Strategies for Identifying and **Retrieving Missed Revenue**

 Jeff Nieman, *CEO,* Meduit

 Greg Rassier, *Chief Strategy Officer,* Meduit

Welcome to the Meduit Podcast. I'm Jeff Nieman, the *CEO* of Meduit, one of the largest full-service healthcare revenue cycle solutions companies in the country. Today we'll be talking about strategies for identifying and retrieving missed revenue. I'm joined by my colleague, Greg Rassier, *Chief Strategy Officer* for Meduit. Welcome, everyone. Let's get started. Greg, can you give us a quick update on how hospitals and health systems are faring financially?

GREG Absolutely. As we discussed in our last podcast, 2022 was a rough year for hospitals and health systems financially. Approximately 50% of US hospitals finished the year with a negative margin as growth and expenses outpaced revenue. Recent data from Kaufman Hall actually shows that hospital operating margins are slowly rising to positive levels this year, largely due to higher revenues from outpatient visits. This is good news compared to 2022, when many hospitals were operating with negative margins. Although finances are stabilizing, staffing shortfalls still exist. To get ahead of the competition, hospital leaders looking to outsourcing and found money solutions such as the ones we're going to share today. So, it is an opportune time to re-evaluate strategies to maximize financial recovery. Identifying missed revenue and retrieving that revenue is ideal low-hanging fruit to pursue.

JEFF Where are the key areas that health systems should be looking for this missed revenue?

GREG Three of the top areas to look for this missing revenue include government reimbursement from Medicare and other uncompensated care, accounts that may have been incorrectly paid by payers, and patients who have lost their Medicaid coverage for technical or other clerical reasons.

JEFF Let's take a look at each one of those. So let's start by telling us more about identifying missed revenue from Medicare and other uncompensated care.

GREG Definitely. Nearly every US hospital with Medicare as a provider is missing more than a million dollars in uncollected revenue related to Medicare bad debt. While Medicare provides bad debt reimbursement of 3.5 billion dollars each year, most US hospitals under-report their Medicare bad dept by an average of 4% to 7% every year. There are many reasons why revenue could be missed as it relates to Medicare bad debt and other uncompensated care. It's never usually due to just one area. There's no silver bullet that's gonna solve these problems. In the everchanging world of healthcare, any one of these items can result in a connectivity gap that could mean lost revenue. There could be new staffing involved; changing of processes, including updates and billing codes; and affiliations and merger adjustments, system upgrades or conversions. And then any new or changing government regulations. We're seeing more and more of that in the Medicare bad debt arena, and staying on top of those changes, just in the Medicare bad debt space, can be a full-time job. While billing teams typically do an excellent job of collecting most of the payments due, money still falls through the cracks.

JEFF How can hospitals get that revenue that they're missing?

GREG It's definitely a multi-step process. Identifying the missed revenue from Medicare, Medicare Advantage payers, and other uncompensated care. Step two, you're really having to amend or reopen those Medicare cost reports to reflect the increase in Medicare bad debt. And then also working through the audits to ensure value is fully recognized and received from the government. As long as the Medicare cost report is still open, meaning that the government has not fully settled that year or if it is settled, that year is still within the 3-year reopening window, hospitals can perform a look-back to add any valid Medicare bad dept for those years that might've been missed. It's important to have the right partner, the right subject matter expertise, when performing this look-back review. There should be a holistic approach that supplements both expertise and technology.

> *... most US hospitals under-report their Medicare bad dept by an average of 4% to 7% every year.*
>
> **– Greg Rassier**

JEFF This solution, Greg, you're discussing is just kind of a no-brainer to me. I know we've kind of tried to educate the market that every hospital out there probably has a million dollars in bad debt cost report revenue that they're not bringing in 'cause they just missed it in a very complicated filing process for those receivables. And to me it just feels like a no-brainer that every hospital should be going after this money and getting it. It's reimbursing them for services they already provided, and it's money that they're technically due from the federal government. All right. Next, let's talk about patient accounts that have been paid incorrectly by payers. How do you identify those accounts?

GREG They're often leaving money on the table from patient accounts that may have been incorrectly paid by the health plan or the government fee schedules. According to the AMA, approximately 7% of paid medical claims are found to have errors, and denied claims average around 5%. We're hearing from our provider partners on a daily basis about denial issues and the need to stem that tide. A potential key to retrieving these funds is to take a deep look at unpaid and underpaid balances from closed patient accounts from all payers, including government, commercial and self-funded accounts. We refer to this process as zero balance review.

JEFF Do you have any data for our listeners on how much cash we're talking about potentially retrieving here?

GREG Yes, yes, I do. Our team has been able to locate an additional 1% to 2% in found revenue from incorrect paid accounts. And that may not sound like much, but to put that in perspective for a hospital with 250 million dollars in yearly revenue, that means an additional 2.5 to 5 million dollars in new revenue added to the hospital's bottom line.

JEFF That's hugely significant. So, now we're talking about, you know, Medicare bad debt and those cost filings that could be a million dollars. Another 1% lift in that revenue from the zero balance review process that we shared with our listeners. I mean, we're talking significant real money here that's just almost gifted to a facility that's willing to go after it.

> *... approximately 7% of paid medical claims are found to have errors, and denied claims average around 5%.*
>
> **– Greg Rassier**

JEFF Let's shift now to the third thing: patients dropped from Medicaid and how hospitals can help drive reimbursements in that space.

GREG Yeah. Unfortunately, millions of people with Medicaid have seen their eligibility change primarily due to changes in income and some enrollees that are being dropped for procedural terminations. Overall, an estimate 15 million people are expected to lose Medicaid coverage during the redetermination process. This is because the federal government's continuous enrollment provision is now lapsed that was part of the Families First Coronavirus Response Act that went into effect in March 2020. With that now ended, an example of what's happening is in Arkansas. In April of this year, 72,802 Arkansas residents were dropped from the state's Medicaid program because they failed to return a renewal form that is now required. This population included 28,000 children and infants. Parents often don't realize that even if they are no longer eligible for Medicaid, their children may still be eligible for Medicaid or Children's Health Insurance Program, as most of us know it by CHiP. To get these patients covered and to maximize hospital reimbursement,

hospital teams should be reviewing patient eligibility for Medicaid, as well as additional charity programs that might be available. Some states have as many as 50 different federal, state, and private charity programs for under-served patients. Getting patients re-enrolled in Medicaid or CHiP, or other charity programs, ensures increased revenue to the hospital. Most states even have an emergency Medicaid program that helps the undocumented noncitizen population. This program requires, however, a new application each visit to the hospital.

> *Meduit has a 99%+ successful outcome when using this additional appeal process step (appeals on applications that are not processed within the state guidelines).*
>
> **– Greg Rassier**

JEFF These are incredible opportunities that every hospital and health system should be taking advantage of. What would you like to leave our listeners today with, kind of regarding strategies for finding missed revenue?

GREG If your hospital does not have the staff today, or the time to work through these areas, find the right subject matter expert, like Meduit, that can help. Regarding the government reimbursement of Medicare and other uncompensated care, we have 100% success in locating and getting that cash for hospitals. Here's how we do it. We use the data that hospitals already have available. We validate it and run automated intelligent algorithms through our proprietary technology to find every missed dollar. Our second supplemental look is different, and here's why. We work directly with the CMS fiscal intermediaries to get certain difficult issues resolved in the client's favor. We have a deep national expertise in complex issues that continues to set us apart in the marketplace. We do all of this in a fraction of the time you might expect. The main goal is the recovery of significant money for our clients, but we'll also report on process improvements that will help to maximize that revenue in the future. So, for example, if we find a gap in the area of the claims Medicare bad debt, we'll not only ensure the gap is closed in previous years, but we'll work with our clients to improve workflows or processes within the billing and collection functions to ensure that gap is closed, and that value is claimed of Medicare bad debt in future years. For zero balance review, our team analyzes at least 6 – 12 months of data on closed claims. We apply our state-of-the-art technology platform to compare paid claims to payer contract obligations. We then pursue variants with the payers to retrieve the full amount that's owed. We also review policies, procedures and contract language in order to improve future claims for payment accuracy. And lastly, on the Medicaid front, for patients that are dropped from Medicaid, our team here at Meduit will thoroughly review patients dropped by the program for changes in eligibility. If the patient was dropped in error, Meduit will contact the county office to get the eligibility reinstated. For the changes in eligibility, then we work with the patient to complete a Medicaid application on their

behalf. We collect the required materials, such as tax forms, and then we submit all of that information for them electronically. If the patient is no longer eligible for Medicaid, we'll look for additional charity programs that the patient may be eligible for. Having a partnership with experts like the folks at Meduit will increase conversions from self-paid to Medicaid. One example is through an appeals process. Our knowledgeable team can overturn erroneous denials and approvals through the appeal process. Applications that are not processed within the state guidelines are also eligible for an appeal. This helps to get quicker turnaround reducing the amount of time that the accounts sit on a hospital's AR. Meduit has a 99%+ successful outcome when using this additional appeal process step. Best of all, across all of these solutions, is Meduit is typically on a fee program that is a contingency basis. So if we don't find any of this missing money, we don't charge anything. The found revenue can add millions of dollars to the hospital's bottom line, and it is critical in order to have the cash that they need to deliver excellence in patient care.

JEFF Thank you, Greg. For more information regarding these strategies for collecting missed revenue, visit **Meduitrcm.com**. Thanks for listening.

Jeff Nieman, *CEO,* Meduit

Mr. Nieman leads Meduit's top-notch team of healthcare revenue cycle professionals to maximize performance and accelerate growth for hospitals, health systems and provider groups. Prior to joining the Meduit team, he was the chief operating officer for Navigant Cymetrix, a revenue cycle management company serving over 200 hospitals. He has also held leadership positions at Conifer Health Solutions, Humana and HCA (Hospital Corporation of America) and has a BA in Economics from Bellarmine University in Louisville, Kentucky where he graduated magna cum laude.

Greg Rassier, *Chief Strategy Officer*, Meduit

Greg joined Meduit in 2019 and is responsible for overseeing the company's day-to-day operations. Greg brings with him a wealth of experience as a Revenue Cycle Strategist, Executive and Consultant, where he focuses in the design, implementation and transformation of the healthcare revenue cycle and call center solutions. He is an expert at creating process efficiency and partnering with our customers to provide industry-leading revenue cycle solutions. He has over 25 years' experience in operations, process management, technology-driven automation, mergers & acquisitions, organizational assessment and consulting. In addition to his recent work as a strategic transformation consultant, he has held executive leadership roles with Convergent, Inc., and Conifer Health Solutions. He has a BA in Economics from Washington State University.