EXECUTIVE SUMMARY

Guam Memorial Hospital Authority to improve its financial management programs, practices, and processes have initiated a series of actions. One of these actions is the development of a Financial Management Improvement Plan (FMIP) for the hospital. Key hospital executives, managers, and staff developed the plan in June 2006 with support from the United States Department of the Interior/Office of Insular Affairs (DOI/OIA) and the Graduate School, U.S. Department of Agriculture, Pacific Islands Training Initiative (GS/PITI).

The FMIP process takes a long-term, broad view of financial management activities and leads to the development of a strategic plan designed to improve financial management programs, practices, and processes. The strategic plan identifies the key financial management goals the Guam Memorial Hospital Authority (GMHA) wants to achieve over the next five years. The FMIP also prioritizes GMHA's strategic goals and lays out the series of activities necessary to accomplish them.

The GMHA FMIP is an important part of several government-wide initiatives and is a vital component of the Government of Guam's overall effort to reduce costs and improve services. The full implementation of the FMIP will strengthen GMHA's financial operations and significantly contribute to its long-term success.

The FMIP consists of four major sections and a series of appendices. *Section 1* is the Executive Summary. *Section 2* provides the background of the FMIP and describes the process used to develop the plan. The FMIP participants followed a five-step process to create strategic goals and supporting action steps designed to improve GMHA's financial management processes. The five steps were to: (1) prepare for the FMIP process by reviewing previous plans, reports, and financial studies; (2) conduct a strategic planning session to identify the major goals for improving financial management; (3) develop detailed action plans for each of the goals; (4) share the plan with stakeholders for their feedback and commitment; and (5) implement the plan.

***Section 3* of the FMIP affirms the GMHA's mission, *'We are committed to excellence in healing and caring for the people of our community'* and presents its vision for the fully implemented FMIP. When the FMIP is completed, GMHA will be a financially self-sustaining regional medical center providing excellent health care to Guam and its neighboring islands.**

***Section 3* also lists 'quick hits'. Quick hits are fairly easy, straightforward actions that can be taken to improve a specific condition. They typically require no planning or additional resources; they just**

need to be done. They can be expected to yield immediate improvements or benefits. The quick hits may also be simple policy or process changes that will help streamline work.

QUICK HITS:

1. **Add GMHA to the GovGuam Employee Separation Clearance Form to ensure all Government of Guam an autonomous agency and legislative and judicial branch employees clear the hospital before separating from employment. The GMHA Administrator should send a letter to the Director of Department of Administration requesting GMHA's inclusion on the form.**

2. **Ensure all collectors have access to a telephone, telephone line, and the Internet. The Supervisor of Collections should submit a request detailing the requirements to the Assistant Administrator for Operations.**

3. **Revitalize the previous linen study and ensure recommendations are fully implemented. The linen study data should be updated and alternative solutions tested to ensure long term success. Additionally, the new Chief of Environmental Sciences should be briefed on the study immediately upon hire.**

4. **Establish an education and accountability campaign on the need to promptly enter billing information. The Assistant Administrator for Professional Support Services should immediately meet with a pilot group to explore the best approach to resolving the delayed charges.**

5. **Monitor registration and billing for cases in which the 23-hour observation period is converted to inpatient status to assess whether charges are being dropped or billed inaccurately.**

6. **Assign a Medicaid/MIP specialist to GMHA to qualify patients' onsite. The GMHA Administrator should meet with the Director of Public Health and Social Services to negotiate this action.**

7. **Compile information on post payment denials. Inform the appropriate departments and take action to improve problem areas.**

8. **Establish a list of account receivables from collection agencies and begin writing off accounts that cannot be collected.**

9. The GMHA Administrator should request the Board pass a resolution allowing electronic record keeping.

10. Eliminate the Master Patient Index Cards.

Finally, *Section 3* briefly describes the *five strategic goals* created and prioritized by GMHA:

Goal 1: GMHA will improve the billing process to ensure (1) patient's information is accurate and complete, (2) properly captured and applied charges, and (3) the bill is issued in an accurate and timely manner.

Goal 2: GMHA will improve cash flow through expanded and more efficient collection efforts.

Goal 3: GMHA will control costs by improving inventory management controls and 'right-sizing' staffing levels.

Goal 4: GMHA will increase its net revenues 75% (by 2009) by providing new services, improving reimbursement rates for insured patients (Medicare, Medicaid, MIP, Compact Impact, and third party payers) and decreasing the percentage of uninsured patients.

Goal 5: GMHA will be a paperless environment by 2010.

The narrative for each strategic goal is structured around four (4) questions:
Where are we now?
Where do we want to be?
How do we get there?
How will we know we did it?

***Section 4* describes steps that should be taken to ensure the full and effective implementation of the FMIP. As with most plans the FMIP is only useful if it is successfully implemented. Developing the plan required a considerable amount of time and resources, but it is only the beginning. This section recommends some actions that will establish the organizational framework to implement the FMIP and increase the likelihood that the FMIP is implemented in a timely and effective manner.**

Below is a chart that indicates major steps that must be taken for each goal and the date by which the step should be done. The supporting information may be found in Section 3: Quick Hits and Strategic Goals.

IMPLEMENTATION PRIORITIES		
	WHAT	**WHEN**
Overall	**Appoint a full-time Project Manager**	**15-Jul-06**
	- Establish regular reporting schedule	
STATUS	**Appointments of both a Project Manager and Project Director – COMPLETED on June 30, 2006**	
Overall	**Establish a public relations and information office**	**15-Jul-06**
STATUS	**Currently, FMIP Information will be announced via the GMHA newsletter. In September, the FMIP Plan will be on-line via the GMHA Web page.**	
Goal 1	**Update charge master**	**1-Oct-06**
	- Establish team	**30-Jun-06**
STATUS	**A team has been established per Project Manager – COMPLETED.**	
	- Install maintenance process and procedures	**1-Oct-06**
Goal 2	**Renew collection activities**	**15-Sept-06**
	- Clarify, document, and approve new policies and procedures	**30-Sep-06**
	- Ensure collection of co-pays and deposits during the registration process	**30-Sept-06**
	- Ensure registration staff have private space in the emergency room area to collect payments	**1-Sep-06**
Goal 3	**Enhance hospital information system to handle inventory management better**	**1-Oct-06**
	- Direct vendor to develop software	**1-Aug-06**
	- Implement bar coding	**1-Dec-06**
Goal 4	**- Implement electronic medical charges and electronic medical reimbursements**	**1-Nov-06**
Goal 4	**Submit amended Medicare Cost Reports**	**15-Sep-06**
STATUS	**Amended Medicare Cost Reports – COMPLETED.**	
Goal 4	**Complete the 'linen study'**	**1-Oct-06**
Goal 5	**Assign paper reduction project to forms committee**	**1-Oct-06**

2. BACKGROUND AND METHODOLOGY

2.1 Background

Over the past six years, GMHA has gone through management reviews and developed several plans to improve its finances and operations. Ernst and Young conducted a management review in 2000. GMHA developed a strategic plan for 2004-2006. In March 2004, Deloitte and Touche conducted a revenue enhancement study, which updates GMHA's pricing model for its products and services. Annual audits for FY2002, 2003, and 2004 identified numerous findings that, if resolved, would improve financial operations. In March 2006, the Guam Economic Development and Commerce Authority commissioned a study, the Guam Memorial Hospital Financial Improvement Review, to identify ways in which GMHA could improve its financial situation. Despite a significant amount of effort invested in these analyses and planning activities, the plans have been implemented minimally, or not at all.

Although the development of the FMIP is a simple process, the implementation of the FMIP, or any of the previous plans, is a major organizational change for GMHA. Full implementation of the plan will take several years, involve many organizational units and staff, affect dozens of processes, procedures, and policies, and require tremendous management energy and attention. For GMHA to be successful in implementing the FMIP, it will need to develop the organizational infrastructure necessary to manage and support the implementation process.

To help GMHA build its organizational infrastructure and prepare for implementing the strategic plan, two consultants from the Graduate School, USDA, conducted an organizational readiness assessment of the hospital from April 3 to April 13, 2006.

The organizational readiness review identified some strengths helping GMHA with FMIP implementation and some risks that the hospital would need to overcome for the FMIP implementation to be successful. The review cited several steps GMHA and its leaders needed to undertake to increase the likelihood of successful implementation. These recommendations still stand and are worth repeating.

'The hospital faces many very significant challenges it must overcome to be successful in improving its financial condition, management, and operations. Hospital leaders and managers must take personal responsibility for leading the organizational change efforts and for implementing the FMIP. The organization is waiting to see whether its leaders are serious about implementing the FMIP. GMHA's leaders and managers must communicate clearly their intent to implement the FMIP and then take strong steps to prove their intent.

Organizational change activities occur throughout the FMIP development and implementation process, but they are essential to getting the process started effectively. Some of the steps GMHA leadership needs to take right now are:

Develop a sense of urgency about improving finances among the staff
Communicate clearly and often about what GMHA is trying to accomplish by developing and implementing the FMIP
Establish, use and communicate performance measures for critical fiscal functions
Create the FMIP implementation team and communicate to the organization what they will be doing
Have the FMIP project manager develop a methodology for managing and following through on accepted recommendations from the A/R team, the organizational readiness assessment, etc.
Have the CFO develop methodology for managing and resolving audit findings
Require the FMIP project manager and the CFO to report on the status of all recommendations and audit findings regularly (at least monthly)
Have selected Fiscal Office staff attend accounting class offered by the Office of the Public Auditor July 11-July 20, 2006.'

The review also identified several actions GMHA needed to take to address some of its more pressing financial issues. Progress has been made on some of these activities, although, all needed to be completed fully. Each tasks and their current statuses (indicated after the hyphen in each action below) is:

Short-term Actions:

1. **Train Accounting Techs in the Follow-Up Section to work with insurance providers to improve collections—see Strategic Goal 2 –**
2. **Establish a project team to develop and implement a project plan to complete the Materials Management to Pharmacy interface—GMHA has provided the vendor its requirements and is waiting for a proposal from the vendor.**
3. **Establish a GMHA and Public Health project team to streamline Medicaid and MIP billings (and eliminate paper UB92)—see Strategic Goal 5.**
4. **Establish a GMHA and Public Health project team to streamline and expand the Medicaid, Medicare, MIP, and SSDI qualification process. Public Health may be willing to place a qualifications person at GMHA in May after PAGU (new automated qualification system) is implemented—still needs to be done.**

5. Require every uninsured (self-pay) patient to consult with a financial counselor to assess eligibility for financial aid from Medicare/Medicaid/MIP or to arrange a payment plan before discharge—see Strategic Goal 1.
6. Code self-pay uninsured different from insured co-pay—see Strategic Goal 1.
7. Establish a GMHA and DRT project team to prepare for offset against the EITC payments that DRT will soon be releasing—GMHA has provided DRT with an updated list of accounts receivable to be offset against tax refunds and EITC.
8. Establish a team from GMHA, DOA, and Retirement Board to offset COLA payments currently being planned for release—Salaries and retirement payments must be levied, not offset. GMHA needs to work on this collection strategy with legal counsel, DOA and the Retirement Board--see

Strategic Goal 2.

Ensure that GovGuam is aware of the need to provide a $3 million matching share to take advantage of the increased Medicaid federal share—

Decide what to do with the A/R team's recommendations. Meet with Department heads to accept or reject recommendations. Determine how accepted recommendations will be implemented. Task the team members back to implement the recommendations or return to their jobs—The A/R team's recommendations have been provided to line managers to implement. The EMC has requested for periodic updates from Rey Vega, the project manager for this effort.

Investigate linen replacement costs—being addressed as a quick hit in the FMIP.

Establish an Audit Improvement Plan to address audit findings. Resolve and implement solutions to internal control problems immediately—the CFO has established working groups to address audit findings.

Begin tracking performance measures for admissions, billing, & collections
$ In up front collections (either at admission or discharge)
 # Days from discharge to billing
A/R in suspense or on hold
A/R coded awaiting billing
$ Unbilled claims
 # and $ of resolved billings
 # Denials by denial category and department

Resolve issues with the Chart of Accounts and Revenue code tables in order to:
Automate Profit & Loss statements by department
Reduce the number of manually prepared reports
Track denials by category

Direct the AS400 Users Group to document and prioritize the requirements and enhancements needed for the Keane HIS before contract and schedule the system upgrade—
See Strategic Goal 5.

Review the data collection processes required for the Medicare Cost Reporting to ensure maximum per diem rate—the FMIP process is addressing this issue.

Establish point-of-service payment process. Strengthen the collection process at either admission or discharge, but before the patient has left the hospital premises—see Strategic Goal 2.

Mid-term Actions:

1. **Conduct workload analysis in administrative areas to determine appropriate staffing levels and pattern—see Strategic Goal 3.**
2. **Conduct a full review and update of the Charge Master—see Strategic Goal 1.**

Long-term Actions:

1. **Conduct economic analysis to determine whether PPS or TEFRA provides better reimbursement plan for GMHA—TEFRA appears to be an appropriate reimbursement plan for GMHA.**
2. **Modify Guam law to require adjudication only for systemic or across-the-board fee changes, not for individual changes or the addition of new products and services—see Strategic Goal 1.**
3. **Amend Federal law to remove or significantly raise the statutory limits on Federal Medicaid spending and adjust FMAP percentage—see Strategic Goal 4.**
4. **Amend Federal law to allow Guam to participate in the Sole Community, Medicare Dependent, and Critical Access, and/or DSH programs— see Strategic Goal 4.**

2.2 Methodology

The FMIP methodology was developed over the past several years and applied in the Commonwealth of Northern Marianas Islands (CNMI), Republic of Palau, American Samoa, the Federated States of

Micronesia (FSM), and the Government of Guam. The methodology requires a few simple steps, typically results in about four to eight strategic goals, and includes a detailed action plan for each goal. The first step in the FMIP methodology is to establish two teams or committees to help create the plan. The FMIP teams are linked although, serves very different roles.

2.3 Role of the Teams

The Executive Management Committee (EMC) was already established in GMHA to allow top-level managers in the hospital to deal with the many issues facing GMHA as a team. The EMC serves as the FMIP's strategic thinking group responsible for establishing broad, multi-year goals and priorities. The EMC is also responsible for assigning resources and ensuring the implementation of the FMIP.

GMHA established a second team, called the Core Team; to analyze the strategic goals and build detailed action plans to achieve them. It is responsible for creating detailed action plans for each goal and, in most cases, implementing the action plans. The Core Team regularly reports to the EMC on progress toward implementation. (See Appendix 1 for a complete list of EMC and Core Team members.)

2.4 Creating the Plan

The EMC and Core Team completed five major steps to develop the plan. They 1) prepared for the FMIP planning process, 2) conducted strategic planning sessions, 3) developed action plans, 4) shared the plan with managers, employees, and other key stakeholders, and 5) implemented the plan. The GS/PITI team facilitated the two teams as they:

1. **Prepared for the FMIP planning process. The GMHA Administrator identified key staff to participate in the FMIP process. The EMC arranged for the Core Team staff to spend all of their time for approximately 3 weeks while the GS/PITI staff was on-island.**
2. **Conducted strategic planning sessions. Each of the teams met independently and completed a SWOC analysis, which is a way to analyze an organization's Strengths, Weaknesses, Opportunities, and Constraints. The results of these assessments were considerations in the strategic goals. Each team then identified strategic issues and established priorities. The Core Team combined both teams' lists into a single list of goals. Finally, the Core Team discussed and agreed on the combined draft goals and priorities.**
3. **Developed detailed action plans. The Core Team members revised the strategic goals based on input and feedback from the EMC. For each goal the Core Team composed a description of the current and desired states for the goal by answering the questions "Where are we now?" and "Where do we want to be?" The team then drafted detailed steps to accomplish**

the goal by answering the question "How do we get there?" Finally, the team created a list of measures or milestones to answer the question "How will we know we did it?" The team solicited feedback from stakeholders and revised the steps when appropriate.

4. **Shared the plan. The Core Team distributed the draft FMIP to the EMC and other stakeholder groups for feedback and revised the plan based on their input.**
5. **Implemented the plan. Before the plan was final, the Core Team and EMC began implementing the "Quick Hits."**

2.5 Quick Hits and Strategic Goals

Throughout the FMIP process, the Core Team and EMC identified actions that could be immediately taken without additional planning or consultation. These actions became a list of "Quick Hits" that may be found in Section 3: Quick Hits and Strategic Goals. The EMC and Core teams merged their respective list of priorities and drafted strategic goals for the top five. Then the Core Team developed action plans for each. The strategic goals and detailed action plans may be found in the next section.

3. QUICK HITS AND STRATEGIC GOALS

The EMC and Core Team dedicated three weeks to creating the quick hits, strategic goals, and action plans. Throughout this period, they frequently mentioned the linkages among the goals and action plan, and the overall positive impact the plan's implementation would have on operations and staff. These discussions and their impact are captured in their expression of the vision for implementation.

The EMC and Core Team first affirmed GMHA's mission—'We are committed to excellence in healing and caring for the people of our community'. Based on this mission, the team members discussed what GMHA would be like if the FMIP could be implemented successfully. This discussion led to a vision for the implementation, or a brief description of the results of the FMIP implementation.

When the FMIP is completed, GMHA will be financially self-sustaining. Each year it will collect revenue greater than its costs and invest the extra revenue in capital improvements, new services, improved technology, staff development, and extended outreach and educational services for the community. The hospital will have raised its credibility with all of its stakeholders and earned the respect of its patient constituency, the medical community, the Legislature, the media, and its vendors. The hospital will be JCAHO certified and serve as a regional medical center serving Guam and its surrounding islands. Audits will have none qualifications and are completed timely and accurately. GMHA will have a stable workforce at all levels—executive, managerial, and staff—with

excellent communications and coordination among functions. Staff will be highly motivated, professional, dedicated to the hospital and its mission, well trained, and appropriately compensated.

The FMIP establishes a strategy for financial improvement, and then identifies what needs to be done to implement this strategy. The strategy allows hospital staff, managers, and stakeholders to see the ultimate goal and the means to get there. The strategy covers both revenue and expenses.

GMHA bills $103M for services in a year while the expenses for the facility are $74M. If GMHA collected 100% of its billing there would be a significant profit. Unfortunately, GMHA is not able to collect 100% of revenues from each payer source. If GMHA collect what it were entitled to based on the various contracts and reimbursement mechanisms, its financial picture would be:

Current

Payer	Billings	Reimbursement
Medicare	25,540,731	9,889,950
Medicaid	11,645,206	7,327,953
MIP	11,044,341	8,528,650
Private Insurance	36,581,082	28,537,852
Contract Totals	78,948,306	54,464,405
Self Pay	24,098,154	7,176,350
Required Totals	103,046,460	61,460,755

Thus, GMHA has an annual deficit of more than $13 million. The strategy for its financial improvement focuses on how to narrow this gap and eventually allow the hospital to have revenues exceeds expenses. To implement the strategy GMHA must control its own costs, improve its billing and collection activities, and fund ways to increase its revenues. The five strategic goals articulate these goals in more detail and identify the specific tasks that must be completed to achieve the goals and fulfill the strategy. (For more detail on the financial improvement strategy and how it influences GMHA's billing and collection activities, see Appendix 4.)

Quick Hits

Throughout the three weeks period the EMC and Core team identified short-term actions that were simple could be taken immediately and would yield quick results. In several instances noted below the action was completed before the FMIP was completed. The accomplishment of these quick hits should serve as a strong indicator of the potential for overall success and encourage further implementation actions.

1. Add GMHA to the GovGuam Employee Separation Clearance Form to ensure all GovGuam, autonomous agency, and legislative and judicial branch employees clear the hospital before separating from employment. The GMHA Administrator should send a letter to the Director of Department of Administration requesting GMHA's inclusion on the form.

2. Ensure all collectors have access to a telephone, telephone line, and the Internet. The Supervisor of Collections should submit a request detailing the requirements to the Assistant Administrator for Operations.

3. Revitalize the previous linen study and ensure recommendations are fully implemented. The linen study data should be updated and alternative solutions tested to ensure long term success. Additionally, the new Chief of Environmental Sciences should be briefed on the study immediately upon hire.

4. Establish an education and accountability campaign on the need to promptly enter billing information. The Assistant Administrator for Professional Support Services should immediately meet with a pilot group to explore the best approach to resolving the delayed charges.

5. Monitor registration and billing for cases in which the 23-hour observation period is converted to inpatient status to assess whether charges are being dropped or billed inaccurately.

6. Assign a Medicaid/MIP specialist to GMHA to qualify patients' onsite. The GMHA Administrator should meet with the Director of Public Health and Social Services to negotiate this action.

7. Compile information on post payment denials. Inform the appropriate departments and take action to improve problem areas.

8. Establish a list of account receivables from collection agencies and begin writing off accounts that cannot be collected.

9. The GMHA Administrator should request the Board pass a resolution allowing electronic record keeping.

10. Eliminate the Master Patient Index cards.

3.2 Goal 1: GMHA will improve the billing process to ensure a) patient information is accurate and complete, b) charges are properly captured and applied, and c) the bill is issued in an accurate and timely manner.

The overall billing process can be distilled into three major components that are inextricably linked and critical to successfully generating revenue for the hospital. First, patients must be registered to establish an initial record of who should be charged for the services. Second, hospital staff provides services and must record charges for those services. Finally, the charges are compiled into a bill and sent to the insurance provider or individual for payment. Because the overall billing process is quite complex, the three major steps will be addressed separately.

Where are we now? – Patient Registration

Patient registration currently takes place in two locations – the main registration office located toward the front of the hospital and in the emergency room (ER). Patient level of care is regularly changed by hospital staff depending on the patient's status. The initial registration process and the changes to the level of care are critical points directly linked to the billing process.

Initial registration

Patient information is not always accurate or complete. If the patient says they have no address or telephone number GMHA does not follow-up. The registration staff uses checklists to ensure they ask the patient for all information. Staff is encouraged to use the 'notes' function in the patient information system to add information that is not included in the standard data fields. In some cases, the return mail report may be an indicator of the volume of patients that claim they have no or have given an incorrect address. A cursory estimate is that approximately 10 percent of patients registered in the ER and the main office do not provide an address. The billing and missing information report may provide additional information on the volume.

During the initial registration, the patient is asked whether he or she has insurance. If the answer is 'no' GMHA policy is to give the patient the Medicaid and MIP application and advise them to complete the forms and submit them to Public Health. Emergency room patients are also encouraged to see the Medicaid specialist. If the patient is not counseled during intake, the discharge clerk on duty (24 hours in the emergency room) is supposed to counsel him/her before departure. Once the forms are filed, the patient must make an appointment to follow up on the Medicaid/MIP and this can take several weeks or months before approval. The Medicaid Specialist may follow up by calling Public Health to determine the status of the application. To improve the initial

registration and insurance counseling the registration office is hiring a new Collection Agent (financial counselor). However, currently there is little private space in the patient registration areas to conduct a financial interview.

When the patient registers, the FormFast system generates labels that nurse and MDs use to identify the patient. The FormFast system includes bar code scanning capability but that feature currently is not used. The labels are used to identify the patient's chart and charge vouchers. Although these labels appear to be helpful, they sometimes are problematic. For example, the amount of labels printed is not monitored. It is estimated between 100 and 200 extra labels are shredded each day.

The patient registration department received two new staff to aid with collections at discharge, but one was temporarily reassigned back to housekeeping. In another case a Medicaid Specialist was reassigned to input claims in Public Health. One staff person is retiring at the end of the month. In some cases, only two people work the shift and it is difficult to talk to all the patients ready for discharge or their guarantors, especially in the ER. Some registration staff needs more training on how to inquire about insurance and press for information that is more accurate.

In order to ensure current accurate patient information, registration staff is asked to re-interview whenever a patient comes into the hospital. The exception is patients who regularly visit the hospital for treatment such as dialysis. Those patients are never re-interviewed. Hence if their address or insurance status changes it is not discovered by the hospital staff.

Verification of eligibility for insurance has been a problem. The Patient Service Representative (PSR) is tasked with verifying eligibility. The verification process varies depending on the insurance company. Staff electronically access TakeCare and Select Care 24 hours daily. Staywell provides a paper listing, which is updated every 3 months. NetCare must be contacted directly. Patients must have a card to verify Medicaid, Medicare and MIP or other insurance. If the patient's insurance cannot be verified, they are considered self-pay and referred to the Medicaid specialist.

For outpatient services, co-pays should be collected when patients are discharged. Registration staff does not usually discuss payment and charges with outpatients or direct admissions. Currently only Labor and Delivery (L&D) patients are told at pre-registration, the cost will be about $3000. Other standard procedures are not estimated for the patient. Self-pay patients are asked for a $250 deposit. However, they are not turned away if the patient says they cannot pay. Staff resists asking for money.

A systematic patient registration's procedure manual is up-to-date. The policy manual is being updated.

Changes to the level of care:

Once registered the patient's level of care may change depending on the medical condition. For example, it can change from outpatient to inpatient if the patient is admitted to the hospital. This change becomes very important because of the relationship between the level of care and the reimbursement amounts. Insurance companies reimburse outpatient observation expenses for up to 23 hours. The current patient information system appears to drop observation room and board charges when the level of care is changed from 23-hour observation to inpatient, if the patient is not "discharged" but is transferred to a different level of care. Nurses and ward clerks can call and change the level of care. Registration staff is required to confirm the change with the physicians' orders.

L&D is the exception because upon verbal orders from the doctors the nurses call to change the level of care. Registration staff cannot readily confirm the physicians' written orders and physicians' frequently change the level of care.

Where are we now? – Charge Capture

The patient's account may be charged in six different ways:

CSR (central supply room) supplies are charged using yellow labels, which have been directly attached to the items. The labels are removed from the CSR items and placed on the patient's charge vouchers that are input by Data Control Clerks via the Order Communications (OC) module. While selecting needed supplies, nurses will place a series of yellow labels on their uniforms, which occasionally, drops off from their uniforms or inadvertently transferred to the wrong patient charge voucher for input by data control clerks.

Charge vouchers are used to charge the record of the patient for procedures, supplies, and nursing services. Charge vouchers are used by physicians to charge for professional services. The physicians are allowed a 90-day window to submit their charge vouchers. The vouchers can be input into one of two systems. – Patient Information System (PI) or Order Communication (OC) System. The Order Communications system currently has a 4-day window for inputting inpatient orders (charges) and 5 days for outpatient. Beyond the window, a service or supply must be input into the Patient Information system. Professional fees are normally input directly to the Patient Information System. Approximately 200 vouchers are input per day.

Physicians' orders are input into the Order Communications System by nurses, ward clerks, and ancillary staff. The ordered services are transmitted to the respective servicing departments via this

system and requisition numbers are assigned to each service. Once, the technical component of service is completed by the servicing department, they must acknowledged the completed service in the Order Communication System, in order to transmit the charge to patients' bills.
The PI system automatically charges for room and board for acute and critical nursing units, except for Labor and Delivery and the Operating Room/Recovery Room. These two nursing units document their room and board charges via their unit specific charge voucher, which is then, inputted via the Order Communications module by data control clerks.
The pharmacy department inputs their data into their own system.
When missing charges are identified, a missing charge form is generated by the Business Office and Quality Management office for billing purpose.

Physician's charge vouchers are input by the Data Control Clerks in a timely manner. Although, submission of physicians' vouchers by physicians are sometimes the service dates and beyond the bill generation date, they are sometimes over 90 days old.

Charge capture is compromise by services or items not being in the Charge Master or on the charge voucher, for example, many operating room supplies and other items.

Charge capture is compromised when the paper charge vouchers are misplaced in the medical records or elsewhere. When Medical Records find vouchers that have not been entered, they are given to the Business Office. Approximately 90 paper vouchers per month are discovered this way and are then input to the Order Communications System.

Charge capture is further compromised by services, which have not been acknowledged by the ancillary departments. The laboratory currently has approximately 500 unacknowledged charge vouchers just for the first 12 days of June and a 30-day backlog. Each ancillary/professional department head is given a printout of un-posted charges that must be appropriately acknowledged or processed by the end of the week.

Two Quality Management (QM) staff is dedicated to researching post payment denial discrepancies. Also, answer patient inquiries and researches business office referrals before the bill is mailed.

The Patient Registration staff cross reference the emergency room record log with the manual charge vouchers to ensure all patients have received an ER charge voucher.

Medical Records staff codes the medical diagnoses and procedures using HIPAA compliant coding classification systems. Four coders review the medical records, history and physical exams,

discharge summary, consultation reports, operations reports and progress notes to verify diagnoses and procedures. Transcription reports are filed immediately in the medical record, which expedites the coding process. Currently, they have no backlog and all coding is completed within 24 hours. However, if the coding is completed before receiving the physician's medical transcript it is possible some of the charges are not input. The workload is regularly distributed by the supervisor among the coders to ensure the 24-hour standard is met. Coders use a 3M encoder that interfaces with medical records abstracting.

In some cases, medical record documentation is missing. Coders call departments to try to get the appropriate documents or, if available, look online for the records. In addition, they ensure that the documents have the required signatures. Medical Records is still somewhat behind in filing the outpatient charts and medical records. Nurses file the lab reports. Radiology files their signed reports. Medical records are scanned and imaged for the insurance companies as part of the reimbursement requirements. In cases of low cash flow the records are photocopied, combined with the bill and hand carried to the insurance company to speed the payment process.

Hundreds of medical record documents are waiting for the physician's signature. GMHA has had a difficult time getting the doctors to stop by the office to sign the records. GMHA is now suspending doctors for not completing the charts (e.g. signing charts). Doctors are given three notices to come in and sign the medical records before suspension. Three are currently suspended.

Some physicians use their own templates to document the history and physical (H & P), operative reports and discharge summary, which then are printed and put directly into the medical record. Otherwise, the hospital provides transcription services to physicians that want to use it for their reports. Radiology has two transcribers and the Laboratory has one transcriber. Both departments are currently backlogged, although Radiology claims to have a 48-hour turnaround and Lab has a 24-hour turnaround. GMHA is considering expanding the current transcription contract to include the Radiology, Laboratory, and Respiratory Therapy.

The bill with all current charges is generated 4 days after discharge. Charges are sometimes received after the bill is generated, such as the missing charge vouchers, unacknowledged services, and the doctor's professional fees. Additional charges require the generation of a supplemental bill.

Charge Master

The Charge Master table is significantly outdated. The charges for professional fees have not been updated in over 5 years. The 1991 version of the Deloitte & Touche pricing model is still used, although the model was updated in 2004. Many chargeable supply items and procedures do not have

charge codes and are therefore absorbed into a non-chargeable category. Room and board rates have not been updated in a number of years. Nurses and servicing department staff complain of missing procedure codes, out of date charge vouchers and poor charge descriptions. The legal requirements to adjudicate all Charge Master changes and additions is applied too broadly, and has hindered the required annual maintenance of the Charge Master. The Charge Master update process is dependent on one individual, putting GMHA at risk because no one is cross-trained. More importantly, one individual cannot process the significant volume of Charge Master updates that are now required.

Where do we want to be?

Patient registration

All patient records include an accurate address, telephone, social security number, and other demographics for the patient and/or guarantor. Self-pay patients are required to meet with a financial counselor upon registration or discharge, or anytime during the hospital stay. A Medicaid & MIP Specialist from Public Health can qualify patients on premises. The policy that requires guarantors such as family members to sign for financial responsibilities is enforced.

Patients are given a reasonable estimate for the cost of standard hospital services upon pre-registration. Co-payments are collected before discharge. Deposits of approximately 50 percent of the estimated bill will be collected upon registration or before discharge. When patients claim they are not employed or are indigent GMHA requests a copy of their tax returns or other proof of their indigent status. At least one staff on each shift is dedicated to collecting the co-payments, deductibles, and deposits from self-pay patients. The Discharge Planning staff ensure the financial information and deposits are collected for inpatients.

Interim patients are interviewed quarterly to update their demographic information.

GMHA will initiate a system, which will allow clinics and patients to register online. Billing claims and remittances are billed on-line. Patients can make payments online. Insurance is verified online.

The patient's bill is complete when it is issued and no pending items remain. The bill is complete and available at discharge.

The public is fully aware of GMHA's registration, billing, and collection policies.

Charge Capture

Ancillary departments ensure at the end of each shift all procedures are acknowledged or deleted in a timely and accurate way.

A daily charge audit report is generated, distributed, and used by supervisors and managers to monitor problem charges.

The Charge Master is current and updated on a timely basis. Charge voucher forms are updated on a timely basis. All charge vouchers are automated.

Where appropriate, doctors directly input their physician reports into the automated systems. When transcription services are used, the physician is required to pay the transcription fee. Doctors submit their charge vouchers for professional fees within four days.

The policy to house and feed pregnant women during typhoons is reviewed to allow for the billing of un-reimbursed charges.

The level of care is appropriately changed in the system and room charges are not dropped.

Bar coded supplies and charge vouchers are used. All hospital staff and private physicians are trained and aware of the importance of charging for all supplies and services.

How do we get there?
The Patient Registration office will review their staffing needs and ensure there is an adequate number of staff to cover both ER and the main patient registration offices. They will conduct regular staff training to focus the patient registration staff on collecting the correct demographic data and insurance data. Patient registration financial counselors will be identified and trained to collect payments and set up payment plans before discharge. The patient registration department will be given the space, and the information to adequately provide financial counseling.

The Nursing and Ancillary managers will lead an effort to ensure that all charges are captured in a timely manner in their departments. The effort will include training, incentives, performance measures, and feedback in addition to the primary task of making their departments and staff fully aware of the need to post charges. They will regularly review the charge audit reports and post payment denial reports for their departments to ensure that corrective actions are taken for problem areas.

A project team and manager will be assigned to perform a major update of the Charge Master to include deleting obsolete and duplicate charges, updating the charge codes for all procedures and supplies used at GMHA, updating the charge amounts to reflect current costs, and updating the charge vouchers to reflect the changes. This limited term task will then be followed by updating the charge master maintenance procedures and cross training for charge master maintenance.

All departments, which are not fully utilizing the OC and billing system, will be identified. A project team will identify the obstacles and gaps in set-up and training for those departments and organize the effort to bring those departments on line.

The Business Office and QM will review the bill generation policy and charge capture procedures to minimize the number of missing charges on initial billings. They will monitor error reports and ensure that the managers of problem areas are aware of the errors so corrective action can be taken.

How will we know we did it?
Decrease in number of items on billing and missing information reports
Decrease in number and amount of post payment denials
Decrease in the number of items on the daily charge audit reports.
Decrease in number of adjustments and re-bills for missing charges.
Increase in number of final bills prepared before patient discharge

3.3 Goal 2: GMHA will improve cash flow through expanded and efficient collection efforts.

Where are we now?
The collection process begins when 1) the patient registers or 2) is discharged from the emergency room. During the registration, process patients are asked to pay the co-payment required by their insurance company. If the patient is not insured he or she is asked to pay a $250 deposit. It is unclear whether all registration clerks are asking for the co-payment when registering patients. Patients that enter via the emergency room are asked for the co-payment or deposit when they are discharged.

For insured patients the bill and statement drop four days after discharge. A summary statement is sent to insured patients notifying them the claim have been forwarded to the insurance company for payment. The co-payment and deductible amounts are included as 'balance due' on the statement. Every 30 days a courtesy statement is sent to the patient. A maximum of two statements are sent.

Once the insurance company has made a final determination, the patient is sent a final statement indicating a balance due not paid by the insurance company.

An itemized bill, a UB 92 form, and a HCFA form 1500 are sent to the insurance company four days after discharge. GMHA billing staff review all detailed charges. They use a UB editor to check the error description for missing or invalid ICD-9 codes and accounts pending medical documents are flagged using the bill hold reason codes. The statement and bill are mailed on the 5th day after discharge.

On the 31st day after discharge, a courtesy statement is sent to the insured patient to notify them the insurance company has not paid. GMHA cannot bill the patient until the insurance company has made a final determination about which charges will be paid and which will be denied, or until 90 days from initial billing have passed.

Insurance companies usually pay within 30 days. If paid within 30 days insurance companies receive an 8 percent discount. Medicare usually pays within 21 days and does not receive a discount. Medicaid and MIP sometimes take a year to pay.

Insurance providers must be billed within 3 months or they do not pay. MIP and Medicaid will pay if the bill is submitted in 12 months, and Medicare will pay if the bill is submitted within 18 months.

For self pays, the bill also drops in four days and indicates 'request payment'. Patients get an itemized bill upon discharge and another is mailed to them on the 5th day. The bill is due 30 days from the discharge date. In some cases, the patient receives a discount if they request it or if they pay the entire bill. GMHA recently gave a 20 percent discount to all patients with outstanding balances. Although this action encourages patients to pay, if they miss the deadline it encourages them to wait until the next time the 20 percent discount is offered.

A reminder is sent to self-pay patients on the 31st day, the 61st day and a final notice is sent on the 91st day. Patient Registration calls to collect bills that are 31 to 61 days outstanding. After 60 days, Patient Affairs calls to collect the payment. Bills 121 days or older are currently being reviewed for possible tax garnishments and seizures. GMHA stopped referring accounts to collection agencies about two years ago. However, the collection agencies are continuing to take legal action for cases referred to them over two years ago. GMHA receives approximately $45,000 each month from collection agencies.

Some payroll deductions and payment agreements are in place and the accounts are regularly paid. GMHA does not currently charge interest on outstanding amounts although they are authorized to charge 12 percent.

In the past GMHA has tried to acquire real property such as real estate through liens and legal procedures it is unclear whether litigation resulted in GMHA having title to real estate. The status of the litigation and similar collection efforts has not been updated within the past three years. It is unclear whether GMHA has legal authority to levy payrolls.

Each quarter the Accounting Tech Supervisor forwards a report on unpaid bills to the insurance companies. This quarterly report includes post payment denials, which are noted in the files and given to QA. Outstanding Medicare claims are followed up by the Medicare Biller. Currently no one follows up with on Medicaid claims because the ceiling has been reached or GovGuam does not have matching funds.

Two collectors work in the Business Office. When the workload is heavy, some Billers are assigned to help collections. Accounts are randomly assigned to the collectors.

Currently GMHA is not writing off bad debt accounts. However, GMHA policy establishes approval authority to do so. Accounts between $25 and $2000 can be approved for write-off by the CFO. Debts between $2000 and $5000 may be approved for write-off by the hospital administrator. Bad debts greater than $5000 must be approved by the Planning and Finance Board.

Collection agency determines when collection efforts have been exhausted and should be suspended. They advise GMHA when the collection efforts should be terminated and the amount considered for write-off. Bankruptcy also triggers the write-off of a bad debt, along with exceeding the statute of limitations for billing, billing errors, physical exams, and drug tests for GMHA employees, and other administrative costs.

Where do we want to be?

Registration staff is fully trained on policies and procedures related to co-payments and deposits. They collect all required funds from registration and emergency room patients. A pre-registration process and system are in place and patients can register and prepay online.

No insurance company or self-pay patient is given a discount for early payment. Everyone is charged 12 percent (12%) per year interest on past due balance over 30 days.

Five collection agencies are under contract. All are required to follow certain timelines and procedures to pursue legal remedy.

Collections (in Patient Affairs) are appropriately staffed to conduct a 100 percent follow up on billings in arrears. The Collection Section uses performances to evaluate how much is collected by GMHA and staffs accordingly. The Collection Section has the authority, responsibility, and policies for referring accounts to outside agencies for collection purposes. Outstanding self-pay bills are offset by the EITC and tax refunds.

The Collections Supervisor and the CFO have changed the GMHA chart of accounts so that they can get reports on the accounts and balances sent to collection agencies. Account receivables that cannot be collected by the collection agencies or through in-house efforts are written off as bad debts. Collection agencies and in-house collectors include probate actions when appropriate.

GMHA has capitalized on automated systems. Electronic billing and remittance are fully utilized, insurance companies and patients can view bills and make payments online. Electronic payroll deduction is available to all employees, private, and government.

GMHA follows up in 25 days after sending claims to insurance companies.

All GovGuam, autonomous agency, legislative and judicial branch employees must clear with GMHA before separating from the government.

GMHA charges for parking.

How do we get there?
The discount for early payment has been eliminated.

Registration staff will be trained on policies and procedures to ensure all co-payments and deposits are calculated and solicited correctly. The registration staff clearly identify whether patients are insured, indigent or self-pay. All Collection and Registration staff fully understands that self-pay patients are not necessarily indigent. The Collections Supervisor and staff and the Registration Supervisor and staff regularly communicate about how to ensure accurate and appropriate information is gathered during the registration process and that guarantors are encouraged to sign appropriate forms.

The Business Office and Collections Section will conduct a workload analysis to compare staff levels with workload demands. Adjustments to staffing patterns and requests for new positions will be made when appropriate. Written collection policies and procedures will be reviewed, revised, and circulated to appropriate individuals for comment. Once final, policies will be approved by the Executive Management Council (EMC). Policies will include guidelines on referrals to agencies for collection, appropriate collection actions and criteria for when those actions will be taken (e.g. liens and garnishments). Collections Section staff will receive regular feedback on their performance via group and individual performance measures.

The Collection Supervisor and the CFO will review the chart of accounts to ensure a clear record of accounts that are sent to collection agencies. Also, the CFO and the Collection Supervisor will work together to write-off bad debts that have accumulated over the past two to three years.

Additionally, the Chief Financial Officer will initiate activities to establish contracts with collection agencies. The CFO will seek input from the Collections Supervisor on standards for the vendors. An RFP will be issued and five vendors selected for contracts. Vendor contracts will include deadlines for taking legal action and guidance on when and how to pursue payment, including probate. Once contracts are established the Collection Supervisor serves as the primary point of contact and authorized to refer accounts to collection agencies. The CFO formally authorizes legal actions. Collections Section has access to credit reporting agencies to check employment, credit ratings, assets, demographics, and related information. Collections will share this with appropriate staff to improve financial counseling and patient information.

How will we know we did it?
Increase in monthly cash collections
Interest collected on past due accounts
Number of legal actions taken by collection agencies
Decrease in the dollar amounts of bad debt
Decrease in the number of days in accounts receivable
Dollars collected from GovGuam separating employees
Number of online transactions

3.4 Goal 3: GMHA will control costs by improving inventory management and 'right-sizing' staffing levels.

Where are we now?

Inventory management involves identifying, acquiring, storing, disbursing, and accounting for all the resources the hospital needs to perform its duties. These resources include pharmaceuticals, supplies, linens, medical equipment, computer technology, and other products the hospital needs to function. The procurement and materials management functions are currently using the Keane software to manage the acquisition, storage, and distribution of most supplies. GMHA has inventory management control from procurement to distribution for its inventory. The pharmacy is beginning to use the pharmacy module to manage its inventory of drugs and pharmaceuticals. Unfortunately, the modules between materials management and pharmacy are not linked, so there is little inventory control from materials management to the pharmacy.

The Materials Management/Central Supply Room (CSR) and Pharmacy staffs currently fill supply carts for each hospital unit. Three types of cart systems are provided--linens, pharmaceuticals, and Nurse Server Exchange. As the medical staff uses items from the carts, they sign out for the items used, except for the Nurse Server carts, which do not provide for signing out supplies. Every 24 hours the carts are returned to CSR and Pharmacy and re-supplied. Frequently the items missing from the carts are different from the items signed for by the medical staff.

GMHA has established PAR (Periodic Automated Replenishment) levels for each nursing station. This process ensures that at specified time intervals room supplies are automatically re-supplied for use in the units.

The current inventory management process and system have several problems. No method currently is in place to identify what items issued to units/wards are not used and should have been returned to inventory. The link between materials management and the pharmacy is weak and cumbersome to operate. Controls of inventory at the user level are weak and difficult to establish accountability. The hospital has no firm control or reporting mechanisms for inventory once items leave the Materials Management and Pharmacy departments. It is difficult, if not impossible, to track an inventory item through the hospital to the patient to whom it is billed.

Linen replacement costs run about $15,000 per month, yet no controls are in place neither to assess whether those costs are reasonable nor to establish accountability for missing linens. No feedback loop exists to determine whether supplies and pharmaceuticals disbursed from inventory are actually used and billed to patients. No regular reporting is done on 'leakage' of inventory items.

No systemic, structured analysis of staffing needs and patterns has been conducted at GMHA for many years. Many opinions have been expressed about staffing levels, but no data have been collected nor analyses done to determine the staffing needs of the hospital, optimal staffing levels and patterns, or skill requirements.

Where do we want to be?

GMHA wants to be able to account for all material, supplies, and equipment in its inventory from 'cradle to grave'. It will control, manage, and account for its inventory of supplies, pharmaceuticals, and linens with at most 1% variance using cost-effective technologies, established management controls, and clear accountability. Once the inventory is controlled, GMHA will be able to explore various alternatives for dispensing supplies and pharmaceuticals on the wards and units—automated disbursement systems, decentralized sites for supplies and pharmaceuticals, etc.

The hospital will employ a fully integrated information system that links all inventory modules across functional areas. Inventory information will easily flow from acquisition to storage to pharmacy to end users, with no breaks or disconnects. The system will automate the tracking, monitoring, and reporting of all items used in each department and ward.

Individual staff and clinical units will be held accountable for managing and controlling their use of supplies and pharmaceuticals.

GMHA will be appropriately staffed with multi-skilled and highly trained personnel operating at the highest levels of efficiency. Unnecessary positions will be eliminated and needed positions will be established and filled. An organizational analysis will be conducted to establish optimal staffing levels and patterns. Staff will be cross-trained to provide greater flexibility to manage fluctuating workloads and operational demands.

How do we get there?

To control inventory better GMHA needs to take two sets of actions, one focused on addressing issues in the short-term and another to deliver longer-term solutions. For the near term, GMHA needs to undertake a process analysis of inventory flow, from acquisition to end user, and document all the steps. Once the process is documented, performance measures would be put in place to monitor the flow of inventory and identify control weaknesses. Based on the weaknesses identified, managers of the process would establish management controls to address the weaknesses and better account for the inventory and its usage.

For the longer term, GMHA needs to develop functional requirements to upgrade and enhance its information system to provide better end-to-end inventory control. With the system appropriately designed and implemented, end user staff would be trained on the new system and their responsibilities for inventory control. The system would generate reports on inventory utilization and billing to ensure all items withdrawn from inventory are also billed.

In addition to managing inventory GMHA needs to ensure its staffing level are appropriate to workloads. Staff may need to be re-trained and re-assigned based on large or increasing work in some areas, while areas experiencing decreases in work may need to decrease staff levels. GMHA will conduct a thorough and detailed workload analysis to ensure staff levels and patterns are appropriate to work demands.

How will we know we did it?
% of supplies purchased that can be accounted for as accurately billed to a patient
% of pharmaceuticals purchased that can be accounted for as accurately billed to a patient
% of linens purchased that can be accounted for as appropriately retired
Variance of actual staffing levels from recommended level.

3.5 Goal 4: GMHA will increase its net revenues by 75% (by 2009) by providing new services, improving reimbursement rates for insured patients (Medicare, Medicaid, Medically Indigent Program (MIP), Compact Impact and third party payers) and decreasing the percentage of uninsured patients.

GMHA can affect its revenues in only a limited number of ways. Some of these ways are internal to the hospital and are completely within its control--improving its billing and collection processes, updating its Charge Master, ensuring payment at the point-of-services, etc. Other ways involve trying to get external entities to pay more of the cost of services—Medicare, Medicaid, MIP, Compact Impact, third party payers, and self-insured. A third general opportunity to enhance revenues is to increase the percentage of patients with health insurance. Another means to increase revenue is to provide new services that have a positive cost-benefit ratio for the hospital.

Strategic goals 1 and 2 address the revenue enhancement processes within GMHA's control, while this strategic goal focuses on the external factors that could enhance GMHA's revenues.

Where are we now?
Medicare reimbursements are primarily affected by the Medicare Cost Report. Medicare, or its intermediaries, uses the cost report to determine a reimbursement rate for GMHA's services. Over

the past few years, the reimbursement rate has declined significantly, from $888 in 2003 to $688 in 2005, while medical costs have increased. Although the interim rate has recently been increased to $767, it is still lower than the 2003 rate. As a consequence of the differences in how Medicare is operated in Guam compared to the states, Medicare spending per beneficiary in Guam for FY2003 was less than half ($2,899) of Medicare spending in the states ($6,800)

Guam's Medicaid program has major limitations placed on it by Federal law. Unlike the states, where no caps are placed on the Federal share of Medicaid funding as long as a state contributes its share of program expenditures, federal funding in Guam is subject to an annual statutory cap. Although, the cap has gradually been rising (from about $6 million in 2005 to over $8 million in 2006 to a proposed $11 million in 2007), it does not fully cover Medicaid-eligible expenses. In 2004, 2005, and 2006, the non-funded needs were $7.8 million, $4.9 million, and $8.7 million, respectively. In addition, the statutory formula used to calculate the Federal share of Medicaid funding (called the federal medical assistance percentage or FMAP), which results in a higher Federal share of Medicaid expenditures in poorer states, does not apply in Guam. The FMAP rate is statutorily set at the minimum rate (50%) available to wealthier states (such as New York and California) although Guam has a much lower median income most states (which receive an FMAP as high as 77%). Finally, Federal statutes and the Medicaid cap limit the ability of Guam to access certain other sources of Medicaid funding. For example, Guam is not included in the Federal legislation that established the Medicaid disproportionate share hospital (DSH) program, which provides supplementary payments to hospitals that serve a large number of Medicaid and low-income uninsured patients. As a consequence of these federal limitations on the Medicaid program, Federal Medicaid per capita funding in Guam was $41 while the comparable figure for the states was $565. (These data are found in U.S. Insular Areas: Multiple Factors Affect Federal Health Care Funding, Report to Congress, GAO-06-75, and October, 2005.)

The MIP is Guam's program to cover low-income, uninsured patients not eligible for Federal programs. The MIP has received funding from GovGuam but it does not cover the needs of this population. In the past three years, MIP has needed additional funding in each year (2004 carryover expenses were over $9 million, 2005 carryover expenses were over $3 million and 2006 carry-over expenses are estimated to be over $6 million).

Compact Impact funds are provided to Guam to cover the effects of immigrants from the freely associated states (FAS), the Federated States of Micronesia, Republic of Palau, and Republic of the Marshall Islands. A specific amount of funds is provided Guam from the Federal government based on a census of the number of immigrants from Compact-covered countries. The amount of funds

provided is adjusted every five years. Guam can then allocate the funds to cover areas impacted by the immigrant population—education, health care, infrastructure, etc.

Until 2004, Compact Impact funds were used only for capital improvement projects. From 2004 to 2006, $4,300,000, $5,216,000 and $1,629,000 (respectively) of Compact Impact funds have been applied to medical expenses. For FY2005, GMHA incurred total Compact Impact costs of $14,170, 994. Of this amount, MIP covered $5,046,333, Medicaid covered $1,699,469, and self-insured patients owed $1,755,779. The remaining $5,671,330 was covered by other sources. Of the total $14 million charged in FY2005 for Compact Impact patients, $6,828,938 remains unpaid. Thus, although GMHA has received Compact Impact funds for the past several years, they do not cover the medical costs incurred by the uninsured Compact Impact patients.

Thus, none of the government-sponsored programs covers the actual costs for medical services provided to its constituency by GMHA. An even more formidable issue is the extremely high percentage of uninsured patients treated at the hospital. According to GMHA's Chief Financial Officer (CFO), 22% of its patients have no insurance and account for 22% of its accounts receivable. Other sources have reported the percentage of uninsured patients to be between 25% and 41%.

As of the date the FMIP was developed, GMHA has introduced limited new services and it is unclear what type of economic analysis was conducted to ensure the service(s) was self-sustaining. However, GMHA has developed a proposal to establish a 'special services' function, which would serve as a clinic most of the year, but would provide certain cardiac services quarterly. The clinic would generate revenue, but perhaps more important, it would provide a means for patients with less than emergency conditions to receive medical care without having to go to the emergency room. This approach saves GMHA funds and frees the emergency room to handle true emergency cases. The proposal included a thorough cost proposal but did not attach specific dollar amounts to the benefits.

Where do we want to be?

GMHA will increase its revenue by 75% in 2012, collecting revenues that exceed its expenses and using the excess funds for capital improvements, the introduction of new services and technologies, and professional development for its staff. The Medicare Cost Report will accurately capture GMHA's costs; be submitted on time, and require minimal adjustments during audits. The Federal government will raise the cap on Medicaid funding and adjust the FMAP to be comparable to similarly situated states. Guam will be allowed to participate in the DSH program.

The MIP will be significantly reduced because its intended population will have been moved into other federally supported programs. Compact Impact funding will also be reduced, as its constituency will be participating in other programs.

The percentage of uninsured patients will be dramatically smaller as the uninsured acquire private insurance, receive expanded government-sponsored coverage, or participate in government-subsidized third-party insurance programs.

GMHA will identify and introduce new services based on community need and a thorough cost-benefit analysis. Services that are not economically self-sustaining will not be added to the hospital.

How do we get there?
GMHA needs to review its Medicare Cost Reports for the last few years and determine why its reimbursement rate has declined so much. If the rate is inaccurate, GMHA needs to submit an amended report and pursue additional reimbursement.

GMHA, with Guam's Governor, Legislator, and Legislature, needs to lead a concerted effort among all the insular areas to persuade Congress to revise Medicaid's statutory limits. The cap needs to be raised by at least $10 million, the FMAP needs to be adjusted based on the formula used to compute the states' rates, and the insular areas need to be allowed to participate in the DSH program. These activities are the most critical ones for GMHA's financial stability and success.

Guam needs to research the most effective use of MIP and Compact Impact funds—paying for services, subsidizing private insurance, subsidizing government-sponsored insurance, etc. A thorough understanding of the uninsured population needs to be established to develop programs that best meet their needs and maximize the effective use of limited funds.

GMHA will conduct a survey of potential new services and identify those that are practical on Guam. Each of these services will then be thoroughly researched and analyzed, including a cost-benefit analysis. Only those services that will be economically self-supporting will be considered for implementation.

How will we know we did it?
% and dollar amount of increase in revenue
Revenue generated by new services
% increase in Medicare per diem rate
% increase in Medicaid cap

% increase in Medicaid reimbursement rate (FMAP)
% decrease in uninsured patients

3.6 Goal 5: GMHA will be a paperless environment by 2010.

Where are we now?
GMHA is extremely paper intensive in all of its processes—clinical, procurement, personnel, financial, medical records, etc. In 2005, the hospital spent more than $476,000 on paper, paper forms, copiers, printers, toner, and paper-related products. GMHA pays to create paper, with a $100,000 per year transcription service. The hospital also pays to route, control, monitor, store, and destroy all of this paper.

The reliance on paper creates many additional problems. Paper gets lost, wet, and illegible. It requires large volumes of file space, and staff to file, retrieve, and protect the files. Paper must be manually routed, signed for, and verified, requiring systems and staff to handle all of these functions.

Clinical processes also require paper and this too causes problems. Paper charge vouchers get lost. It takes time to route vouchers, orders, and reports from one department to another. Written documents are often hard to read, causing errors in medication, treatment, or billing.

Where do we want to be?
While it is probably impossible to become a completely paperless environment, GMHA will reduce its use of paper by at least 90% by 2010. As many processes as possible will be electronic, producing no paper, forms, or vouchers. Documents will be routed, controlled, acknowledged, and approved electronically. The hospital will conduct business with all of its vendors, payers, partners, and stakeholders electronically. Medical staff will use automated tools to manage patient care, prepare medical histories and reports, and transmit laboratory and other tests. All documentation will be electronic, eliminating the need for files, document storage, and some of the staff needed to handle these functions.

How do we get there?
GMHA will develop and implement a multi-year plan to introduce new technologies to gradually increase its electronic environment and decrease its reliance on paper. The plan will identify 'targets of opportunity' to eliminate paper. For instance, as part of an upgrade to its information system, GMHA may decide that it would be a good opportunity to convert to electronic procurement processes. As the information system introduces new modules, these modules will be electronic rather than paper. Similarly, as new services are introduced, they will be required to integrate into

the electronic environment. Over time, the environment will become increasingly electronic until the hospital hits a 'tipping point' and completes the final few steps in going electronic.

How will we know we did it?
$ spent on paper, paper forms, copiers, printers, toner, and paper-related products each year
Number and percent of business processes converted to electronic operation
Number of paper medical records generated
Amount of storage space required for paper medical records

4. IMPLEMENTING THE FMIP

GMHA spent a considerable amount of financial and staff resources creating the Financial Management Improvement Plan. In many cases, the goals and recommendations that were identified in the FMIP were also identified in previous studies, reports, and team initiatives. GMHA has seldom if ever, taken full and complete action based on these previous studies. Turnover in senior management has also resulted in the loss of continuity and contributed to the dissolution of the initial efforts. GMHA needs to create a culture of collaboration and an implementation structure to help ensure improvement actions are completed.

The EMC and Core Team each discussed the obstacles to implementing the FMIP. Those obstacles can be found in Appendix 3 – Obstacles to Implementation. Among the items listed:

1. **No follow-through after previous reports were issued**
2. **Lack of communication across departments and up and down in the organization**
3. **Politics**
4. **No accountability for making changes**
5. **Complacency**

Additionally, throughout the FMIP readiness assessment and development activities the FMIP consultant team observed many instances when departments or groups were not particularly inclined to share information or cooperate on finding solutions to longstanding problems. Many discussions were confusing because team members became defensive rather than collaborative. All of the above suggests GMHA's organization culture is not conducive to working together to solve problems.

It is incumbent on the EMC to set the tone in order to change the culture. Individually and collectively, the EMC should begin to ask 'how do we solve this' rather than 'why haven't we done this'. Similarly, creative solutions should be encouraged and explored, and what has been tried

before may be worth a second look. The EMC members must serve as role models for a new GMHA culture that values solutions, teamwork, creative problem solving, and collaboration.

To ensure the FMIP receives appropriate energy and attention the FMIP team emphasizes EMC must take the following actions.

The EMC should select a full time Project Manager for FMIP implementation. Historically, the most successful FMIP implementations have occurred in departments that a well respected, full time Project Manager was assigned responsibility for implementing the FMIP. Similarly, GMHA should identify a Project Manager and ensure he or she is dedicated to the project without competing responsibilities or job assignments. GMHA's Project Manager should report directly to the EMC and have sufficient authority to ensure inter-departmental action steps will be taken by all parties involved. Ideally, the Project Manager should have a proven record of accomplishment that demonstrates the ability to follow through and get things done. The Project Manager must establish a regular schedule for meeting with the implementation teams and track and report progress. The Project Manager should establish a reporting process so that various individuals and teams are held accountable for implementing the steps. Additional the PM must take primary responsibility for ensuring the 'quick hits' receive adequate and appropriate attention. Finally, under no circumstances should the PM unilaterally alter the plan.

The EMC should strengthen the implementation structure by assigning a 'champion' from the EMC to each goal and a core team member as a 'sponsor'. The Champion serves as a high level advocate to ensure cross department activities are accomplished and that appropriate and adequate resources are devoted to the steps. The Sponsor contacts appropriate individuals and ensure their involvement in completing the day-to-day action steps. The Project Manager, Champion, and Sponsor create a three-person team to be held responsible for accomplishing the overall goal through the individual action steps.

The following assignments should be considered:
Goal 1 – Billing: Jennifer R. Cruz and Bertha Pangelinan
Goal 2 – Collections: Wilfred Aflague and Frank Torres
Goal 3 – Control Costs: PeterJohn D. Camacho and Danny Matanane
Goal 4 – Improve Net Revenue: PeterJohn Camacho and Glenda Leon Guerrero
Goal 5 – Paperless Environment: Joseph Mesa and Vince Quichocho

The EMC should establish a public information and relations office to regularly communicate with the public and staff about the hospital. Public announcements should be written and disseminated about the FMIP goals, the new policies and procedures on collections and billings, and the need for

patients to bring their insurance cards and other information when they come to the hospital. A representative from the public relations office should attend the EMC meetings.

The EMC should establish a regular meeting schedule focused only on FMIP implementation and make its completion a high priority. The FMIP implementation status should also be a brief agenda item for weekly EMC meetings. During the weekly meetings, the Project Manager should provide the EMC with individual and collective action items specific to the EMC members. A thorough, overall implementation update should be provided to the EMC at least once a month. Similarly, the status of FMIP implementation should be reported to the GMHA Board of Directors and the Department of Interior.

The EMC needs to hold the Project Manager, implementation teams, and line managers accountable for implementing the action steps. The EMC must investigate when steps are not taken in a timely manner and ensure everyone contribute to a successful implementation. Staff who do not cooperate or present unnecessary obstacles should be disciplined.

GMHA and the Project Manager will need to adjust the plan when appropriate. The FMIP is a living plan that will need to be adjusted as implementation unfolds. Changes to the plan should be thoroughly discussed with those involved and revisions agreed upon. The EMC and Project Manager must ensure action steps; timelines, responsibility for action and other aspects of the plan are updated in writing and disseminated to the EMC and implementation teams.

The EMC members should hold each other accountable for supporting the implementation actions. As GMHA's executive team the EMC has responsibility for institutionalizing the FMIP implementation. They must integrate the FMIP into their day-to-day information gathering and decision making processes. Further, the FMIP should be referred to during conversations with each other, implementation team members, and the overall staff. FMIP success stories must be shared throughout the hospital.

As part of improving accountability, the EMC and the Project Manager should establish a regular performance measurement reporting process. Each strategic goal includes measures that will demonstrate implementation actions are having a positive impact on the hospital's performance. The PM and the Champion and Sponsor for each goal should review the proposed performance measure, add or delete measures when appropriate, and establish specific targets for each measure. The proposed strategic goals and measures:

Goal #1 – Improve the billing process

Decrease in number of items on billing and missing information reports

Decrease in number and amount of post payment denials

Decrease in the number of items on the daily charge audit reports.

Decrease in number of adjustments and re-bills for missing charges.

Increase in number of final bills prepared prior to patient discharge

Goal #2 – Improve the collection process

Increase in monthly cash collections

Interest collected on past due accounts

Number of legal actions taken by collection agencies

Decrease in the dollar amounts of bad debt

Decrease in the number of days in accounts receivable

Dollars collected from GovGuam separating employees

Number of online transactions

Goal #3 – Control costs

% of supplies purchased that can be accounted for as accurately billed to a patient

% of pharmaceuticals purchased that can be accounted for as accurately billed to a patient

% of linens purchased that can be accounted for as appropriately retired

variance of actual staffing levels from recommended levels

Goal #4 - Increase net revenues

% and dollar amount of increase in revenue

Revenue generated by new services

% increase in Medicare per diem rate

% increase in Medicaid cap

% increase in Medicaid reimbursement rate (FMAP)

% decrease in uninsured patients

Goal #5 – Establish paperless environment

$ spent on paper, paper forms, copiers, printers, toner, and paper-related products each year

Number and percent of business processes converted to electronic operation

Number of paper medical records generated

Amount of storage space required for paper medical records

For GMHA to implement the FMIP successfully it needs the participation and cooperation of many other entities—legislative changes, an active partnership with DPHSS, effective business

relationships with vendors and payers, an involved and committed medical community, and a public that is willing to fulfill its responsibility for ensuring success at the hospital. The EMC should ensure all stakeholders are familiar with the FMIP; the importance of the FMIP to GMHA's current financial status, and the role the FMIP plays in improving GMHA's circumstances. The EMC should organize a public relations campaign to inform the Governor, the public and other stakeholders about upcoming changes that should be expected because of the FMIP. A full explanation of significant changes (e.g. charging 12 percent interest) and why it is necessary should be disseminated to everyone. In addition, the EMC should seek the assistance of the Governor and Legislators in seeking the cooperation of other GovGuam departments and administrators.

GMHA needs to communicate, communicate, and communicate. Many staff is poorly informed about hospital policies, procedures, and processes. Staff also holds many 'organizational myths', untruths, or half-truths that are passed from person to person as facts but are simply not correct. Many staff firmly believes things that are incorrect. These misguided beliefs involve operations, performance data, and virtually all aspects of the hospital. Misconceptions alone are problematic, but when staff acts on these misconceptions, it can be both costly and destructive. GMHA needs to make a concerted effort to educate staff, communicate with staff, base its decisions on firm factual bases, and dispel some of the myths.

The hospital tends to be both 'stove-piped' and hierarchical. These two characteristics make problem solving and communications very difficult. GMHA need to purposefully and aggressively break down the barriers between its units and the rigid structures within its units. Hospital operations and processes are extremely intertwined and interactive; the hospital's structures, management processes, and communication paths must be equally flexible, interactive, and inter-related to support and improve hospital performance.

Regardless of its success, the FMIP will have important repercussions on GMHA and its entire staff. It is incumbent upon those involved in creating it to ensure the FMIP receives proper attention and evolves into a highly successful project, evokes pride and is seen as a valued agent of change.

APPENDIX 1: FMIP TEAM MEMBERS

Executive Management Committee
PeterJohn Camacho, Hospital Administrator / CEO
Joseph Mesa, Associate Administrator, Operations
Wilfred Alfague, Chief Financial Officer, Acting
Dr. Jim Stadler, Associate Administrator of Medical Services
Jennifer R. Cruz, Assistant Administrator for Nursing Services
(Vacant), Assistant Administrator of Professional Support Services
(Vacant), Risk Manager, and Quality Management Administrator

Core Team Members
Martha Babauta, Business Office Manager
Tony Lorenzo, Medical Health Record Administrator
Vince Quichocho, MIS Manager
Bertha Pangelinan, Computer Operator III
Frank Torres, Collection Supervisor
Danny Matanane, Supply Management Administrator
Joy Villarual, Quality Improvement Coordinator
Glenda Leon Guerrero, Hospital Nurse Supervisor, II
Lou Tenorio, Chief of Admissions
Frumen Patacsil, Charge Library Custodian
Jun Infanti, Chief of Accountant
James Barnhart, Assistant Supply Management Administrator

Graduate School USDA
Pat Keehley
Steve Medlin
Debbie Milks
Jeff Wolf

APPENDIX 2 – SESSION NOTES FROM TEAM MEETINGS

First, the Core Team established the following Ground Rules:

Be on time

Speak one at a time

Open & honest

Participate

No sidebars

Confidentiality

Hold your temper

Do not shoot the messenger

Own the product

Have fun

If you commit to doing something, do it, otherwise tell us

Communicate

Be realistic

Do not get personal

Keep eyes open for "quick hits"

Next, they brainstormed the strengths and weaknesses experienced by the hospital over the past five years and the opportunities and constraints expected during the upcoming five years:

Strengths	Weaknesses
Current automation	don't always receive updates
Needed to become current with automation	
Improve collections	Collections
Improved communications with dept & staff	Nurses fail/unaccountable to charge supplies
Perform duties despite staff shortages financial management	
	(Identified by audits)
Upgrading equipment	Lack of support of govt
Core strength of skill level of hospital staff	insufficient technology
Immediate entry by data staff	(can't afford it)
	Medical staff interference
	Federal reimbursement rate

Opportunities	Constraints
Military expansion 2008	Resistance to automation
JCAHO	Lack of funds
Software upgrades	Legal restraints
EITC	(Guam and Federal)
Upgrade of equipment	Political interference
Training	

Projecting approximately five years into the future the team discussed what they did to capitalize on the strengths and opportunities, and overcome the weaknesses and constraints. Then they identified the five most important actions.

Electronic medical records
1 Electronic claims
Reduced A/R 99%
Recovered AR through EITC & tax refunds
2 Fixed the chart of accounts
Fully integrated MIS
Appropriately staffed (right people at the right place)

1 Revenues exceed expenses

1 Accurate billing (reduce denials)

3 Improved revenue cycle

Most efficient organization ever

JCAHO certified (patient care)

Improve public opinion

3 Good relationship btwn management & staff (2 way communications between mgmt & staff)

Offering more services

1 Better facilities

Employee retention (nurses & doctors)

Increased Medicare reimbursement rate (dup)

Increased grants from Federal govt for military expansion

Reduce the # of uninsured

1 Applied discounts from supply vendors

1 Distribute stock items & control

Discounts to self-pay patients

5 Accurate & current charge master

1 Laws changed to help with insurance collections/payments (electronic)

Convert receivables into loan pymts

Increase compact impact funding

1 Change law to increase Medicaid cap & reimbursement rate

Accurate & timely cost report

3 Automate charge voucher & other services system

2 Clean audits (zero audit findings)

4 Accurate & complete patient intake information (insurance, verification, patient info,etc)

5 Accurate capture of documentation for billing information

(Excellent documentation by nursing staff so reduce denials

Accurate & complete patient information & demographics

5 Hold staff/depts accountable for not following policies & procedures

**** The number represents how many votes the item received from the team.**

The high priority items were rewritten into the following draft strategic goals:

1. **Provide an updated, accurate and current charge master**
2. **Review charge master**
3. **Prices**
4. **Eliminate obsolete services**
5. **Update pricing model**

6. **Automate charge master**
7. **Integrate PI charge master with other charge masters**
8. **Maintain updates and accuracy of charge master**
9. **Train department mangers on charge master**
10. **Automate charge entry**
11. **Train staff**
12. **Ensure accurate and complete patient information ie demographics, insurance, financial info**
13. **Review/create policy & procedures to**
14. **Trained staff**
15. **Receiving and process patient information at point of registration**
16. **Clarification on job description for Patient Registration staff**
17. **Automate admission process**
18. **Train staff**
19. **Service information is complete accurate timely and fully supported by documentation**
20. **Train staff on documentation needs**
21. **Automate charge vouchers**
22. **Automate charge entry (bar coding)**
23. **Establish standard policy and procedures**
24. **Train staff on policy & procedures**
25. **Review & improve billing info capture & documentation process**
26. **GMHA has clearly documented policies and procedures that establish best practices for hospital administration and standards of care and all staff are held accountable for complying/adherence to them**
27. **Update/Create/Establish policies & procedures**
28. **Assess current policies & procedures to identify charges needed updates, missing P&P**
29. **Educate Staff**
30. **QI/PI review**
31. **Mgmt follow up**
32. **Compliance audits**

The Executive Management Committee (EMC) initially discussed questions raised during the Core Team's initial meeting. Then their discussion was structured identically to the Core Team.

Core Team Questions:

1. GMHA is "not for profit". Why are we concerned about improving our financial management? As long as we are required to treat indigent patients, we will not make a profit.

Response: It is okay for a not for profit to have revenues exceed expenditures in order to be able to provide additional services, new facilities, etc. Additionally, we need to lessen our dependence on GovGuam's general fund.

2. Why is our scope limited to administrative processes only? We must include the administrative processes within the clinical side. We are concentrating on administrative processes because we are in a fiscal crisis

3. We seem to be missing some members of the Core Team. For example, why have accounting, facilities, and the planning offices not been represented?

Someone should be included from accounting and patient registration. We will add the appropriate individuals. The planning office focuses on areas such as bioterrorism and is currently devoted to HERSA grant deadlines. We cannot add someone from planning. We can add someone from facilities if the need arises.

4. Considering management turnover, how will we institutionalize changes outlined in the FMIP? The core team is the classified middle management and they have the authority and responsibility to make the necessary changes. The EMC can provide guidance, but they do not micro-manage. The EMC must support them—that is their responsibility. Business processes must be based upon standard policies and nationally accepted practices. They are not subject to interpretation, so new management should follow them. If there are no policies or procedures, then there are judgment calls on the part of management. Part of the FMIP process is to set up an institutionalized process.

5. How will we get this done when most private companies do not implement?

Failure is not an option. The FMIP is a roadmap to success. We have goals and objectives down the line, too.

Strengths	**Weaknesses**
Long term, committed employees with institutional knowledge at both staff & mgmt levels	**Turnover in clinical side**
Resilient & adaptive staff	**Senior employees can be complacent**
CMS certified	**Resistance to change**
	Some supervisors who are not formally trained

Creative employees Buy-in from Gov Guam, Legislature, Administration Open door policy Transparency in management Diversity in staff Merit system Strong stable EMC Competent & Resourceful Staff Love to Eat!	Geographic location is a problem with continuing Ed, bringing in supplies, other resources Unclassified positions are difficult to fill (not secure) Low salaries Inadequate or lack of SOPs leading to inefficiencies Physicians don't participate White coat superiority to the back side of the house

Opportunities	Constraints
Dr. Noel Concepcion heart operations Pockets of revenue enhancers (CT scan) Fiscal initiatives (EITC garnishments) Availability of Fed Grants (HERSA & CDC) Federal & Local subsidies FMIP Requirements for reporting is a good thing "Divorce" from civil service commission Hay Study Training opportunities Move of Marines to Guam (expanded military presence) (PE407) Paperless Environment by April 2007 Advances in technology	Public Laws Mandates Cannot turn anyone away Cannot increase fee schedules at will Detractors in medical field and media Management instability Lack of employee buy-in to change (fear of change) Past sins ($6M owed to the Retirement Fund) Potential new hospital competition Possible overload of military dependents Privatized management (creating stress and anxiety)

Projecting approximately five years into the future the EMC discussed what they did to capitalize on the strengths and opportunities, and overcome the weaknesses and constraints. Then they identified the five most important actions.

We had a strategic goal

Input from staff

Better communication

Staff buy-in

Tightened up policies (changed processes)

4 Collected revenues

1 Improved and added new services (radiology, outpatient)

Captured all charges

4 Controlled Costs

Consistently reported costs of indigent care

Decreased liability by ensuring more nursing staff at the bedside

1 Unqualified audits

Provided resources & tools to implement

Implemented Paperless Environment

Competitive salaries

Empowering staff to do their jobs (Staff buy-in)

2 Steady flow of supplies (No more NIS)

1 Paid $16M in debt

Reduced subsidy (subsidy only for uninsured)

1 Fees for services, not subsidy

2 JCAHO certification

4 Expanded & upgraded facilities (Expanded bed capacity)

Regional medical center for Micronesia (Specialize in cardio vascular services)

Decreased turnover

1 More patients with insured status

More access to care for uninsured

3 Increased efficiencies

2 Revenue reporting at dept level

The high priority items were expanded into the following strategic goals:

1. **Improve/Increase Operational Efficiencies (Fiscal)**
2. **Review & revise fiscal services policies & procedures by 12/31/06**
3. **(May need to add as mentioned in audit report)**
4. **Streamline/simplify the procurement process by 10/01/06**
5. **Can take 2-3 months, a year from the time of RQ to receiving goods**
6. **Cost too much time, energy & manpower to follow up**
7. **Improve the supplies inventory/control by 9/30/06**
8. **Too much leakage**
9. **Training/education opportunities for fiscal services staff (ongoing)**
10. **Need to enforce policies after training**
11. **Implement PE407**

12. **Increase Collections**
13. **Revenue Enhancement**
14. **Establish P/P & SOP**
15. **Improve capture of Charges**
16. **Billing cycle**
17. **Once patient is discharged—what happens**
18. **Need to ensure data is correct**
19. **When bills go out they must be clean**
20. **When bills is denied, need to follow up with physician (or problem area)**
21. **Cleaner & quicker production of bills**
22. **Collection cycle—increase effort**
23. **Account management**
24. **Relationship with 3rd party payers**
25. **Collection efforts (bad debts)**
26. **Garnishment**
27. **Liens & Levies**
28. **Correctly recording in timely fashion**
29. **New Services**
30. **Review of Charge Master**
31. **Fees for Services instead of flat subsidy**
32. **Indigent**
33. **Govt agencies**
34. **Need better revenue codes posting to the correct GL**
35. **The accounting cycle is a "diary" of what has happened starting with admissions**
36. **Control Costs**
37. **To control costs by initiating achievable processes within the organization**
38. **Selectively implement PE407 (procurement & pharmacy)**
39. **Identify areas where measurable success will be accomplished**
40. **Pharmacy inventory**
41. **Materials inventory**
42. **Fiscal**
43. **Implementing the PIXUS system**
44. **Linking pharmacy & MM**
45. **Update charge master**

APPENDIX 3 – OBSTACLES TO IMPLEMENTATION

Core Team

The current information system is fragmented

The laws that changed in 2001 prevent some FMIP actions

No continuity in management since 1993

Some people do not have full access to the system

Turnover in the CFO position

Committees' decisions when setting up the new system

Internal friction

Hospital administration will not mandate use, change, etc.

No accountability for overspending budgets

No follow-up after distribution of recommendations

High turnover after reports have been issued

Lack of communication across departments at the executive level and down through the organization

EMC

Complacency

Lack of accountability, top to bottom and bottom to top

Failure to communicate

Lack of documentation related to poor performance

Politics

Buy in from the media, public, Board, etc.

Disasters

Sins of the past

Resistance to change

Lack of commitment

Lack of professionalism

Resource availability

Implementation structure

Competing initiatives

Rotating management

Performance management

Failure to follow through

Support from upper management

Lack of credibility and reliability with overall administrative performance

APPENDIX 4 – STRATEGY FOR FINANCIAL IMPROVEMENT

The FMIP establishes a strategy for financial improvement, and then identifies what needs to be done to implement this strategy. The strategy allows hospital staff, managers, and stakeholders to see the ultimate goal and the means to get there. The strategy covers both revenue and expenses.

GMHA bills $103M for services in a year while the expenses for the facility are $74M. If GMHA collected 100% of its billing there would be a significant profit. Unfortunately, GMHA is not able to collect 100% of revenues from each payer source. If GMHA collect what it were entitled to based on the various contracts and reimbursement mechanisms, its financial picture would be:

Current Payer	Billings	Reimbursement
Medicare	25,540,731	9,889,950
Medicaid	11,645,206	7,327,953
MIP	11,044,341	8,528,650
Private Insurance	36,581,082	28,537,852
Contract Totals	78,948,306	54,464,405
Self Pay	24,098,154	7,176,350
Required Totals	103,046,460	61,460,755

Thus, GMHA has an annual deficit of more than $13 million. The strategy for its financial improvement focuses on how to narrow this gap and eventually allow the hospital to have revenues exceeds expenses. To implement the strategy GMHA must control its own costs, improve its billing and collection activities, and fund ways to increase its revenues. The five strategic goals articulate these goals in more detail and identify the specific tasks that must be completed to achieve the goals and fulfill the strategy.

Each of the Payer Groups has improvements that need to happen in order to achieve the vision. The following is the type of analysis that GMHA should go through in building the process for improvement:

Medicare:

Currently Medicare pays GMHA for services under the TEFRA (Tax Equity Fiscal Responsibility Act) methodology. This means that all IP (Inpatient) services are limited by an aggregate $5,900 per discharge amount. GMHA currently runs about a $1,000,000 overage on Medicare cost which is lost due to this reimbursement mechanism. OP (Outpatient) services are reimbursed at 95% of cost. Currently GMHA loses about $150,000 because of this reimbursement mechanism. To correct this situation GMHA needs to pursue the following actions:

Ensure the correct preparation of the cost report to obtain the maximum entitlement of reimbursement

Work with the Governor of Guam, the Guam Delegate, and other invested parties (DOI, CHC, etc.) to allow GMHA to obtain additional funding related to the treatment of a significant portion of Indigent patients. This reimbursement is titled DSH (Disproportionate Share Hospitals).

Work with the Governor of Guam, the Guam Delegate, and other invested parties (DOI, CHC, etc.) to allow GMHA to obtain specialty status as either a Sole Community Hospital or a Critical Access Hospital. These special designation hospitals receive favorable reimbursement rates related to their costs.

Medicaid:

Currently the Medicaid program pays GMHA based on the Medicare determined per-diem interim reimbursement rate. Guam Medicaid is provided Federal funding on a block Grant basis, rather than on a matching basis, which is enjoyed by each of the states Medicaid programs. This means that the Guam Medicaid program frequently runs short of funds for services provided to its patient population. To correct this situation GMHA needs to pursue the following actions:

Work with Guam Medicaid to ensure that the reimbursement is at least equal to the cost of service. (This may require the filing of a Medicaid cost report to demonstrate the true cost of services experienced by GMHA in treating the Medicaid population.)

Work with the Governor of Guam and the Guam Legislature to ensure the necessary matching funds are available for the Medicaid program.

Work with the Governor of Guam, the Guam Delegate, and other invested parties (DOI, CHC, etc.) to increase the Medicaid block grant.

Work with the Governor of Guam, the Guam Delegate, and other invested parties (DOI, CHC, etc.) to obtain Federal Grants to fund the documented shortfall of Reimbursement related to the Hospitals treatment of the Medicaid patients.

MIP:

Currently the MIP program pays GMHA based on the Medicare determined per-diem interim reimbursement rate. Guam MIP is provided funding solely by the Government of Guam. This means that the Guam Medicaid program frequently runs short of funds for services provided to its patient population. To correct this situation GMHA needs to pursue the following actions:

Work with Guam MIP to ensure that the reimbursement is at least equal to the cost of service. (This may require the filing of a MIP cost report to demonstrate the true cost of services experienced by GMHA in treating the MIP population.

Work with the Governor of Guam and the Guam Legislature to ensure the necessary funds is available for the MIP program.)

Private Insurance:

The private Insurance payers currently reimburse GMHA based on their negotiated contracts. GMHA has allowed several of the contracts to lapse while continuing to negotiate for new contracts. GMHA is continuing to provide the Private Insurance with a prompt pay discount even though these payers have no current contract. Guam has passed a law recently that requires all private health insurance payers to have a contract with GMHA. GMHA needs to make sure that the private insurance payers are reimbursing the hospital properly per the negotiated contracts. To correct this situation GMHA needs to pursue the following actions:

Re-Negotiate the Private Insurance Contracts. These contracts need to have stringent requirements for the Private insurance to pay promptly, and accurately. Provide a 5% discount for payment within 30 days and a 5% penalty for each 30 days period claims are delayed payment after that.

Ensure that the contract is specific about what is allowed for claim denials. In the past, the private insurance denied claims to postpone payments. At a minimum, the penalty time clock should not stop running due to a denial.

Ensure that the contract is clear that all amounts denied or unpaid by the private insurance will be billed to the patient in addition to the patients co-insurance and deductible.

GMHA needs to strictly enforce the terms of the contracts on the private insurance payers.

It needs to be noted that the private insurance companies are paying less money to the hospital now than they were in FY 2000. The negotiation of stricter contracts and enforcement of proper payments should not result in the increase in individual insurance rates until the insurance companies are paying amounts above their historical levels.

The only real threat for enforcement that GMHA has of the contracts is for the facility to stop taking assignment of the particular insurance that is not living up to its obligations. Stopping assignment means that GMHA will no longer honor the insurance when a patient comes into the facility for services. If the patient is receiving services, the patient will be billed 100% of the claim and will be responsible for the debt. The patient must then go to the insurance and obtain reimbursement for the services from the insurance company. In this way, the patient still can receive services, but the private insurance will have a public relations problem that is designed to bring the insurance company back in line.

Self Pay:
The self-pay population at GMHA is comprised of several types of patients. They are:
Patients that have insurance and have an outstanding balance for their Co-Insurance or Deductible
Patients that are unwilling to provide their insurance information and therefore are in the self pay category
Patients that can qualify for Medicaid and/or MIP but refuse to sign up due to the negative stigma that these programs represent to their social status
Patients that have no insurance, can not qualify for Medicaid and/or MIP, and have the means to pay their bills
Patients that have no insurance, can not qualify for Medicaid and/or MIP, and have no means to pay for their services (True Indigent)

One of the problems that GMHA is facing in trying to collect from the self-insurance population is a belief by the Collection staff that all of these patients are indigent. "If the patient is a self pay they must be poor". The staff needs to feel comfortable that the individuals that they are collecting from have the financial means to pay the bill. Otherwise, the collection effort will be half hearted at best. These patients should be boiled down to three categories as follows:

1. **Patients who need to get/provide their insurance information**
2. **Patients who are truly unable to pay their bills (True Indigent)**
3. **Patients that can pay their bills (not indigent)**

GMHA needs to make sure that they have a way of identifying the patients that truly are indigent. This can be done with a Charity care policy. The charity care policy should be developed such that any patient unable to pay their debt (Co-Insurance, Deductible, or Self Pay) is identified, their financial situation is verified, and the AR written off as Charity care. Once the Charity care patients are not in the collection pool, then the collection staff should be very aggressive in the collection efforts towards these individuals. If an individual who qualifies is not willing to sign-up for Medicaid and/or MIP then they must be placed in the self-pay category of patients that need to pay their bills. This will cause the collection effort to start and the patient will have significant incentive to sign up for Medicaid/MIP or provide their insurance.

Once GMHA has sorted out the Self Pay population, they will have a better understanding of the true Charity Care, Self Pay, Medicaid, MIP, and Private Insurance populations. That will allow them to better pursue the funding sources for those payer types.

GMHA should also consider looking for Foundation services that will focus on the solicitation of Donations from people of wealth to compensate for the documented charity care population. This would alleviate some of the need to approach the Guam Legislature for a subsidy for the Charity care cases.

The example above is not fully complete, but it is a representation of the type of financial strategy that GMHA needs to develop.