



GEORGIA DEPARTMENT OF  
COMMUNITY HEALTH

# Critical Access Hospital Financial Analyses – 2008

**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 the 11 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. Ten of the 11 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.

Since June 2007, eight of the 11 participants have experienced significant turnover in key management positions. One hospital also has changed ownership during 2008. 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. Only one of the 11 CAHs included in this report had a positive operating margin or return on equity. The median days cash on hand was less than 11 days. The median occupancy was 29 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 68 percent. The remaining 32 percent of inpatients were largely uninsured.

Poverty and unemployment levels in the CAH counties are higher than the state average. Each of the 11 participants is 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. 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 11 participants, seven 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.

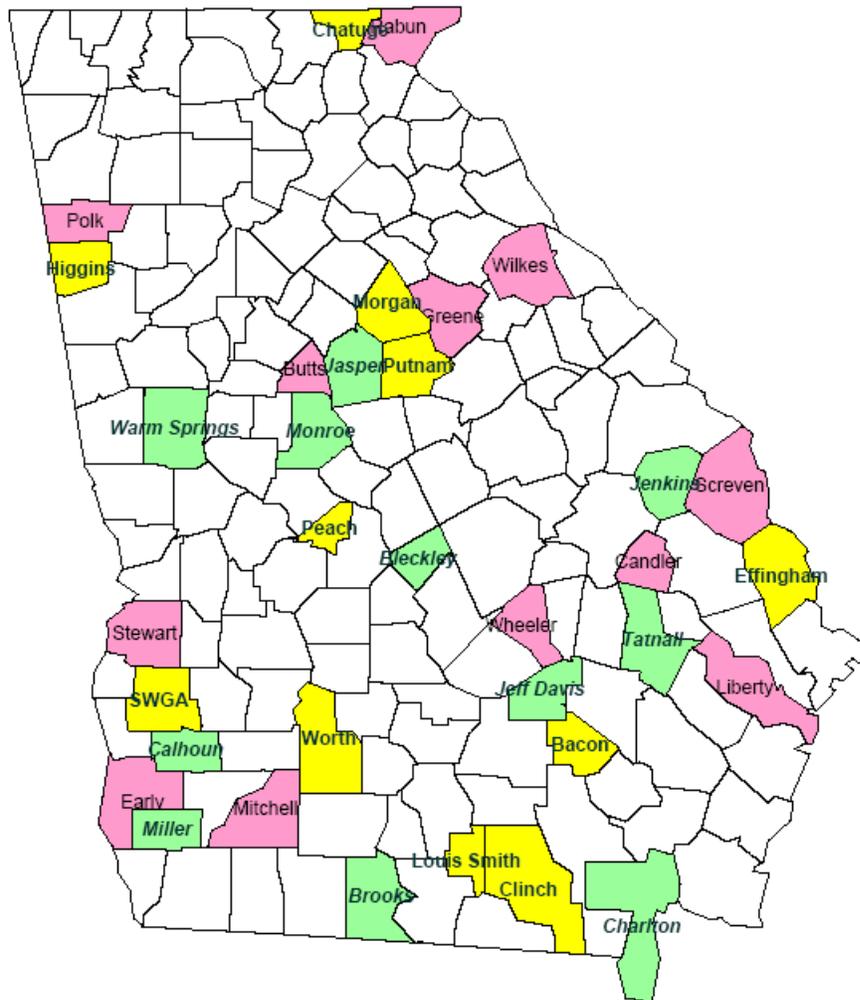
Revenue cycle improvements are needed. The CAH national average of days in accounts receivable average was 59. The CAH average for the southern part of the country was 58.7. The median among the participants was 59.27. There were notable differences in the business office staffing of the facilities, ranging from low staffing to outsourcing. Charge description masters were not current and 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, 22 have participated in this project. The counties highlighted in green 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 a previous fiscal analysis. The counties highlighted in pink represent the locations of the remaining CAHs.



## Jeff Davis Hospital



Jeff Davis Hospital, located in Hazlehurst, Georgia, is part of the Jeff Davis County Hospital Authority. Located in the middle of southeast Georgia, Jeff Davis County is in the heart of farming country. As of 2007, the population of the county was 13,291. The hospital attained CAH status on October 1, 2004 and is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JACHO).

### Community Information

Hazlehurst compared to Georgia state average:

- Median household income below 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:

- Providing new services to the community
- Recruiting new physicians
- Staying current on regulatory changes
- Keeping revenue in the community
- Reimbursement issues

## Monroe County Hospital

Monroe County Hospital is located in Forsyth, Georgia. The Hospital Authority of Monroe County was created in 1954 with financial assistance from the Hill-Burton Act. A new hospital was built in 1976 and is the building currently in use today. The hospital attained CAH status on September 12, 2001 and is JCAHO accredited. The hospital received statewide quality awards for 2006, 2007 and 2008. Services provided by the hospital include:



- Surgery and endoscopy
  - General, GYN, podiatric, interventional radiology
- ER is physician staffed 24/7, average turnaround 1.5 hours
- Radiology: 5 day per week MRI, 16-slice CT, Ultrasound, Echocardiography, Mammography, all digital PACS system
- Laboratory: Any test available, in-house microbiology
- Inpatient care: Adult, pediatrics, geriatrics
- Swing bed service

Forsyth has a population of approximately 4,600 while Monroe County has a population of approximately 25,000 residents. Forsyth is located approximately 24 miles from Macon and 60 miles from Atlanta, Georgia.

### Community Information

Forsyth 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

Management feels that the most significant challenges facing the hospital are:

- Uncertainty of state and local financial support for indigent and charity care
- Inability to attract new physicians to the community

# Calhoun Memorial Hospital

Calhoun Memorial Hospital, located in Arlington, Georgia, is part of the Hospital Authority of Calhoun County. In addition to the hospital, the Authority operates Calhoun Nursing Home, Robert E. Jennings Medical Clinic and Willowood Personal Care Home. The hospital elected CAH status in August 2000. The hospital has just completed a \$1.2 million capital expansion and upgrade of diagnostic imaging equipment.



In 2007 Calhoun County had approximately 6,100 residents, while the city of Arlington had 1,500 residents. Arlington is located approximately 40 miles east of Albany, Georgia.

## Community Information

Arlington 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 greatest challenge to the financial viability of the hospital is:

- Providing services to area citizens without insurance coverage or ability to pay for services rendered

## Jenkins County Hospital

The Jenkins County Hospital Authority operates the Jenkins County Hospital, a general medical and surgical facility serving the healthcare needs of the people of Millen and neighboring areas in Jenkins County. Hospital services include outpatient surgery, swing beds, therapy and hospice services. The hospital has recently received over \$500,000 in Congressional grants. The hospital elected CAH status on December 7, 2000.

The estimated population of Jenkins County is 8,700, while that of Millen is estimated at 3,500.

### Community Information

Millen compared to Georgia state average:

- Median household income significantly 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

No specifics provided.

:

# Bleckley Memorial Hospital



The Hospital Authority of Bleckley County was created in 1969 to operate Bleckley Memorial Hospital. Located in Cochran, Georgia, the hospital elected CAH status on October 14, 1999. The hospital is accredited by JCAHO. Services provided by the 25 bed hospital include outpatient surgery, physical therapy and emergency services.

The population of Bleckley County is estimated at 12,000. Cochran, with a population of 4,500 is home to Middle Georgia College, the oldest two-year college in America.

## Community Information

Cochran compared to Georgia state average:

- Median household income 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

According to hospital management, the most significant challenges to the financial viability of the hospital are:

- Inability to attract physicians to rural areas
- Physicians' preference to treat only outpatients

## Brooks County Hospital



Brooks County Hospital (BCH) is located in Quitman, Georgia. BCH first opened its doors in 1935 with 15 beds. In 1987 the Hospital Authority of Brooks County leased the facility to John D. Archbold Memorial Hospital. On May 1, 2003, Brooks County Hospital elected CAH status. BCH offers a variety of services to the community including cardiovascular, diagnostic, dialysis and rehabilitation services. BCH maintains full accreditation

by the JCAHO. The hospital has recently experienced significant improvement in customer satisfaction scores.

The population of Brooks County is estimated at 16,450 and the city of Quitman has approximately 450 residents.

### Community Information

Quitman compared to Georgia state average:

- Median household income significantly 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

According to hospital management, the most significant challenges to the financial viability of the hospital are:

- Increasing aged, uninsured population
- Recessed economy

## Warm Springs Medical Center

Warm Springs Medical Center (WSMC) was founded in 1957 as Meriwether Memorial Hospital. Originally a 38 bed hospital, WSMC was leased by Georgia Baptist in 1996. Georgia Baptist invested over 12 million dollars to add new radiology services, an operating room, labor and delivery suites, an endoscopy suite and a Dual Energy X-ray Absorptiometry (DEXA) scanner. In April 2001, WSMC attained CAH status. In July 2004, the hospital name was changed to Warm Springs Medical Center. The hospital is 100 percent owned by the Hospital Authority of Meriwether County. The hospital is JCAHO accredited.

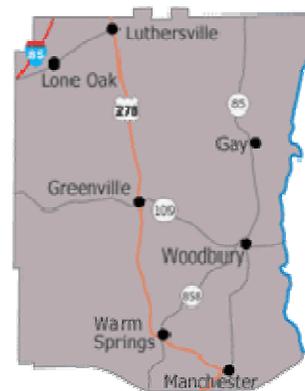


Meriwether County has a population of approximately 22,500, while the population of Warm Springs is estimated at 485.

### Community Information

Warm Springs compared to Georgia state average:

- Median household income 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

According to hospital management, the most significant challenge to the financial viability of the hospital is:

- Governmental third-party (Medicare/Medicaid) reimbursement

## Doctors Hospital of Tattnall



The Doctors Hospital of Tattnall is located in Reidsville, Georgia. The hospital became a CAH on March 1, 2002. Hospital services include orthopedic surgery, physical therapy, hospice, swing bed, respite care and other ancillary services. The hospital also has affiliate satellite sites for outpatient care.

The estimated population of Tattnall County is 22,500, while that of Reidsville is 2,235.

### Community Information

Reidsville compared to Georgia state average:

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

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



### Challenges

According to hospital management, the most significant challenge to the financial viability of the hospital is:

- Control of bad debts

## Jasper Memorial Hospital

Jasper Health Services, Inc., operates Jasper Memorial Hospital and The Retreat Nursing Home. Jasper Memorial Hospital is a facility of the Oconee Regional Health System. Located in Monticello, Georgia, the hospital elected CAH status on January 1, 2000.



The population of Jasper County is estimated at 11,500, while that of the county seat of Monticello is estimated at 2,428.

### Community Information

Monticello compared to Georgia 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

According to hospital management, the most significant challenges to the financial viability of the hospital are:

- Low patient volume
- Need for financial support from county
- Uncertainty of continued state indigent care supplemental payments
- Bad debt reimbursement

# Charlton Memorial Hospital



Charlton Memorial Hospital, located in Folkston, Georgia, has been operated by the Charlton County Hospital Authority since 1970. The hospital elected CAH status on March 1, 2001. Located in extreme southeast Georgia, Charlton County contains a large portion of the Okefenokee National Wildlife Refuge.

The estimated population of Charlton County is 10,282, while that of Folkston is 2,178.

## Community Information

Folkston 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

According to hospital management the most significant challenges to financial viability are:

- Training of staff
- Access to capital funding
- Physician recruitment
- Funding depreciation
- Finding quality staff

## Miller County Hospital

Miller County Hospital has been serving Colquitt, Georgia residents since 1957. This 25 bed, critical access not-for-profit hospital was named "The Hospital of the Year" in 2000 by the Home Town Health Association. The hospital elected CAH status on February 24, 2000.



The hospital offers a full range of inpatient and outpatient services that include 24-hour emergency room services, outpatient mental health services, an outpatient surgery program and rehabilitative services.

The estimated population of Miller County is 6,383, while that of Colquitt is 1,839.

### Community Information

Colquitt 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))

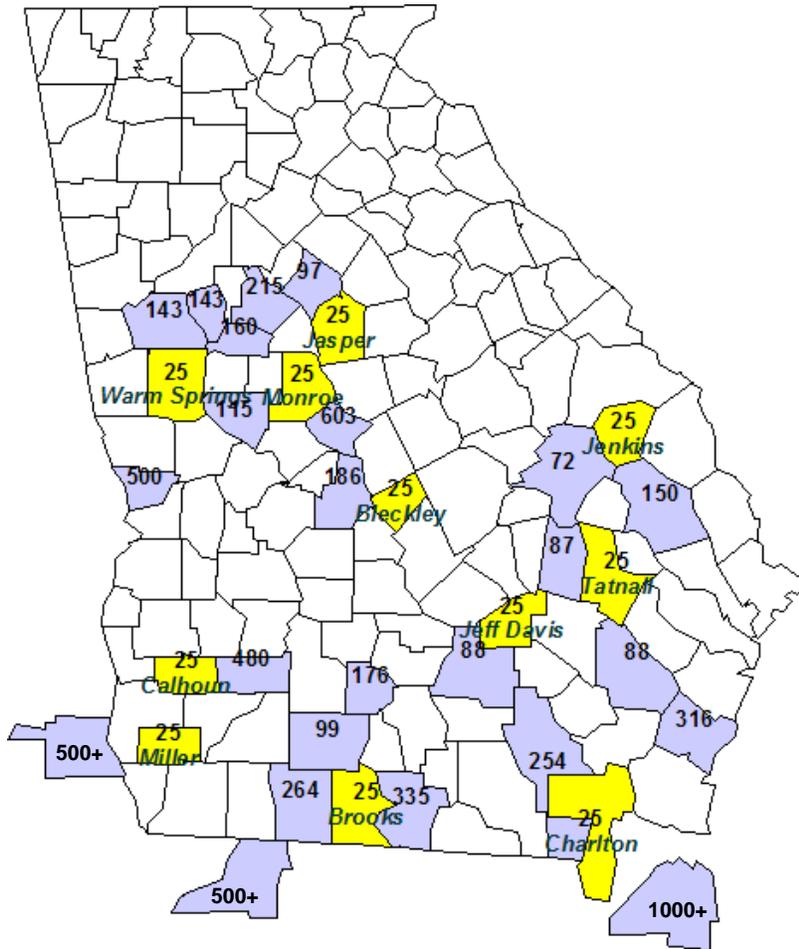
### Challenges

According to hospital management, the most significant challenges to the financial viability of the hospital are:

- Debt of facility
- Volatility of cash flow

## 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 yellow are locations of the participating CAHs, while counties highlighted in blue represent the closest tertiary care facilities and their bed sizes.



CAH	Distance to larger facility
L	37 miles
M	27 miles
N	25 miles
O	35 miles
P	28 miles
Q	24 miles
R	35 miles
S	46 miles
T	20 miles
U	29 miles
V	36 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 experience of the Chief Executive Officers (CEOs) and the Chief Financial Officers (CFOs) of the participants as indicated in the table below.

	Chief Executive Officer			Chief Financial Officer		
	AGE	YEARS TENURE	YEARS AGGREGATE HOSPITAL EXPERIENCE	AGE	YEARS TENURE	YEARS AGGREGATE HOSPITAL EXPERIENCE
<b>L</b>	76	6 months	40+ years	30	1 year	3 years
<b>M</b>	50	10 years	18 years	45	10 years	10 years
<b>N</b>	34	3 months	12 years	Corporate position		
<b>O</b>	48	3 months	20+ years	29*	3 months	< 1 year
<b>P</b>	50	<6 months	< 6 months	54	28 years	28 years
<b>Q</b>	54	4 years	23 years	42	11 years	15 years
<b>R</b>	67	15 months	42 years	67	18 months	36 years
<b>S</b>	51	2 months	30 years	48	1 month	6 years
<b>T</b>	50	8 years	20+ years	44	2 months	8 years
<b>U</b>	69	10 years	10 years	Position is vacant		
<b>V</b>	52	1 year	29 years	50	18 months	28 years

\*Finance Director

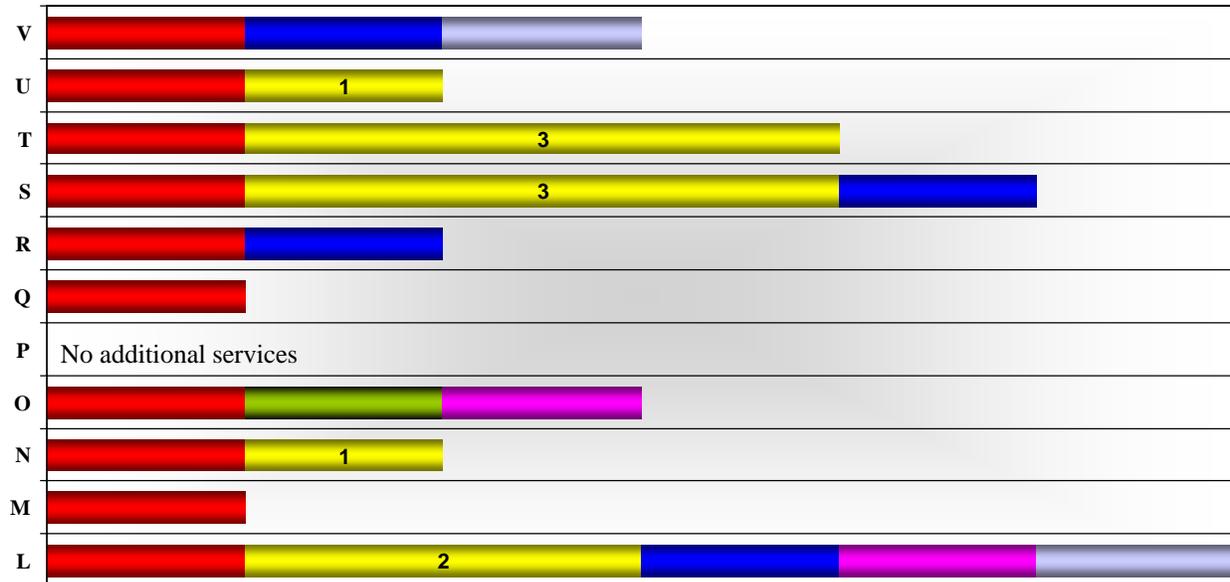
Hospital experience ranged from a low of six months, to a high of 42 years among the CEOs and a low of three years to a high of 28 years among the CFOs. Tenure at the participating hospitals ranged from a low of two months to a high of 10 years for the CEOs and a low of 18 months to a high of 28 years for the CFOs.

Ages of the CEOs ranged from 34 to 76, while those of the CFOs ranged from 29 to 67.

Hospital O employs a Finance Director rather than a CFO, Hospital U does not have a CFO position.

## Service Components

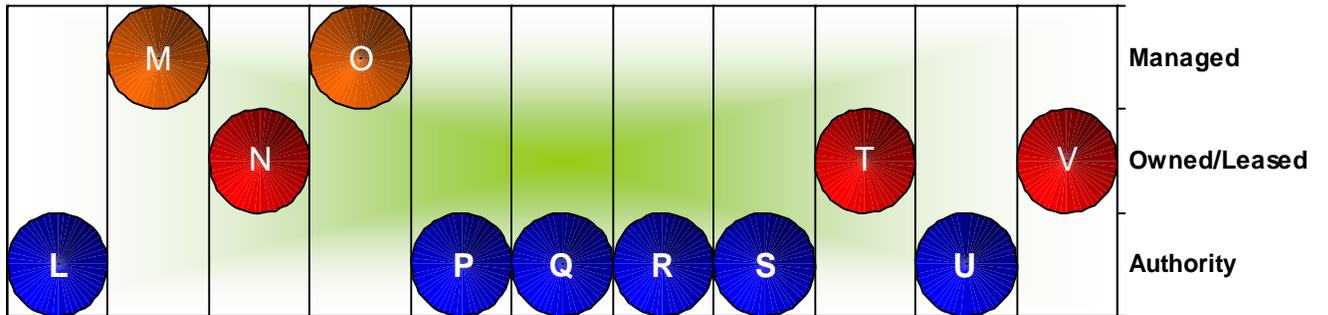
A significant factor affecting the comparability of CAH financial information is the degree of service integration among the participants. Medicare and Medicaid cost per day will be reduced with the ability to spread fixed costs over other service components. As indicated below, each facility offers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



Summary	
<b>Swing Beds</b>	<b>10</b>
<b>Rural Health Clinic(s)</b>	<b>5</b>
<b>Skilled Nursing Facilities</b>	<b>4</b>
<b>Physician Practices</b>	<b>1</b>
<b>Ambulance Services</b>	<b>2</b>
<b>Other</b>	<b>2</b>

## 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.

CAH	Fiscal Year End
L	03/31/08
M	03/31/08
N	09/30/07
O	06/30/07
P	09/30/07
Q	09/30/07
R	12/31/07
S	06/30/07
T	12/31/07
U	06/30/07
V	09/30/07

National CAH averages included in various charts were obtained from the *2008 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 August 2007.

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.

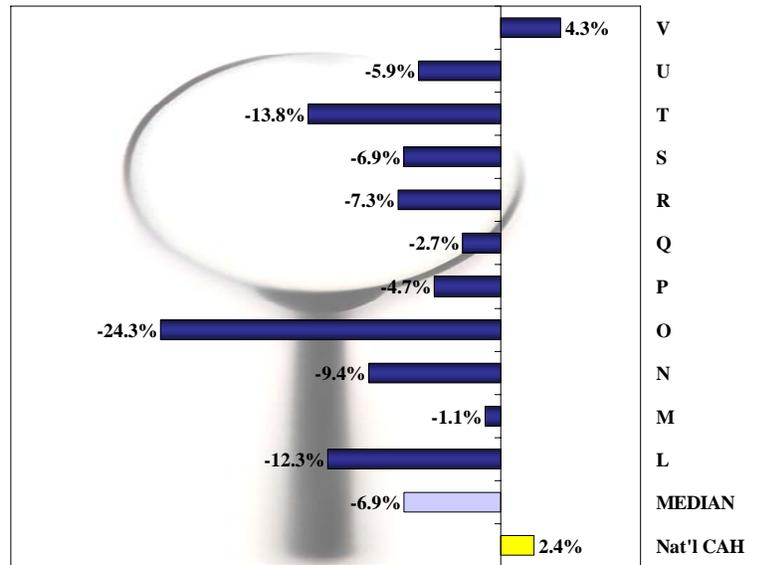
## Key Financial Ratios

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

Ten of the 11 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.

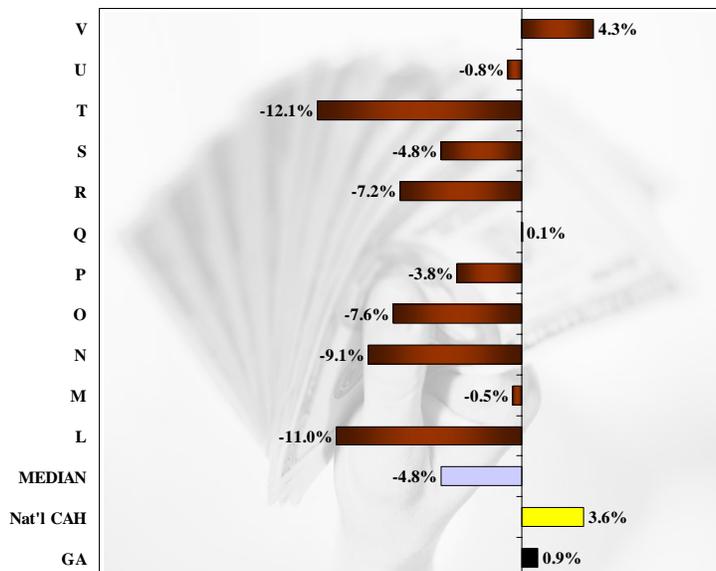
### Operating Margin

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



### Total Margin

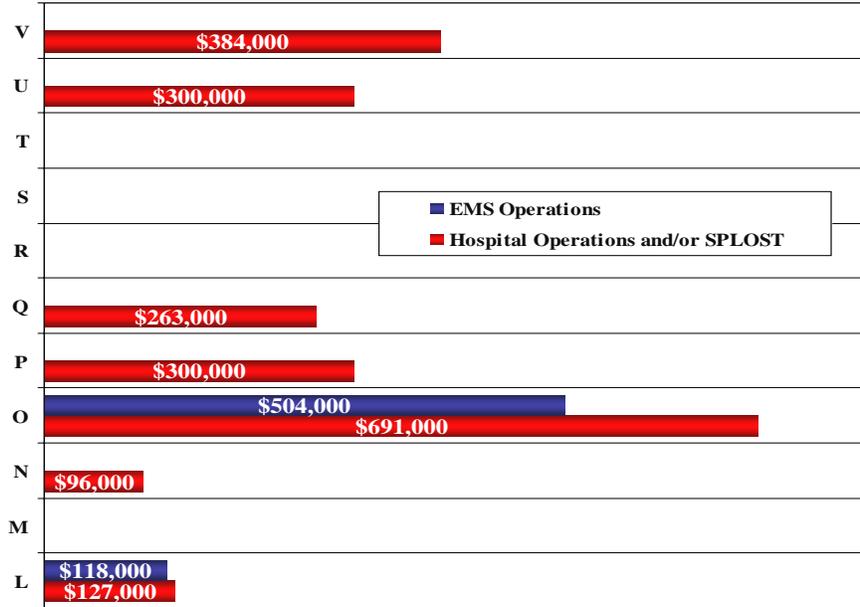
$(\text{Excess Revenues over Expenses} / \text{Total Revenue}) \times 100$



Nine of the 11 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 O, received county support of over one 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.

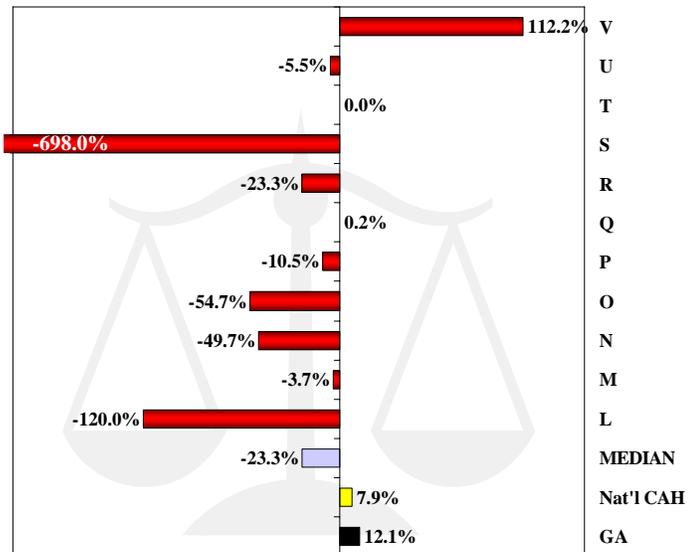
### County Contributions toward Hospital Operations



Eight of the participants experienced negative return on equity. These eight facilities also had net losses for the fiscal year. 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. Due to a recent sale, Hospital T's percentage is not included in this chart. The percentage for Hospital S is -698.0 percent.

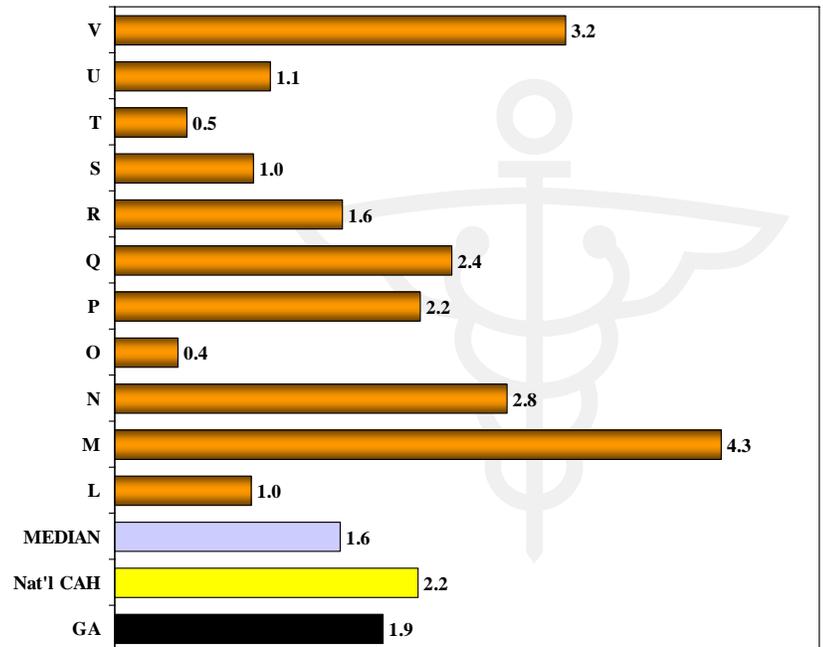
### Return on Equity

(Excess Revenues over Expenses / Net Assets) x 100



# Current Ratio

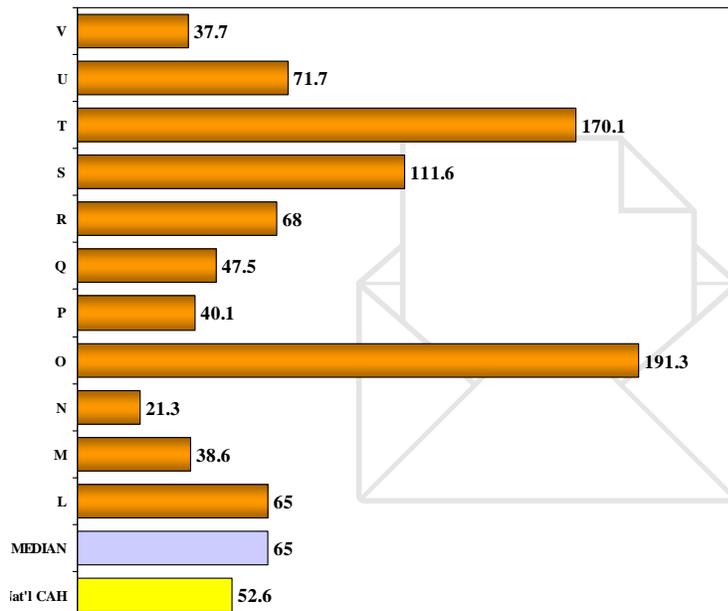
Current Assets / Current Liabilities



There were significant variances in current ratio among the participants, ranging from .4 to 4.3. 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.

# Average Days Payment Period

Current Liabilities / ((Total Expenses – Depreciation Expense) / 365)

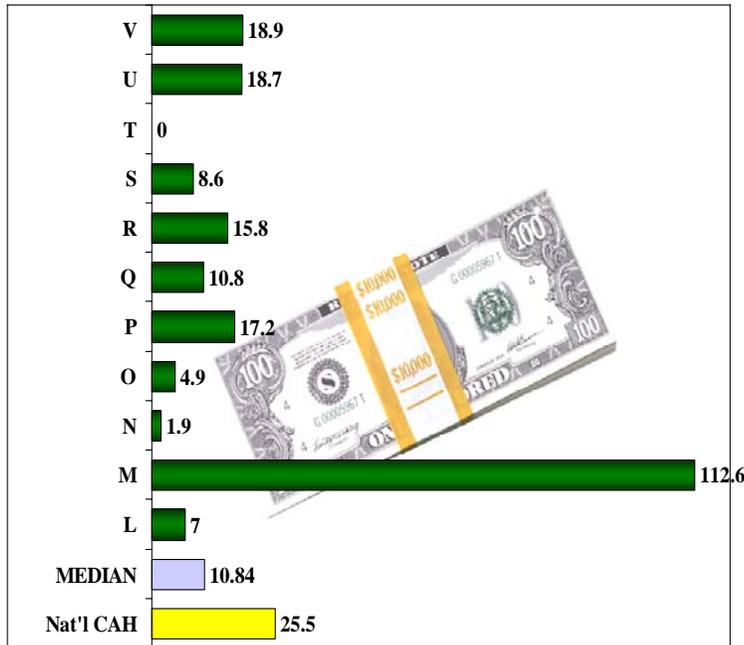


The Average Days Payment Period of the participants ranged from 21.3 days to 191.3 days. This ratio provides a measure of the average time that elapses before current liabilities are paid. The denominator in the ratio is an estimate of the hospital's average daily cash expenses minus depreciation. The 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.

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

## Days Cash on Hand, Short-term

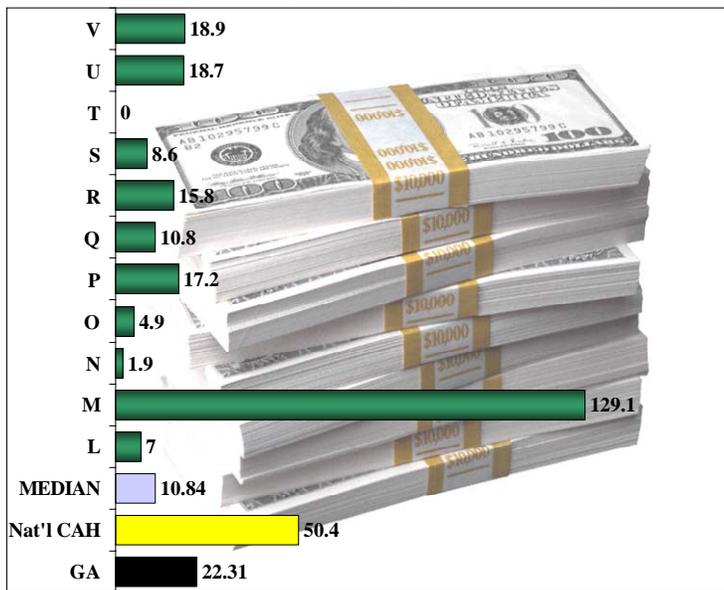
$(\text{Cash} + \text{Short term Investments}) / ((\text{Total Expenses} - \text{Depreciation Expense}) / 365)$



The short-term days cash on hand ranged from zero days to 112.6 days. 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. The cash for Hospital N is swept nightly to the home office account.

## 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 zero days to 129.1 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.

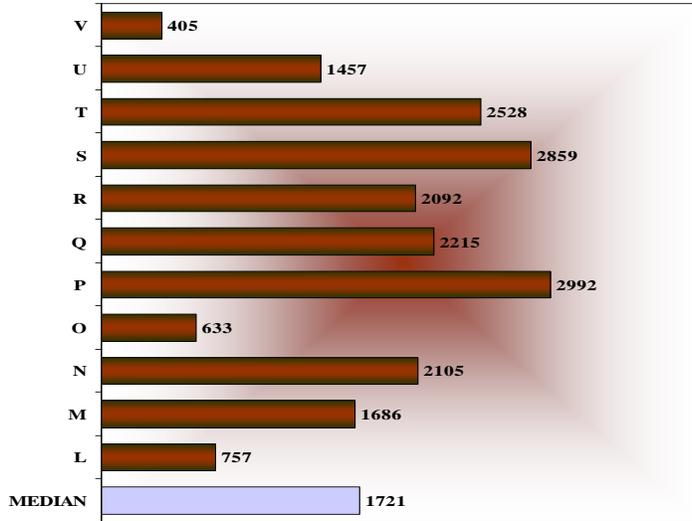
Medicaid SWB providers are reimbursed a prospective rate per patient day which will be the statewide average Medicaid rate per diem paid to SNFs for routine services furnished during the previous calendar year. Medicaid will reimburse the Medicare Part A coinsurance for skilled level of care SWB services 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

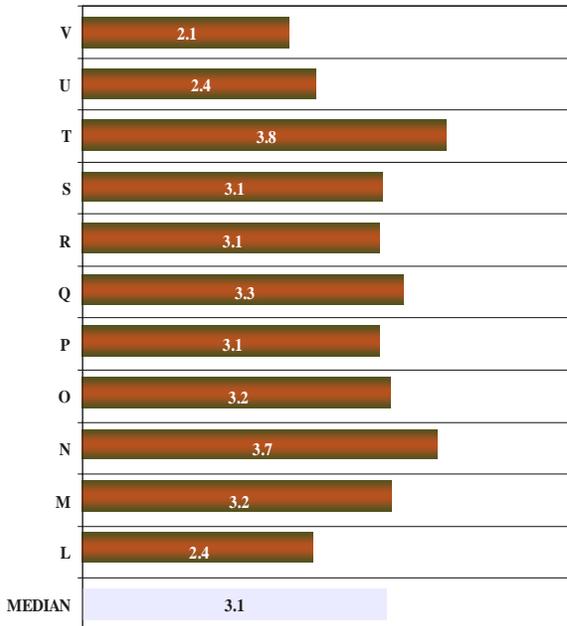
### Patient Days - Acute



Amounts shown indicate days

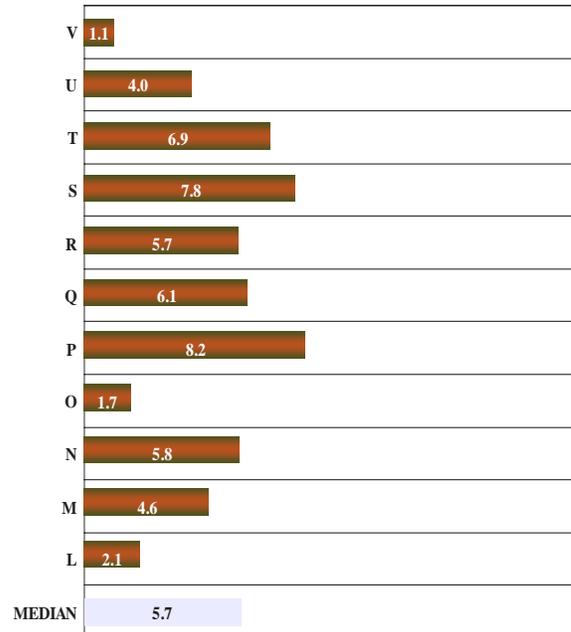
Inpatient volume varied significantly among the study participants ranging from a low of 405 days to a high of 2,992 days. Patient volume is significantly affected by the ability of the CAH to attract physicians to the community, as well as, referral patterns from nearby hospitals.

### Average Length of Stay



Amounts shown indicate days

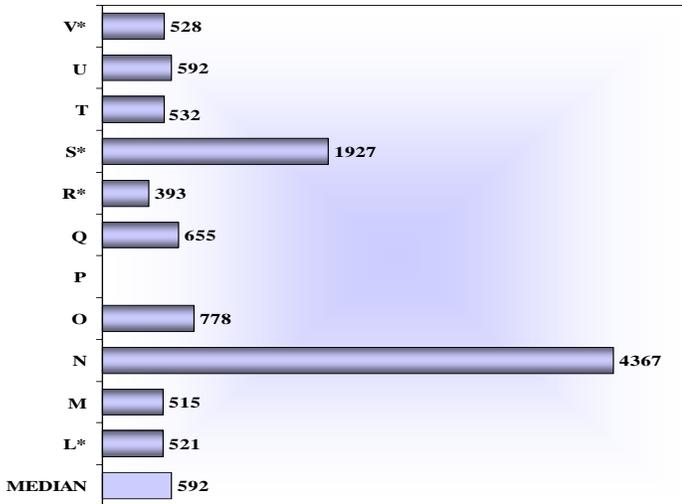
### Average Daily Census



Amounts shown indicate patients

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

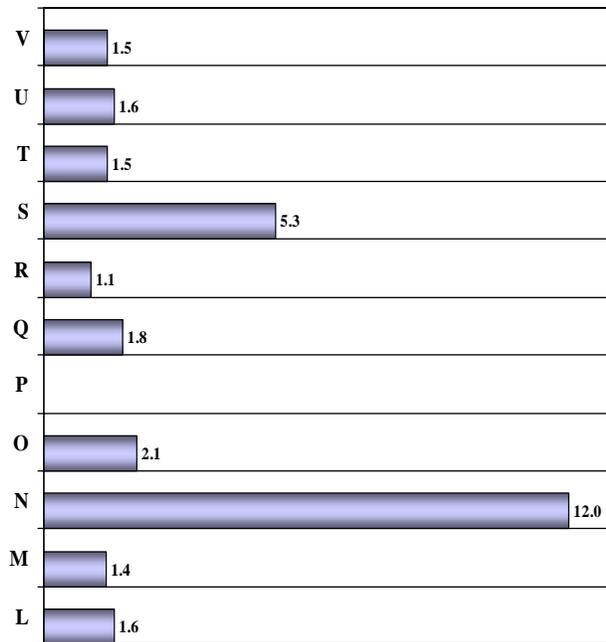
## Patient Days – Swing Bed



\* CAHs with SNFs

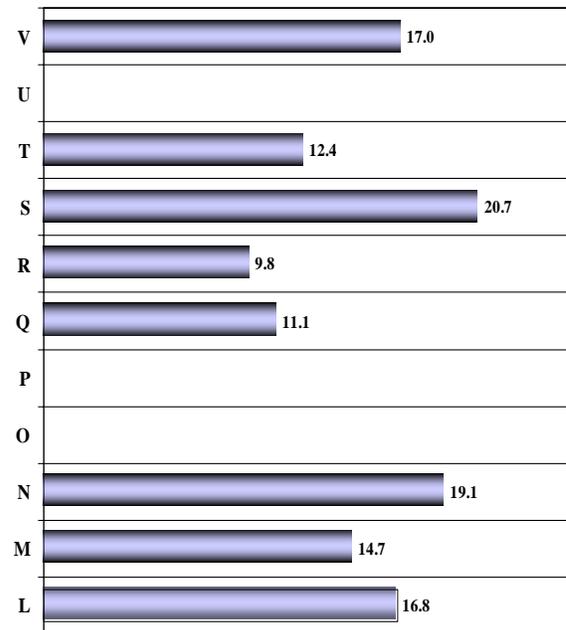
SWB volumes ranged from a low of 393 days to a high of 4,367 days. Hospital P does not participate in the SWB program. SWB reimbursement typically results in increased Medicare use and therefore more cost coverage. Hospital N is part of a hospital system and provides rehabilitation and follow-up services to the system's patients. There were mixed comments regarding the impact of a provider-based SNF on the SWB program. Some hospital executives stated this positively impacted SWB volume, while others stated the opposite.

## SWB Average Daily Census



Amounts shown indicate days

## SWB Average Length of Stay

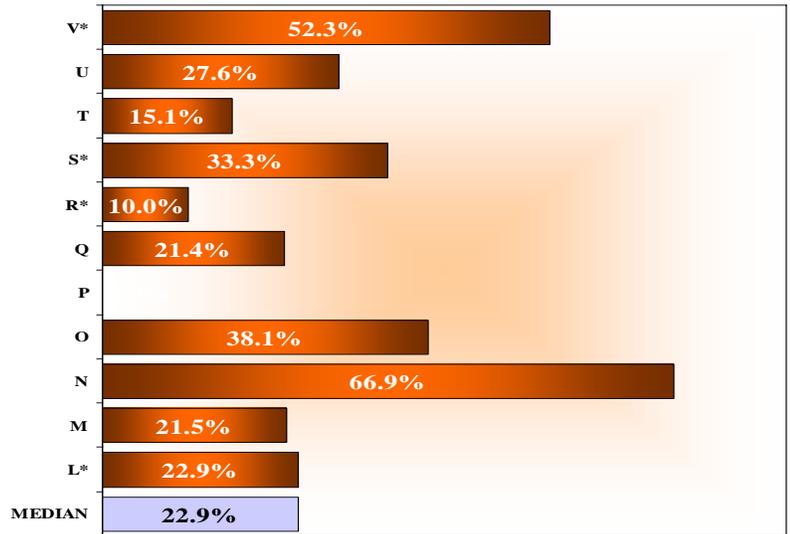


Amounts shown indicate patients

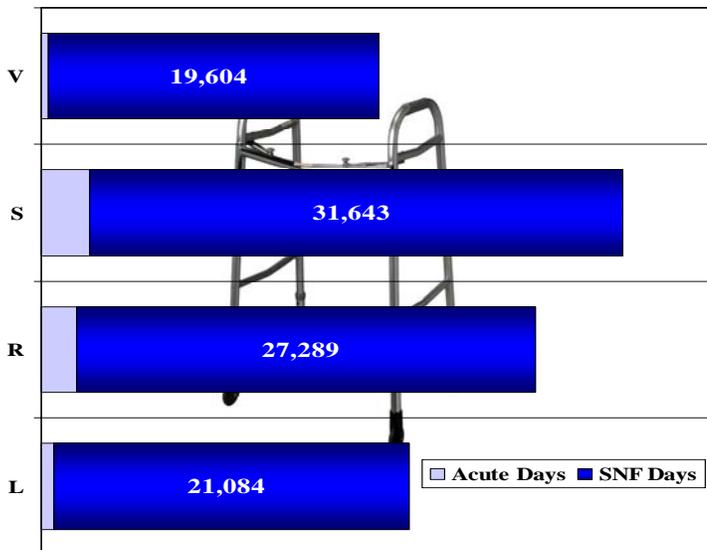
There were significant differences in both average daily census and average length of stay among the participants. Some CAHs are providing post-orthopedic and stroke after-care to the patients, while others are using the swing beds as an interim level of care between the acute and SNF setting.

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



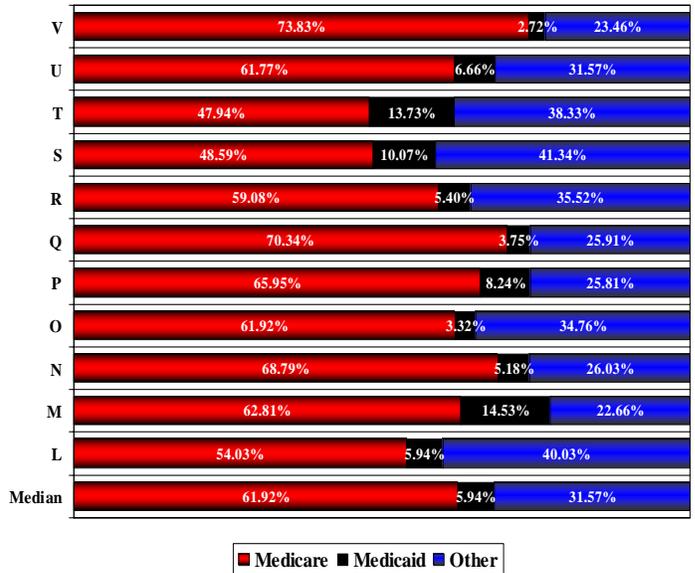
Four of the participants also operate SNFs. The SNF patient days in these facilities overshadow those from the CAH acute stays. This situation will significantly impact expense comparisons due to the sharing of staff among the components. The presence of a SNF can prove beneficial to the overall profitability of the CAH if costs can be maintained below the state Medicaid cost limits. Due to recent budgetary constraints, Georgia Medicaid is more strictly enforcing eligibility requirements. Some SNFs are experiencing census reductions due to these enforcement actions.

## Patient Volumes by Payer

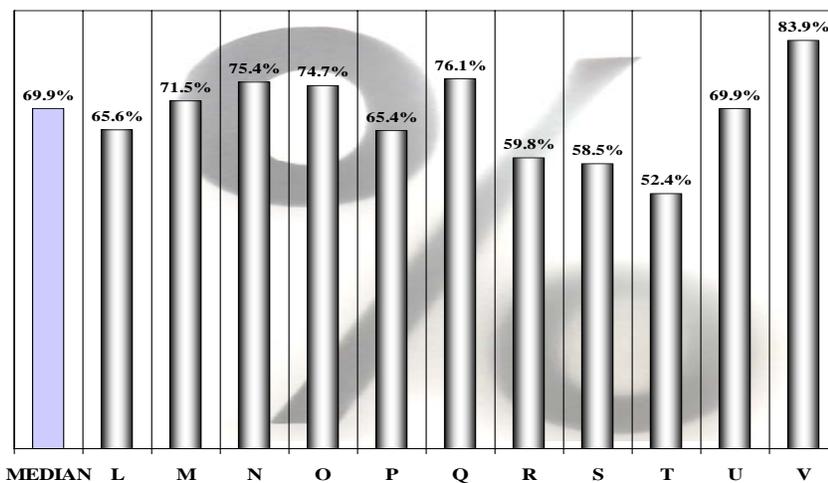
The higher the Medicare utilization, the more difficult it is for a CAH to generate a profit. Medicare will reimburse 101 percent of its share of allowable cost; therefore profits must come from other payer sources.

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 & Swing Bed)

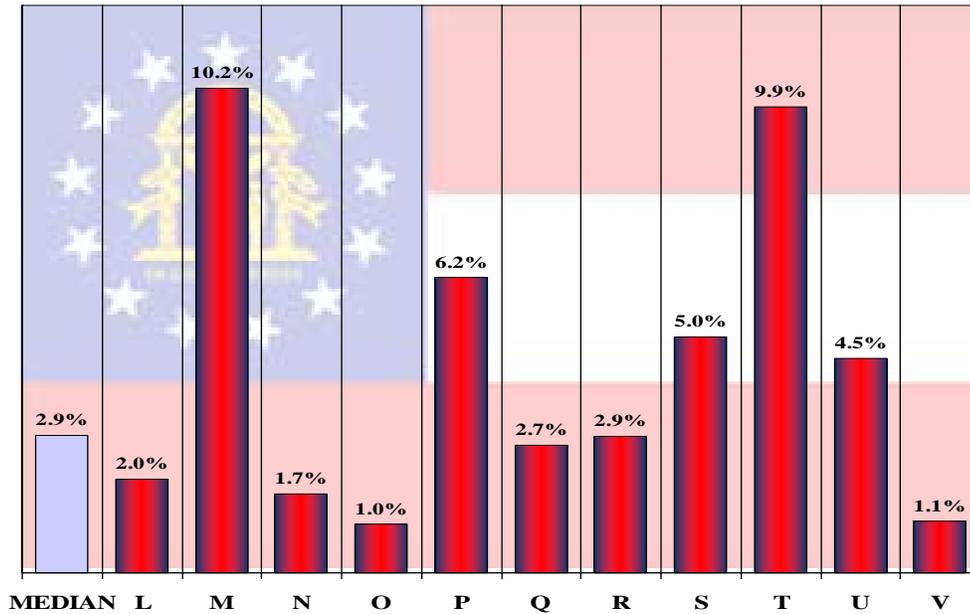


Combining inpatient utilization in the acute and swing bed programs resulted in higher concentrations of Medicare utilization. Hospital T has the lowest combined percentage of 52.4 percent, while Hospital V had the highest combined percentage of 83.9 percent.

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)

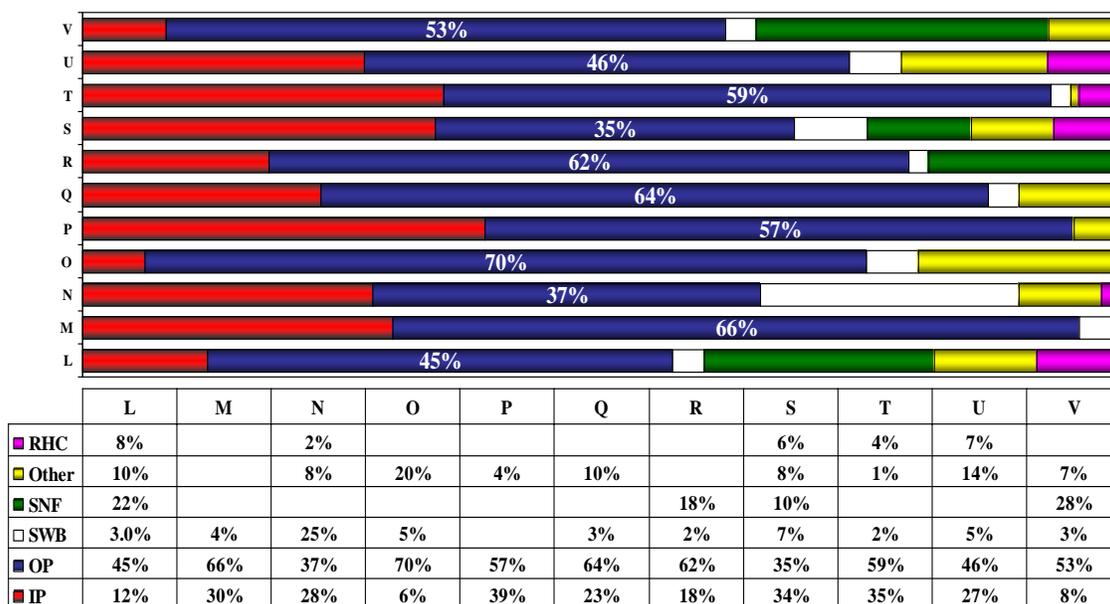
Does not include Medicaid Managed Care days



## 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.

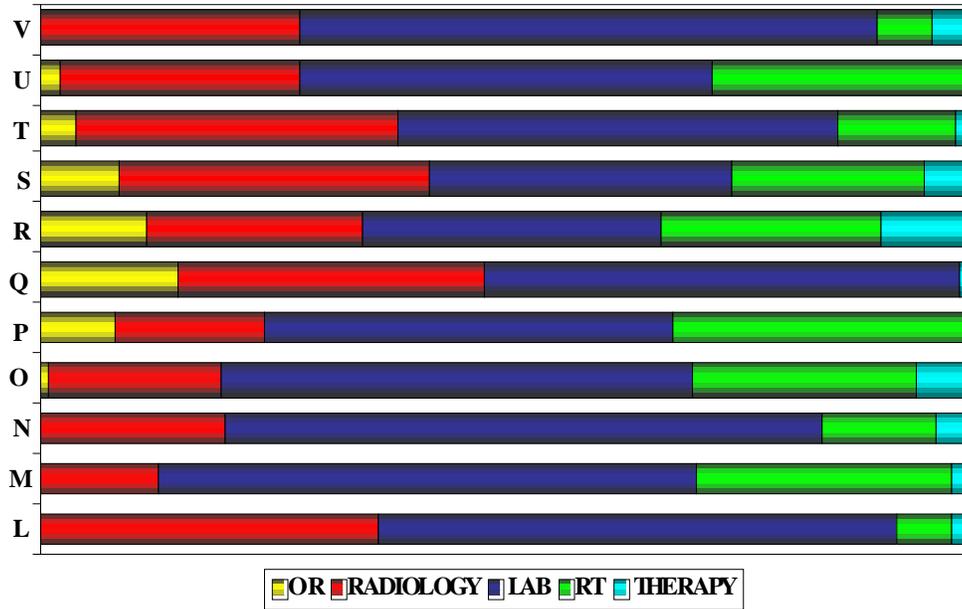
### Revenue Percentage by Service Type



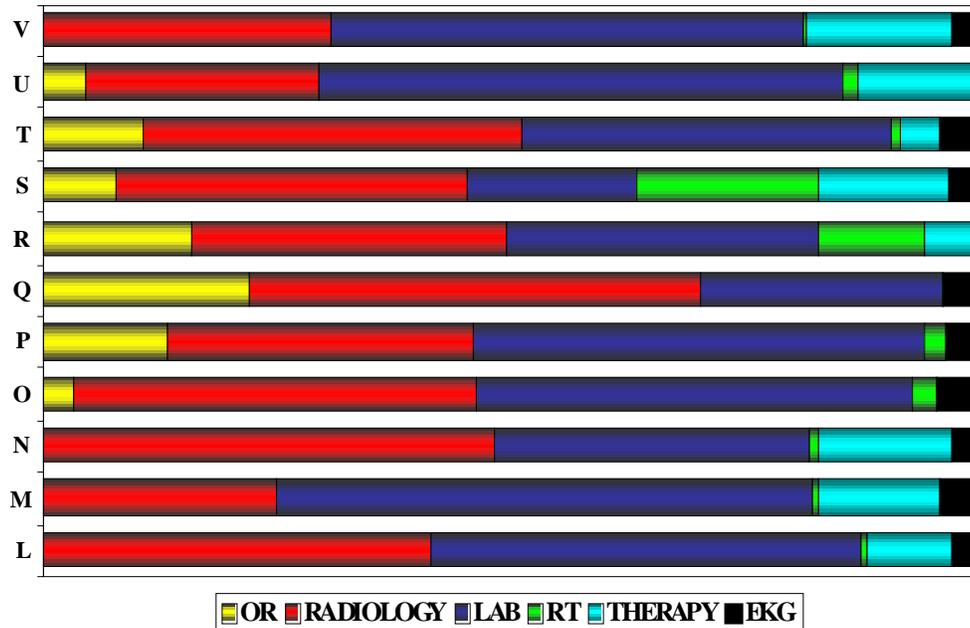
The data table provides further detail regarding the composition of revenues generated from various components of the participating hospitals. Outpatient revenues ranged from a low of 35 percent to a high of 70 percent.

The variety and volume of ancillary services provided will also affect comparability among the CAH participants. Seven of the participants provided limited surgery services, primarily endoscopic surgeries. 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

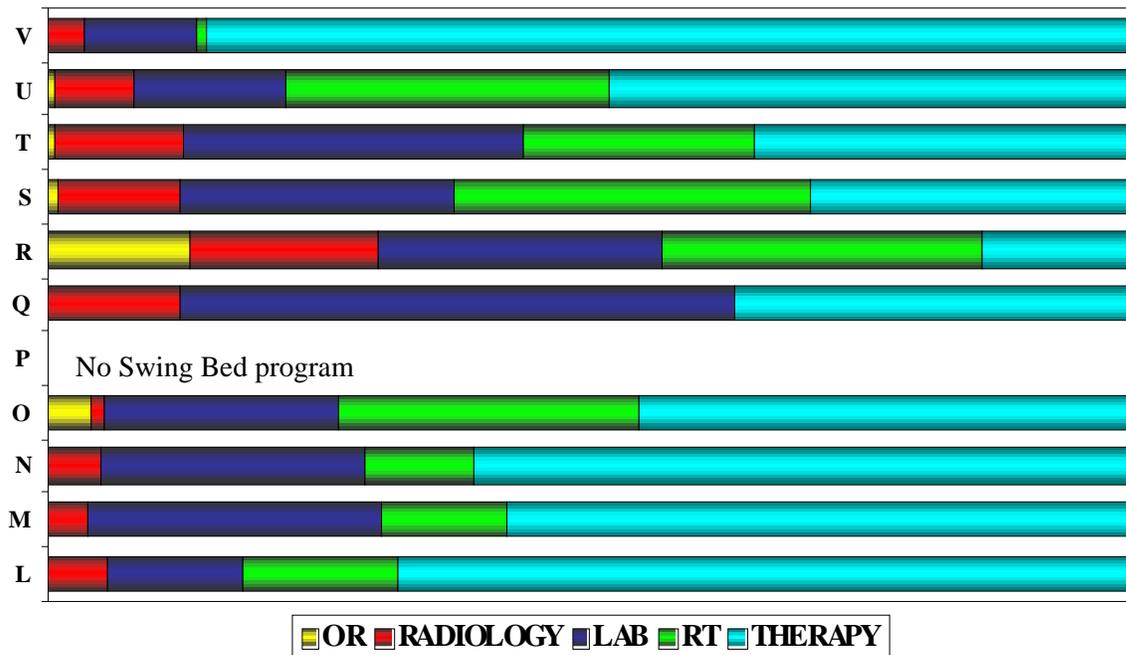


### Medicare Outpatient Ancillary Services



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



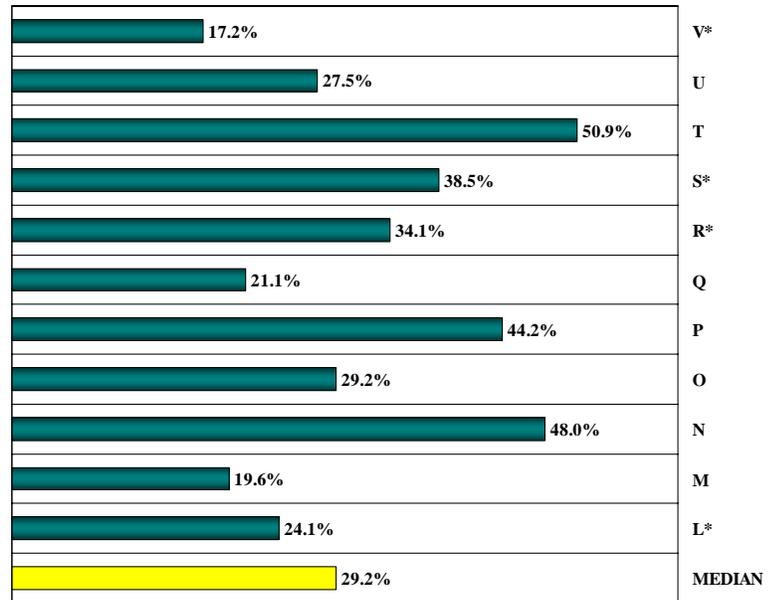
## Deductions from Revenues

The contractual allowance percentages ranged from a low of 17.2 percent to a high of 51.9 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 the inclusion of:

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

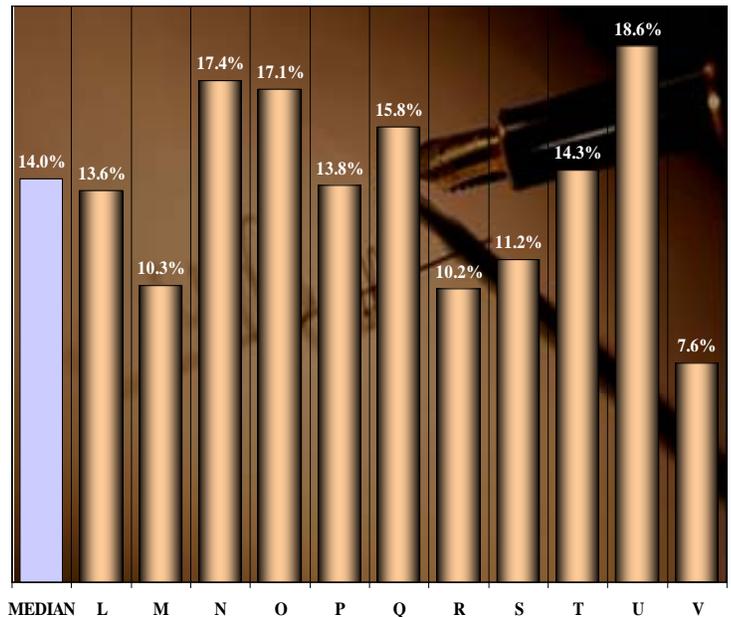
Hospitals noted with asterisks have SNF components.

### Contractual Allowance Percentage



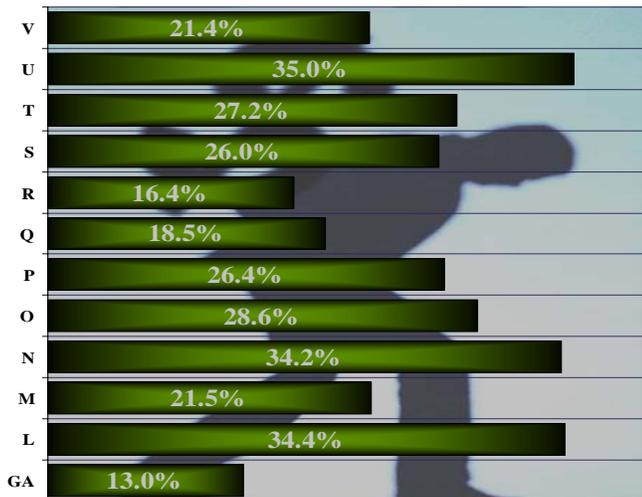
Bad debt and charity write-off percentages ranged from a low of 8 percent to a high of 19 percent. These ratios will be directly affected by the poverty and unemployment levels in the market area. Several hospitals stated that there was not an accurate segregation between bad debts and charity; therefore, 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.

### Bad Debt and Charity Write-Off Percentage



## Poverty Levels

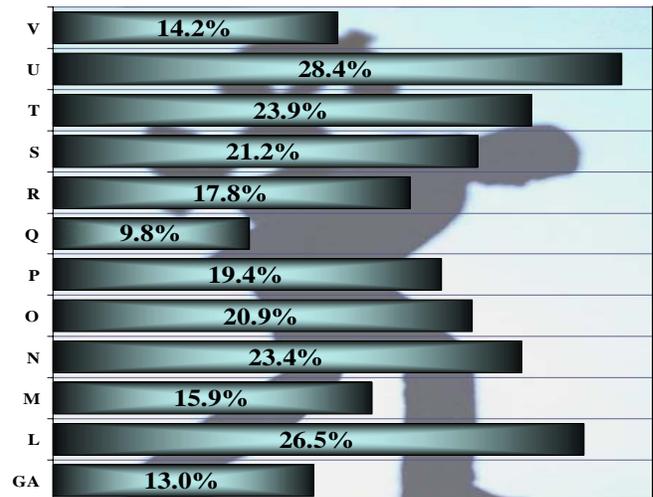
City residents with income below poverty levels in 2007



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

## Poverty Levels

County residents with income below poverty levels in 2007

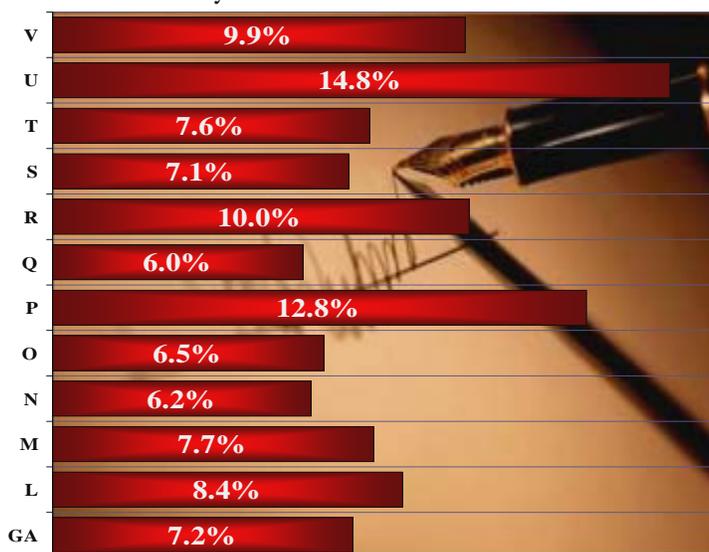


Source: [www.city-data.com](http://www.city-data.com)

Each of the 11 participants' cities has poverty levels above the state average. Ten 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. Most of the participants were receiving sizable amounts of county support to care for the indigent population of the county. Continued Medicaid supplemental funds, such as ICTF and UPL payments, will be critical to the survival of these hospitals.

## Unemployment Levels

County labor force estimates – November 2008



Source: <http://www.dol.state.ga.us/pdf/pr/laborforce.pdf>

Seven of the participants are located in counties with unemployment levels higher than the state average. Hospital U has the highest unemployment, more than twice the state average. 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 study. The prices highlighted in yellow are above the median prices of the group. Outpatient coinsurance is based on 20 percent of the price. In each price reviewed, 20 percent of the CAH median price exceeded the outpatient ambulatory payment classification (APC) coinsurance amounts charged by PPS hospitals.

	HCPCS	MEDIAN	L	M	N	O	P	Q	R	S	T	U	V
Private Room	PRIVATE	\$ 418	\$ 453	\$ 418	\$ 515	\$ 560	\$ 500	\$ 403	\$ 481	\$ 385	\$ 325	\$ 400	\$ 334
Semi-private Room	SEMI PVT	\$ 433	\$ 453	\$ 418	\$ 505	\$ 544	\$ 460	\$ 403	\$ 481	na	\$ 300	\$ 400	\$ 334
E&M	99281	\$ 109	\$ 109	\$ 85	\$ 78	\$ 100	\$ 80	\$ 125	\$ 134	\$ 140	\$ 196	\$ 72	\$ 131
E&M	99282	\$ 186	\$ 126	\$ 95	\$ 106	\$ 168	\$ 130	\$ 195	\$ 201	\$ 200	\$ 221	\$ 85	\$ 178
E&M	99283	\$ 280	\$ 148	\$ 195	\$ 136	\$ 260	\$ 210	\$ 290	\$ 435	\$ 273	\$ 320	\$ 92	\$ 266
E&M	99284	\$ 373	\$ 159	\$ 295	*	\$ 420	\$ 310	\$ 352	\$ 802	\$ 394	\$ 475	\$ 128	\$ 398
E&M	99285	\$ 511	\$ 250	\$ 395	**	\$ 651	\$ 410	\$ 428	\$ 803	\$ 605	\$ 821	\$ 198	\$ 593
IM	90772	\$ 50	\$ 57	\$ 20	\$ 68	\$ 133	\$ 32	\$ 10	\$ 47	\$ 50	\$ 121	\$ 8	\$ 60
INF HYDRA 1ST	90760	\$ 137	\$ 209	\$ 120	\$ 328	\$ 222	\$ 133	\$ 104		\$ 79	\$ 137		\$ 196
VENIPUNC	36415	\$ 12	\$ 22	\$ 15	\$ 12	\$ 18	\$ 7	\$ 15	\$ 10	\$ 7	\$ 16	\$ 4	\$ 12
BMP	80048	\$ 93	\$ 64	\$ 85	54 OP 139 IP	\$ 128	\$ 98	\$ 103	\$ 88	\$ 111	\$ 141	\$ 83	\$ 78
CMP	80053	\$ 118	\$ 65	\$ 104	88 OP 198 IP	\$ 147	\$ 124	\$ 89	\$ 112	\$ 133	\$ 172	\$ 103	\$ 142
UA W/MICRO	81001	\$ 42	\$ 60	\$ 24	32 OP 86 IP	\$ 32	\$ 41	\$ 43	\$ 48	\$ 21	\$ 47	\$ 22	\$ 43
CBC W/DIFF	85025	\$ 66	\$ 60	\$ 32	85 OP 133 IP	\$ 78	\$ 102	\$ 45	\$ 11	\$ 70	\$ 123	\$ 79	\$ 62
TROPONIN	84484	\$ 88	\$ 108	\$ 50	110 OP 141 IP	\$ 88	\$ 78	\$ 47	\$ 170	\$ 70	none	\$ 144	\$ 124
CPK	82550	\$ 52	\$ 60	\$ 40	38 OP 68 IP	\$ 58	\$ 44	\$ 53	\$ 50	\$ 45	\$ 108	\$ 31	\$ 61
EKG	93005	\$ 109	\$ 109	\$ 100	\$ 94	\$ 98	\$ 112	\$ 117	\$ 235	\$ 109	\$ 172	\$ 80	\$ 96
PA/LAT CHEST	71020	\$ 165	\$ 143	\$ 110	\$ 192	\$ 168	\$ 165	\$ 136	\$ 153	\$ 165	\$ 267	\$ 102	\$ 188
AP CHEST	71010	\$ 116	\$ 126	\$ 90	\$ 159	\$ 43	\$ 124	\$ 109	\$ 116	\$ 145	\$ 191	\$ 75	\$ 99
CT BRAIN W/WO	70470	\$ 1,411	\$ 1,540	\$ 880	\$ 1,411	\$ 475	\$ 1,733	\$ 1,381	\$ 1,387	\$ 1,559	\$ 3,800	\$ 1,110	\$ 1,568
CT BRAIN W/O	70450	\$ 1,042	\$ 1,373	\$ 700	\$ 1,042	\$ 325	\$ 1,403	\$ 978	\$ 1,089	\$ 1,243	\$ 1,695	\$ 709	\$ 1,032
EGD W/BX	43239	\$ 1,320	none	\$ 2,737	N/A	\$ 1,232	\$ 1,320	none	\$ 1,391	\$ 1,001	\$ 10,000	\$ 650	none
C-SCOPE W/BX	45380	\$ 1,391	none	\$ 2,632	N/A	\$ 920	\$ 1,320	none	\$ 1,391	\$ 1,413	\$ 10,000	\$ 650	none
OBS/HR 1st hour		\$ 100	\$ 25	\$ 18	\$ 515	\$ 100	\$ 138	\$ 150	\$ 22	\$ 20	\$ 205	\$ 81	\$ 180

\* <2 hours \$220; 2-4 hours \$462; 4-6 hours \$799; >6 hours \$969

\*\*<2 hours \$376; 2-4 hours \$526; 4-6 hours \$866; >6 hours \$1032

Note that some hospitals have 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.

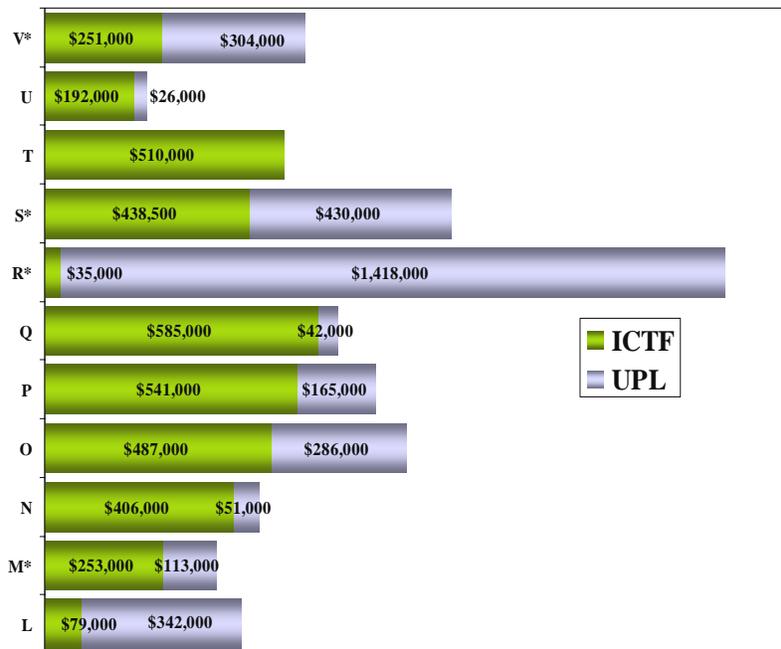
## Medicaid Supplemental Payments

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)



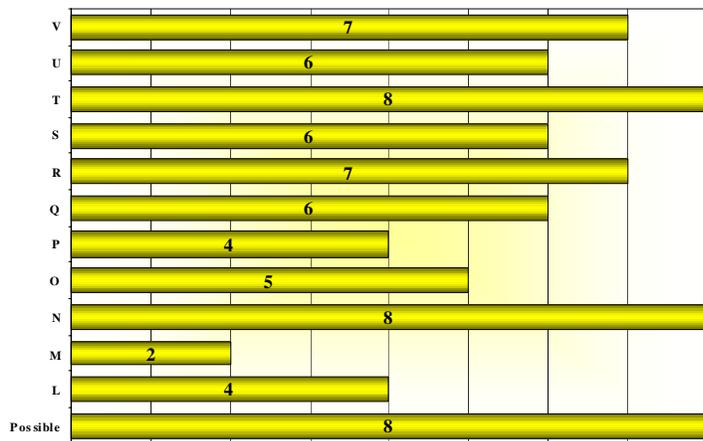
\* Hospitals with SNF components

## Charge Capture

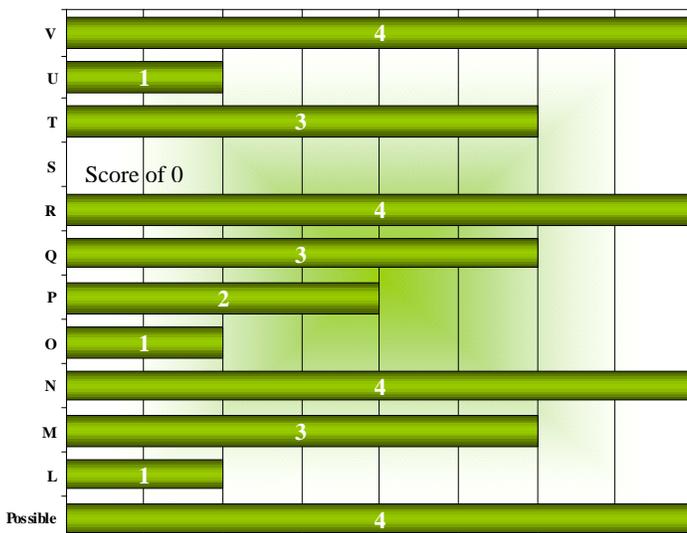
As part of this study a quality assessment questionnaire was used to evaluate critical factors in the revenue cycle. Participants were asked to respond to various questions related to the revenue cycle of their facility. (Appendix C includes the complete questionnaire.) Each revenue cycle area was scored 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. In the review of medical records, it was noted that Hospital M was experiencing 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, six of the 11 hospitals in this study have 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 with state and federal laws and regulations. One of the most important steps in working toward compliance should be an ongoing review of the facility’s CDM. 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 the majority of 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.

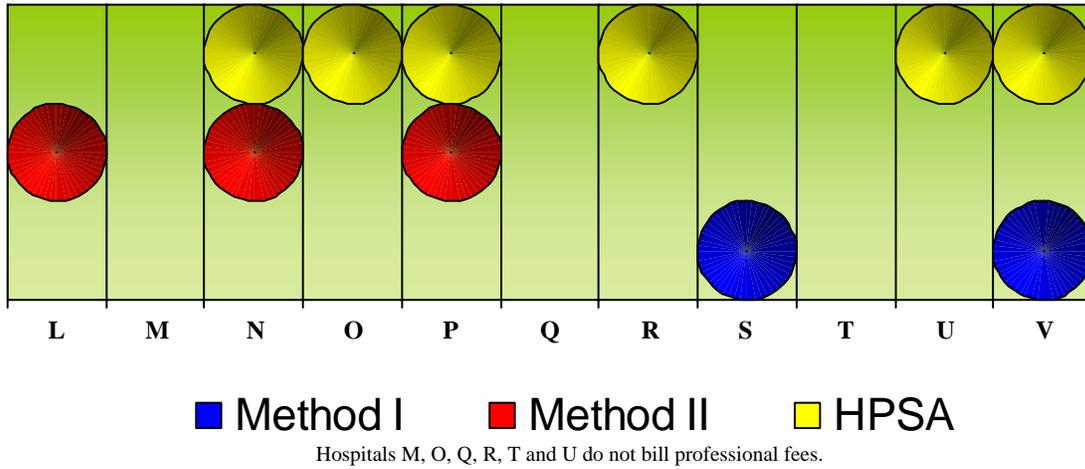
Incorrect revenue code assignments can lead to lost reimbursement and compliance issues. Drugs that can be self-administered are not covered by Medicare for outpatient services, including observation services. Based on Medicare regulations, self-administered drugs should be billed as “non-covered” charges on the claim and assigned a 637 revenue code. To view the Georgia Medicare fiscal intermediary’s injectable drugs that are usually “self-administered” refer to: <http://www.georgiamedicare.com/MedicalReview.cfm>.

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 sheet 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 the Centers for Medicare and Medicaid Services (CMS) guidelines.

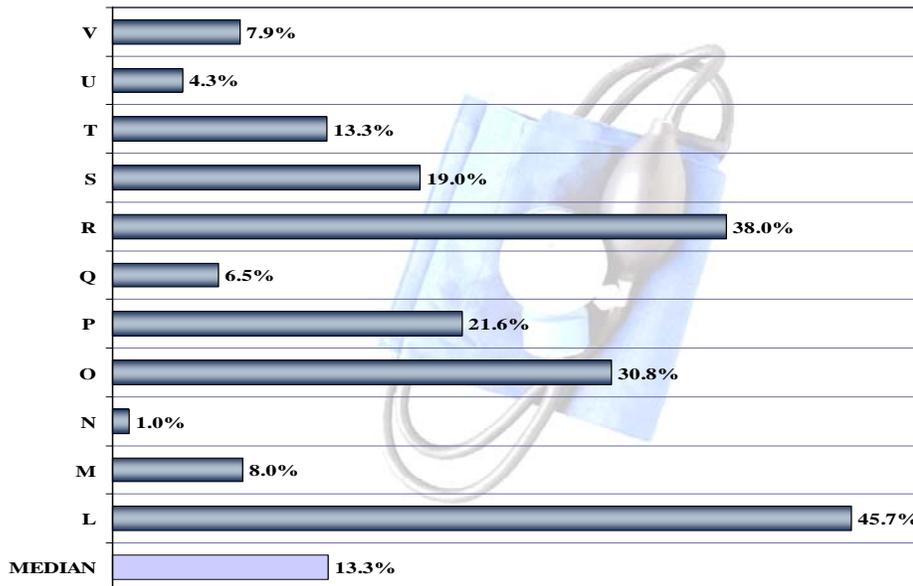
Professional fee billing is causing confusion. Some hospitals do not understand how to appropriately bill professional fees under Method II guidelines or the billing for health professional shortage area (HPSA) add-on payments. The following chart identifies the participating hospitals’ professional billing methods, and those that are located in HSPAs. HPSA locations are often updated; therefore, hospitals should continually monitor these designations.

## Professional Fee Billing



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



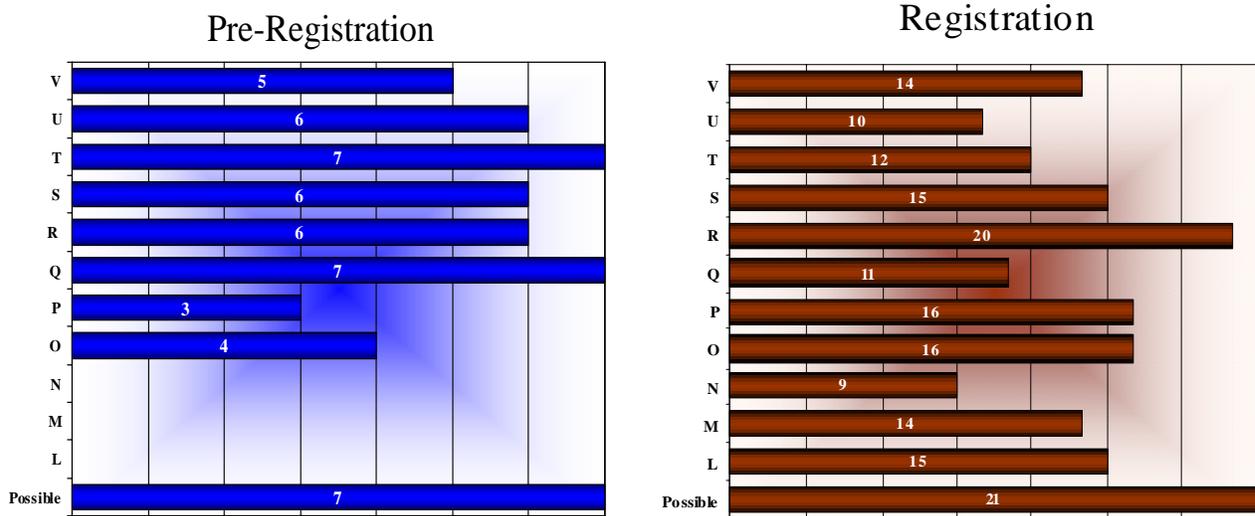
As stated in the Medicare Claims Processing Manual (Pub. 100-04), Chapter 4, Section 290, observation services must be reasonable and necessary to be covered by Medicare. In only rare and exceptional cases do reasonable and necessary outpatient observation services span more than 48 hours. In the majority 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.



Eight of the 11 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 L, M, and N do not perform pre-registration.

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

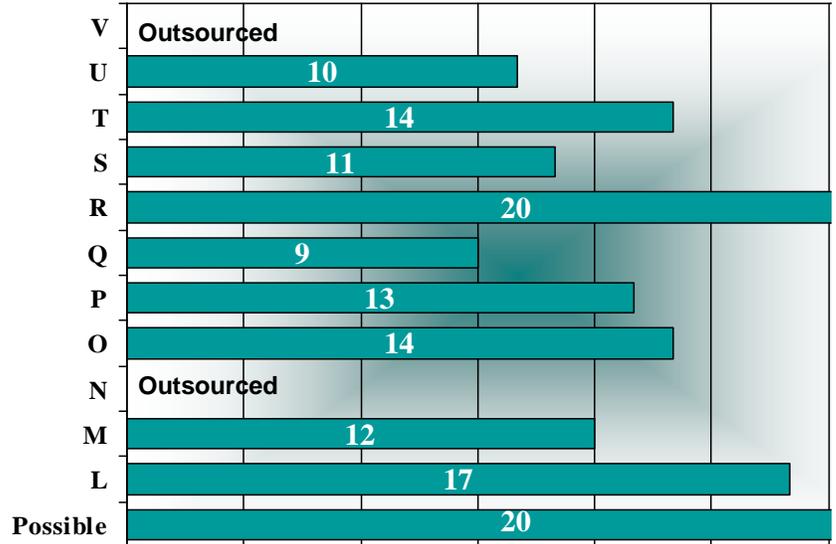
- Hospitals should implement a formal and consistent means of tracking both registration elements and registration errors. Hospitals may consider depicting the results in graphs to give management a more vivid illustration of the outcomes.
- Efforts should be made to discuss and present in writing to 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).

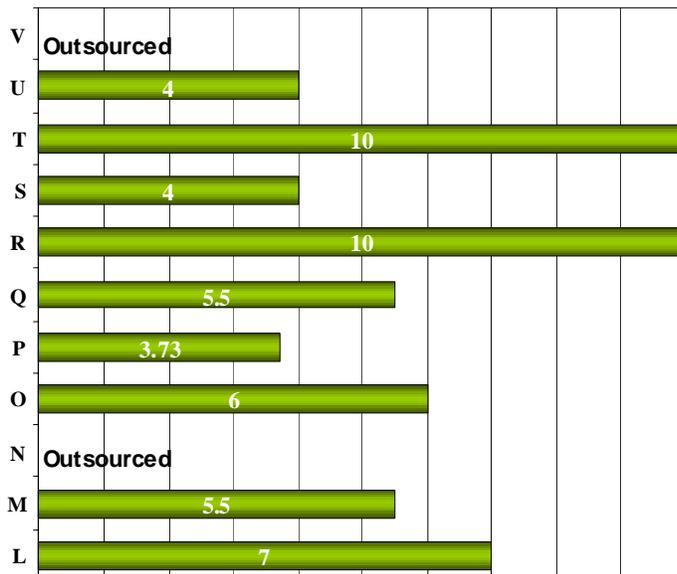
Business office quality assessment scores ranged from a low of 9 points to a high of a perfect score of 20 points. Recommended areas for improvement include:

- 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



### Business Office Staffing



Business office full time equivalents ranged from a low of 3.73 to a high of 10. 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.

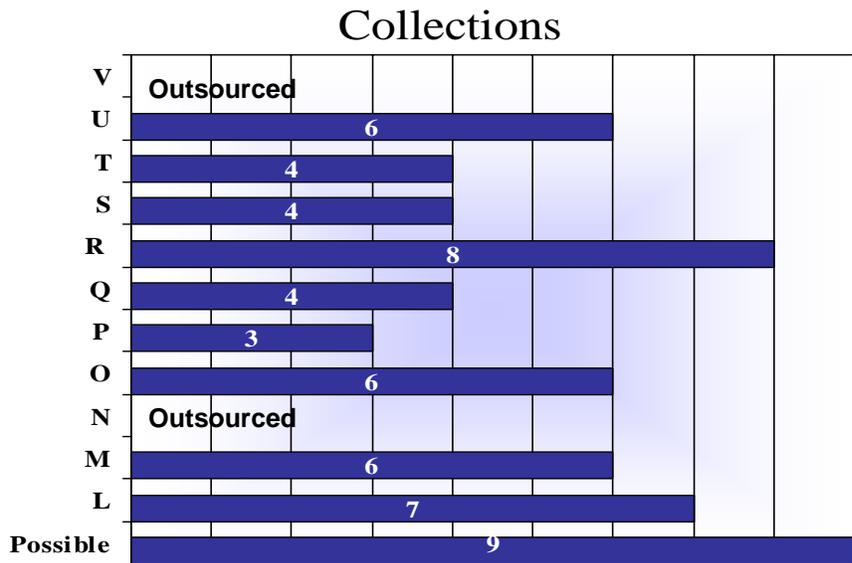
In a small rural hospital, the quality and knowledge of the personnel is highly dependent upon the availability of staff in the market area.

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.

There were significant variances in the quality assessment scoring related to the collections functions. 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
- Staff are held accountable for productivity by measurable criteria (i.e. days in A/R, Patient Stay Trial Balances)
- Goals are set to track performance (i.e. time, system, quantity and quality, revenues)

## **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 11 hospitals participating in this study.

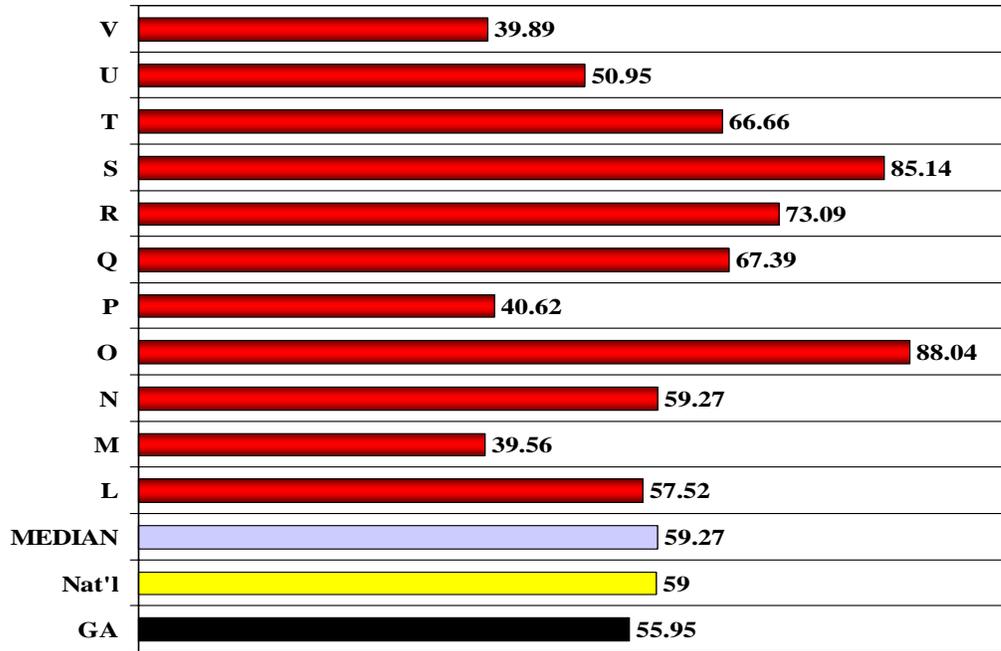
A certain level of expertise and monitoring is required to assure A/R is converted to cash in a timely manner. A diligent approach to A/R management will immediately improve the facility's cash flow. In addition, there are many difficulties that can affect the appropriate management of A/R. The following 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 11 hospitals ranged from 39.56 days to 88.04 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 A/R



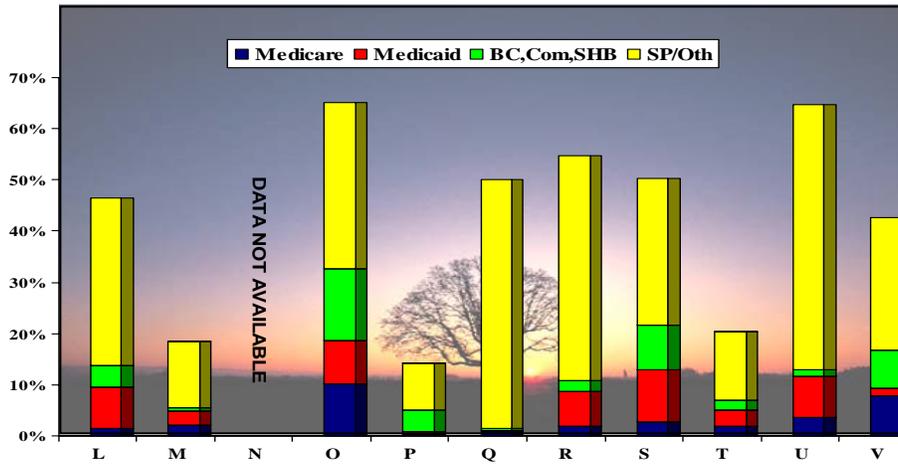
Bad debt write-off policies can directly affect the days in net A/R. Each hospital's bad debt policy was reviewed. Most hospitals are posting bad debts at 120 days after last collection; however, some use longer periods and others shorter. Aggressive write-off policies tend to reduce days in bad debt. In several instances it was noted that actual procedures did not agree with the written policies. Some hospitals submitted policies that have been effective since 2001 and 2004, with no revisions made since that time. Two hospitals have no bad debt policy. 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. All credit balances should be monitored for Medicare and Medicaid credit balance reporting. Refunds due should be identified and remitted promptly.

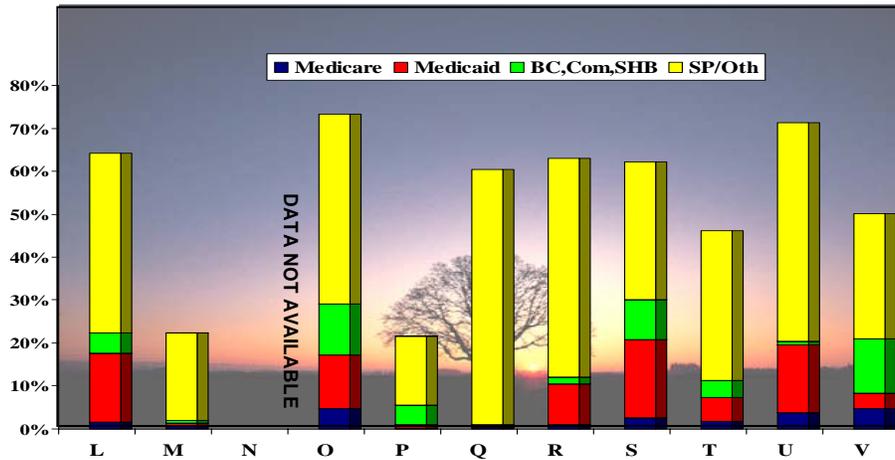
Self-pay accounts comprise the largest percentage of discharged A/R greater than 90 days by payer. The two charts below identify the percentage of these aging accounts by dollar amount and by number of accounts. Hospital U had the highest dollar amount of older self-pay accounts, while Hospital P had 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

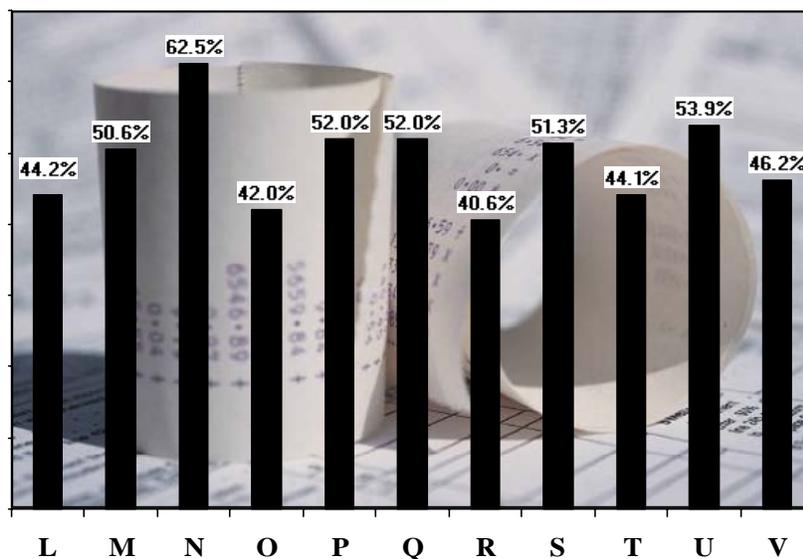


## Analyses of Costs

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.

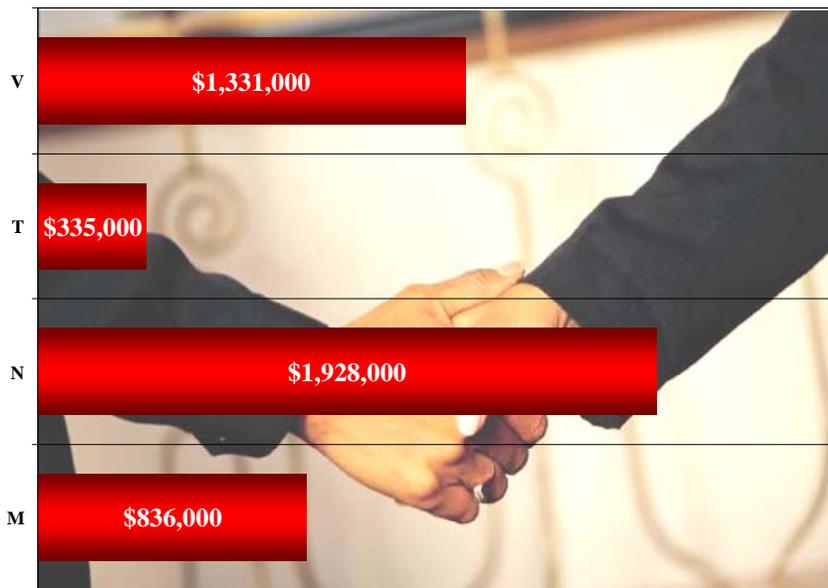
Percentage of Hospital Costs Which Are Cost Based Reimbursed  
(includes SWB)



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 four of the 11 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

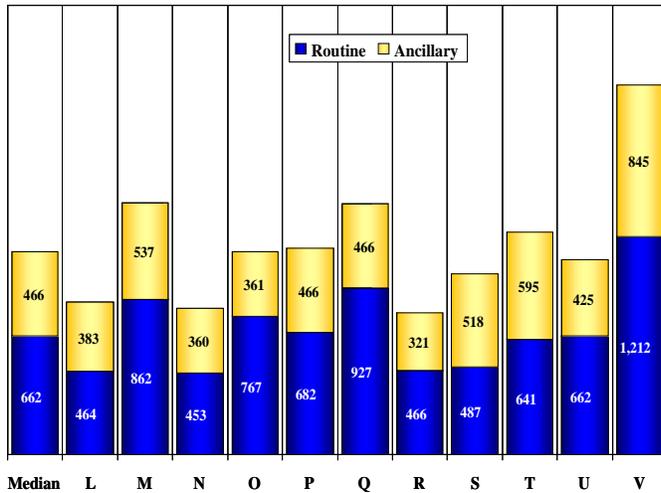


Costs per day comparisons should be reviewed with caution. Hospital costs are directly affected by a number of factors such as:

- 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. It is noticeable from these charts, that Hospital V has higher costs per day. This hospital has a lower number of patient days than the other participants. Lower patient days result in fewer patients over which to spread fixed costs.

Medicare Inpatient Cost per Day



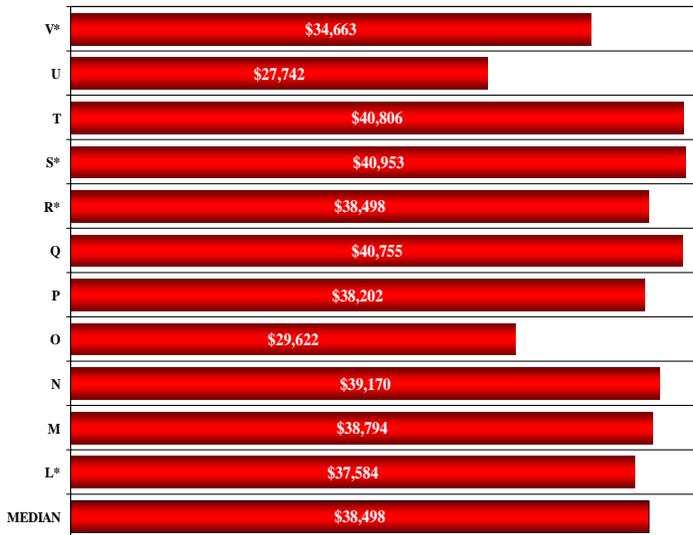
Medicare Swing Bed Cost per Day



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)

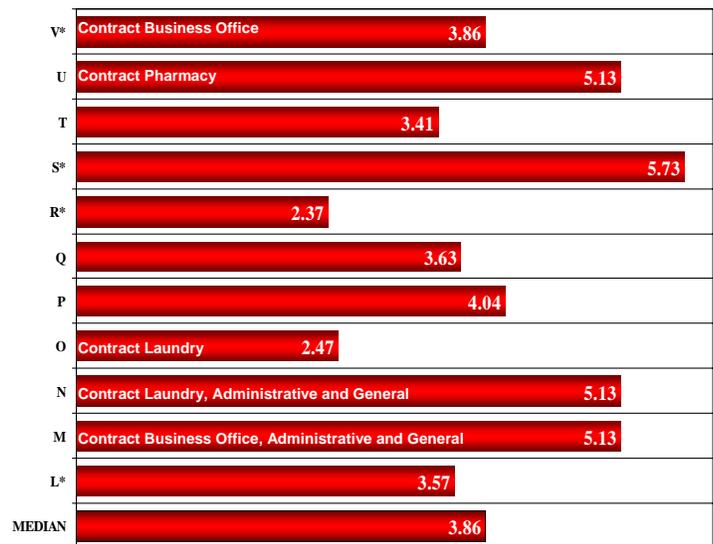


\* SNF components

The average salaries per full time equivalent ranged from a low of \$29,622 to a high of \$40,963. 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.

As noted on the chart, many of the participants use contract services, rather than employed staff to perform certain functions. The use of contract staff will affect the full time equivalent comparisons. There are also participants that, as a component of a hospital system, benefit from consolidated billing functions.

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



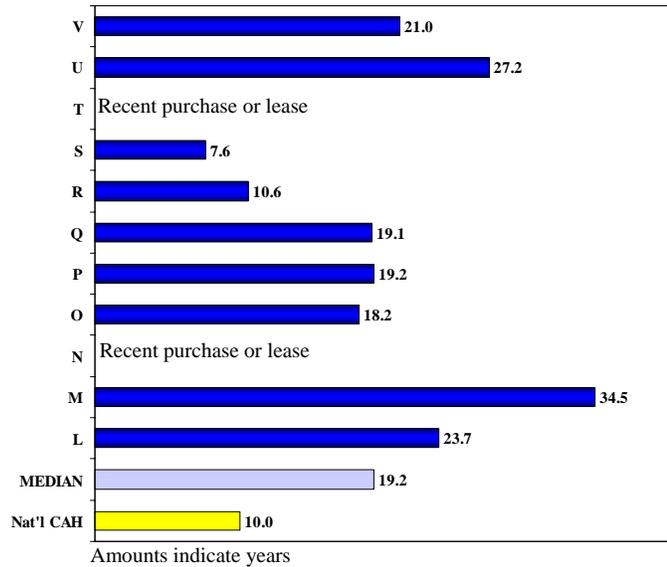
\* SNF components

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 11 CAHs spans from 7.6 years to 34.5 years. The average age is directly affected by ongoing renovations to the facility. Hospitals T and N are not included in this chart due to recent purchases or leases of these facilities.

## Average Age of Plant

Accumulated Depreciation / (Depreciation & Amortization Expense)



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.

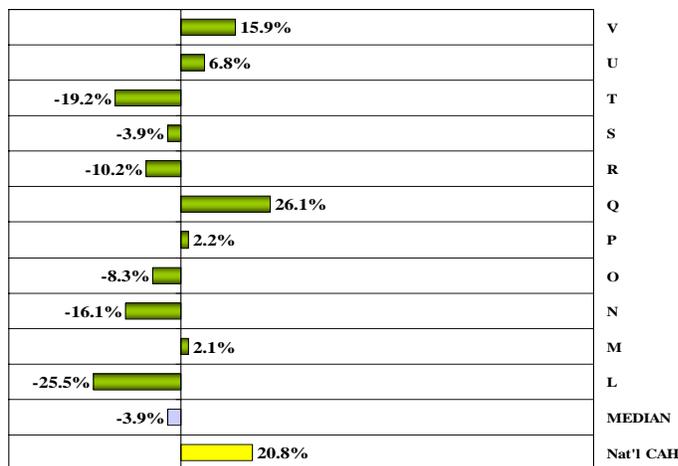
The chart below indicates each participant's plan for future renovations or replacements.

	<i>Future Renovations</i>
<i>L</i>	<i>No plans for renovations</i>
<i>M</i>	<i>No plans for renovations</i>
<i>N</i>	<i>Plans for renovations</i>
<i>O</i>	<i>No plans for renovations</i>
<i>P</i>	<i>Undergoing renovations</i>
<i>Q</i>	<i>Undergoing renovations</i>
<i>R</i>	<i>No plans for renovations</i>
<i>S</i>	<i>Undergoing renovations</i>
<i>T</i>	<i>Plans for renovations</i>
<i>U</i>	<i>Plans for renovations</i>
<i>V</i>	<i>No plans for renovations</i>

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

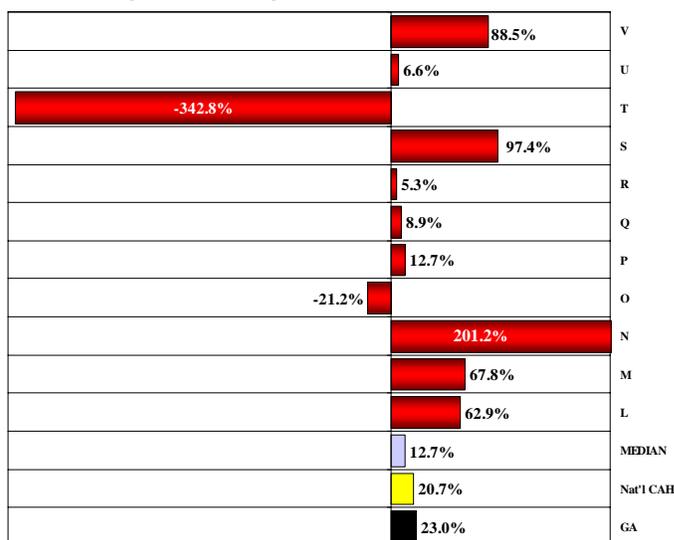
$(\text{Excess Revenues over Expenses} + \text{Depreciation \& Amortization Expenses}) / (\text{Current Liabilities} + \text{Long-Term Debt}) \times 100$



The cash flow to total debt percentages for the 11 CAHs span from -25.5 percent to 26.1 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

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

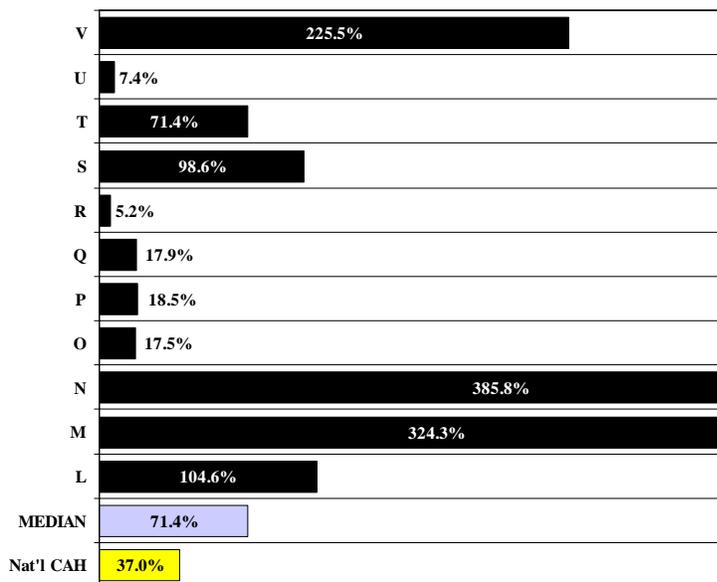


The long-term debt to capitalization ratio for the 11 hospitals span from -342.8 percent to 201.2 percent. This ratio measures the relative importance of long-term debt in the hospital's permanent capital structure. Hospitals with high values for the long-term debt to capitalization ratio have relied 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.

The fixed asset financing ratio for the hospitals ranged from 5.2 percent to 385.8 percent. 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)

## Fixed Asset Financing Ratio

(Long-Term Debt / Net Fixed Assets) x 100



financed with long-term debt.

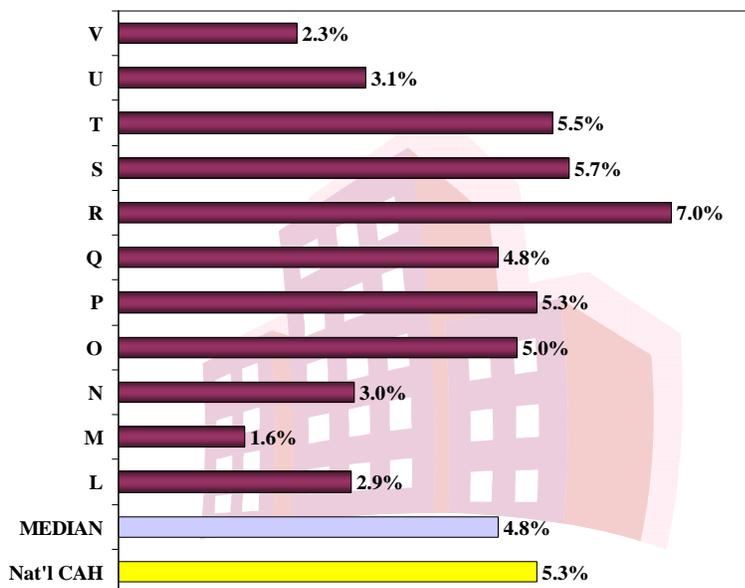
This ratio is used by mortgage lenders to provide an index of the security of the loan.

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. Hospitals M, N and V have intercompany accounts included in long-term debt. These long-term liabilities include amounts other than capital expenditures.

The capital expense ratio for the hospitals ranged from 1.6 percent to 7 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

((Interest Expense + Depreciation & Amortization Expense) / Total Expense) x 100



The debt service coverage ratio for the hospitals ranged from -1.9 to 2.8. 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. Hospital N's long-term debt is due to intercompany expenses with no fixed principal payments.

## Debt Service Coverage

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

	2.1	V
	0.5	U
-1.7		T
	0.1	S
-0.6		R
	2.8	Q
	0.6	P
-0.5		O
		N
	0.2	M
-1.9		L
	0.1	MEDIAN
	3.4	Nat'l CAH
	2.3	GA

## 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. All participants in this study used square footage for the allocation of plant, maintenance and repair costs. In addition, nine of the participants used square footage statistics for housekeeping allocations. Hospitals O and V used the preferred measure of time studies.

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.

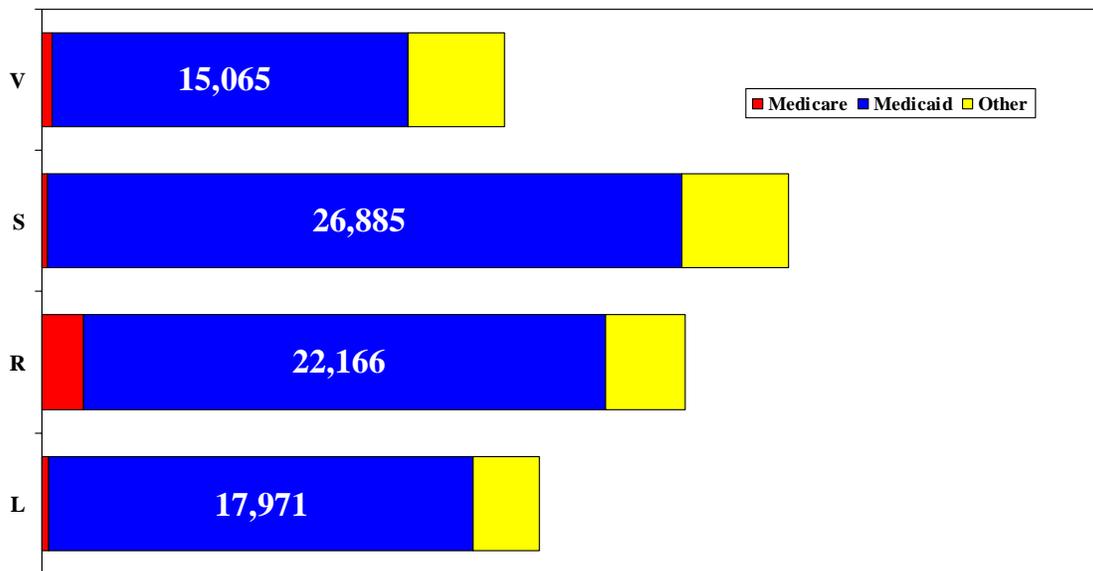
Administrative costs are often allocated to non-hospital areas using accumulated costs. Components such as SNFs, RHCs and physician practices may have their

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.

Four of the CAHs with RHCs appear to have opportunities to increase RHC reimbursement. Two of the RHCs are limited by provider productivity and three are experiencing reduced reimbursement due to Medicare costs exceeding Medicare charges. We recommend that additional analyses be performed of these issues in order to insure optimal reimbursement.

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>L</b>	Interim Cost Report
<b>M</b>	No monitoring
<b>N</b>	Interim Cost report
<b>O</b>	Planning interim cost report
<b>P</b>	Planning interim cost report
<b>Q</b>	Interim cost report
<b>R</b>	Interim cost report
<b>S</b>	Planning interim cost report
<b>T</b>	Internal monitoring
<b>U</b>	No monitoring
<b>V</b>	Interim 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 L**

Computer operations is responsible for producing the write-off data according to specifications and for delivering the data based on a pre-determined and agreed upon schedule or upon special request. All accounts are turned over to bad debt after 120 days. Transfers of bad debt accounts to external agencies shall occur within three business days of data production and be reconciled with agency acknowledgements within five business days of receipt of the acknowledgements. Transfers of accounts to an agency may be cancelled and returned to the active Accounts Receivable under limited circumstances. These circumstances include: accounts of patients flagged by senior management for monitoring, risk management accounts, prior paid accounts (cash not yet posted to the account), or disputed services accounts. Cancellation requests must be in writing, approved by the Director of Patient Financial Services or designee, and acknowledged by the agency in writing. Accounts that should be directly written off as non-collectible with no further pursuit include those with legal impediments and unidentified patients.

## **Hospital M**

Accounts with no payment activity for sixty days are referred to a collection agency. Accounts for all financial classes which have been deemed uncollectible after 120 days are returned to the facility by the collection agency.

## **Hospital N**

Information not available.

## **Hospital O**

Hospital does not have a policy related to bad debts.

## **Hospital P**

All accounts which remain unpaid after the in-house collection process are turned over to a third party collection agency. Accounts are determined to be uncollectible based on an evaluation of relevant information. Self-pay accounts receive request for payments through 75 days old. If no payment has been received after 75 days, the patient will receive a final letter requesting a payment or payment plan. If no response after this step, the account will be turned over to a collection agency. If the patient has a payment plan

in place and does not pay as stated in the plan, they will receive a notification that the account will be turned over to a collection agency if payment is not received.

## **Hospital Q**

Accounts are reviewed prior to placement with an outside collection agency to ensure that all possible in-house collection efforts have been exhausted. Each account should have a minimum of three written correspondences (statements and letters) and one phone call. The only exception to this would be for mail returns and disconnected telephones. A small balance adjustment is made on the patient account for any balance less than \$5.00. A bad debt no agency adjustment is made on the patient account for any balance between \$5.00 and \$14.99. (Exception would be made in the event a patient has multiple accounts to be turned over to an outside collection agency.) Collect code is changed on account to be assigned code for "Ready to Place" accounts for approval by Patient Accounts Director. When approved, accounts are adjusted off accounts receivable as placed to a specified outpatient agency for further collection procedures. A list is prepared for placement with the outside collection agency for further collection efforts which is then downloaded on disks for mailing to outside agencies to put into their systems.

For Medicare account balances, collection agency will notify patient accounts director when agency has ceased collection efforts on those accounts and removed them from credit bureau report. Only then will the Medicare bad debt balance be included on the Medicare Bad Debt listing. Collection agencies must agree to apply the same collection efforts to Medicare and non-Medicare accounts to be able to provide collection services to the hospital.

## **Hospital R**

All bad debt write-offs are performed based on the following guidelines. Proper system documentation must accompany all requests for accounts to be written off to bad debt. The manager will approve all bad debt write-offs/adjustments. All accounts written off to bad debt will be placed with the facilities approved collection agency unless approved otherwise by the manager.

The appropriate business services representative shall identify accounts for bad debt placement using the following schedule:

Payor Type	Skip(*)	> 60 days	> 90 days	> 120 days	> 150 days
Medicare/Medicaid (insurance & patient portion)	Immediately	Ongoing follow-up	Cannot send until > 120 days; monitor statements and phone attempts	Immediately, if no indication of intention to pay	Immediately
HMO/PPO (insurance portion)	Immediately	Ongoing follow-up	Ongoing follow-up	Ensure that at least 3 phone contacts and/or phone attempts have been made to payor	Immediately, if no indication of intention to pay, notify Manager
Commercial/BCBS/Other (insurance portion)	Immediately	Ongoing follow-up	Ongoing follow-up	Ensure that at least 3 phone contacts and/or phone attempts have been made to payor.	Immediately, if no indication of intention to pay.
Self Pay/Patient Portion	Immediately	Ongoing follow-up	Ensure that at least 3 statements have been sent	Immediately, if no indication of intention to pay (in full or with acceptable installments)	Immediately

(\*) A patient account shall be handled as a “skip” if there is no manner of reaching the patient due to incorrect demographic and insurance information.

1. Once the account has been identified as bad debt using the bad debt schedule, the appropriate business services representative will forward the account to the manager for approval. Accounts should be forwarded to the manager on a weekly basis, not one by one.
2. All accounts must have appropriate documentation in the system as to the actions taken in collecting the account. If the account is not appropriately documented, it will be sent back to the representative for further follow-up.
3. The manager will provide a monthly report to the chief financial officer (CFO) for review.
4. The manager is to provide the monthly report to the CFO prior to forwarding the approved accounts to designated collection agencies.
5. All accounts approved for submission to a collection agency will be written off of the accounts receivable by the representative utilizing the proper account adjustment or journal and utilizing the correct write-off/adjustment code.
6. The manager will maintain the logs for all bad debt write-offs and keep a separate log for Medicare Bad Debt Write-Off's.

**NOTE:** Third party payor accounts for which the carrier does not pay will be converted to patient responsibility and worked prior to writing off to bad debt. This will not be done when a specific contract forbids balance billing patients.

## **Hospital S**

When accounts are deemed to be non-collectible based on both the non-response by debtors to established collection efforts, the debtors history of payments to the hospital, when applicable, and/or other factors brought to the attention of the responsible patient account representative, they will be written off the hospital's current accounts receivable and placed with a collection agency for further processing. Identified accounts will be listed on a "Bad Debts Write-off Listing" for the purpose of obtaining written approval and necessary data processing input. Notes will be made on the patient's account indicating the reason for write-off. A copy of the patient's account A/R Inquiry Collection Notes Screen will be attached to the listing to aid in the review and approval process. The bad debt write-off of any accounts receivable requires the written approval of the hospital's CFO and/or chief executive officer (CEO). After approval is obtained, listings will be forwarded to data processing for the purpose of posting the write-off transactions required by the hospital's data processing system. The accounting entries generated by this process will provide for a credit to the hospital's general ledger accounts receivable and a debit to the appropriate general ledger bad debt reserve.

## **Hospital T**

All patients are sent a statement of their account monthly. Three monthly statements are sent to all accounts except Medicaid (for which there is no patient responsibility). Following receipt of three monthly statements, each account is sent a collection letter. A second collection letter is sent after 30 days. If a patient has not responded to the three statements and two collection letters, the business office manager may write-off the account to bad debt status. At the time the account is sent to bad debt status, the account is turned over to collection agency for collection. Any account of \$500.00 or more must be approved by the CFO before it is written-off to bad debt.

## **Hospital U**

Hospital does not have a policy related to bad debts.

## **Hospital V**

The system used by this hospital for resolution of accounts receivable is geared to determine the patient's ability and willingness to pay within 120 days period. The guarantor will receive an initial statement within seven days of service or final bill and monthly statements thereafter which accurately reflect patient/guarantor and/or insurance amounts due. Self-pay balances will be reviewed and the guarantor contacted for payment in full. The hospital has an established payment arrangement policy for patients unable to pay estimated liability in full at time of service. Patients/guarantors requesting a deferred payment program lasting greater than 12 months from the date of service will be required to complete a personal financial statement. The status of in-house accounts

will be monitored by the financial counselor or designee, and the patient/guarantor requested to make payment or payment arrangements when the patient portion exceeds \$1,000.

Accounts with a patient liability for which payment cannot be obtained after reasonable follow-up efforts have been exhausted in accordance with guidelines will be transferred to bad debt status and written off accounts receivable. These accounts shall be referred to an outside collection agency after appropriate approval. Accounts are written off when determined to be uncollectible, but no later than 365 days from the date of service. Any exceptions are reviewed on an account-by-account basis and fully documented.

The director of business office services and the hospital controller must approve all hospital write-offs exceeding \$1,000. The CFO must also review material accounts. The CFO may also review the listing of written off accounts. Approval for write-off is evidenced by the reviewer's signature on the supporting documentation, and supporting documentation is retained.

A review of Medicare and non-Medicare accounts is made to determine if the following conditions exist prior to submitting for bad debt write-off:

- Account is returned from outsourcing company with all collection efforts exhausted
- No self-pay payment has been posted (no self-pay payment posted within previous thirty days for self-pay portion of Medicare accounts)
- Guarantor has received a minimum of three statements
- Balances greater than \$1,000 have had a personal telephone call unless outsourced
- Guarantor has defaulted on an agreed contract arrangement
- Financial comments have been reviewed to determine if extenuating circumstances exist regarding lack of self-pay payments
- Account has been screened for indigent/charity eligibility
- Account has been screened for appropriate eligibility programs
- Account has return mail without a new address obtained
- Review patient/guarantor payment history
- Accounts for which the internal collection cycle has been completed
- Self-pay unresolved mail return(s)
- Self pay account is aged greater than 150 days from discharge or date of service.
- Accounts for patients/guarantors who have existing accounts in bad debt status or have had checks returned for insufficient funds, or who have repeatedly broken payment promises

In no case, with the exception of documented indigence, will the hospital deem Medicare accounts to be uncollectible, unless the debt remains unpaid more than 120 days from the date the first bill is mailed to the beneficiary or party responsible for the patient's personal financial obligations.

When Medicare accounts are placed with a collection agency, they are not claimed for cost report purposes until they have been returned from the collection agency as uncollectible. At this time they are logged in the Medicare bad debt log and become eligible for cost report settlement.

## **Appendix B**

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

## Medical Record and CDM Findings

As part of this study, there was a review of 15 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	L	M	N	O	P	Q	R	S	T	U	V
1. Medical records		X				X				X	X
2. Emergency room charges	X	X		X	X	X	X			X	
3. Observation charging						X		X			
4. Venipuncture charging	X	X	X	X	X	X	X	X	X	X	
5. Injections and infusions	X	X		X	X	X	X	X	X	X	
6. Revenue code assignment	X	X	X	X	X	X	X	X	X	X	X
7. Drug units and dosage											
8. Method II billing	X										
9. CDM Issues	X	X		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 several instances this information was not readily located in the medical records reviewed. Additionally, nursing documentation should reflect start and stop times to support intravenous infusion charges. 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. There were a number of lost charges noted related to determination of appropriate evaluation and management level assignments and charging of ER procedures. The staff at many of the CAHs is confused regarding the appropriate charging of injections and infusions in the outpatient setting. The staff is also uncertain regarding

when it is appropriate to bill for specific procedures performed in the ER, such as laceration repairs. It is permissible to bill for such services, as long as all patients are charged consistently.

Most hospitals are using a “mapping sheet” to assist in assigning the level of evaluation and management service (99281 – 99285) in the ER. However, there were inconsistencies noted in the application of this tool for patient charges. Such a mapping sheet should be used in all instances, for all patients seeking treatment in an outpatient facility setting. Copies of the mapping sheet should be readily available for use in supporting the charge billed.

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.
4. Venipuncture is not an allowable charge for inpatients but may be charged for outpatients. 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. No significant findings.
8. Hospitals need education on the appropriate billing under Method II for outpatient professional fees. Several hospitals are billing for outpatient professional fees; however, there appears to be a lack of understanding of the Method II billing. This is an area that should be reviewed carefully in order to avoid lost reimbursement and/or incorrect billing.
9. 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 a number of instances, 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 or correct number of views specific to x-rays. 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?

---

---

# CAH Quality Assessment by Functional Area

## Assessment Criteria

## Discussion

---

**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?

---

---

# CAH Quality Assessment by Functional Area

## Assessment Criteria

## Discussion

---

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

---

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?

---

**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?

---

---

# CAH Quality Assessment by Functional Area

## Assessment Criteria

## Discussion

---

What are significant causes of billing delays?

---

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

---

### 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?

---

---

# 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?

---

---

# 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?

---

---

# CAH Quality Assessment by Functional Area

## Assessment Criteria

## Discussion

---

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

---

Are electronic remittance files maintained for future reference?

---

Are detailed remittances received from other payers?

---

Are remittances posted directly to patient accounts from electronic remittances?

---

Are contractuals computed and posted at time of billing?

---

Are contractuals 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

---

---

# CAH Quality Assessment by Functional Area

## Assessment Criteria

## Discussion

---

**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.

---

---

# 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?

---

**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?

---

---

# CAH Quality Assessment by Functional Area

## Assessment Criteria

## Discussion

---

Are bad debtors reported to credit bureaus?

---

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

---

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

---

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

---

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.

---

### Staff Issues

Describe the staffing in collections

---

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

---

---

# 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 %