS from MM/DD/YYYY</td>
</tr>
<tr>
<td>DOS to MM/DD/YYYY</td>
</tr>
<tr>
<td>Indigency &amp; Wel. Recip. (Ck If Appl)</td>
</tr>
<tr>
<td>Medicaid Number</td>
</tr>
<tr>
<td>Date 1st Bill to Beneficiary</td>
</tr>
<tr>
<td>Write-off Date</td>
</tr>
<tr>
<td>Remittance Advice Date (MC)</td>
</tr>
<tr>
<td>Deductibles (excludes PC and FS amounts)</td>
</tr>
<tr>
<td>Co-Ins (excluded PC and FS amounts)</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>

### Suggested Additional Fields

<table>
<thead>
<tr>
<th>Field</th>
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<tbody>
<tr>
<td>Patient Account Number</td>
</tr>
<tr>
<td>Medical Record Number</td>
</tr>
<tr>
<td>Total Covered Charges</td>
</tr>
<tr>
<td>Non Covered Charges (includes PC and FS)</td>
</tr>
<tr>
<td>Hospital Charity Care Determination</td>
</tr>
<tr>
<td>120-Day (from last payment) Test (non X/0)</td>
</tr>
<tr>
<td>Date Ret. from Coll. Agencies (non X/O)</td>
</tr>
<tr>
<td>MA Remittance Date and/or MA RA #</td>
</tr>
<tr>
<td>Document no other insurance exists</td>
</tr>
</tbody>
</table>
“Shadow Billing”

- Additional GME and IME reimbursement attributable to services rendered to Medicare Managed Care Organization (MCO) enrollees
  - GME: Patient days for IPPS, IPF and IRF components included on the 118 PSR report
  - IME: Simulated DRG amounts for MCO IPPS patients reflected on the 118 PSR report

- To preserve this reimbursement opportunity
  - Identify all Medicare Managed Care plans and patients
  - Complete shadow billing on a timely basis
  - Monitor PSR reports and reconcile adjudicated claims with the 118 PSR report

MCO days and simulated DRG percentages should be similar

Also used for Meaningful Use Calculation and special payment provisions
## Example Revenue Cycle KPIs

<table>
<thead>
<tr>
<th>Key performance indicator</th>
<th>Cost Report WS</th>
<th>Target Range</th>
</tr>
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<tbody>
<tr>
<td>Days Revenue Outstanding in Total A/R</td>
<td>S-3 PT I &amp; G</td>
<td>≤ 40 days (net) From HFMA</td>
</tr>
<tr>
<td>Days Revenue in Unbilled (DNFB) A/R</td>
<td>N/A</td>
<td>≤ 6 days (gross) From HFMA</td>
</tr>
<tr>
<td>Percent of Billed A/R Aged over 90 Days (DOS vs. Final Billed Date)</td>
<td>N/A</td>
<td>≤ 20% From HFMA</td>
</tr>
<tr>
<td>Bad Debt Write-offs as a Percent of Gross Patient Revenue</td>
<td>S-10 &amp; C</td>
<td>≤ 2% From HFMA</td>
</tr>
<tr>
<td>Charity Care Write-offs as a Percent of Gross Patient Revenue</td>
<td>S-10 &amp; C</td>
<td>≤ 3% * Charity target should be provider Specific based on community needs and provider’s own financial assistance policy</td>
</tr>
<tr>
<td>Denial Write-offs as a Percent of Gross Patient Revenue</td>
<td>C</td>
<td>≤ 1%</td>
</tr>
<tr>
<td>Cash Collections as a Percent of Net Patient Revenue (Net of Charity Care and Bad Debt)</td>
<td>FS, S-10 &amp; C</td>
<td>100%</td>
</tr>
<tr>
<td>Point-of-Service Collections as a Percent of Total Cash Collections</td>
<td>FS</td>
<td>≥ 8%</td>
</tr>
<tr>
<td>Collection of Patient-Pay Amount Prior to Discharge/Service (IP and OP)</td>
<td>N/A</td>
<td>≥ 65 - 75%</td>
</tr>
<tr>
<td>Collection of Emergency Department Patient-Pay Amount Prior to Departure</td>
<td>N/A</td>
<td>≥ 50%</td>
</tr>
<tr>
<td>Insurance Verification Rate of Scheduled Patients</td>
<td>N/A</td>
<td>≥ 98%</td>
</tr>
<tr>
<td>Late Charges as a Percent of Total Billed Charges</td>
<td>N/A</td>
<td>≤ 2%</td>
</tr>
<tr>
<td>Payment Posting Transaction Processing Backlog</td>
<td>N/A</td>
<td>&lt; 1 day</td>
</tr>
<tr>
<td>Days Gross Revenue in Credit Balances</td>
<td>N/A</td>
<td>&lt; 1 day</td>
</tr>
</tbody>
</table>
Conclusion

- Understanding the key reimbursement drivers and the connection to the revenue cycle will identify many potential opportunities
- Asking the right questions will create a strategy for implementing change
- Communicating results to constituencies will influence their behavior and thought process
Questions
Contact Information

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Thank You!