



FULTON COUNTY

Policies and Procedures

**SUBJECT: Fulton-DeKalb Hospital Authority
Standard Operating Procedure-
Financial and Standards of Care Review**

DATE: February 22, 2010

NUMBER: 01-01

Statement of Policy

It shall be the policy of Fulton County to conduct an independent review of financial and Standard of Care information reasonably necessary to verify the contribution amount as required by the Memorandum of Understanding.

Background

Under the terms of the operating contract, the Authority has agreed that it will at all times during the term of the contract, provide facilities for the indigent sick and emergency services on behalf of Fulton and DeKalb County, GA in exchange for payments from the counties for such care and services. On April 3, 2009, a Memorandum of Understanding between the Fulton-DeKalb Hospital Authority and Fulton County was signed to clarify the revisions of the contract. The Memorandum of Understanding mandates the submission and review of the data.

General Procedures

The Fulton-DeKalb Hospital Authority shall cause the Grady Memorial Hospital Corporation to provide quarterly reports substantially containing income verification, residency documentation, and other information relating to Standards of Care of eligible patients within 30 days following the end of each quarter. Reconciliation by Fulton County for each quarter shall take place no later than 30 days after the report has been submitted. Any overpayment by Fulton County as determined by such reconciliation shall be deducted from the next quarterly payment to the Authority. However, in subsequent quarterly payments the Authority will be eligible to recapture prior deductions up to the pro rata amount of Fulton County's annual budgeted amount, provided that the reconciled data indicates that the Cost for services to Eligible Patients (as defined in the MOU) equals or exceeds the total of the prior quarterly payment amount plus previously deducted amounts.

Financial Procedures

The Internal Audit Division will review those documents submitted to verify income eligibility and residency:

1. Receive MOU Report and reconcile the MOU with supporting documentation.
2. Inquire whether there have been changes to the Hospital's patient admissions and discharges policy since our last procedures date.

3. Obtain an electronic copy of the data detail of patient charges during the month for services eligible for Fulton County reimbursement by hospital, outpatient pharmacy and nursing home for financial eligibility codes K and M.
 - a. Reconcile the charges from these reports to the total per the Fulton County Indigent Care Analysis Patients Discharged for the month.
 - b. Review the reports for duplicate patient charges.
 - c. Compute a sample size of patients to review using a 95% confidence level and 10% confidence interval.
 - d. After determining the sample size, utilize a random number generator and apply to the population range to determine the sample.

4. Provide the list of patients selected from our sample procedures to our hospital contact and request the patient's medical records and financial counseling.
 - Financial counseling form affidavit
 - Patient and outpatient registration or demographic form
 - HDX document (3rd party insurance coverage or non-coverage verification)
 - Letter with original signature from Program Director of Transitional Housing, if applicable
 - Confidential registration form
 - Medicaid slip for current month, if applicable
 - Financial counseling month expense statement
 - Proof of residency
 - Proof of income
 - Proof of dependents, if applicable
 - Picture ID
 - Medicare health insurance card
 - Cost allocation schedules
 - Encounter forms showing patient charges

5. Prepare an analysis of patients selected and review the following attributes for compliance with hospital policy.
 - Patient medical account number
 - Admission and discharge dates
 - Total charges and costs allocation
 - Verify charges on encounter forms or medical records
 - Agree charge to Charge Master and verify cost allocation ratio
 - Patient registration form
 - Demographic data sheet
 - Patient ID
 - Review registration form and verify identification from driver's license, GA identification card, Mexico Matricula
 - Consular ID or school picture ID
 - Fulton County zip code
 - Residency (continuously for at least 30 days)
 - One of the following is required: valid GA driver's license, 3 pieces of mail, lease contract, rent receipt, food stamps, GA voter registration card, other business documents such as bank statements, check stubs and mortgage statements
 - Income eligibility

- One of the following is required: 3 current paychecks stubs, SSA letter, unemployment claim, letter from employer, decision letter from government agency, food stamps, letter from local housing shelter
 - Verify appropriate eligibility code K or M
 - Benefit eligibility
6. Document the results of our procedures including any exceptions. Determine the nature of any exceptions and consider whether additional selections are necessary in order to satisfy our objections.
 7. Summarize the results of our procedures, including findings if any, and prepare a report to the Director of the Fulton County Internal Audit Division.

Quality (Standards) of Care Procedures

The Health Services Division will review those documents submitted to monitor quality of care.

Performance Reporting

1. GHS will submit performance results in 4 overall areas: process measures, patient flow measures, patient access measures, and customer satisfaction measures.
2. GHS will submit performance results for the following measure sets: congestive heart failure (CHF), acute myocardial infarction (AMI), pneumonia (PN), surgical care improvement project (SCIP), stroke, average emergency room wait time, average length of stay after admission, third available appointment and next available appointment for new and established patients and customer satisfaction measures.
3. GHS will submit performance results for the specific metrics for each measure set as shown in attachment A.

Performance Auditing

1. Fulton County will audit 6 charts of patients for each of the 6 measure sets listed above for a total of 30 charts.
2. In addition Fulton County will audit the same 5 records that have been selected for audit by the Center for Medicaid and Medicare Services.
3. Fulton County will assess these records for documentation that supports compliance with the benchmarks for specified metric. (See attachment A for benchmarks.)
4. For the patient flow measures, Fulton County will review data regarding total service time in the ER and the number of patients.
5. For the patient access measures, Fulton County will audit appointment availability using a "secret shopper" technique.

6. For customer satisfaction measures, Fulton County will review the data from Press-Ganey, an independent contractor used by GHS to collect and report data regarding customer satisfaction.

Analysis of Quality of Care Data

1. The Director of Health Services will receive the results from Grady Health Systems.
2. The Director will forward the data and copies of charts to the external auditor.
3. The Auditor will audit the data and prepare a report to submit to the Director of Health Services.
4. The Director will prepare a quarterly report summarizing and analyzing the results for each specific performance indicator, any variances from compliance standards, the status of any corrective action plans, and a review of any updates to policies and procedures related to quality of care for submission to the County Manager.
5. The Quality Measure Sets, Metrics and Benchmarks shall be reviewed annually by the Director of Health Services to ensure adherence to the most up to date practices for quality review and measurement.

Final Review and Reconciliation of Data

1. The County Manager shall meet with Internal Audit to discuss audit findings.
2. The County Manager shall review reconciliation of next payment.
3. The County Manager shall approve payment of the next quarter contribution.