



# **Critical Access Hospital Financial Analyses - 2009**

**Prepared for  
Georgia State Office of Rural Health (SORH)  
An office of the Georgia Department of Community Health (DCH)**

**Prepared by  
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## **Executive Summary**

**“If you’ve seen one Critical Access Hospital, you’ve seen one Critical Access Hospital.”**

The Critical Access Hospital (CAH) Program was created by the 1997 Federal Balanced Budget Act as a safety net device to assure Medicare beneficiaries access to health care services in rural areas. It was designed to allow more flexible staffing options for community needs, simplify billing methods and create incentives to develop local integrated health delivery systems including acute, primary, emergency and long-term care.

The CAH Program gives small rural hospitals a chance to enhance their services and improve the quality of care. The financial benefits for being a CAH include:

- Medicare reimbursement of allowable costs for inpatient and outpatient services at 101 percent of costs, and
- Full Medicaid reimbursement of allowable costs for outpatient services

The Georgia Department of Community Health (DCH)/State Office of Rural Health (SORH) is interested in the fiscal sustainability of each CAH. For this reason, DCH/SORH contracted with Draffin & Tucker, LLP to perform certain analyses related to the financial condition of the hospitals. This report provides comparative financial analyses of 10 CAHs participating in this project.

### **Procedures**

There was an on-site visit made to each CAH, during which time interviews were held with key management personnel. Extensive financial data from the latest audited statements, statistics and Medicare cost reports were gathered and analyzed. Financial data from each hospital was then compiled to present comparative financial information.

CAHs are identified in this report by a unique alpha character to maintain facility confidentiality.

## **Summary of Findings**

Each CAH is unique. For this reason, it is difficult to establish financial benchmarks for CAHs. Comparative data can be misleading if the reader is not fully aware of the differences in hospital operations. Therefore, hospital management should use intelligent skepticism when approached with “one size fits all” recommendations or solutions to financial issues.

Diversification of services provides additional revenue sources. There was no one operating model that applied to the participating CAHs. All 10 CAHs operated swing bed (SWB) programs; however, the utilization of this program varied greatly. Some CAHs also operated skilled nursing facilities (SNFs) and/or rural health clinics (RHCs). With shrinking inpatient volume, it is necessary to maintain other revenue sources.

The ownership and management of the CAHs affects fiscal sustainability. The participants ranged from independent hospital authorities to CAHs managed or owned by larger tertiary care facilities or private individuals. The related party arrangements and support received by the affiliated and owned facilities resulted in notable differences among the CAHs.

In the past five years, six of the 10 participants have experienced significant turnover in key management positions. Three hospitals changed ownership during the past five years. Due to these changes, the fiscal condition of the hospitals indicated in this report may not be indicative of current operations.

The CAHs are struggling for financial viability. Each of the 10 CAHs included in this report had negative operating margins. Only one CAH had a positive return on equity. The median days cash on hand was less than five days. The median occupancy was 25 percent. Without increases in the volume of insured patients, the hospitals will require supplemental funding and county support to remain sustainable.

The Medicare and Medicaid reimbursement methodologies are not structured to provide a profit to the CAH. These programs are designed to reimburse only the allowable COSTS related to the beneficiary stay without a markup for profit. The median Medicare and Medicaid inpatient payer mix of the participants was 69 percent. The remaining 31percent of inpatients were largely uninsured.

Poverty and unemployment levels in the CAH counties are higher than the state average. Nine of the 10 participants are located in a county with higher than average poverty levels. Seven of the facilities were located in counties with higher than average unemployment levels. Due to the high level of poverty and unemployment, CAHs are faced with an increasing financial burden of caring for patients with no

payment sources. It is critical to the survival of the CAHs to obtain alternate financial resources to cover the cost of the growing uninsured population.

CAHs compete for patients with larger tertiary care facilities. Most of the participants are located in close proximity to larger tertiary care facilities which detracts from the CAH commercial patient volume. Several of the CAHs were part of larger hospital systems which referred patients to the CAH swing bed programs. CAHs must have sufficient commercially insured volume to offset the losses from uninsured or underinsured patients.

County support is vital to the sustainability of the CAH. Of the 10 participants, six received financial support from their county governments. This support can be the difference between continued operations and closure of the facilities.

State supplemental payments are crucial to survival of the CAH. Without participation in the Georgia Medicaid Indigent Care Trust Fund Program (ICTF) and the receipt of Upper Payment Limit (UPL) reimbursement, the CAHs future operations are in jeopardy.

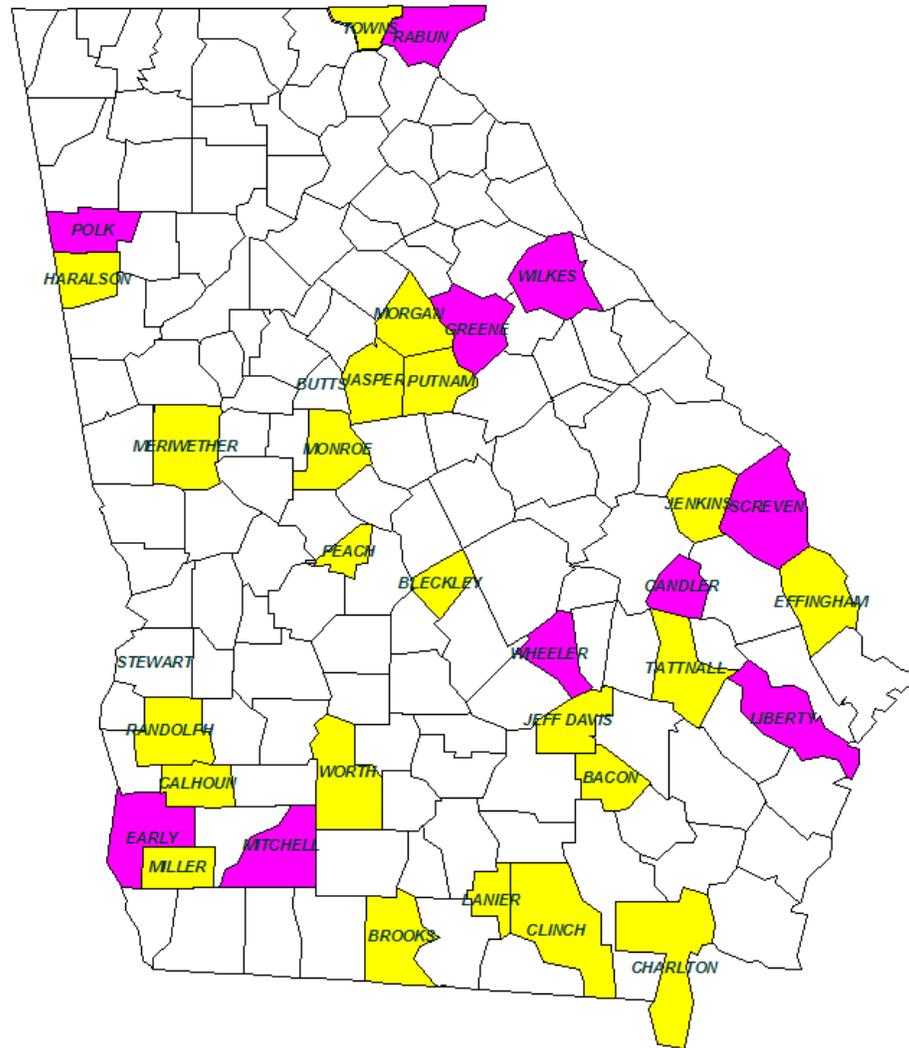
Revenue cycle improvements are needed. The CAH national average of days in accounts receivable average was 60. The CAH average for Georgia was 60.7. The median among the participants was 61.05. There were notable differences in the business office staffing of the facilities, ranging from low staffing to outsourcing. Charge description master coding errors, lost charges and compliance issues were noted.

Medicare and Medicaid cost reporting statistics should be reviewed. Although cost reports no longer have a direct impact on most hospital's payments, this is not true of CAHs. Cost report statistics are used in calculating reimbursement and should be as specific and accurate as possible. Inaccurate statistics lead to lost reimbursement.

Medicaid CMO contracts may include settlement provisions for interim under (over)payments based upon Medicaid cost report settlements. Hospitals should verify that the CMO settlement provisions are appropriately applied.

## The Participants

Of the 34 CAHs operating in the State of Georgia, 32 have participated in this project. The counties highlighted in pink represent the locations of the participants which are included in this report. The counties highlighted in yellow represent the locations of the participants which were included in previous fiscal analyses.



# Wills Memorial Hospital



Wills Memorial Hospital, located in Washington, Georgia, is a 25-bed full service hospital governed by the Hospital Authority of Wilkes County. The hospital is JCAHO accredited. The estimated population of Wilkes County is 10,262 while that of Washington is 4,062.

## Community Information

Washington compared to Georgia state average:

- Median household income below state average
- Black population percentage significantly above state average
- Hispanic population percentage significantly below state average
- Foreign-born population percentage significantly below state average

(Source: [www.city-data.com](http://www.city-data.com))



## Challenges

Hospital management states that the most significant challenges to the financial viability of the hospital are:

- Debt service
- Physician retention/recruitment
- Increased unemployment
- Aging physician population

# Candler County Hospital



Candler County Hospital, located in Metter, Georgia, is governed by a Hospital Authority Board who in turn appoints a Chief Executive Officer to oversee the daily operations of the hospital. The hospital originally opened in 1961 and expanded in 1971 to its current size of 25 beds. In 1973

the hospital opened the first renal dialysis unit to be located in a rural area of Georgia. The hospital attained CAH status in 2004 and is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). In July 2008, the population of the county was 10,550 and the city of Metter population was 4,345.

## Community Information

Metter compared to Georgia state average:

- Median household income significantly below state average
- Black population percentage above state average
- Hispanic population percentage below state average
- Foreign-born population percentage significantly below state average



(Source: [www.city-data.com](http://www.city-data.com))

## Challenges

Hospital management states that the most significant challenges to the financial viability of the hospital are:

- Increased uninsured coupled with Medicare and Medicaid budget cuts
- Lack of industry in the county

## Saint Joseph's at East Georgia



Saint Joseph's at East Georgia is a 25-bed acute care critical access hospital accredited by the Joint Commission on Accreditation of Health Care Organizations, serving the Lake Oconee area of East Georgia. The hospital is part of the Saint Joseph's Health Systems, Inc. (SJHS). SJHS is recognized as one of the 50 top hospitals in the country and is Atlanta's oldest hospital. The estimated population of Greene County is 15,662, while that of Greensboro is 3,282.

### Community Information

Greensboro compared to Georgia state average:

- Median household income below state average
- Black population percentage significantly above state average
- Hispanic population percentage below state average
- Foreign-born population percentage significantly below state average

(Source: [www.city-data.com](http://www.city-data.com))



### Challenges

Hospital management states that the most significant challenges to the financial viability of the hospital are:

- Governmental reimbursement
- Timeliness of payments



# Screven County Hospital



Screven County Hospital is a 25-bed facility located in Sylvania, Georgia. The hospital has served the community since the early 1950's, when the original facility was built on the same site the existing building occupies. Renovations over the years have added to and updated the hospital as needs changed.

The estimated population of Screven County is 15,037, while that of Sylvania is 2,511.

## Community Information

Sylvania compared to Georgia state average:

- Median household income below state average.
- Black race population percentage above state average.
- Hispanic race population percentage significantly below state average.
- Foreign-born population percentage significantly below state average.

(Source: [www.city-data.com](http://www.city-data.com))



## Challenges

Hospital management states that the most significant challenges to the financial viability of the hospital are:

- Magnitude of free care as percentage of total business volume
- Lack of access to capital

## Liberty Regional Medical Center



Liberty Regional Medical Center was opened to serve Liberty County on December 3, 1961 as a 28-bed acute care hospital. On November 22, 1998, the Hospital Authority of Liberty County celebrated the Grand Opening of Liberty Regional Medical Center's

new 70,000 square foot facility in Hinesville.

The estimated population of Liberty County is 60,503, while that of Hinesville is 30,152. Hinesville is located approximately 33 miles west of Savannah, Georgia and is approximately 2 miles north of Fort Stewart Army Base in Fort Stewart, Georgia.

### Community Information

Hinesville compared to Georgia state average:

- Median household income below state average
- Black population percentage above state average
- Foreign-born population percentage below state average

(Source: [www.city-data.com](http://www.city-data.com))



### Challenges

Hospital management states that the most significant challenges to the financial viability of the hospital are:

- Increase in indigent population
- Regulatory reform

## Polk Medical Center



Polk Medical Center (PMC) is a 25 bed CAH located in Cedartown, Georgia. The facility is leased by the Healthcare Corporation of America (HCA). PMC is affiliated with HCA-owned Redmond Regional Medical Center in Rome, Georgia.

The estimated population of Polk County is 41,460, while that of Cedartown is 10,123.

### Community Information

Cedartown compared to Georgia state average:

- Median household income below state average.

(Source: [www.city-data.com](http://www.city-data.com))

### Challenges

Hospital management states that the most significant challenges to the financial viability of the hospital are:

- Increased bad debt, charity and indigent patient mix



## Lower Oconee Community Hospital



Lower Oconee Community Hospital is a for-profit, physician-owned 25 bed CAH located in Wheeler County Georgia in the town of Glenwood. The hospital was purchased in July 2007 by its current owners. Lower Oconee Community Hospital is accredited by JCAHO.

The estimated population of Wheeler County is 6,830, while that of Glenwood is 895.

### Community Information

Glenwood compared to Georgia state average:

- Median household income significantly below state average
- Black population percentage above state average
- Hispanic population percentage significantly below state average
- Foreign-born population percentage significantly below state average

(Source: [www.city-data.com](http://www.city-data.com))



### Challenges

Hospital management states that the most significant challenges to the financial viability of the hospital are:

- Increasing patient volume
- Physician recruitment and retention
- Staff education

## Mountain Lakes Medical Center



Mountain Lakes Medical Center is a 25 bed CAH located in Rabun County, Georgia in the city of Clayton. The estimated population of Rabun County is 16,519, while that of Clayton is 2,185.

### Community Information

Clayton compared to Georgia state average:

- Median household income below state average.
- Black population percentage significantly below state average.

(Source: [www.city-data.com](http://www.city-data.com))



### Challenges

Hospital management states that the most significant challenges to the financial viability of the hospital are:

- Increase in uninsured
- Increase in area unemployment
- State Medicaid cuts
- Aging population
- Physician recruitment

# Mitchell County Hospital



Mitchell County Hospital (MCH) became affiliated with John D. Archbold Memorial Hospital in 1990. MCH is located in Camilla, Georgia. The estimated population of Mitchell County is 24,139, while that of Camilla is 5,660.

Mitchell Convalescent Center, a 48 bed facility, and Pelham Parkway Nursing Home, a 108 bed facility, are provider-based skilled nursing facilities associated with the hospital.

## Community Information

Camilla compared to Georgia state average:

- Median household income below state average
- Black population percentage significantly above state average
- Hispanic population percentage significantly below state average
- Foreign-born population percentage significantly below state average.



(Source: [www.city-data.com](http://www.city-data.com))

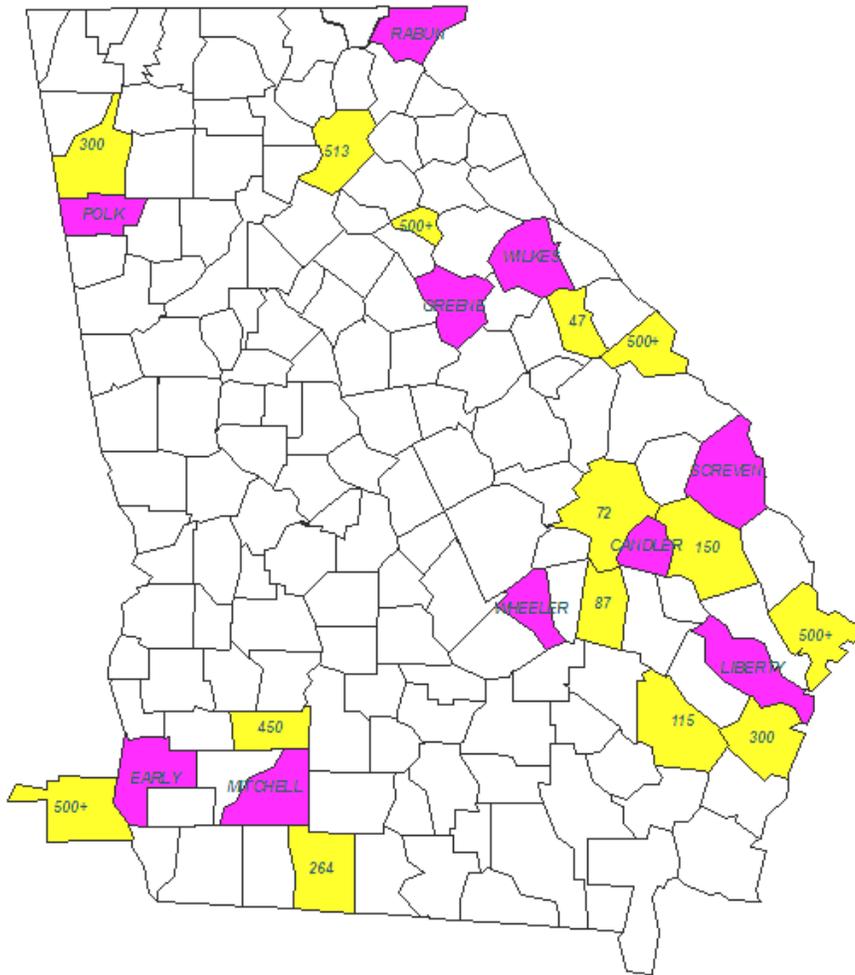
## Challenges

Hospital management states that the most significant challenges to the financial viability of the hospital are:

- Increase in uninsured patients
- Declining reimbursement rates

## Proximity to Larger Tertiary Hospitals

A common factor among the participants is the close proximity to larger hospitals, which results in a highly challenging market position. The counties highlighted in pink are locations of the participating CAHs, while counties highlighted in yellow represent the closest larger acute care facilities and their bed sizes.



CAH	Distance to larger facility
RABUN	54 miles
POLK	19 miles
WILKES	22 miles
GREENE	35 miles
SCREVEN	25 miles
CANDLER	16 miles
WHEELER	16 miles
LIBERTY	26 miles
EARLY	30 miles
MITCHELL	22 miles

The table above provides information as to the distance between each CAH and the closest larger hospital.

## Management Experience

There are notable differences among the tenure of the Chief Executive Officers (CEOs) and the staffing by Chief Financial Officers (CFOs) in the participating hospitals.

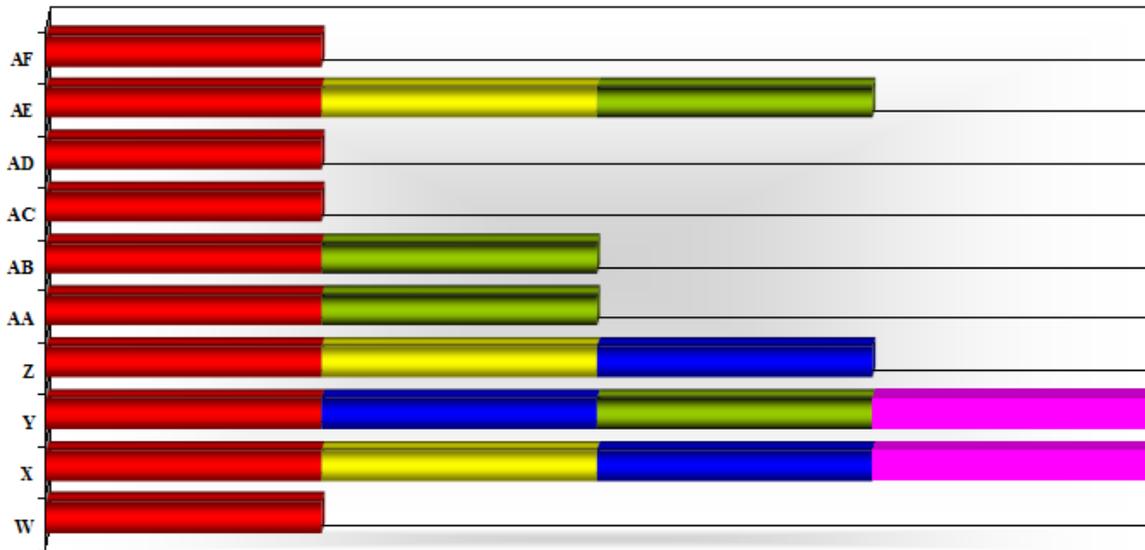
	Chief Executive Officer			Chief Financial Officer		
	AGE	YEARS TENURE	YEARS AGGREGATE HOSPITAL EXPERIENCE	AGE	YEARS TENURE	YEARS AGGREGATE HOSPITAL EXPERIENCE
<b>W</b>	61	11	35			Vacant
<b>X</b>	61	2	30			System level
<b>Y</b>	60	16	32	51	5	25
<b>Z</b>	41	4	12			System level
<b>AA</b>	50	1	30	60	1	1
<b>AB</b>	62	12	45	56	22	22
<b>AC</b>	66	7	40	60	10	22
<b>AD</b>	47	4	28			System level
<b>AE</b>	46	1	2	66	1	30
<b>AF</b>	59	2	25			System level

The tenure in the facilities by the CEOs ranged from 1 year to a high of 16 years; however all CEOs had many years of aggregate hospital experience. Sixty percent of the CEOs had less than 5 years experience as CEO in their current hospital. Sixty percent of the CEOs were over 50 years of age.

Fifty percent of the participants did not have full-time CFOs on-site. Four of the participants were sharing CFOs with another hospital or system. One hospital had a vacant CFO position. All on-site CFOs were over 50 years of age.

## Service Components

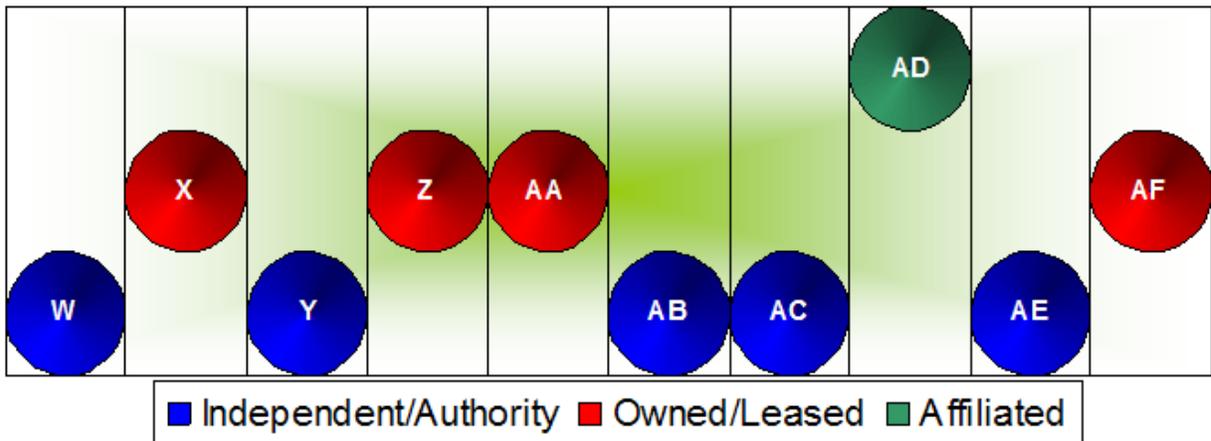
A significant factor affecting the comparability of CAH financial information is the degree of service integration among the participants. Medicare and Medicaid cost per day will be reduced with the ability to spread fixed costs over other service components. As indicated below, each facility offers various types of services with no one common model found.



Summary	
<b>Swing Beds</b>	10
<b>Rural Health Clinics</b>	3
<b>Skilled Nursing Facilities</b>	3
<b>Physician Practices</b>	4
<b>Ambulance Services</b>	2
<b>Other</b>	1

## Ownership and Management

The chart below summarizes the various management and control structures of the CAHs participating in this study. Consulting and management services provided by affiliated organizations can distort financial comparisons. Efforts were made to identify and account for such differences when presenting comparative data.



## Data Sources

Unless otherwise noted, data used in this report was taken from the hospitals' latest audited financial statements and/or the latest filed Medicare cost reports. One hospital's cost report and financial statements were for a ten-month period, however data was annualized to be comparable to other participants.

CAH	Fiscal Year End
W	12/31/08
X	9/30/09
Y	11/30/09
Z	9/30/09
AA	12/31/08
AB	6/30/09
AC	4/30/09
AD	9/30/09
AE	12/31/08
AF	12/31/08

National CAH averages included in various charts were obtained from the *2009 Almanac of Hospital Financial and Operating Indicators* published by Ingenix.

Georgia CAH averages included in several charts were obtained from the *CAH Financial Indicators Report: Summary of Indicator Medians by State*, published by the Flex Monitoring Team of the University of Minnesota, University of North Carolina at Chapel Hill and the University of Southern Maine in October 2009.

Median values included in charts were the mid-point values of the participating hospitals.

A quality assessment questionnaire, developed by Draffin & Tucker, LLP, was used to provide a baseline indication of revenue cycle performance. The questionnaire assessed the factors involved in each step of the revenue management process including pre-registration, registration, charge capture, medical records, charge description master, business office and collections. Each hospital's functional score in each area was compared to the maximum possible score associated with questions identified as "critical factors." The overall scoring based on responses to "critical factors" are included throughout this report.

A copy of the complete quality assessment questionnaire is included in the Appendix C of this report.

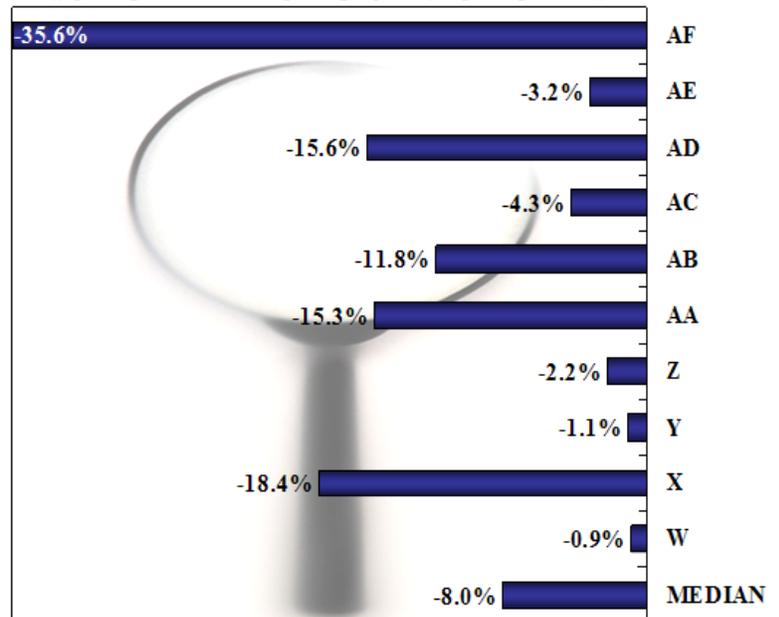
## Key Financial Ratios

The following key financial ratios present an overall picture of each hospital's profitability. Detailed underlying information regarding financial performance follows in this report.

All of the 10 CAHs are operating with a negative operating margin. Operating margin measures how profitable a hospital is when looking at the performance of its primary activities. Operating income comes from normal operations of a hospital, including patient care and other activities, such as research, gift shops, parking and cafeteria, minus the expenses associated with such activities. A negative operating margin is usually an early sign of financial difficulty.

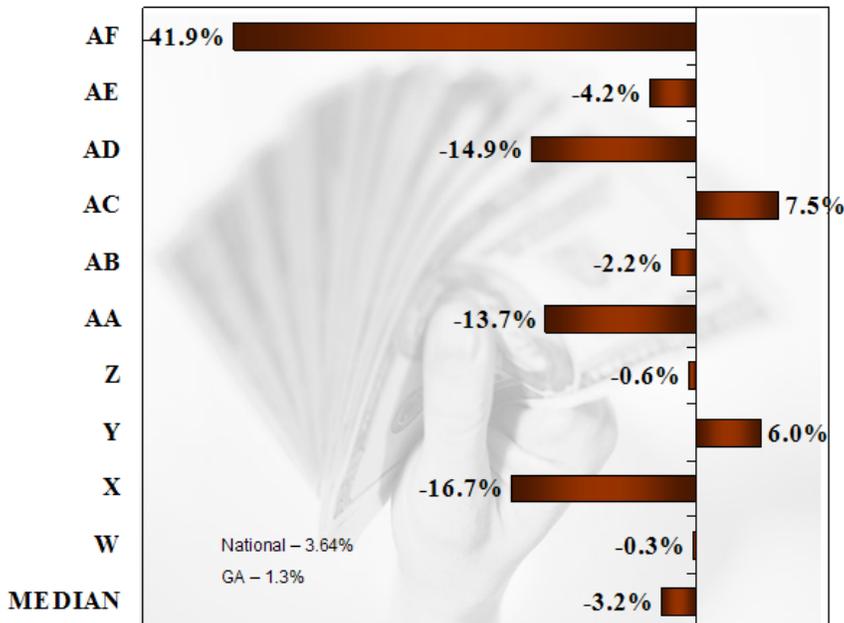
### Operating Margin

$((\text{Operating Revenue} - \text{Total Operating Expenses}) / \text{Operating Revenue}) \times 100$



### Total Margin

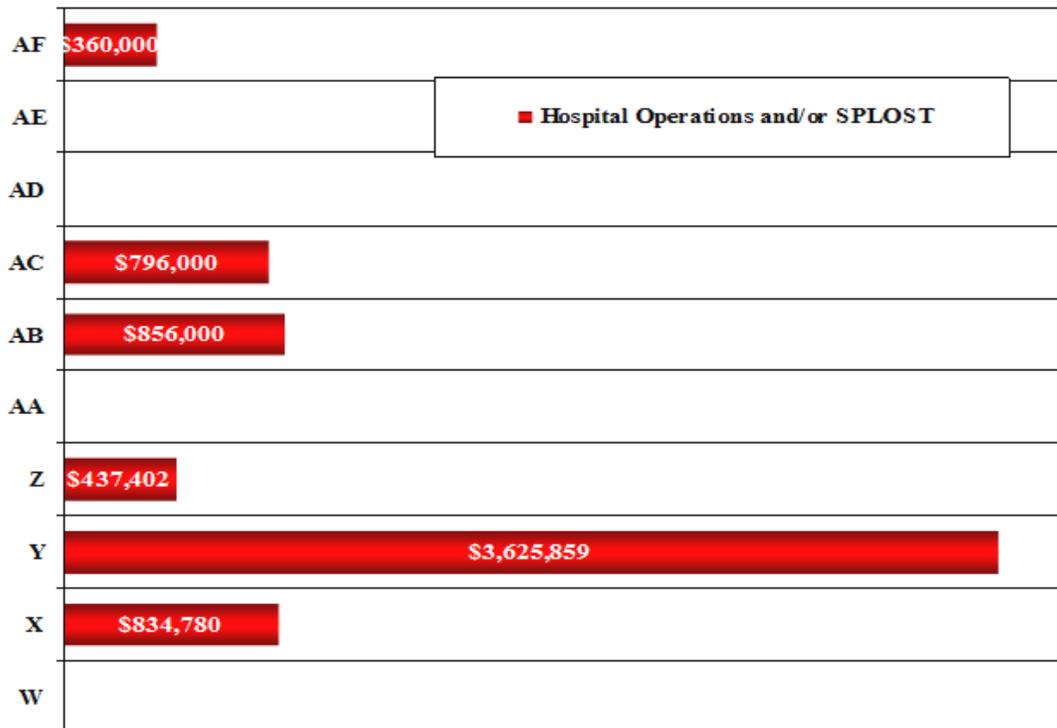
$(\text{Excess Revenues over Expenses} / \text{Total Revenue}) \times 100$



Eight of the 10 CAHs are operating with a negative total margin. This ratio defines the percentage of total revenue that has been realized in the form of net income, or excess revenues over expenses. It is used by many analysts as a primary measure of total hospital profitability. The total margins differ from operating margins primarily due to other revenue sources such as county support, the levels of which are indicated on the following chart.

One of the participating hospitals, Hospital Y, received county support of over three million dollars during their reporting year. County financial support contributes considerably to the profitability of any hospital. In comparing the financial ratios of the participating hospitals, it is important to recognize the level of county support received.

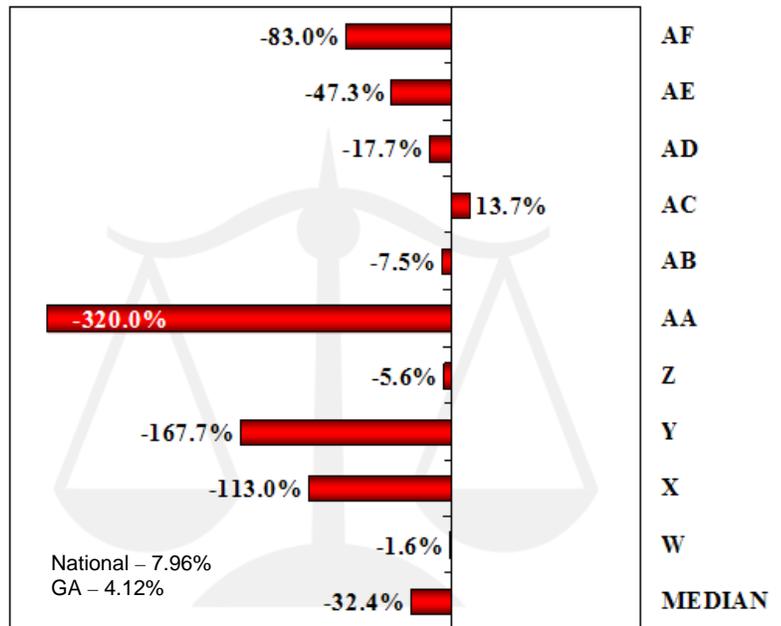
## County Contributions toward Hospital Operations



Nine of the participants experienced negative return on equity. These nine facilities also had net losses for the fiscal year. Five of the participants had negative net assets. The return on equity ratio defines the amount of net income or excess revenues over expenses and losses earned per dollar of equity investment. This ratio has been discussed by some hospitals, especially investor- owned, as an alternative way to establish rates. Many financial analysts consider the return on equity ratio the primary test of profitability. Failure to maintain a satisfactory value for this ratio may prevent the hospital from obtaining equity capital in the future.

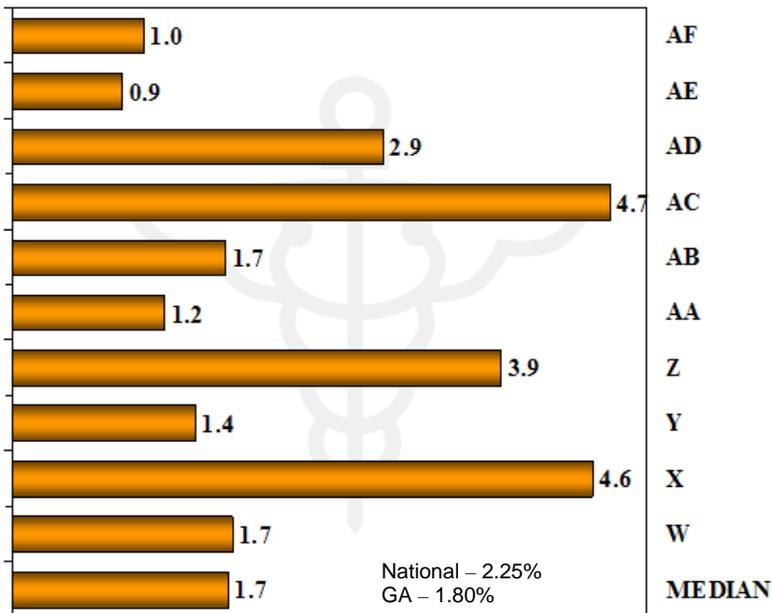
## Return on Equity

(Excess Revenues over Expenses / Net Assets) x 100



## Current Ratio

Current Assets / Current Liabilities

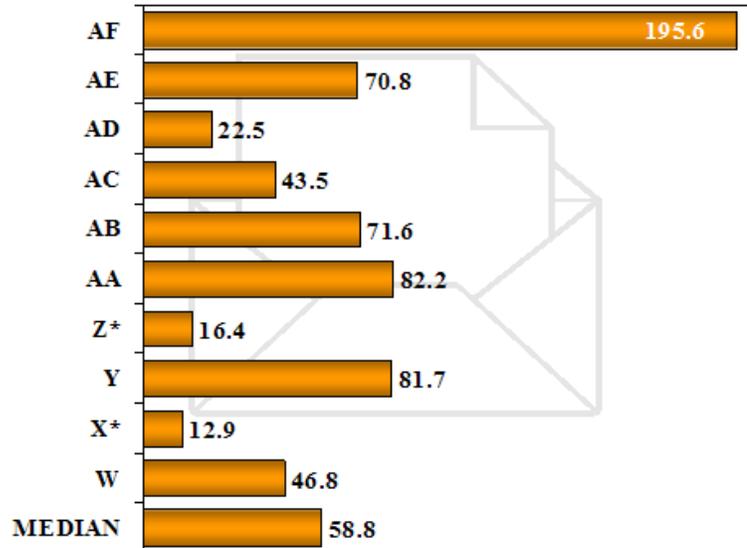


There were significant variances in current ratio among the participants, ranging from .9 to 4.7. Current ratio is the most widely used measure of liquidity. The value of the current ratio measures the number of dollars held in current assets per dollar of current liabilities. From an evaluation perspective, high values for the current ratio imply a good ability to pay short term obligations and thus a low probability of technical insolvency.

The Average Days Payment Period of the participants ranged from 12.9 days to 195 days. This ratio provides a measure of the average time that elapses before current liabilities are paid. The denominator in the ratio is an estimate of the hospital's average daily cash expenses minus depreciation. The resulting division into current liabilities provides a measure of the number of days of cash expenses not currently paid. Creditors regard high values for this ratio as an indicator of potential liquidity problems.

## Average Days Payment Period

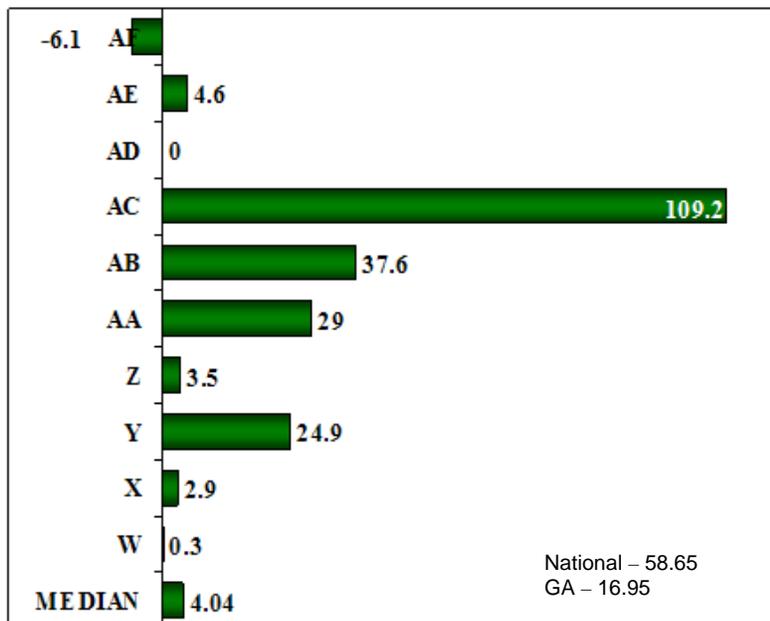
$\text{Current Liabilities} / ((\text{Total Expenses} - \text{Depreciation Expense}) / 365)$



\* Intercompany accounts are considered as long-term debt.

## Days Cash on Hand, Short-term

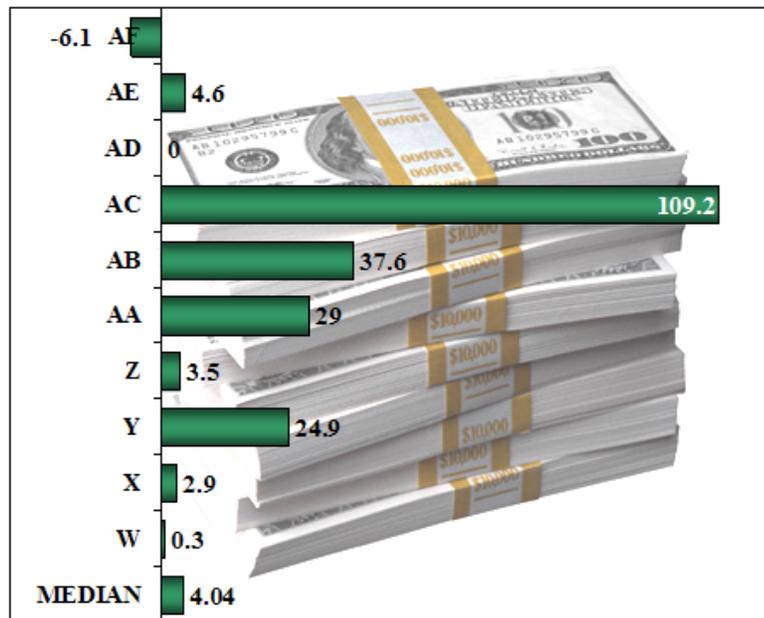
$(\text{Cash} + \text{Short term Investments}) / ((\text{Total Expenses} - \text{Depreciation Expense}) / 365)$



The short-term days cash on hand ranged from -6.1 days to 109.2 days. Hospital AF had a negative cash balance. This ratio measures the number of days of average cash expenses that the hospital maintains in cash and marketable securities. The denominator in this ratio measures the estimated average daily cash expenses during the year, less depreciation. High values for this ratio usually imply a greater ability to meet short term obligations and are viewed favorably by creditors.

## Days Cash On Hand – All Sources

$(\text{Cash} + \text{Short-term Investments} + \text{Unrestricted Long Term Investments}) / ((\text{Total Expenses} - \text{Depreciation Expense} \& \text{Amortization Expense}) / 365)$



The days cash on hand from all sources ranged from -6.1 days to 109.2 days. This ratio is identical to the days cash on hand, short-term sources ratio except that unrestricted long-term investments are included in the numerator. The value of this ratio provides a measure of total liquidity for the organization and indicates the number of days the organization could meet its average cash payments without collecting any revenue.

## **CAH Reimbursement Methodology**

Medicare acute care services are paid on an interim basis using a per diem for inpatient services. Interim payments for outpatient services are based on a percentage of allowable charges billed. An annual cost report is prepared to determine the actual costs of inpatient and outpatient services rendered. Allowable costs determined from these reports are compared to the interim payments and final settlements are computed. Certain outpatient services (i.e. professional fees, emergency medical services) are paid under a fee schedule.

Medicaid acute care services for inpatients are paid using a Diagnosis Related Group (DRG) methodology. Payment rates vary according to a patient classification system that is based on clinical, diagnostic and other factors. Outpatient services rendered to Medicaid program beneficiaries are reimbursed under a cost based methodology. Interim outpatient payments are based on a percentage of charges billed during the year with a final settlement determined after submission of annual cost reports and audits by the Medicaid Fiscal Intermediary.

In addition, Georgia CAHs have recently entered into payment agreements with certain commercial insurance carriers, health maintenance organizations and preferred provider organizations (Amerigroup, Peachstate, and Wellcare) for the provision of services to a target Medicaid population. The basis for payment under these agreements includes prospectively determined rates per discharge, discounts from established charges and prospectively determined daily rates.

Medicaid Care Managed Organizations (CMO) contracts may include settlement provisions for interim under (over)payments based upon Medicaid cost report settlements. Hospitals should verify that the CMO settlement provisions are appropriately applied.

Medicare skilled nursing facilities (SNF) services are paid a comprehensive per diem under a prospective payment system (PPS). This SNF PPS per diem represents Medicare's payment for all costs of furnishing covered Part A services (routine, ancillary, and capital-related costs), except for costs associated with operating approved educational activities and costs of those services that are excluded from SNF Consolidated Billing.

Medicaid long-term care services are reimbursed based on a prospective daily rate. The rate is determined by the facility's historical allowable operating costs which are subjected to cost ceiling limitations and are adjusted for case mix, as well as certain incentives and inflation factors.

Medicare SWB services are paid based on the cost of providing services. Interim payments are made based upon a per diem rate, with settlements occurring after the filing of the annual Medicare cost reports.

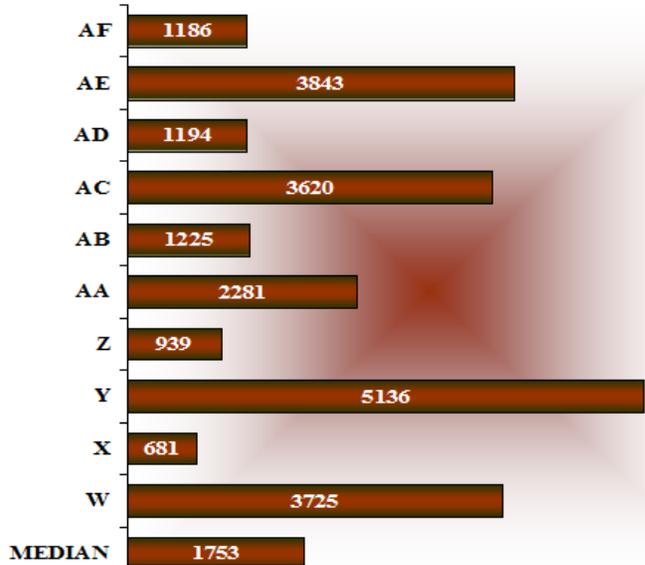
Medicaid SWB providers are reimbursed a prospective rate per patient day which will be the statewide average Medicaid rate per diem paid to SNFs for routine services furnished during the previous calendar year. Medicaid will reimburse the Medicare Part A coinsurance for skilled level of care SWB services provided to Medicaid/Medicare recipients. Medicaid reimbursement will be reduced by the amount of the recipient's liability (patient income). The recipient's liability is applied to the Medicaid reimbursement rate until the full liability amount has been exhausted. The hospital is responsible for collecting the appropriate patient income amount.

Medicare Rural Health Clinics (RHC) receive cost-based reimbursement for a defined set of core physician and certain non-physician outpatient services. Payment for RHC services furnished to Medicare beneficiaries is made on the basis of an all-inclusive payment methodology. RHCs that are provider-based with hospitals having less than 50 beds are not subject to a per visit payment ceiling; however, productivity limits still apply.

Medicaid RHCs in Georgia are given several options regarding payment methodology for traditional Medicaid patients. RHCs may elect to be paid under a cost based methodology or under a PPS methodology. In addition, Medicaid patients enrolled in CMOs are paid on a per visit basis, with the opportunity for additional "wrap-around" payment. These payments provide the RHC with the same reimbursement for the CMO population as the traditional Medicaid patients. CAH management should ensure that careful analyses and monitoring are implemented to verify that accurate and optimal payments are received.

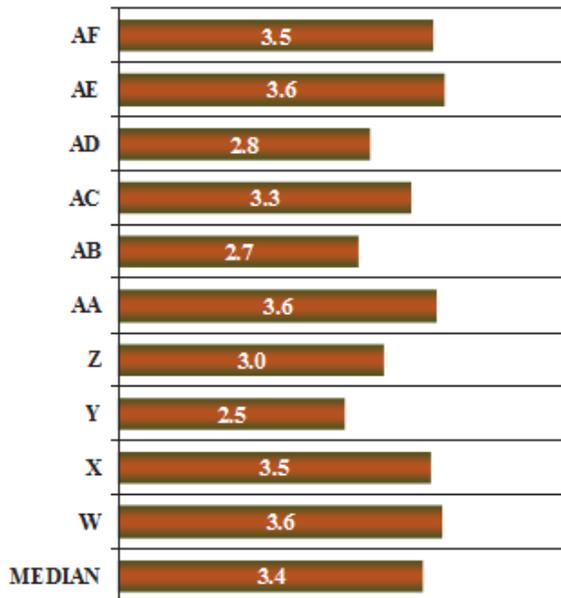
## Patient Volumes by Type of Service

### Patient Days - Acute

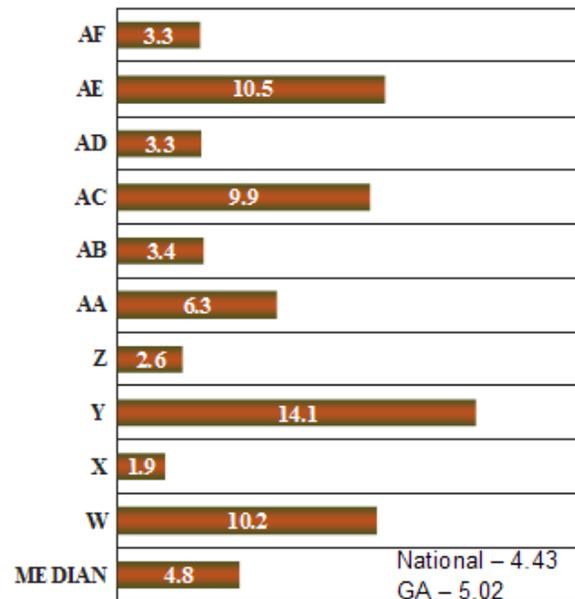


Acute inpatient volume varied significantly among the study participants ranging from a low of 681 days to a high of 5,136 days. Patient volume is significantly affected by hospital location, ability of the CAH to attract physicians to the community, as well as, referral patterns from affiliated hospitals.

### Average Length of Stay

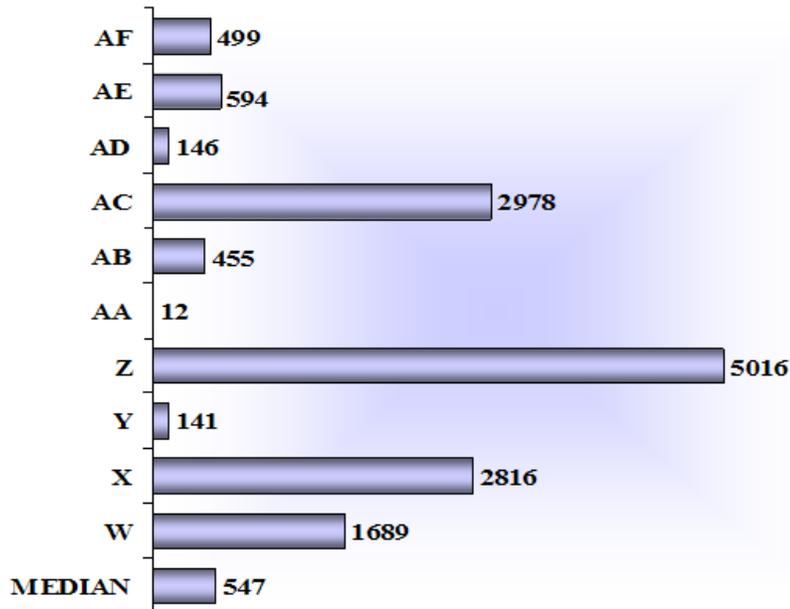


### Average Daily Census



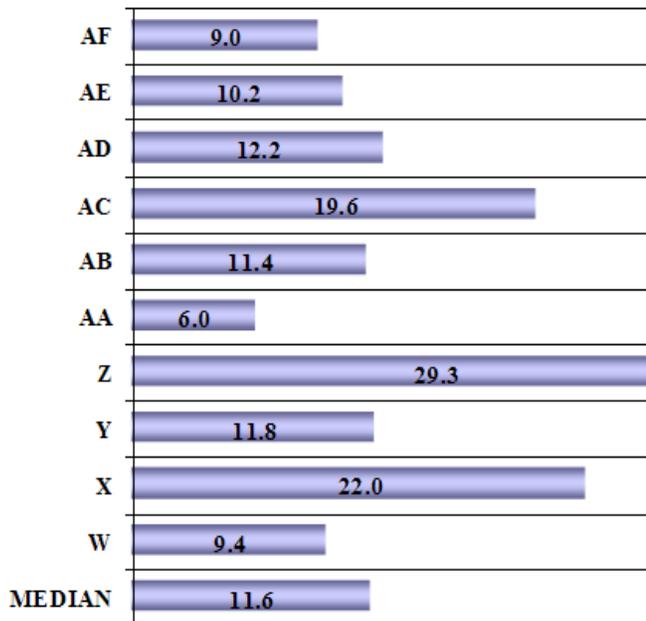
There were no significant differences among hospitals in the average length of stay. The average daily census parallels the number of patient days.

## Patient Days – Swing Bed

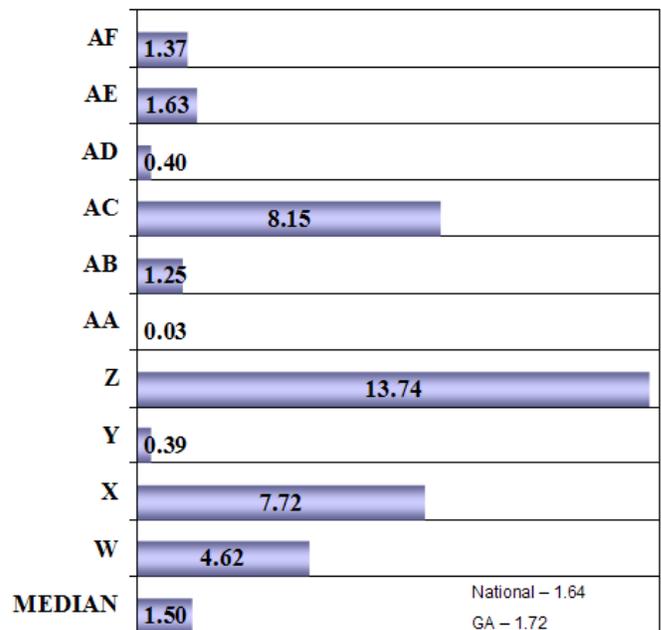


SWB volumes ranged from a low of 12 days to a high 5016 days. SWB reimbursement typically results in increased Medicare use and therefore more cost coverage. Hospital Z is part of a hospital system and provides rehabilitation and follow-up services to the system's patients.

## SWB Average Length of Stay



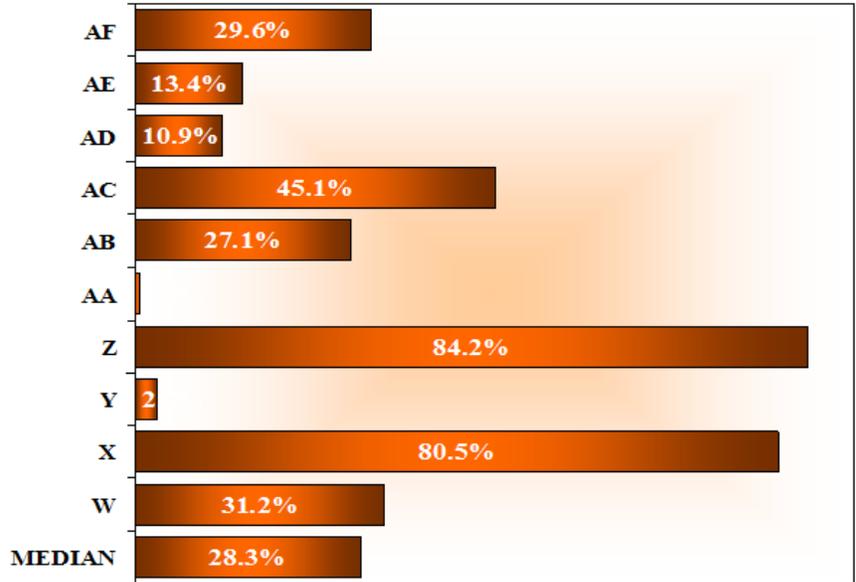
## SWB Average Daily Census



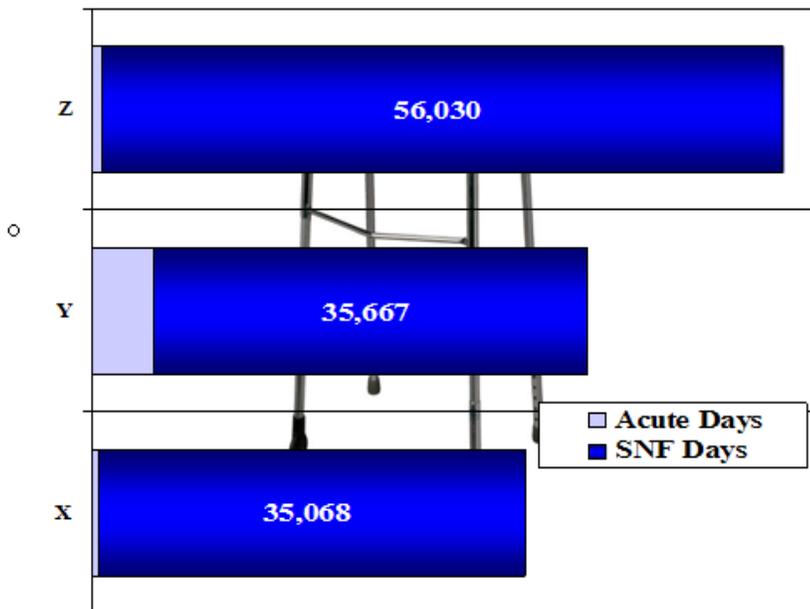
There were significant differences in both average daily census and average length of stay among the participants. Some CAHs are providing post-orthopedic and stroke after-care to the patients, while others are using the swing beds as an interim level of care between the acute and SNF setting.

SWB days comprised the majority of total patient days during the reporting years for two participants. It is fiscally advantageous for PPS hospitals to transfer patients to swing beds once clinically appropriate. Transfers to swing beds will limit patient costs incurred under the PPS DRG payment system. Critical Access Hospitals should encourage the transfer of community patients from nearby PPS hospitals when appropriate.

### Swing Bed Days as Percentage of Total Days (Includes NF Days)



### Patient Days – Acute & SNF



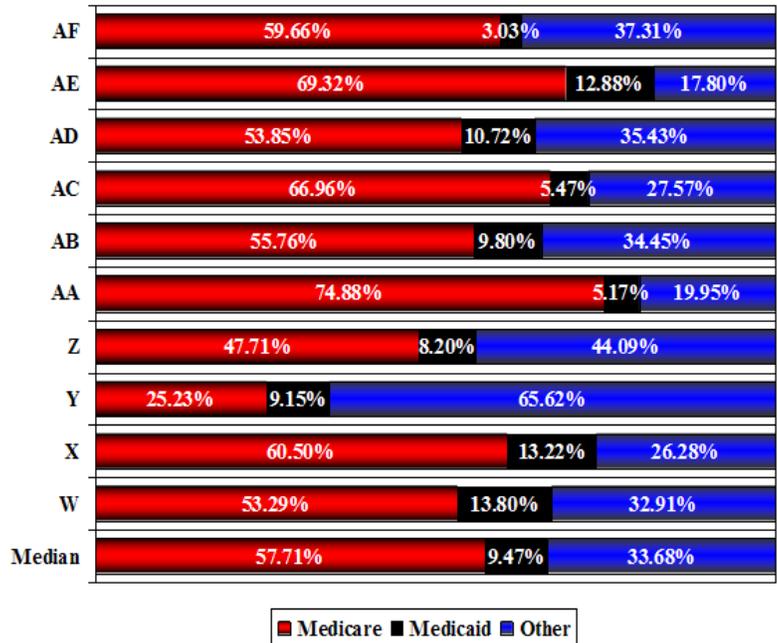
Three of the participants also operate SNFs. The SNF patient days in these facilities overshadow those from the CAH acute stays. This situation will significantly impact expense comparisons due to the sharing of staff among the components. The presence of a SNF can prove beneficial to the overall profitability of the CAH if costs can be maintained below the state Medicaid cost limits.

## Patient Volumes by Payer

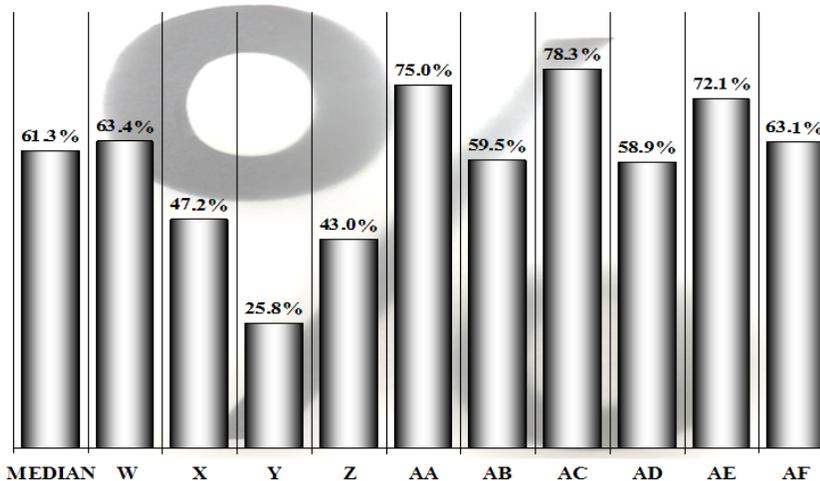
The higher the Medicare utilization, the more difficult it is for a CAH to generate a profit. Medicare will reimburse 101 percent of its share of allowable cost; therefore profits must come from other payer sources.

More than half of acute patient days for nine CAHs are attributed to Medicare patients. This payer percentage is significantly higher than that experienced in PPS hospitals. CAHs are, therefore, particularly vulnerable to Medicare regulatory changes. Medicaid, commercial, self-pay and other payer types comprise the remaining percentage, with the largest component being self-pay.

## Patient Days Percentage by Payer (Acute Only)



## Medicare Days as Percentage of Total Days (Total includes Acute & SWB)



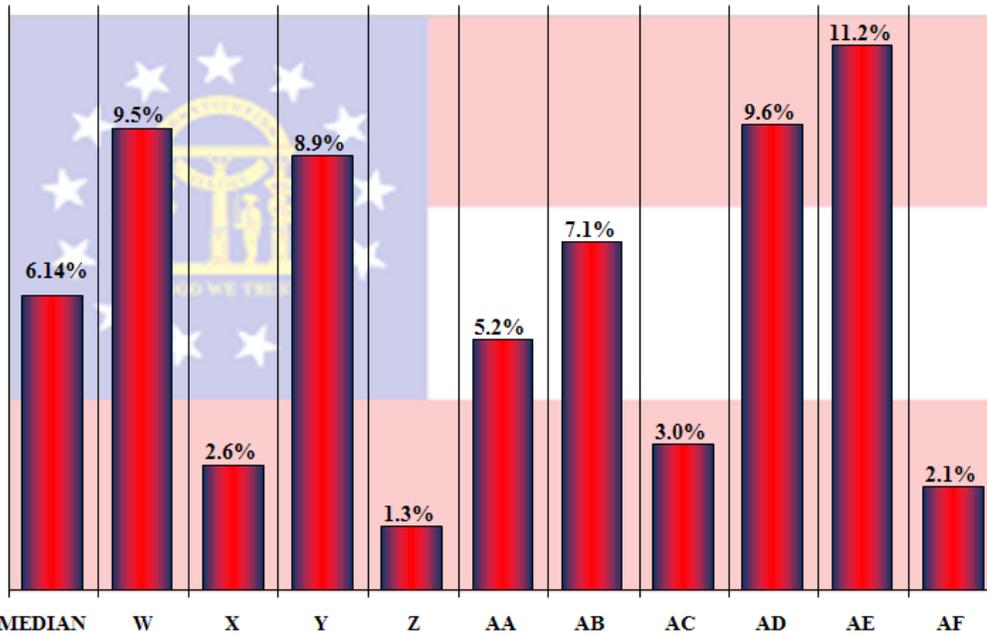
Hospital Y had the lowest combined percentage of Medicare days for acute and swing bed at 25.8 percent, while Hospital AC had the highest combined percentage of 78.3 percent. Hospitals X and Z had a higher Medicare utilization in the acute care beds than in the swing beds, resulting in a lower combined percentage.

Georgia Medicaid reimbursement has changed radically since 2006 when Georgia implemented the Medicaid managed care program. This chart reflects only days related to the traditional Medicaid cost based reimbursement system. Inpatient Medicaid payments are based upon fixed fees per diagnosis. Medicaid managed care days are included in the commercial insurance categories and are paid under negotiated rates.

## Medicaid\* Days as Percentage of Total Days

(Total includes Acute and Swing Bed)

Does not include Medicaid Managed Care days



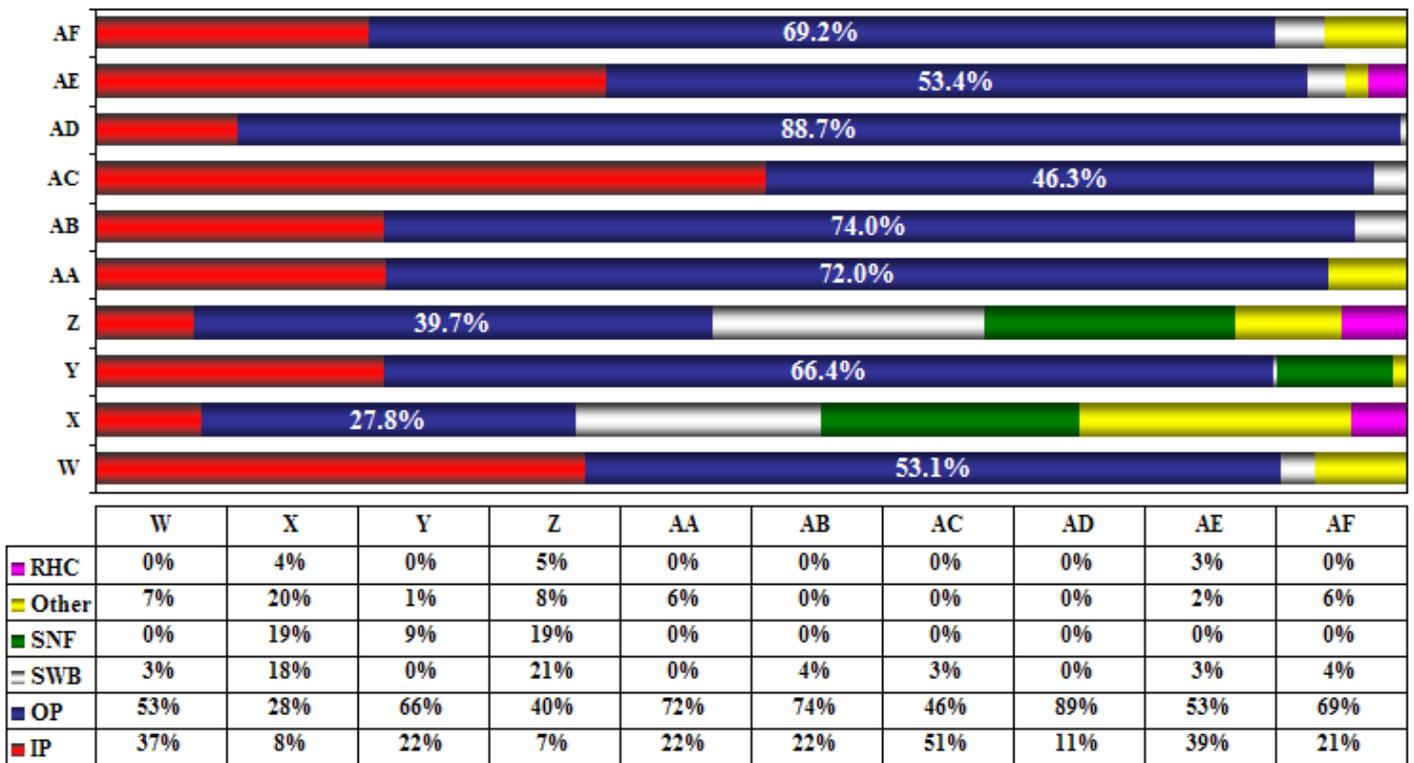
\*acute Medicaid days only

## Revenues by Type of Service

Outpatient services now comprise the majority of many hospitals' revenue base. It is apparent from this chart that outpatient revenues have become a dominant factor in CAH revenue generation. The more successful CAHs have diversified operations through other revenue components such as swing beds, RHCs and SNFs.

The data table provides further detail regarding the composition of revenues generated from various components of the participating hospitals.

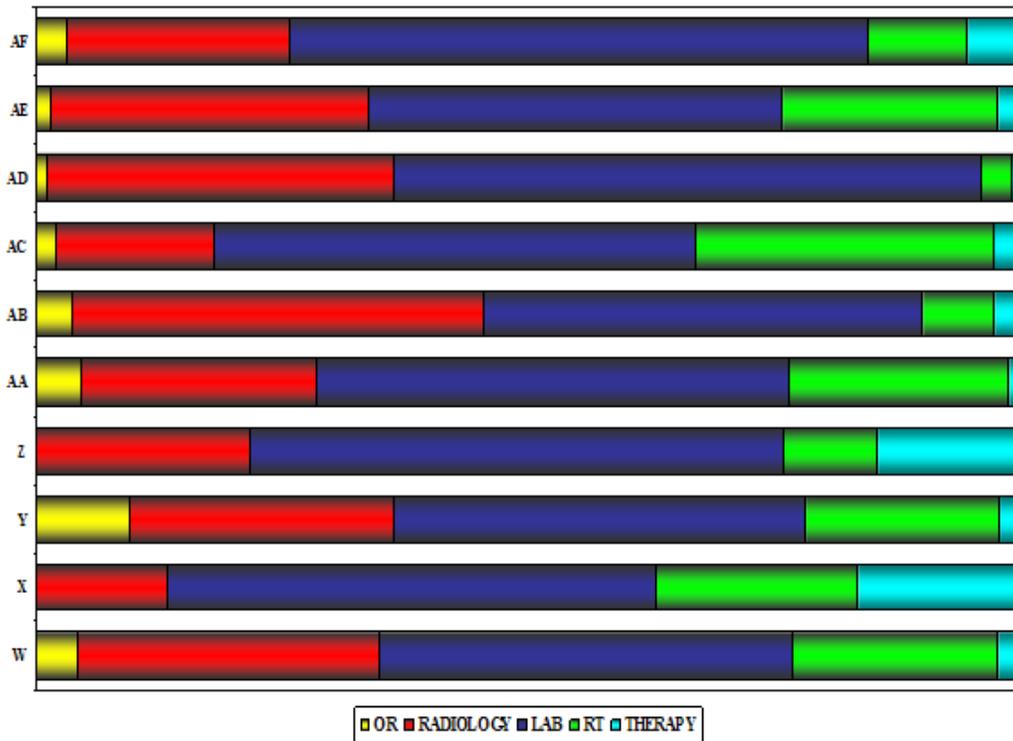
### Revenue Percentage by Service Type



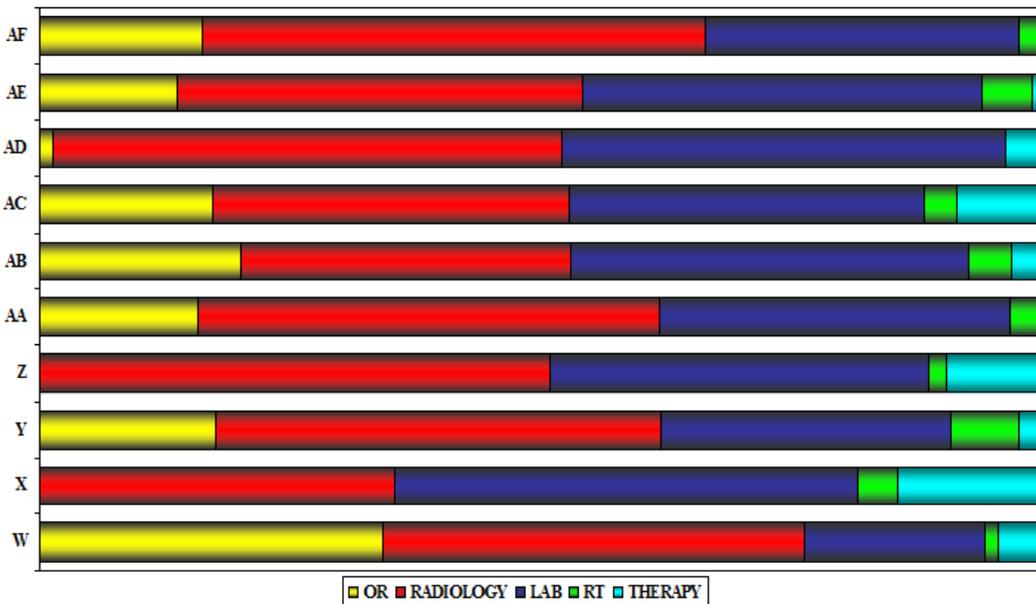
Outpatient revenues ranged from a low of 28 percent to a high of 74 percent. Swing bed services ranged from a low of less than one percent to a high of 21%.

The variety and volume of ancillary services provided will also affect comparability among the CAH participants. Most of the participants provided minor surgery services, primarily endoscopy. The composition of ancillary services will affect the average salaries per employee and other costs dependent upon the level of skilled personnel needed.

### Medicare Inpatient Ancillary Services

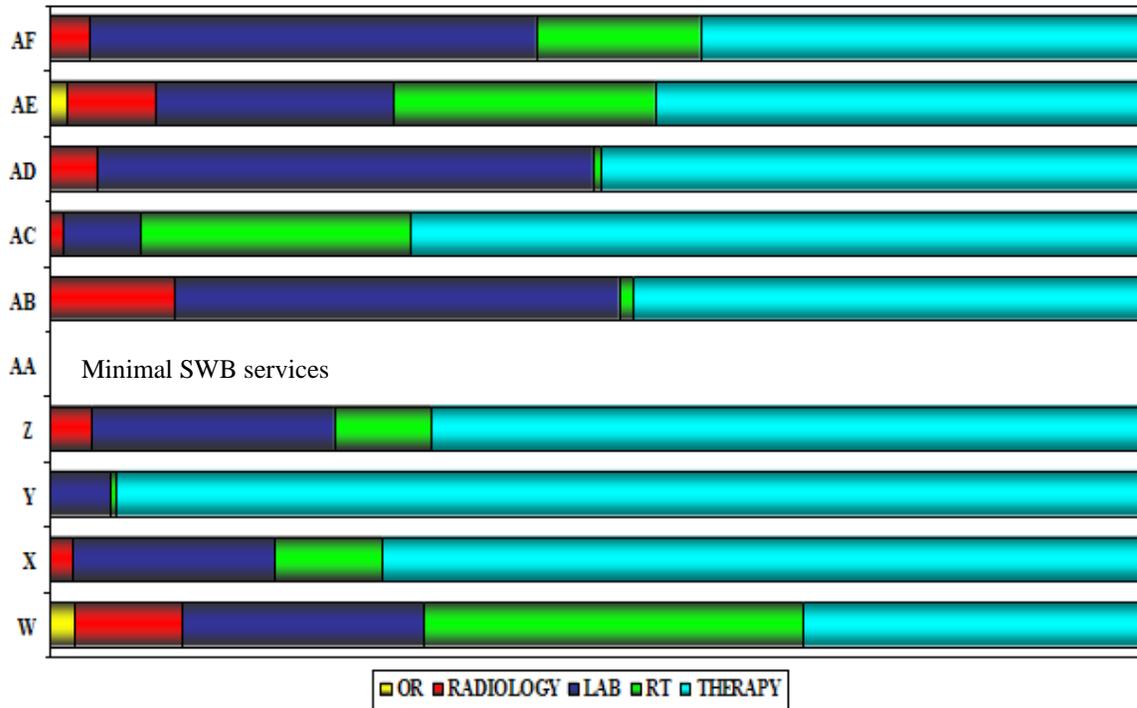


### Medicare Outpatient Ancillary Services



Therapy services were used extensively in most of the participants' SWB programs. This would be an indication that many of the patients were post-orthopedic or stroke care patients. Therapy services are especially lucrative in treating patients transferred from PPS facilities for rehabilitation services. As previously stated, a successful SWB program can contribute significantly to the survival of a CAH.

## Medicare SWB Ancillary Services



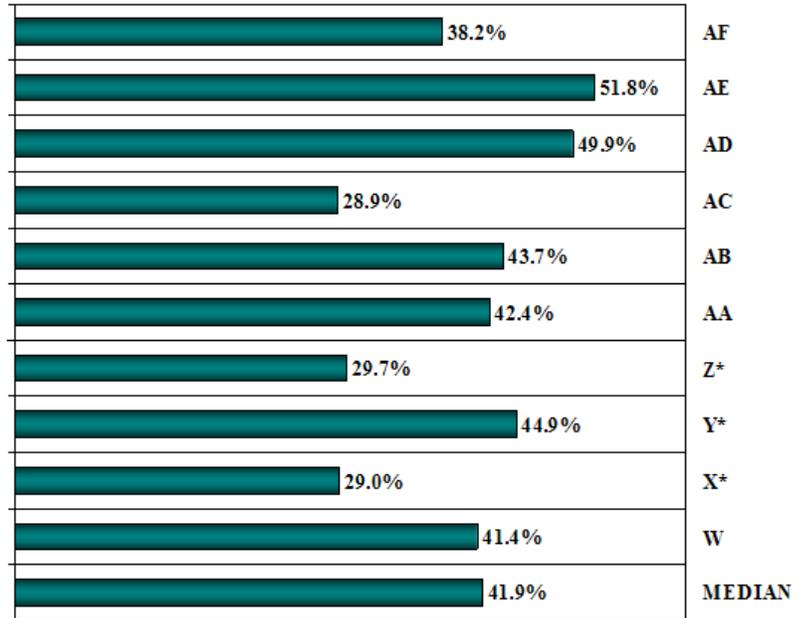
## Deductions from Revenues

The contractual allowance percentages ranged from a low of 28.9 percent to a high of 51.8 percent. Contractual allowance percentage defines the percentage of gross patient revenue, both inpatient and outpatient, that will not be collected due to the third-party allowances and discounts. Comparability of data will be affected by:

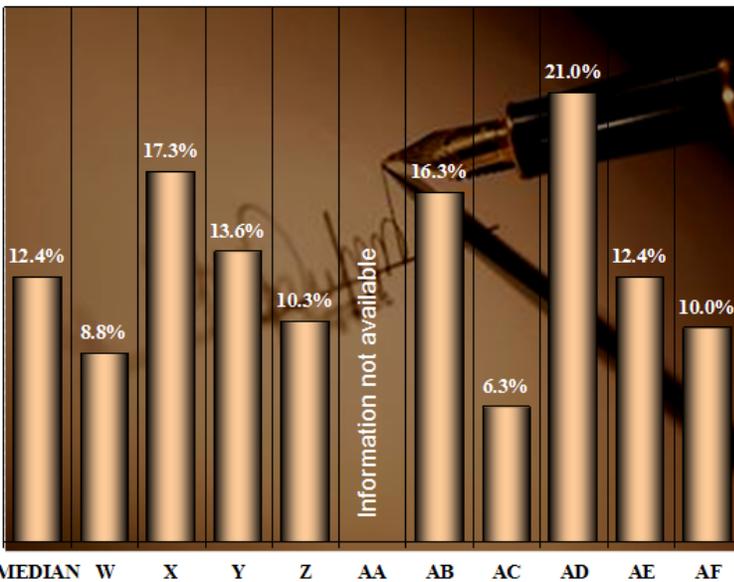
- SNF contractual allowances
- ICTF/UPL monies
- Cost report settlements
- Hospital pricing

Hospitals noted with asterisks have SNF components.

### Contractual Allowance Percentage



## Bad Debt and Charity Write-Off Percentage

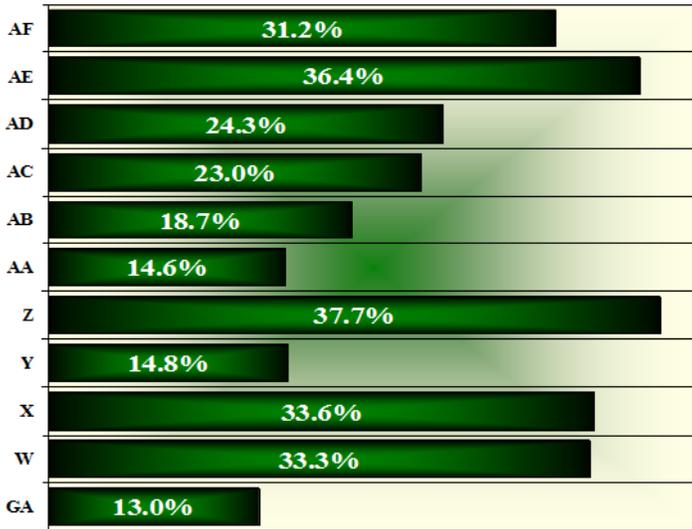


Bad debt and charity write-off percentages ranged from a low of 6 percent to a high of 21 percent. These ratios will be directly affected by the poverty and unemployment levels in the market area. Several hospitals stated that there was not an accurate segregation between bad debts and charity; therefore, these percentages were combined. It was noted

that hospitals were not consistent in the timing of bad debt and charity write-offs. It is advisable to utilize a consistent and uniform monthly approach when recording bad debts and charity write-offs.

## Poverty Levels

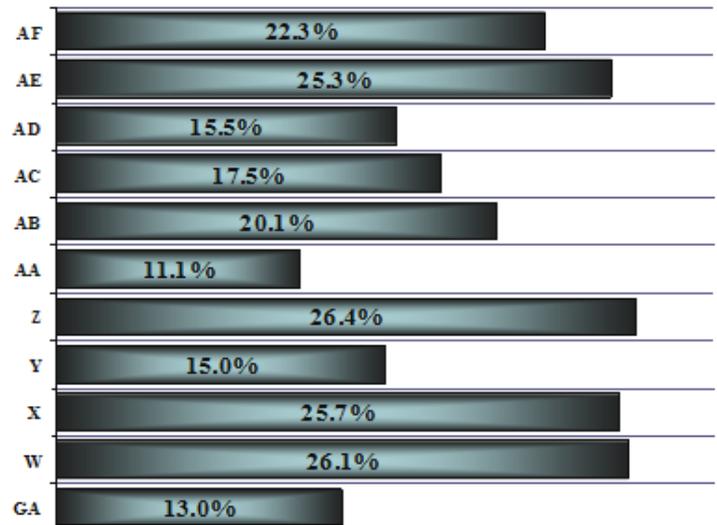
City residents with income below poverty levels in 2008



Source: www.city-data.com

## Poverty Levels

County residents with income below poverty levels in 2008

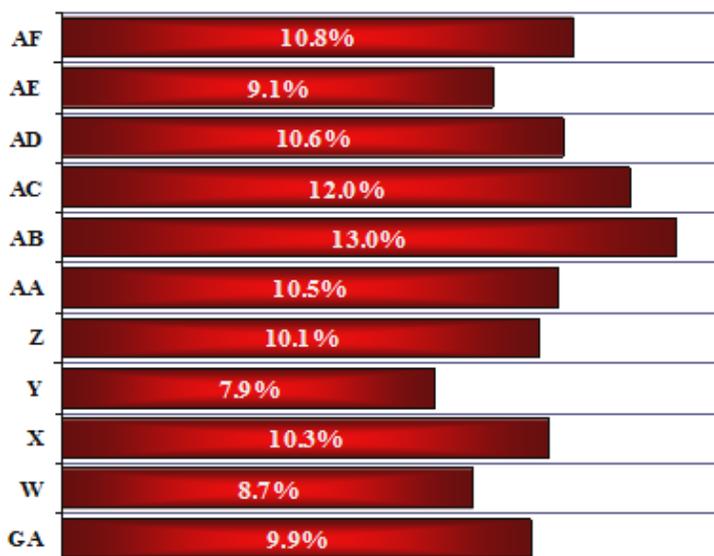


Source: www.city-data.com

Each of the 10 participants' cities has poverty levels above the state average. Nine of the participants' counties are above the state average. Many participants cited growing indigent and charity populations as one of the most significant challenges faced by their hospitals. As government reimbursement shrinks and the poverty levels rise, many hospitals will be in jeopardy of continued operations. With health care reform reductions are expected in Medicaid supplemental funds, such as ICTF and UPL payments. Such payments are critical to the survival of these hospitals.

## Unemployment Levels

County labor force estimates – November 2009



Source: www.city-data.com

Seven of the participants are located in counties with unemployment levels higher than the state average. Hospital AB has the highest unemployment. High unemployment translates into uninsured patients and high bad debt write-offs. The combination of high poverty and unemployment levels contribute significantly to the financial burden of the local healthcare facilities.

## Pricing Comparison

A hospital's pricing structure has a direct impact on the comparability of key financial ratios. For instance, the contractual allowance percentage can be affected due to higher or lower pricing. Generally, the higher the price, the higher the contractual write-off will be. For this reason, care should be taken in comparing ratios that use gross revenue as a component.

Below is a comparison of prices for a few common services provided by hospitals participating in this project. In order to protect the anonymity of the participants, this report does not detail individual prices by hospital.

	HCPCS	MEDIAN	HIGH	LOW
Private Room	PRIVATE	\$ 530	\$ 787	\$ 360
Semi-private Room	SEMI PVT	\$ 463	\$ 749	\$ 350
E&M	99281	\$ 118	\$ 245	\$ 60
E&M	99282	\$ 162	\$ 372	\$ 80
E&M	99283	\$ 231	\$ 577	\$ 135
E&M	99284	\$ 465	\$ 831	\$ 195
E&M	99285	\$ 675	\$ 1,582	\$ 275
IM	96372	\$ 71	\$ 134	\$ 41
INF HYDRA 1ST	96360	\$ 191	\$ 553	\$ 90
VENIPUNC	36415	\$ 14	\$ 46	\$ 7
BMP	80048	\$ 110	\$ 380	\$ 56
CMP	80053	\$ 174	\$ 369	\$ 85
UA W/MICRO	81001	\$ 40	\$ 131	\$ 18
CBC W/DIFF	85025	\$ 50	\$ 299	\$ 33
TROPONIN	84484	\$ 129	\$ 334	\$ 40
CPK	82550	\$ 52	\$ 132	\$ 31
EKG	93005	\$ 115	\$ 319	\$ 90
PA/LAT CHEST	71020	\$ 160	\$ 339	\$ 124
AP CHEST	71010	\$ 144	\$ 424	\$ 78
CT BRAIN W/WO	70470	\$ 1,535	\$ 3,244	\$ 975
CT BRAIN W/O	70450	\$ 1,172	\$ 3,264	\$ 956
EGD W/BX	43239	\$ 1,400	\$ 1,650	\$ 723
C-SCOPE W/BX	45380	\$ 1,020	\$ 1,757	\$ 630
OBS/HR 1st hour		\$ 39	\$ 530	\$ 11

Some of the hospitals had differing price schedules for private and semi-private rooms. In cost reporting, *private room differentials* will decrease the inpatient routine service costs. This reduction in costs also has the potential for reducing participation in the Georgia Medicaid ICTF. Consideration should be given to implementing a reduction in or elimination of the difference between private and semi-private room rates.

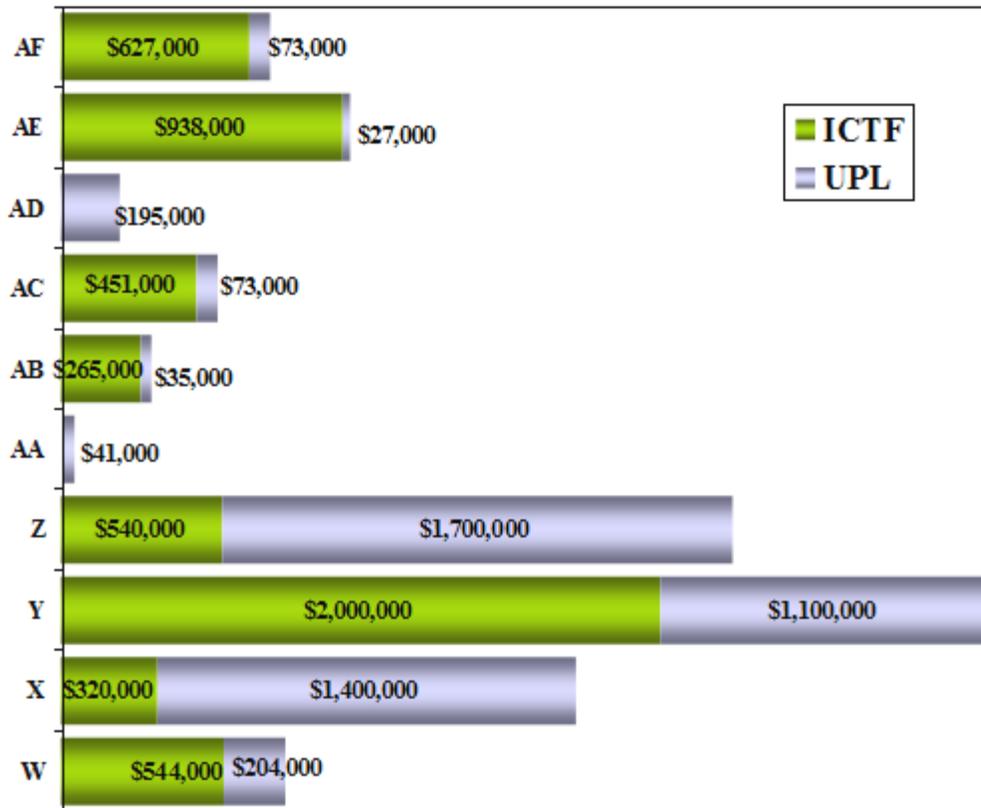
## Medicaid Supplemental Payments

The Georgia Medicaid Disproportionate Share Hospital (DSH) Program is a federal program that works to increase health care access for the poor. Hospitals that treat a "disproportionate" number of Medicaid and other indigent patients qualify for ICTF payments through the state's Medicaid program based on the hospitals' estimated uncompensated cost of services to the uninsured.

The Medicare, Medicaid and State Children's Health Insurance Program Benefits Improvement and Protection Act of 2000 (BIPA) provide for enhanced payments to Medicaid providers under the UPL methodology. Subsequent to the implementation of the UPL methodology, federal budget concerns have led to reconsideration of the BIPA legislation with possible elimination of enhanced Medicaid payments. Legislation has been enacted to reduce the level of UPL payments in future periods.

Continuation of both the ICTF and UPL enhanced reimbursement methodologies in the future is uncertain. Without ICTF and UPL revenue, the CAHs financial results will be dramatically different and future financial viability will be questionable.

## ICTF / UPL Participation (includes SNFs)

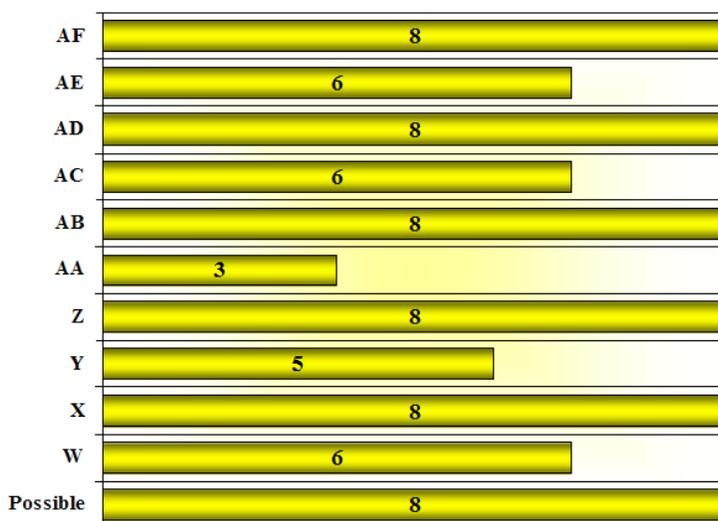


## Charge Capture

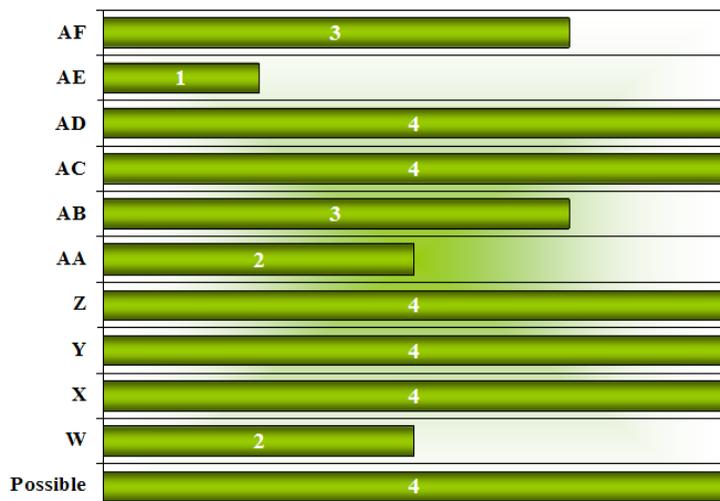
As part of this study a quality assessment questionnaire was used to evaluate critical factors in the revenue cycle. Participants were asked to respond to various questions related to the revenue cycle of their facility. (Appendix C includes the complete questionnaire.) Each revenue cycle area was scored based upon responses to certain questions in each area. The “scored” questions are referenced on the questionnaire with a “CF”. The following charts compare the participating hospitals’ scores for charge capture and charge description master maintenance. Each chart indicates the highest possible score for the area, as well as, the actual score for the participant.

Charge capture is a critical area of the revenue cycle. Lost charges result in no opportunity for reimbursement. Although in the review of medical records it was noted that nine of the 10 hospitals were experiencing some type of lost charges, we found that Hospital AA had the highest incident rate of lost charges. The ancillary departments in this hospital have little or no responsibility related to charge capture. The lack of a daily charge reconciliation process has resulted in lost charges. Therefore, implementation of a reconciliation process is recommended.

### Charge Capture



### CDM



According to the quality assessment findings, one of the 10 hospitals (Hospital AE) in this study has not updated or reviewed their charge description master (CDM) in its entirety within the past year. An up-to-date and accurate CDM is critical for accurate charging and compliance. At a minimum, every hospital should perform an annual in-depth review of their CDM.

During the course of this study, it was noted that eight of the 10 hospitals have a dedicated CDM individual or committee. For those hospitals without a dedicated person(s), in order to ensure that the CDM is maintained appropriately in the future, management should assign an individual or committee the responsibilities of CDM updates.

Common CDM issues identified throughout this study included lack of knowledge regarding “not separately-billable” items, confusion over appropriate billing methods and incorrect Healthcare Common Procedure Coding System (HCPCS) and revenue code assignments.

The following comments are intended to provide more information concerning the appropriate billing of services.

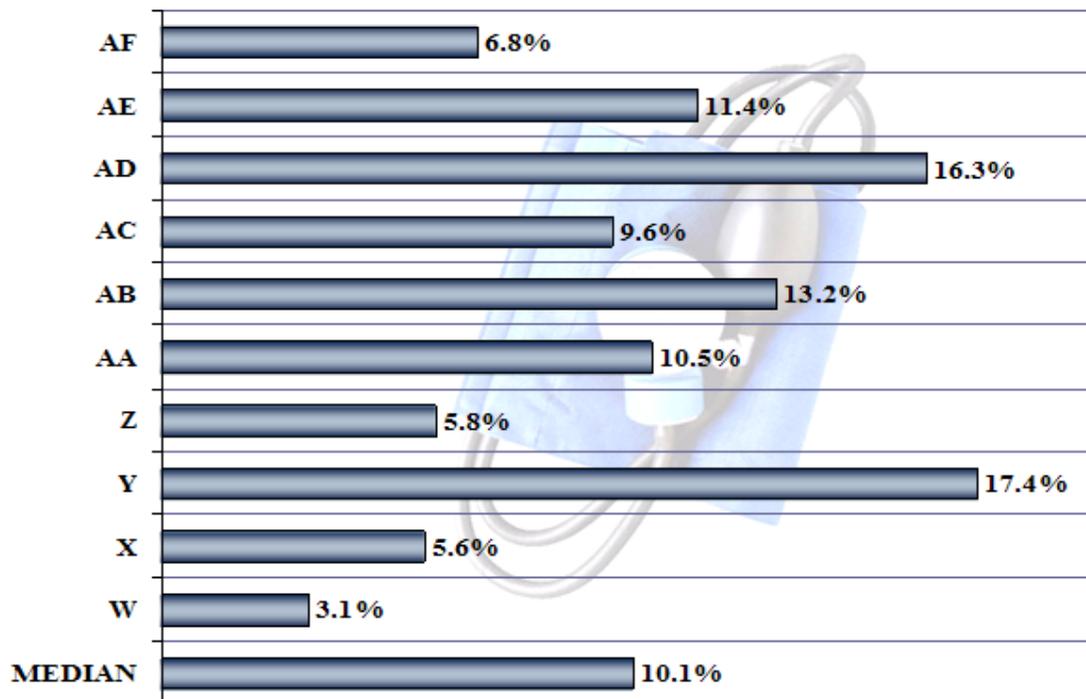
Incorrect revenue code assignments can lead to lost reimbursement and compliance issues. Drugs that can be self-administered are not covered by Medicare for outpatient services, including observation services. Based on Medicare regulations, self-administered drugs should be billed as “non-covered” charges on the claim and assigned a 637 revenue code. Medicare Administrative Contractor’s (MACs) are responsible for making the determination concerning whether a given drug or biological is “usually self-administered”. A MAC's determination applies only to the geographic area served by that specific contractor. If the MAC determines that a given drug is “usually self-administered,” it cannot be covered by Medicare under any circumstance, regardless of whether the drug is administered by a physician or anyone else. To view the Georgia MAC-B injectable drugs that are usually “self-administered” refer to the Centers for Medicare and Medicaid Services (CMS) website.

Venipuncture is considered a routine service and should not be charged separately to Medicare inpatients. Medicare expects to see only one venipuncture charge per patient encounter, regardless of the number of specimens collected. Medicaid should not be billed for venipuncture.

Emergency room evaluation and management criteria should be reviewed. All hospitals should have an emergency room evaluation and management mapping sheets and utilize these appropriately to determine the level of service charged. Procedures that are separately billed should not be considered in determining the evaluation and management level. We recommend each hospital review their mapping sheets carefully and make any necessary revisions based on CMS guidelines.

The use of observation services has appeared on the Office of Inspector General’s target list for several years. It is also a focus of the Medicare Recovery Audit Contractors (RACs). Low observation utilization could be an indicator of unnecessary admissions, while high utilization could indicate non-qualifying observation stays. The following chart provides further information regarding observation usage among the participants.

## Observation Days as Percentage of Total Days



As stated in the Medicare Claims Processing Manual (Pub. 100-04), Chapter 4, Section 290, observation services must be reasonable and necessary to be covered by Medicare. In only rare and exceptional cases do reasonable and necessary outpatient observation services span more than 48 hours. In the majority of cases, the decision about discharging a patient from the hospital following resolution for the reason for the observation care or admitting the patient as an inpatient can be made in less than 48 hours and usually in less than 24 hours. The CAH should ensure that once there is sufficient information to render this clinical decision, the patient should be expeditiously admitted, appropriately transferred or discharged.

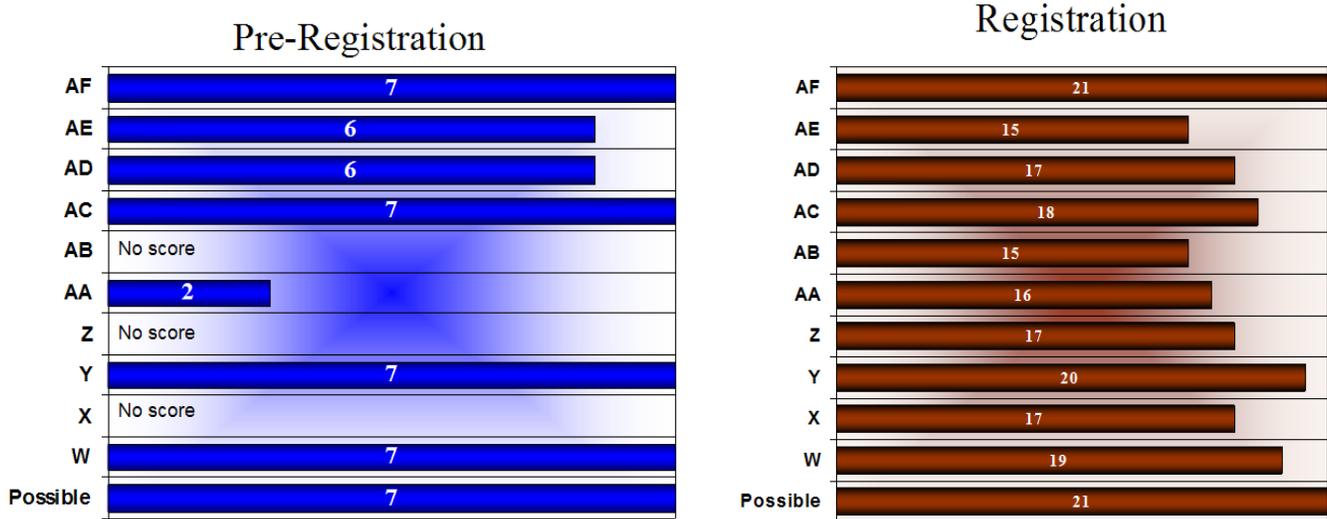
Since Medicare clearly states that observation over 48 hours should be rare and exceptional, qualified personnel should review all observation cases over 48 hours

to verify the medical necessity of all hours to be billed. If the documentation clearly shows that a physician actively treated the patient, and that the physician is trying to make the determination whether to admit the patient as an inpatient or discharge him or her, then all observation hours should be billed.

Hospitals should be aware of a regulation issued by CMS April 4, 2008, that states, “Except as permitted for CAHs having distinct part units under §485.647, observation beds are not included in the 25-bed maximum, nor in the calculation of the average annual acute care patient length of stay.” In other words, a CAH may maintain beds used solely for outpatient observation services without counting these beds toward the statutory CAH maximum of 25 inpatient beds.

## Patient Financial Services

Registration processes are critical components to the revenue cycle. The charts below provide information derived from the quality assessment questionnaires submitted by the participants. Complete copies of the questionnaire can be found in Appendix C.



Seven of the 10 participants either pre-register all patients or only pre-register patients in specific ancillary areas. Pre-registration is a key area and the first step of the revenue cycle. As many patients as possible should be pre-registered to speed up the admitting process, allow financial arrangements to be made prior to treatment and alert providers about high-risk patients with prior outpatient accounts and poor credit history. Hospitals X, Z and AB do not perform pre-registration.

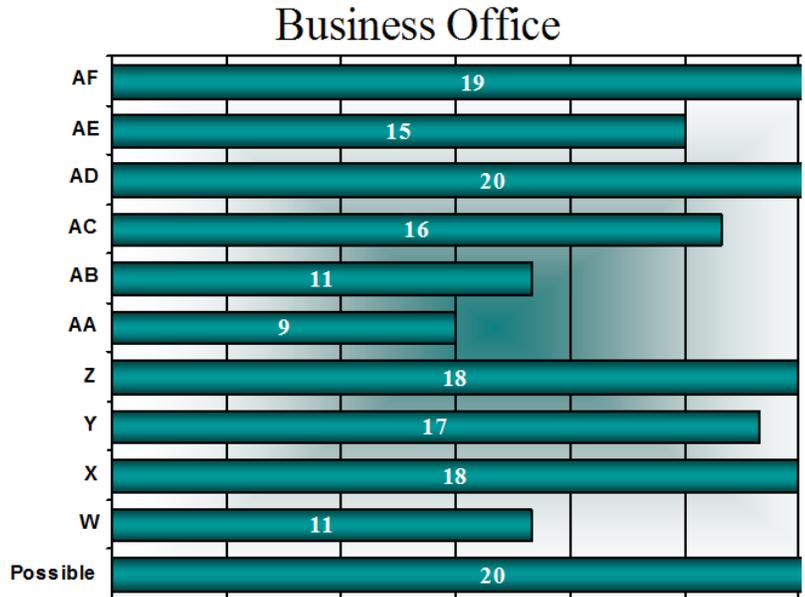
Recommendations on common areas of weakness associated with the registration process are:

- Hospitals should implement a formal and consistent means of tracking both registration elements and registration errors. Hospitals may consider depicting the results in graphs to give management a more vivid illustration of the outcomes.
- Efforts should be made to discuss and present in writing to the patient an estimate of their beneficiary liabilities at time of registration.
- Registration personnel should have appropriate software to determine if a service will be covered. Ancillary staff should also be trained to identify specific services requiring certain diagnoses for coverage. Advance beneficiary notices should be provided to patients outlining their

responsibilities for payment of non-covered services. Specific regulations governing the issuance of advance beneficiary notices are located on the Internet at [www.cms.hhs.gov/bni](http://www.cms.hhs.gov/bni).

Business office quality assessment scores ranged from a low of 9 points to a high of a perfect score of 20 points. Recommended areas for improvement include:

- Weekly accounts receivable reporting to management
- Productivity standards related to claims filed, outstanding A/R, cash collected, etc.
- Reporting to management of the number of days in A/R for discharged, not billed patients
- Trending analyses of Medicare denials
- Appropriate reporting of credit balances



Business office full time equivalents ranged from a low of two to a high of 11. As is typical in most small rural hospitals, managers function as staff personnel and perform many hands-on duties to ensure claims are filed and collected in a timely manner. Most employees are cross-trained and perform multiple tasks.



In a small rural hospital, the quality and knowledge of the personnel is highly dependent upon the availability of staff in the market area.

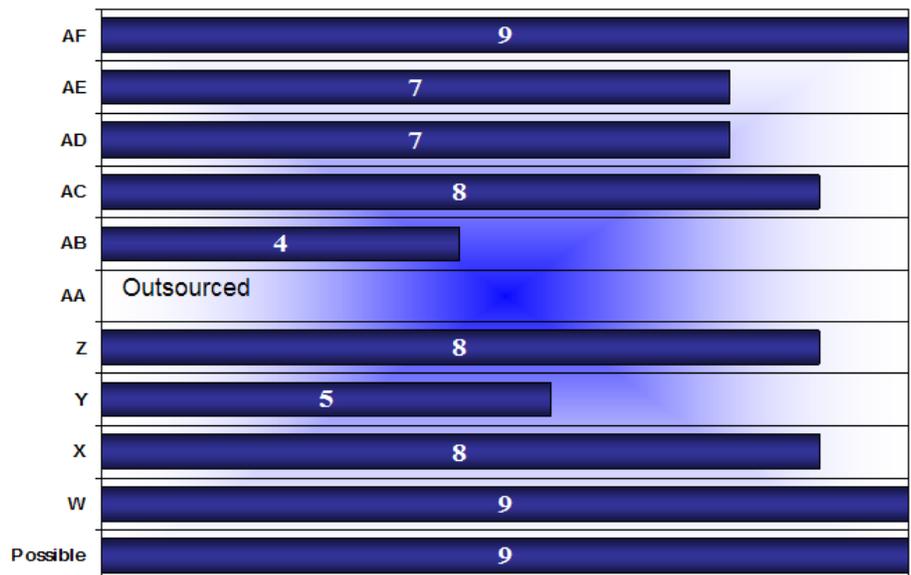
Reimbursement and billing knowledge is gained more from experience rather than formal training, which is true for the majority of the hospitals included in our study.

Having fewer employees than needed will significantly impact the efficiency of the revenue management process. Fewer employees can be a result of the hospital's financial constraints, hardware and software limitations, as well as location in a market with limited staffing resources. Understaffing contributes to inefficient billing and collection efforts, overwhelmed staff and billing errors that could manifest into cash flow concerns.

Variances among hospitals in the quality assessment scoring related to the collections functions were minimal with the exception of hospitals AB and Y. The following practices were noted in achieving high performance.

- Patients are informed of their payment obligations at time of service
- Formal credit/collection policies are in place and staff is held accountable to adhere to these policies
- Performance reports (i.e. denials, appeals, recoupment and write-offs) are presented to management
- Collections are aggressively pursued through point of service, statements, phone calls and referrals to collection agencies

## Collections



## **Review of Accounts Receivable**

Accounts Receivable (A/R) is often the largest asset on a hospital's balance sheet. Current accounts receivable was reviewed for all 10 hospitals participating in this study.

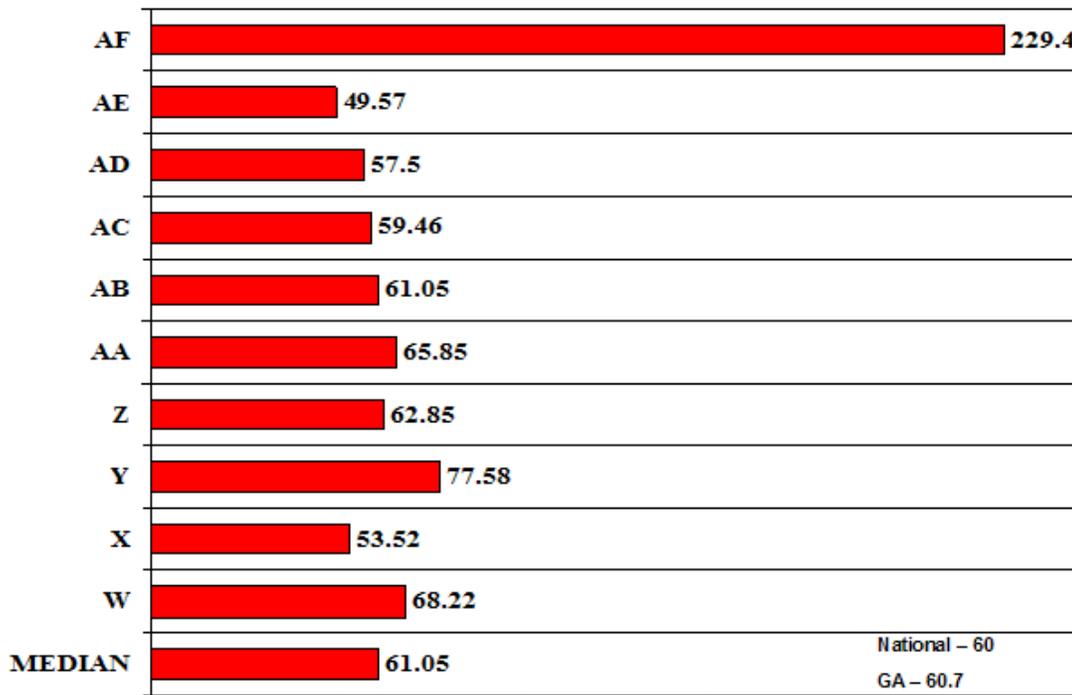
A certain level of expertise and monitoring is required to assure A/R is converted to cash in a timely manner. A diligent approach to A/R management will immediately improve the facility's cash flow. In addition, there are many difficulties that can affect the appropriate management of A/R. The following are a few areas that significantly affect the A/R collection process:

- Staffing
- Collection procedures and aggressiveness
- Follow-up procedures
- Tracking and monitoring returned claims, rejections, and denials (trend analysis)
- Holding staff accountable for productivity by measurable criteria
- Providing and posting reports of daily production for staff to see
- Reporting the number of days in A/R to management (periodic reporting to management)
- Analyzing the causes of billing delays
- Maintaining denial logs
- Requiring documentation of all communications with patients
- Remitting credit balances to Medicare or the state as unclaimed property
- On-going formal training in job functions
- Improving communication between the business office staff and registration staff
- Reviewing and following collection, bad debt and charity policies
- Reviewing patient "check-out" procedures
- Using collection letters and credit agencies
- Implementing a bonus/incentive plan for collections

The following charts provide comparative data related to accounts receivable at each of the participating facilities. Net days in accounts receivable is based upon the latest audited fiscal year end. The remaining charts are based on accounts outstanding at the time of the on-site visits.

Days Net Revenue in Net Accounts Receivable for the 10 hospitals ranged from 49.57 days to 229.4 days. This ratio is a liquidity ratio. Liquidity refers to the ability of an organization to meet its short-term maturing obligations. Some facilities experience financial issues due to a liquidity crisis or the inability to pay current obligations as they become due. The days net revenue in net A/R provides a measure of the average time receivables are outstanding.

## Days Net Revenue in Net Accounts Receivable



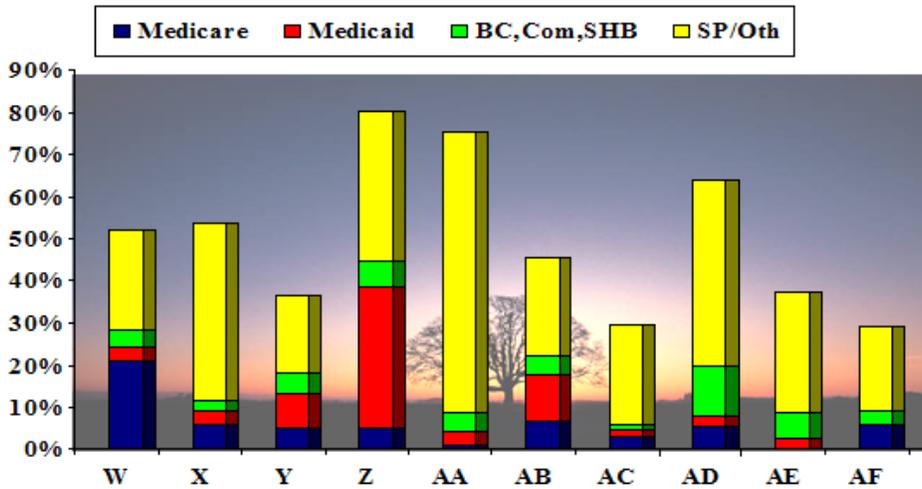
Bad debt write-off policies can directly affect the days in net A/R. Each hospital's bad debt policy was reviewed, with the exception of one which did not have a policy. Most hospitals are posting bad debts at 120 days after last collection; however, some use longer periods and others shorter. Aggressive write-off policies tend to reduce days in accounts receivable. One hospital submitted a policy that has been effective since 2006, with no revisions made since that time. There were several policies that had no effective date. Summaries of each hospital's policies can be found in Appendix A.

Credit balances can reduce the days in net A/R. Care should be taken when evaluating outstanding accounts receivable to identify credit balances. Credit balances can artificially reduce the days in net accounts receivable. Recent legislative changes underscore the need to remit credit balances to payers on a timely basis.

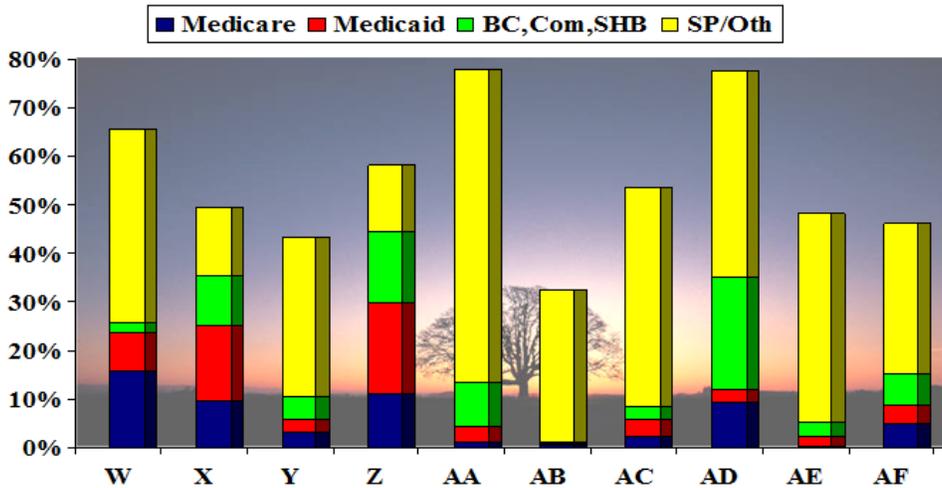
Self-pay accounts comprise the largest percentage of discharged A/R greater than 90 days by payer. The two charts below identify the percentage of these aging accounts by dollar amount and by number of accounts. Hospital AA had the highest dollar amount of older self-pay accounts, while Hospital Y had the lowest. The notation “BC, Com, SHB” refers to Blue Cross, Commercial and State Health Benefit plans.

Small balance self-pay accounts can place a strain on in-house collectors. These should be prioritized by high dollar amount for collection efforts. Attention should also be focused on the non-self pay accounts that are in this category. These may be an indication of inadequate insurance follow-up or untimely filing issues.

### Percentage of Discharge A/R Dollars Greater than 90 Days by Payer



### Percentage of Discharge A/R Claims Greater than 90 Days by Payer

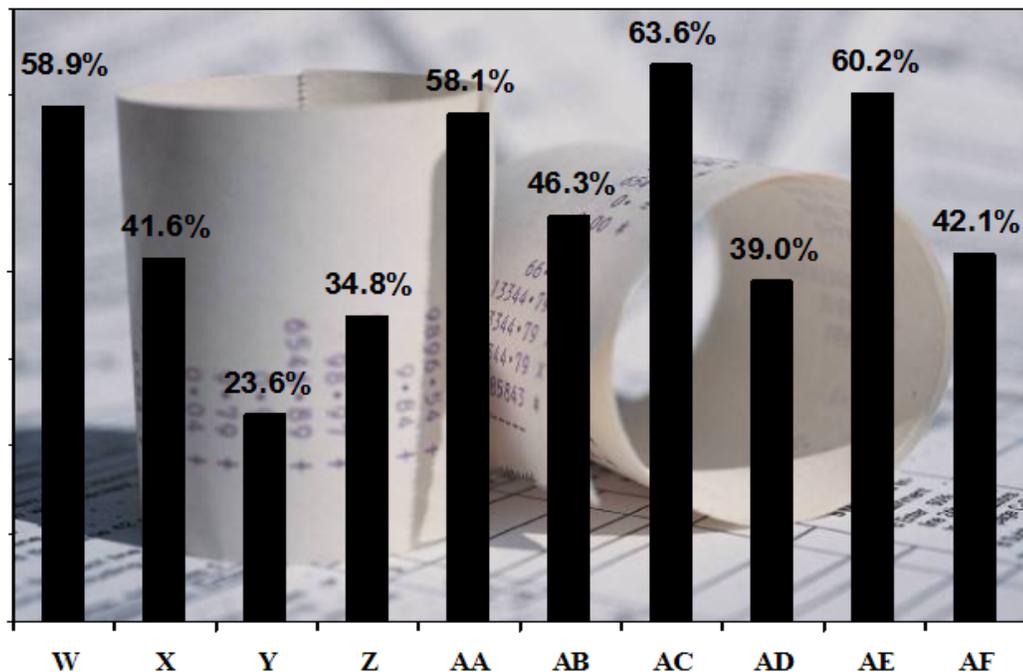


## Analyses of Costs

Often the public has the misconception that CAHs are reimbursed for full costs of operations. The Medicare (inpatient and outpatient) and Medicaid (outpatient) payment methodologies reimburse only the portion of the allowable COSTS that are related to the Medicare and Medicaid beneficiary's stay. The remaining hospital expenses related to other patients must be recovered from other sources. Due to significant indigent and charity patient percentages, it is extremely difficult to recover these remaining expenses without supplemental funding from the county and state.

The chart below indicates the portion of hospital costs that were reimbursed at 100 to 101 percent of allowable costs. The remaining portion must be recovered from fixed fee payments or supplemental funding.

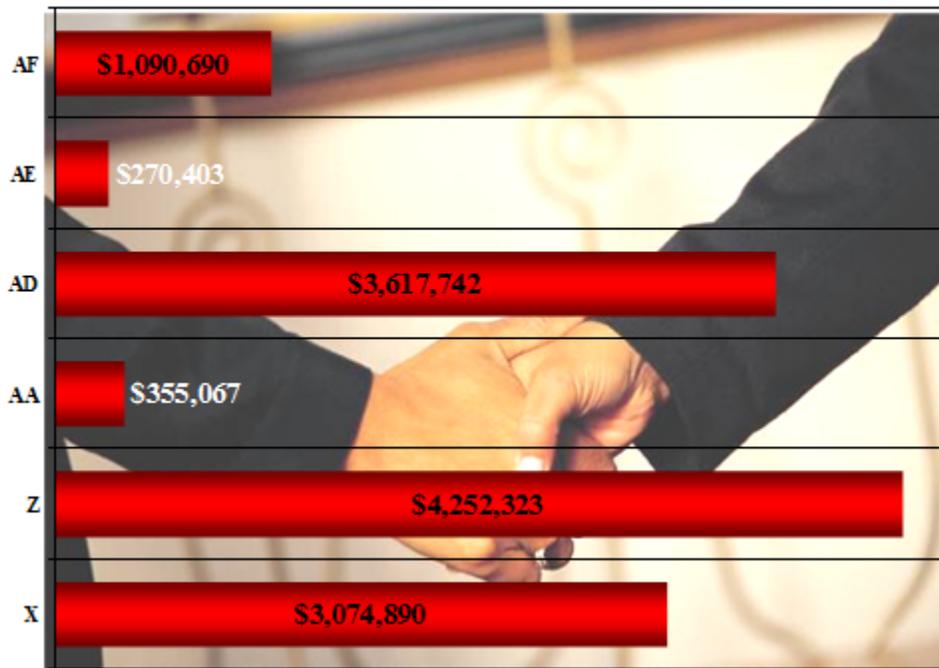
**Percentage of Hospital Costs Which Are  
Cost Based Reimbursed**  
(includes SWB)



In comparing the expenses of the CAHs, one must always consider the various factors that make them unique. Cost comparisons among the hospitals in this study are significantly affected by organizational structure, related party costs and diversity of services offered.

Allocations from related party organizations can significantly affect comparative data. Based on information in the Medicare cost reports, it was noted that six of the 10 hospitals received related party allocations. These allocations are made to recognize the cost of services provided to CAH patients by a related health facility. Material amounts of overhead allocations can significantly distort comparability of costs among the CAHs.

## Related Party Costs

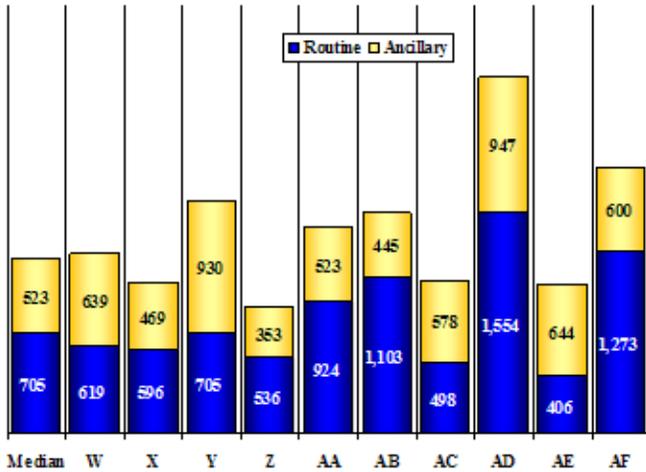


Costs per day comparisons should be reviewed with caution. Hospital costs are directly affected by a number of factors such as:

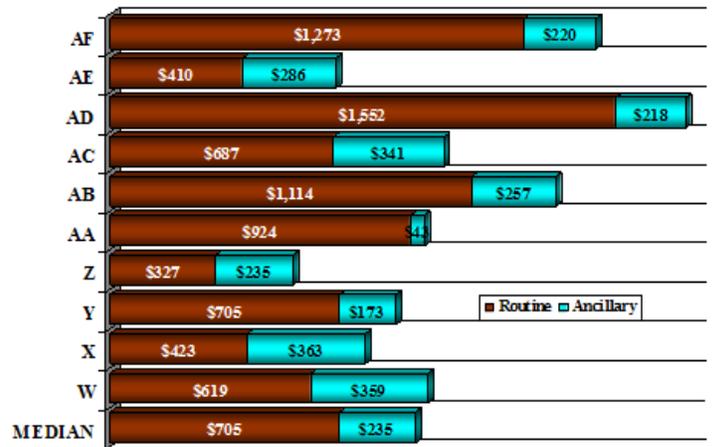
- cost allocations from affiliated health systems
- fixed costs compared to patient day volume
- service mix
- sharing of costs among components
- use of contract services

The cost per Medicare day among the study participants are indicated below. The median amount shown is the median value of the participants. Cost per day can be affected by low census since there will be fewer patients over which to spread fixed costs. Cost per day can also be affected by overhead allocations from related parties.

Medicare Inpatient Cost per Day



Medicare Swing Bed Cost per Day

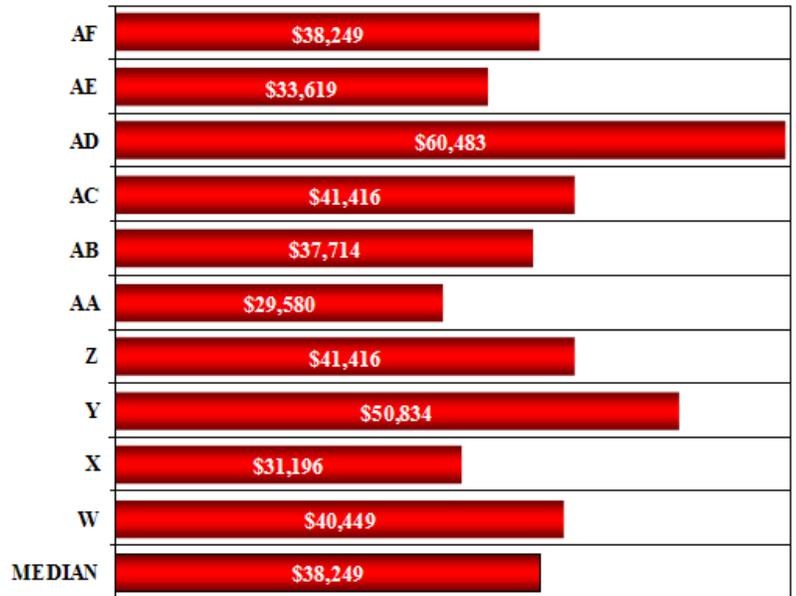


Salaries comprise the most significant portion of hospital operating expenses. Once again, comparisons of salary costs can be materially affected by allocations from related organizations, contract services, management agreements and other factors discussed above.

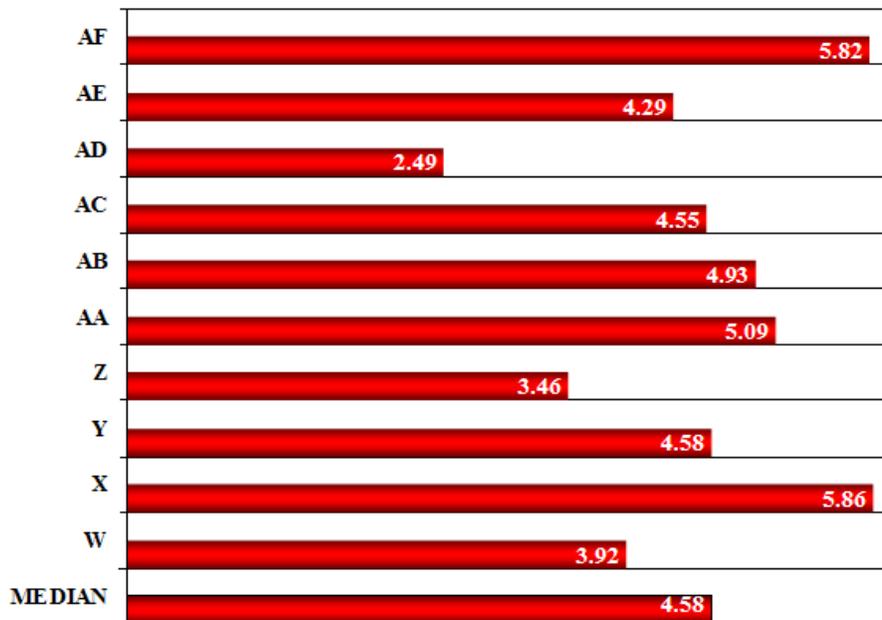
Several of the participating hospitals use contract support services, while others share staff with provider-based SNFs or clinics. These factors are noted on the following charts. Although comparative information can serve to provide areas requiring further study, decision makers should recognize the unique qualities of each facility.

## Average Salaries per Full Time Equivalent (excludes non-hospital components)

The average salaries per full time equivalent ranged from a low of \$29,580 to a high of \$60,483. The use of shared staffing in hospitals with SNF components may distort the average salary comparisons. Use of contract services, rather than employed staff, will also affect comparability. Component and contract staff were excluded from the average salaries calculations.



## Full Time Equivalents per Average Daily Census (excludes non-hospital components)



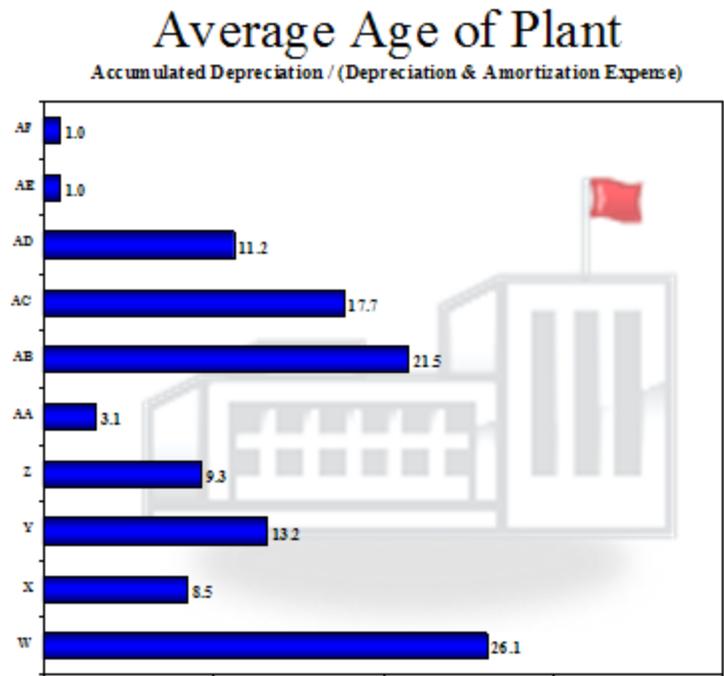
The use of contract staff will affect the full time equivalent comparisons. There were several participants that, as a component of a hospital system, benefited from consolidated billing functions and shared administrative staff.

Capital expenditures are necessary for the sustained financial viability of any company. Dwindling or negative profit margins combined with aging facilities present significant challenges to CAH management. Without county support many hospitals are unable to obtain capital financing.

The average age of plant ratio for the 10 CAHs spans from 1 year to 26.1 years. The average age is directly affected by ongoing renovations to the facility.

Some facilities have been able to make needed capital improvements through the use of Special Purpose Local Option Sales Tax (SPLOST) funds. It is evident that in order to be a financially successful hospital, chief executives must be creative, as well as tenacious, in order to provide needed facility upgrades.

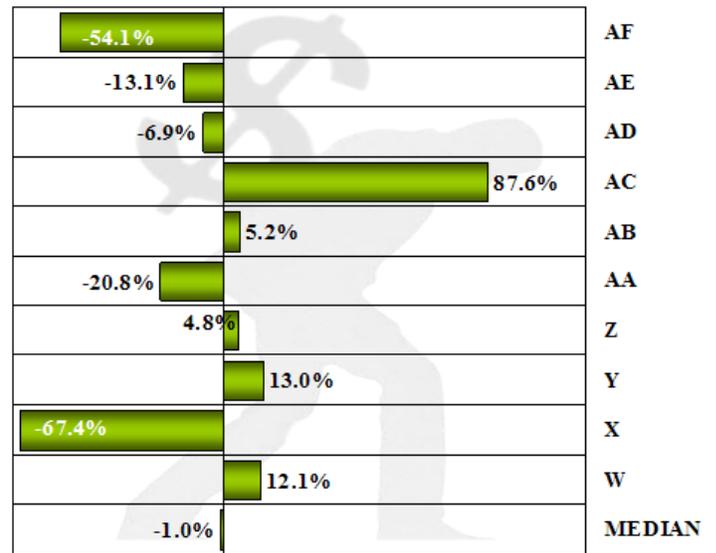
Several key financial ratios are used by lenders in determining the viability of financing capital improvements. The following charts provide comparative data regarding these indicators.



## Cash Flow to Total Debt

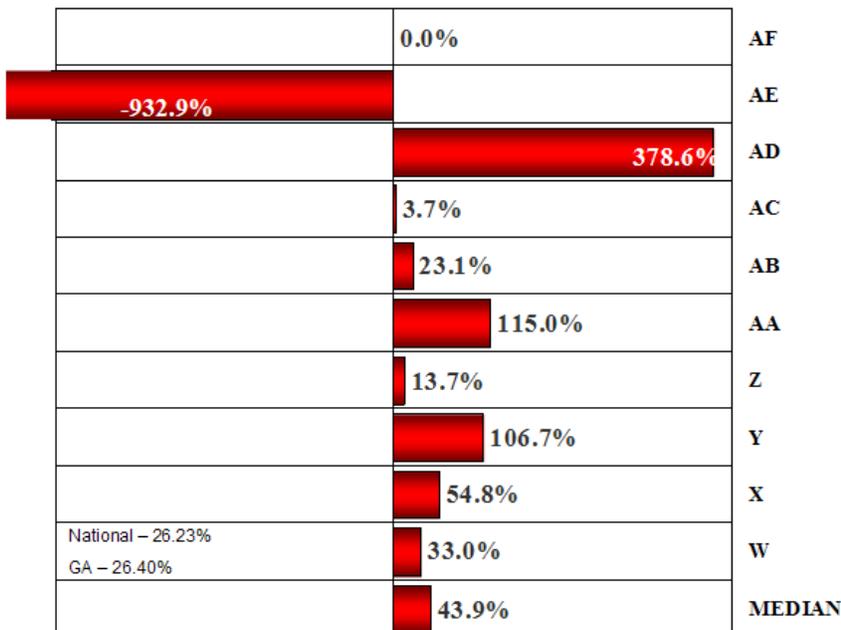
$(\text{Excess Revenues over Expenses} + \text{Depreciation \& Amortization Expenses}) / (\text{Current Liabilities} + \text{Long-Term Debt}) \times 100$

The cash flow to total debt percentages for the 10 CAHs span from -67.4 percent to 87.6 percent. Cash flow to total debt has been found to be an important indicator of future financial problems or insolvency. The numerator measures the current amount of funds available from operations. This source of funds is used to retire debt principal, increase working capital or replace capital assets. A decrease in the value of the cash flow to total debt ratio may indicate a future debt replacement problem.



## Long-Term Debt to Capitalization

$\text{Long-Term Debt} / (\text{Long-Term Debt} + \text{Net Assets}) \times 100$

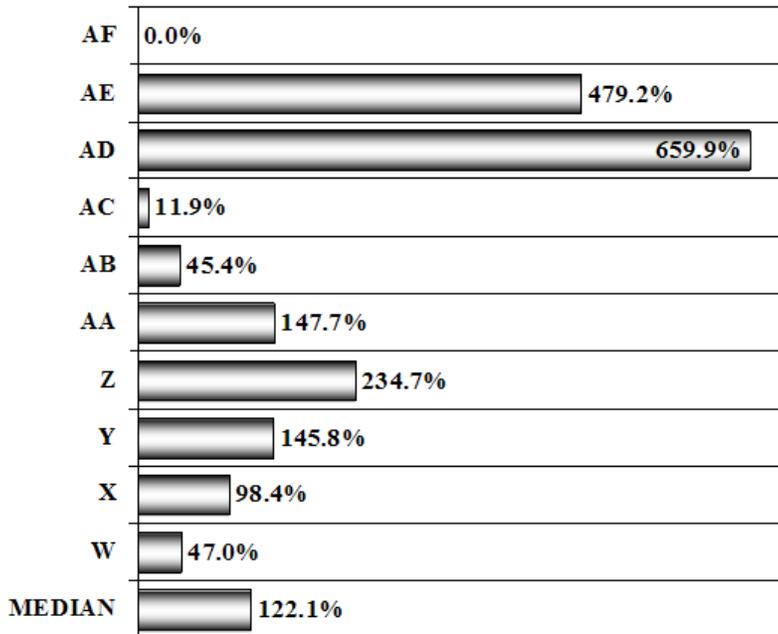


The long-term debt to capitalization ratio for the 10 hospitals ranged from -932.9 percent to 378.6 percent. Hospital AF had no long-term debt. Hospitals X, Z, AD and AE long-term debt is comprised of intercompany payables. Hospital AE had negative net assets in excess of long-term debt. This ratio measures the relative importance of long-term debt in the hospital's permanent capital structure. Hospitals with high values for the long-term debt to

capitalization ratio have relied extensively on debt as opposed to equity to finance their assets and are said to be leveraged. Hospitals with negative ratios indicate negative net assets due to current or previous years' operating losses. This means risk in the minds of many creditors and may be viewed unfavorably.

## Fixed Asset Financing Ratio

$(\text{Long-Term Debt} / \text{Net Fixed Assets}) \times 100$



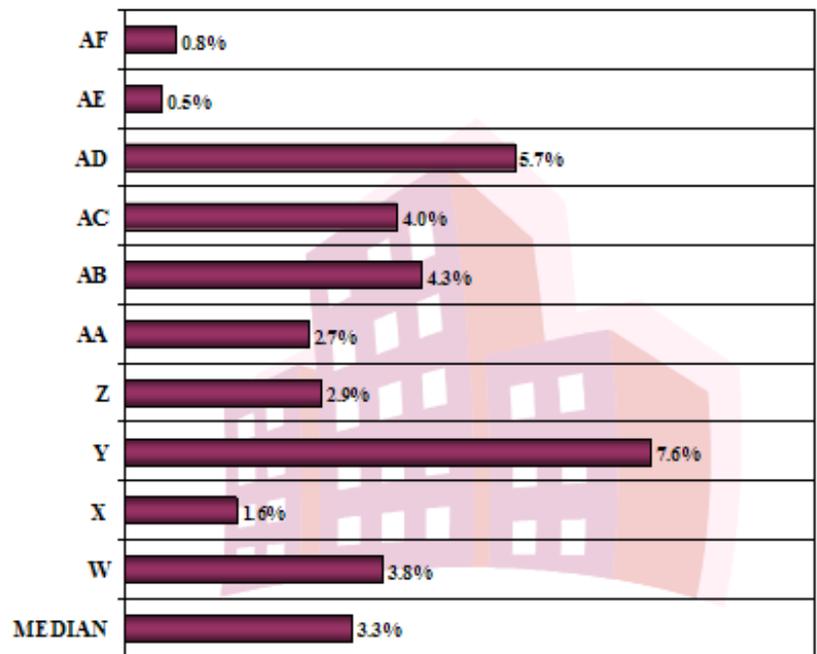
The fixed asset financing ratio for the hospitals ranged from zero percent to 6.6 percent. Hospital AF did not have any long-term debt. Hospitals X, Z, AD and AE long-term debt is comprised of intercompany payables. This ratio has been used by creditors for many years. The ratio defines the proportion of net fixed assets (gross fixed assets less accumulated depreciation) financed with long-term debt. This ratio is used by mortgage lenders to provide an index of the security of the loan. Providers must be able to determine the optimal level of long-term debt which can meet the long-term

goals of improving the facilities yet at the same time not place an overwhelming burden on short-term operations from a cash-flow standpoint.

The capital expense ratio for the hospitals ranged from 0.5 percent to 7.6 percent. This ratio provides a measure of the proportion of capital expenses, defined as interest and depreciation, to non-capital operating expenses. Since capital expenses are largely fixed and do not vary in the short term, a high capital expense ratio would imply greater operating leverage in the cost structure of the hospital. The implication of this greater operating leverage would be an increased sensitivity of average cost per discharge to volume indicators. Reductions in volume would most likely result in large increases in average cost per discharge.

## Capital Expense Ratio

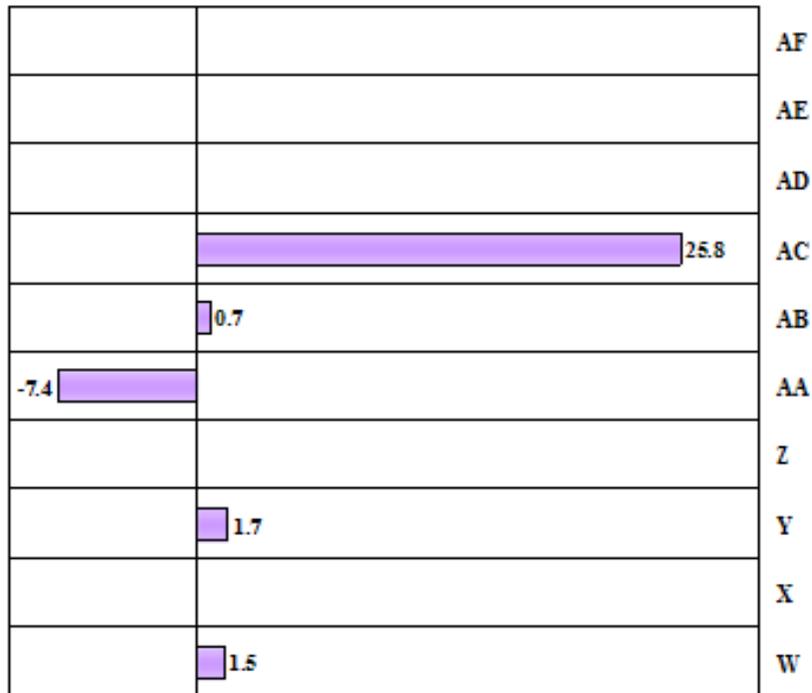
$((\text{Interest Expense} + \text{Depreciation \& Amortization Expense}) / \text{Total Expense}) \times 100$



The debt service coverage ratio for the hospitals ranged from -192.42 to 25.8. This ratio measures total debt service coverage (interest plus principal). Since cash flow is defined as excess revenues/expenses plus depreciation, debt service coverage is affected by both profitability and depreciation patterns. Higher values for the debt service coverage ratio are viewed positively by creditors. Hospitals X, Z, AD, AE and AF had no long-term debt principal payments.

## Debt Service Coverage

(Excess revenues over Expenses + Interest Expense + Depreciation & Amortization Expense) /  
(Debt Principal Payments + Interest Expenses)



## Cost Reporting

Every hospital must file a Medicare cost report annually. Over the past twenty years, the reimbursement impact of these reports has been minimized for most hospitals. However information reported for CAHs directly affect cost reimbursement for Medicare and Georgia Medicaid. Therefore, data must be accurately compiled and reported to ensure appropriate reimbursement.

Statistical data is used to allocate hospital overhead costs to areas receiving these services. Some hospitals provide support services to non-hospital components such as SNFs, RHCs and/or physician practices. Costs associated with these services must be identified and removed from hospital costs when determining Medicare and Medicaid reimbursement.

As part of this study, the statistical data provided to cost report preparers was reviewed. Common issues were noted that should be investigated further to ensure that hospitals are accurately reimbursed.

Square footage statistics should be reviewed closely for appropriateness. Square footage is often used to allocate capital, plant, maintenance and housekeeping costs to non-hospital components. Use of square footage statistics in these areas could cause unreasonable allocations if the square footage statistic does not provide an accurate representation of the services received. For instance, a physician's office is not open 24 hours a day, seven days a week. Therefore it is unreasonable to assume that the physician practice housekeeping or plant cost per square foot would be the same as the hospital. Direct identification of costs through the use of time studies would provide a more reasonable representation of the costs incurred. In addition, hospitals should consider an analysis to determine if the lost reimbursement from allocated housekeeping costs is more than the direct cost of contracting for such services. Reduced allocations to non-reimbursable areas will result in higher reimbursement to the hospital. Nine of the ten participants in this study used square footage for the allocation of plant, maintenance, housekeeping and repair costs.

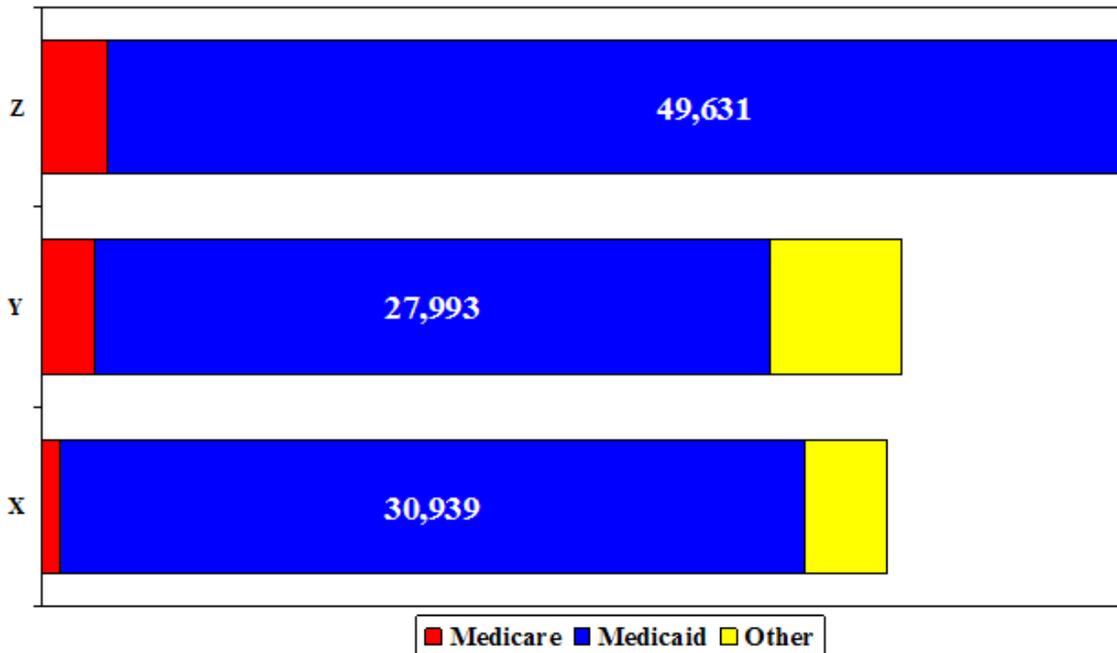
Since square footage is a critical statistic in cost allocations, care should be taken to insure that the statistics are up-to-date and accurate. It was noted that most of the CAHs reviewed have not performed recent square footage studies to ensure that the reported amounts are accurate.

Administrative costs are often allocated to non-hospital areas using accumulated costs. Components such as SNFs, RHCs and physician practices may have their own registration and billing departments. In these cases, it may not be reasonable to allocate to these components a portion of all administrative and general costs of

the hospital. It would be more accurate to subdivide the administrative and general areas into separate cost centers for admitting and/or billing functions and only allocate to components receiving these services from hospital personnel. None of the participants utilized subcommittee in the allocation of administrative and general costs.

The Medicaid program is the largest payer source for CAH SNF programs. Due to recent budgetary constraints, Georgia Medicaid is more strictly enforcing eligibility requirements. SNFs are experiencing census reductions due to these enforcement actions. The resulting reduction in SNF patient volumes and Medicaid funding is contributing to the financial distress of the CAHs.

### SNF Days by Payer



CFOs should monitor interim reimbursement to avoid year end settlement surprises. Since the significant amount of the CAH's reimbursement is based on cost reimbursement principles, many CAHs conduct mid-year reviews of their operations to determine if they are being significantly overpaid or underpaid. Some CFOs perform internal interim reviews and others actually prepare interim cost reports. Multiple factors may cause the CAH to be over or under paid during the year. These include:

- Expenses may increase from the prior year
- Charges may fluctuate due to price increases during the year
- Patient volume may fluctuate from year to year
- The Medicare intermediary may change the interim rates and even issue lump sum advances or advance recoveries based on historical data

An interim cost report is the most accurate method of identifying and/or avoiding significant settlements at year-end.

	<b>Interim Reimbursement Monitoring</b>
<b>W</b>	Internal Monitoring
<b>X</b>	Information not available
<b>Y</b>	Internal Monitoring
<b>Z</b>	Internal Monitoring
<b>AA</b>	Internal Monitoring
<b>AB</b>	Information not available
<b>AC</b>	Information not available
<b>AD</b>	Internal Monitoring
<b>AE</b>	Quarterly Cost Reports
<b>AF</b>	Mid-Year Cost Report

**Appendix A**  
**Bad Debt Policies**

# Summary of Bad Debt Policies

The following are summaries related to each hospital's bad debt policy that may directly affect their days in total A/R and outstanding balances greater than 90 days.

## **Hospital W**

Self-pay and Patient Responsibility accounts are reviewed every 30 days and reasonable collection efforts made in-house. After no less than (3) three statements are provided within a 90 day period from the first notice date and a consecutive span of 120 calendar days has occurred from the date of the first statement notice, the account is then sent to the collection agency. If the responsible party has received at least three statements, one collection letter, and no payment has been made within 30 days, the account is eligible for Bad Debt write-off and the financial class is changed.

## **Hospital X**

Patient's financial responsibility is determined and the patient is sent a series of three collection letters. Once the account reaches the 100<sup>th</sup> day (from date the account is deemed patient's responsibility or last payment), account balances less than \$250 are referred to an outside collection agency. After the collection agency has attempted to collect through letters and telephone calls, the agency then places all accounts on the patient's credit file after thirty days if no payment is received. If the account has been at the collection agency for over one year and has not had a payment within the last 120 days, the account is deemed uncollectible and these accounts are reviewed for classification as a bad debt.

## **Hospital Y**

Self-pay accounts are sent to a pre-collect agency. If this agency is unable to collect on the self-pay account because the patient/guarantor has not responded to any attempts at collections or the account has reached 120 days since placement, the account is deemed uncollectible. The account is returned to the provider at which time it is reviewed to determine patient responsibility and then the account is written off to bad debt.

## **Hospital Z**

The patient is sent a series of three collection letters. Account balances less than \$250 are referred to an outside collection agency. Attempts are made by the collection agency through letters and phone calls to collect and if no payment is received after thirty days, the account is placed on the patient's credit file. If the account has been at the collection agency for over one year and has not had a payment within the last 120 days, the account is deemed uncollectible and these accounts are reviewed for classification as a bad debt.

## **Hospital AA**

Information not available.

## **Hospital AB**

Collection report is run and used for accounts that are delinquent and are assigned to a collection agency, small claims court, or working in-house. For bad debt write-off, a collect code is assigned and accounts are posted to bad debt. A bad debt report is run and sent to the collection agency or small claims court. After bad debt write-off is completed, an A/R monthly file is run and accounts will be written off within 90-120 days. Each account receives two letters. If patient calls and makes payment arrangements, the account is written-off and put in an in-house collect code where they will receive monthly statements to monitor their payment terms. If they are in default, the account is turned over to a collection agency.

## **Hospital AC**

The financial counselor will review unpaid accounts on a regular basis to identify nonpayment of co-payments, coinsurance or deductibles required by any third party payer or for any services for which a patient is responsible for self pay. If a bill remains unpaid more than 165 days from the date it was first mailed to the beneficiary and reasonable collection attempts have failed, the debt may be deemed bad debt.

Reasonable collection efforts include, but are not limited to the issuance of a bill for medical services on or shortly after discharge, delivery of services or death of the patient to the party responsible for patient's personal financial obligations, and subsequent billings, collection letters, telephone calls or personal contacts with the party, demonstrating a genuine collection effort. The provider may use a collection agency to obtain payment.

A Medicare bad debt log will be maintained by the financial counselor's office and will contain the Medicare patient's name and other pertinent information along with all unpaid charges that meet the criteria for bad debt. This log will be updated monthly.

## **Hospital AD**

All Medicare accounts are reviewed for bad debt pre-list in addition to all non-Medicare and government accounts with balances greater than \$3,000. Patient receives a minimum of three statements or letters before an account is written off to bad debt. Accounts that were bad debt pre-list accounts are monitored in addition to the age of accounts with recent admit and discharge dates. Account notes are reviewed for appropriateness of bankruptcy, charity and estate write-offs.

A list of accounts in “legal status” with the collection agencies are reviewed to ensure they are not rolled to a secondary agency and to bad debt. The accounts placed in bad debt are removed and placed with the primary agency or recalled to active AR and assigned a collection series, as appropriate. Days related to legal accounts are reset to prevent them from rolling to bad debt in error.

### **Hospital AE**

Once Medicare and insurance have paid and the balance is determined to be owed by the patient, three statements will be sent. If payment is not received in 120 days, the account will be deemed bad debt and moved to bad debt accounts receivable. Once the balance is deemed bad debt an outside agency will be notified and collection efforts will stop immediately. During the first 120 day collection period, an attempt will be made to contact the patient via letter and phone call. If the patient was Medicare eligible and the balance was the patient’s responsibility, once moved to bad debt log balance it will be submitted to Medicare on the cost report. If during the initial 120 day collect effort any payment is made on account, the 120 day rule and three statements will start over.

### **Hospital AF**

After reasonable collection efforts have been made, three statements are sent to the patient once liability is established. A collection letter is sent to the patient after the three statement cycle. Once account is deemed non-eligible for further assistance such as Medicaid or Charity Care, proper follow-up is performed by an outside collections vendor. When collection efforts are exhausted by the outside collections vendor, the hospital will identify and write-off accounts eligible for bad debt noting that the account has aged appropriately (at least 120 days from the first statement date) for write-off eligibility.

## **Appendix B**

### **Medical Record and Charge Description Master Findings**

## Medical Record and CDM Findings

As part of this study, there was a review of Medicare claims chosen from each CAH. Each claim was reviewed to verify that charges billed agreed with medical record documentation. There were several common issues noted among the hospitals that suggest the need for additional training and/or CDM revisions. The chart below indicates the applicability of each comment to each participating hospital.

Issue / CAH	W	X	Y	Z	AA	AB	AC	AD	AE	AF
1. Medical records			X		X	X		X	X	X
2. Emergency room charges		X		X	X		X	X		X
3. Observation charging	X				X	X	X		X	X
4. Venipuncture charging	X	X	X	X	X	X		X	X	X
5. Injections and infusions	X				X		X			X
6. Revenue code assigned	X		X		X			X		X
7. CDM Issues		X		X		X				X

1. The medical record should contain all information to support charges billed. This includes physician orders as well as test results. In a couple of instances test results were not readily located in the medical records reviewed. Additionally, there were several instances where physician admission orders were not specific to the type of admission (i.e. observation versus inpatient status). It was also noted that physician orders were not always “timed” to compute observation hours. Hospitals should conduct internal chart reviews to insure that all supporting documentation is present within the medical record chart.
2. Emergency room (ER) charges should be reviewed. The staff at many of the CAHs is confused regarding the appropriate charging of injections and infusions in the outpatient setting. Nursing staff should document start and stop times related to infusions. There were several instances where IVs were started; however, no drug charges were on the UB. We also noted instances where vaccines were administered but neither the vaccine or administration of the vaccine was charged.

3. Staff and physicians should be educated related to observation billing criteria and documentation requirements. There appears to be confusion among staff and physicians regarding the appropriate use of observation. Hospital staff and physicians should review Medicare observation guidelines which can be found in the CMS Medicare Claims Processing Manual, Chapter 4, Section 290.2.2. Additionally, in a number of instances, the physician's admission orders were unclear related to whether the physician was admitting the patient to observation versus inpatient or there was no order at all to support observation status. Oftentimes it was difficult to compute observation hours because the physician did not "time" the orders.
4. Venipuncture is an allowable charge for outpatients but may not be charged for inpatient Medicare patients. In a number of hospitals it was noted that venipuncture is not charged in the ER and observation. This is an allowable charge (limited to one per encounter) and failure to bill will result in lost reimbursement.
5. Injection and infusion administration may be billed for outpatients. There were many inconsistencies in injection and infusion administration charges in the emergency room and observation settings. Such services are billable, in addition to the drugs given. However, there are specific guidelines regarding the units of services which may be billed. Failure to charge for administration may result in lost reimbursement. Additionally, injection and infusion administration related to operative procedures are considered inherent in the procedure charge and should not be charged separately.
6. Hospitals should review the CDM for appropriate revenue code assignment. Hospitals continue to misunderstand appropriate revenue code assignment and its impact on billing. Revenue codes will directly affect CAH Medicare and Medicaid reimbursement. Inappropriate assignment can lead to both overpayments and underpayments. Revenue codes assigned should correlate with the hospital and Centers for Medicare and Medicaid Services (CMS) cost report cost center. For example, supplies should be assigned a 27X revenue code and should be grouped to the Central Supplies cost center on the cost report. If the hospital "maps" supply charges on its general ledger to other departments (operating room, emergency room etc.), the cost report preparer should be notified. Inappropriate grouping on the cost report will lead to reimbursement over/underpayments.

Drugs administered (regardless of hospital department utilizing service) should be billed using a 25X revenue code, except in instances of self-administered drugs. Drugs that can be self-administered are not covered by Medicare for

outpatient services, including observation services. If a drug is self-administered by more than 50 percent of Medicare beneficiaries, the drug is excluded from coverage and should be assigned a 259 or a 637 revenue code for Medicare outpatients to identify these drugs as self-administered.

There were instances where self-administered drugs were billed with the correct revenue code; however, they were billed as “covered” rather than “non-covered” charges. Self-administered drugs were not charged to the patient. It is recommended that all patients be charged for drugs consumed; however, as previously stated, self-administered drugs should not be billed as covered services to the Medicare Program.

7. Hospitals should review the CDM for appropriate CPT/HCPCS code assignment and accurate CDM item descriptions. Although critical access hospitals are not required to use CPT/HCPCS codes, all hospitals included in this study have elected to do so. In one instance, the use of incorrect or deleted CPT/HCPCS codes was noted.

In other instances, CDM item descriptions related to drugs did not include the dosage. It is important that hospitals review the CDM for correct code assignment and accurate CDM item descriptions in order to avoid improper coding and/or billing of services provided.

## **Appendix C**

### **Quality Assessment Questionnaire**

**(Questionnaire is proprietary to Draffin & Tucker, LLP)**

**CF = Critical Factor used in scoring**

---

# CAH Quality Assessment by Functional Area

*Assessment Criteria*

*Discussion*

---

## *Pre registration*

### *Departmental Issues*

**CF** Is pre-registration performed at the hospital?

---

Is a pre-registration policy and procedure in place?

---

### *Procedures*

Are all scheduled outpatients pre-registered?

---

Are all non-emergency inpatient admissions pre-registered?

---

Are all outpatient surgery patients pre-registered?

---

**CF** Is insurance verified during pre-registration process?

---

**CF** Are payment obligations reviewed with patient during pre-registration?

---

**CF** Are prior patient's account balances reviewed as part of the pre-registration process?

---

---

# CAH Quality Assessment by Functional Area

## Assessment Criteria

## Discussion

---

**CF** Are financial arrangements for payments made during pre-registration?

---

**CF** Are payment assistance options discussed with patients during pre-registration?

---

**CF** Are any on-line computer capabilities available to assist in insurance verification & eligibility?

---

Check items listed below that are requested at registration.

---

Patient name

---

Address

---

Home Telephone

---

Work Telephone

---

Race

---

---

# *CAH Quality Assessment by Functional Area*

*Assessment Criteria*

*Discussion*

---

Sex

---

Marital Status

---

Spouse's name

---

Guarantor

---

Emergency Contact

---

Primary Care Physician

---

Referring Physician

---

Insurance information

---

Review of financial obligations

---

---

# *CAH Quality Assessment by Functional Area*

*Assessment Criteria*

*Discussion*

---

*Pre registration*

*Critical Factor Scoring*

Hospital Score

Possible Score

Assessment %

---

# CAH Quality Assessment by Functional Area

*Assessment Criteria*

*Discussion*

---

## *Registration - Business Office*

### *Physical location issues*

Is there one place to sign in when registering? If not, describe other areas.

---

**CF** Are any signs used in registration area to inform patient of payment obligations?

---

**CF** Are any signs used in registration area to inform patient of charity or indigent policies?

---

Is there visible signs or notices to patients of credit card payment option?

---

Where is after-hours registration performed?

---

### *Departmental Issues*

How are physician orders received in registration area? (i.e., fax, original copy, patient brings etc.)

---

Do registration staff subsequently receive the original order when a copy is first received via fax?

---

**CF** Do registration staff contact the physician's office when the order is not specific and/or incomplete?

---

---

# CAH Quality Assessment by Functional Area

## Assessment Criteria

## Discussion

---

Are credit cards accepted?

---

Is there a written payment policy statement or brochure to give to patients?

---

Are there written registration policies and procedures?

---

### Management Reporting

**CF** Do staff prepare any types of productivity or statistical reports for management?

---

Do management reports graphically depict results? If so, provide example.

---

### Procedures

**CF** Is a "checklist" available as a reminder of information to request from patient?

---

Is the patient reminded to bring payment to registration?

---

Is the patient reminded to bring identification to registration?

---

---

# CAH Quality Assessment by Functional Area

## Assessment Criteria

## Discussion

---

Is the patient reminded to bring insurance cards to registration?

---

Is the patient reminded to bring physician's order, if available, to registration?

---

**CF** Is insurance coverage (each plan) verified prior to service?

---

**CF** Is insurance verified for pre-certification of procedures?

---

Do registration staff work with a current "insurance master" listing of third party payor information?

---

Is insurance verified for coinsurance and/or deductibles?

---

Is a copy of the front and back of the insurance card obtained?

---

Is a copy of patient's driver's license obtained, if available?

---

Is a copy of patient's social security card obtained?

---

---

# CAH Quality Assessment by Functional Area

## Assessment Criteria

## Discussion

---

Is a "Consent for treatment" form signed each time a patient is registered?

---

Are Patients given a copy of Patient Rights?

---

**CF** Is Medicare Secondary Payer (MSP) questionnaire completed at registration?

---

**CF** Are Advance Beneficiary Notices (ABN) signed by patient for non-covered services at registration? If not, why?

---

**CF** Is the computer system equipped with "front-end" edits to identify non-covered or not medically necessary services?

---

Do patients receive an "information sheet" during registration which includes date, time, and expectations of services to be rendered?

---

**CF** Are hospital's payment policies fully explained to patient?

---

**CF** Are the hospital's financial policies and patient's obligation to pay coinsurance and deductibles presented to patient in writing?

---

**CF** Are payment options reviewed with patient at time of registration?

---

---

# CAH Quality Assessment by Functional Area

## Assessment Criteria

## Discussion

---

Is an estimate of charges provided to the patient?

---

Is an estimate of patient's financial obligation determined and given to patient?

---

**CF** Is payment requested at time of service?

---

Is the registration document reviewed by the patient for accuracy?

---

**CF** Are registration errors tracked by error type? If so, provide example.

---

**CF** Are registration errors tracked by staff member? If so, provide example.

---

Is staff training tailored to error tracking reports? Describe how.

---

At time of hiring, are staff members compared to the Medicare listing of "excluded individuals"?

---

**CF** Does the hospital screen patients for charity program eligibility?

---

---

# CAH Quality Assessment by Functional Area

## Assessment Criteria

## Discussion

---

**CF** Does the hospital maintain documentation of patient's charity program eligibility?

---

**CF** Does the hospital maintain a log of patient charity program eligibility?

---

### Staff Issues

Does each staff member have a current job description?

---

Do registration staff receive on-going training? If so, describe.

---

**CF** Are registration staff cross-trained in other functions?

---

Are cross-trained staff paid more?

---

**CF** Are staff held accountable for productivity by measurable criteria? If so, describe criteria and how used.

---

Describe the staffing in the registration area.

---

### Registration - Business Office

#### Critical Factor Scoring

Hospital Score

Possible Score

Assessment %

---

# CAH Quality Assessment by Functional Area

*Assessment Criteria*

*Discussion*

---

## *Charge Capture - CDM*

### *Departmental Issues*

Is electronic order entry utilized to order services?

---

Do ancillary departments maintain a manual log of patient names and services?

---

**CF** Is a "superbill" or other charging document used to identify services provided?

---

**CF** Do ancillary departments receive documentation of previous day's charges entered into billing system?

---

Are ancillary departmental personnel responsible for entering all charges provided?

---

**CF** Do ancillary departments verify/reconcile services to the charges entered in the billing system? If so, provide example.

---

**CF** Do ancillary departments verify that units billed equal units provided?

---

Are charges entered electronically?

---

---

# CAH Quality Assessment by Functional Area

## Assessment Criteria

## Discussion

---

Are late charges entered manually required to be supported by written documentation?

---

### Procedures

**CF** Do ancillary departments perform only services that have been ordered by the physician?

---

**CF** Do clinical staff contact the physician's office when the order is not specific and/or incomplete?

---

Are ancillary departments responsible for verifying coverage of services (medical necessity) prior to rendering service?

---

**CF** Do ancillary departments have access to information to identify non-covered or not medically necessary services?

---

**CF** Do ancillary departments obtain Advance Beneficiary Notices (ABN) signed by patients for non-covered services? If not, why?

---

Do ancillary departments utilize standing orders or written protocols?

---

Is a copy of any standing orders and/or written protocols included in the patient's record?

---

### Charge Capture - CDM

#### Critical Factor Scoring

Hospital Score

Possible Score

Assessment %

---

# CAH Quality Assessment by Functional Area

*Assessment Criteria*

*Discussion*

---

## *Medical Records*

### *Departmental Issues*

**CF** Are average coding backlogs less than five days? If not, what is the backlog?

---

What type services are coded by medical records coders? List

---

**CF** Are computerized tools available to assist in coding? Describe.

---

**CF** Is the hospital's coding software (ICD9 and CPT) up-to-date?

---

Are staff adequately trained in use of software?

---

What are significant causes of coding delays?

---

### *Management Reporting*

**CF** Are periodic reviews performed of coding accuracy? What types and how often?

---

Are production standards set for medical records staff? If so, what are the standards?

---

---

# CAH Quality Assessment by Functional Area

## Assessment Criteria

## Discussion

---

**CF** Are staff held accountable for productivity by measurable criteria? If so, describe criteria.

---

Are incentive plans available for coders? If so, describe incentives.

---

Are job descriptions current and in-depth?

---

### Procedures

Are coding staff able to see all services charged on the patient claim? If not, what can be seen?

---

Do coding staff assign codes other than surgical codes?

---

Are all diagnoses required to be coded on the patient record?

---

Are all procedures required to be coded (ICD-9) on the patient record?

---

Do coders only code from complete records? (All documentation is in chart)

---

Are pathology reports required to be in the chart before coding?

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# CAH Quality Assessment by Functional Area

## Assessment Criteria

## Discussion

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**CF** Prior to coding, are outpatient tests required to have a physician order in the chart?

---

Are discharge summaries required to be in the chart before coding?

---

**CF** Do only coders assign diagnosis codes on the record?

---

**CF** Are diagnoses only assigned based upon the physician documentation, rather than test results?

---

Do coders review records for medical necessity and compliance with Local Medical Review Policies?

---

Do coders contact physicians for diagnosis clarification if medical necessity criteria is not met?

---

With the exception of the Charge Description Master codes, do only coders assign CPT codes to record? If not, who else?

---

**CF** Are there policies in place regarding physicians' timely completion of charts?

---

Are physicians queried for additional clarification on what is in the chart?

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# CAH Quality Assessment by Functional Area

## Assessment Criteria

## Discussion

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Is the physician query/response (or lack thereof) documented in the chart?

---

Are physicians required to verify testing results in patient's record?

---

### Staff Issues

Describe the staffing in medical records

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Are coders' job duties limited to coding?

---

Do coders code ONLY inpatient or ONLY outpatient records?

---

How many coders are assigned solely to inpatient coding?

---

How many coders are assigned solely to outpatient coding?

---

**CF** Are hospital coding staff required to have continuing education? What types?

---

Are coders allowed to work flexible hours?

---

---

# *CAH Quality Assessment by Functional Area*

*Assessment Criteria*

*Discussion*

---

*Medical Records*

*Critical Factor Scoring*

Hospital Score

Possible Score

Assessment %

---

# CAH Quality Assessment by Functional Area

*Assessment Criteria*

*Discussion*

---

## *CDM - Charge Description Master*

### *Departmental Issues*

**CF** Has the CDM been updated or reviewed within the past year? If not, when was the most recent review?

---

**CF** Does the hospital have either a chargemaster committee or a CDM coordinator? Who is responsible for updates to codes?

---

**CF** Are Ancillary department managers responsible for annually updating CDM for new/deleted CPT codes?

---

Are surgical codes assigned by coders, rather than hard coded in the CDM?

---

**CF** Are Medicare remittance denials or non-covered charges due to invalid codes communicated to the CDM coordinator?

---

## *CDM - Charge Description Master*

### *Critical Factor Scoring*

Hospital Score

Possible Score

Assessment %

---

# CAH Quality Assessment by Functional Area

*Assessment Criteria*

*Discussion*

---

## *Business Office*

### *Departmental Issues*

Is there a "flow-chart" depicting the processes utilized in your department regarding revenue cycle activities?

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**CF** What billing software is used? Is the billing software up-to-date?

---

**CF** Is the billing software adequate for the hospital's needs?

---

**CF** Are computer edits in place to assist in filing clean claims?

---

Is there good cooperation between ancillary and business office staff?

---

Does the hospital's billing and collections effort have a good community reputation?

---

Does hospital have a designated "customer service representative" to handle patient inquiries, separate from the billers? Who is this representative?

---

What payers are not billed electronically?

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# CAH Quality Assessment by Functional Area

## Assessment Criteria

## Discussion

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What are significant causes of billing delays?

---

Are inservice meetings held periodically between the business office and registration staff? How often?

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### Management Reporting

**CF** Do staff prepare weekly A/R reports for management? What types of reports?

---

What types of reports are used to manage A/R?

---

**CF** Are reports of daily production (i.e. claims filed, outstanding A/R, cash collected etc.) posted for the staff to see? Provide examples.

---

**CF** Do staff report to management the number of days in A/R for discharged, not billed patients?

---

**CF** Are trend analyses performed of Medicare claims regarding denials or return to provider issues? Describe?

---

Are denial logs maintained?

---

**CF** Are denials reported to management and the responsible parties for corrective action?

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---

# CAH Quality Assessment by Functional Area

## Assessment Criteria

## Discussion

---

### Procedures

Are accounts assigned to billers based on payer?

---

Are accounts assigned to biller based on alphabet?

---

**CF** Are outpatient bills filed within five days of discharge? If not, how often?

---

**CF** Are inpatient bills filed within seven days of discharge? If not, how often?

---

Do billing staff have authority to adjust charges or codes on claims?

---

Do the billing staff identify missing charges?

---

Do the billing staff identify missing codes?

---

Is there a record of changes made to the claim form by billing staff? What type of record?

---

**CF** Do changes made by billing staff to the claim form require any approval? Whose approval?

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---

# CAH Quality Assessment by Functional Area

## Assessment Criteria

## Discussion

---

**CF** Is discharged, not billed A/R less than 7 days old?

---

Does staff have physician's current provider number(s)?

---

Are Medicare Bulletins distributed to all affected department managers?

---

What types of reports are available to identify edit problems? Describe.

---

**CF** Is documentation required in the patient record of all telephone conversations or communications with payers?

---

Are large dollar claims sent certified mail?

---

Are files maintained on insurance carriers with pertinent information regarding contacts, contract terms, etc?

---

Are claims stratified for follow-up efforts? If so, how?

---

**CF** Is information concerning missing or invalid registration information forwarded to the registration supervisor?

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# CAH Quality Assessment by Functional Area

## Assessment Criteria

## Discussion

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Are electronic remittances (Version 3051 4A) received from Medicare?

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Are electronic remittance files maintained for future reference?

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Are detailed remittances received from other payers?

---

Are remittances posted directly to patient accounts from electronic remittances?

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Are contractals computed and posted at time of billing?

---

Are contractals computed and posted directly from remittances?

---

**CF** Are credit balances remitted to payer or patient within 30 days? If not, when?

---

**CF** Are unclaimed credit balances remitted to state as unclaimed property? If not, why?

---

### *Staff Issues*

Describe the staffing in the business office

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# CAH Quality Assessment by Functional Area

## Assessment Criteria

## Discussion

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**CF** Do staff receive ongoing formal training in job functions? What types of training?

---

**CF** Is there low staff turnover in the business office?

---

Are there current job descriptions that fully describe the duties of staff?

---

**CF** Do you feel the department is adequately staffed?

---

**CF** Are staff held accountable for productivity by measurable criteria? If so, what criteria is used?

---

<i>Business Office</i>			
<i>Critical Factor Scoring</i>	Hospital Score	Possible Score	Assessment %

---

# CAH Quality Assessment by Functional Area

Assessment Criteria

Discussion

---

## Collections

### Departmental Issues

Is there a "flow-chart" depicting the processes utilized in your department regarding revenue cycle activities?

---

**CF** Are signs on display stating that co-pays are expected at time of service unless other arrangements have been made?

---

**CF** Is there a formal credit/collection policy?

---

Are collection procedures specific for certain payer types?

---

Are collection procedures specific for certain patient types (ER, OP, IP, Surgery)?

---

Are collection procedures specific for certain account balances?

---

Are collection procedures specific for certain collection methods (telephone, mail, etc.)?

---

Are any automated "follow-up" tools used? If so, list.

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# CAH Quality Assessment by Functional Area

## Assessment Criteria

## Discussion

---

Are multiple collection agencies used?

---

### Management Reporting

**CF** Do staff prepare performance reports for management? If so, what types of reports?

---

Are reports of daily production (i.e. claims filed, outstanding A/R, cash collected etc.) posted for the staff to see? If so, provide example.

---

### Procedures

Do staff keep patients informed about an account's status? How?

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**CF** Does the hospital aggressively pursue collection efforts? How?

---

**CF** Does the hospital actively pursue Medicaid status for eligible patients? How?

---

**CF** Are patients required to "check out" before leaving hospital to arrange payment?

---

Do hospital collections staff make collection calls after business hours?

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# CAH Quality Assessment by Functional Area

## Assessment Criteria

## Discussion

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Are bad debtors reported to credit bureaus?

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Does hospital utilize small claims (magistrate's) court to collect small claims?

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Do hospitals collections staff provide insurers with requested documentation within 3 days of request by insurer?

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Do hospital collections staff utilize timely payment laws in pursuing collection from insurance companies?

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Do staff report credit balances of Medicare patients to Medicare on a timely basis? How often?

---

**CF** Are collection letters used?

---

Is there a policy to determine at which point in a collection process, certain letters are mailed? If so, discuss.

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### Staff Issues

Describe the staffing in collections

---

**CF** What is the ratio of collectors to claims?

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# CAH Quality Assessment by Functional Area

## Assessment Criteria

## Discussion

---

What is the average experience of collectors?

---

Do collectors receive ongoing formal training in job duties? What types of training?

---

**CF** Are staff held accountable for productivity by measurable criteria? What criteria?

---

**CF** Are goals set to track performance? Describe goals.

---

Is a bonus/incentive plan in place? Describe.

---

Are flexible hours used for staffing department?

---

Are job descriptions current?

---

### *Collections*

#### *Critical Factor Scoring*

Hospital Score

Possible Score

Assessment %