AUDIT REPORT

UNIVERSITY OF MISSOURI HEALTH SYSTEM
BILLING PRACTICES AND OTHER FINANCIAL MATTERS

From The Office Of State Auditor
Claire McCaskill

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Office Of The
State Auditor Of Missouri
Claire McCaskill

September 2002

YELLOW SHEET

The following problems were discovered as a result of an audit conducted by our office of the University of Missouri Health System - Billing Practices and Other Financial Matters.

From July 1999 through January 2002, the University Hospital and Clinics lost almost $10 million in revenues due to insurance denials and other write-offs that could have been prevented. The University Physicians (UP) also lost over $2 million for similar reasons.

Insurance companies and other third-party payers will sometimes deny payment of hospital billings for various reasons, some of which could be prevented. From July 1, 1999 to December 31, 2001, the University Hospital and Clinics' billing entity, Hospital Patients Accounts (HPA), wrote off over $8.7 million in charges which were either denied due to untimely filing or were not billed because the filing deadline had passed. During that same period, the HPA wrote off $8.4 million in charges due to the services not being preauthorized. Based on the average collection rate for HPA (46%), we estimate revenues totaling $4 million and $3.8 million, respectively, were lost as a result of this situation.

While such denials have decreased since fiscal year 2000, problems persist. For the month of January 2002, denials due to untimely filing and lack of preauthorization resulted in an additional $840,000 in lost revenues.

In addition, from July 1, 1999 to December 31, 2001, approximately $2.3 million in outpatient charges were written off due to them not being entered into the billing system prior to the final billing being sent. Based on the HPA's average collection rate, we estimate over $1 million was lost as a result of this situation. The amount of such write offs has increased significantly since July 1, 2000, in large part due to the HPA's efforts to file more timely billings with insurance companies and other third-party payers.

The value of Columbia Regional Hospital (CRH) to the university and the Health System has not been maximized because Health System officials have been unable to implement some needed policy and management changes.

In 1999, the University of Missouri System began considering the purchase of CRH. A consultant was hired to perform a financial analysis of that entity, provide information regarding CRH's value, and recommend a proposed bid price. The consultant recommended the university submit a bid for CRH in the range of $30-35 million; however, the consultant advised "if the University does not believe it can operate CRH with proper management and policy oversight, then the University **should not submit a bid at any price** (emphasis added) …"

(over)

The university subsequently acquired CRH in September 1999, and since its acquisition, CRH has consistently posted operating losses. It appears CRH has not operated more profitably because the Health System has been unable to implement, or fully implement, some of the key management and policy changes the consultant recommended. The consultant had estimated the implementation of these changes would provide a significant amount of additional revenues annually.

The HPA accounts receivable records had over $6.3 million in credit balances at December 31, 2001, involving over 15,000 patient accounts, and insufficient effort has been made to resolve many of the older credit balances. Credit balances generally represent patient accounts where payments received on behalf of those accounts exceed the actual charges. Credit balances accumulate when there is failure to resolve or refund such overpayments on a timely basis. Between December 2000 and December 2001, total HPA credit balances ranged between $5 and $6.7 million.

The HPA has taken steps to reduce its level of accounts receivable; however, its overall accounts receivable balances still exceed industry standards. At December 31, 2001, actual accounts receivable totaled over $99 million compared to an accounts receivable amount of $76 million based on industry standards. In addition, other problems were noted regarding the documentation, follow-up, and write-off of outstanding accounts.

The Health System frequently provides medical services to patients who have limited income, do not have health insurance, and cannot afford to pay the costs of care. Patients who meet certain criteria can receive those medical services at no charge or at reduced rates. Such care is referred to as charity care.

The HPA has not handled all charity care cases in a consistent manner and has not fully documented any changes in its related policies/procedures. We also noted some inconsistencies in the way the HPA and UP handled the same patients, resulting in patients receiving different levels of financial assistance from each billing entity.

In recent years, the University of Missouri System has hired an outside auditing firm to perform internal audits of various university functions. Since July 2000, that firm has conducted three internal audits related to the Health System and its billing efforts. Some recommendations made by those auditors have not yet been implemented and a formal tracking system providing current information regarding the status of audit recommendations has not been established.

Community practice clinics funded and operated by the Health System have incurred operating losses totaling $2.3 million during the years ended June 30, 2001 and 2000. Health System officials have not conducted a cost-benefit analysis to determine if the benefits of these clinics offset their losses. Similar clinics funded by the School of Medicine and operated by the UP have also incurred significant losses.

UNIVERSITY OF MISSOURI HEALTH SYSTEM
BILLING PRACTICES AND OTHER FINANCIAL MATTERS

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and
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We have audited the billing practices and other financial matters of the University of Missouri Health System (the Health System). The scope of this audit included, but was not necessarily limited to, the period from July 1, 1999 to December 31, 2001. The objectives of this audit were to:

1. Review billing practices and related procedures of the Health System. This review concentrated on the billing records and activity of the University Hospital and Clinics (University Hospital, Children's Hospital, and Ellis Fischel Cancer Center) and the University Physicians Medical Practice Plan. The University Hospital and Clinics is served by the Hospital Patient Accounts (HPA) billing system and the University Physicians Medical Practice Plan is served by the University Physicians (UP) billing system. The audit did not include a review of the billing activity of the Missouri Rehabilitation Center (in Mount Vernon) or Columbia Regional Hospital.

2. Perform a limited review of financial trends and operating results of the Health System in recent years and review selected financial matters that affected those results.

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Our audit was conducted in accordance with applicable standards contained in *Government Auditing Standards*, issued by the Comptroller General of the United States, and included such procedures as we considered necessary in the circumstances. In this regard, we reviewed written policies, financial records, and other pertinent documents and interviewed various personnel of the Health System.

Our audit was limited to the specific matters described above and was based on selective tests and procedures considered appropriate in the circumstances. Had we performed additional procedures, other information might have come to our attention that would have been included in this report.

The accompanying History, Organization, and Statistical Information is presented for informational purposes. This information was obtained from the Health System's management and was not subject to the procedures applied in the audit of the Health System.

The accompanying Management Advisory Report presents our findings arising from our audit of the billing practices and other financial matters of the University of Missouri Health System.

Claire McCaskill
State Auditor

May 2, 2002 (fieldwork completion date)

The following auditors participated in the preparation of this report:

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MANAGEMENT ADVISORY REPORT -
STATE AUDITOR'S FINDINGS

1. Lost Revenues

From July 1999 through January 2002, the University Hospital and Clinics lost almost $10 million in revenues due to insurance denials and other write-offs that could have been prevented. The University Physicians (UP) also lost over $2 million in revenues for similar reasons.

A. Insurance companies and other third-party payers will sometimes deny payment of hospital billings for various reasons. During our audit of the billing practices of the University Hospital and Clinics, we noted a significant amount of such payment denials that could have been prevented. This resulted in a significant amount of lost revenues to the Health System, as discussed below:

1) Insurance companies and other third-party payers will deny claims for untimely filing when a medical provider does not submit the patient billing within the time frames specified in the insurance/third-party payer contracts. These time frames vary, but in the case of insurance companies most are 60 to 90 days.

From July 1, 1999 to December 31, 2001, the University Hospital and Clinics' billing entity, Hospital Patients Accounts (HPA), wrote off over $8.7 million in charges which were either denied due to untimely filing or were not billed because the filing deadline had passed. Based on the average collection rate for HPA (46 percent), we estimate the Health System lost approximately $4 million in revenues as a result of this situation. A health provider's average collection rate is affected by various factors, including contractual adjustments, uncollectable accounts, and denied claims.

It appears these billings were denied for various reasons, including: untimely initial filing of the claim, untimely follow-up of claims that had not yet been paid, and the untimely correction and resubmission of claims that were initially denied for other reasons.

Prior to July 2000, the departments and clinics had up to 100 days to enter the charges into the billing system. The HPA has gradually reduced this period of time and the departments and clinics currently have 20 days to enter charges. These changes have been partially successful in reducing the extent of billings being rejected due to untimely filing.

2) Insurance companies and other third-party payers will frequently deny claims if the medical services are not preauthorized. This occurs when the medical provider does not call the insurance company or other payer to obtain approval for a medical procedure prior to the date of service. We were informed that while emergency room services are sometimes initially denied due to a lack of preauthorization, such claims are generally paid upon appeal.

From July 1, 1999 to December 31, 2001, the HPA wrote off approximately $8.4 million in charges due to claims being denied due to medical services not being preauthorized. Based on HPA's average collection rate, we estimate the Health System lost approximately $3.8 million in revenues as a result of this situation.

Based on a review of some billings which were denied due to the lack of preauthorization, it appears the HPA had sufficient time to contact the insurance company or other payer, but failed to do so. Health System officials have indicated that several new admissions employees have recently been hired in an effort to address this problem. These individuals will be responsible for contacting the insurance companies and other third-party payers to get preauthorization before a medical procedure is performed.

Denials due to timely filing and lack of preauthorization have declined since fiscal year 2000; however, problems continue to persist. We noted that for the month of January 2002, denials due to untimely filing and lack of preauthorization totaled over $430,000 and $1.4 million, respectively, resulting in an additional $840,000 in lost revenues.

It should be noted the UP also had a significant amount of billings denied due to untimely filing and lack of preauthorization. From July 1, 1999 to December 31, 2001, approximately $4.8 million and $450,000 in UP billings were denied for these reasons. Based on the average collection rate for UP (42 percent), we estimate the UP lost $2 million and $189,000, respectively, in revenues as a result of this situation. While UP revenues do not directly benefit the Health System, a portion of UP revenues are used to help support the University of Missouri (MU) Medical School.

B. In many cases, a billing will be sent out before all of the charges relating to the services have been entered into the billing system. Any charges entered into the system after the bill has been sent are referred to as late charges. It is the HPA's policy to re-bill the claim if the additional charges are over $500 and would result in additional revenues. This applies primarily to outpatient charges, rather than

inpatient charges which are limited to a daily per diem rate. However, if the additional charges are less than $500, the charges are automatically written-off. It is believed the time and expenses involved in re-billing additional charges under $500 would not be justified.

These unbilled charges result in additional lost revenues to the Health System. From July 1, 1999 to December 31, 2001, approximately $2.3 million in outpatient late charges were written off due to them not being entered into the billing system prior to the final billing being sent. Based on HPA's average collection rate, we estimate the Health System lost over $1 million in revenues as a result of this situation.

The amount of late charge write offs has increased significantly since July 1, 2000. As noted previously, prior to that date, the various departments and clinics were allowed 100 days to enter charges into the billing system. In an effort to address the untimely filing problems as discussed in Part A above, that time frame has been reduced several times. Since July 2001, the departments and clinics have had twenty days to enter charges into the system. However, if charges have been entered prior to the twenty-day cutoff, the system will generate a bill, send it through edit checks, and send the billing out as early as five days after the date of service. While the HPA has established this procedure to ensure the timely filing of billings, it has also resulted in many charges entered prior to the twenty-day deadline from being billed because the initial billing has already been sent.

For example, we noted one instance in which $159 in charges were assessed to an account seven days after the service date; however, because the bill had already been sent, the charges were written off. In another instance, $388 in charges were assessed to an account nine days after the service date; however, they were subsequently written off because the billing had already been sent.

While Health System officials should ensure billings are sent out timely, they should also make every effort to ensure all billable charges are billed to the extent practical. The Health System should consider either further reducing the amount of time departments and clinics have to enter charges into the system, increasing the amount of time prior to when the billing can potentially being sent (without sacrificing timeliness), or lowering the $500 threshold for writing off late charges.

WE RECOMMEND the Health System management:

A. Keep preventable billing denials to a minimum by ensuring billings are sent to insurance companies and other third-party payers in a timely manner and ensuring medical procedures are properly preauthorized, as required.

B. Take action to reduce the extent of charges being entered into the billing system after the billings are sent.

AUDITEE'S RESPONSE

A. We concur with the recommendation.

We have negotiated much more aggressively for better rates and terms to allow greater time frames for processing claims.

We have developed a denial management function that has provided the information required to identify the problem reported by the State Auditor. We have moved the denial management function to contracting, making that function a more formal unit independent of billing, and providing additional resources in that area to further define and develop our denial tracking systems and to assist us in our appeals process. It will provide information to our registration, billing, and contracting groups, to continue making changes to reduce denials for both the hospital and physician contracts.

We have established a functional pre-registration/pre-certification process to avoid unauthorized non-emergent services. We have established the policies and procedures and begun to apply them in our larger patient care areas. Within the next six months, we should have the process fully implemented and consistently applied across all areas. In certain cases this will require us to deny non-emergent services when satisfactory payment arrangements have not been made for patients who do not qualify for financial assistance.

We have installed and are improving software that electronically verifies eligibility and special editing software to identify and correct potential problems with claims before they are submitted.

Another component of the delay problem is timely and complete documentation accurately coded to reflect services rendered. We have major efforts under way in this area that will result in fewer denials and proper and timely reimbursement. We have recently installed a new document imaging system, which will reduce handling and retention costs while allowing us to more effectively store and retrieve documentation, reducing delays. In August 2002, we implemented a new dictation and transcription service that is centralized and integrated into our developing electronic medical record. Once dictated and transcribed, notes become available immediately to all areas of the enterprise that need them, removing bottlenecks that formerly caused significant delays.

We have initiated a review to assess the adequacy of our coding resources that are necessary to produce bills. Once that review is complete, we will make the changes necessary to provide adequate coding in coordination with all the other improvements to our revenue cycle.

B. We concur with the recommendation. We have reduced the threshold for automatic write-offs of late charges from $500 to $100 as of May 2002. In July 2002, we developed a monitoring report that will be provided to all revenue-producing departments, informing them of all transactions processed as late charges. The report will be used to

establish standard acceptable levels of late charges and all departments will be required to meet those standards. The report will also be used to monitor compliance with the standards established.

2. Acquisition of Columbia Regional Hospital

The value of Columbia Regional Hospital to the university and the Health System has not been maximized because Health System officials have been unable to implement some needed policy and management changes.

In the spring of 1999, the University of Missouri System began considering the purchase of Columbia Regional Hospital (CRH) from a private health care corporation. Prior to submitting a bid for the purchase of this hospital, a financial consulting firm was hired to perform a financial analysis of CRH's future operating results under various scenarios. In addition, the consultant was to provide the university with information regarding the estimated value of CRH and recommendations regarding a proposed bid price.

In June 1999, the consultant recommended the university submit a bid in the range of $30-35 million, with an optimum bid of $31 million. However, the consultant advised "if the University does not believe it can operate CRH with proper management and policy oversight, then the University **should not submit a bid at any price** (emphasis added). Strong management, vision of the role of CRH in the University health care delivery system, and commitment to make necessary changes will be what ultimately determines the value of CRH." In its study of the CRH, the consultant identified certain management and policy changes which should be made if the university were to acquire CRH.

The university subsequently acquired CRH on September 30, 1999, for a base purchase price of $34.5 million. Although this price was within the bid range recommended by the consultant, it appears the university was willing to pay an amount in excess of the optimum bid amount because of various factors, including the elimination of a competitor from the service area and to prevent another area competitor from gaining a dominant market share.

According to profit and loss statements provided by the Health System, since its acquisition CRH has consistently posted a net operating loss as follows:

	Six Months Ended 12/31/2001	Year Ended 06/30/2001	Nine Months Ended 06/30/2000	Total
Net Loss	$ (2,231,182)	$ (2,333,945)	$ (6,538,258)	$ (11,103,385)

It appears much of the reason CRH has not operated more profitably is because the Health System has been unable to implement, or fully implement, some of the key management and policy changes which the consultant recommended.

One of the changes recommended by the consultant was that a single set of medical staff by-laws should be adopted for the University Hospital and Clinics (UHC) and CRH. The consultant indicated that doing so would allow these facilities to provide Medicare services under a single provider number and result in an increase in net revenues of $3 million annually. Health System officials currently believe a more accurate estimate is closer to $2.3 million annually, based on more recent data.

To affect this change, various federal requirements must be met, including the unification of the medical staff. It appears unification of the medical staff has been proven to be very difficult, partly because of the fundamentally diverse nature of the community-based, private practice medical staff of CRH compared to the academic medical staff of the other facilities. However, in the fall of 2000, representatives of the Health System submitted an informal, preliminary proposal to the Health Care Financing Administration (HCFA) for consolidating the hospitals under one Medicare provider number. At a subsequent meeting between HCFA officials and Health System representatives, the HCFA officials indicated the proposal as submitted was not sufficient to obtain single provider number status.

No real progress has been made in securing the single provider status since that time. Health System officials have indicated they are currently studying their options with legal counsel.

Another proposed change recommended by the consultant was to change the university employee Point of Service (POS) health plan to encourage university employees to utilize university-owned hospitals. The consultant estimated this would increase net revenues by $1.3 million annually. However, this change has not been fully implemented.

According to university officials, the CRH is now a network provider for the employee POS health plan; however, the Health System's primary area competitor is also a network provider in that plan. As a result, university employees are not being encouraged to utilize university-owned hospitals to the extent envisioned by the consultant.

The consultant also indicated management should take steps to increase the average daily census from 93 to 100 inpatients per day. However, during the year ended June 30, 2001, the average daily census was only 84 inpatients. In addition, for the nine months ended March 31, 2002, the average daily census has dropped even further to 67 inpatients per day. This most recent drop is due in large part to the closing of a 34-bed skilled nursing unit at CRH in July 2001. It appears CRH will continue to experience operating losses unless the Health System can increase the average daily census to the level recommended by the consultant.

University officials have indicated the net operating results presented above do not accurately reflect the overall financial impact of CRH on the Health System. They indicated those results include expenses allocated to the CRH that would have been incurred by the Health System even if CRH had not been acquired. Those expenses include interest expense on bonds issued prior to the purchase of CRH and university overhead costs as follows:

Expense	6 Months Ended 12/31/2001	Year Ended 06/30/2001	9 Months Ended 06/30/2000	Total
Interest	$ 1,470,826	$ 2,958,095	$ 2,242,866	$ 6,671,787
Overhead	1,555,082	1,711,834	935,674	4,202,590
Total	$ 3,025,908	$ 4,669,929	$ 3,178,540	$ 10,874,377

University officials contend that if these allocated expenses are not considered, the CRH has had a positive overall financial impact on the university and the Health System since July 1, 2000. Even if that is the case, it is apparent the value of CRH to the university and Health System has not been maximized.

WE RECOMMEND Health System management continue efforts to implement the policy and management changes recommended by the consultant to maximize the value of CRH and make it a more profitable part of the Health System.

AUDITEE'S RESPONSE

We concur. Although our initial efforts to obtain single provider status from the Center for Medicare/Medicaid Services (formerly HCFA) were unsuccessful, it is pivotal to our financial plan and we are stepping up our efforts to obtain this status as soon as possible.

We have been moving services from the overcrowded University Hospital to CRH to increase utilization of that space and provide additional space at University Hospital. We have partnered with community groups to increase services. We will be moving obstetrical services as part of this plan. We will continue these efforts to make CRH a more profitable part of the health system.

3. Credit Balances

The Health System's HPA accounts receivable records had over $6.3 million in credit balances at December 31, 2001, and insufficient effort has been made to resolve many of the older credit balances. In addition, the UP records similarly had an excessive amount of credit balances.

Credit balances generally represent patient accounts where payments received on behalf of those accounts exceed the actual charges. Such credit balances may occur if the

related charges have been paid by both the patient, a private health insurer, or another third-party payer (i.e. Medicare or Medicaid). Credit balances accumulate when there is a failure to resolve or refund such overpayments on a timely basis.

During a review of credit balances, we noted the following concerns:

A. Between December 2000 and December 2001, total HPA credit balances ranged between $5 and $6.7 million. At December 31, 2001, credit balances totaled over $6.3 million and involved over 15,000 patient accounts.

   The HPA has a goal of reducing credit balances to no more than the equivalent of 2 days' revenue. This would equate to approximately $2.5 million as of December 2001. Industry standards indicate that total credit balances should be even lower than this. According to one industry standard we noted, the HPA should have no more than the equivalent of 1.12 days' revenue in credit balances. This would equate to approximately $1.3 million as of December 2001.

   The UP accounts receivable records also had an excessive amount of credit balances, although not to the extent of the HPA. At December 31, 2001, UP credit balances totaled approximately $3.7 million, which exceeded the industry standard by approximately $2.6 million.

B. The HPA does not ensure old credit balances are resolved in a timely manner. We were initially told that work to resolve credit balances is done on a rotating basis, whereas one week employees might work on the largest credit balances and the next week they would work on the oldest balances.

   However, upon further investigation, we determined this rotating schedule is not used. During our audit period, it appears HPA employees only worked on resolving accounts with the largest credit balances. Many smaller, but older credit balances remain on the accounts receivable records. We noted 4,404 accounts, involving over $1.4 million in credit balances and dating back to fiscal year 2000 or before, remain unresolved. While many of these accounts are relatively small, 249 of these credit balances exceeded $1,000, with one of these credit balances exceeding $17,000.

A greater effort should be made to reduce the overall amount of credit balances to a more acceptable level, while also ensuring old credit balances are resolved on a timely basis. By failing to resolve credit balances in a timely manner, amounts due to patients, private health insurers, and other third-party payers have not been refunded on a timely basis. In addition, maintaining these old accounts adds to the administrative burden of the system.

WE RECOMMEND Health System management:

A. Ensure the amount of total credit balances of the HPA as well as the UP are reduced to an acceptable level and more in line with industry standards.

B. Ensure efforts are made to resolve older credit balances on a timely basis.

AUDITEE'S RESPONSE

We concur with the recommendations. We have developed better reports to distinguish between true overpayments, other types of adjustments, and accounts that have been corrected where we are waiting for the insurance carriers to take back the money. During the next month we will establish written standards of acceptable levels and reallocate existing staff to accomplish achieving those standards by the end of the fiscal year.

4. HPA Accounts Receivable and Related Issues

The HPA has taken steps to reduce its level of accounts receivable; however, its overall accounts receivable balances still exceed industry standards. HPA staff do not always add adequate notes to the billing system to document changes made or actions taken to patient accounts, and adequate efforts have not been made to follow-up on all outstanding accounts. In addition, the HPA has not established formal policies and procedures regarding the writing off of old outstanding accounts.

A. From July 1999 to December 2001, total HPA accounts receivable balances have been excessive and above industry standards. Total month end HPA accounts receivable balances totaled $111 million in July 1999 and $99 million in December 2001, with total accounts receivable peaking at $171 million in January 2000.

Between July 1999 and January 2000, there was a steady rise in total HPA accounts receivable. We determined this increase was partially due to the explanation of benefit statements (EOBs), which support insurance and other third-party benefit payments, being allowed to accumulate without the payments being entered into the accounts receivable system. During this time, the HPA manager was terminated and a consultant was hired to oversee the conversion to a new billing system. During this transition period, the procedures for entering information from EOBs into the new accounts receivable system were not adequately followed. As a result, while many patient billings were being paid and the monies deposited, the accounts receivable records for the applicable accounts showed these accounts as unpaid and outstanding.

Since January 2000, the total HPA accounts receivable balances have declined. This is partly attributable to the HPA getting caught up on entering payment data from the backlog of EOBs which had not been recorded in the accounts receivable system. Accounts receivable balances have also been reduced by HPA writing off old outstanding accounts. For example, we noted in May 2000, approximately $16 million in old accounts receivable accounts were written off as bad debts. In addition, we determined the average number of days a claim is maintained in a hold or unbilled accounts receivable status has dropped in the past year. As a

result, it appears bills are being sent out quicker and the payments on accounts receivable are being received sooner.

While the HPA has reduced its total accounts receivable balance significantly in the past two years, its accounts receivable levels continue to exceed industry standards. According to an HPA official, the industry standard for hospitals in this region is an accounts receivable level equal to 69 days times the average daily revenue. The following table presents the actual HPA accounts receivable, average daily revenue, actual days of revenue in accounts receivable, and acceptable account receivable balances (per industry standards) at selected dates:

Date	Actual Accounts Receivable	Average Daily Revenue	Actual Days of Revenue	Accounts Receivable Per Industry Standards
December 31, 1999	$161,346,243	$1,075,642	150	$74,262,297
June 30, 2000	133,593,592	1,086,127	123	74,986,192
December 31, 2000	126,412,048	1,089,759	116	75,236,964
June 30, 2001	101,451,076	1,045,887	97	72,208,065
December 31, 2001	99,879,740	1,109,775	90	76,618,858

As noted above, as of December 31, 2001, the amount of accounts receivable has dropped consistently since December 31, 1999, and was at a level that is approaching industry standards; however, further improvement could be made. The HPA should continue efforts to further reduce total accounts receivable balances to a level consistent with industry standards.

B. HPA staff does not always document relevant information related to specific accounts in the billing system. In several instances, adequate notes were not prepared to document changes made or action taken related to an account. In one instance, a duplicate refund check was issued to a patient because the initial refund was not properly documented in the billing system. Even though the duplicate refund was eventually recovered, the problem could have been prevented with better record keeping.

If HPA staff do not adequately document notes within the billing system, it is difficult for adequate follow-up efforts to be performed on an account. By adequately documenting changes made or actions taken, any subsequent follow-up actions are more efficient and effective.

C. For one account reviewed, adequate efforts had not been made to follow-up and bill the unpaid balance to a third-party payer. It was determined the applicable patient's account was a 970 Financial Status Code (FSC), which indicated the patient had a cancer insurance policy. While the insurance company paid a per

diem related to the charges, the remaining balance ($1,065) could have been billed to Medicaid; however, no follow-up action had been taken related to this account at the time of our review.

We determined the HPA section responsible for following up on unpaid accounts was unaware of this FSC and therefore, had not included accounts with this code in its follow-up efforts. As of April 2002, there were 159 outstanding accounts, totaling over $150,000, with this FSC. Most of these accounts were over 180 days old and it appears no follow-up efforts have been made to pursue these accounts.

The HPA should ensure all outstanding patient accounts are followed-up on a timely basis to maximize collections. This would include ensuring responsibility is assigned for the follow-up of every established FSC.

D. The HPA has not established formal policies or procedures for writing off old outstanding accounts. In addition, a threshold amount has not been established over which management approval is required to write off an account. According to an HPA official, the clerks who write off accounts normally discuss the accounts with him prior to doing so.

Formal policies and procedures should be established for writing off old accounts to provide staff adequate guidance in this area. Such policies and procedures should establish a threshold amount over which management approval is required.

WE RECOMMEND the Health System management:

A. Continue efforts to further reduce total HPA accounts receivable balances to a level consistent with industry standards.

B. Ensure HPA staff adequately document changes made or actions taken related to patient accounts in the billing system to assist in follow-up efforts.

C. Ensure HPA staff perform timely follow-up activities on all outstanding accounts. This would include ensuring responsibility is assigned for the follow-up of every established FSC.

D. Establish formal policies and procedures for the writing off of old accounts. This should include the establishment of a threshold amount over which management approval is required.

AUDITEE'S RESPONSE

A. We concur with the recommendation. The changes we have instituted to manage and reduce denials will also reduce our accounts receivable balances.

B&C. We concur with the recommendations. We have established internal testing and quality assurance programs that will ensure staff adequately document changes and perform timely follow-up activities.

D. We concur with the recommendation. We have established formal policies and procedures for the appropriate writing off of account balances.

5. Charity Care

The HPA has not handled all charity care cases in a consistent manner and has not fully documented any changes in its related policies/procedures. We also noted some inconsistencies in the way the HPA and UP handled the same patients, resulting in patients receiving different levels of financial assistance from each billing entity. In addition, HPA does not always maintain charity care applications.

The Health System frequently provides medical services to patients who have limited income and do not have health insurance, but are not eligible for federal Medicaid assistance. These people generally cannot afford to pay the costs of care. Those patients who meet certain criteria can receive those medical services at no charge or at reduced rates. Such care is referred to as charity care. Uncompensated charity care costs incurred by the University Hospital and Clinics totaled approximately $9.2 million and $16 million during the years ended June 30, 2001 and 2000, respectively. The Health System received approximately $24 million in state appropriations during each of these years; however, those appropriations were not sufficient to offset the costs of charity care and unreimbursed Medicaid costs.

The HPA and UP both require patients who are requesting financial assistance to complete a financial assistance application whereby the patient (or their financially responsible party) lists their income, assets, and liabilities. HPA and UP employees evaluate the applications to determine whether a patient is eligible to receive assistance. A Financial Assistance Determination Guide (referred to as the determination grid) was created to assist the applicable employees in determining what percentage of assistance or charity care a patient is eligible to receive. Depending on the income and family size of the patient, the determination grid provides for a reduction in an eligible patient's bill ranging from 5 percent to 100 percent. The determination grid was developed based on 150 percent of the federal poverty guidelines.

A review of HPA's handling of charity care accounts disclosed the following concerns:

A. The HPA has not been consistent in its use of the determination grid and has not always documented when any changes were made in its handling of charity care accounts. In addition, we noted inconsistencies in the manner it handles charity care cases compared to the UP, resulting in different levels of assistance being provided to the same patients.

During our review, we determined there was a period of time in which the HPA allowed a 100 percent reduction (care at no charge) to patients that fell anywhere within the determination grid, instead of using the percentages in the grid. There was no documentation to indicate when the HPA followed this procedure.

While HPA employees indicated this only occurred in May 2001, we noted an instance where this also occurred in October 2001. In that instance, the HPA allowed a 100 percent reduction in a patient's bill even though the grid allowed only a 60 percent reduction in the bill. The HPA wrote off a total of $1,700 in charity care for this patient. In contrast, the UP allowed the same patient a 60 percent reduction in its applicable charges, in accordance with the determination grid.

Another inconsistency was noted related to a recent policy change of the HPA. In early 2002, the HPA amended its procedures to award charity care based on income after taxes; however, UP continues to award charity care based on gross income (before taxes). This inconsistency in procedures between HPA and the UP will result in the same patients receiving different levels of assistance from these two entities. In addition, this change in policy/procedure will result in an increase in the amount of charity care costs absorbed by the Health System.

The HPA should be consistent in its use of the determination grid to ensure all patients eligible for financial assistance are treated equitably. Any changes in its handling of charity care cases should be well documented. In addition, the Health System should require the HPA and UP to adopt policies and procedures that are uniform in the awarding of charity care.

B. HPA does not always maintain financial assistance applications completed by charity care patients. In two of twelve charity care cases reviewed, HPA staff could not locate these documents.

HPA should retain all documents used in the determination of charity care to adequately support the amount of financial assistance awarded and assist in any future follow-up of the accounts.

WE RECOMMEND Health System management:

A. Ensure the HPA is consistent in its use of the determination grid. Any changes in its handling of charity care cases should be fully documented. In addition, the system should require the HPA and UP to adopt charity care policies and procedures that are uniform.

B. Ensure the HPA maintains all records used in the determination of financial assistance for charity care patients.

AUDITEE'S RESPONSE

A. We concur with the recommendation. We have adopted uniform charity care policies for HPA and UP.

We have instituted training programs to ensure we are consistent in the use of the determination grid, and we perform competency tests to ensure training is effective.

We have developed internal reviews of our procedures and processes on a regular basis as a quality improvement measure. During the coming fiscal year, we will formalize this function to further strengthen and improve the quality assurance process.

B. We concur with the recommendation. We have installed a new document imaging system to maintain the records used in the determination of financial assistance for charity care patients.

6. Internal Audits

Some recommendations related to the Health System's billing and collection procedures have not been implemented and a formal tracking system providing current information regarding the status of audit recommendations has not been established.

In recent years, the University of Missouri System has hired an outside auditing firm to perform internal audits of various university functions. Since July 2000, that firm has conducted three internal audits related to the Health System and its billing efforts. Our review of these internal audits noted the following concerns:

A. While it appears action has been taken to address many of the concerns noted by the auditors, some recommendations have not yet been implemented.

The first internal audit, dated October 2000, was a Revenue Cycle Analysis at the University of Missouri Hospital. This audit was intended to evaluate the entire HPA billing cycle operations, from registration through the ultimate disposition of a bill. The audit reported a number of efficiency and effectiveness weaknesses involving the registration of patients and billing and collection activities, and identified many opportunities for improvement.

Health System officials provided us a copy of a draft report prepared by the internal auditors which presented an update on the status of recommendations presented in the October 2000 internal audit as of February 2002. That document indicated action has been taken to address many of the opportunities for

improvement; however, some of them had not yet been implemented. Examples of areas where improvements were still pending included: changes in the patient registration process to ensure the preauthorization of services and the collection of co-payments at the time services are provided.

Health System officials indicated they are in the process of redesigning the entire revenue cycle process. This process, when complete, will substantially address and implement the various opportunities for improvement identified in this internal audit. The redesign was originally scheduled to be implemented by February 2002; however, the redesign had not been completed as of May 2002.

Another internal audit, dated March 2001, was a Patient Revenue Charge Capture Analysis at the University of Missouri Hospital. It focused on the flow of departmental patient service information from the time of the initial patient revenue charge entry through the patient account billing functions. According to this internal audit, the various departments were not always reconciling charges between the charge entry system and the billing system. Such reconciliations are needed to ensure all charges entered into the charge system are being correctly transferred to the billing system. In addition, the internal auditors reported there were no written procedures for reconciliations completed by the departments.

The Health System has not formally followed up on the recommendations included in this internal audit; however, we determined all of the concerns reported by the auditors have not been addressed. For example, written procedures documenting the reconciliations to be performed by the departments have not yet been developed.

The third internal audit, dated April 2001, was a Patient Revenue Cycle Analysis of the University Physician Medical Practice Plan (UP). This audit focused on the entire UP revenue cycle from the point of initial contact with a patient through the payment processing. It identified a number of areas within the patient revenue cycle where improvements were needed to ensure efficiency and effectiveness. While some of these areas overlapped the Revenue Cycle Analysis of the University Hospital (see above), many of these areas were specific to the UP revenue cycle.

We could not assure ourselves that all the recommendations made in this internal audit have been implemented. While a UP official indicated the recommendations in this internal audit were implemented at the time the report was issued, a formal follow-up of this audit report has not been completed.

B. The Health System has not established a formal tracking system to determine and report the status of the recommendations or opportunities for improvement noted in the internal audits. As noted above, an update of the first internal audit has

been performed by the internal auditors; however, a system has not been established to periodically track and provide management with up-to-date information regarding the status of recommendations made in internal or other audit reports.

A formal tracking system should be established to determine and report to management the status of audit recommendations on a periodic basis. Such a system would help to enhance the implementation of the recommendations and provide management with necessary information.

WE RECOMMEND Health System management:

A. Continue efforts to fully implement the recommendations or opportunities for improvement noted in the internal audits.

B. Develop a system to formally track the status of audit recommendations that have not been fully implemented. If it is management's intention not to implement a recommendation, that decision and the reason(s) should be documented.

AUDITEE'S RESPONSE

A. We concur. We are continuing efforts to fully implement the recommendations.

B. We concur. We are developing the recommended system this fiscal year and we will hold each individual unit audited responsible for reporting to the CFO on a quarterly basis on the status of the actions taken pursuant to the audit report recommendations.

7. Community Practice Clinics

Community practice clinics funded and operated by the Health System have incurred operating losses totaling $2.3 million during the years ended June 30, 2001 and 2000. Health System officials have not conducted a cost-benefit analysis to determine if the benefits of these clinics offset their losses. Similar clinics funded by the School of Medicine and operated by the UP have also incurred significant losses.

The University of Missouri School of Medicine and the Health System fund the operations of nineteen community-practice clinics located primarily in small communities in Mid-Missouri. According to Health System officials, these clinics were established to: 1) provide health care to rural residents of the Mid-Missouri area, 2) generate revenue for the University Hospital and Clinics through referrals, and 3) provide clinical education and experience for students enrolled in the School of Medicine.

There are two types of community practice clinics: Hospital ("H") clinics and Campus ("C") clinics. The type "H" community practice clinics are funded and operated by the

Health System, are considered independent entities of the system, and the Health System receives any revenues generated by these clinics. There are currently four of these clinics and they are staffed primarily by medical professionals employed by the Health System. There are currently thirteen type "C" clinics and these clinics are funded by the School of Medicine. While the Health System handles the accounting needs of these clinics, it bears no financial responsibility for them. These clinics operate under the oversight of the UP and they are staffed primarily by faculty of the School of Medicine.

The four community practice clinics funded and operated by the Health System (the "H" clinics), have incurred substantial operating losses. During the years ended June 30, 2001 and 2000, the Health System incurred losses totaling $2.3 million related to these clinics. While Health System officials indicated these clinics refer a number of patients to the University Hospital and other primary facilities of the system, information regarding the number of such referrals and the additional revenue generated by them was not readily available. In addition, Health System officials have not conducted a cost-benefit analysis to determine if the continued operation of these clinics is justified.

Even though the type "C" community practice clinics do not directly effect the financial condition or operations of the Health System, it should be noted these clinics also incurred substantial operating losses. During the years ended June 30, 2001 and 2000, these clinics incurred losses totaling $4 million.

WE RECOMMEND Health System management perform a cost-benefit analysis of the four community practice clinics to determine whether the continued operation of these clinics is justified. This would include reviewing the number of referrals and additional revenues generated for the system by these clinics.

AUDITEE'S RESPONSE

We concur with the State Auditor's recommendation to evaluate the Community Practice Clinics. In fact, such an analysis is under way and will be completed by the end of the year.

This report is intended for the information of the management of the Health System and other applicable government officials. However, this report is a matter of public record and its distribution is not limited.

HISTORY, ORGANIZATION, AND STATISTICAL INFORMATION

UNIVERSITY OF MISSOURI HEALTH SYSTEM
BILLING PRACTICES AND OTHER FINANCIAL MATTERS
HISTORY, ORGANIZATION, AND STATISTICAL INFORMATION

The University of Missouri Health System is a part of the University of Missouri System. The Health System consists of the University Hospital and Clinics (University Hospital, Children's Hospital, and Ellis Fischel Cancer Center), Columbia Regional Hospital, Missouri Rehabilitation Center (in Mt. Vernon), and the University Physicians Medical Practice Plan (UP). The UP is the organized practice plan for the faculty of the University of Missouri-Columbia School of Medicine.

The Health System has expanded since 1990, with various facilities being added to the system during the following years:

Facility	Year Acquired
Ellis Fischel Cancer Center	1990
Missouri Rehabilitation Center	1997
Columbia Regional Hospital	1999

The University Hospital and Clinics maintain one primary billing system that serves two separate billing entities within the system: Hospital Patient Accounts (HPA) and the University Physicians (UP). The UP side of the billing system is used to bill patients for physician services and certain lab fees, while the HPA side of the billing system is used to bill patients for all other charges related to a patient's visit. Patients that incur charges from both HPA and the UP billing systems will receive a separate invoice from each billing entity. Net revenues generated by HPA go to the Health System, while net revenues generated by the UP primarily go to provide additional compensation to the physicians and do not directly benefit the Health System. The UP and HPA also distribute funds to the School of Medicine and the University.

The Missouri Rehabilitation Center and the Columbia Regional Hospital maintain separate billings systems from the University Hospital and Clinics and those systems and the related procedures were not reviewed during this audit.

The Health System is governed by the Board of Curators of the University of Missouri System, which is comprised of 9 members appointed by the Governor and confirmed by the Senate. The board also has a non-voting position for a student representative.

At December 31, 2001, the Health System employed 3,965 full time equivalent employees, excluding physicians. The individuals serving as officers of the Health System and the University Hospital and Clinics at that date were as follows:

Name	Position
Daniel Winship, MD	Vice Chancellor & Chief Executive Officer
John O'Shaughnessy	Executive Director of Clinical Affairs
Weldon Webb	Associate Vice Chancellor
Nicholas Braccino	Chief Financial Officer
Keith Weinhold	Director of University Hospital and Clinics

During recent years, the University Hospital and Clinics has experienced and reported various problems with its billing system and related procedures. In addition, the Health System has incurred significant operating losses during the last two and half years. Appendix A presents the operating results of the Health System in recent years.

Appendix

UNIVERSITY OF MISSOURI HEALTH SYSTEM
BILLING PRACTICES AND OTHER FINANCIAL MATTERS
COMPARATIVE STATEMENT OF REVENUES, EXPENSES, AND INCOME (LOSS) FROM OPERATIONS
FIVE YEARS ENDED JUNE 30, 2001, AND PARTIAL YEAR ENDED JANUARY 31, 2002
(Dollars In Thousands)

	Seven Months Ended January 31, 2002	Year Ended June 30, 2001	2000	1999	1998	1997
REVENUES:						
Net patient service revenues	$ 231,864	397,375	368,268	324,742	310,106	295,726
State of Missouri appropriations	13,214	24,414	23,935	23,466	22,827	25,629
Sales by auxiliary enterprises and other	9,547	14,414	15,606	13,716	13,426	12,611
Total revenues	254,625	436,203	407,809	361,924	346,359	333,966
EXPENSES:						
Professional care of patients	-	-	-	150,963	143,479	140,529
Administrative and general	-	-	-	125,690	116,069	102,943
Salaries and benefits	105,777	174,803	170,181	-	-	-
Medical supplies and drugs	42,126	66,202	63,103	-	-	-
Administrative and support services	5,874	17,109	18,471	-	-	-
Interest	6,234	10,365	8,555	-	-	-
University Physicians distributions	38,631	53,115	67,341	67,704	64,114	60,098
Depreciation	15,219	25,060	23,221	16,964	15,248	13,205
Provision for bad debts	10,369	37,820	21,136	-	-	-
Other expenses	39,047	67,081	63,499	-	-	-
Total expenses	263,277	451,555	435,507	361,321	338,910	316,775
INCOME (LOSS) FROM OPERATIONS	$ (8,652)	(15,352)	(27,698)	603	7,449	17,191

Note: The information presented above for the five years ended June 30, 2001, was obtained from the annual independent audit reports prepared for the University of Missouri Health System. The expense categories presented in the independent audit reports were changed for the fiscal year 2001 audit. Because of this change, the expenditure data for the year ended June 30, 2000, was restated in the fiscal year 2001 audit report for comparison purposes. The expense data presented for the year ended June 30, 2000, reflects this restatement. The data presented for the seven months ended January 31, 2002, has not yet been audited and was obtained from Health System officials.

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