AUDIT DEPARTMENT

Eligibility and Financial Services Audit

for the period July 1, 2009, through December 31, 2010

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Angela M. Darragh, CPA, CFE, CISA, Acting Director

June 20, 2011

Mr. Don Burnette
Clark County Manager
500 South Grand Central Parkway, 6th Floor
Las Vegas, Nevada 89106

Dear Mr. Burnette:

We have conducted an audit of the Eligibility and Financial Services (EFS) Department. The audit covered the period of July1, 2009 through December 31, 2010.

The objectives of the audit are to determine:

- The cost to qualify patients for financial assistance
- Whether some processes could be streamlined or improved
- Significant barriers in meeting EFS goals

We found that the EFS department's performance should be commended. The department meets their standard of seeing a patient within 24 hours of the patient entering the hospital. Additionally, the department has successfully instituted revenue collection efforts, while providing their overall service at a relatively low cost to the hospital. With respect to the department performance, EFS adequately manages their caseloads despite significant Family Medical Leave Act (FMLA) issues within the department.

Information Technology improvements are needed to streamline processes. In our opinion, barriers outside the control of EFS are causing additional cost to the hospital, delays or inability to collect revenue, and additional cost to the taxpayer. Despite successful efforts to approve accounts, EFS faces medical necessity and utilization review issues. (See the Case Management audit report.) Further, UMC's Medicaid postings have been reduced by $9.5 million since fiscal year 2008. Finally, delays in the state and federal processes raises concerns about cash flow and quality of care.

Sincerely,

/s/ Angela M. Darragh, CPA

Angela M. Darragh, CPA
Acting Audit Director

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BACKGROUND When patients present at University Medical Center (UMC) and are admitted without insurance, the Eligibility and Financial Services Department (EFS) will contact the patient and determine if the patient is eligible for financial assistance. The interview process consists of asking the patient various questions related to their financial and family situation. From the information EFS gathers through the interview process, EFS determines the programs for which the patient may be eligible. EFS then attempts to qualify individuals for aid in order of Federal, State and local assistance, respectively. If the patient cannot qualify for any of those programs due to being over income determination levels, EFS will discuss pay arrangements. Every EFS case is unique and requires different methods to work with the patient.

The EFS Department's mission is to:

- Identify a pay source for the uninsured
- Find assistance for the patient
- Identify the program the client is eligible for
- Educate people on healthcare
- "Do the right thing for the client"

The EFS Specialist's average case load is 156 cases. The cases are tracked by financial class. For example, a patient is admitted as a self pay with the financial class associated with self pay. Once the EFS worker sees the patient within 24 hours of admission, the financial class is changed to reflect that the patient was seen. When an application for financial assistance is initiated, there are financial classes that are associated to the type of application started. Once the application is completed and submitted for eligibility, the financial class is changed to a pending status until an approval or denial is received. Upon approval, the claim can be billed.

The EFS Department also participates in the discharge planning

for long term care (LTC) by seeking a pay source for the patient in order to transition the patient into a LTC facility. When patients are no longer acute but still require some level of care, a pay source must be ensured to discharge the patient from UMC to the nursing home. If not, the patient remains at the hospital until a pay source can be found or the patient becomes healthy enough to be safely discharged home.

OBJECTIVES, SCOPE, AND METHODOLOGY

The objectives of the audit are to determine:

- The cost to qualify patients for financial assistance
- Whether some processes can be streamlined or improved
- Significant barriers in meeting EFS goals

Our examination covered the period from July 1, 2009 through December 31, 2010. Our procedures included interviews of EFS management and staff at UMC, reviews of financial and other documentation, and analysis of data.

We conducted this performance audit in accordance with generally accepted governmental auditing standards. These standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

RESULTS IN BRIEF

We found that the EFS Department's performance should be commended. The department meets their standard of seeing a patient within 24 hours of the patient entering the hospital. Additionally, the department has successfully instituted revenue collection efforts while providing their overall service at a relatively low cost to the hospital. With respect to the

department's performance, EFS adequately manages stale dated claims despite significant Family Medical Leave Act (FMLA) issues within the department.

Information Technology improvements are needed to streamline processes. In our opinion, barriers outside the control of EFS are causing additional cost to the hospital, delays or inability to collect revenue, and additional cost to the taxpayer. The current economic situation and budget shortfalls, have resulted in less Medicaid money paid to the hospital. UMC's Medicaid postings have been reduced by $9.5 million since fiscal year 2008. Although payments have been reduced, claims to Medicaid have not decreased. EFS also encounters difficulty with uncooperative clients. During the audit period, 3,712 patients with accounts totaling in gross charges of over $112, 000,000 were classified as uncooperative. Despite successful efforts to approve accounts, EFS faces medical necessity and utilization review issues. (See the Case Management audit report.) Finally, delays in the state and federal processes raises concerns about cash flow and quality of care.

With the barriers the department faces, and the caseload staff carries, the Eligibility and Financial Services Department is very dedicated towards their mission of helping the patient obtain financial assistance for their hospital visit.

DETAILED RESULTS

EFS Program Performing Admirably

Despite facing various barriers, the EFS program is performing admirably. As part of their standards, EFS workers must see patients within 24 hours of the patient entering the hospital. When an uninsured patient arrives at UMC, the EFS workers assist by attempting to identify whether the patient qualifies for any of a variety of pay sources that are available at the local,

state and federal level. (See Appendix A for the listing of pay sources.) In order to establish eligibility for the patient, EFS obtains information from the patient and completes applications for the different sources in which the patient may be eligible. EFS tracks the application (and related approval) information for performance monitoring and reference purposes.

We found that EFS workers met their standard of seeing patients within the 24 hour requirement. We also observed that the Director and Managers track employees' performance and audit the employees' work. While stale dated claims still occur, we found that the department is closely tracking the stale dated claims. Additionally, as described later in the report, the majority of stale dated claims are related to funding sources that have been exhausted and no further funding would have occurred even if eligible, although the lack of funding is not the reason for the stale dated claim.

In FY 2010, EFS appealed 40 denied cases from the Division of Welfare and Supportive Services (DWSS) and were able to overturn and win 17 cases. The gross charges on the 17 cases came to $1,769,288, for which UMC will receive Medicaid reimbursement. Of the remaining cases, 10 are still awaiting a hearing, while 13 were upheld by DWSS. In 2008, EFS also developed a sliding fee program for patients unable to qualify for financial assistance. The program provides the patient with a reduced rate based on the Federal Poverty Guidelines. During the 18 month audit period, the program collected over $2.5 million. Finally, EFS started a courtesy discharge program. The program allows the patients to resolve their co-pays, deductibles, or other financial criteria prior to the day of discharge. The payment prior to discharge allows the patient to bypass the discharge process in Admitting. Audit examined one week of payments and over $10,000 was collected. The program eliminates the billing of the patient for their co-pay or deductible

after the third party payer is billed and paid.

Limited Cost to Administer Program

EFS cost to qualify patients and collect revenues related to those costs are relatively low. EFS' efforts in qualifying a patient for financial assistance costs UMC $.07 for every dollar that is billed and collected. The $.07 rate is based on the EFS fiscal year 2010 department expenses divided by the total Medicaid and CCSS postings that are in the financial class associated with EFS efforts. The rate does not include previously qualified patients returning to UMC, or the other programs initiated by EFS that bring in patient payments, such as the sliding fee schedule program or the courtesy discharge program as previously described. To put the $.07 rate in perspective, in 2005 through 2007 UMC had an outside company assisting in qualifying patients for financial assistance. Any Medicaid or CCSS payments received as a result of the outside company's effort resulted in a charge of $0.18 per dollar collected.

EFS Management believes their cost is closer to $.03 per dollar collected because they have projected pending estimated payments. While the $.03 might be a closer approximation, we did not audit estimated payments and consequently did not verify the $.03 rate.

Some Stale Date Accounts Still Occur

For the 17 month period from 7/1/09 through 11/30/10, there were 248 accounts with gross charges of $5,505,172 that became stale dated and can be attributable to the EFS Department. A stale date account is one that cannot be billed due to a missed deadline. These 248 stale dated accounts are divided between Medicaid and Clark County Social Services financial classes. Most of the 248 accounts were from dates of service outside the audit period. However, 68 accounts with gross charges of $1,225,163 had dates of service from January 1, 2009 forward. These accounts were adjusted off the accounts receivable with no reimbursement. All accounts with a third

party pay source should be billed timely and paid according to negotiated rates.

There were seven stale dated Medicaid accounts with dates of service of 1/1/09 forward, totaling $199,507 in gross charges. Based on the audited financial statements for FY 2010, the percentage of the cost of uncompensated care was 30.28%. Therefore, the cost of current Medicaid accounts that became stale dated had a financial effect of $60,411. UMC had no additional financial effect from the stale dated CCSS accounts due to the hospital qualifying more claims than there were available funds in past fiscal years.

EFS monitors stale dates regularly. As a result, they were able to identify a process change with State Medicaid HMO patients that resulted in stale dated claims. Once the problem was identified, they worked to revise their process to prevent the stale dates from recurring. Also, our testing found one Medicaid account was not paid when a billing deadline was missed.

In researching any further possible underlying causes for stale dated claims, we found that EFS had 29 intermittent and 18 consecutive FMLA approvals that occurred in 2010. These FMLA approvals represent 20 employees on intermittent leave and 10 employees on consecutive leave throughout the year. EFS has 55 employees, which means that over half of the employees were on some type of FMLA leave during 2010. EFS also had 22 rejected FMLA applications, leading us to believe that significant other sick leave is occurring.

Despite these statistics, the EFS Department has already taken action to resolve the issue with the Medicaid HMO's by issuing a new policy. EFS Managers counsel staff on stale dates to prevent the same issues from arising.

Recommendation We recommend EFS management continue with their proactive handling of stale dated claims.

Opportunities Exist to Streamline Processes

Currently EFS staff completes two applications for each patient. One is for DWSS and the other is for CCSS, in case DWSS denies eligibility. This is a manual process that requires the transfer of information from one application to the other. Also, there are a number of other documents required from the patient when submitting the application. The statutes for record retention require the hospital to keep this information for five years. EFS does not scan any documents but keeps physical copies of client information. Specialists' case load averages around 156 cases per Specialist, which the Director believes is manageable. Maintaining physical copies is manual work for the EFS staff that requires the physical submission of the application. Also, there is the possibility of DWSS or CCSS misplacing an application and UMC having to resubmit another application.

The process should allow EFS to electronically complete an application on-line. The scanning of documents eliminates the physical retention of patient files. To handle the large caseload, the Specialists must be organized and any streamlining of the process will help the Specialist.

To streamline the process, it would require DWSS and CCSS to have a system in place that would allow for electronic applications. DWSS and CCSS will have new systems that will perform on-line applications in the near future. Also, the scanning of documents would require Electronic Health Records (EHR) at UMC to utilize the functionality of an organized storage that could be easily retrieved.

Significant Barriers Prevent Maximizing Reimbursement

EFS encounters barriers in collecting the maximum reimbursement possible in its efforts to obtain financial assistance for the patients. These barriers are outside the department's ability to control. These barriers can range from the number of non-cooperative patients, to Medicaid denials due to medical necessity or utilization review, to technology issues to lack of funding to overly restrictive regulations.

Uncooperative Patients

Not every patient that enters the hospital is a willing supplier of personal or financial information. EFS staff exhaust valuable time with some patients through phone calls, mail and a field representative visiting a patient's home before EFS submits the account to bad debt. Despite extraordinary efforts, EFS could not qualify patients who were not willing to provide information to EFS.

While the EFS Department is following criteria and diligence in qualifying patients, failure to obtain cooperation from patients greatly hinders the performance of the office and places a financial burden on the hospital. We found 3,712 inpatient accounts having dates of service from 7/01/2009 through 11/30/2010 where the patients were uncooperative and the account sent to bad debt. The gross patient charges were over $112,000,000. The cost of these accounts was $34,014,165 not including the cost of the EFS department's man hours to attempt to qualify these patients.

Inability to Collect Due to Medical Necessity or Utilization Review Denial

EFS cannot collect on some patient accounts due to circumstances beyond the control of EFS. For example, EFS qualified 177 accounts in fiscal year 2010 totaling $4,973,406 in gross charges which were denied as a result of Utilization Review. The cost of the charges denied was $1,505,947. "Utilization Review is the analysis of the necessity, appropriateness, and efficiency of medical services, procedures, facilities, and practitioners. In a hospital, this includes review of

the appropriateness of admissions, services ordered and provided, and length of stay and discharge practices, on concurrent and retrospective bases."[1] All of the 177 accounts were Medicaid denials.

Additionally, in fiscal year 2010, EFS qualified 65 Medicaid accounts that had $1,270,350 in gross charges denied due to lack of Medical Necessity. The cost of the adjustments was $384,662. Once again, these were accounts that staff received eligibility for a pay source. It is important to note that the whole account is not always denied and that some payment was received on some accounts.

Reduced Medicaid Payments Not Attributable to EFS

Medicaid payments received by UMC in FY 2009 were $9,468,794 less than in FY 2008 due to the State's budget issues. This represented an 18.4% reduction from the previous year. While UMC is collecting less, the decrease is not attributable to inefficiency in EFS.

UMC submits a claim to Medicaid and is paid the rates set by Nevada Medicaid. On September 8, 2008, the State reduced its per diem rate due to budget shortfalls. While Medicaid payments have decreased from previous years, UMC is still caring for a large percentage of Medicaid or Pending Medicaid patients. This results in rising costs to care for a patient while receiving less revenue per patient.

[1] TheFreeDictionary by Farlex

Unnecessary Delays Due to NOMADS and EVS

The hospital incurs unnecessary costs from delays in processing claims and payments due to delays in information being transmitted between Medicaid information systems.

For eligibility determination, DWSS utilizes a system called Nevada Operations of Multi Automated Data System (NOMADS). Once a patient becomes eligible for DWSS benefits, DWSS will post a date of decision (DOD) for approval on its' NOMADS system. Once the patient's eligibility is determined, the information is also transferred to the Electronic Verification System (EVS). Only when the DOD is posted on EVS, can UMC bill DWSS' third party administrator. The EFS Department monitors EVS for an approval decision date. However, EFS began to discover long delays for eligibility approvals from the DOD on NOMADS to the DOD on EVS. One example we saw was a delay of 165 days from the time NOMADS showed approval until the decision date was posted on EVS. UMC cannot bill until EVS shows the patient eligible. From April 2010 to December 2010, there were 328 cases that were approved on NOMADS but delayed postings on EVS. The delays between NOMADS and EVS began to occur when DWSS changed their programming in March 2010.

UMC needs to bill the Pending Medicaid account as soon as the patient becomes eligible. Although the hospital eventually gets paid, there is a delay in the cash flow. Also, if the hospital is waiting for Medicaid approval on EVS and waiting to discharge a patient to a non-acute facility, additional costs are absorbed by UMC as well as potential patient health risks while waiting for approval.

Federal Delays and Presumptive Eligibility

EFS staff attempting to assist clients for Medical Assistance for Aged, Blind or Disabled (MAABD) eligibility must first qualify the patient for Supplemental Security Income (SSI) for their hospital stay. SSI can be a complex and lengthy process while the

patients remain in an acute care setting. SSI is a federal program handled by Social Security Administration (SSA). SSA has 120 days to make a decision on patient disability. SSA denies over 70% of initial SSI claims. If the claim is denied, the client has 60 days to apply for reconsideration. SSI then has 180 days to reconsider their initial decision. This process can take a year before approval is given for SSI. According to the 2009 Annual SSI Report,[2] from 2000 through 2008, nationwide there were 12,651,024 adult claims filed. However, 9,032,800 claims were initially denied or a 71.4% denial rate.

UMC is delayed payment until these cases are approved for SSI. EFS staff still must monitor accounts so they can bill the State for MAABD when the client is approved SSI. When UMC receives proper payment, it is essentially using last year's money to pay today's bills.

In addition to the process presenting a terrible cash flow scenario, UMC has patients who are waiting to be discharged into a lower level of care. However, until a pay source is secured, the patient remains at the hospital. At this point the patient is considered non-acute, and non-acute days are paid at a lesser administrative rate. For patients who are SSI eligible, Medicaid becomes their medical pay source at time of approval.

Currently, Medicaid pays $237 for "Administrative Days" for a non-acute patient at the hospital, while an average of $175 is paid to a non-acute facility. For example, UMC Management prepared a chart of six patients who were waiting to be discharged to a lower level of care. The six patients had a total of 727 non-acute days at UMC while waiting for Medicaid approval. Had those patients been transitioned as soon as they were classified as non-acute patients, taxpayers would have

[2] Annual Report of the Supplemental Security Income Program - Social Security Administration May 2009

saved $45,074 on these six patients. That represents the difference of Medicaid paying UMC $237 versus $175 to a non-acute facility.

To address the cost, cash flow and patient placement issue, the Nevada Legislature passed SB24 at the 2009 Legislature for "Presumptive Eligibility." However, the following qualifying condition was in the bills language; "within the limits of available money." While presumptive eligibility was approved, the funding was not. If "presumptive eligibility" was funded, while waiting for an SSI decision, the patient could be discharged to a more appropriate lower level of care. This means Medicaid would pay prior to SSI approval.

Presumptive eligibility is not just a financial issue but also a humanitarian and a quality of care issue. Non-acute patients in the hospital can be at risk for infection and debilitation that would increase medical needs and costs. Also, while waiting to discharge these patients, a bed is occupied that could be used for an acute patient.

MANAGEMENT RESPONSE LETTER

Management generally agreed with our findings, conclusions, and recommendations and provided technical comments which we incorporated as appropriate.

The manager responsible for the area we audited provided the attached response to our audit report.

APPENDIX A

Payment Sources

Appendix A
Payment Sources

UMC Eligibility Financial Services Department mission is to obtain a payment source for all self pay admissions utilizing the following funding sources and options:

Identification of insurance coverage or COBRA benefits

Identification of Third party liability

SSI/SSD

Medicaid (MAABD – Medical Assistance for the Aged, Blind or Disabled)

Medicaid – Maternal and child coverage (CHAP's/FMC)

Nevada Check up – For children over income for Medicaid (does not provide retroactive Coverage)

VOVC – Victims of Violent Crime

VA Aid and Attendance (Long term care services)

Clark County Social Services – Indigent funds with Supplemental state funds (Supplemental State funds swept by legislature 2010/2011)

Indigent Accident Fund – County/State funding for patients injured on Nevada public roadways (majority of funding swept by State Legislature for 2010/2011)

Section 1011 funds – Federal support for undocumented emergency stabilizing services (Nevada has exhausted this funding)

Sliding fee payment plan that is means based using FPL guidelines

Payment arrangements with a Clark County Resident rate reduction for County residents

Collections for non-cooperation with above services

APPENDIX B

Management Response

1800 W. Charleston Blvd.
Las Vegas, NV 89102
(702) 383-2000

UMC
UNIVERSITY MEDICAL CENTER

Kathleen Silver
Chief Executive Officer

To: Angela Darragh, Acting Director, Audit

From: Virginia Carr, Director EFS

Date: June 9, 2011

RE: Eligibility and Financial Service Audit

Thank you for the opportunity to review and provide response to the recent Internal Audit completed by your department reviewing the Eligibility Financial Services Department. I appreciate the opportunity to work with your staff on this project. While there were no identified recommendations we recognize the need to be diligent in identifying opportunities to improve processes and reimbursement. Currently a majority of the processes and tracking mechanisms continue to be manual. Technology implementations by UMC and its assistance partners will have a positive impact.

Eligibility Financial Services reviews and determines the root cause for stale dates, revising processes or addressing performance as appropriate. Eligibility Financial Services continues to look at innovative ways to manage FMLA impacts. EFS is actively participating in a LEAN project to review and flow all processes for the Revenue Cycle to identify both current opportunities and flow changes that will occur as part of an implementation of an Electronic Health Record.

Eligibility Financial Services is currently an active participant in the ACES implementation with Clark County Social Services. This is the case management system that will allow applications to be submitted electronically. Eligibility Financial Services has offered to be a pilot facility to Nevada's Division of Welfare and Supportive Services as they move to an electronic application in the future. Eligibility Financial Services is actively participating in the preparation for UMC to move to an Electronic Health Record.

The work accomplished by Eligibility Financial Services also has a positive impact to the amount of Federal funds provided to UMC, Clark County and the State of Nevada based upon Medicaid clients and patient days. When a client of Eligibility Financial Services becomes eligible, the community, the patient and the medical providers benefit as the client has ongoing services that are funded. Partnering with other assistance agencies occurs, but a commitment to the contribution and value of UMC's Eligibility Financial Services department continues to be underutilized. Collaboration with all agencies at the most efficient level requires political and legislative changes to develop shared systems and processes.

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