Objectives

By the end of this course, you will be able to:

• Understand current issues in Medicare bad debts (Early Bird Bonus)
• Identify the cost/charge ratios in the Medicare cost report and their importance
• Calculate margin analysis based on cost report formats
Mike Nichols, CPA, FHFMA

- 34 years of nationwide health care experience
  - Cost reporting (auditing, preparing, reviewing)
  - Contractual allowance and settlement analysis determinations
  - Reimbursement opportunities and strategies
- RSM US LLP
  - Healthcare Advisory Services
  - Partner (health care consulting)
- HFMA
  - First Illinois Chapter
  - Past President
  - 2013-2014 Regional Executive Region 7
  - Medal of Honor recipient

Chad Krcil, MBA, FHFMA

- 25 years of health care experience
  - Cost reporting (auditing, preparing, reviewing)
  - Contractual allowance and settlement analysis determinations
  - Reimbursement opportunities and strategies
  - Third party reimbursement audit and review and due diligence analysis
- RSM US LLP
  - Healthcare Advisory Services
  - Director (health care consulting)
- HFMA
  - Colorado Chapter
  - Chapter Secretary (FY 2015/2016)
  - VP of Education (FY 2016/2017)
  - Recipient of the Bronze Follmer, Reeves Silver and Muncie Gold Merit Awards
Consumer liability
High deductible health plans increase consumer exposure

Health Care Trends—Statistics

"According to America’s Health Insurance Plans (AHIP), the growth in HDHPs is a major contributor to current expectations that out-of-pocket payments for insured patients are expected to grow from $250 billion in 2009 to $420 billion by 2015, a 68 percent increase in five years."

- 80% of the public covered by employer-sponsored health insurance must meet an annual deductible.
- 41% of those workers have a deductible that exceeds $1,000 annually for single coverage.
- Larger employers plan to reduce a projected increase in the cost of healthcare coverage in 2015 from 6.5 percent to 5 percent primarily by expanding the use of high-deductible health plans. These employers that plan to offer high-deductible plans as an option for their employees will increase from 72% to 81%.
- The average per-person deductible increased 117% between 2003 and 2011 (from $518 to $1,123). This rate continues to rise each year reaching an average of $1,230 in 2013 among high deductible health plans that meet the HHS definition. The average deductibles among HDHPs were $1,123 in 2013 compared to $660 in 2009.

Figure 1. Growth of HSA-Qualified High-Deductible Health Plan Enrollment (Millions), March 2004 to January 2014

<table>
<thead>
<tr>
<th>Month</th>
<th>Small Group</th>
<th>Large Group</th>
<th>Other Group</th>
<th>Individual</th>
</tr>
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<tbody>
<tr>
<td>March 05</td>
<td>1.6</td>
<td>2.3</td>
<td>1.3</td>
<td>1.0</td>
</tr>
<tr>
<td>January 06</td>
<td>1.7</td>
<td>2.5</td>
<td>1.5</td>
<td>1.1</td>
</tr>
<tr>
<td>January 07</td>
<td>2.0</td>
<td>3.0</td>
<td>2.0</td>
<td>1.5</td>
</tr>
<tr>
<td>January 08</td>
<td>2.5</td>
<td>3.5</td>
<td>2.5</td>
<td>2.0</td>
</tr>
<tr>
<td>January 09</td>
<td>3.0</td>
<td>4.0</td>
<td>3.0</td>
<td>2.5</td>
</tr>
<tr>
<td>January 10</td>
<td>3.5</td>
<td>4.5</td>
<td>3.5</td>
<td>3.0</td>
</tr>
<tr>
<td>January 11</td>
<td>4.0</td>
<td>5.0</td>
<td>4.0</td>
<td>3.5</td>
</tr>
<tr>
<td>January 12</td>
<td>4.5</td>
<td>5.5</td>
<td>4.5</td>
<td>4.0</td>
</tr>
<tr>
<td>January 13</td>
<td>5.0</td>
<td>6.0</td>
<td>5.0</td>
<td>4.5</td>
</tr>
<tr>
<td>January 14</td>
<td>5.5</td>
<td>6.5</td>
<td>5.5</td>
<td>5.0</td>
</tr>
</tbody>
</table>

Source: AHIP, Data on HDHPs and Health Savings Accounts (HSA). OPM, 2013 Federal Employees Health Benefits Survey

1. HDHPs are defined as having deductibles of $1,200 or more for self-only coverage and $2,400 or more for family coverage in 2014
2. HSA = Health Savings Account
3. Insurance plans for large and small group enrollment are based on employee enrollment
4. Data may not add due to rounding

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E Series Medicare bad debts

- Unpaid deductible and coinsurance amounts related to covered hospital services
  - Excludes pro fees and fee screen amounts
  - Excludes MCO amounts
- Reimbursed @ 65% of actual Medicare bad debt write-offs
- 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

- 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
- MAC auditors are now reviewing collection agency activity
- 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

- 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 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
- Prorated recoveries not specifically identified as payment for covered/non-covered services

Bad debt – Review workplan

- Trace amounts from the detailed listings (by hospital) to the summaries and actual cost report files
- Develop a small sample from the detailed listings in order to validate the required Medicare bad debt attributes
- Pay close attention to large dollar amounts included in listings
- Read and understand Medicare bad debt policies in place for the cost reporting periods included in the review
- Obtain collection agency agreements
- Interview PFS personnel responsible for the Medicare bad debt process
- Test accounts identified in each list for the required attributes based on the available documentation
- Develop a log of observations related to the small scale sampling list
- Estimate a range of potential financial impacts by applying sample results to the entire population
COST-TO-CHARGE RATIOS IN THE MEDICARE COST REPORT

B Series step-down process

- Overhead Cost Centers
- Revenue Producing & Other CC
- Fully Allocated Costs for Apportionment
Matching issues

- WS A and B-1/B Pt II
  - Match Medicare allowable costs with related cost allocation statistics to accurately determine fully allocated costs for apportionment purposes
- WS C
  - Match total hospital charges with the cost
- WS D-3 and D Pt V
  - Match program charges with total charges
- Result:
  - Accurate fully allocated departmental costs for apportionment for payment purposes (CAH) and rate setting (PPS)
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

Provider-based status

- Applies to both PPS and CAH facilities
- Relationship between an entity and the main hospital
- Additional reimbursement related to facility services reimbursed under OPPS
- May be additional patient coinsurance responsibilities
- Professional services reimbursed under reduced physician fee schedule
- Sites may be identified for inclusion in 340B program
- Potential issues for GME reimbursement
- Future of PBS?
Provider-based status charging issues

- May only apply to Medicare (Medicaid and commercial payers not likely to recognize two bills (technical and facility component charges))
- Chargemaster should identify both professional and technical component charge elements
- Hospital should develop a charge split that covers the fee screen amounts for most prevalent procedures
- Need to develop methodology to include correct charges for cost apportionment

Future of Provider-based Status

Worksheet C: “The Bridge”

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

- Although Worksheet C is total costs, same approach is used for capital costs identified on B Pt II

- Overall objective is PROPER MATCHING: costs, total charges, program charges
## Cost report Worksheet C

### 2552-10 Description Source

<table>
<thead>
<tr>
<th>Description</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Summary of Allocated Costs and Charges (Cost/Charge Ratios)</td>
<td>Cost from Worksheet B part I; charges are input from grouping</td>
</tr>
<tr>
<td>Outpatient Service Cost/Charge Ratio</td>
<td>Calculated; may be used for state purposes</td>
</tr>
</tbody>
</table>

### 4023.1 Computation of Ratio of Cost to Charges

This worksheet computes the ratio of cost to charges for inpatient services, ancillary services, outpatient services and other reimbursable services.

All charges entered on this worksheet must comply with CMS Pub. 15-I, chapter 22, §§2202.4 and 2203.

This ratio is used on Worksheet D, Part V, for titles V and XIX and for title XVIII; Worksheet D-3; Worksheet D-4; Worksheet H-3, Part II; and Worksheet J-2, Part II, to determine the program’s share of ancillary service costs in accordance with 42 CFR 413.53.

This worksheet is also needed to determine the adjusted total costs used on Worksheet D-1 because of your status as IPPS, TEFRA or other.
Cost report Worksheet C

Columns 6 and 7—
Enter on each cost center line the total inpatient and outpatient gross patient charges, including charges for charity care patients and, where applicable, standard customary charges for items reimbursed on a fee schedule (e.g., DME, oxygen, prosthetics and orthotics).

Also include the total inpatient and outpatient gross charges for cost centers which have a credit balance on Worksheet B, Part I, column 26 and, therefore, do not contain “cost” in column 1 of Worksheet C, Part I.

Cost report Worksheet C

Column 9, lines 50 through 98—Always complete this column.

Divide the cost for each cost center in column 1 by the total charges for the cost center in column 8, to determine the ratio of total cost-to-total charges (referred to as the "Cost or Other" ratio) for that cost center.

Enter the resultant departmental ratios in this column; round ratios to six decimal places.
### Cost report Worksheet C

<table>
<thead>
<tr>
<th>Description</th>
<th>FY 2016</th>
<th>FY 2017</th>
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<td>Final 19</td>
<td>Proposed 19</td>
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<tr>
<td></td>
<td>CCRs</td>
<td>CCRs</td>
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<tr>
<td>Regular Days</td>
<td>0.469</td>
<td>0.469</td>
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<tr>
<td>Intensive Days</td>
<td>0.369</td>
<td>0.379</td>
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<tr>
<td>Therapeutic Services</td>
<td>0.207</td>
<td>0.209</td>
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<tr>
<td>Therapy Services</td>
<td>0.333</td>
<td>0.339</td>
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<tr>
<td>Therapeutic Services</td>
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<td>0.339</td>
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<td>Laboratory</td>
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<td>Operating Room</td>
<td>0.159</td>
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<tr>
<td>Radiology</td>
<td>0.118</td>
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<tr>
<td>Cardiac Catheterization</td>
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<td>Ultrasound</td>
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<td>MRI</td>
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<td>CT Scan</td>
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<td>Other Services</td>
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<td>Other Radiology</td>
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<tr>
<td>Anesthesia</td>
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<td>0.170</td>
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<tr>
<td>Reimbursement</td>
<td>0.106</td>
<td>0.090</td>
</tr>
</tbody>
</table>

### National cost/charge ratios

- Provider CCRs will vary from national average CCRs from FY 2016 Final Rule
- National average CCRs from FFY 2016 Final Rule
- Values:
  - Mark-up formula
  - Cost center groupings
  - CMS groupings
- Can this information be used to evaluate pricing strategy beyond Medicare?
- Why is the CCR for MRI and CT so much different from the radiology diagnostic CCR?
S-10 Uncompensated care cost

- Overall cost-to-charge ratio applied to various uncompensated care program charges to impute costs (based on Medicare defined costs)

Cost report instructions:
- **Line 1**--Enter the of cost-to-charge ratio resulting from Worksheet C, Part I, line 202, column 3 divided by Worksheet C, Part I, line 202, column 8
- For all inclusive rate no-charge-structure providers, enter your ratio as calculated in accordance with CMS Pub. 15-1, chapter 22, §2208

- Other mechanisms can be used for GAAP and IRIS reporting purposes

Outliers

- Additional payment for extremely costly cases under Medicare PPS systems:
  - Inpatient PPS operating
  - Inpatient PPS capital
  - Outpatient PPS
  - Inpatient psychiatric (IPF PPS)
  - Inpatient rehabilitation (IRF PPS)
  - LTCH PPS
Outliers

- Payment formula based on hospital specific Medicare cost/charge ratio, or statewide average
- Most recently filed or settled cost report may be used by MAC for interim rate setting process
- Applied to potential outlier claims during claims adjudication process
- **Subject to retroactive reconciliation at cost report settlement (including time value of money penalty)**

### Outliers CCR data sources

<table>
<thead>
<tr>
<th>Type</th>
<th>Medicare Cost</th>
<th>Medicare Charge</th>
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<tbody>
<tr>
<td>IP PPS Operating</td>
<td>Title XVIII IP PPS W-S D-1 Line 53</td>
<td>D-3 Total Routine and ancillary charges Hospital IP PPS</td>
</tr>
<tr>
<td>IP PPS Capital</td>
<td>W-S D part I Col 7, line 200 + D part II col 5 line 200</td>
<td>Same as above</td>
</tr>
<tr>
<td></td>
<td>(Can Use D-1 line 52 if no Med Ed or Paramedical programs)</td>
<td></td>
</tr>
<tr>
<td>OP PPS</td>
<td>E part B Line 2</td>
<td>Title XVIII Hospital D part V Col 2, Line 200</td>
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</tbody>
</table>
Outliers CCR data sources

<table>
<thead>
<tr>
<th>Type</th>
<th>Medicare Cost</th>
<th>Medicare Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>IPF PPS</td>
<td>Title XVIII IPF (Sub I)</td>
<td>D-3 Total Routine and ancillary charges Title XVIII IPF (Sub I)</td>
</tr>
<tr>
<td></td>
<td>W-S D-1 Line 53</td>
<td></td>
</tr>
<tr>
<td>IRF PPS</td>
<td>Title XVIII IRF (Sub II)</td>
<td>D-3 Total Routine and ancillary charges Title XVIII IRF (Sub II)</td>
</tr>
<tr>
<td></td>
<td>W-S D-1 Line 53</td>
<td></td>
</tr>
<tr>
<td>LTCH PPS</td>
<td>Title XVIII LTCH (or hospital)</td>
<td>D-3 Total Routine and ancillary charges LTCH component or entire LTCH hospital</td>
</tr>
<tr>
<td></td>
<td>W-S D-1 Line 53</td>
<td></td>
</tr>
</tbody>
</table>

IP PPS outlier CCRs SR917

1 Ref: Change Req #9253 and Fed Reg B 17-15 pg 49785

I. COST TO CHARGE RATIO FOR PPS HOSPITALS

11 Hospital Part A Title XVIII charges (Sum of routine charges (D-3 col 2 lines 30-35) plus anc) 277,490,174

12 Hospital Part A Title XVIII charges (Line 1/Line 2) (Operating Max is 1.210) 0.249 0.158

II. COST TO CHARGE RATIO FOR CAPITAL

21 Total medicare inpatient PPS capital related costs (W/S D Part I, Lines 30-35, column 7) 3,755,153

22 Hospital Part A Title XVIII charges (Sum of routine charges (D-3 col 2 lines 30-35) plus anc) 277,490,174

23 Ratio of cost to charges (Line 21/Line 22) (Capital Max is 0.175) 0.022 0.014

III. MEDICAID PATIENT DAYS TO TOTAL DAYS

31 Medicaid Patient Days (S-2, Part I Column 1-6, Line 24) 20,529

32 Total Days (S-3, Part I Column 8 Line 14 + Column 8 Line 32 minus sum of Lines 5-6, plus 63,857

33 Medicaid Ratio (Line 1 divided by Line 2) 0.3277

IV. BED SIZE

41 Bed Size (W/S E, Part A, Line 4 Logic) 267.17
OP PPS outlier CCRs SR916

<table>
<thead>
<tr>
<th>RCC Calculation (B)</th>
<th>Charges</th>
<th>Cost</th>
</tr>
</thead>
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<tr>
<td>211 Total Cost (Col 4, Line 202 which equals D Pt V col 5, Line 200)</td>
<td>224,261,221</td>
<td>46,362,213</td>
</tr>
<tr>
<td>212 Total Charges (Col 3, Line 202 which equals D Pt V col 2 and subscripts, Line 200)</td>
<td>224,261,221</td>
<td>46,362,213</td>
</tr>
<tr>
<td>213 OPPS / Charge Ratio (OPPS Cost/Charge Ratio Max is 1.600)</td>
<td></td>
<td>0.207</td>
</tr>
</tbody>
</table>

Statewide Average Operating RCC

| Urban | 0.217 |
| Rural | 0.252 |

Bed Size (E Pt A line 4 logic) 221
- 267.17

Section III - Non Opps RCC for FISS-Core, 41 Screen, Page 3

| W/S E Part B, line 1, col 1 | 30,999 |
| W/S E Part B line 12, col 1 | 486,611 |
| Non OPPS RCC (line 231 / line 232) | 0.064 |

(A) Cost/Charge Ratio Calculated after omitting the Costs for Paramed Ed & Allied Health
(B) Worksheet A line numbers. If lines 96-97 present, review to ensure that "Non Implantable DME" is Excluded
(C) Wks A lines 61, 66-68, 74, 88, 89, 94, 95 are not included in Totals

Revenue cycle KPIs in cost report

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<tr>
<th>Performance Indicator</th>
<th>CR Ref</th>
<th>Target Range</th>
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<tbody>
<tr>
<td>Days Revenue Outstanding in Total Accounts Receivable</td>
<td>(G, L4) – (G, L6)</td>
<td>&lt; 40 days (net)</td>
</tr>
<tr>
<td>Bad Debt Write-off % of Gross Patient Revenue</td>
<td>(S-10, L26)</td>
<td>&lt; 2%</td>
</tr>
<tr>
<td>Charity Care Write-offs % of Gross Patient Revenue</td>
<td>(S-10, L20, C3)</td>
<td>&lt; 3%</td>
</tr>
<tr>
<td>Cash Collections % of Net Patient Revenue</td>
<td>(G, L1)</td>
<td>100%</td>
</tr>
</tbody>
</table>

HFMA comment: Charity target should be provider specific based on community needs and provider’s financial assistance policy
Caution: Consider GAAP presentation of bad debts in this calculation
Key definitions: Margin

• Difference between net revenue (expected payment) and allocated costs for a particular procedure, department, product line or financial class
• Different from financial statement net income due to the treatment of other operating and non-operating items included in the entity’s operations
• Margin calculation under management principles will be different from amount determined under payer specific rules (such as Medicare principles of reimbursement)
Charges and net revenue/payment comparison

- Charges = Net Revenue/Payment = Awesome
  - Never happens because there are still bad debt and charity care adjustments
- Charges > Net Revenue/Payment = Typical Situation
  - Contractual allowance
  - Pricing transparency?
- Charges < Net Revenue/Payments = Possible
  - Rare: May occur with individual situations (see also the prior points
  - Impact of “special payments (federal or state)
- **Depends on pricing strategy and contracting**

Net revenue/payment and cost comparison

- Net Revenue/Payment = Cost = Possible
  - Specific cost reimbursement formulas
  - Defensible pricing approximates cost of services provided
  - Luck
- Net Revenue/Payment > Cost = Awesome
  - Most commercial payers do cover cost of providing care
- Net Revenue/Payments < Cost = Typical
  - Governmental payers are the majority of most hospitals payer mix
  - Most governmental payers reimburse at levels below cost
  - They say their prospective payment methodologies are working
- **Depends on definition of costs**
What is the hospital’s Medicare margin?

- Who calculates the margin?
- What mechanism is used?
- When is it updated?
- Where is the information distributed?
- Why do we calculate the margin?

Medicare margin analysis: General definitions

- Margin/(deficit)
  - Reimbursement > Cost: Margin
  - Reimbursement < Cost: (Deficit)
Medicare margin analysis

- Comparison of Medicare cost report information
  - Charges
  - Medicare defined fully allocated cost
  - Reimbursement
- Reports
  - Contractual allowance
  - Margin or deficit
- High level executive summary
  - Senior financial executives
  - Corporate governance
  - Education advocacy

What opportunities exist to (legally) improve the hospital’s Medicare margin?

- Cost
- Pricing strategy
- Reimbursement opportunities
<table>
<thead>
<tr>
<th></th>
<th>Changes</th>
<th>Cost</th>
<th>Gross</th>
<th>Net of Seq</th>
<th>Margin</th>
<th>Allowance</th>
<th>% Charges</th>
<th>% Charges</th>
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<tbody>
<tr>
<td>Inpatient Acute</td>
<td>1,126,996</td>
<td>28,993,982</td>
<td>27,749,708</td>
<td>27,268,961</td>
<td>(1,725,021)</td>
<td>85,425,881</td>
<td>2</td>
<td>4.20%</td>
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<tr>
<td>Operating IME</td>
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<td>3,906,399</td>
<td>3,906,399</td>
<td>3,906,399</td>
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<tr>
<td>Nonreimbursable Share / Uncompensated Care</td>
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<td>3,906,399</td>
<td>3,906,399</td>
<td>3,906,399</td>
<td>(3,906,399)</td>
<td>2.74%</td>
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<tr>
<td>Inpatient Capital</td>
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<td>2,793,648</td>
<td>2,679,068</td>
<td>2,679,068</td>
<td>(2,679,068)</td>
<td>2.74%</td>
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<tr>
<td>Accountable Care IME (Imputed)</td>
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<td>1,941,197</td>
<td>1,941,197</td>
<td>1,941,197</td>
<td>(1,941,197)</td>
<td>2.74%</td>
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<tr>
<td>Nonreimbursable Bad Debts</td>
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<td>0</td>
<td>2,173,089</td>
<td>2,173,089</td>
<td>2,173,089</td>
<td>(2,173,089)</td>
<td>2.74%</td>
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<tr>
<td>Total Inpatient</td>
<td>1,126,996</td>
<td>28,993,982</td>
<td>27,749,708</td>
<td>27,268,961</td>
<td>(1,725,021)</td>
<td>85,425,881</td>
<td>2</td>
<td>4.20%</td>
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<th>Net of Seq</th>
<th>Margin</th>
<th>Allowance</th>
<th>% Charges</th>
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<td>Outpatient</td>
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<td>(2,199,219)</td>
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<tr>
<td>Swing-Bed</td>
<td>7,715,375</td>
<td>2,130,362</td>
<td>2,130,362</td>
<td>2,130,362</td>
<td>(2,130,362)</td>
<td>5,585,013</td>
<td>31.87%</td>
<td></td>
</tr>
<tr>
<td>Rural Health Clinic</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>(0)</td>
<td>0.00%</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>11,230,215</td>
<td>4,833,888</td>
<td>4,694,196</td>
<td>4,626,941</td>
<td>(771,857)</td>
<td>6,678,374</td>
<td>41.38%</td>
<td></td>
</tr>
</tbody>
</table>

Total Sequestration (reflected above): (57,958)
**HFMA Hospital**

**Third Party Settlement Estimate**

**FYE 12/31/15**

<table>
<thead>
<tr>
<th>Reimbursement Issue</th>
<th>Estimated</th>
<th>Interim</th>
<th>Diff</th>
<th>Estimated</th>
<th>Interim</th>
<th>Diff</th>
</tr>
</thead>
<tbody>
<tr>
<td>DSH - Old (IE 25% of Trad DSH)</td>
<td>1,286,655</td>
<td>1,175,478</td>
<td>111,177</td>
<td>1,282,124</td>
<td>1,167,445</td>
<td>14,679</td>
</tr>
<tr>
<td>DSH - New (Uncompensated Care Pool)</td>
<td>2,079,152</td>
<td>2,072,264</td>
<td>6,888</td>
<td>2,070,894</td>
<td>1,999,893</td>
<td>71,001</td>
</tr>
<tr>
<td>Medicare Advantage</td>
<td>2,389,855</td>
<td>3,389,026</td>
<td>999,171</td>
<td>2,392,052</td>
<td>3,330,205</td>
<td>(4,153)</td>
</tr>
<tr>
<td>Capital MK</td>
<td>33,812</td>
<td>107,849</td>
<td>74,037</td>
<td>22,312</td>
<td>185,492</td>
<td>(163,180)</td>
</tr>
<tr>
<td>Medicare Bad Debt</td>
<td>16,665</td>
<td>72,685</td>
<td>56,020</td>
<td>16,412</td>
<td>72,685</td>
<td>(56,273)</td>
</tr>
<tr>
<td>Total</td>
<td>7,470,311</td>
<td>5,815,042</td>
<td>1,655,269</td>
<td>10,896,922</td>
<td>5,698,707</td>
<td>5,198,215</td>
</tr>
</tbody>
</table>

**Key Drivers**

### Inpatient PPS and Outpatient Services

<table>
<thead>
<tr>
<th>Key Drivers</th>
</tr>
</thead>
<tbody>
<tr>
<td>DRGs &amp; Outliers; TDRG APCS Specialized Payments</td>
</tr>
<tr>
<td>Medicare Volume</td>
</tr>
<tr>
<td>CMI</td>
</tr>
<tr>
<td>Wage Index</td>
</tr>
<tr>
<td>Pricing Strategy</td>
</tr>
<tr>
<td>Case management/payment accuracy/transfers?</td>
</tr>
<tr>
<td>Post payment reviews (TDRG analyses)?</td>
</tr>
<tr>
<td>CDI/documentation/chart audits/MD education?</td>
</tr>
<tr>
<td>Provider-based status analysis?</td>
</tr>
<tr>
<td>Is pricing strategy impacting outlier reimbursement?</td>
</tr>
<tr>
<td>IME (IP Only)</td>
</tr>
<tr>
<td>DRG Payments</td>
</tr>
<tr>
<td>Count of Residents</td>
</tr>
<tr>
<td>Available Beds</td>
</tr>
<tr>
<td>Prior Year Ratios</td>
</tr>
<tr>
<td>Case management/payment accuracy/transfers?</td>
</tr>
<tr>
<td>Opportunities through bed management?</td>
</tr>
<tr>
<td>Shadow billing for MCO claims?</td>
</tr>
<tr>
<td>DSH (IP Only)</td>
</tr>
<tr>
<td>DRG Payments</td>
</tr>
<tr>
<td>Medicaid Eligible Days</td>
</tr>
<tr>
<td>SSI %</td>
</tr>
<tr>
<td>Case management/payment accuracy/transfers?</td>
</tr>
<tr>
<td>Process to identify, verify and report ALL eligible days?</td>
</tr>
<tr>
<td>Impact of MCO days in SSI?</td>
</tr>
</tbody>
</table>
### Key drivers

<table>
<thead>
<tr>
<th>Post Acute Services</th>
<th>Key Drivers</th>
<th>Opportunities/Questions</th>
</tr>
</thead>
</table>
| **Psychiatric Units**  
IPF PPS | - IP Volume  
- Length of Stay  
- Patient Acuity | - Case management/documentation/transfers?  
- Is the actual length of stay clinically appropriate?  
- Are the diagnosis codes reported accurately? |
| **Rehabilitation Units**  
IRF PPS | - IP Volume  
- Length of Stay  
- Patient Acuity  
- LIP% | - Case management/documentation/transfers?  
- Is the actual length of stay clinically appropriate?  
- Are the diagnosis codes reported accurately?  
- What process exists to validate the reported Medicaid and SSI % attributable to the rehab unit? |
| **Skilled Nursing Units**  
| - IP Volume  
- Length of Stay  
- Patient Acuity  
- Strategy | - Is the actual length of stay clinically appropriate?  
- Is the patient being treated in the most appropriate setting?  
- Are there opportunities to improve reimbursement through accurate coding? |

### Net margin pressure

- **Contractual (Commercial insurance and other)**
  - Accountability to stakeholders  
  - Reduced payment levels through tighter contracting  
  - Increase focus on paying for quality over quantity  
  - Implementation of ICD-10 coding  
  - Reduced employer participation in employee health insurance (less coverage; high deductible plans)  
  - Increased patient obligations resulting in larger bad debt and charity care adjustments

- **Regulatory (Governmental)**
  - Same as contractual  
  - Extreme public awareness and oversight (state and federal matters)  
  - Increased budgetary concerns (too many beneficiaries and insufficient resources) Sequester  
  - Threat of increased enforcement activities related to overpayments and “fraudulent activities” (RAC, MIC, ZPIC)

- **Economic (All payers)**
  - Higher bad debt and charity adjustments due to general economic conditions in certain markets  
  - Improvements in technology not adequately reflected in payment rates  
  - Aging physical plant replacement needs  
  - Alternative delivery models  
  - Industry consolidation
Strategic questions

- Have you projected how payment reform will impact your future profitability/viability?
- Have you projected how payment reform will impact your patient mix and volumes?
- Do you have a mechanism in place to meet the pay-for-performance reporting guidelines?
- What structure will be your best opportunity?
- How will you reduce costs to serve patients?
- Have you implemented revenue cycle improvement initiatives?

Conclusion

- Understanding the key reimbursement drivers and their connection to the revenue cycle will identify many potential opportunities
- Asking the right questions will create a strategy for implementing change
- Revenue cycle and reimbursement collaboration contributes to financial viability and success for your organization
Questions?

RSM US LLP
Speaker Contact Information

<table>
<thead>
<tr>
<th>Presenter</th>
<th>Office Phone</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
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<td><a href="mailto:mike.nichols@rsmus.com">mike.nichols@rsmus.com</a></td>
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<td>Chad Krcil</td>
<td>+1 303 298 6463</td>
<td><a href="mailto:chad.krcil@rsmus.com">chad.krcil@rsmus.com</a></td>
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</tbody>
</table>