

CAH/FLEX National Tracking Project

FINDINGS FROM THE FIELD

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Staffing the Business Office in Critical Access Hospitals While Meeting Regulatory and Payment System Challenges

CAH administrators are facing multiple simultaneous challenges. Recruiting and retaining a workforce while keeping up with regulatory requirements and a highly complex billing environment is costly and requires creativity and strong management; the Medicare Rural Hospital Flexibility Program (Flex Program) is credited with helping maintain a sufficient cash flow to help with these challenges.

Background

The University of Washington surveyed Critical Access Hospital (CAH) administrators in 2003 about their problems and successes in the area of workforce staffing, with a special focus on the business office. A survey was mailed to 605 eligible hospitals (all those that had converted to CAH status as of June 30, 2002). A total of 329 hospitals responded from 43 states for a response rate of 54.4%. Most CAHs, and hence most of the responding hospitals in our survey, were located in the central U.S.

Business Office

The average CAH had 6.9 business office full-time equivalent (FTE) employees. Only 14.5% of hospitals reported vacancies in their business offices. Hospitals reported it was not difficult, typically, to fill openings for these positions.

Two in five hospitals (39.9%) reported that, compared to 1997, they had increased their business office staffing. The average increase in FTEs for these hospitals was 2.4 FTEs. Only 16.8% said their business office staffing had decreased, but one-third (35.2%) of this small group also reported they now have business office functions performed outside their facility (which could explain a decline in hospital-based business office personnel). Those hospitals that experienced a decrease in business office staffing reported an average reduction of 2.5 FTEs.

Table 1 details staffing levels of various job categories in the business office. The largest FTE commitment was for billing (2.5 FTEs per hospital for 187 hospitals). Average wages in the business office ranged from \$9.09 per hour for cashiers to \$27.40 for chief financial officers (CFOs). The most longevity was typically found among supervisors and CFOs, accounts payable personnel, cashiers, and payroll personnel.

Educational credentials varied by job category in the business office. While 73.5% of CFOs were college graduates, there was no other business office job category for which the majority of workers were college graduates.

Hospital administrators were asked, in an open-ended question, to describe their "biggest personnel issue" in the hospital's business office. "Keeping up with insurance and payer changes" was the largest single category of responses in our analysis, followed by a variety of staffing problems related to turnover, absenteeism, retention, shifts, and workload (see Figure 1).

Enter HIPAA Compliance

Hospital administrators were asked about the workforce impacts of complying with the Health Insurance Portability and Accountability Act (HIPAA). Only 31 respondents (9.1%) said there had been no change in staff commitments or cost.

Most respondents (56.8%) reported they had increased personnel for purposes of HIPAA compliance, at an average .81 FTE (or a median of .5). A further 65.3% said they had diverted personnel time by redirecting staff duties, estimated to average .79 FTE (or a .5 median). Consultants were hired by more than one-third of facilities (39.2%) to aid with HIPAA compliance, at an average cost of \$10,647 or a median of \$8,750. Capital expenses were incurred by half the facilities in pursuit of HIPAA compliance (49.2%), at an average cost of \$60,293 (or a median of \$16,500).

Expenditures for the 112 hospitals that reported HIPAA consultant expenses totaled \$1.2 million, and another \$8.2 million was spent by the 136 hospitals that reported capital expenses. Assuming a modest \$35,000 per FTE on personnel costs, we can calculate at least another \$4.5 million was spent on new hires by 157 hospitals, and \$4.9 million was spent in diverted FTEs at 178 hospitals. For the 245 hospitals that responded to this question, this comes to a total of \$18.8 million in costs attributable to HIPAA, or about \$76,807 per hospital.

Conclusion

The cost of business office functions for CAHs was significant. Our review of survey responses' internal consistency indicates some hospitals did not report the full complement of staffing in these offices, but even given this limitation, the average business office staffing costs for hospitals (that do not contract out functions) amounted to at least \$365,451 per year (or a \$262,080 median). Adding together the costs for 194 responding hospitals tells us these small rural hospitals are spending almost \$71 million simply on business office salaries, primarily for billing. These totals were likely to be significantly understated, as not all hospitals listed every staff member in their business office on the survey form, and they don't include any costs other than salaries. The cost of billing myriad insurers and government payers in the U.S. health care marketplace poses a significant challenge for small rural hospitals in our survey. Transforming the hospital payment system to a single payer system (or at least single claim form and process) could potentially save hospitals an amount equivalent to their bad debt and charity costs combined.

The Flex Program was viewed very positively by CAH administrators. Cash flow improvements created by cost-based Medicare reimbursement were widely credited with improving the ability to retain staff. Half the administrators surveyed said their Flex Program network hospital has helped with recruitment or other workforce problems.

Appendix. Characteristics of CAHs Surveyed

The daily census of acute care patients averaged 4.1, with a median of 3.1. The mean number of discharges was 423 per year, with a median of 336 (under one per day). Average FTEs per hospital numbered 103, ranging from 21 to 351.

Almost half of the facilities (45.7%) reported having nursing home operations, and the average size of these units was 47 beds, with a median of 40 and a range of 4 to 247. Almost all facilities (95%) were operating swing beds, with a mean of 12¹ and a median of 10. More than half (52.9%) the facilities were running a clinic, and one-third (31.4%) were operating home health facilities. Only 9.2% had assisted living services, and about 17.4% reported operating "other" long-term care services.

One in five responding CAH administrators (20.6%) said their hospitals had fewer than 15 acute care beds, the maximum number of such beds allowed under the Flex Program.

Hospitals had mean total revenues of \$9.4 million and a median of \$7.7 million (see Table 2). Mean outpatient revenues totaled 59.8% of total revenues, indicating the important role of outpatient care in CAHs. Average non-operating revenues (typically grants, donations, and tax revenues) totaled just over \$500,000, an amount that offsets the bad debt and charity costs, which averaged \$400,000. Contractual allowances (in essence, the difference between charges and payments) averaged \$2.3 million. Administrators reported an average 68.9 days in accounts receivable (AR).² A small number of hospitals (6.2%) had AR days numbering 100 or more, typically an indication of poor financial health or management problems.

¹It is possible for hospitals to license all 15 acute care beds as swing beds, in addition to the 10 "extra" for swing-bed purposes alone.

²AR days are calculated as the net patient receivable dollars divided by net patient revenues over 365 days—a measure of how long it takes to collect on accounts.

Table 1. Characteristics of business office staff in CAHS

Job	Number of hospitals reporting they have this job	Number of FTEs per hospital	Average number of years in job	Average hourly wage (\$)	Education in Job category		
					High school grad (%)	1+ years college (%)	College grad (%)
CFO	199	.91	8.45	27.40	6.9	19.6	73.5
Supervisor	173	1.35	11.55	17.43	33.6	39.7	26.7
Accountant	40	1.01	6.73	15.82	11.6	48.8	39.5
Payroll staff	76	.87	8.22	12.59	39.2	32.4	28.4
Accounts payable staff	108	.89	8.31	11.74	57.8	33.3	8.8
Data entry staff	52	1.05	7.52	10.81	66.7	27.8	5.6
Billing staff	187	2.46	7.71	10.66	65.6	27.9	6.6
Patient account representative	48	2.38	7.44	10.64	76.0	18.8	5.2
Collections/accounts receivable staff	123	1.35	6.51	10.28	67.7	20.5	11.8
Clerical staff	104	1.51	6.97	9.54	67.3	26.2	6.5
Cashier	36	1.06	8.30	9.09	78.4	18.9	2.7
Other	24	1.30	9.81	13.65	46.9	21.9	31.3

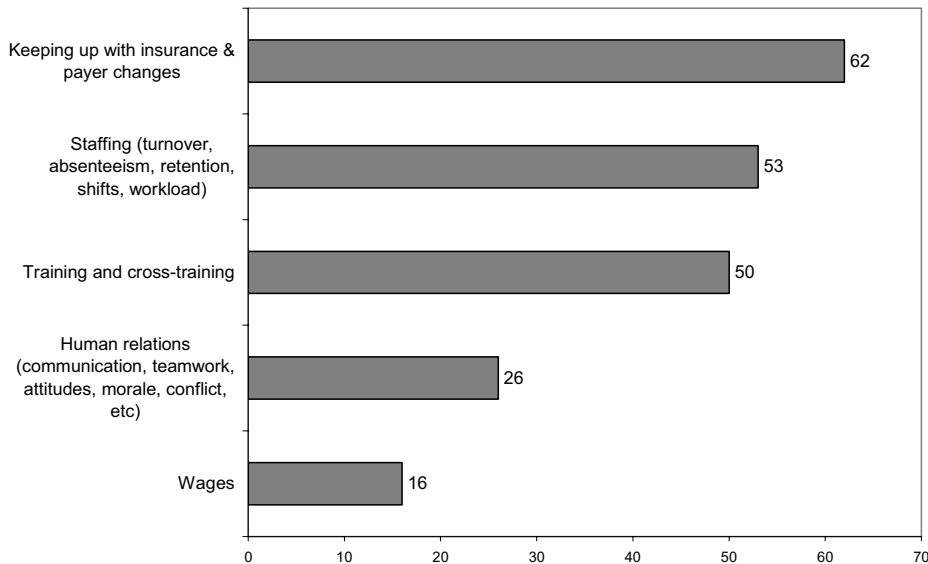
Source of data: Survey of 329 CAH administrators in 2003 conducted by University of Washington. N = 241 hospitals that both responded to question and report not contracting out any business office functions.

Table 2. Characteristics of CAHS

	Mean	Median	Minimum Value	Maximum Value
Average daily census	4.1	3.1	0	51
Annual discharges	423	336	2	3,105
Total revenue	\$9,435,909	\$7,690,233	\$186,000	\$35,724,000
Outpatient revenue	\$5,645,742	\$4,322,013	\$54,000	\$24,800,000
Bad debt and charity	\$408,373	\$252,000	0	\$2,285,381
Contractual allowances	\$2,348,447	\$1,593,000	0	\$15,680,799
Full-time equivalent employees	103	90	21	351
Accounts receivable days	69	65	6	417

Source of data: Survey of 329 CAH administrators in 2003 conducted by University of Washington.

Figure 1. What is your biggest business office personnel issue?



Number of CAH administrator respondents to open-ended question. (Remainder not categorizable or missing.)

Where can I get more information?

About this report: Amy Hagopian, WWAMI Rural Health Research Center, University of Washington, Box 354982, Seattle, WA 98195-4982, hagopian@u.washington.edu, or (206) 685-3676. Additional authors: Karin Johnson, research associate; Meredith Fordyce, graduate research associate; Seth Blades, research assistant; and L. Gary Hart, Director

About this project: Check our website: <http://www.rupri.org/rhfp-track/>

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RUPRI Center
for Rural Health Policy Analysis
University of Nebraska Medical Center
984350 Nebraska Medical Center
Omaha, NE 68198-4350

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