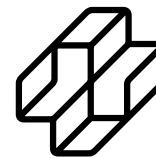


# Revenue Cycle Strategist



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## Recovery Audit Contractor Reviews: Risks and Opportunities

By John K. Dugan

*The expansion of the RAC program represents considerable financial risk—and opportunities—for providers.*

The national expansion of the Medicare recovery audit contractor (RAC) program, following the settlement between the Centers for Medicare & Medicaid Services (CMS) and the bidders protesting the contractor selections, is now under way. Hospitals, rehabilitation centers, and other providers are likely to face one of the biggest revenue threats in years: possible recoupment of billions of dollars in perceived overpayments of Medicare fees across the healthcare delivery system.

Yet a close reading of the results of the three-year RAC demonstration project that identified more than a billion dollars in improper Medicare payments and CMS guidance for the program provides an effective, if tricky, road map to navigating this minefield.

Early experience with RAC compliance also has shown that preparing for a recovery

audit represents not only a revenue risk but also an opportunity to improve the provider's operational health and be part of a larger revenue cycle improvement strategy.

### Financial Risks

Before embarking on this effort, revenue cycle managers need to convince their C-suite executives that it is worth the cost and commitment of resources. The scale of the revenue threat is clear: The U.S. Office of Management and Budget estimated that Medicare made \$10.8 billion in improper fee-for-service payments in 2007, a figure that can be seen as the baseline risk to providers. The possibility of recouping money on this scale was what motivated Congress to make the RAC program permanent and expand it to all 50 states.

The reality is that RACs—working on a contingency fee basis, which will net them between 9.4 percent and 12.5 percent of

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### COMING IN JUNE

**What are denials costing your organization? Learn about a framework for calculating the costs of collection in the next issue of *Revenue Cycle Strategist*!**

### NEW HFMA RESOURCES

**Readying for the RACs: What You Should Know, [www.hfma.org/library/reimbursement/medicare/400643.htm](http://www.hfma.org/library/reimbursement/medicare/400643.htm)**

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the recovered overpayments—will have every incentive to review claims aggressively and maximize identified overpayments.

A second financial risk comes from the requirement that providers immediately return any overpayments identified. They also must make reasonable efforts to refund deductibles, copayments, or other funds collected from Medicare patients. Together, these repayments create a cash-flow hazard for institutions operating on thin margins. Providers that fail to repay may have overpayments deducted from their future Medicare payments, although payment plans can be negotiated.

Providers can recover Medicare payments recouped by RACs only through appeal. Yet the appeals process is potentially costly, and providers had a low success rate in the demonstration project: Fewer than one in five denied claims were appealed, and providers won only about a third of those

decisions.<sup>a</sup> The cost of the appeals for a single denied claim could total as much as \$2,000, according to the American Hospital Association, providing a disincentive to pursue appeals.<sup>b</sup>

Providers have another reason to take steps to protect themselves against recovery audit-generated recoupments: the possibility that the program could be expanded to Medicaid, which, depending on previous state audits, may have an even higher rate of perceived overpayments, or that private insurers could adopt the tactics used in the RAC program. Either of these possibilities would leave providers vulnerable to more onerous compliance demands and even greater revenue losses. Also, large commercial insurers will likely consider using recovery contractors to help evaluate whether claims are being paid according to contractual terms.

### What To Do

So what can providers do to protect themselves? Plenty. The CMS report on the demonstration project (available at [www.cms.hhs.gov/RAC](http://www.cms.hhs.gov/RAC)) offers insights into the types of improper payments most likely to attract RAC attention, and the new CMS guidance on the program (also available at the CMS web site) clearly explains the process, including what rights providers have while undergoing an audit. Generally, preparation efforts include the following.<sup>c</sup>

**Establish a management structure.** Providers should begin by establishing a strong program management structure. The RAC process will likely involve a wide cross section of personnel, from physicians to health information managers to legal

counsel to financial staff. Although all need to be involved, a strong central coordinator should be designated. Ideally, the coordinator should be someone at a senior level who has ready access to C-suite executives and the facility's board and is heard by them. In advance of a RAC inquiry, the coordinator should work with an interdisciplinary team to identify risks and implement solutions. Once an inquiry begins, the coordinator should be empowered to demand—and obtain—cooperation from anyone in the organization.

**Train staff.** Education is crucial at all levels and across the organization, so providers need to get smart. Personnel need to understand the Medicare regulations and guidelines used by the RAC, how they align with facility practices, and how to ensure compliance. For example, two in five claims denials in the demonstration project were attributed to lack of medical necessity. Although medical necessity is often a matter of professional judgment, many physicians may not be familiar with the Medicare guidelines for determining inpatient versus outpatient place of service. Physicians and hospital case managers need to learn Medicare guidelines and use existing medical necessity criteria established within the hospital, while aligning care with appropriate place of service. Incorrect coding, the cause of another 35 percent of denials, is often the result of a lack of trained coding staff, coupled with unclear medical documentation that is subject to interpretation.

**Manage requests.** The process for responding to RAC requests for medical records is highly structured, with stiff penalties for

**Robert Fromberg**  
Editor-in-Chief

**Carole Bolster**  
Senior Editor

**BCN Communications**  
Production

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To submit an article, contact Carole Bolster at [cbolster@hfma.org](mailto:cbolster@hfma.org).

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a. "Medicare Recovery Audit Contractors (RACs) Program," presentation by Timothy Hill, CFO and director, Office of Financial Management, Centers for Medicare & Medicaid Services, Sept. 9, 2008 ([www.healthport.com/viewDocument.aspx?id=501](http://www.healthport.com/viewDocument.aspx?id=501)).

b. "Audits Sting Hospitals, Physicians: Health Care Providers Protest as Auditors Take Closer Look at Medicare Bills," by Kevin Freking, Associated Press, March 1, 2008 ([abcnews.go.com/Politics/wireStory?id=4369079](http://abcnews.go.com/Politics/wireStory?id=4369079)).

c. The following actions and others discussed in this article are presented solely for informational and educational purposes and in no way constitute professional guidance. Providers are urged to seek guidance in accordance with their own organization's particular needs.

noncompliance. For example, failure to provide a record within 45 days of a request can lead to the claim being automatically designated an overpayment. Consequently, providers should ensure that proper mechanisms are in place to deal with requests. Providers also need to carefully document all contacts with the RAC, retain copies of all information provided, track denied claims and appeals, and document progress in fixing errors and ensuring future compliance with Medicare requirements.

**Evaluate risk.** Providers should review the CMS report on the demonstration project as a first step in evaluating known risk areas and implementing related controls. The report details the kinds of problems that were most common, in terms of the types of errors (e.g., lack of medical necessity) and the services with the highest error rates (e.g., short-stay admissions, excisional debridements). These problems are likely to be targeted when the RAC program goes national, although recent *Coding Clinic* updates may help providers with the excisional debridement issue. Additionally, of coincidence is the timing of the RAC audit start period, which for the permanent program mirrors the beginning of Medicare severity diagnosis-related groups (MS-DRGs). The MS-DRGs were not part of the demonstration project. Providers should assume that the contractors will certainly focus on DRGs with major complications or co-morbid conditions. Technological solutions may ease the burden: In some cases, for example, software programs that monitor coding can reduce errors by alerting the hospital to opportunities for improved documentation, coding, and billing accuracy, including comparisons with peer facilities.

**Look for underpayments.** The RACs are supposed to identify and remedy both overpayments and underpayments. However, in the demonstration project, 96 percent of the improper payments identified were overpayments to providers; just 4 percent

were underpayments. If the RAC identifies overpayments but not underpayments, then the provider should go on the offensive and search its books for underpayments during the period allowed by the “look-back” rule. The downside is that providers will not be on a level playing field: RACs may “look back” three years, but providers can go back only 60 days for inpatient DRG adjustments and anywhere from 15 months to 26 months for outpatient claims, depending on the submission of original claim. Regardless, any instances identified as underpayments can help offset RAC recoupments.

**Appeal denials.** The RAC claims denial appeals process, like that of Medicare itself, will have five levels. Providers should be familiar with this process and aggressively appeal claims denials. Given the potential cost of pursuing an appeal all the way through the process, providers should be realistic about the chances of success for a given appeal and also decide, given limited resources, whether an appeal would be cost-effective. They should be sure to file their appeal within the 120-day time frame allowed. Customized workflow and tracking programs are available to assist in monitoring appeal deadlines and track the status of accounts for multiple facilities throughout the hospital RAC response process.

**Establish adequate reserve funding.** Many hospitals have an established reserve for potential paybacks of known issues for Medicare fee-for-service payments, quite often set up as a percentage of overall net Medicare revenue. Recognizing that the risk of payment recoupment has increased with the establishment of the RAC program, providers should understand potential reserve requirements and establish an appropriate level of reserve funding. Finance staff should review their organization’s reserving standards and consult with legal counsel and revenue cycle management to determine whether an increase in reserve levels is warranted.

**Stay informed.** Finally, providers need to keep up to speed on developments. There is little doubt that the RAC program will evolve as issues emerge from broader implementation. Coordinators should keep current with changes to the RAC program and its implementation by monitoring the CMS web site and communications from CMS, as well as the various professional and industry associations that are monitoring the RAC reviews. In addition, providers need to stay current with other developments that can affect compliance, such as the substantial changes that will accompany implementation of the ICD-10 diagnostic and billing coding system over the next several years.

These represent the minimum steps that providers should take to protect their revenue from the possibility of RAC recoupments. In the end, many denied claims will not be the result of “waste, fraud, and abuse,” but instead the product of legitimate errors or omissions that, corrected, should still result in a Medicare payment. Therefore, providers need to identify shortcomings in their systems, processes, and procedures, and make needed changes to avoid overpayment risk in the first place.

## CMS Hosts Open Door Forums on the RACs

The Centers for Medicare & Medicaid Services (CMS) held two special open door forums in April to introduce providers to the new recovery audit contractors and provide more information about the RAC program. A call on April 8 was for Medicare Part A providers, and a call on April 14 was for Medicare Part B providers. CMS is making recordings of the calls available on its open door forums web page ([www.cms.hhs.gov/OpenDoorForums](http://www.cms.hhs.gov/OpenDoorForums)).

## Opportunities

Although much of the focus on the RAC program rests on compliance and reducing the risk of revenue loss, the program also offers significant opportunities. Although the RAC demonstration project audits appeared to focus on overpayments, there is evidence that underpayments may be just as prevalent. Poor documentation and errors in billing and coding are directly tied to payment, and efforts toward correcting such issues often have potential to increase revenue.

The RAC program creates a strong incentive for identifying such areas and the resultant underpayments with as much vigilance as is being given to overpayments. In some cases, this vigilance may actually lead to increases in revenue.

This focus on the nuts and bolts of the revenue cycle is important, since monitoring coding and billing accuracy is essential for appropriate payment. Many hospitals that do not already do so are turning to automated means to monitor coding and identify opportunities to improve accuracy in accordance with a health information management coding improvement strategy.

The key to success in such efforts is to identify problems in the prebilling phase, but these automated tools also are useful to retrospectively review, change, and resubmit inaccurate claims. The value of this type of monitoring is a better understanding of the trends that might be causing documentation, billing, and coding errors to drive future improvements in people, process, and technology.

## Start Now

The time to act on both preventive and proactive revenue cycle improvements is today, now that the expanded national RAC program is upon us. Starting early will allow providers to gather their resources, scope out potential problems, and resolve them before receiving any RAC requests. It also will allow them to get ready to respond to the medical record requests when they are made, successfully deal with any issues that are raised, and file any appeals in a timely fashion. Providers that take these steps now will be the proverbial “step ahead” in a very high stakes game. ☞

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John K. Dugan, CPA, is a partner, Pricewaterhouse Coopers LLP, Philadelphia ([john.k.dugan@us.pwc.com](mailto:john.k.dugan@us.pwc.com)).

## CMS Answers FAQs on the RACs

### Q. How will the recovery audit contractors (RACs) determine which claims to review?

A. The RACs will use their own proprietary software and systems as well as their knowledge of Medicare rules and regulations to determine what areas to review.

### Q. Will CMS use calendar days or business days when determining the number of days a provider has to submit medical records?

A. CMS will use calendar days when making these determinations.

### Q. If a provider repays or Medicare recoups an alleged overpayment identified by the RACs and the provider later wins an appeal, will CMS reimburse the provider with interest?

A. At certain times, CMS is required to pay interest when an appeal decision is favorable to the provider. The payment of interest in response to a favorable provider appeal decision is determined by CMS's interpretations of the appeal regulations. These regulations determine the process for all overpayments, not just RAC-identified overpayments.

### Q. Do RACs look for underpayments? What happens if they find an underpaid claim?

A. Yes, RACs will identify underpayments as well as overpayments. In situations where a RAC identifies both overpayments and underpayments for a provider, the RACs offset the underpayment from the overpayment. In situations where a RAC identifies an underpayment for which there is no overpayment from which to offset, the RACs will inform

the carrier or intermediary who will proceed with the claim adjustment and payment to the provider. A *MLN Matters* article, SE0617, was released on April 10, 2006, with additional information for providers concerning the identification of an underpayment by a RAC. The *MLN Matters* article can be found at [www.cms.hhs.gov/MLNMattersArticles/download/SE0617.pdf](http://www.cms.hhs.gov/MLNMattersArticles/download/SE0617.pdf).

### Q. If a provider has performed a self-audit prior to RAC review and wants to extrapolate these findings, will all these claims included in a self-audit be excluded from RAC review?

A. If a provider self-discloses a payment error and the claims processing contractor confirms that a payment error exists and the sampling/extrapolation methodology used was correct, these claims will not be reviewed by the RAC. The claims processing contractor will exclude the self-disclosed claims in the RAC data warehouse.

### Q. What is the reimbursement procedure and rate for photocopy charges associated with records for RAC audits?

A. RACs are required to reimburse PPS providers and long-term care providers. The reimbursement rate is 12 cents per page for reproduction of medical records. Facilities are not required to submit vouchers to the RAC requesting payment. Rather, the RACs will automatically issue payments to the hospitals for photocopying charges. RACs are required to pay for copying on a monthly basis. All checks should be issued within 45 days of receiving the medical record.

Source: Centers for Medicare & Medicaid Services.

# Patient Communications Drive Revenue and Patient Satisfaction

*Every step of the revenue cycle offers opportunities to improve communication with patients, which can lead to increased revenue and patient satisfaction.*

Revenue cycle leaders can use each step of the revenue cycle to communicate with patients, remembering that each communication should be clear, brief, relevant, and useful to connect effectively with every patient. Communications should be integrated with the revenue cycle in a way that reaches as many patients as possible cost-effectively. The delivery should be automated whenever possible for efficiency, cost-effectiveness, and ease of use. Whether oral or written, patient communications should include a confirmation process so providers will know that the message has been delivered and understood.

For example, automated phone reminders can include an option for patients to “press 1 to confirm, or press 2 to change” their appointment. Similarly, written communications should include clear directions regarding whom to contact if patients need to change their appointment. Please note the language here. We avoid using the word *cancel*, as you want to prompt patients to change or reschedule, not cancel. On an Internet notification system, because of the nature of the medium, you should also add a confirm or change functionality so that your patients can notify you if they will not be present, but also can arrange to reschedule their appointment.

When planning communications, think like a new patient. If you were going to receive medical care at a hospital you had not dealt with previously, what you would want to know? Would you want to receive brochures and booklets that describe the hospital or health system and its services? Or would you simply prefer a telephone call to remind you of your scheduled appointment? The patient experience begins with the first contact, not when the patient shows up. Use every opportunity to communicate clearly and concisely, telling patients only what they need to know. Then follow that reasoning throughout the revenue cycle process.

## The Johns Hopkins Patient Communications Program

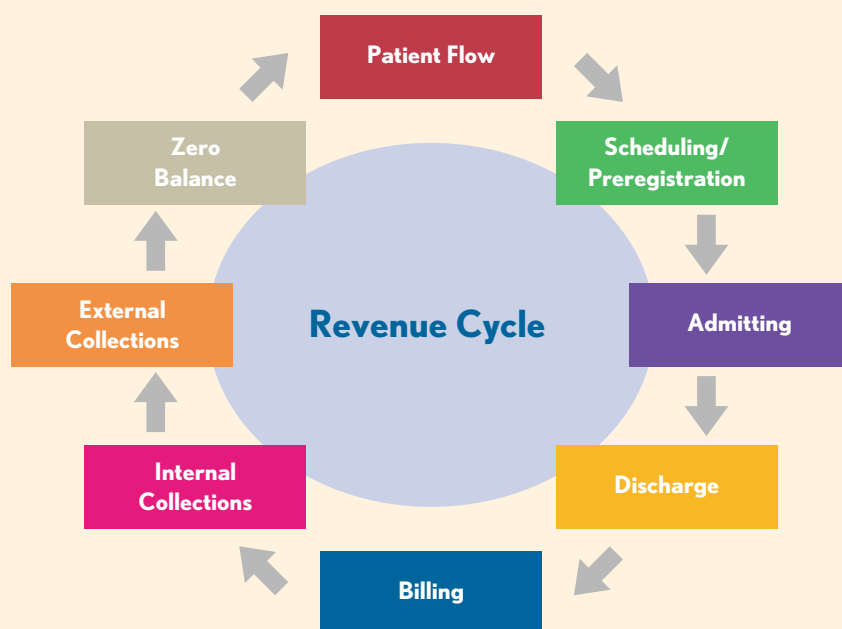
Some organizations are focusing their communications on the whole patient experience. They have realized the financial benefits of clear, targeted, automated patient communications beginning with the patient’s first contact. They use data already captured in their scheduling and billing software to deliver specific messaging that will help patients get to the right place, at the right time, with the right preparation.

Johns Hopkins Hospital and Health System has initiated a comprehensive patient communication program that includes phone reminders, printed reminders, and electronic reminders. The health system is gradually implementing the program across the entire enterprise. Beginning with phone reminders, Johns Hopkins began tracking improvements in no-show rates as well as staff productivity. Although the health system had been printing and mailing reminder letters from each department, the mailings tended to be erratic and unappealing. Additionally, the organization had not attempted to use electronic communications at all, and patients were beginning to ask for this option.

One of the complications contributing to the inconsistency of the mailings was the use of multiple scheduling systems within the organization. A decision was made to

## Communications Affect the Revenue Cycle

**Using each phase of the revenue cycle to communicate with your patients will result in a continuum of touch points that will improve patient satisfaction. It is an easy way to develop a program.**



outsource the process of integrated patient communications, using automated communications to clearly communicate to patients what they need to do and how they need to prepare for their procedures and appointments. As a result, Johns Hopkins was able to automate the printing, mailing, and electronic delivery of patient information (regardless of which system the data reside in). Benefits included improving the patient experience and unburdening the staff. The soft benefits included an

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See an example of improved patient communications used by Johns Hopkins Hospital and Health System at [www.hfma.org/rcs](http://www.hfma.org/rcs).

opportunity to promote corporate branding, improve the “first-impression” image, and establish the expectation of excellence before the patient even arrives. The idea is to optimize existing systems without compromising quality by enhancing,

manipulating, and augmenting the data available. To see an example of patient communications used by Johns Hopkins, visit [www.hfma.org/rcs](http://www.hfma.org/rcs).

The financial benefits realized by Johns Hopkins were not insignificant either. The exhibit Johns Hopkins Medicine Show Rate Analysis illustrates the improvement in show rates experienced by some of the clinics before and after implementation of the integrated patient communications program.

**Johns Hopkins Medicine Show Rate Analysis**

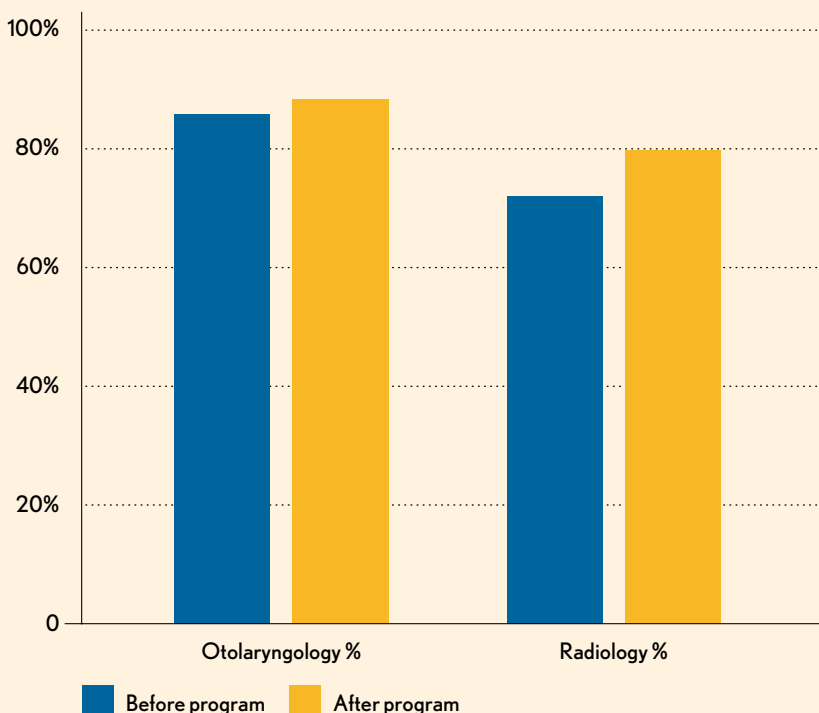
This shows the actual improvement in show rates experienced by Johns Hopkins.

Department	Pre	Post	Difference
Dermatology	78.1%	78.6%	0.5%
GYN/OB	83.7%	86.1%	2.4%
Neurology	89.0%	89.8%	0.8%
Ophthalmology	84.6%	87.3%	2.7%
Orthopaedics	86.4%	88.5%	2.1%
Otolaryngology	85.8%	88.4%	2.6%
Radiology	75.3%	80.8%	5.5%

The exhibit Measuring and Tracking Show Rate illustrates the improvement in two departments with a conservative calculation of the value of the improvement to the organization’s financial bottom line. This is the payback realized by the allocation of costs for a typical appointment and does not include extra value for the high dollar costs associated with typical radiology procedures. With an outreach communications program in place, no-shows have decreased, staff members work more efficiently and sensitively, and patient satisfaction is improving.

**Measuring and Tracking Show Rate**

This net revenue gain is real and is for two departments only.



As patient financial responsibility increases, providers need to ensure that patients receive bills they can read, understand, and take appropriate action on. Providers need to be flexible, extracting existing data and maximizing their effectiveness by clarifying the language and delivering the message via multimedia—print, Internet, text messaging, oral communication, and e-mail. Providers need to be mindful of the challenges that patients are facing in the current economy, and approach communications with sensitivity.

**Use every opportunity to communicate clearly and concisely, telling patients only what they need to know. Then follow that reasoning throughout the revenue cycle process.**

## What You Can Do

Here are a few tips on how to use the revenue cycle to develop a comprehensive, integrated patient communication program that drives revenue and patient satisfaction.

**Scheduling/preregistration.** Every patient's hospital experience starts with scheduling an appointment. Tell patients where they need to go, what they need to do, and what they need to bring. Tell them by phone, and mail them helpful information. Enable electronic registration that can be managed by patients whenever possible. Create the expectation of excellence before patients arrive at the hospital.

**Admitting.** Ideally, send patients educational information about their condition prior to their visit so they can begin the process of dealing with their illness or injury. If this is not possible, provide them with information about their situation when they arrive.

**Discharge.** Give patients instructions on how to properly care for themselves when they return home, including information to help them improve their health. This information helps to remind patients of the compassionate treatment they received while in your care and how they can sustain that feeling of caring after they leave by staying "connected" to you through continual communications. Then send them a survey to see if they were happy with their experience. Happy patients are loyal patients, and loyal patients ensure revenue streams.

**Billing.** Send patients a bill that describes in layman's terms the products and services they received. Include a brochure that explains medical billing, how it works, and how to read their bills.

**Internal collections.** Clearly communicate payment expectations, and offer help and guidance if patients are unable to meet

## Communications should be integrated with the revenue cycle in a way that reaches as many patients as possible cost-effectively.

these expectations for any reason. Use simple language, including non-English when necessary, and pictures, graphs, or diagrams whenever possible. Be sensitive to the financial challenges patients are facing in the tough economy.

**External collections.** Make sure patients understand the collection process so they know they will be responsible for their healthcare bill just as they are for a car repair or clothing purchase. Communicate in writing, by phone, and electronically. Carefully screen anyone speaking on your behalf so they understand your culture, mission, and goals, and specific guidelines for treating patients with respect at all times.

**Zero balance.** Communicate to patients as individuals with targeted messages that encourage them to use the other services of your organization that they might personally benefit from to improve their health. Encourage them to return to your organization for services they may not have received there before.

In the current economy, it is more important than ever to communicate clearly and sensitively with patients. Using existing data is a cost-effective way to target patient communications. And improving communications can result in improved payment processes and greater patient satisfaction. ☎

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Barbara McLaughlin is vice president/principal, SmartSource, Wellesley, Mass. (bmclaughlin@smartsourcecellc.com).

John C. Lowery, RN, BSN, MHA, FACHE, senior director, Johns Hopkins Medicine Access Services and Revenue Recovery Operations, Baltimore (jclowery@jhmi.edu).

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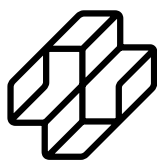
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## Figures at a Glance

### Hospital Discharges, Days of Care, and Average LOS in Nonfederal, Short-Stay Hospitals, 1990-2006

	1990	2000	2006
<b>Discharges per 10,000 population</b>			
Total	1,222.7	1,128.3	1,168.7
Northeast	1,332.2	1,274.8	1,261.4
Midwest	1,287.5	1,109.2	1,168.0
South	1,325.0	1,209.2	1,198.8
West	1,006.6	894.0	964.1
<b>Days of Care per 10,000 population</b>			
Total	7,840.5	5,546.5	5,577.8
Northeast	10,266.8	7,185.9	6,608.5
Midwest	8,306.5	5,005.3	4,893.5
South	8,204.1	5,925.1	5,844.8
West	5,755.1	4,082.0	4,451.6
<b>Average length of stay in days</b>			
Total	6.4	4.9	4.8
Northeast	7.7	5.6	5.2
Midwest	6.5	4.5	4.2
South	6.2	4.9	4.9
West	5.7	4.6	4.6

Source: CDC/NCHS, National Hospital Discharge Survey, In: National Center for Health Statistics, *Health, United States, 2008, with Chartbook*, Hyattsville, MD, 2009, Table 102.