



# **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  
Draffin & Tucker, LLP**

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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 per cent of costs, and
- Full Medicaid reimbursement of allowable costs for outpatient services

The Department of Community Health (DCH)/State Office of Rural Health (SORH) are 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 was gathered and analyzed. Financial data from each hospital was then compiled to present comparative financial information.

This information is presented for each hospital with comparative data provided. Please note the advice below concerning the use of the comparative data for decision making.

## 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.

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

**Community support is vital to the sustainability of the CAH.** Of the 11 participants, only four received any appreciable financial support from their county governments.

**State supplemental payments are crucial to survival of the CAH.** Without participation in the Georgia Medicaid Indigent Care Trust Fund Program and the receipt of Upper Payment Limit reimbursement, many CAHs are in jeopardy.

**Diversification of services provides additional revenue sources.** There was no one operating model that applied to the participating CAHs. All 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.

**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 patient volume.

**Poverty levels in the CAH counties are higher than the state average.** Ten of the 11 participants are located in counties with higher than average poverty levels. This contributes to decreased profitability.

**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 80.39. There were notable differences in the business office staffing of the facilities, ranging from low staffing to

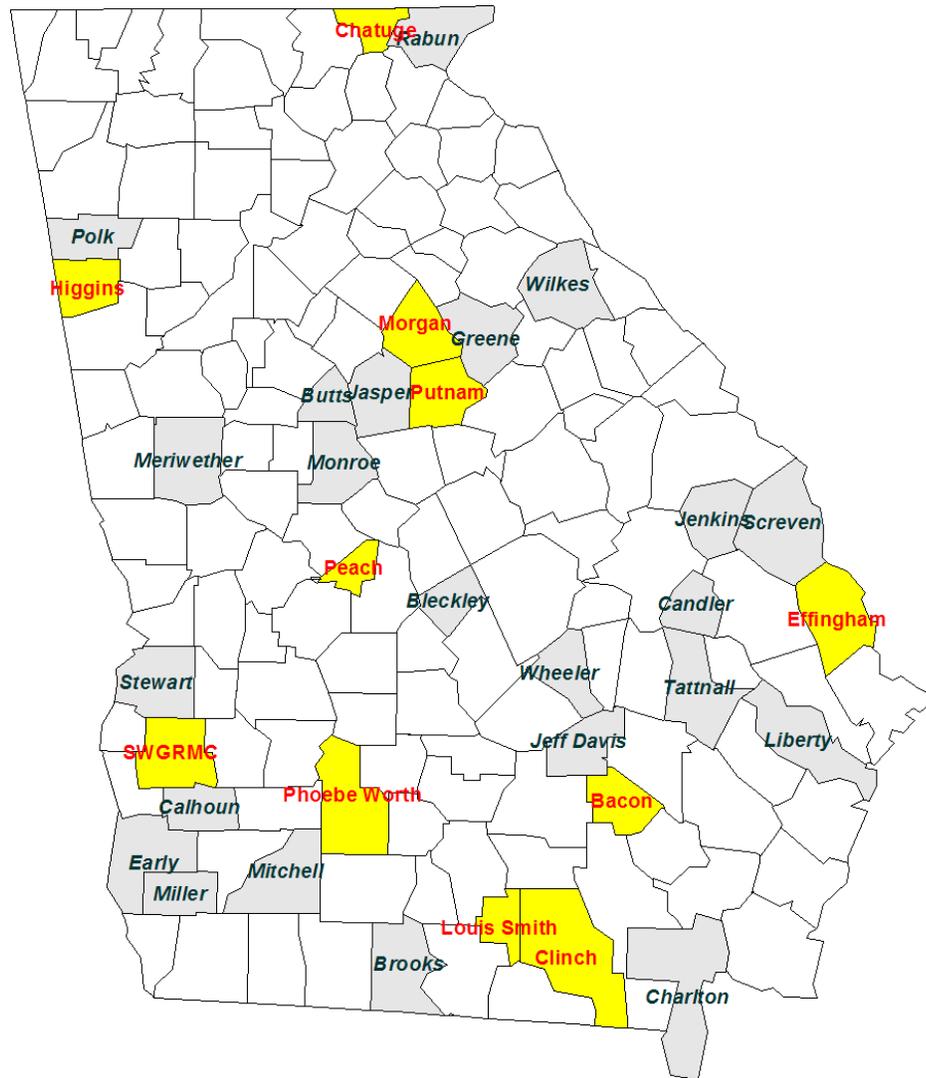
outsourcing. Charge description masters were not current and lost charges and compliance issues were noted.

**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.

**CAHs are not fully cost based reimbursed.** Oftentimes, the public's perception is that CAHs are paid full costs for ALL services. However the percentage of CAH reimbursement based on costs is decreasing, causing greater price shifting to the few remaining commercially insured patients.

## The Participants

Of the 34 CAHs operating in the State of Georgia, 11 participated in this project. The counties highlighted in yellow represent the locations of the participants. The counties highlighted in gray represent the locations of the remaining CAHs.



The following pages provide additional background information concerning the CAHs participating in this study.

## Higgins General Hospital



Located in Bremen, Georgia, Higgins General Hospital became part of Tanner Health System in 1998. The 25-bed CAH recently underwent an extensive \$7.5 million renovation and expansion. It offers its community inpatient as well as outpatient medical services, including a 24-hour Emergency Department, same-day surgery, lithotripsy, and a wide range of outpatient services. Villa Rica City Hospital, located in Villa

Rica, Georgia, is also affiliated with Tanner Health System.

Bremen is located approximately 45 miles from Marietta, Georgia and 51 miles from Atlanta, Georgia. The population of Bremen is estimated at 5,500.

### Community Information

Bremen compared to Georgia state average:

- Median household income below state average.
- Black race population percentage below state average.
- Hispanic race population percentage significantly below state average.
- Foreign-born population percentage significantly below state average.
- Percentage of population with a bachelor's degree or higher below state average.

### Challenges

Hospital management states that the most significant challenge to the financial viability of the hospital is:

- Growing uninsured and underinsured population

# Clinch Memorial Hospital



Clinch Memorial Hospital, located in Homerville, Georgia, originally opened in 1957 as a 40-bed, rural community hospital. In 1997, South Georgia Medical Center, a 335-bed, not-for-profit, authority-governed hospital, entered into an agreement to provide an administrator and clinical and management consulting services at Clinch.

On December 6, 2005, the Clinch County Hospital Authority broke ground for a “new” Clinch Memorial Hospital. The new 25-bed CAH opened in April 2007, and is currently located at 1050 Valdosta Highway in Homerville. This is the first and only CAH replacement facility in Georgia.

Clinch Memorial Hospital is the fourth largest employer in Homerville with a population of approximately 2,800 while Clinch County has a population of approximately 7,000 residents. Homerville is located approximately 30 miles from Waycross and 90 miles from Jacksonville, Florida.

## Community Information

Homerville compared to Georgia state average:

- Median household income significantly below state average.
- Black race population percentage above state average.
- Hispanic race population percentage significantly below state average.
- Foreign-born population percentage significantly below state average.
- Institutionalized population percentage significantly above state average.
- Percentage of population with a bachelor's degree or higher significantly below state average.

## Challenges

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

- The changing Medicare and Medicaid reimbursement issues
  - Increasing self-pay population leading to decreased collections

## Peach Regional Medical Center



Peach Regional Medical Center, located in Fort Valley, Georgia, opened in September 1953 as a non-profit acute-care hospital and elected CAH status in November 2000. In the last five years, Peach Regional Medical Center opened a Cardiac Rehab unit, began a wellness program and added sleep and nerve conduction studies in Fort Valley. Peach County has 24,665 residents, making it the 68th largest of Georgia's 159 counties.

The hospital has recently received awards for safety and quality of services. Management is also actively pursuing plans for a replacement facility.

Fort Valley is located approximately 26 miles from Macon, Georgia.

### Community Information

Fort Valley compared to Georgia state average:

- Median household income significantly below state average.
- Unemployed percentage significantly above state average.
- Black race population percentage significantly above state average.
- Hispanic race population percentage significantly below state average.
- Median age below state average.
- Foreign-born population percentage significantly below state average.
- Percentage of population with a bachelor's degree or higher below state average.

### Challenges

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

- Uninsured / Charity / Bad Debt costs
- Lack of medical specialists
- Lack of ICU services
- Staff turnover – no pension or retirement

## Bacon County Hospital



Bacon County Hospital and Health System is located in Alma, Georgia, a community of 3,000. The population of Bacon County is estimated at 10,000. Alma is 110 miles from Savannah, 70 miles from Brunswick and 110 miles from Jacksonville, Florida. The Health System is comprised of Bacon County Hospital (25-bed CAH), Twin Oaks Convalescent Center (88 beds), ABC Child Development Center (average daily census, 153 children) and Community Care Centers. The System (including the nursing home) has been JCAHO accredited since 1995.

Bacon County Hospital is the only hospital in Georgia to apply for and receive a \$2.2 million Federal Communications Commission grant. The hospital is in the 90<sup>th</sup> percentile for at least one of the five acute myocardial infarction indicators, at least one of the two heart failure indicators, and at least one of the three pneumonia indicators for the Appropriate Care Measures (ACM). The hospital's goal is to continue to improve and hit the target of having an ACM composite score of 88.1 percent.

### Community Information

Alma compared to Georgia state average:

- Median household income significantly below state average.
- Black race population percentage above state average.
- Hispanic race population percentage significantly below state average.
- Foreign-born population percentage significantly below state average.
- Institutionalized population percentage above state average.
- Percentage of population with a bachelor's degree or higher significantly below state average.

### Challenges

Hospital management feels that the greatest challenges to the financial viability of the hospital are:

- Growing indigent population
- Flat or decreased reimbursement from governmental payers
- Rapidly increasing cost of delivering care
- Implementing government mandates

## Effingham Hospital



Located in Springfield, Georgia, Effingham Hospital is a fully accredited Joint Commission on Accreditation of Healthcare Organizations (JCAHO) facility. In the most recent JCAHO survey, the hospital ranked within the nation's top two percent of accredited institutions. Located in southeast Georgia, just south of the South Carolina border and 20 miles northwest of the historic city

of Savannah, Effingham County is one of the fastest growing communities in the state of Georgia. The county population is approximately 37,500.

The hospital recently received the Hometown Health Association Hospital of the Year award, as well as an American Healthcare Quality award.

### Community Information

Springfield compared to Georgia state average:

- Unemployed percentage significantly below state average.
- Hispanic race population percentage significantly below state average.
- Foreign-born population percentage significantly below state average.
- Institutionalized population percentage significantly above state average.
- Percentage of population with a bachelor's degree or higher below state average.

### Challenges

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

- The continued increase in the percentage of intentional underpayment by all governmental payers

## Phoebe Worth Medical Center



Phoebe Worth Medical Center is located in Sylvester, Georgia, a community of 5,900. Phoebe Worth joined the Phoebe Putney Health System in 2001. Central to the Phoebe Putney Health System is a 443 bed teaching hospital located in Albany, Georgia. Sylvester is located 23 miles from Albany, 24 miles from Tifton and 60 miles from Valdosta.

Phoebe Worth manages the county-owned ambulance service.

### Community Information

Sylvester compared to Georgia state average:

- Median household income below state average.
- Median house value below state average.
- Unemployed percentage above state average.
- Black race population percentage significantly above state average.
- Hispanic race population percentage significantly below state average.
- Foreign-born population percentage significantly below state average.
- Percentage of population with a bachelor's degree or higher significantly below state average.

## Southwest Georgia Regional Medical Center



Southwest Georgia Regional Medical Center (SGRMC) is a District Authority owned hospital located in Cuthbert, Georgia. Cuthbert is the county seat of Randolph County with a population of 3,500. This 25-bed facility is located 43 miles from Albany, 28 miles from Eufaula, Alabama and 110 miles from Montgomery, Alabama.

The Hospital Authority has a contract with Phoebe Putney Memorial Hospital to provide management services. The Chief Executive Officer and Chief Financial Officer positions are shared with another CAH in the Phoebe Putney Health System.

The SGRMC system also includes a Behavioral Care department, two RHCs, an 80 bed SNF, and three physician clinics. There is also a freestanding EMS that receives county funding.

### Community Information

Cuthbert compared to Georgia state average:

- Median household income significantly below state average.
- Black race population percentage significantly above state average.
- Hispanic race population percentage significantly below state average.
- Foreign-born population percentage significantly below State average.
- Institutionalized population percentage above state average.
- Percentage of population with a bachelor's degree or higher significantly below state average.

## Chatuge Regional Hospital



Chatuge Regional Hospital & Nursing Home is located in the city of Hiawassee, Georgia. Now a CAH, it originally opened as a 13-bed hospital and was the smallest hospital in Georgia. The attached nursing home provides services to 112 Medicare and Medicaid residents.

Hiawassee is the county seat of Towns County which has a population of 10,000 residents. Hiawassee is a resort and retiree community surrounded by the mountains of north Georgia and 7,000 acre Lake Chatuge. It is within two hours driving time of Atlanta and one hour from Gainesville.

Recent refurbishments have been made to the hospital from its operating funds. The hospital has been named to the Georgia Hospital Association Quality Honor Roll.

### Community Information

Hiawassee compared to Georgia state average:

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

### Challenges

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

- Increased indigent population due to economic downturns
- Cash flow issues
- Balancing need for fiscal responsibility with retention of community support and goodwill

## **Morgan Memorial Hospital**



Established in 1960, Morgan Memorial Hospital is a 20-bed non-profit CAH and 21-bed SNF located in Madison, Georgia. Madison is located 26 miles from Athens and 65 miles from Atlanta. The population of Morgan County is estimated at 17,500. In addition to offering a 24-hour emergency room and a wide array of diagnostic outpatient services, Morgan

Memorial has an acute care and SWB program as well as a transitional care unit. Morgan Memorial was recently designated a Level IV trauma center. Morgan Memorial is accredited by the JCAHO.

All of the Hospital Authority members have elected to participate in the Georgia Hospital Association's board member certification program. They were the first Board in the State to have 100 per cent participation. The surgery program has been significantly expanded in 2008. The business office was outsourced in 2007, but was brought in-house in 2008.

### **Community Information**

Madison compared to Georgia state average:

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

### **Challenges**

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

- Maintaining/increasing patient volume
- Increasing commercial insurance patient volume
- Recruiting/retaining qualified personnel
- Generating resources to maintain/improve building and equipment
- Operating with a high Medicare payer mix with corresponding decreasing reimbursement

## Putnam General Hospital



Putnam General Hospital is located in Eatonton, Georgia, a community of 6,700. Eatonton is located 20 miles from Madison, Georgia and Milledgeville, Georgia. The original facility opened on March 1, 1968. A surgery wing was opened in 1974, and then in June of 1978, a modern intensive care unit was opened. After

completing a five million dollar renovation in 1993, the hospital became a modern state-of-the-art hospital. In 2004, the hospital began expanding once again to enlarge the areas of physical therapy, cardiac rehabilitation and storage. As part of this expansion, two additional recovery beds were added to the Operating Room area, as well as a family waiting room.

Putnam General Hospital has received numerous awards including Hometown Health Hospital of the Year 2002-2003, 2004 Safety Award from the Georgia Hospital Association Workers' Compensation Self-Insurance Fund for a low number of workplace injuries, 2006 Care Science Select Practice National Quality Leader in the category of Pneumonia and 2006 Georgia Hospital Association Top CARE Hospital.

### Community Information

Eatonton compared to Georgia state average:

- Median household income below state average.
- Black race population percentage significantly above state average.
- Hispanic race population percentage significantly below state average.
- Foreign-born population percentage significantly below state average.
- Institutionalized population percentage above state average.
- Percentage of population with a bachelor's degree or higher significantly below state average.

### Challenges

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

- Decreased reimbursement
- Regulatory changes
- Aging physicians and staff
- General economy
- Recruitment and retention of staff and physicians

## **Louis Smith Memorial Hospital**



Louis Smith Memorial Hospital (LSMH), a component of South Georgia Health System is located in Lakeland, Georgia. It is a 25-bed CAH accredited by JCAHO. LSMH and its neighboring convalescent home, Lakeland Villa, a 62-bed nursing home, are the cornerstones of health care in Lanier County.

Louis Smith Memorial Hospital, received the first place 2006 CAH Patient Quality & Safety

Award from the Georgia Hospital Association. The Hospital was recognized by the Partnership for Health and Accountability (PHA) division of GHA, a statewide organization of hospitals, for its efforts in improving patient safety and elevating the quality of care. The award winning project involved the implementation of a Teleradiology/Picture Archiving and Communication System (PACS).

### **Community Information**

Lakeland compared to Georgia state average:

- Median household income below state average.
- Unemployed percentage above state average.
- Black race population percentage above state average.
- Hispanic race population percentage significantly below state average.
- Foreign-born population percentage significantly below state average.
- Institutionalized population percentage significantly above state average.
- Percentage of population with a bachelor's degree or higher significantly below state average.

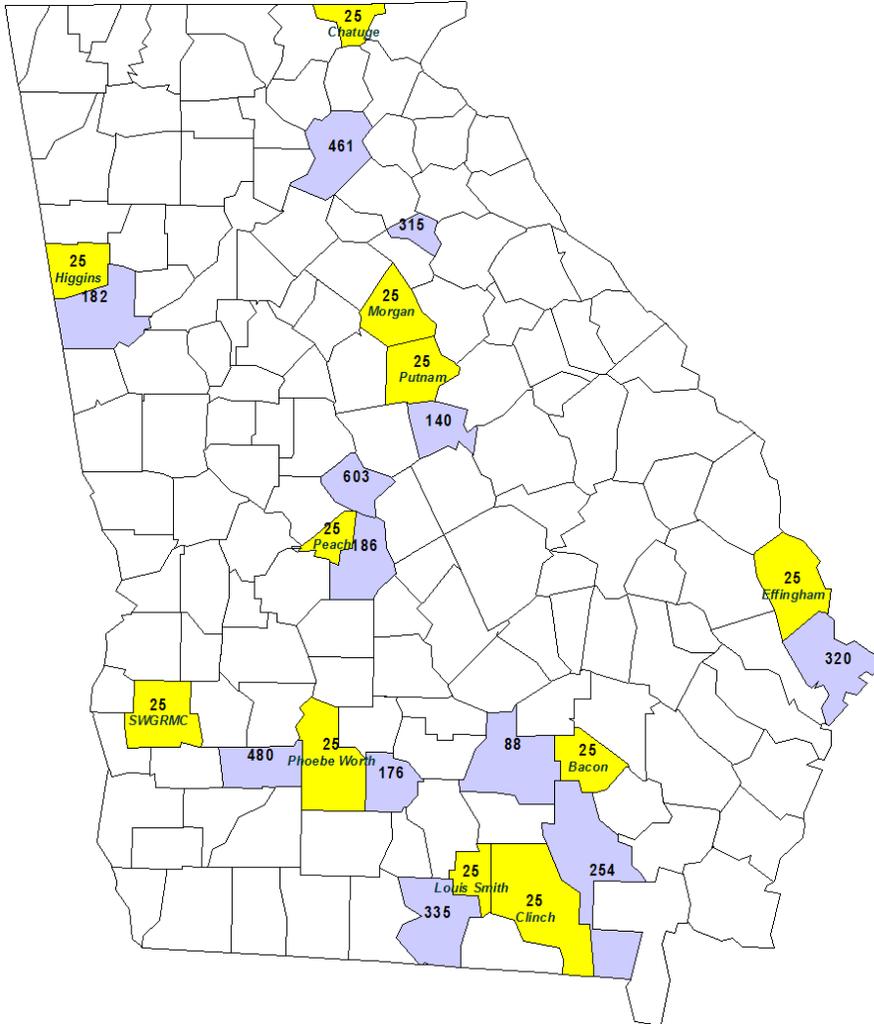
### **Challenges**

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

- No community support financially
- Increasing indigent / charity population

## 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
A	22 miles
B	53 miles
C	27 miles
D	25 miles
E	12 miles
F	19 miles
G	31 miles
H	26 miles
I	21 miles
J	22 miles
K	45 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.

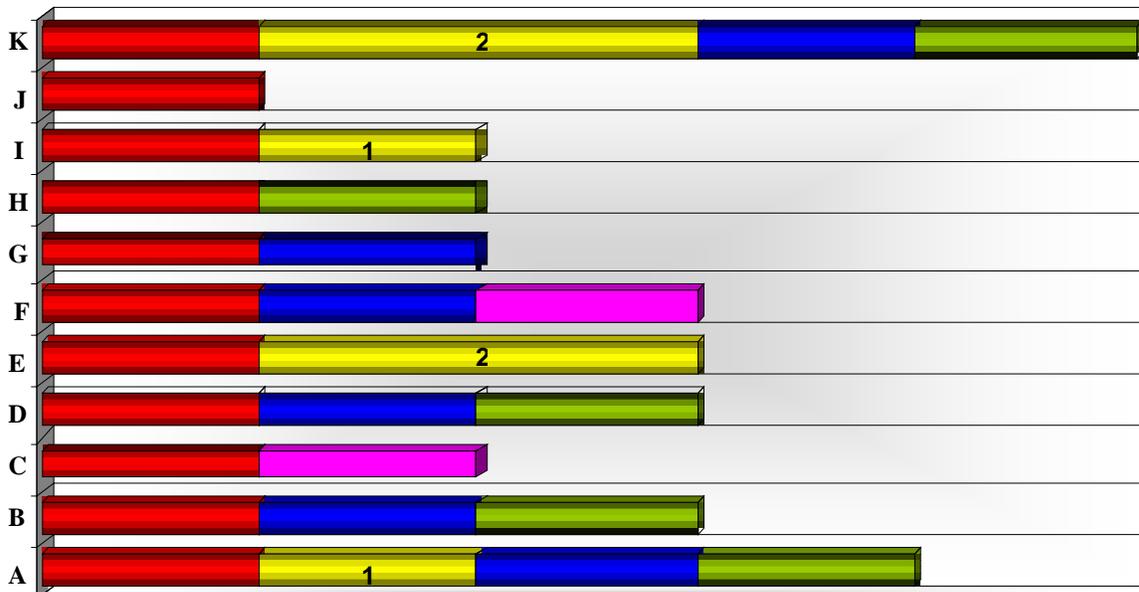
	Chief Executive Officer			Chief Financial Officer		
	AGE	YEARS TENURE	YEARS AGGREGATE HOSPITAL EXPERIENCE	AGE	YEARS TENURE	YEARS AGGREGATE HOSPITAL EXPERIENCE
<b>A</b>	46	3	29	33	7 mo.	7 mo.
<b>B</b>	58	19	22	54	5	30
<b>C</b>	53	5 mo.	5 mo.	40	4	4
<b>D</b>	57	12	26	55	6	15
<b>E</b>	42	6 mo.	18	60	10	38
<b>F</b>	54	8	30	40	3 mo.	3 mo.
<b>G</b>	59	16 mo.	33	42	14 mo.	15
<b>H</b>	46	12.5	20+	31	8.5	8.5
<b>I</b>	NA	NA	NA	NA	NA	NA
<b>J</b>	69	19	36	43	8.5	25
<b>K</b>	NA	NA	NA	NA	NA	NA

Hospital experience ranged from a low of five months, to a high of 36 years among the CEOs and a low of three months to a high of 30 years among the CFOs. Tenure at the participating hospitals ranged from a low of five months to a high of 19 years for the CEOs and a low of three months to a high of 10 years for the CFOs.

Ages of the CEOs ranged from 42 to 69, while those of the CFOs ranged from 31 to 60.

## Service Components

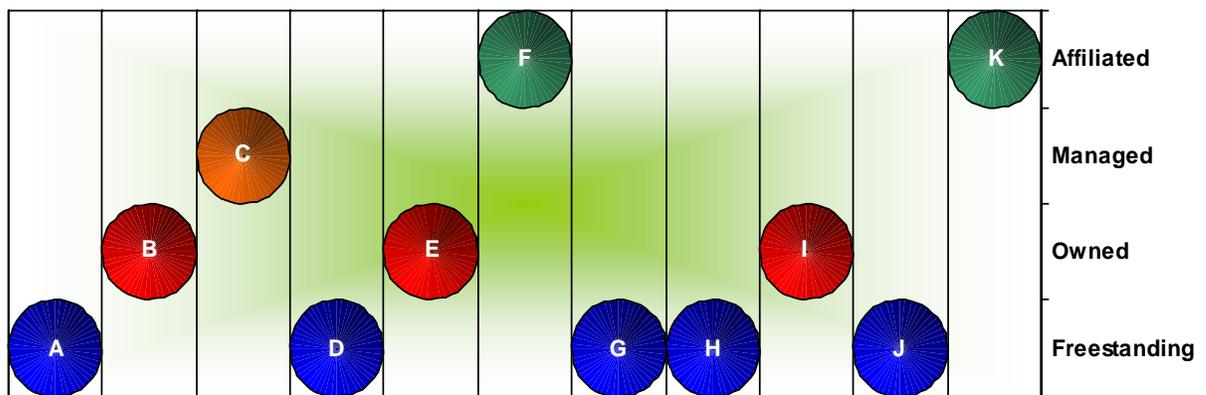
A significant factor affecting the comparability of CAH financial information is the degree of service integration among the participants. Medicare and Medicaid reimbursement will be affected by overhead allocations from the hospital to other service components. As indicated below, each facility offers various types of services with no one common model found.



Summary	
<b>Swing Beds</b>	<b>11</b>
<b>Rural Health Clinic(s)</b>	<b>4</b>
<b>Skilled Nursing Facilities</b>	<b>6</b>
<b>Physician Practices</b>	<b>5</b>
<b>Emergency Medical Services</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' audited financial statements and/or the as filed Medicare cost reports for fiscal years ending during 2007.

**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** 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.

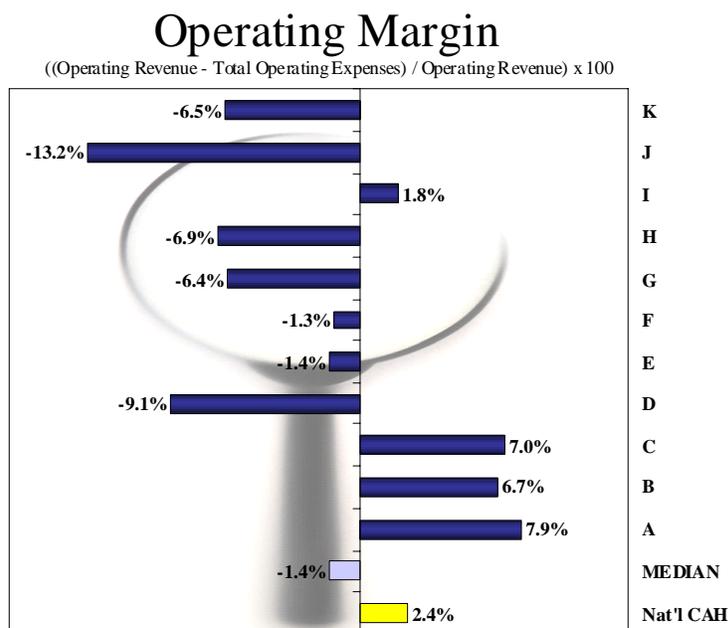
A copy of the complete quality assessment questionnaire is included in the Appendix C of this report.

## 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.

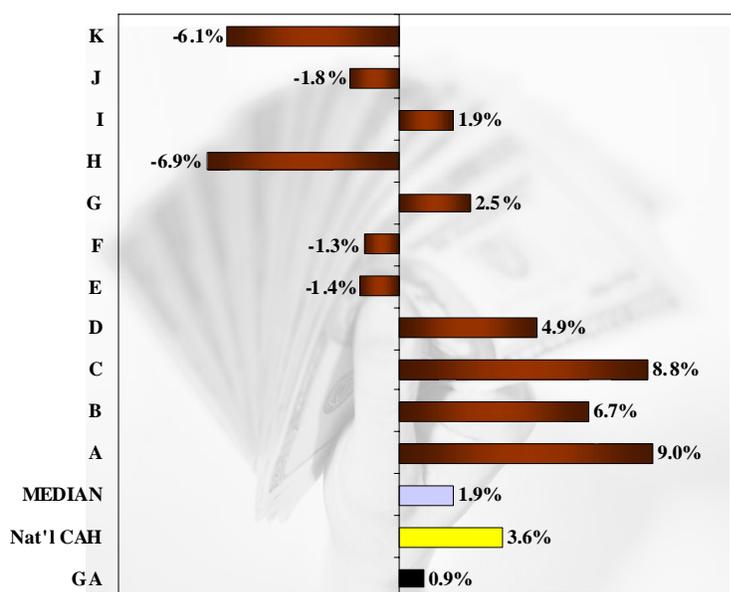
### Seven of the 11 CAHs are operating with a negative operating margin.

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.



### Total Margin

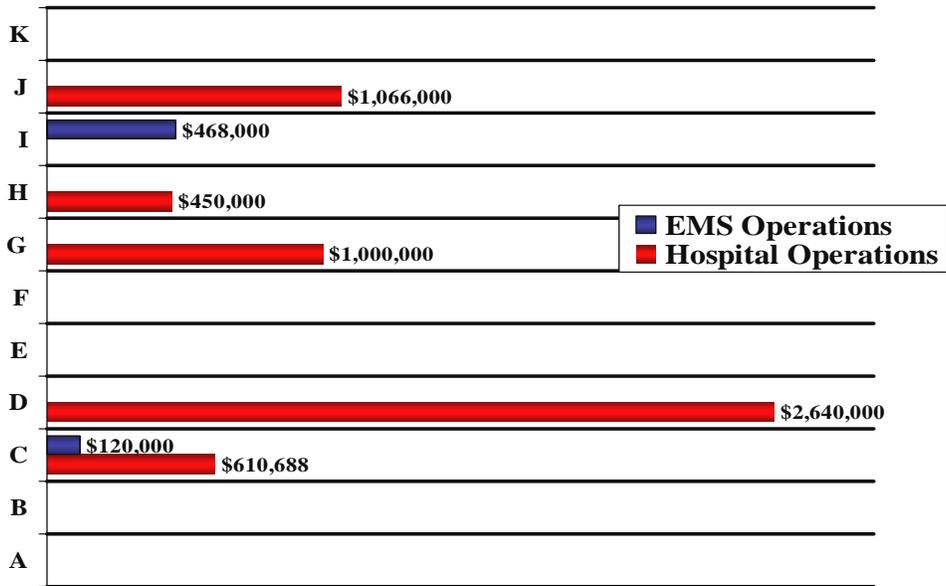
$(\text{Excess Revenues over Expenses} / \text{Total Revenue}) \times 100$



**Five 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.

**Three of the participating hospitals received county support of over one million dollars during their 2007 fiscal 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.

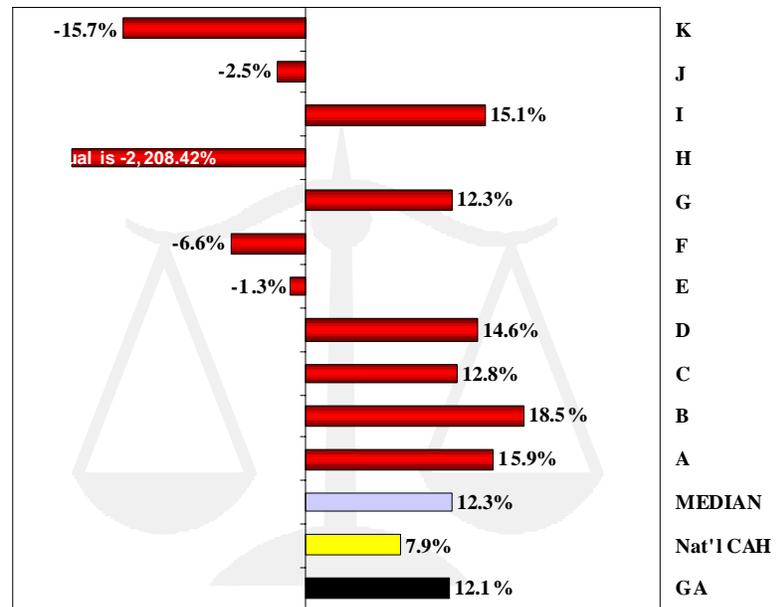
## County Contributions toward Hospital Operations



**Five of the participants experienced negative return on equity. These five 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.

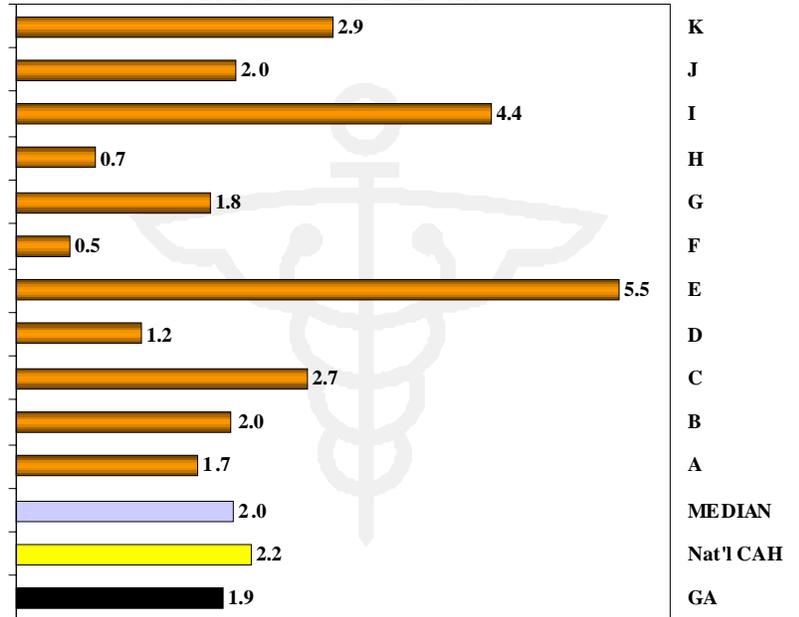
## Return on Equity

(Excess Revenues over Expenses / Net Assets) x 100



## Current Ratio

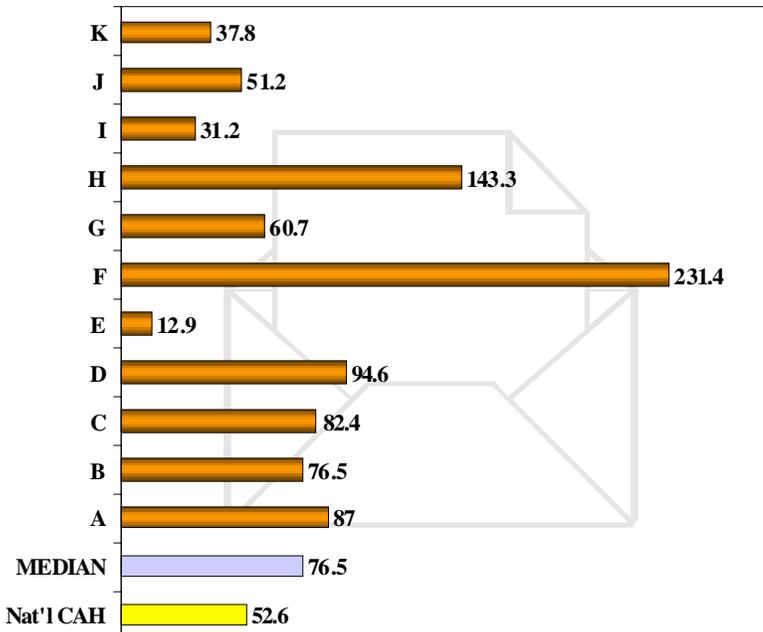
Current Assets / Current Liabilities



There were significant variances in current ratio among the participants, ranging from .5 to 5.5. 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 Payment Period

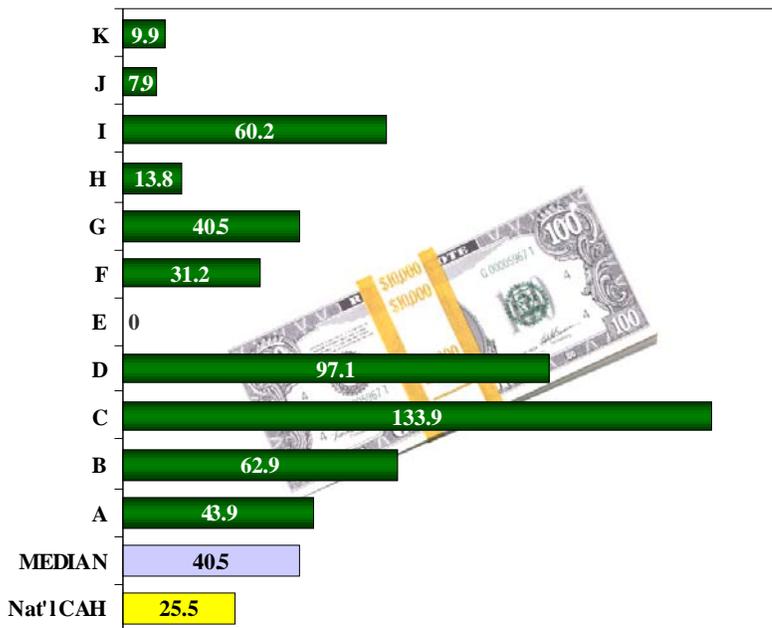
Current Liabilities / ((Total Expenses – Depreciation Expense) / 365)



The Average Payment Period of the participants ranged from 12.9 days to 231.4 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.

## Days Cash on Hand, Short-term

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

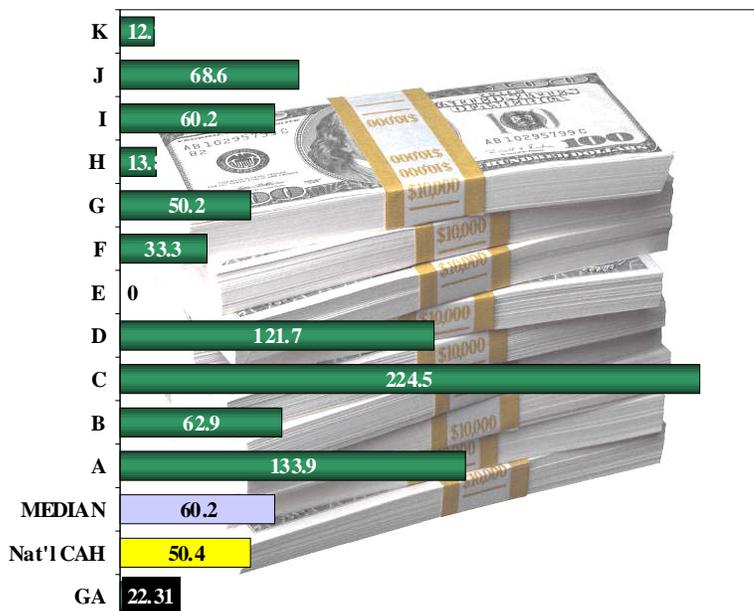


**The short-term days cash on hand ranged from zero days to 133.9 days.**

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.

## 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 224.5 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.

**Medicare 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

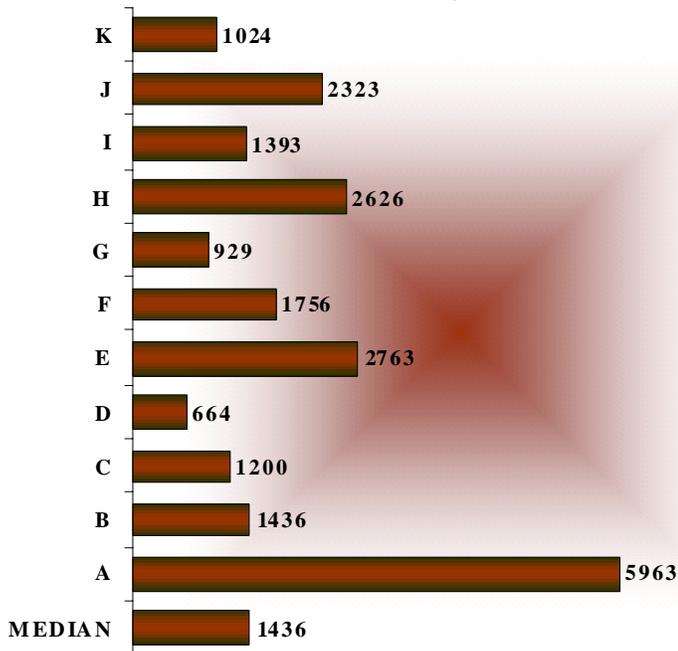
Part A coinsurance for skilled level of care SWB services provided to Medicaid/Medicare recipients. Medicaid reimbursement will be reduced by the amount of the recipient's liability (patient income). The recipient's liability is applied to the Medicaid reimbursement rate until the full liability amount has been exhausted. The hospital is responsible for collecting the appropriate patient income amount.

**Medicare RHCs** 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 Care Managed Organizations (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.

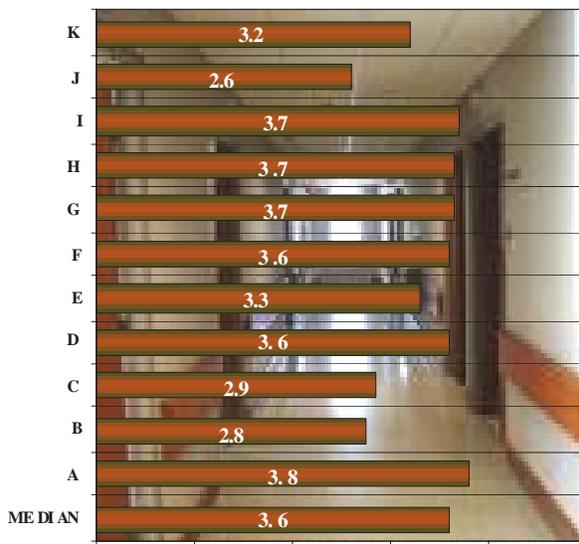
## Patient Volumes by Type of Service

### Patient Days – Acute



Inpatient volume varied significantly among the study participants ranging from a low of 664 days to a high of 5,963 days. Hospital A had the highest volume of patients. The decision of a nearby hospital not sign a contract with a major insurer has led to increases in Hospital A's volume. Although Hospital G experienced the lowest number of acute inpatient days, this was offset by having among the highest volume of swing bed days.

### Average Length of Stay

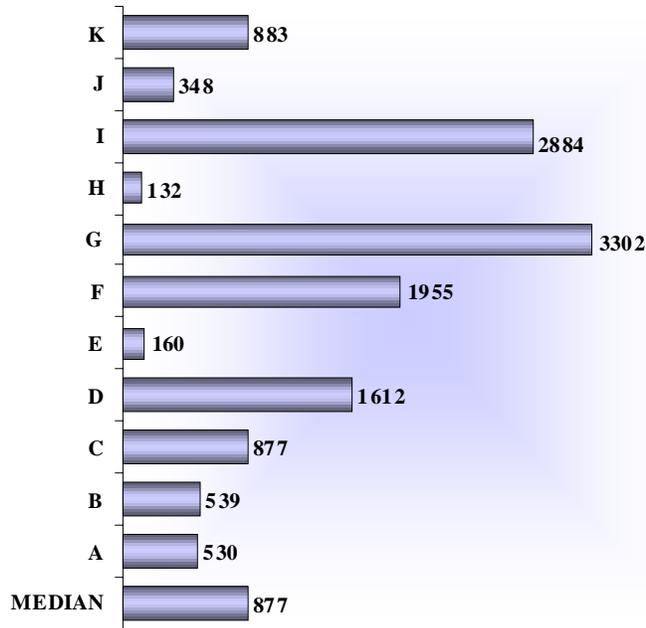


### Average Daily Census



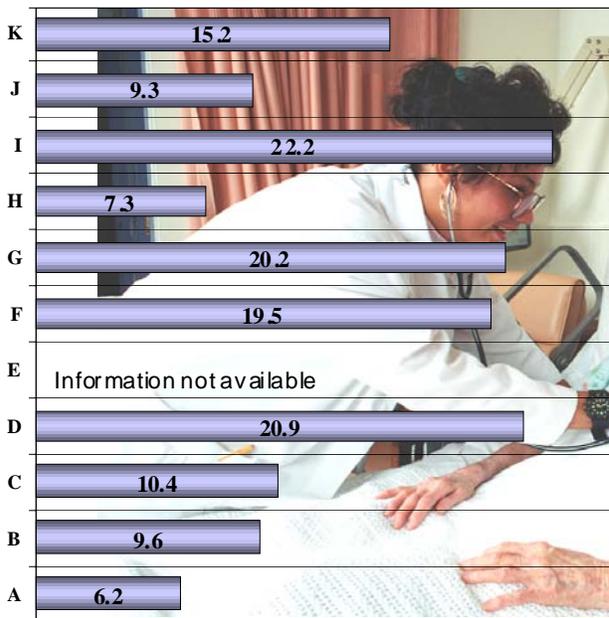
There were no significant differences noted in the average length of stay. The average daily census parallels the number of patient days.

## Patient Days – SWB

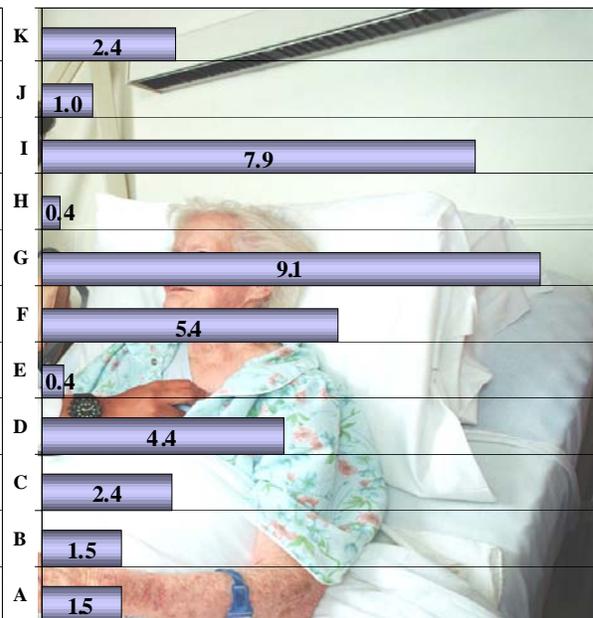


SWB volumes ranged from a low of 132 days to a high of 3,302 days. SWB reimbursement typically results in increased Medicare use and therefore more cost coverage. Several of the hospitals have been successful in partnering with nearby tertiary care facilities to provide rehabilitation and follow-up services to discharged patients. The SWB program provides an excellent mechanism for increasing CAH volumes and reimbursement.

## SWB Average Length of Stay



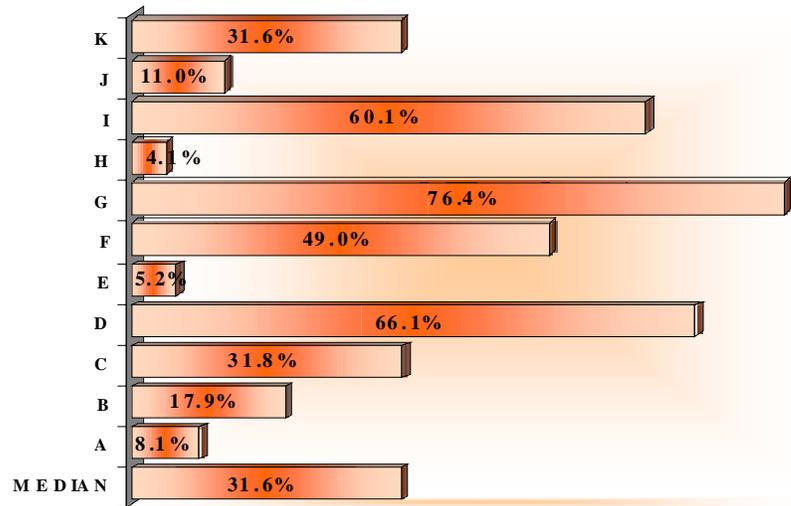
## SWB Average Daily Census



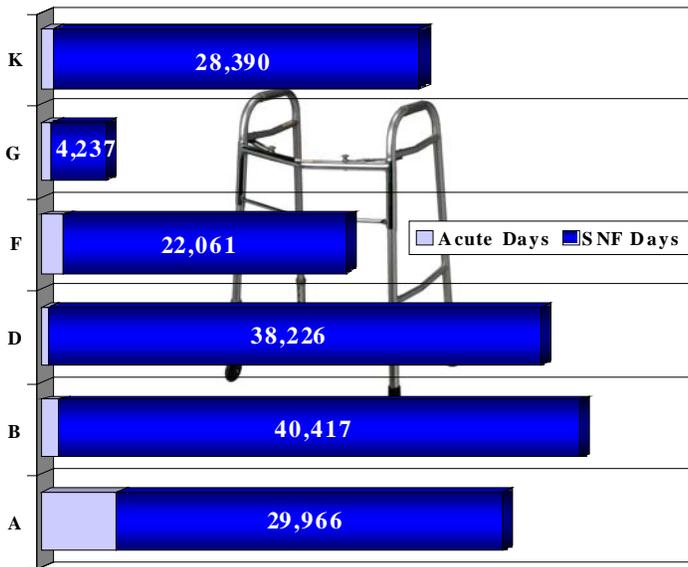
There were significant differences in both average daily census and average length of stay among the participants. Hospitals D, G and I provided high volumes of therapy services to their SWB patients, which would indicate that a majority of the SWB patients were admitted for rehabilitative services.

SWB days comprised the majority of total patient days during the 2007 fiscal year for three participants. A fourth participant had almost half of its patient days in the SWB program. 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.

## SWB Days as Percentage of Total Days (Includes Nursing Facility Days)



## Patient Days – Acute and SNF



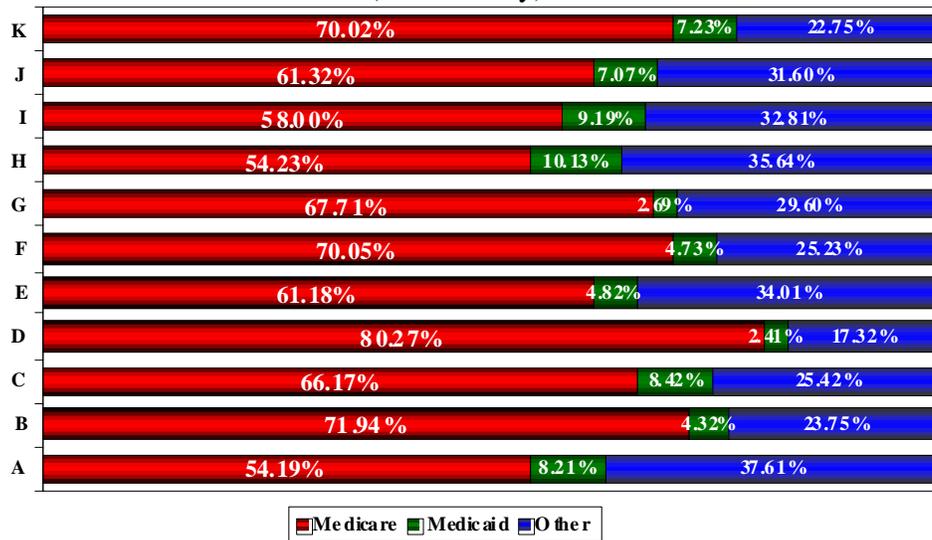
Five of the participants also operate SNFs and one CAH operates a Transitional Care Unit. The SNF patient days in these facilities overshadow those from the CAH acute stays. This situation will significantly impact expense comparisons due to the sharing of staff among the components. The presence of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

## Patient Volumes by Payer

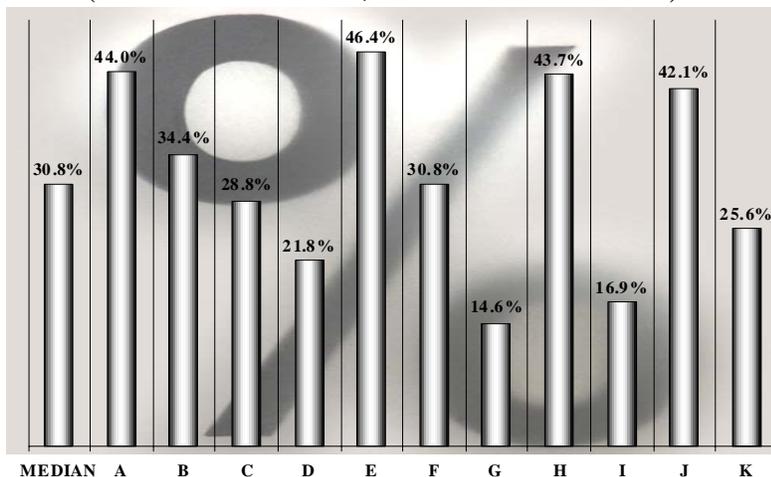
More than half of acute patient days for the Critical Access Hospitals are attributed to Medicare patients. Medicaid comprises a small portion and commercial, self-pay and other comprise the remaining percentages. For this reason, Critical Access Hospitals are particularly vulnerable to Medicare regulatory changes.

## Patient Days Percentage by Payer

(Acute Only)



## Medicare Acute Days as Percentage of Total Days (Total includes acute, observation and SWB)

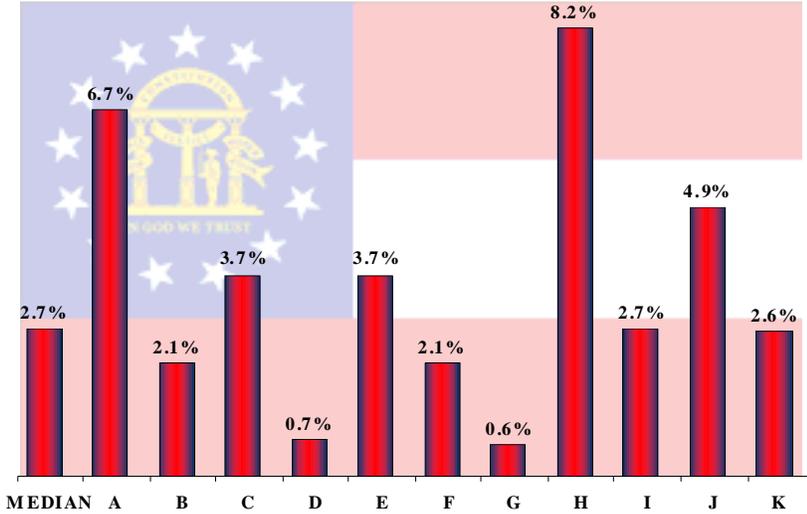


There was a wide range of Medicare inpatient utilization among the participating Critical Access Hospitals. This percentage can be significantly affected by the SWB utilization in the facility. The higher the SWB use, the lower the acute days percentage. For example, Hospital G indicates a very low Medicare Acute Days percentage; however, its SWB percentage was the highest among the participants.

# Medicaid Acute Days as Percentage of Total Days

(Total includes acute, observation and SWB)

Does not include Medicaid Managed Care days

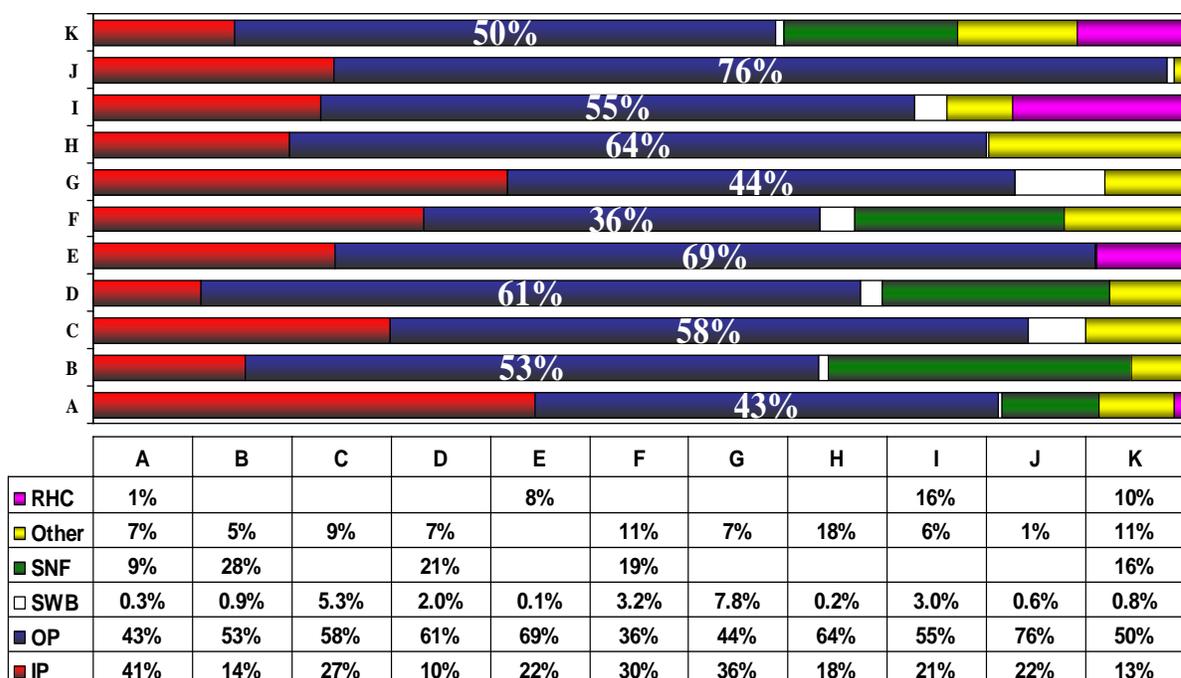


**Georgia Medicaid reimbursement has changed radically since 2006** when Georgia implemented the Medicaid managed care program. This chart reflects only days related to the traditional Medicaid cost based reimbursement system. Medicaid managed care days are included in the commercial insurance categories. Note the significant variances of Medicaid use.

## 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.

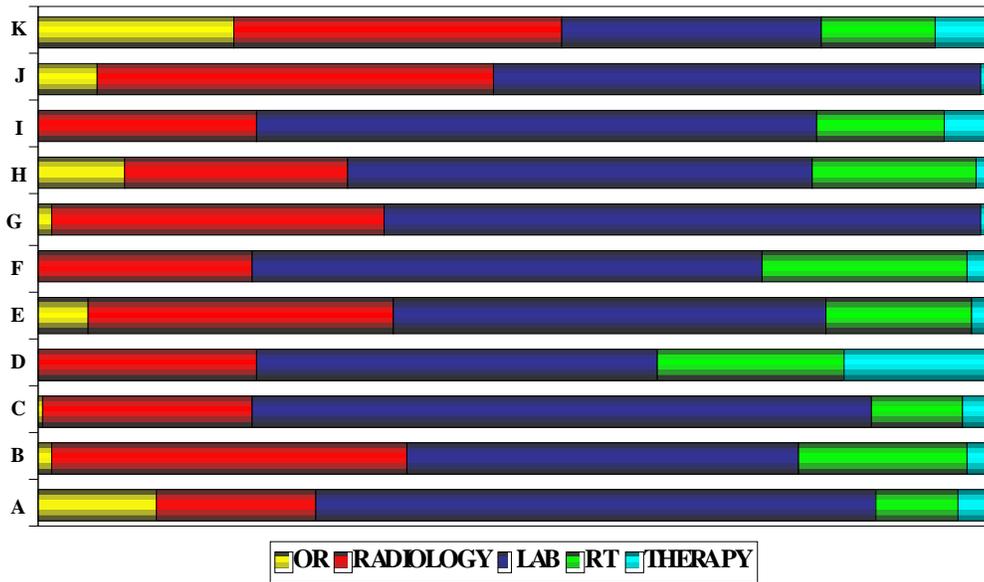
### Revenue Percentage by Service Type



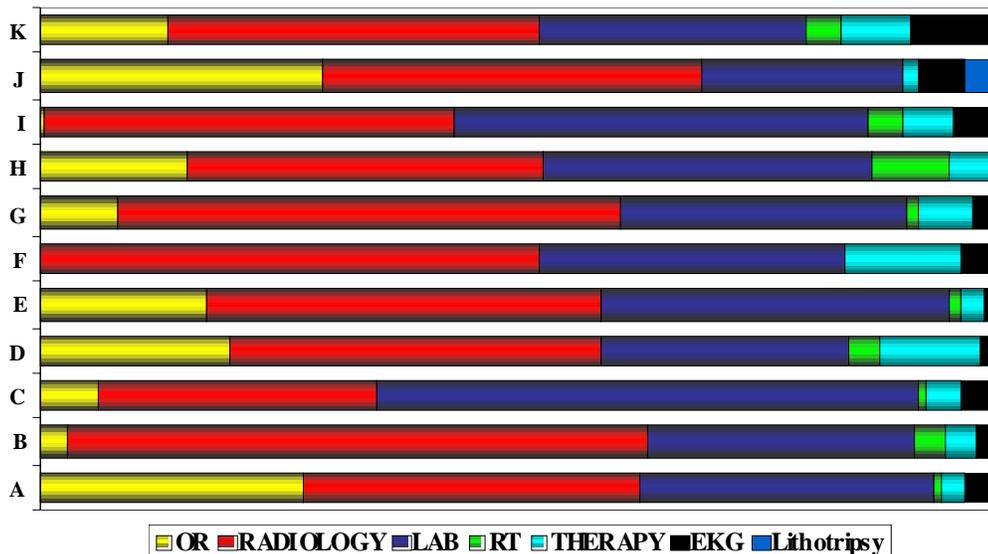
The data table provides further detail regarding the composition of revenues generated from various components of the participating hospitals. Hospitals A and K had the most similar operating components; however, the revenue distribution among these components was significantly different.

**The variety and volume of ancillary services provided will also affect comparability among the CAH participants.** Five of the participants have notable amounts of surgical services. Two of the participants did not provide surgical services during 2007. The use of these and other ancillary services will affect the average salaries per employee and other costs dependent upon the level of skilled personnel needed.

### Medicare Inpatient Ancillary Services

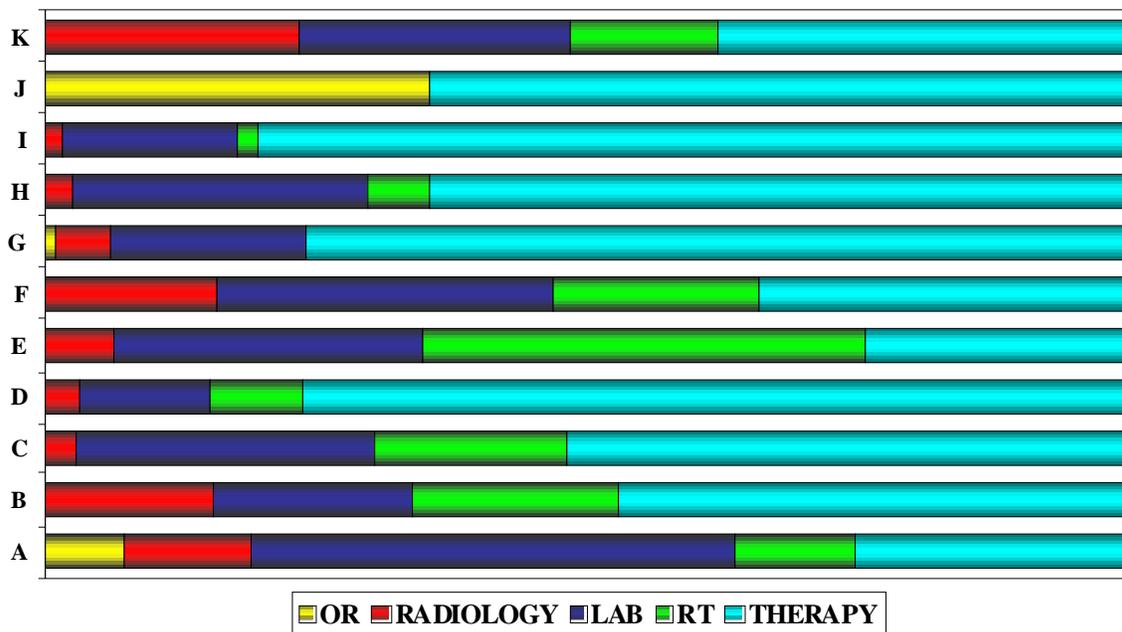


### Medicare Outpatient Ancillary Services



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

### Medicare SWB Ancillary Services

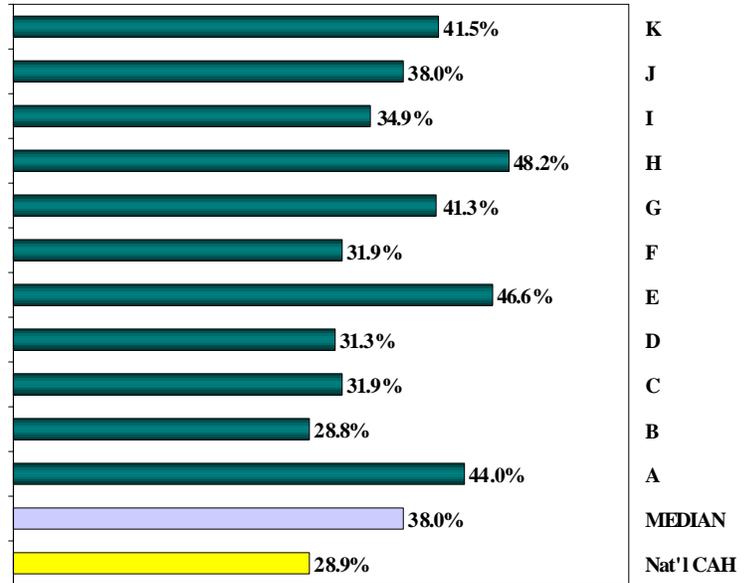


## Deductions from Revenues

**The contractual allowance percentages ranged from a low of 28.8 percent to a high of 48.2 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.

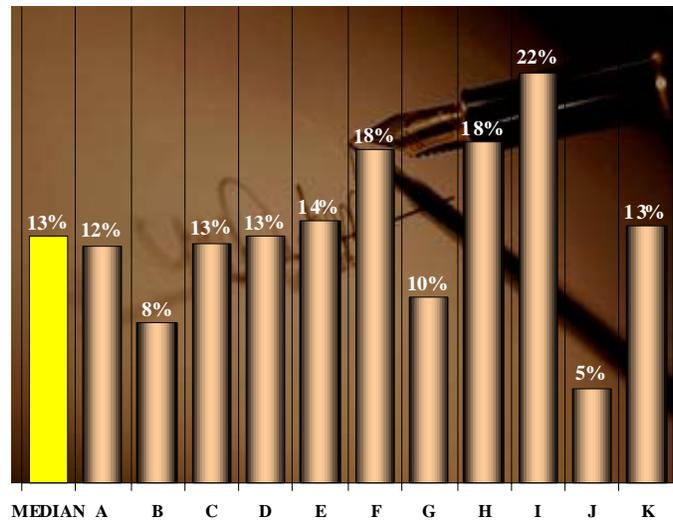
Comparability of data will be affected by differing price structures among hospitals. Generally the higher the hospital charges, the higher the contractual allowance percentage. Although increasing commercial payer mix will reduce this percentage, competitive markets, unavailability of physicians, aging populations and the poverty levels make this difficult.

Contractual Allowance Percentage



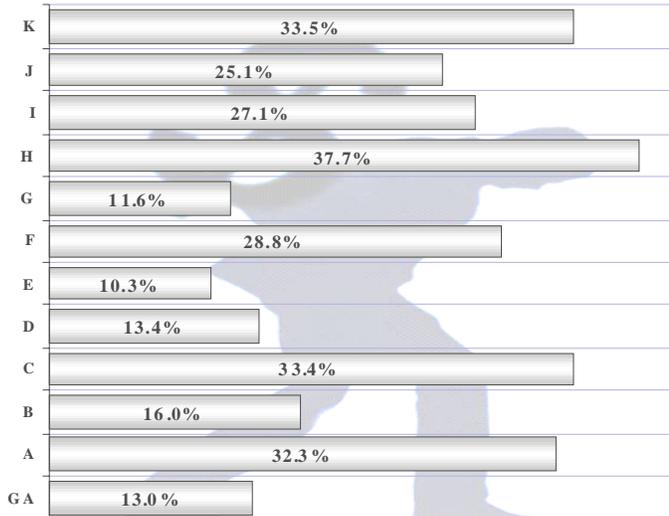
**Bad debt and charity write-off percentages ranged from a low of 5 percent to a high of 22 percent.** These ratios will be directly affected by the poverty and unemployment levels in the market area. Several hospitals stated that there was not an accurate segregation between bad debts and charity; therefore, these percentages were combined. It was noted that hospitals were not consistent in the timing of bad debt and charity write-offs. One hospital was “cleaning up” its accounts during 2007, while other hospitals were not consistently following bad debt policies. 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

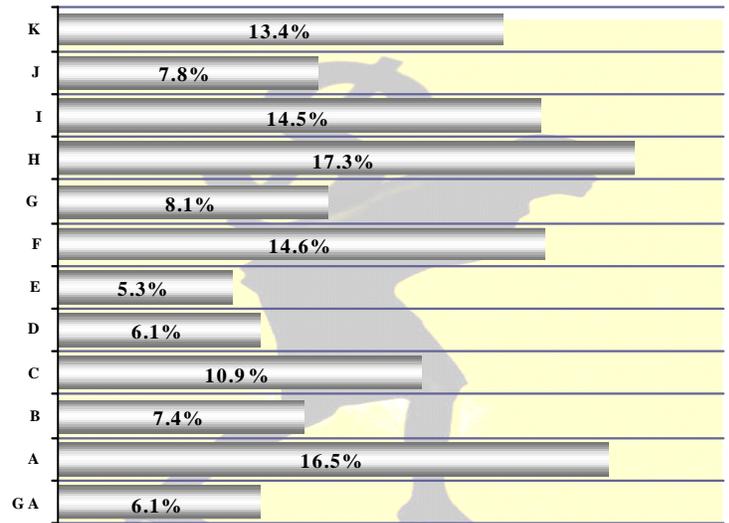
Residents with income below poverty levels in 1999



Source: www.city-data.com

## Poverty Levels

Residents with income below 50% poverty levels in 1999



Source: www.city-data.com

**Ten of the 11 participants' market areas have poverty levels above the state average. Nine of the participants' area markets are above the state average for residents with income below 50 percent of the poverty levels.** 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. Only four of the participants were receiving sizable amounts of county support to care for the indigent population of the county. Continued Medicaid supplemental funds (ICTF and UPL funds) will be critical to the survival of these hospitals.

## 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 a few common services provided by hospitals participating in this study. Those prices highlighted in yellow are above the median prices of the group. Outpatient coinsurance is based on 20 percent of charges. In each charge reviewed, 20 percent of the CAH median charge exceeded the outpatient ambulatory payment classification (APC) coinsurance amounts charged by PPS hospitals.

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 Indigent Care Trust Fund. Consideration should be given to implementing a reduction in or elimination of the difference between private and semi-private room rates.

		MEDIAN	A	B	C	D	E	F	G	H	I	J	K
Private Room		400	504	400	305	1,160	739	371	-	365	430	325	418
Semi-private Room		400	488	400	275	1,100	734	351	-	345	420	325	408
E&M	99281	116	148	75	96	172	133	116	106	100	140	99	143
E&M	99282	170	176	100	96	270	196	170	151	125	287	135	280
E&M	99283	253	253	150	150	316	344	260	226	145	421	182	419
E&M	99284	420	420	225	228	502	598	420	433	216	559	234	557
E&M	99285	604	472	275	228	821	686	655	604	324	699	426	697
IM	90772	42	48	52	42	-	43	55	-	25	80	21	25
INF HYDRA 1ST	90760	151	166	89	126	-	236	260	-	151	375	68	185
VENIPUNC	36415	16	15	5	14	20	16	9	16	17	25	17	18
BMP	80048	106	201	68	138	147	138	48	128	106	97	76	98
CMP	80053	158	235	80	158	171	195	56	162	158	179	123	113
UA W/MICRO	81001	48	48	36	49	32	59	48	55	34	68	32	33
CBC W/DIFF	85025	71	72	45	76	51	125	68	94	40	98	43	71
TROPONIN	84484	99	101	87	58	172	138	50	99	55	136	70	122
CPK	82550	43	55	43	68	38	63	30	21	27	44	12	44
EKG	93005	135	150	77	152	116	166	135	153	103	157	70	89
PA/LAT CHEST	71020	159	151	225	141	149	201	159	165	124	183	109	174
AP CHEST	71010	128	129	105	110	106	201	128	141	92	143	95	146
CT BRAIN W/WO	70470	1,579	1,654	1,900	1,186	1,579	1,591	1,423	2,040	1,005	1,704	1,144	1,563
CT BRAIN W/O	70450	1,100	1,075	1,100	1,024	1,128	1,494	1,032	1,545	840	1,119	915	1,221
EGD W/BX	43239	1,129	1,233	476	614	1,107	-	-	-	-	-	-	1,129
C-SCOPE W/BX	45380	1,353	-	512	949	1,353	-	-	-	1,710	-	-	1,448
OBS/HR		14	11	14	9	46	38	27	26	3	-	3	17

## Medicaid Supplemental Payments

**All participants receive supplemental payments from Medicaid from the ICTF and/or the UPL reimbursement.**

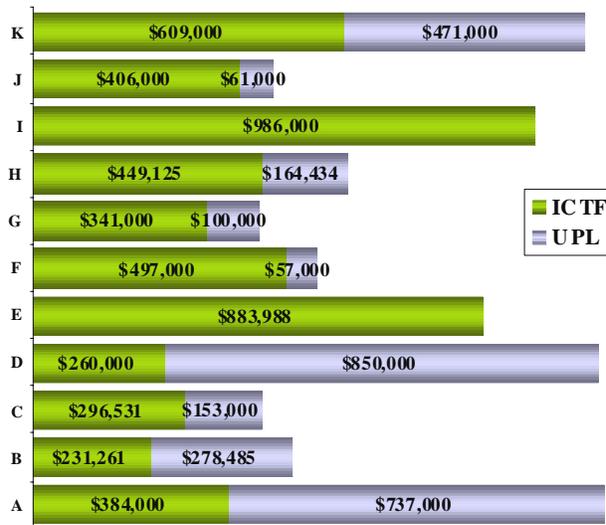
The Georgia Medicaid Disproportionate Share Hospital (DSH) Program is a federal program that works to increase health care access for the poor. Hospitals that treat a "disproportionate" number of Medicaid and other indigent patients qualify for ICTF payments through the state's Medicaid program based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

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

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

### ICTF / UPL Participation

(includes SNFs)

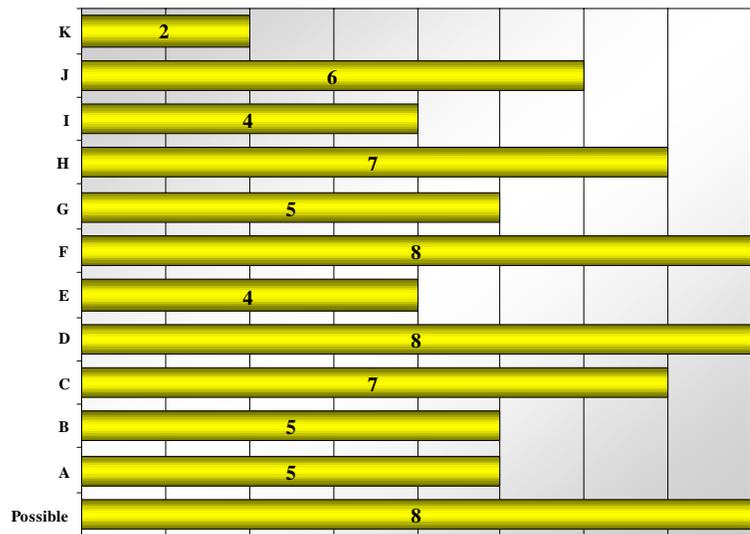


## Charge Capture

**Charge Capture is a critical area of the revenue cycle.** Lost charges result in no opportunity for reimbursement. 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 regarding charge capture in their facility. (Appendix C includes the complete questionnaire.) The chart below identifies the quality assessment scores for the participating hospitals. The highest possible score was eight.

In the review of medical records, it was noted that Hospital K 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



**According to the quality assessment findings, four of the 11 hospitals in this study have not updated or reviewed their charge description master (CDM) in its entirety within the past year.**

### CDM



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 did not have a dedicated CDM individual or committee; however, the business office manager played a significant role in updating CPT codes. 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.

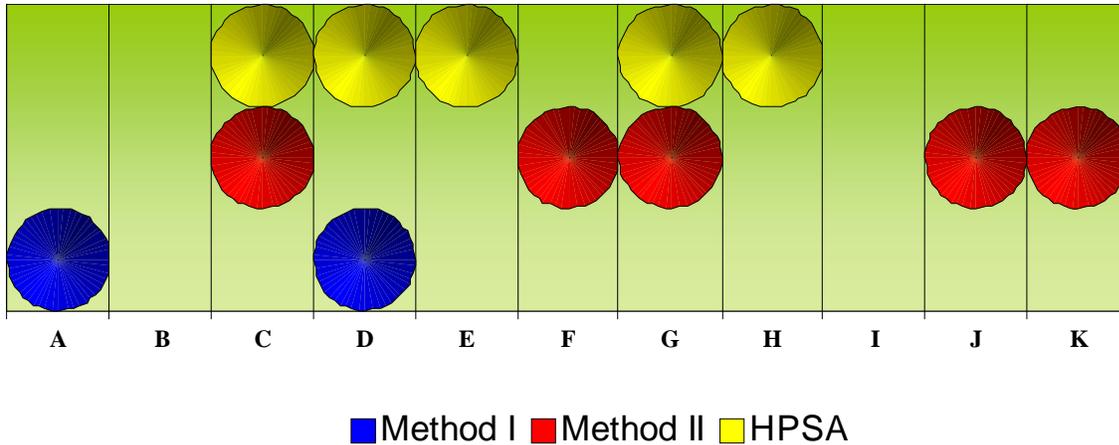
**Incorrect revenue code assignments can lead to lost reimbursement and compliance issues.** Drugs that can be self-administered are not covered by Medicare for outpatient services, including observation services. Based on Medicare regulations, self-administered drugs should be billed as “non-covered” 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 following the Centers for Medicare and Medicaid Services (CMS) guidelines.

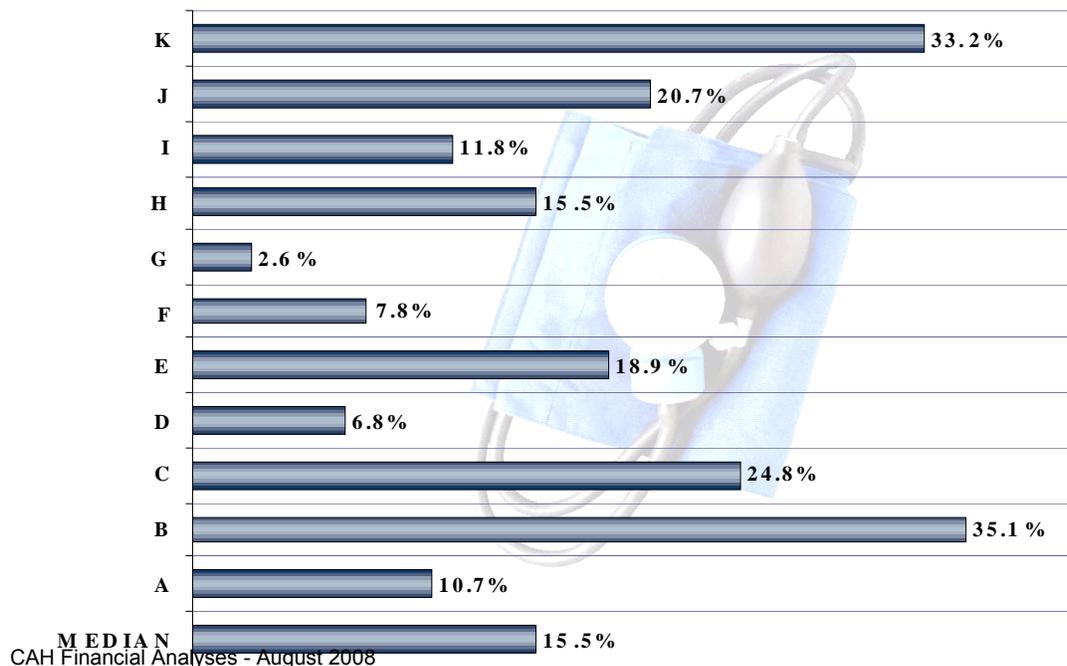
**Professional Fee billing is causing confusion.** Some hospitals do not understand how to appropriately bill professional fees under Method II guidelines or the billing for health professional shortage area (HPSA) add-on payments. The following chart identifies the participating hospitals’ professional 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



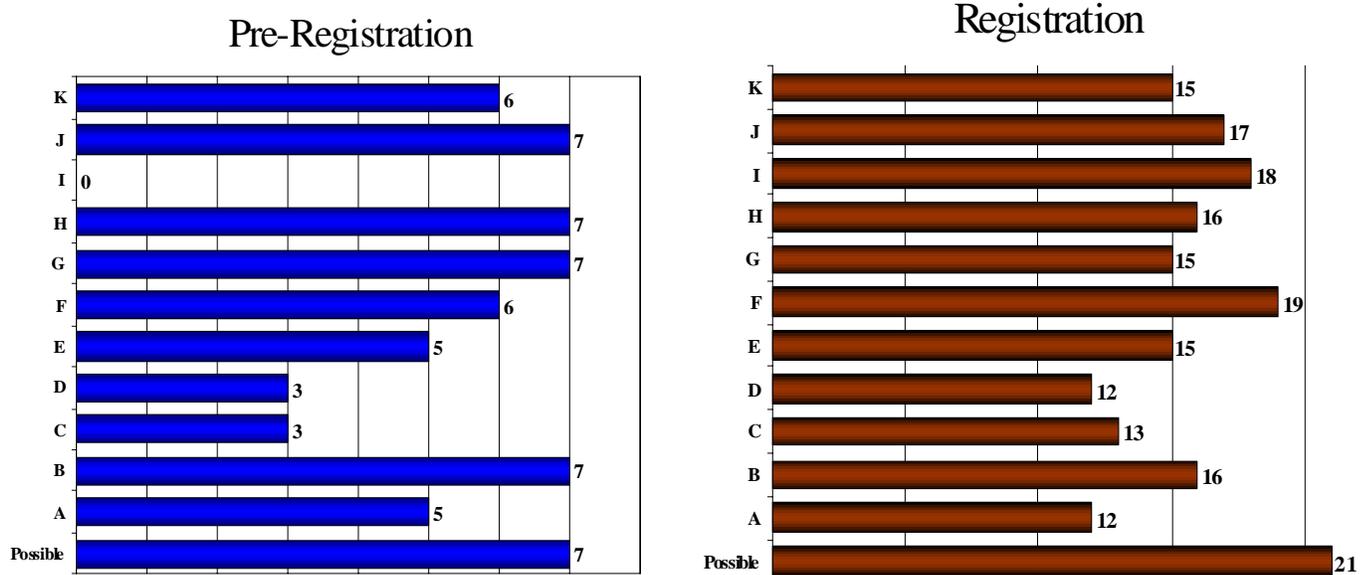
As stated in the Medicare Claims Processing Manual (Pub. 100-04), Chapter 4, Section 290, observation services must be reasonable and necessary to be covered by Medicare. In only rare and exceptional cases do reasonable and necessary outpatient observation services span more than 48 hours. In the majority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



**All participants, with the exception of Hospital I, 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.

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

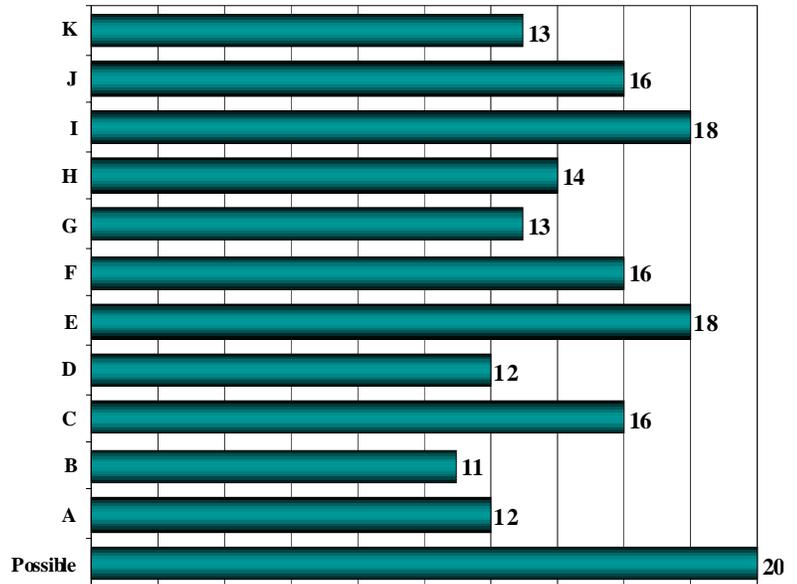
- Hospitals should implement a formal and consistent means of tracking both registration elements and registration errors. Hospitals may consider depicting the results in graphs to give management a more vivid illustration of the outcomes.
- Efforts should be made to discuss and present in writing to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

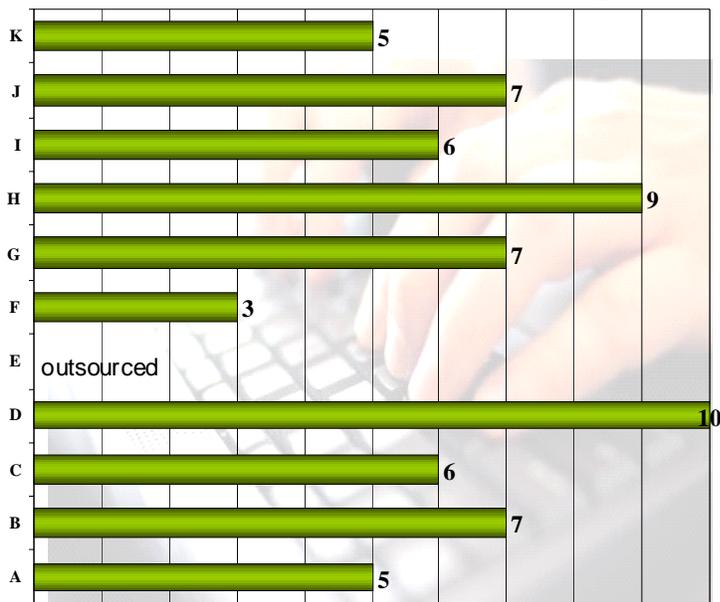
**Business office quality assessment scores ranged from a low of 11 points to a high of 18 points.** Recommended areas for improvement include:

- 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, and
- 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 three 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 issues 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**

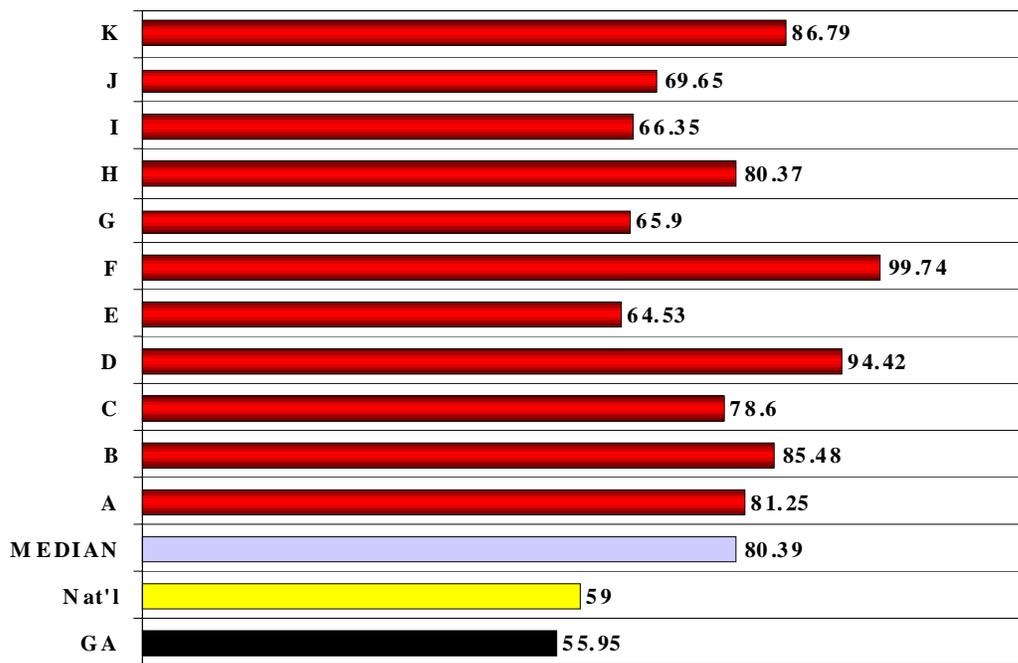
Accounts Receivable (A/R) is often the largest asset on a hospital's balance sheet. Current accounts receivable was reviewed for all 11 hospitals participating in this study.

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 A/R



**Days Net Revenue in Net Accounts Receivable for the 11 hospitals ranged from 64.53 days to 99.74 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.

**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 2003, with no revisions made since that time. Summaries of each hospital's policies can be found in Appendix A.

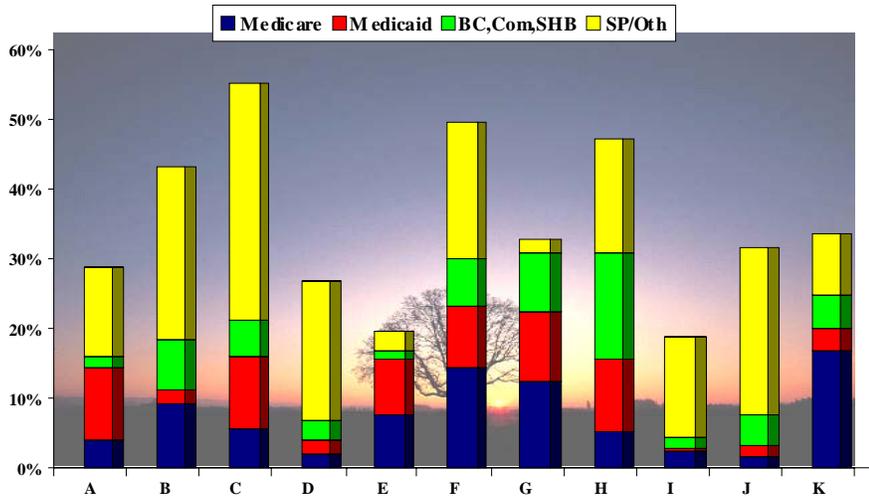
**Credit balances can reduce the Days in Net A/R.** Care should be taken when evaluating outstanding accounts receivable to identify credit balances. Credit balances can artificially reduce the days in net accounts receivable. All credit balances should be monitored for Medicare and Medicaid credit balance 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 C had the highest amount of older accounts, while Hospital I had the lowest.

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.

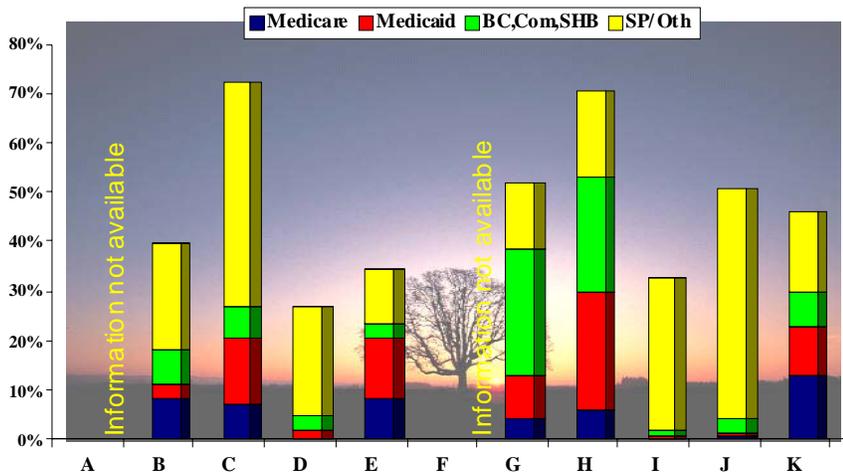
## Percentage of Discharge A/R Dollars Greater than 90 Days by Payer

Based on A/R at time of on-site visit



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

Based on A/R at time of on-site visit

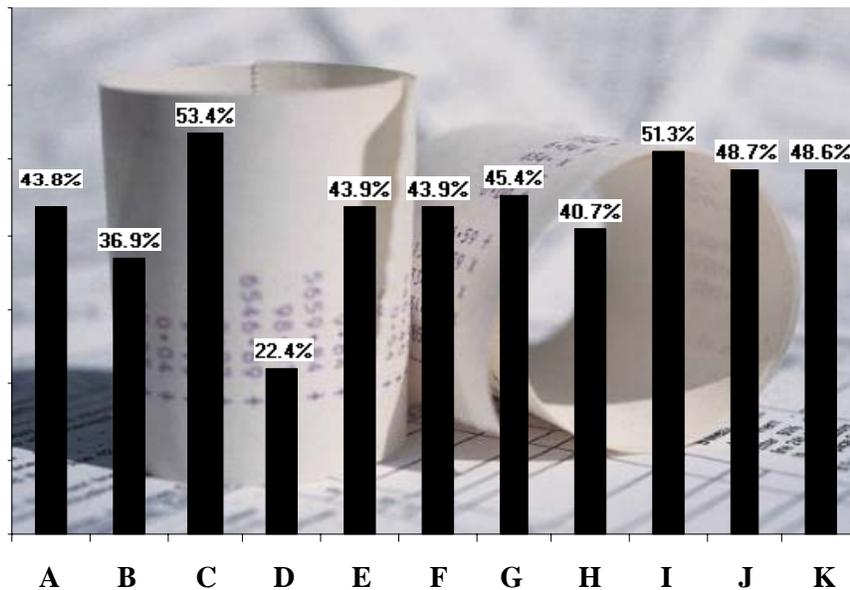


## Analyses of Costs

**Often the public has the misconception that CAHs are reimbursed for full costs of operations.** Although a portion of expenses are cost-based reimbursed, the majority of expenses are not. Therefore it is critical that CAHs monitor the cost of services offered. 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 through fixed fee payments.

When making operational decisions, it is extremely important to understand how costs will be reimbursed. For instance, Medicare and Medicaid will only pay Hospital D 22 cents of each dollar spent. The remaining 78 cents of costs must be recovered from fixed fee governmental programs or commercial payers.

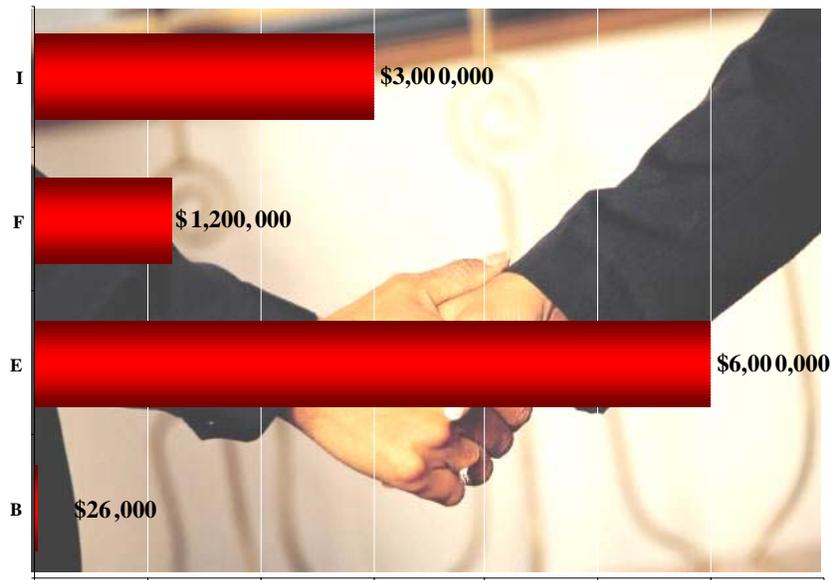
### Percentage of Hospital Costs Which Are Cost Based Reimbursed (includes SWB)



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

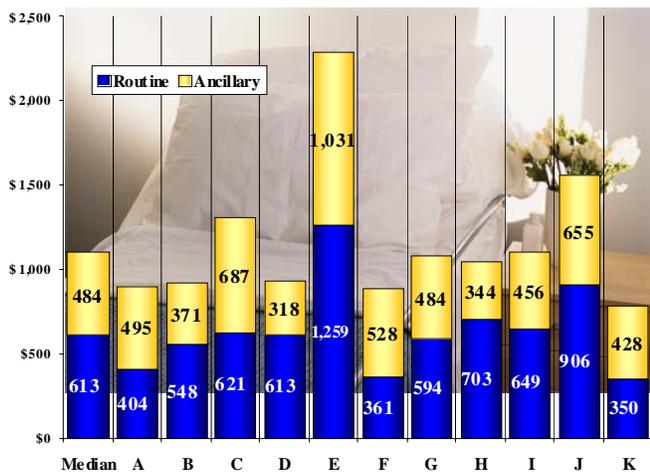


**Costs per day comparisons should be reviewed with caution.** Hospital costs are directly affected by a number of factors such as:

- 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 E has higher costs per day. This hospital is part of a larger health system and receives significant overhead allocations for various services provided by the larger facility. Hospital J is undergoing significant market pressure related to salaries, which results in a higher than average cost per day.

Medicare Inpatient Cost per Day



Medicare Swing Bed Cost per Day



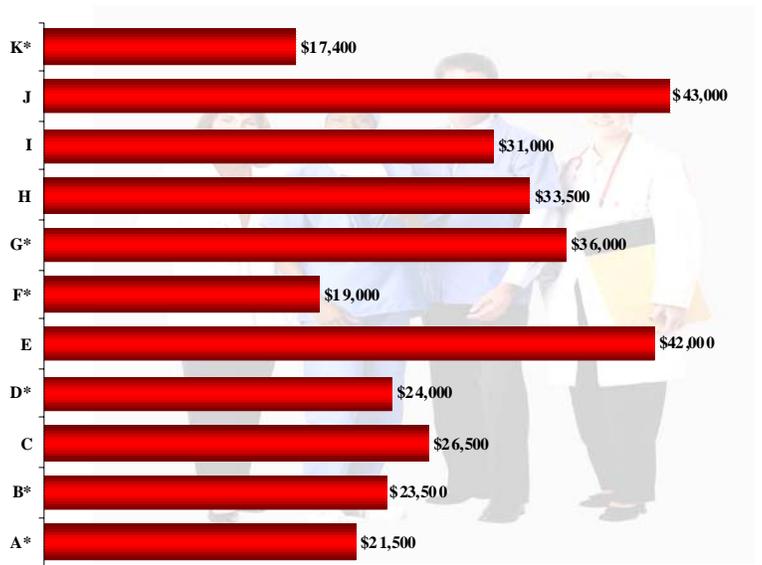
**Salaries comprise the most significant portion of hospital operating expenses.**

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 used contract support services, while others shared 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)

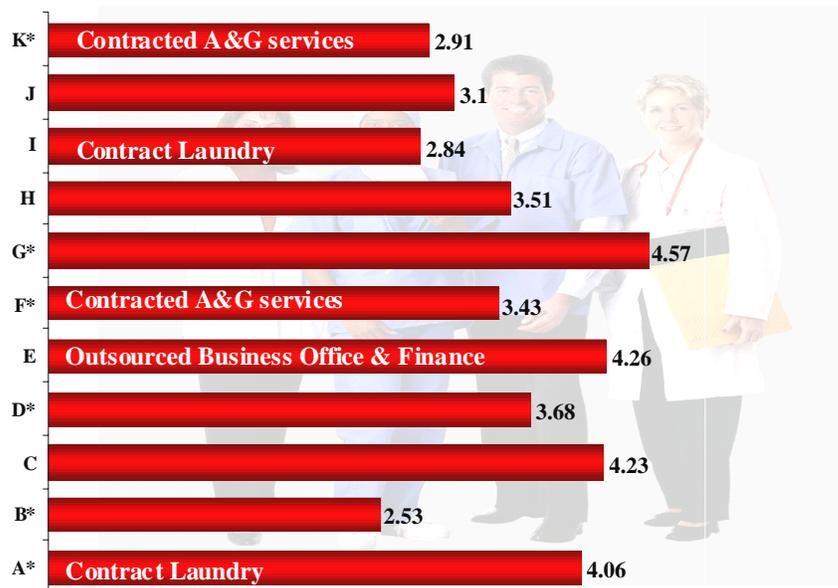


Hospitals A, B, D, F, G and K all have SNF components which use shared staffing with the hospital. Also Hospitals A, E, F, I and K use contract services, rather than employees for certain functions. Hospital E, I and F use contract management personnel.

## Full Time Equivalents per Average Daily Census

(excludes non-hospital components)

Hospitals A, E, F, I and K use contract services as indicated on the chart. Also note the sharing of staff with SNFs as indicated by the asterisk.

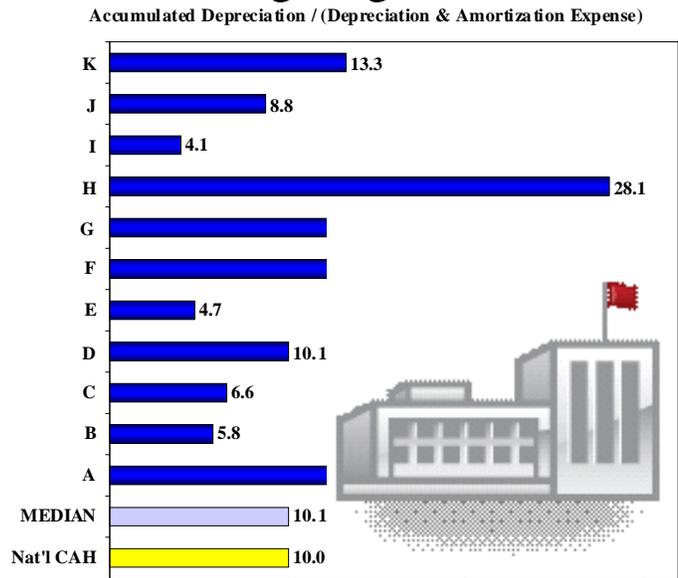


\*sharing of staff with SNF and Transitional Care Unit components

**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. Financing resources are scarce or cost prohibitive. Without county support many hospitals are unable to obtain capital financing.

The average age of plant ratio for the eleven CAHs spans from 4.1 years to 28.1 years. The National average for CAHs is 10.0 years.

## Average Age of Plant



One participant in the study recently opened a new replacement facility that was financed with funds obtained from the United States Department of Agriculture. Other 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.

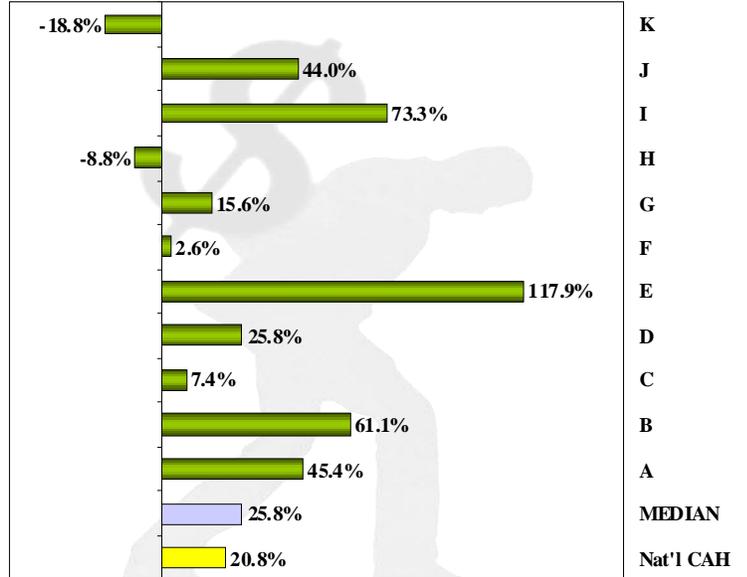
The chart below indicates each participant's plan for future renovations or replacements.

	<i>Future Renovations</i>
<i>A</i>	<i>Undergoing renovations</i>
<i>B</i>	<i>No plans for renovation</i>
<i>C</i>	<i>No immediate plans for renovation</i>
<i>D</i>	<i>Currently planning for renovation</i>
<i>E</i>	<i>No immediate plans for renovation</i>
<i>F</i>	<i>No immediate plans for renovation</i>
<i>G</i>	<i>Currently planning for facility replacement</i>
<i>H</i>	<i>Currently planning for facility replacement</i>
<i>I</i>	<i>No immediate plans for renovation</i>
<i>J</i>	<i>No immediate plans for renovations. Last major renovation 2003</i>
<i>K</i>	<i>No immediate plans for renovation</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.

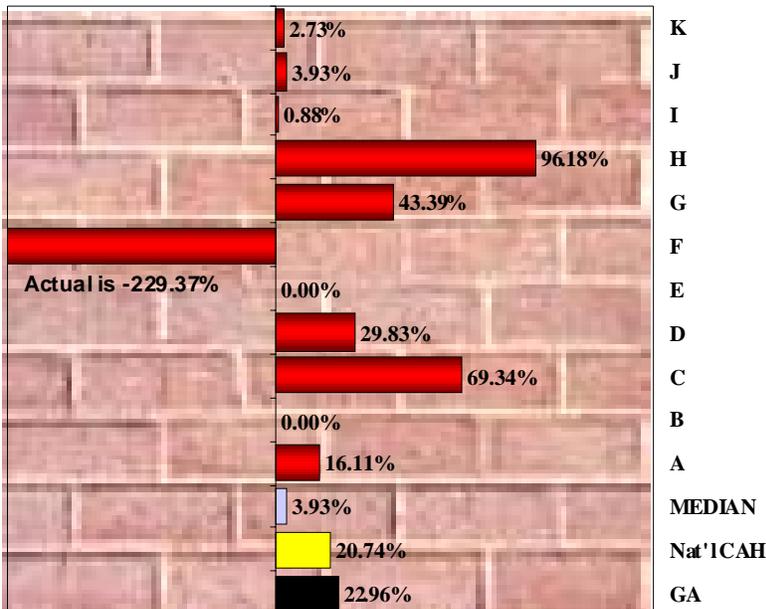
**The Cash Flow to Total Debt percentages for the 11 CAHs spans from -18.8 percent to 117.9 percent.** Cash flow to total debt has been found to be an important indicator of future financial problems or insolvency. The numerator measures the current amount of funds available from operations. This source 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. Hospital E reported no long term debt.

**Cash Flow to Total Debt**  
 (Excess Revenues over Expenses + Depreciation & Amortization Expenses) / (Current Liabilities + Long-Term Debt) x 100



## Long-Term Debt to Capitalization

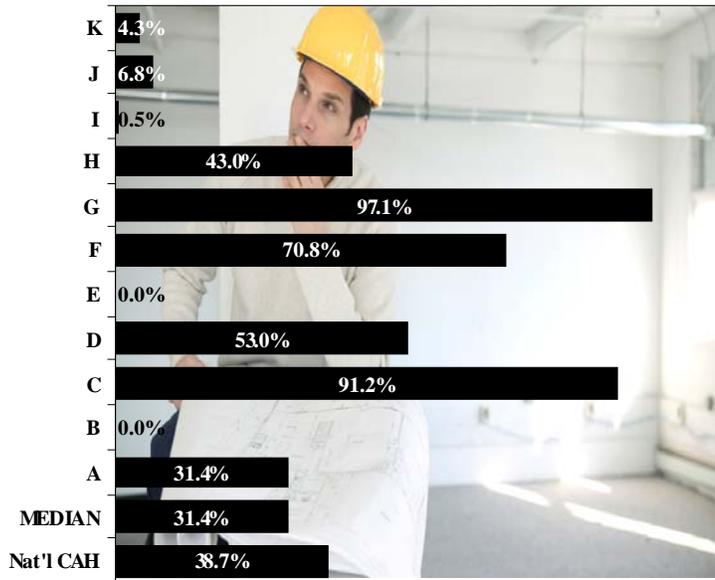
Long-Term Debt / (Long-Term Debt + Net Assets) x 100



**The Long-Term Debt to Capitalization ratio for the 11 hospital spans from 0.0 percent to 96.2 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. This means risk in the minds of many creditors and may be viewed unfavorably. Hospitals B and E did not indicate long term debt on their financials.

## Fixed Asset Financing Ratio

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



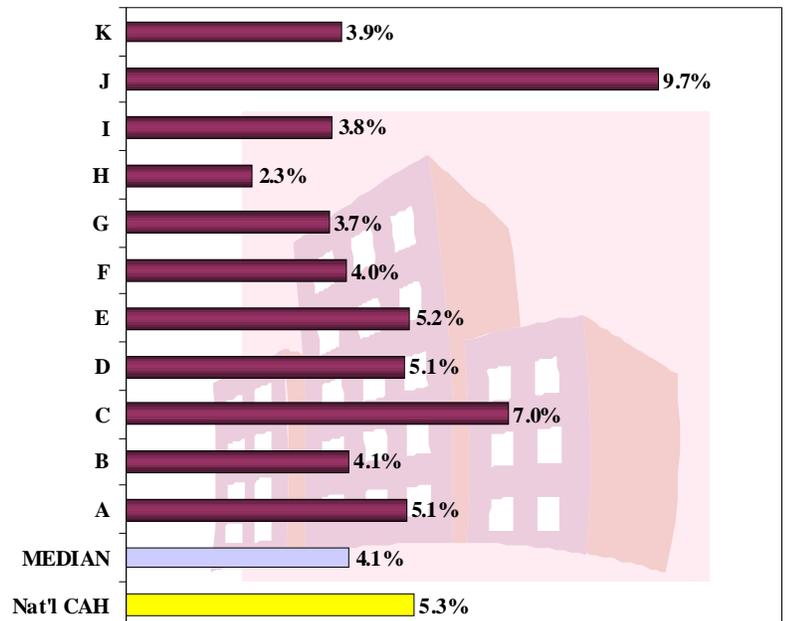
**The fixed asset financing ratio for the hospital ranged from 0 percent to 97.1 percent.** This ratio has been used by creditors for many years.

The ratio defines the proportion of net fixed assets (gross fixed assets less accumulated depreciation) 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 B and E did not indicate any long term debt in their financial information.

**The capital expense ratio for the hospital ranged from 3.2 percent to 9.7 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

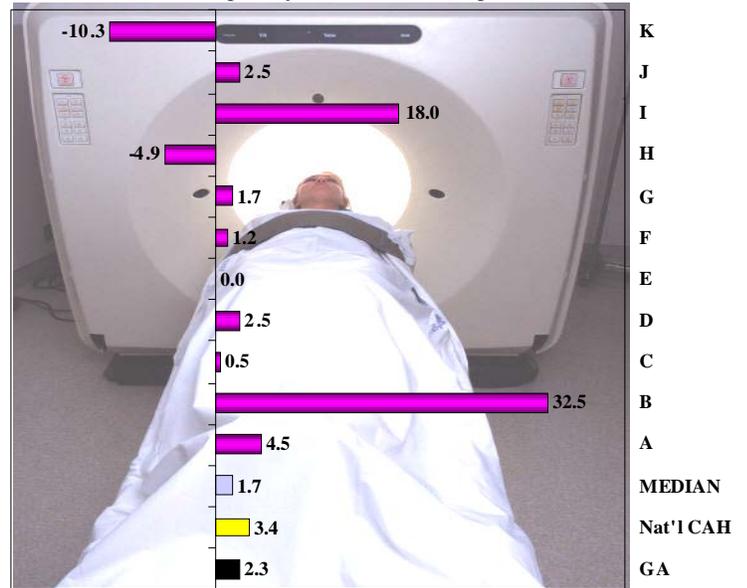


**The debt service coverage ratio for the hospitals ranged from -10.3 to 32.5.**

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.

## Debt Service Coverage

$$\frac{(\text{Excess revenues over Expenses} + \text{Interest Expense} + \text{Depreciation \& Amortization Expense})}{(\text{Debt Principal Payments} + \text{Interest Expenses})}$$



## Cost Reporting

Every hospital must file a Medicare cost report annually. Over the past twenty years, the reimbursement impact of these reports has been minimized for most hospitals. However information reported for Critical Access Hospitals 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. 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, 10 of the participants used square footage statistics for housekeeping allocations. Hospital K 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.

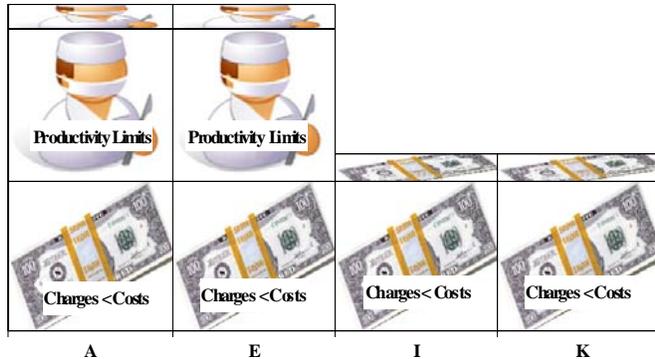
**Administrative costs** are often allocated to non-hospital areas using accumulated costs. Components such as SNFs, RHCs and physician practices may have their own registration and billing departments. In these cases, it may not be reasonable to allocate to these components a portion of all administrative and general costs of the hospital. It would be more accurate to subscript 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. Hospitals A and G were the only participants that utilized subscribing in the allocation of administrative and general costs.

**Four of the CAHs with RHCs appear to have opportunities to increase RHC reimbursement.**

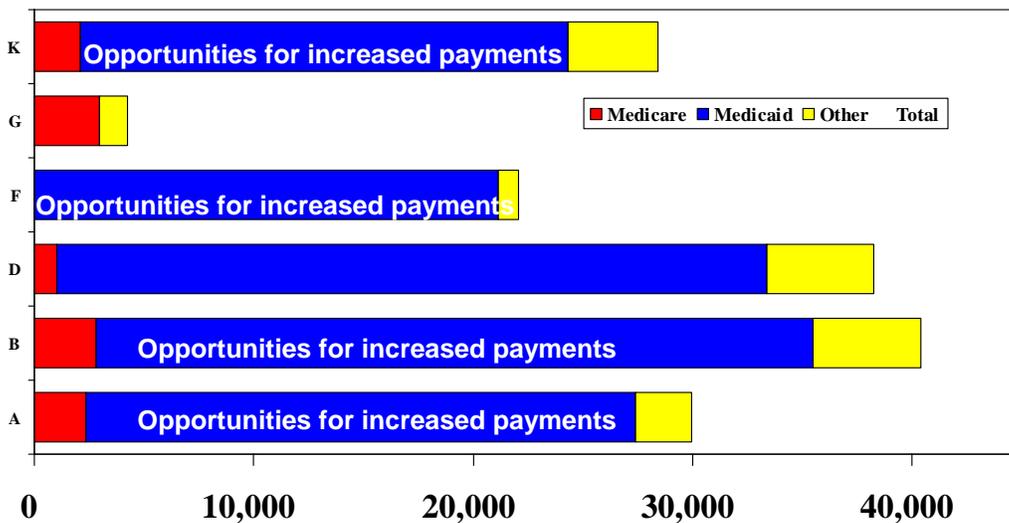
Two of the RHCs are limited by provider productivity and four are experiencing reduced reimbursement due to Medicare costs exceeding Medicare charges. We recommend that additional analyses be performed of these issues in order to insure optimal reimbursement.

### RHC Reimbursement Issues



The Medicaid program is the largest payer source for CAH SNF programs. If a nursing facility’s cost exceeds the per diem ceilings, there may be no opportunity for cost recovery. However in four of the CAHs reviewed, there were situations in which costs were below the cost ceiling, thus providing opportunities for increased payments. Additional analyses should be performed to address these issues.

### 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>A</b>	Internal monitoring
<b>B</b>	Internal monitoring
<b>C</b>	Interim cost report prepared
<b>D</b>	Internal monitoring
<b>E</b>	Internal monitoring
<b>F</b>	No monitoring during year
<b>G</b>	Interim cost report prepared
<b>H</b>	Internal monitoring
<b>I</b>	Interim cost report prepared
<b>J</b>	Interim discussions with cost report preparer
<b>K</b>	Interim cost report prepared

**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 A**

Self-pay accounts are generally considered uncollectible if no payment is made and no financing could be arranged despite at least four contacts with the guarantor and the account has aged 120 days without full payment. Self-pay accounts receive two data mailer statements and two collection cycle letters (if the balance remains unpaid and no monthly arrangements are made). Statements and letters are mailed on a monthly basis, allowing approximately 120 days before the account is referred to a collection agency or suit is filed.

Medicare accounts that remain unpaid at least 120 days from the date of the first bill may be written off to a bad debt and referred to an agency unless it is considered charity.

Commercial and Medicare accounts are changed to self-pay after all the insurance tied to an account are marked paid or rejected. Once the account is changed to self-pay, the collector mails a demand letter to the patient explaining what the insurance or Medicare paid and the patient's responsibility.

### **Hospital B**

All aged accounts 120 days and over after becoming self-pay will be reviewed for bad debt consideration if no payment has been received on the account. Accounts deemed to be uncollectible aged less than 120 days shall not be removed from the active accounts receivable:

- If all collection efforts have been exhausted by the hospital, the account can be assigned to an agency once determined uncollectible, even though the account is less than 120 days.
- Accounts deemed as uncollectible should be written off of the active accounts receivable at 140 days based on the discharge date. Accounts assigned to an agency should not be booked as bad debt prior to 140 days from discharge. The account should remain with the same agency until paid or until it has been determined to be uncollectible and worthless by the agency.
- Patients with dual eligibility should have secondary billed to receive remittance advice in order to claim as a bad debt.

## **Hospital C**

All patient accounts that have received three statements (once monthly), after being turned to a self pay status are reviewed for payments. If no payment has been received, a balance due letter is printed and mailed on the 30th day after the third statement. Ten days after the balance due letter the patient accounts are reviewed and any accounts with payments are transferred into the budget accounts. If no payment has been made then the patient receives a final demand letter. Once these letters are sent, collection personnel attempt to contact the patient by phone. If no payments are made within the allowed ten days the patient is then sent to the appropriate collection agency.

Total time from changing to self pay to transferring to collection agency is approximately 120 days.

## **Hospital D**

After reasonable and customary attempts are made to collect, and the debt remains unpaid for more than 120 days from the date the first bill is mailed (either by the hospital or the collection agency), the debt may be deemed uncollectible. The collection agency shall close and return all accounts that have no payment activity for 120 days or more. All debts deemed uncollectible by the collection agency are returned to the Hospital and are listed as uncollectible in the computer system.

The collection agency will apply the same standards of collection to Medicare and non-Medicare patients.

## **Hospital E**

Self pay accounts receive three collection notices over a 60-day period. These accounts are then assigned to a collection agency 15 days after the last collection notice. Insurance accounts receive four notices over a 120-day period. These accounts are then assigned to a collection agency 15 days after the last collection notice. Insurance accounts are changed to self-pay status after 60 days with no activity unless intervention is made by business office staff during their follow-up and account review process.

## **Hospital F**

Self-pay accounts receive two statements and then qualify for referral to a collection agency, which is a third-party letter vendor that sends three letters over a 42-day period. If the account is not paid in full, a payment plan established, or the account is

qualified for financial assistance, the account closes with the agency and pre-lists for bad debt. Accounts are referred on the last day of the month. The average age of straight self-pay accounts referred to an agency is approximately 100 days.

For balances after insurance, the account typically receives two statements following insurance payment and then qualifies for the same agency process. The average age of referral for this population of accounts is probably greater than 150 days due to the insurance process.

### **Hospital G**

Accounts must meet the following minimum criteria prior to being written-off to bad debt expense:

- No payment within the previous 90 days
- One noted successful collection phone contact attempt other than an automatic dialer message within the previous 30 days,
- Minimum of four billing statements

The pre-bad debt list shall be reviewed by hospital management. Accounts identified as requiring additional collection efforts or further review shall be removed from the list. The reviewed list shall be forwarded to the CEO for final review and approval by the last business day of the month. The CEO shall complete his review by the fifth day of the month and return the finalized list to the business office.

Upon receipt of the finalized bad debt list, the business office shall make corrections to accounts on the list and create a final bad debt transfer list. Those accounts shall then be moved from the A/R file to the bad debt accounts file. A listing of those accounts transferred to bad debt shall be forwarded to the hospital's collection agency and will include patient demographics, past payment information, and collection notes.

### **Hospital H**

Self Pay accounts are to be reviewed by the collector and accounts with no payment activity within 120 days following the discharge date are referred to the collection agency. Balances after insurance accounts are to be reviewed by the collector and accounts with no payment activity within 120 days following the first patient statement are referred to the collection agency. Follow-up and collection efforts include but are not limited to three patient statements, phone calls and reminder letters.

## **Hospital I**

The patient will receive a series of statements for 90 days after any and all third party payers have contributed to the account. After the account has been delinquent for 90 days in-house without resolution, it is forwarded to a collection agency pre-collect status. At that time the patient will receive a letter from the agency notifying them of their status, the amount of the bill and a letter reminding them that the hospital has an indigent care program. Patients who have been set up on a monthly payment plan will be considered delinquent on their account if a payment has been missed for two consecutive months. After six months, the collection agency will deem whether an account is uncollectible. The account is then sent back to the hospital and written off the patient's account.

## **Hospital J**

The policy states that an account is considered a bad debt when the self-pay unpaid account has aged at least 120 days from the date of the first bill. Once written off as a bad debt, the account will be placed with an outside collection agency.

## **Hospital K**

The patient receives a series of statements for 120 days after all payers have paid. After the account is delinquent for 120 days in-house, the account is sent to a collection agency. The patient receives a letter from the collection agency notifying them of their status, the amount of the bill and a letter reminding them of the hospital's indigent care program.

Patients on a monthly payment plan are considered delinquent when the payment has not been received for two consecutive months. After six months, the collection agency will deem whether an account is uncollectible. The account is then sent back to the hospital and written off the patient's account.

## **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	A	B	C	D	E	F	G	H	I	J	K
1. Medical records	X		X	X			X			X	X
2. Emergency room charges	X	X	X	X	X	X		X		X	
3. Observation charging	X				X		X				
4. Venipuncture charging	X	X	X	X	X	X	X	X	X	X	X
5. Injections and infusions	X	X				X	X	X	X	X	
6. Revenue code assignment	X	X		X		X	X	X	X		X
7. Drug units and dosage		X	X				X				
8. Method II billing				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. Hospitals should conduct internal chart reviews to insure that all supporting documentation is present within the medical record chart.
  
2. **Emergency room 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. **Hospital staff should be educated on the appropriate billing of observation.** There were several situations in which observation hours were not charged at all or were undercharged on the claim form. Such situations will result in lost reimbursement. Observation should be charged when appropriate. The Medicare guidelines can be found in the CMS Medicare Claims Processing Manual, Chapter 4, Section 290.2.2.
4. **Venipuncture is a 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 emergency room 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.
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 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.

7. **Incorrect drug units billed can lead to lost reimbursement.** In a number of instances it was noted that the units billed related to drugs did not equal the dosages administered. Pharmacy staff should review all drug charges to ensure that the dosages per the CDM equal the dosages administered.
  
8. **Hospitals need education on the appropriate billing under Method II for outpatient professional fees.** Several hospitals are billing for outpatient professional fees; however, they do not have a good 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.

## **Appendix C**

### **Quality Assessment Questionnaire**

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# 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 %

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# CAH Quality Assessment by Functional Area

Assessment Criteria

Discussion

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## 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

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**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

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---

# 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 %