Using Analytics to Maximize Revenue and Minimize Out-of-pocket Burden on Patients
The underinsured and how hospitals can meet the challenges

HFMA Lone Star Waco Road Show
September 21, 2018

Todd Doze
CEO, Healthcare Payment Specialists, LLC,
a wholly owned subsidiary of TransUnion Healthcare
Agenda

→ Understand the industry trends with uninsured and underinsured

→ Understand how the uninsured and underinsured population impacts Medicare reimbursement

→ Optimize your revenue cycle through a coordinated strategy of reimbursable bad debt, uncompensated care reimbursement, and collection efforts to maximize revenue

→ Review of a Case Study to demonstrate the impact of a coordinated strategy between the business office and finance teams
The Uninsured and Underinsured
Texas has the highest uninsured rate in the U.S.

Source: U.S. Census Bureau
We know what uninsured is, but what is underinsured?

→ Out-of-pocket costs, excluding premiums, over the prior 12 months are equal to 10 percent or more of household income; or

→ Out-of-pocket costs, excluding premiums, are equal to 5 percent or more of household income if income is under 200 percent of the federal poverty level; or

→ Deductible is 5 percent or more of household income

Source: Commonwealth Fund – The problem of underinsurance and how rising deductibles make it worse
Uninsured vs Underinsured: A question of access and affordability

<table>
<thead>
<tr>
<th>Percent adults ages 19–64 insured all year who were underinsured*</th>
<th>2003</th>
<th>2005</th>
<th>2010</th>
<th>2012</th>
<th>2014</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>12%</td>
<td>13%</td>
<td>22%</td>
<td>23%</td>
<td>23%</td>
<td>28%</td>
</tr>
<tr>
<td>Insurance source at time of survey**</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employer-provided coverage</td>
<td>10%</td>
<td>12%</td>
<td>17%</td>
<td>20%</td>
<td>20%</td>
<td>24%</td>
</tr>
<tr>
<td>Individual coverage^</td>
<td>17%</td>
<td>19%</td>
<td>37%</td>
<td>45%</td>
<td>37%</td>
<td>44%</td>
</tr>
<tr>
<td>Marketplace^^</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>Medicaid</td>
<td>22%</td>
<td>16%</td>
<td>32%</td>
<td>31%</td>
<td>22%</td>
<td>26%</td>
</tr>
<tr>
<td>Medicare (under age 65, disabled)</td>
<td>39%</td>
<td>24%</td>
<td>45%</td>
<td>32%</td>
<td>42%</td>
<td>47%</td>
</tr>
</tbody>
</table>

Firm size (base: full- or part-time workers with coverage through their own employer)^^^

<table>
<thead>
<tr>
<th></th>
<th>2–99 employees</th>
<th>100 or more employees</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>14%</td>
<td>16%</td>
<td>26%</td>
</tr>
<tr>
<td>11%</td>
<td>16%</td>
<td>16%</td>
</tr>
<tr>
<td>14%</td>
<td>16%</td>
<td>22%</td>
</tr>
</tbody>
</table>

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* Underinsured defined as insured all year but experienced one of the following: out-of-pocket costs, excluding premiums, equaled 10% or more of income; out-of-pocket costs, excluding premiums, equaled 5% or more of income if low-income (<200% of poverty); or deductibles equaled 5% or more of income.

** Adults with coverage through another source are not shown here. Respondents may have had another type of coverage at some point during the year, but had coverage for the entire previous 12 months. ^ For 2014 and 2016, includes those who get their individual coverage through the marketplace and outside of the marketplace. ^^ Adults enrolled in marketplace coverage are not shown for 2014 because no one in the sample would have had marketplace coverage for the full year. ^^^ Does not include adults who are self-employed. — Data not available.

A migration to high deductible health plans is growing considerably

Source: Commonwealth Fund

Patients are The New Payer™, and the yield of patient revenue is at significant risk...

![Pie chart showing the percentage of Payer and Patient revenue in 2002 and 2020 forecast]

### Self Pay A/R Analysis

<table>
<thead>
<tr>
<th>Year</th>
<th>Patient Payment</th>
<th>Charity</th>
<th>Bad Debt</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002</td>
<td>3%</td>
<td>2%</td>
<td>5%</td>
</tr>
<tr>
<td>2017</td>
<td>10.2%</td>
<td>4.8%</td>
<td>6.1%</td>
</tr>
<tr>
<td>2020 Forecast</td>
<td>15%</td>
<td>10%</td>
<td>5%</td>
</tr>
</tbody>
</table>
How the uninsured and underinsured population impacts Medicare reimbursement
As patient payments increase as a percentage of net patient revenue, the ability to optimize patient collections and drive payments earlier in the process, will take on even greater importance.

Industry trends...

→ Often, providers also are calculating a propensity to pay score whether the patient is insured or not

→ High pre-service patient balances (i.e. Deductibles) or self-pay patients are key areas to focus

→ Transactions like credit score, mortgage balance inquiry, address verification, and more can help:
  
  → Determine a patient’s propensity to pay
  
  → Give insight into payment options
  
  → Determine if a patient is a candidate for payment plans or charity care

Source: JPM Key trends in healthcare patient payments
Stratifying patient risk and potential reimbursement

**Rapidly determine**

Identity Verification
- Prevent fraud
- Reduce returned mail

Insurance Discovery / Presumptive Charity
- Establish Coverage
- Re-classify accounts as charity, but follow policy

Propensity to Pay vs. Reimbursable Bad Debt
- Prioritize high balance accounts
- Must treat Medicare and non-Medicare accounts the same
- Ensure collection efforts follow CMS guidelines and best practices
Medicare Bad Debt Best Practices and Likely Update
Understanding Medicare Bad Debt

**Medicare Bad Debt** is Medicare Coinsurance and Deductible amounts that are *unpaid* and *uncollectable* from the patient.

→ Medicare Bad Debt (MBD) is a significant revenue opportunity for many hospitals; however, claiming these payments is complicated.

→ Hospitals must accurately identify potential coinsurance and deductible amounts, eliminate non-eligible amounts and cross-match the remaining amounts against the hospital’s own bad debt write-off information.

→ Many hospitals lack the internal resources and/or technology to accurately determine eligible Medicare Bad Debt reimbursement.

→ Hospital revenue teams must understand the difference between allowable vs. unallowable bad debts as well as complex rules regulating Medicare Bad Debt processes and reporting.
# Common rules for claiming Medicare Bad Debt

**Regulations related to Medicare Bad Debt**

**Allowable**

- The debt must be related to covered services and derived from deductible and coinsurance amounts
- The provider must be able to establish that reasonable collection efforts were made
- The debt was actually uncollectible when claimed as worthless
- Sound business judgment established that there was no likelihood of recovery at any time in the future

**Non-allowable**

- Coinsurance/Deductible amounts related to professional services
- Coinsurance/Deductible amounts related to fee reimbursed services
- Coinsurance/Deductible amounts related to non-covered services
- Other Amounts (Copays, TPLs, Spend down, Share of Cost), and Settlements
- Accounts that do not meet the CMS allowable regulations
What are the different categories of Medicare Bad Debt?

General categories of Medicare Bad Debt

**Crossover | Dual-eligible**
- Beneficiaries with Medicare Primary and Medicaid Secondary

**Self Pay | Traditional**
- Beneficiary with Medicare Primary and no additional coverage or inadequate additional coverage
- Patient is responsible for remaining Deductible/Co-Pay
- Hospital must use “sound business judgment” to establish no likelihood of recovery

**Charity | Indigent**
- Beneficiary with Medicare Primary and no additional coverage or inadequate additional coverage
- Patient is responsible for remaining Deductible/Co-Pay
- Patient meets Hospital Charity Care policy requirements
Stay away from common errors

Certain amounts cannot be claimed as Medicare Bad Debt

<table>
<thead>
<tr>
<th>Type</th>
<th>Definition</th>
<th>Identifiers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fee Reimbursed Amounts*</td>
<td>Mostly outpatient services that are paid under a fee schedule or payment system other than OPPS</td>
<td>• PSR Report Types&lt;br&gt;• Map 171A in DDE&lt;br&gt;• HCPCS codes  &lt;br&gt;○ CMS published Addendum B</td>
</tr>
<tr>
<td>Spend Down</td>
<td>Share of Cost</td>
<td>If individual monthly income is over the Medicaid Level, some states allow patient to become eligible for Medicaid if hospital “spends down” or subtracts medical expenses from patient income</td>
</tr>
<tr>
<td>Co-Pay</td>
<td>Patient Responsibility</td>
<td>A fixed payment for a covered service, paid when an individual receives service, derived per state and Medicaid plan</td>
</tr>
</tbody>
</table>

* Services include: Ambulance; Clinical Diagnostic Laboratory; Non-Implantable Prosthetic and Orthotic Devices; EPO for ESRD Patients; Routine Dialysis Services for ESRD Patients provided in a certified dialysis unit of a hospital; Physical, Occupational & Speech Therapy; Diagnostic Mammography; Screening Mammography
### Additional Medicare Bad Debt Pitfalls

#### Crossover-Dual eligible dangers

<table>
<thead>
<tr>
<th>COMMON PITFALLS</th>
<th>MISSED OPPORTUNITIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Billing Medicaid for total charges</td>
<td>Claiming Out of State Medicaid Patients</td>
</tr>
<tr>
<td>• Charges should match those billed to Medicare</td>
<td>• Includes validating other state EOB codes</td>
</tr>
<tr>
<td>• Even if Medicaid rarely or never pays a coinsurance or deductible, a bill should still be sent to Medicaid OR those amounts will not be considered eligible</td>
<td></td>
</tr>
<tr>
<td>• Be mindful of timely filing deadlines for your state</td>
<td></td>
</tr>
<tr>
<td>Not Excluding accounts not paid by Medicaid to an allowable amount based on primary payer (Medicare)</td>
<td>Claiming Managed Medicaid Patients</td>
</tr>
<tr>
<td>• Identifiable by state EOB codes</td>
<td>• Identifying all Managed Medicaid plans may be difficult</td>
</tr>
<tr>
<td>• Claim status should always be PAID (with limited exceptions)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Recurring Patients</td>
</tr>
<tr>
<td></td>
<td>• Difficult to track and account for on consistent basis</td>
</tr>
<tr>
<td></td>
<td>• Hard to capture all the associated coinsurance for a given series</td>
</tr>
</tbody>
</table>
Self-pay Medicare Bad Debt

Self-pay and understanding reasonable collection efforts

**Regulations**

- The effort to collect Medicare amounts must be similar to the effort the provider puts forth to collect comparable amounts from non-Medicare patients.
- It must involve the issuance of a bill on or shortly after discharge or death of the beneficiary to the party responsible for the patient’s personal financial obligations.
- It also includes subsequent billings, collection letters and telephone calls or personal contacts with the party which constitute a genuine, rather than a token, collection effort.
- The provider’s collection effort may include using or threatening to use court action to obtain payment.
- A provider’s collection effort may include the use of a collection agency. Where a collection agency is used, Medicare expects the provider to refer all uncollected patient charges of like amount to the agency without regard to class of patient.
- The provider’s collection effort should be documented in the patient’s file by copies of the bill, follow up letters, reports of telephone and personal contact, etc.

**MAC Interpretations**

- What is “Dunning”? Communication escalation from gentle reminders to threatening letters.
- If an account is still at agency, the debt is technically not yet determined to be uncollectible.
- Often times, hospitals do not return accounts from external collection agencies.
- Collection processes can not differ between Medicare and non-Medicare Accounts.
- An account cannot be claimed multiple times. Prior client bad debt logs should be cross-checked before completing an as-filed listing.

**Guidelines for Collection Efforts**

- **Dunning in Nature & Exact Balance**
- **Follow Hospital Written Policy**
- **Reasonable and Consistent**
- **Consistent across all Payers**
- **Discontinue after write-off date**
Testing your reimbursement

Self-pay and national FI guidance on timely billing

**Noridian [JE | JF]: “Shortly After” =**
- A provider is expected to submit a bill to the Medicare Contractor within 30 days of discharge date.
- The contractor has 30 days to process and pay a clean claim.
- The provider is expected to bill the beneficiary or responsible party within the next 120 days.
- The provider should be billing the beneficiary or responsible party within 180 days of the date of discharge or death.
- If the provider does not bill the beneficiary within 180 days the bad debt is not necessarily disallowed.
- The auditor should investigate further with the provider as to why they could not bill the beneficiary within the 180 days.

**Novitas [JL | JH]: “Shortly After” =**
- Providers must issue the first bill within 90 days of the last processed Medicare remit.
- When secondary insurance is involved, providers must issue the first bill to the beneficiary within two months of receiving the remittance advice from the secondary payer.

**First Coast: “Shortly After” =**
Timely billing to the patients should be within 90 days from the date of discharge.

**WPS [J8 |J5]: “Shortly After” =**
Providers must bill the patient either 180 days from discharge or 60 days from the latest Medicare payment.

**First Bill Date Testing**
There may be a difference in the date used as the “first bill” on the final bad debt listing compared to the “first bill” used for the timely billing testing. See the difference in how each date would be derived:

**Cost Report Requirement:**
First Bill Date = The date of the first collection letter to the beneficiary after the last non-Medicare payment, if non-Medicare payments were made, and after the first Medicare payment.

**Timely Billing Requirement:**
The first bill date on the Cost Report Exhibit may not be the date used to test the “shortly after” billing requirement.
Updating your reimbursement strategies

Self-pay: Return from collection agency strategies

- Must treat Medicare and Non-Medicare alike.
- Accounts can only be claimed as bad debt in the accounting period for which they were written off (in this case, returned from agency).
- **Best Practice**: Hospitals should make an adjustment or post the date the account was placed and returned from collections in their patient accounting system.
- Characteristics such as the following would be acceptable measures to return accounts from collections:
  - Days outstanding at collection agency
  - Balance
Patient's indigence must be determined by the provider, not by the patient; i.e., a patient's signed declaration of his inability to pay his medical bills cannot be considered proof of indigence;

Provider should take into account a patient's total resources which would include, but are not limited to, an analysis of assets (only those convertible to cash, and unnecessary for the patient's daily living), liabilities, and income and expenses. The provider should take into account any extenuating circumstances that would affect the determination of the patient's indigence;

Provider must determine that no source other than the patient would be legally responsible for the patient's medical bill; e.g., Title XIX, local welfare agency and guardian; and

Patient's file should contain documentation of the method by which indigence was determined in addition to all backup information to substantiate the determination.

- Financial Application procedure must follow written hospital policies
- Due to recent audit adjustments made in this category it is advisable for a hospital to revisit their policies and procedure documentation
- Maintaining on file patient financial applications and supporting documentation is key
- Deceased patients qualify under this category if proof of no estate is documented
- Bankruptcy patients also qualify if bankruptcy court documents can be provided
Auditing your Medicare Bad Debt claims

Commonly requested supporting documents

- Medicare Remit
- Medicaid Remit
- Other Remittance Advice (Other Payers)
- Patient Account Detail (Financial & Demographic)
  - Proof of write off date
  - Proof of Collection attempts
  - Proof of Return from Agency
- Charity Financial Application & Support
- Map 171A
  - Proof of Fee Reimbursed amounts removed
- UB-04
- Proof of consistency in Medicare vs. Non-Medicare
  - Returns
  - Collections
Working the audit

Extrapolation

1. MACs will pull a sample per log
   - Sample size is dependent on the individual MAC’s process
   - Usually a statistical sample + high dollar accounts
     A “log” represents a single list of accounts
     ▪ A hospital can create as many “logs” per year they want (i.e. Inpatient Crossover, Outpatient Crossover, Inpatient Self-Pay, Outpatient Self-Pay, etc.)

2. The error rate for the sample is calculated

3. That error rate could be applied or “extrapolated” to the entire log
   - Also dependent on the MAC’s discretion
   - At times, auditors have allowed us to work with them to remove specific accounts from the error rate, and not extrapolate.

<table>
<thead>
<tr>
<th>Example of Audit Adjustment Calculation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Amount on Log</td>
</tr>
<tr>
<td>Total Sampled</td>
</tr>
<tr>
<td>Total Allowed</td>
</tr>
<tr>
<td>Total Non-Allowed</td>
</tr>
<tr>
<td>Error Rate</td>
</tr>
<tr>
<td>Total Audit Adjustment</td>
</tr>
</tbody>
</table>
The ebbs and flows of Medicare Bad Debt reimbursement

Re-openings

- Cost Report re-openings are becoming more and more difficult
- Information must be new and material
- Some MACs are more lenient than others
- If the cost report has been audited and no NPR has been issued, most likely the MAC will not allow adding new information to the Cost Report, may force providers to wait for NPR issuance and ask for a re-opening. This can potentially delay reimbursement dollars to the Hospital.

Reduction Factors

- Regulations have changed the percentage that hospitals are reimbursed for Medicare bad debts overtime by provider type:

<table>
<thead>
<tr>
<th>Federal Fiscal Year</th>
<th>Reimb %</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;1997</td>
<td>100%</td>
</tr>
<tr>
<td>1997</td>
<td>75%</td>
</tr>
<tr>
<td>1998</td>
<td>60%</td>
</tr>
<tr>
<td>1999</td>
<td>55%</td>
</tr>
<tr>
<td>2000</td>
<td>70%</td>
</tr>
<tr>
<td>2012</td>
<td>65%</td>
</tr>
<tr>
<td>Future</td>
<td>25%?</td>
</tr>
</tbody>
</table>

Source: Federal Register, Volume 77, Issue 218
Scrutiny on Medicare Bad Debt continues to increase

MACs/FI’s have given extra scrutiny on self-pay and charity care categories of bad debt

(Self-pay) CMS clarification on Medicare Bad Debt Moratorium (05/02/08)

- “It has been the CMS longstanding policy that when an account is in collection, a provider cannot have determined the debt to be uncollectible and cannot have established that there is no likelihood of recovery under the regulations.”

- “Therefore…. Until a provider’s reasonable collection effort has been completed, including both in-house efforts and the use of a collection agency, unpaid deductible and coinsurance amounts cannot be recognized as a Medicare Bad Debt.”

(Indigent/Charity Care) CMS clarification

- The patient’s indigence must be determined by the provider, not the patient.

- The provider should take into account a person’s total resources which would include, but are not limited to, an analysis of assets, liabilities, income, and expenses.

- The provider must determine that no source other than the patient would be legally responsible for the patient’s medical bill.

- The patient’s file should contain documentation of the method by which indigence was determined in addition to all backup information to substantiate the determination.
Scrutiny on Medicare Bad Debt continues to increase

- Palmetto has recently begun denying cross-over Bad Debts that were written off to a contractual allowance or adjustment account
- CMS continues to provide oral guidance that supports Palmetto’s position
- CMS continues to provide oral guidance that PRM 15-2, Chapter 3 will be revised to support recent denials
  
  All bad debts, including cross-overs, should be properly written off to a bad debt account that is an expense account, and not a contra-revenue account
Internal Alignment to Maximize Revenue
Bridging the gap to higher reimbursement

- Identify/Quantify Opportunity
- Determine Root Cause
- Develop Solutions
- Establish Controls and Measures
- Align KPIs to Objectives
Benchmarking analytics for Texas hospitals

Texas State Average Medicare Claimed Ratio for 2014 = 26.3%

Texas State Average SSI Ratio for 2015 = 11.4%

Hospitals above the trend line are likely leaving money on the table
Benchmarking against peers

- Understand potential opportunity by comparing the percentage of Medicare co-insurance and deductible dollars claimed as bad debt vs. your hospital’s Supplemental Security Income ratio.

- Benchmark your performance against state averages, indexed to another proxy specific to the hospital’s indigent patient mix to gauge performance of your internal team or your external consultants.

### Competitive Peer Review Analysis

<table>
<thead>
<tr>
<th>Provider ID</th>
<th>Hospital Name</th>
<th>Claimed %</th>
<th>SSI %</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Average</td>
<td>State Average</td>
<td>15.83%</td>
<td>10.51%</td>
</tr>
<tr>
<td>100038</td>
<td>MEMORIAL REGIONAL HOSPITAL</td>
<td>3.51%</td>
<td>13.08%</td>
</tr>
<tr>
<td>100039</td>
<td>BROWARD HEALTH MEDICAL CENTER</td>
<td>29.90%</td>
<td>14.30%</td>
</tr>
<tr>
<td>100126</td>
<td>TAMPA GENERAL HOSPITAL</td>
<td>4.17%</td>
<td>10.39%</td>
</tr>
<tr>
<td>100157</td>
<td>LAKELAND REGIONAL MED CTR</td>
<td>12.68%</td>
<td>6.71%</td>
</tr>
<tr>
<td>100017</td>
<td>HALIFAX MEDICAL CENTER</td>
<td>5.66%</td>
<td>4.67%</td>
</tr>
</tbody>
</table>
A common scenario we encounter

Finance Blames the Business Office

Unexpected Medicare audit adjustments due to:

- Incomplete documentation
- Inaccurate/inconsistent documentation
- Process doesn’t follow CMS rules

Business Office Blames Finance

Wasted time and resources due to:

- Forced to spend time on audit funding believed to be anomalies but finance thinks are systemic
- Thinks cost reporting issues are not their problem

**Result:** Poor communication and lack of teamwork lead to missed reimbursement opportunities
Organizational challenges to best practices

Different environments produce conflicting goals and misaligned strategies

Chief Financial Officer

Business Office
- Director of PFS
- Manager of Patient Accounts/Collections
- Billing Staff and Collectors

Process-driven

Finance Dept.
- Director of Reimbursement
- Reimbursement Analysts

Project-driven
Achieving best practices requires partnership

Finance
Quantify the available opportunity:

→ Sell the opportunity
→ Use data to ensure buy-in
→ Collaborate with Business Office to realize opportunity

Business Office
Realize the available opportunity:

→ Train staff on best practices
→ Revise key processes and KPIs
→ Enact controls and measurement process

CFO must drive departmental objectives, gain buy-in, establish goals and KPIs, and demand accountability
Case Study: Alignment in Action
Case Study: Memorial Healthcare

Review prior year data for missed reimbursement opportunities

Project Objective
Identify additional Medicare Bad Debt reimbursement not previously claimed for Memorial Healthcare System facilities for FYEs 2009-2013

Project Started First 30 Days

Data Gathered
- Hospital Patient Accounting System Data
- Detailed Medicare PS&R
- State Paid Claims Data
- Outside Collection Data
- Previous Medicare Bad Debt Logs

Project Work: Day 31-90

Process Steps
- Review analytics to identify missed opportunity to be claimed via re-openings
- Review analytics to identify missed opportunities because of process
- Submit reopening request to MAC

Results: Day 91

Internal Meeting
- Discuss project results
- Communicate steps to improve process to appropriate stakeholders in hospital system
Case Study: Memorial Healthcare

Project results: Over $2.7M in total gross reimbursement found

Total Gross Reimbursement: $2,762,897
Case Study: Memorial Healthcare

Project results: Reimbursement rate increased by 26%

Percentage Increase in Medicare Bad Debt Reimbursement

Note: These are based on gross recovery amounts.
Actual recoveries would be subject to Medicare reductions of 30% for FY 2009-2012 and 35% for FY 2013.
Several key process issues were identified as root causes of missed opportunity.

<table>
<thead>
<tr>
<th>Issue</th>
<th>Overview</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of Coordination Between Primary/Secondary Collection Agencies</td>
<td>Primary collection agency had historically not forwarded accounts to the secondary collection agency</td>
</tr>
<tr>
<td>Not All Accounts Sent to Collection Agency</td>
<td>CMS requires Hospitals to follow internal collection policies as well as make a reasonable collection effort for all outstanding coinsurance/deductibles</td>
</tr>
<tr>
<td>Denied Medicaid Remittances not Addressed (Out-of-State)</td>
<td>CMS requires that Medicaid is billed properly until a “Paid” remittance is returned to the Hospital</td>
</tr>
<tr>
<td>Adjustment Prior to Medicaid Remit Date</td>
<td>Potential contractual adjustment change to ensure date is post Medicaid remittance date</td>
</tr>
<tr>
<td>Erroneously Included Fee Reimbursed Amounts</td>
<td>These amounts are not allowable Bad Debt and must be removed from submitted listings</td>
</tr>
</tbody>
</table>
Case Study: Memorial Healthcare

Financial impact of deficient processes was significant

Potential Impact of Key Issues

- Coordination Between Primary/Secondary Collection Agencies: $3,606,893
- Never Sent to Agency: $3,002,401
- Denied Medicaid Remittances: $1,214,195
- Adjustment Prior to Medicaid Remit Date: $1,150,642
- Erroneously Included Fee Reimbursed Amounts: $43,686

Note: This represents potential improvement in future periods if issues are addressed. Amounts are gross recovery amounts. Actual recoveries would be subject to Medicare reductions of 35%.
# Case Study: Memorial Healthcare

Action taken as a result of Case Study

<table>
<thead>
<tr>
<th>Issue</th>
<th>Action Taken to Improve Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of Coordination Between Primary/Secondary Collection Agencies</td>
<td>All agencies have been educated on process. A look back was performed to ensure that all unpaid accounts placed with primary agency were sent to secondary agency. Lastly, transfer and return dates for all accounts were recorded in PAS.</td>
</tr>
<tr>
<td>Not All Accounts Sent to Collection Agency</td>
<td>Reviewing all accounts that fit criteria to be sent to collections on regular basis to ensure they are sent to collection agency and appropriately returned.</td>
</tr>
<tr>
<td>Denied Medicaid Remittances not Addressed (Out-of-State)</td>
<td>Analysis performed to identify cost of not being set up as a Medicaid provider for out-of-state patients. Finance is evaluating strategy for those states where the impact is significant.</td>
</tr>
<tr>
<td>Adjustment Prior to Medicaid Remit Date</td>
<td>Instructed business office to write off accounts after Medicaid payments are posted to the GL. Using software tool to track on an ongoing basis as a safety net.</td>
</tr>
<tr>
<td>Erroneously Included Fee Reimbursed Amounts</td>
<td>Using software tool to automatically identify and exclude fee reimbursed revenue codes from amounts written off.</td>
</tr>
</tbody>
</table>
Integrating Medicare Bad Debt into the strategy to maximize revenue

“New Thinking”

- Business Office Processes must align with Medicare bad debt requirements
- Utilizing analytics to identify gaps in reimbursement
- Bridging the communication gap between business office and finance
- Slowed payment by snail mail
- Inquiry Payments (how much can you afford)?

“Must Haves”

- Defined best practices for collection efforts
- Updated best practices for accounting to ensure bad debts are properly written off
- Commitment from all levels within the organization
- Strong interdepartmental communication and alignment
- Shared strategy for implementation of updated bad debt procedures
- Strong Q&A process to ensure quality
QUESTIONS?

THANK YOU!

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