Continuing Education

The planners and presenters of this activity disclose no relevant relationships with any commercial entity pertaining to the content.

- Nurse attendees may earn a maximum of 15.5 contact hours
- Accountant attendees can earn up to 18.9 CPEs

Accreditation Statement
NAHC is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center’s Commission on Accreditation.
NAHC is [also] approved by the California Board of Registered Nursing, provider #10810.

Commercial Support provided by Brightree, Excel Health Group, Healthcare Provider Solutions, and Simione Healthcare Consultants.
Today’s Objectives

- Review Targeted Probe & Educate (TPE) initiatives
- Review optimization & compliance strategies
- Review key performance indicators

Financial Manager’s Responsibilities
Consequences of Poor Revenue Cycle Performance

- Compliance violations
- Cash flow impairment
- Financial reporting inaccuracies
- Impaired decision support

Hospice Revenue Cycle

Document  Bill  Get paid
Hospice Revenue Cycle

- People
- Process
- Technology

**Typical process weaknesses**
- Incorrect payer assignment
  - Traditional Medicaid vs. Medicaid managed care
  - In-network vs. out-of-network plans
  - Authorization vs. no-authorization required plans
  - Lapses in contract coverage

<table>
<thead>
<tr>
<th>Plan</th>
<th>VS.</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCBS</td>
<td>BCBS (in state, no auth req)</td>
</tr>
<tr>
<td>BCBS</td>
<td>BCBS (out of state, auth req)</td>
</tr>
<tr>
<td>BCBS (visit-pay)</td>
<td>BCBS (visit-pay)</td>
</tr>
<tr>
<td>Medicaid</td>
<td>Medicaid</td>
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<td>Medicare</td>
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<table>
<thead>
<tr>
<th>Plan</th>
<th>VS.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid MCO, Amerigroup (auth req)</td>
<td>Medicaid MCO, Sunflower (auth req)</td>
</tr>
<tr>
<td>Medicaid MCO, United HC (auth req)</td>
<td>Medicaid MCO, United HC (auth req)</td>
</tr>
</tbody>
</table>
Hospice Revenue Cycle

**Typical process weaknesses (continued)**

- Incorrect hospice effective date
- Cumbersome or ineffective benefit eligibility verification processes
  - Incorrect benefit period assignment
    - Incorrect scheduling of face-to-face (FTF) encounter
  - Incorrect high/low day assignment
- Poor coordination with prior hospices on transfers or discharges/readmissions
- Poor system management of software platform(s)
- Poor contract management processes

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Hospice Revenue Cycle

**Typical process weaknesses**

- Inefficient or ineffective use of technology platform(s)
- Use of outdated &/or noncompliant manual forms
- Incorrectly obtaining & documenting verbal certifications
- Incorrectly documenting responsible attending &/or hospice physician(s)
- Untimely coordination with physicians & members of interdisciplinary team
Hospice Revenue Cycle

**Typical process weaknesses**
- Inefficient or ineffective use of technology platform(s)
- Lack of communication & coordination with intake/clinical personnel
- Weekends, holidays & limited or no backup trained personnel
- Lack of follow-up & reconciliation after transaction submission

Hospice Revenue Cycle

**Typical process weaknesses**
- Poor documentation management processes
  - Poor prioritization &/or escalation processes
  - Inattentive scheduling of FTF encounters
  - Poor communication of changes in levels of care
  - Lack of diligence related to high risk documentation areas
    - General inpatient care (GIP)
    - Continuous home care (CHC)
- Untrained personnel & lack of accountability
- Inefficient or ineffective use of technology platform(s)
**Hospice Revenue Cycle**

**Typical process weaknesses**
- Inefficient or ineffective use technology platform(s)
- Lack of communication & coordination with intake/clinical personnel
- Lack of follow-up & reconciliation after transaction submission

**Collections & Reporting**

**Typical process weaknesses**
- Untrained, inexperienced, or ineffective personnel in key positions
  - Payment vs. adjustment posting
  - Billing vs. collecting
  - Problem solving & critical thinking
- Lack of reconciliation for high/low rates & service intensity add-on payments
- Poor processes for pre-pay review & approval of nursing facility room & board invoices
- Lack of personnel & process oversight & accountability
- Inefficient or ineffective use of technology platform(s)
Hospice Revenue Cycle

Process OPTIMIZATION opportunities

- Enhance use of software platform(s)
- Improve relationships with business office contacts in contracted facilities
- Automate submission of NOEs
- Enhance use of billing clearinghouses & payer web portals
- Conduct prebilling evaluation of GIP, CHC & live discharge claims
- Enhance diligence of collections activities
Know Industry Risks

- Program integrity contractors
- Comprehensive Error Rate Testing Contractor (CERT)
- Medicare Administrative Contractors (MACs)
- Recovery Audit Contractor (RAC)
- Supplemental Medical Review Contractor (SMRC)
- Unified Program Integrity Contractors (UPICs) replacing Zone Program Integrity Contractors (ZPIC)
Know Industry Risks

- AdvanceMed
- Monitors accuracy of claim payments across Medicare programs
- Conducts post-pay medical review
- Publishes results annually

Source: 2018 Medicare Fee-for-Service Supplemental Improper Payment Data

Table D3: Top Service Types with Highest Improper Payments: Part A Excluding Hospital IPPS

<table>
<thead>
<tr>
<th>Part A Excluding Hospital IPPS Services (TOB)</th>
<th>Projected Improper Payments</th>
<th>Improper Payment Rate</th>
<th>95% Confidence Interval</th>
<th>Percentage of Service Type Improper Payments by Type of Error</th>
<th>Percent of Overall Improper Payments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>No Doc</td>
<td>Insufficient Doc</td>
</tr>
<tr>
<td>House Health</td>
<td>$3,159,762,318</td>
<td>17.0%</td>
<td>15.3% - 20.0%</td>
<td>2.0%</td>
<td>61.9%</td>
</tr>
<tr>
<td>Hospital Inpatient (Part A)</td>
<td>$3,028,843,725</td>
<td>27.3%</td>
<td>23.8% - 31.5%</td>
<td>0.1%</td>
<td>17.0%</td>
</tr>
<tr>
<td>SNF Inpatient</td>
<td>$3,148,184,957</td>
<td>92.2%</td>
<td>82.7% - 92.7%</td>
<td>81.3%</td>
<td>1.7%</td>
</tr>
<tr>
<td>Hospital Outpatient</td>
<td>$2,054,966,891</td>
<td></td>
<td></td>
<td>85.5%</td>
<td>1.4%</td>
</tr>
<tr>
<td>Nonhospital based hospice</td>
<td>$1,780,999,205</td>
<td>11.0%</td>
<td>8.6% - 13.3%</td>
<td>5.2%</td>
<td>36.6%</td>
</tr>
<tr>
<td>Clinic ESRD</td>
<td>$394,644,185</td>
<td>3.5%</td>
<td>2.1% - 5.0%</td>
<td>0.0%</td>
<td>99.9%</td>
</tr>
<tr>
<td>Critical Access Hospital</td>
<td>$386,619,186</td>
<td>6.1%</td>
<td>2.9% - 9.5%</td>
<td>0.0%</td>
<td>88.4%</td>
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<tr>
<td>Hospital based hospice</td>
<td>$275,887,344</td>
<td>19.3%</td>
<td>12.6% - 25.9%</td>
<td>1.1%</td>
<td>83.4%</td>
</tr>
<tr>
<td>Hospital Other Part B</td>
<td>$133,323,795</td>
<td>16.2%</td>
<td>6.2% - 26.2%</td>
<td>1.0%</td>
<td>77.7%</td>
</tr>
<tr>
<td>SNF Inpatient Part B</td>
<td>$69,041,788</td>
<td>2.3%</td>
<td>0.5% - 4.1%</td>
<td>0.0%</td>
<td>69.9%</td>
</tr>
</tbody>
</table>

Source: 2018 Medicare Fee-for-Service Supplemental Improper Payment Data
Know Industry Risks

- CGS, NGS & Palmetto GBA
- Provide Medicare administrative functions
  - Claims processing
  - Cost report processing & other reimbursement functions
  - Provider enrollment processing
- Conduct pre-pay medical review
  - Targeted Probe & Educate (TPE)
    - Additional development requests (ADRs)
  - Electronic notification only
    - Status location code “S B6001”
  - 30 days to respond
  - Automatically denied after day 45 if requested documentation not received

Provider selected for TPE → Letter issued by MAC informing provider of TPE → One round of 20-40 ADRs selected

Letter issued by MAC informing provider of TPE results → Depending on TPE results two additional rounds could occur → MAC offers provider education after each round of TPE

**Good Outcome**
TPE discontinued for at least 12 months

**Bad Outcome**
MAC refers provider to program integrity contractor
You have been selected for Targeted Probe and Educate Review. The purpose of the claim review is to ensure documentation supports the reasonable and necessary criteria of the services billed and follows Medicare rules and regulations. Targeted Probe and Educate Review consists of up to three rounds of review. A prepayment sample of claims will be selected over at least six (6) weeks, or until claims have been identified for review with each round. The claim sample selected may be less than 20 based on your billing pattern history, but will not exceed 40 claims.

You are receiving this letter because analysis of your billing data has indicated aberrancies that may suggest questionable billing practices.

A prepayment review has been initiated to probe a sample of your claims billed with the following:

- Seven or more units of revenue code 656, and a from date of service on or after May 1, 2018.

Review Process:
The TPE review process includes up to three rounds of a prepayment probe review with education. If there are continued high denials after three rounds, CGS will refer the provider to CMS for additional action, which may include 100% prepay review, extrapolation, referral to a Recovery Auditor, etc. Discontinuation of review may occur if appropriate improvement, an error rate of < 25%, is achieved during the review process.

HOSPICE
A CELERIAN GROUP COMPANY

HOSPCODES

<table>
<thead>
<tr>
<th>HOSPCODES</th>
<th>Description</th>
<th>Revenue Code Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>LOS with Non-Oncologic Diagnosis</td>
<td>This edit selects hospice providers who submitted claims with length of stay (LOS) &gt;730 days and non-oncologic diagnosis code</td>
<td>SC0006, SE006, SF006</td>
</tr>
<tr>
<td>LOS in LTC, NF or SNF</td>
<td>This edit selects hospice providers who submitted claims with HCPCS codes Q0003 (Hospice care provided in a long term care facility (LTC) or non-skilled nursing facility (NF)), and Q0004 (Hospice care provided in skilled nursing facility (SNF) for any non-oncologic diagnosis code with a length of stay greater than 180 days</td>
<td>SC0004</td>
</tr>
<tr>
<td>GIP LOC</td>
<td>This edit selects hospice providers who submitted claims with revenue code 0056 greater than or equal to 7 days</td>
<td>SC0006, SE006, SF006</td>
</tr>
<tr>
<td>LOS &gt;180 Days</td>
<td>This edit selects hospice providers with LOS greater than 180 days (currently 2 providers on edit)</td>
<td>SC0003, SC003, SE003, SF003</td>
</tr>
<tr>
<td>LOS &gt; 120 Days</td>
<td>This edit selects hospice providers with LOS greater than 120 days (currently 1 provider on edit)</td>
<td>SC0003, SC003, SE003, SF003</td>
</tr>
</tbody>
</table>

Top Denial Reasons January 1, 2019 - March 31, 2019

1. Terminal prognosis not supported
2. Physician Narrative missing/invalid
3. Notice of Election is invalid

Source: CGS

Hospice
Probes completed January 1, 2019 - March 31, 2019
LOS with Non-Oncologic Diagnosis with 0006

<table>
<thead>
<tr>
<th>Results</th>
<th>Hospice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Providers Compliant</td>
<td>7</td>
</tr>
<tr>
<td>Providers Non-compliant after Round 1 Completion</td>
<td>3</td>
</tr>
<tr>
<td>Providers Non-compliant after Round 1 Completion (advancing to Round 2)</td>
<td>6</td>
</tr>
<tr>
<td>Providers with Non-Repeaters to ADNs for Round 1</td>
<td>1</td>
</tr>
</tbody>
</table>

GIP LOC with 0006

<table>
<thead>
<tr>
<th>Results</th>
<th>Hospice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Providers Compliant</td>
<td>4</td>
</tr>
<tr>
<td>Providers Non-compliant after Round 1 Completion</td>
<td>2</td>
</tr>
<tr>
<td>Providers Non-compliant after Round 1 Completion (advancing to Round 2)</td>
<td>2</td>
</tr>
<tr>
<td>Providers with Non-Repeaters to ADNs for Round 1</td>
<td>0</td>
</tr>
</tbody>
</table>

Hospice
Round 1 Review Decisions by State
January 1, 2019 - March 31, 2019

[Graph showing state-wise distribution of review decisions]
January – March, 2019, Hospice Medical Review Top Denial Reason Codes

We encourage all providers to review this information when filing claims to prevent denials and to ensure their claims are processed timely. The following information affects providers billing 81X bill types.

81X bill type denials: Total denials 75

<table>
<thead>
<tr>
<th>Rank</th>
<th>Denial Code</th>
<th>Denial Description</th>
<th># Claims</th>
<th>% Claims Denied</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>S5900</td>
<td>Auto Denial - Requested Records not Submitted</td>
<td>9</td>
<td>12.0</td>
</tr>
<tr>
<td>2</td>
<td>S5F36</td>
<td>Not Hospice Appropriate</td>
<td>9</td>
<td>12.0</td>
</tr>
<tr>
<td>3</td>
<td>S5F9H9</td>
<td>Physician Narrative Statement Not Present or Not Valid</td>
<td>2</td>
<td>2.7</td>
</tr>
<tr>
<td>4</td>
<td>S5FIP</td>
<td>Invalid Plan of Care Submitted</td>
<td>1</td>
<td>1.3</td>
</tr>
<tr>
<td>5</td>
<td>S5F2F</td>
<td>Face to Face Encounter Requirements Not Met</td>
<td>1</td>
<td>1.3</td>
</tr>
<tr>
<td>6</td>
<td>S5FNER</td>
<td>The notice of election is invalid because it doesn't meet statutory/regulatory requirements</td>
<td>1</td>
<td>1.3</td>
</tr>
<tr>
<td>7</td>
<td>S5F9H9</td>
<td>Physician Narrative Statement Not Present or Not Valid</td>
<td>1</td>
<td>1.3</td>
</tr>
</tbody>
</table>

Source: PGBA

Know Industry Risks

- Performant Recovery
- Conducts nationwide post-pay medical review
  - Three year period
- All issues approved by CMS & published on RAC website
- Limitations to amount of review focused on single provider
- No current CMS approved hospice issues
Know Industry Risks

- Noridian Healthcare Solutions
- Conducts nationwide post-pay medical review
- Determines whether Medicare claims were billed in compliance with coverage, coding, payment, & billing practices
- Targets program vulnerabilities identified by CERT
- Carries out other special projects as directed by CMS

01-009 General Inpatient Hospice Notification of Medical Review

Noridian Healthcare Solutions, LLC (Noridian), as the Supplemental Medical Review Contractor (SMRC) for the CMS, is conducting post-payment review of claims for general inpatient hospice billed on dates of service from January 1, 2017 through December 31, 2017. This notification includes the reasons for the review, documentation that will be requested in the Additional Documentation Request (ADR) letter and resources providers/suppliers may wish to consult when submitting claims.

Background

The Office of Inspector General (OIG), under report OEI-02-10-00491: Hospices Inappropriately Billed Medicare Over $250 Million for General Inpatient Care, dated March 2016, found that hospices commonly billed for General Inpatient Care (GIP) when the beneficiary did not have uncontrolled pain or unmanaged symptoms. According to the report, Hospices inappropriately billed Medicare over $250 million for the GIP level of care.

Reason for Review

In response to the OIG report, the CMS tasked Noridian, as the SMRC, to conduct medical review. The SMRC will perform review activities on GIP hospice claims to ensure the services were paid appropriately.

Source: Noridian
Know Industry Risks

**UPICs**
*(formerly ZPICs)*

- Contractors vary according to region
  - AdvanceMed, Qlarant, SafeGuard Services, etc.
- Combines functions of ZPICs & Medicaid Integrity Contractors
- Targets fraud, waste & abuse detection & prevention
  - Data analysis & referrals
- Conducts multiple types of program integrity functions
  - Post-pay medical review
    - Probe audits
    - Statistically valid audits with extrapolations
  - Pre-pay medical review
  - Payment suspensions

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**Delivery Method: Federal Express**

March 15, 2019

In order to fulfill its contractual obligation with the Centers for Medicare & Medicaid Services (CMS), Qlarant Integrity Solutions, LLC (“Qlarant”), the Unified Program Integrity Contractor (UPIC) for the state in which you practice, performs reviews to determine whether services billed for by providers and paid for by Medicare were reasonable and necessary and that all other requirements for coverage were met.

This letter is to inform you of the results of our review, which was based on the documentation provided in response to Qlarant’s recent request for information. We take this opportunity to thank you for your cooperation in submitting medical records.

You have received Medicare payments in error, which has resulted in an overpayment of $333,200.66 for the claims with process dates 06/01/2015 through 07/27/2018. Please refer to the enclosed encrypted CD for an explanation and details of the findings, which includes the Provider Education document and the Financial Spreadsheet.
Office of Inspector General
Illinois Department of Healthcare and Family Services

March 19, 2013

Determination after review of all supporting documentation submitted by in support of claims billed. The enclosed Final Audit Report identifies an overpayment in the amount of $182,308.80 and this overpayment is now subject to recovery under 89 Ill. Admin. Code, Chapter 1, Section 140.15.

The Centers for Medicare & Medicaid Services (CMS), Medicaid Integrity contractor, Health Integrity, LLC, conducted an audit of Medicaid claims paid to . Enclosed in the Final Audit Report, Health Integrity, LLC issued its Final Audit Report after reviewing claims submitted for Medicaid payment for services provided between January 1, 2011 and December 31, 2011. Dwellakult LLC had the opportunity to submit additional documentation for services billed to Medicaid during that time period. Enclosed in this letter is the Final Audit Report.

Determination of overpayment after review of all supporting documentation submitted by is supported by the information in the enclosed Final Audit Report. The enclosed Final Audit Report identifies an overpayment in the amount of $182,308.80 and this overpayment is now subject to recovery under 89 Ill. Admin. Code, Chapter 1, Section 140.15.

Within fourteen (14) days of receiving this letter, Provider must contact the OEI by calling at 1-866-228-8282 for assistance in logging into the Healthcare.gov and submit the Department of your choice to initial the Department's system to dispute the final audit findings. If you disagree with the final audit findings, you have the right to appeal, pursuant to the hearing process established at 89 Ill. Adm. Code Part 130. If you disagree with the final audit findings, you may request the overpayment by referring the account against a default payment in full, and/or by establishing an installment payment agreement. Enclosed with this letter is a copy of a Payment Agreement. You must notify the Department of the payment method of your choice within fourteen (14) days of receiving this letter.
Know YOUR Risks

- 4QFY18 data released April 5, 2019

Source: CMS PEPPER

PEPPER Target Areas

| Live discharges no longer terminally ill | RHC provided in a nursing facility (NF) |
| Live discharges, revocations | RHC provided in a skilled nursing facility (SNF) |
| Live discharges with length of stay (LOS) 61 – 179 days | Claims with single diagnosis coded |
| Long LOS (greater than 180 days) | No general inpatient care (GIP) or CHC |
| Continuous home care (CHC) provided in an assisted living facility (ALF) | Long GIP stays (greater than five consecutive days) |
| Routine home care (RHC) provided in an ALF |

Source: CMS PEPPER
Performance Risks

X Regulatory changes

X Technology changes

X Personnel changes

X Payer changes
Identify & Manage YOUR Risks

- Select sample of paid claims
- Compare paid claims to supporting documentation
- Document & quantify findings
- Track & trend findings
- Repeat, periodically
- Assess, act & educate on findings

Typical Risk Areas

**General inpatient care (GIP)**
- Documentation weak to support uncontrolled symptoms
- Documentation indicates patient actively dying

**Example 1**
Documentation indicated patient fell and hit head prompting transfer to GIP and need for observation. Documentation did not support uncontrolled symptoms or frequent monitoring. Physician note dated 10/02/17 stated "chest pain unrelieved by home medication" but documentation elsewhere did not support such. Physician note dated 10/03/17 stated "no further chest pain."

**Example 2**
Documentation indicated patient transferred to GIP from hospital due to fall, mental status change, pain with IV medications in port, and ascites with peritoneal drain. Documentation indicated sudden decline and "frequent monitoring" due to patient's fall rather than uncontrolled symptoms related to hospice diagnosis. Physician note stated "Patient no longer GIP appropriate." Physician notes made frequent reference to implementing "safe plan" for discharge from GIP level of care and indicated social issues preventing discharge, rather than symptom management.
Example 1
Physician narrative did not present a clear decline for this billing period.

Example 2
Patient was readmitted to hospice in 17th benefit period. FTF encounter for 21st benefit period was weak in presenting objective measures to support decline, as was narrative documented for same benefit period.

Example 3
The election statement indicated patient chose Dr. Jones as attending physician but Dr. Jones did not sign certification or plan of care.

Typical Risk Areas

Physician certifications
- Narrative weak in describing decline
- Certification requirements not met

Senior financial leader

Medicare billing specialist(s)

Medicaid billing specialist(s)

Insurance billing specialist(s)

Collection specialist(s)

Insurance authorization specialist(s)

Payment posting specialist(s)

Accounts payable specialist(s)

Accountability void
### Suggested Hospice Key Performance Benchmarks

<table>
<thead>
<tr>
<th>Metric</th>
<th>Poor</th>
<th>Average</th>
<th>Best</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare days in AR</td>
<td>45 days or more</td>
<td>40 days</td>
<td>35 days or less</td>
</tr>
<tr>
<td>Total days in AR*</td>
<td>More than 55</td>
<td>55 days</td>
<td>45 days or less</td>
</tr>
</tbody>
</table>

*52.5 median days per BKD analysis of 2017 Medicare cost reports for freestanding hospices*
• Assess ongoing issues
  • Regulatory
  • Technology
  • Efficiency
  • Effectiveness
• Avoid complacency
• Avoid unintended consequences
• Manage change
• Direct with intent
**Determine metrics most meaningful for managing performance**

**Set desired performance ranges**
Track actual performance results

<table>
<thead>
<tr>
<th>Performance Measures</th>
<th>Incentive Category</th>
<th>Expected Minimum Performance Measures</th>
<th>Optimal Performance Goals</th>
<th>Actual Performance Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average days in accounts receivable</td>
<td>Quality</td>
<td>60.0</td>
<td>45.0</td>
<td>57.2</td>
</tr>
<tr>
<td>Accounts receivable older than 120 days</td>
<td>Quality</td>
<td>8.0%</td>
<td>3.0%</td>
<td>5.2%</td>
</tr>
<tr>
<td>Collections</td>
<td>Quality</td>
<td>100.0%</td>
<td>110.0%</td>
<td>98.2%</td>
</tr>
<tr>
<td>Writeoffs</td>
<td>Quality</td>
<td>3.0%</td>
<td>0.0%</td>
<td>1.4%</td>
</tr>
<tr>
<td>Attendance</td>
<td>Personnel</td>
<td>95.0%</td>
<td>100.0%</td>
<td>92.0%</td>
</tr>
<tr>
<td>Personnel evaluation scores</td>
<td>Personnel</td>
<td>85.0%</td>
<td>95.0%</td>
<td>98.0%</td>
</tr>
<tr>
<td>Billing compliance scores</td>
<td>Compliance</td>
<td>90.0%</td>
<td>100.0%</td>
<td>99.0%</td>
</tr>
</tbody>
</table>

Weight performance metrics to best represent desired focal areas

<table>
<thead>
<tr>
<th>Performance Measures</th>
<th>Incentive Category</th>
<th>Expected Minimum Performance Measures</th>
<th>Optimal Performance Goals</th>
<th>Actual Performance Results</th>
<th>Maximum Success Measures</th>
<th>Actual Success Measure</th>
<th>Percent of Optimal Goals Achieved</th>
<th>Maximum Incentive Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average days in accounts receivable</td>
<td>Quality</td>
<td>60.0</td>
<td>45.0</td>
<td>57.2</td>
<td>15.0</td>
<td>2.8</td>
<td>18.7%</td>
<td>25.0%</td>
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<tr>
<td>Accounts receivable older than 120 days</td>
<td>Quality</td>
<td>8.0%</td>
<td>3.0%</td>
<td>5.2%</td>
<td>5.0%</td>
<td>2.8%</td>
<td>50.0%</td>
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<td>Quality</td>
<td>100.0%</td>
<td>110.0%</td>
<td>98.2%</td>
<td>10.0%</td>
<td>-1.8%</td>
<td>-18.0%</td>
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Account for over- & under-performance

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<th>Performance Measures</th>
<th>Incentive Category</th>
<th>Expected Minimum Performance Measures</th>
<th>Optimal Performance Goals</th>
<th>Actual Performance Results</th>
<th>Maximum Success Measures</th>
<th>Actual Success Measure</th>
<th>Percent of Optimal Goals Achieved</th>
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<td>57.2</td>
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<td>2.8</td>
<td>18.7%</td>
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<td>$234</td>
</tr>
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<td>5.0%</td>
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<td>-3.0%</td>
<td>-50.0%</td>
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Summary

- Monitor evolving TPE initiatives by MACs
- Assess YOUR opportunities for aligning compliance, efficiency & effectiveness
- Assess YOUR key performance indicators against suggested benchmarks
102. Hospice Revenue Cycle Management

M. Aaron Little, CPA
Managing Director
BKD, LLP