Oregon Chapter of HFMA

PIPELINE

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In this issue

President's Message

The year in review: Oregon HFMA flourishes

Spring is here! The sun has finally decided to shine (at least occasionally), and the flowers and trees (and allergies) are in full bloom. And this means the Oregon HFMA Spring meeting at Salishan is just around the corner! Check out the agenda online at **www.oregonhfma.org**, get yourself registered, and be sure to bring a costume for the Thursday evening banquet (the theme: dress as your favorite musical star).

As we prepare to install the 2012–13 leadership team at Salishan, I'd like to take a few moments to review some of our chapter's accomplishments for the 2011–12 year:

- Education remains our number one area of focus. National measures the number of education hours provided based on meeting attendance (this includes chapter, regional, and national events). Oregon currently has 9,607 hours for 2011–12, or 19.1 hours/member. This is a 6.75 percent increase over last year, and is 35 percent above the scorecard goal set by National.
- As part of our focus on education, this chapter fully supports certification for our members. We are proud that as of March 31, Oregon has 16 newly certified members! This means 12.9 percent of our membership is now certified, which ranks us tenth out of 68 chapters.
- Sixty-nine percent of respondents were very or extremely satisfied on the national member survey held last fall. This was the highest score in our region, above the national average, and part of a five-year upward trend for our chapter.
- While some chapters have experienced declining revenue from sponsors, our sponsorship revenue has remained strong, with small but consistent increases in both number of sponsors and overall revenue. This steadiness was noted by National, and our chapter was asked to speak on a leadership webinar designed for sponsorship chairs. Thank you sponsors — we could not do what we do without you!
- The new member mentorship program continued, along with an HFMA 101 session in the fall, and a new member night in the spring. Despite tough economic times, our membership numbers have held steady, with a slight increase from 502 to 507.
- The board approved a student discount policy, making it more affordable for full-time student members to attend local chapter meetings. We also communicated this new policy to faculty members at some of our

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in-state universities. Our student membership increased from 22 to 46!

- We held our first-ever charity fundraising event at our fall 2011 conference in October. We raised $283 for the American Red Cross, and donated approximately 20 food items to the Hood River food bank. Our members went above and beyond in donations, and we had a great time playing Wii bowling!

The National chairman's theme for this year was Believe to Achieve. The above accomplishments were made possible because a whole team of great people believed, worked hard, and achieved. **Thank you to the entire 2011–12 leadership team — you made these dreams a reality!**

It has been my privilege and honor to serve as your chapter ppresident this past year. I will continue to serve as director and past-president, and will also remain involved with Region 11 Symposium planning, since Oregon is the lead chapter in 2013! Thank you for allowing me the opportunity to lead this great team, and thank you all for your support.

See you at Salishan — and no matter what costume you wear, you are all *stars*!

Respectfully,
Megan Underwood, FHFMA
2011–12 Oregon Chapter President

Please send information and articles for upcoming issues to:
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Pipeline is the official newsletter of the Oregon Chapter of the Healthcare Financial Management Association. Our objectives are to provide members with information about chapter and national HFMA activities and to provide a forum for reporting state and national issues relating to the healthcare industry. Opinions expressed in articles are those of the authors and do not necessarily reflect the view of the Oregon HFMA Chapter or its members. The editor reserves the right to edit material and accept or reject contributions, whether solicited or not. All correspondence is assumed to be a release of information for publication unless otherwise indicated. ©2012 Editor 2011–12: Chris Brazil

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Certification Committee reports on a busy year, announces certified members

By Mark Sayler, FHFMA, Certification chair

The certification committee has been busy. In January and February, we offered a certification practicum, led by Christoph Stauder, FHFMA, with assistance from Bill Bigcraft, CHFP, and Mandeep Bawa, CHFP. The Oregon and Northern California chapters were invited to participate. We planned to limit the group to 20, but the response was overwhelming. Thirty members from the Oregon chapter and 14 members from the Northern California chapter signed up. Fortunately, Christoph, Bill and Mandeep stepped up and took on the challenge of the additional participants.

At the conclusion of the practicum, Liana Hans, FHFMA, certification co-chair, arranged for the group to take the CHFP exam. Several groups took the exam together and then shared feedback on the process.

The certification committee is pleased to announce the members who became certified this year:

Martha Bewley, CHFP, Mountain View Hospital
Beth M. Brown, CHFP, Silverton Hospital
Todd Bybee, CHFP, Tuality Healthcare
John Chivers, CHFP, Lower Umpqua Hospital
Todd Graneto, CHFP, Health Net
Suzi Hill, CHFP, Legacy Health
William Hoffman, CHFP, Samarian Health Services
Sarah K. Jensen, CHFP, Samaritan Health Services
Jenna Morganthaler, CHFP, OHSU
Michelle J. O'Malley, CHFP, Salem Hospital
Sarah Opfer, CHFP, KPMG
Hongboa Ren, CHFP, Legacy Health
Michael A. Rodeen, CHFP, PeaceHealth
Andrew Rybolt, CHFP, consultant
Jori Scruggs, CHFP, PeaceHealth
Catherine L. White, CHFP, Harney District Hospital

Several of the practicum members are scheduled to take the CHFP exam in the near future. The successful CHFP candidates will be announced in the next *Pipeline*.

Also, we are pleased to announce that **Hongboa Ren**, FHFMA, was awarded Fellow status in February.

If you are interested in becoming certified or learning more about certification, contact Mark Sayler, FHFMA, certification chair, at msayler@curryhealth.org, or Liana Hans, FHFMA, certification co-chair, at lhans@ima-consulting.com.

Survey results offer great news

By Megan Underwood, Oregon Chapter President

The results of the 2011 membership survey conducted by National HFMA are in, and I have great news to share: Once again, our chapter has *increased* our overall satisfaction score! Sixty-nine percent of survey respondents were very or extremely satisfied with the Oregon chapter overall. This was the highest overall score in our region, above the National average of 62 percent, and part of a five-year upward trend for our chapter.

I have already expressed my gratitude to this year's leadership team for all they have done to make this happen, and to our predecessors, who developed a firm foundation for the chapter. I would like to extend my gratitude to you, our members, for attending our education meetings, for responding to the survey, and for giving us feedback. Please know that while we are taking a moment to enjoy this measure of success, we are also still working diligently to improve the chapter. Our leadership team is reviewing all comments from the survey, and working to address each one.

Thanks again for a great survey!

Volunteer and leadership opportunities

If you have an interest in becoming involved in our chapter leadership, and helping us work towards constant improvement, please let us know! We are currently in the process of identifying new volunteers for the 2012–13 year. Our chapter secretary, Aaron Crane, is leading this effort. Contact Aaron at aaron.crane@salemhealth.org, or speak to any current chapter officer or board member.

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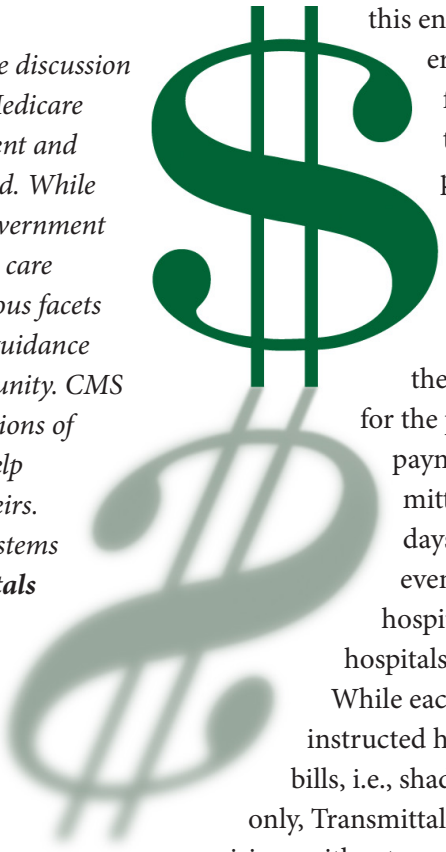
Medicare Advantage shadow billing
Are providers leaving money on the table?

By Liana Hans and Mario Feher, IMA Consulting

IMA Consulting hopes to provide a comprehensive discussion of shadow billing by hospital providers for their Medicare Advantage enrollees, focusing on the reimbursement and compliance implications that need to be considered. While information has been published either through government sources or through articles published in the health care arena, little is available that ties together the various facets of shadow billing. This lack of clear and detailed guidance should come as no surprise to the provider community. CMS is well aware that hospital providers have left millions of dollars on the table and they are in no hurry to help hospitals recover the monies that are rightfully theirs. Depending on the sophistication of a provider's systems and the strength of their internal processes, ***hospitals could be leaving hundreds of thousands to millions of dollars on the table every year****.*



Background

Shadow billing — synonymous with no-pay or information-only claims — is an unofficial term that refers to the process wherein hospitals submit claims to their Medicare administrative contractor (MAC) for inpatient services provided to Medicare beneficiaries who are enrolled in a Medicare Advantage (MA) plan. These claims are submitted through a series of transmittals, as instructed by the Centers for Medicare and Medicaid Services (CMS), for requesting supplemental Indirect Medicare Education (IME), Graduate Medical Education (GME), and Nursing Allied Health Education (NAHE) payments, and for the proper reporting of Medicare beneficiary days to be counted in the Medicare fraction of the disproportionate share hospital (DSH) calculation.

Shadow Billing for MA patients by hospitals began with the passage of Balanced Budget Act of 1997 (BBA '97). Sections 4622 and 4624 of the law provide hospitals with additional payments for IME and GME costs for their patients enrolled in a Medicare-managed care program. Initially the MA plans were responsible for reporting all of the claim encounter data to CMS. However, MA plans did such a sub-par job with reporting that the burden of submitting this encounter data was shifted to providers. Obviously, CMS felt they could force providers to submit the data that they were unable to get the MA plans to provide.

CMS released a series of three transmittals from July 2007 to May 2010 requiring that non-teaching hospitals submit no-pay claims for the MA beneficiaries they treat, but not for the purpose of requesting additional payments. The purpose of these transmittals was to ensure that these MA days were captured so that they could eventually be captured in an acute care hospitals DSH calculation or in a rehab hospitals low-income patient calculation.

While each of these transmittals clearly instructed hospitals to submit these no-pay bills, i.e., shadow bills, for their MA patients only, Transmittal 696, issued May 5, 2010, contained provisions without any real consequence to providers for failing to complying with the instructions. In that transmittal, CMS stated it believed many hospitals had not reported MA days, and therefore CMS was providing those hospitals with a final opportunity to do so. Furthermore, the transmittal required that hospitals attest in writing that they had either submitted all of their MA claims for the periods indicated (FY 2007 and 2008), or that they have no MA claims for those years. However, if providers failed to file their MA claims and attestations, they would be considered not in compliance and with the instructions. As a result, *CMS may instruct the MAC to use an SSI ratio of zero percent to calculate Medicare DSH payments, or take other actions*. For those providers who receive DSH payments, failure to comply with this requirement could be very costly. It is worth noting that in each of these three transmittals, teaching hospitals are specifically excluded because they are supposedly already submitting shadow claims based on prior CMS communications.

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Medicare Advantage shadow billing

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Clearly there are significant negative implications that providers face if they do not properly identify and shadow bill claims for the MA patients they treat. For teaching facilities, there are missed opportunities for optimizing your IME, GME, and NAHE reimbursement. For non-teaching facilities there is the issue non-compliance and the risk of losing your DSH reimbursement.

Issues and challenges

In today's environment, hospitals are under increased pressure to make sure they identify and recoup money that is rightfully theirs while balancing the challenges of dealing with a myriad of compliance issues. As mentioned earlier, in order for hospital providers to submit shadow bills for their MA patients, they must submit a separate claim to their MAC (and not the MA plan). This methodology places the onus on the hospital to ensure that the necessary information is provided on the claim, including specific information that must come from the beneficiary upon registration. Often all of the information needed to submit a shadow claim is not obtained during the registration process, causing large amounts of claims to never be submitted.

Further, providers must ensure that the claim includes the applicable condition codes and other necessary information so that the claim can be properly processed. For many teaching facilities, this issue is likely to have been on their radar screen for a while. For the non-teaching facilities, that may not necessarily be the case.

While many providers have addressed this issue by conducting retrospective reviews and incorporating internal processes to identify these claims prospectively, providers often fail to identify all of the eligible claims that they should be billing. Even in organizations that are doing retrospective reviews, simply missing 1–2 percent of these claims can result in significant lost revenues.

There are a variety of factors that may contribute to this dilemma including the fact that the regulatory guidance is complex and sometimes unclear; hospitals sometimes lack proper internal resources; there is often miscommunication or a lack of effective communication among key hospital departments, e.g., patient accounting, reimbursement, managed care, compliance, decision support, and finance; disparate systems often make it difficult to obtain all of the required data; time and competing initiatives; and turnover of staff leading to gaps in processes. So the challenge for providers is to develop and maintain processes and controls to identify MA patients, ensure proper data is collected and successfully bill shadow claims.

With regard to filing shadow bill claims, the conventional belief in the industry is that these claims must be filed according to the timely filing rules. In May 2010, CMS issued new filing guidelines in Change Request (CR) 6960, which went into effect on Jan. 1, 2010. In that CR, CMS instructed Medicare contractors — based on provisions of the Patient Protection and Affordable Care Act — to adjust their system edits to ensure the following changes for the processing of claims. Beginning Jan. 1, 2010, claims must be filed within 12 months of the date of service. This change is significant and dramatically shortened the amount of time a provider has to file a claim. For providers that rely on retrospective reviews to ensure that they have captured the money they are entitled to, this change dramatically shortens the time available to get those reviews completed.

Insight

Despite the many challenges that exist with shadow billing for MA patients, there are many things the provider can do to address those challenges. More importantly, given the potential negative impact of not doing so, providers cannot be complacent on this issue.

- First, establish a comprehensive understanding of MA shadow billing requirements and their implications for your facility. That will ensure that the appropriate departments in your organization are familiar with the requirements and continue to educate themselves accordingly.
- Second, establish a shadow billing task force, with all previously mentioned stakeholders participating.
- Third, conduct ongoing reviews to ensure that you are capturing and shadow billing all MA patients you treat.
- Fourth, based on the results of your reviews, you may need to tighten existing internal processes and controls

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The Medicare Cost Report *returns to relevancy*

As hospitals compete for business, the Medicare Cost Report, whether for patients, physicians or third party payors, is a useful benchmark for senior leadership.

By Scott Besler

Providers that participate in the Medicare program must submit an annual Medicare Cost Report (MCR) to their Medicare administrative contractor (MAC), also known as their fiscal intermediary (FI). The MCR is a rather large financial report of various data, including certain data related to patient statistics such as visits, discharges, and days, as well as a provider's gross and net revenue and expenses. A provider's payer mix — the amount of Medicare and Medicaid, as well as commercial and private third-party payer patients — is also included and is an important part of the MCR. This data is submitted and separated by hospital services. The MCR determines each provider's total costs and charges that are associated with all patients, and allocates a portion of these costs and charges to Medicare patients. The amount is compared to the payments received by the provider from Medicare and a settlement is calculated. From this streamlined perspective, the MCR has been compared to a tax return.

The cost reporting process includes subsystems for the Hospital Cost Report (CMS-2552-10, previously CMS-2552-96), Skilled Nursing Facility Cost Report (CMS-2540-96), Home Health Agency Cost Report (CMS-1728-94), Renal Facility Cost Report (CMS-265-94) and Hospice Cost Report (CMS-1984-99). (Visit **https://www.cms.gov/manuals/PBM/list.asp** to find instructions for completing cost report forms, which are also included in the provider reimbursement manual.)

The MCR is divided into worksheets which allow for the correct submission and flow of the report and also simplify the comparison of data elements among providers and between cost reporting years. The table below provides a brief description of the most common worksheets.

There may be other worksheets that a hospital is required to submit due to the type of services provided. For example, providers that offer renal services will have to complete the I series worksheets, and those that offer provider-based

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Most common worksheets of the Medicare Cost Report

Worksheet	Description	Purpose/Goal
S Series	Statistical data	To properly report statistics related to payer
A Series	Proper classification of expenses by cost center	To report allowable Medicare costs by cost center or department
B Series	Matching of costs to revenue by utilization of a step-down approach	Allocation of overhead costs
C Series	Matching of cost to revenue — gross revenue by cost center or department	Calculation of cost-to-charge ratios
D Series	Calculation of Medicare share of hospital cost	Determine a hospital's portion of Medicare cost
E Series	Calculation of Medicare settlement	Determine amount owed by or owed to the Medicare program
G Series	Hospital financial statements	Report the financial statements into the cost report software

The Medicare Cost Report

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services for hospice and home health will need to submit the H and J series worksheets, respectively.

Worksheet S-10

The Centers for Medicare and Medicaid Services (CMS) have made several changes to the Hospital Cost Report data system, and the new CMS-2552-10, after having a few minor snags, is in full use. Of the many changes, no worksheet has seen more change than worksheet S-10, Hospital Uncompensated and Indigent Care Data.

The purpose of worksheet S-10 is to provide charges and payments for uncompensated care and indigent care and to calculate the associated cost for providing patient care services for which the hospital is not compensated. Hospitals will use several data elements, including but not limited to:

- Uncompensated care policies
- Bad debt listing by write-off date applicable to cost reporting period
- Charity care listing based on service date with the cost reporting period
- Medicaid traditional and managed care listing including patient charges and payments
- Documentation to support Disproportionate share (DSH) or supplemental payments for Medicaid (State subsidy funding)

There are three major components of worksheet S-10:

- **Uncompensated care** — Listed as charity care but also the bad debt which would include both non-Medicare bad debt and non-reimbursable Medicare bad debt. Note: Uncompensated care does not include courtesy allowances or discounts given to patients.
- **Charity care** — Includes all health services at the hospital where it was demonstrated 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. Note: For Medicare purposes, charity care is not reimbursable and unpaid amounts associated with charity care are not considered as an allowable Medicare bad debt.
- **Bad debt** — This is the provision for actual or expected uncollectible accounts. Bad debts that would be included are those that are non-Medicare patients and those that are non-reimbursable Medicare bad debt. Note: Bad debts are normally reported as an expense and not as a reduction from revenue. Therefore the gross charges that result in bad debts will remain in net revenue.

> Preparation of the Medicare Cost Report should be a year-long process involving not only financial staff, but clinical and other departments as well.

The importance of the calculation of your hospital's DSH payments will change beginning in federal fiscal year 2014. At a recent session at the American Health Lawyers conference on Medicare and Medicaid Issues, members of CMS and the United States Department of Health and Human Services (HHS) would not commit that worksheet S-10 would be the sole source of calculating the uncompensated care portion of the 2014 DSH payments. It was stated here that both CMS and HHS are currently reviewing and listening to comments from the provider community regarding this calculation and that it was too early to say what could and should be used. CMS also stated that they are aware of many different sources for uncompensated care and would need to evaluate each before any final determination is decided. The 2552-10 version of worksheet S-10 has changed from the previous year. These changes could impact the amount of uncompensated care applied to the new DSH calculation, as it is currently one of the controllable variables in future DSH calculations, and should be reviewed before submission.

Conclusion

The MCR continues to play a critical role in the determination of Medicare reimbursement to hospitals and health systems. In the present environment the staff at many hospitals is challenged to allocate their time and resources toward the preparation and thorough review of the MCR. Preparation of this report is or should be a year-long process that involves not only financial staff but clinical and other departments as well. The employees completing your

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The Medicare Cost Report

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cost report need to invest their time by implementing policies and creating procedures for cost report data accumulation and preparation. This may involve time that staff is borrowing from time spent focusing on future issues for the hospital. Historically, the cost report is seen as a retrospective report; however, with the appropriate understanding and review, this report can assist management in future budgeting, decision support and strategic planning. As we have mentioned the MCR preparation is a yearlong process and a hospital should assure that a formal cost report preparation process is in place. Hospitals should maintain a cost report inventory that includes status and deadlines as time management plays a key role. A hospital should also keep a log of their Medicare cost report reserves and estimated settlement amounts, in addition to understanding the open appeal items for the hospital.

The U.S. Supreme Court recently heard cases challenging the constitutionality of certain provisions of the Patient Protection and Affordable Care Act, leaving the fate of the health care reform law in question. If the act's individual mandate is struck down by the court, it is uncertain what portions of the law, if any (including the DSH changes), will survive.

The provider community has withstood similar changes to the cost reporting requirements in the past. The use and importance of cost report data for Medicare inpatient and outpatient prospective payment systems will continue to be a crucial piece of hospitals' future plans. Hospital leadership needs to be aware of various re-opening and appeal processes. For many hospitals, having a proactive plan in place can result in witnessing increased revenue through corrected payments, which has helped them to meet their fiscal responsibilities and their social missions.

For more information about changes to the MCR forms, preserving your appeal rights, and assistance with navigating the process, contact Scott Besler at sbesler@besler.com or 732-839-1219.

Medicare Advantage shadow billing

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and create new ones as needed based on the results of your review. Part of your review should include a retrospective assessment.

- Finally, stay in touch with your peers and industry experts and continually investigate new areas, such as completing a 100 percent review traditional HMO claims to look for misclassified MA patients — another opportunity to capture shadow bills.

Summary

Opportunities exist for providers to re-coup additional reimbursement to which they are legally entitled and to make sure that they are in compliance with instructions set forth by CMS. It is clearly demonstrated that a financial opportunity exists for teaching facilities to recoup additional dollars as well as non-teaching facilities to ensure they are to the best of their abilities are capturing and attesting to shadow billing requirements.

In our experience, providers are successfully capturing 92–99 percent of the claims that should be shadow billed. While this success rate appears strong, don't lose sight of the fact that even missing only 1 percent of these claims can result in the loss of over $1,000,000 annually!

IMA Consulting is a full-service professional services firm providing shadow billing recovery services to over 700 hospitals nationwide.

HFMA National's online membership directory gives you access to members across the country

You can find HFMA National's online membership directory at **www.hfma.org/login/index.cfm**.

Select "HFMA Directory" and you can search for members of our chapter and all of your HFMA colleagues by name, company and location regardless of chapter.

Using an online directory instead of a printed directory ensures that you always have up-to-date contact information.

Take a moment to review your own record to make sure it is up-to-date, so HFMA can keep you in touch with valuable information and insights that can further your success.

TriWest clarifies need for referral or authorization requests

It is important for providers to understand the difference between referrals and authorizations as well as to understand when to submit a request to TriWest Healthcare Alliance. Submitting unnecessary requests creates excess work for your staff, as well as for TriWest, and can result in processing delays.

Referrals

A referral occurs when the primary care manager (PCM) sends a patient to another professional provider for consultation or treatment when the requested service is outside the referring provider's scope of practice.

Active duty service members must always have a referral for all specialty care provided outside of a military treatment facility, except for emergencies. Other prime beneficiaries require referrals for all specialty services not provided by their PCM, except for emergencies, the initial eight behavioral health visits annually and most preventive services.

Authorizations

- A prior authorization is required for specified services, procedures, or admissions for a Tricare beneficiary that require medical necessity review before services are rendered.
- Authorizations are required for services listed on the prior authorization list (PAL) for all Tricare beneficiaries in programs administered by TriWest.
- If a service is not listed on the PAL, an authorization is not required.
- Outpatient services rendered by a network provider in a non-network facility require prior authorization; otherwise, a penalty will be applied to the network servicing provider's claim.
- If an authorization is not required, please do not submit a referral or authorization request to TriWest. Submitting unnecessary requests creates unnecessary work for you, as well as for TriWest. As a result, processing requests that are required and urgent requests are delayed. Note: all services must be covered benefits under Tricare in order to be reimbursed.

Tricare Standard — Tricare Standard is available to Tricare-eligible active-duty family members and retirees and their family members. Beneficiaries with Tricare Standard never require referrals. However, as noted above, prior authorization is required for services on the PAL.

Other health insurance — Prior authorization is not required when the beneficiary has other health insurance (OHI) that covers the treatment required, except as noted on the PAL.

Submitting your request — Submit all requests online at TriWest.com with supporting clinical documentation, which can be electronically attached.

TriWest has online tools and a dedicated team to assist you in registering for our secure website and learning how to submit your requests online. Visit our website at **triwest.com/provider** to:

- Get more information about online referral or authorization requests
- View the online referral/authorization submission website demonstration
- Take a Secure Website Referrals and Authorizations webinar
- Refer to the referral/authorization reference guide.

TriWest password requirements simplified

If you are tired of getting frequent reminders to update your TriWest.com password, relief has arrived, because the government has eased the password expiration requirements.

As of February, passwords are good for 150 days, instead of 60 days, for registered userws of TriWest.com. When a password expires, registered users still need to be in compliance with government requirements. Passwords for accessing the secure provider portal must:

- Be at least nine characters long (shortened from 15)
- Contain one or more upper- or lowercase letters
- Contain one or more of these special characters: #, $ or @
- Contain one or more number(s)

The new password must not:

- Repeat any of your last five passwords
- Contain a Social Security number
- Contain a username, first name, last name or full name

The password is case sensitive. You can reset a password only once each day.

New Members • New Members • New Members • New Members • New Members

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UPCOMING EVENTS

Spring Conference 2012 (11 hours CPE)
May 16–18
Salishan Spa and Golf Resort
7760 Highway 101 North
Gleneden Beach, OR 97388

Summer Conference 2012 (11 hours CPE)
July 25–27
Valley River Inn
Eugene, OR

Fall Conference 2012 (11 hours CPE)
September 19–21
The Heathman Lodge
7801 N.E. Greenwood Drive
Vancouver, WA 98662