

AUDIT REPORT



CITY OF NEW YORK
OFFICE OF THE COMPTROLLER
BUREAU OF MANAGEMENT AUDIT
WILLIAM C. THOMPSON, JR., COMPTROLLER

Follow-up Audit Report on the Collection Practices and Procedures of the Health and Hospitals Corporation Related to Medicaid Managed Care / Health Maintenance Organizations

MD02-152F

June 17, 2003



THE CITY OF NEW YORK
OFFICE OF THE COMPTROLLER
1 CENTRE STREET
NEW YORK, N.Y. 10007-2341

WILLIAM C. THOMPSON, JR.
COMPTROLLER

June 17, 2003

To the Citizens of the City of New York

Ladies and Gentlemen:

In accordance with the Comptroller's responsibilities contained in Chapter 5, § 93, of the New York City Charter, my office has performed a follow-up audit on Health and Hospitals Corporation's (HHC) collection practices and procedures related to Medicaid Managed Care/Health Maintenance Organizations (MMC/HMOs). We determined whether HHC implemented the recommendations made in an earlier audit, *Audit of the Health and Hospitals Corporation's Collection Practices and Procedures Related to MMC/HMOs*, issued October 6, 1997 (Audit No. ME96-081A).

The results of our audit, which are presented in this report, have been discussed with HHC officials, and their comments have been considered in the preparation of this report. Audits such as this provide a means of ensuring that HHC receives payment to which it is entitled to by promptly and properly billing HMOs for services provided by HHC to Medicaid managed care patients.

I trust that this report contains information that is of interest to you. If you have any questions concerning this report, please e-mail my audit bureau at audit@comptroller.nyc.gov or telephone my office at 212-669-3747.

Very truly yours,

A handwritten signature in cursive script that reads "William C. Thompson, Jr.".

William C. Thompson, Jr.

Report: MD02-152F

Filed: June 17, 2003

*The City of New York
Office of the Comptroller
Bureau of Management Audit*

**Follow-up Audit Report on the Collection Practices and
Procedures of the Health and Hospitals Corporation Related
to Medicaid Managed Care /
Health Maintenance Organizations**

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SUMMARY OF FINDINGS AND CONCLUSIONS

This is a follow-up audit to determine whether the New York City Health and Hospitals Corporation (HHC) implemented the recommendations made in an earlier audit, *Audit of the Health and Hospitals Corporation's Collection Practices and Procedures Related to Medicaid Managed Care (MMC) / Health Maintenance Organizations (HMOs)*, issued October 6, 1997 (Audit No. ME96-081A). The earlier audit determined the extent to which HHC collects payments from HMOs for services provided by HHC to MMC patients. This follow-up report discusses the details of the recommendations of the previous audit report and the status of each recommendation.

The previous audit made 22 recommendations to HHC. Of the 22 recommendations, 11 were implemented, three were partially implemented, one was not implemented, and seven were no longer applicable. Those recommendations and their current implementation status are as follows:

- 1) HHC should ask the City, through the Mayor's Office of Medicaid Managed Care, to consider exercising the local option in the New York State Medicaid Managed Care plan, whereby a locality can require Medicaid managed care providers to contract with local public hospitals. **NO LONGER APPLICABLE**
- 2) HHC should regularly prepare a statistical report on emergency and clinic services provided to MMC patients who are enrolled in plans that do not contract with HHC. Using this information, HHC and other public health providers throughout the State should define a statistical threshold for identifying plans that receive an excessive amount of free services from local public hospitals or Health Department clinics. HHC can then use the information in the regular reports to pressure HMOs to make payments for legitimate HMO services. **IMPLEMENTED**
- 3) HHC, in conjunction with the City and with other local public hospitals or Health Department clinics, should pursue passage of New York State legislation requiring that Medicaid managed care plans reimburse them for legitimate, unreimbursed services

provided to their members at the Medicaid fee-for-service rate. HHC should then use the information developed pursuant to Recommendation #2, above, to specifically target those HMOs with excessive uncontracted services for which reimbursement has not been received. **NO LONGER APPLICABLE**

- 4) The President of HHC should appoint a high-level individual to take charge of a task force or committee that would be responsible for further pursuing the problems and recommendations discussed in this report. **IMPLEMENTED**
- 5) The task force should test the billing process by entering dummy bills into its data processing system over a period of time, to see whether bills are actually being mailed out and arriving at their destinations. **PARTIALLY IMPLEMENTED**
- 6) HHC should develop formal procedures requiring that hospitals be more aggressive in pursuing collection efforts for payments due from HMOs. These procedures should:
 - Ensure that HMOs are billed within 30 days of the date of service.
 - Ensure that HMOs that do not pay are billed again within 30 days of the first billing.
 - Define collection efforts to be made in situations where HMOs do not pay after receiving the first two bills from HHC. **PARTIALLY IMPLEMENTED**
- 7) HHC should consider reducing its standard from 30 days to seven days of the date of service—the non-governmental hospital standard—to increase its chances of securing payments from the HMOs. **NO LONGER APPLICABLE**
- 8) HHC should provide extensive training on Siemens Medical Solutions (SMS) and the procedures discussed above to all HHC personnel responsible for billing and collecting amounts owed to HHC from HMOs. **IMPLEMENTED**
- 9) HHC should closely monitor the hospital’s compliance with the above-mentioned procedures and determine if the collection rate has significantly improved. **IMPLEMENTED**
- 10) HHC should program SMS to automatically generate repeat bills to HMOs for unpaid services. **NO LONGER APPLICABLE**
- 11) HHC should consider using a private collection agency to pursue collection efforts for amounts owed to HHC by HMOs if the HHC collection rate does not significantly improve. **NOT IMPLEMENTED**
- 12) Prior to transferring services to bad debt, HHC should require that hospitals review all relevant billing records to ensure that all required collection efforts were initiated. **PARTIALLY IMPLEMENTED**
- 13) HHC should track individual hospital collection rates, hold each hospital accountable, and require that each report on why it is not collecting. **IMPLEMENTED**

- 14) The high-level task force discussed in Recommendation #4 should be directly responsible for ensuring that the necessary steps are taken to overhaul the billing system and to implement the recommendations made in this report. **IMPLEMENTED**
- 15) HHC should arrange for SMS to be programmed to indicate the Medicaid reimbursable rate for the appropriate service, as opposed to the current practice of posting a different rate, to ensure that SMS and the MMC accounts receivable reflect the true amount due from the HMOs. **NO LONGER APPLICABLE**
- 16) HHC should establish a data field in SMS to record the effective date that a patient enrolls in a MMC plan. This data field should also allow HHC to record dates when a patient transfers from one HMO to another, to ensure that the appropriate HMO is billed. **IMPLEMENTED**
- 17) HHC should review the computer tapes provided by private vendors on ancillary service to ensure that the information they provide corresponds to the information on SMS. **NO LONGER APPLICABLE**
- 18) HHC should ensure that the HHC's MMC Accounts Receivable contains only HMO-billable services; thus, HHC should:
 - (a) Immediately review its MMC Accounts Receivable and program SMS to write-off all services that do not belong on the MMC Accounts Receivable because they are not eligible for any reimbursement—especially such services identified by the auditors as ancillary charges, contractual balances, capitated charges, and ambulance charges—to prevent the MMC Accounts Receivable from being cluttered and inflated by such data. **IMPLEMENTED**
 - (b) Incorporate, for the long-term, monthly reviews of the MMC Accounts Receivable in HHC standard operating procedures. HHC should also program SMS to automatically write off services that do not belong to the MMC Accounts Receivable (such as ancillary charges, capitated charges, and ambulance charges that are not due from HMOs) to prevent MMC Accounts Receivable from being cluttered and inflated by such data. **IMPLEMENTED**
- 19) HHC should conduct periodic reviews of the data contained on SMS to ensure that services specifically covered by Medicaid (even though the patient is HMO-eligible) are billed to Medicaid and not the HMO. **IMPLEMENTED**
- 20) HHC should issue a memorandum to all hospitals reminding them about HHC's bad debt policies. **NO LONGER APPLICABLE**
- 21) HHC should routinely monitor HHC hospitals' adherence to the above policies. **IMPLEMENTED**

22) HHC should require that hospitals collect and analyze the following information to determine whether the HMOs are properly reimbursing HHC for services provided to their patients. **IMPLEMENTED**

Specifically, HHC hospitals should:

- (a) Obtain valid authorization numbers and referral slips from the HMOs for all emergency room and specialty care visits, and record this information on SMS. **IMPLEMENTED**
- (b) Keep a record of all attempts made on SMS to obtain valid authorization numbers and referral slips from HMOs. **IMPLEMENTED**
- (c) Where appropriate, post on SMS all payment denials and the reasons for such denials received from HMOs. HHC hospitals should also maintain copies of such denials, and record on SMS the services for which pre-authorization was obtained from HMOs and for which no payment or response was received. **IMPLEMENTED**
- (d) Conduct monthly analyses of services that were approved by the HMOs for which payments were denied. For these services, the staff should follow up with the HMO and attempt to obtain reimbursement. **IMPLEMENTED**
- (e) Review the above information to identify and take the necessary action against any HMO that routinely denies payment to HHC after HMOs pre-authorized these services. **IMPLEMENTED**

This follow-up audit found that HHC has improved its billing and collection procedures. Also, HHC's increasing use of electronic submission of claims data should further expedite the submission, review and payment process. However, HHC still needs to improve its posting of initial payments into its computer system and the timeliness of its initial billings to HMOs. Also HHC patient account directors and managers should monitor outstanding accounts and ensure that hospital care investigators promptly follow up to ensure payment from managed care plans.

To address the problems noted in this report, HHC should implement the recommendations of the previous audit that were not fully addressed. We believe that upon implementation of these recommendations HHC will have corrected the conditions cited in both the previous report and this follow-up report. The recommendations are repeated below, somewhat revised according to the findings of this report.

HHC should:

1. Develop procedures to ensure that outpatient bills are mailed and arrive at their destinations.
2. Develop formal collection procedures for inpatient accounts like those for outpatient accounts, as described in the Third Party Policy-Ambulatory Care Manual. Ensure that hospitals adhere to these procedures.
3. Consider using private collection agencies to pursue collection efforts for amounts owed to HHC by HMOs.

4. Prior to transferring services to bad debt, require that hospitals review all relevant billing records to ensure that all required collection efforts were initiated.

Discussion of Audit Results

The matters covered in this report were discussed with HHC officials during and at the conclusion of this audit. A preliminary draft report was sent to HHC officials on April 15, 2003 and was discussed at an exit conference held on May 15, 2003. We submitted a draft report to HHC officials on May 19, 2003, with a request for comments. We received a written response from HHC officials on June 5, 2003.

In their comments, HHC officials agreed with the recommendations, stating, “The Corporate Facilities, with guidance and assistance from Revenue Management, will take the necessary steps to implement the recommendations cited in the audit report.”

The full text of the response is included as an addendum to this report.

INTRODUCTION

Background

The New York City Health and Hospitals Corporation (HHC) is a public benefit corporation created by the New York State Legislature on July 1, 1970, to operate the City's municipal hospital system. Its mission is to provide comprehensive and quality medical, mental health, and substance abuse treatment services equally to all New Yorkers, regardless of their ability to pay.

Through six regional health care networks, HHC operates 11 acute care hospitals; four long-term care facilities; six comprehensive diagnostic and treatment centers; a certified home health agency; and more than 100 community-based clinics.

The focus of this audit was HHC's 11 acute care hospitals, which are located throughout the city and provide outpatient, inpatient, and emergency room services. Many acute care hospital patients are enrolled in Medicaid Managed Care (MMC) plans. For Medicaid recipients, these plans coordinate, control, and pay for services. HHC hospitals bill the plans when members receive hospital services. According to the HHC *Cash Disbursements and Receipts Report* for Fiscal Year 2001, HHC acute care hospitals reported receipts of approximately \$111.5 million for inpatient and outpatient MMC accounts.

The nationwide trend toward managed care plans and health maintenance organizations (HMOs) has had an impact on HHC's relationships with its patients. Given the emerging role of managed care plans, HHC established its own health maintenance organization, MetroPlus, to compete with private HMOs for MMC patients. Currently, MetroPlus has contracts with all HHC acute care facilities to provide comprehensive health care services to enrollees.

According to the HHC Fiscal Year 2001 Consolidated Financial Statements, it had operating revenue of \$4.29 billion and operating expenses of \$4.31 billion. Table I shows the number of patient discharges or visits, along with receipts reported for the 11 acute care hospitals.

Table I
General Information for HHC's 11 Acute Care Hospitals
Fiscal Year 2001

Hospital	Total Hospital Discharges	Total MMC Inpatient Receipts (\$ in 000's)	Total MMC Outpatient Receipts (\$ in 000's)	Other Cash Receipts (\$ in 000's)	Total Cash Receipts (\$ in 000's)
Bellevue	21,792	\$13,034	\$2,464	\$334,663	\$350,161
Coney Island	15,198	9,994	2,785	167,731	180,510
Elmhurst	24,424	4,477	1,387	317,275	323,139
Harlem	11,539	7,996	2,293	215,671	225,960
Jacobi	20,860	9,690	1,547	287,765	299,002
Kings County	21,978	15,799	4,778	329,674	350,251
Lincoln	21,470	11,582	2,040	258,290	271,912
Metropolitan	12,796	5,825	895	203,822	210,542
North Central Bronx	8,647	3,797	1,578	115,360	120,735
Queens	13,375	3,901	419	166,081	170,401
Woodhull	15,775	3,971	1,240	230,228	235,439
Totals	187,854	\$90,066	\$21,426	\$2,626,560	\$2,738,052

Objectives

This is a follow-up audit to determine whether the New York City Health and Hospitals Corporation (HHC) implemented the 22 recommendations made in an earlier audit, *Audit of the Health and Hospitals Corporation's Collection Practices and Procedures Related to Medicaid Managed Care (MMC) / Health Maintenance Organizations (HMOs)*, issued October 6, 1997 (Audit No: ME96-081A). The earlier audit determined the extent to which HHC collects payments from HMOs for services provided by HHC to MMC patients. This follow-up report discusses the details of the recommendations of the previous audit report and the status of each recommendation.

Scope and Methodology

The scope of our audit was Calendar Year 2001. Although the earlier audit pertained only to outpatient or Ambulatory MMC billing and collection procedures, our audit pertains to inpatient billing and collection procedures as well.

In this follow-up report, we classified the current status of the recommendations made in the previous audit report as follows:

IMPLEMENTED: The agency agreed with the recommendation by adopting the recommendation and by instituting corrective action.

PARTIALLY IMPLEMENTED: The agency instituted some corrective action.

NOT IMPLEMENTED: The agency either disagreed with the recommendation or there was no evidence of implementation.

NO LONGER APPLICABLE: The agency took other actions, or regulations were revised that rendered the recommendation moot.

To understand HHC's MMC billing and collection procedures, we interviewed the Assistant Vice President and two Senior Directors from the Revenue Management/Operations Unit at the HHC Central Office, as well as the HHC Senior Vice President of Finance. To determine the current status of the prior audit's recommendations we reviewed HHC Audit Implementation Plan submitted to the Mayor's Office of Operations on December 24, 1998. We also met with HHC officials to discuss the implementation status of each of the prior audit's recommendations.

In addition, we reviewed the following: standard operating procedures related to MMC patients, the corporation's consolidated financial statements for Fiscal Year 2001 and Fiscal Year 2000, the *Cash Disbursements and Receipts Reports* for Fiscal Year 2000 and 2001, the *Medicaid Managed Care Reports* for calendar year 2001 for inpatient and outpatient services and the *Accounts Receivable Management Report* for year ended December 31, 2001, and the MMC contracts currently in effect in HHC's hospitals.

We reviewed billing and collection practices for a sample of inpatient and outpatient accounts at three randomly selected HHC acute hospitals: Bellevue Hospital, Kings County Hospital, and Elmhurst Hospital. To obtain information on each hospital's procedures, we interviewed each hospital's patient accounts director, ambulatory patient accounts director, as well as managers, supervisors, and senior hospital care investigators (HCIs).

To review the hospitals' billing and collection practices for outpatient accounts we randomly selected a sample of 25 MMC patients from each of our sampled hospitals, who were discharged in June 2002.¹ We reviewed the billing and collection data for all discharges related

¹ Patient account records were not available for the audit scope period. Therefore, we selected this sample from a population of patients who were discharged in June 2002.

to those patients during June 2002. Since some of the patients had multiple discharges within the month, we reviewed a total of 66 outpatient accounts at Bellevue Hospital, 54 outpatient accounts at Elmhurst Hospital, and 87 outpatient accounts at Kings County Hospital.

To review billing and collection practices for inpatient accounts, we randomly selected a sample of 25 MMC patients, from each of our sampled hospitals who were discharged during Calendar Year 2001. We reviewed the billing and collection documentation for all visits related to those patients during Calendar Year 2001. Since some of the patients had multiple visits within the year, we reviewed a total of 35 inpatient accounts at Bellevue Hospital, 27 inpatient accounts at Elmhurst Hospital, and 34 inpatient accounts at Kings County Hospital.

For our inpatient and outpatient sampled accounts we did the following:

- Reviewed billing and repeat billing information to determine whether the appropriate HMOs were repeatedly billed according to HHC policies and procedures.
- Determined whether HHC correctly posted payments and adjustments for the services provided to patients in our sample.
- Determined whether HHC followed billing policies for MMC patient services that should have been billed directly to Medicaid.

To review the hospitals' practices for handling outstanding account balances, we also selected a sample of 10 MMC accounts for inpatients who were discharged from each of our sampled hospitals during calendar year 2001 and who still had outstanding balances as of October 2002. We reviewed the reasons why the accounts were outstanding and what efforts the hospitals made to ensure payments of the balances owed.

Our audit was conducted in accordance with Generally Accepted Government Auditing Standards (GAGAS), and included tests of the records and other auditing procedures considered necessary. This audit was performed in accordance with the Comptroller's audit responsibilities as set forth in Chapter 5, § 93, of the New York City Charter.

Discussion of Audit Results

The matters covered in this report were discussed with HHC officials during and at the conclusion of this audit. A preliminary draft report was sent to HHC officials on April 15, 2003 and was discussed at an exit conference held on May 15, 2003. We submitted a draft report to HHC officials on May 19, 2003, with a request for comments. We received a written response from HHC officials on June 5, 2003.

In their comments, HHC officials agreed with the recommendations, stating, "The Corporate Facilities, with guidance and assistance from Revenue Management, will take the necessary steps to implement the recommendations cited in the audit report."

The full text of the response is included as an addendum to this report.

RESULTS OF FOLLOW-UP AUDIT

Previous Finding: HHC received payment by HMOs for only 72 billable accounts (14.5%), totaling \$9,323, of the 514 billable accounts in the sample, totaling \$63,957. This low collection rate was due to certain weaknesses in the HHC billing and collection system, as follows:

- HHC does not have contracts with most managed care organizations. All 11 HHC hospitals have contracts with MetroPlus, HHC's wholly owned subsidiary. The only other HMO contracts hospitals have are as follows: Coney Island Hospital had contracts with Cigna and Oxford Health Plans, Harlem Hospital had contracts with CenterCare and Primecare, and Bellevue Hospital had a contract with CenterCare. By entering into contracts with more HMOs, HHC could increase its revenues by increasing its chances of getting paid for services and obtaining the prepaid capitation² amounts related to managed care patients.
- HMOs did not pay HHC for legitimate services.
- HHC never billed the HMOs for 85 (16.5%) of the sampled 514 services. In most cases, HHC could not explain why the services were not billed.
- HHC lacked detailed procedures on how hospital staff should bill and re-bill for HMO services. In addition, the staff needed training on how to access basic billing and collection information on the HHC computer system.

Previous Recommendation #1: "HHC should ask the City, through the Mayor's Office of Medicaid Managed Care, to consider exercising the local option in the New York State Medicaid Managed Care plan, whereby a locality can require MMC providers to contract with local public hospitals."

Previous HHC Response: "The Corporation and its facilities have jointly negotiated contracts and are currently in the process of negotiating contracts with many plans."

Current Status: NO LONGER APPLICABLE

HHC has increased the number of contracts it has with HMO providers. As of October 2001, HHC had 188 MMC contracts with 15 MMC health plans. HHC has different agreements with MMC companies for different services. For example, an agreement may cover emergency, inpatient, and certain diagnostic procedures. Another agreement with the same company may be for specialty physician services and primary care. According to HHC officials, it is not in HHC's best interest to have contracts with all HMOs they deal with. They will only negotiate contracts with

² Capitation is a payment system whereby managed care plans pay health care providers a fixed amount to care for a patient over a given period, no matter what the actual number or nature of services delivered. Providers are not reimbursed for services that exceed the allotted amount.

HMOs that are financially sound.

Previous Recommendation #2: “HHC should regularly prepare a statistical report on emergency and clinic services provided to MMC patients who are enrolled in plans that do not contract with HHC. Using this information, HHC and other public health providers throughout the State should define a statistical threshold for identifying plans that receive an excessive amount of free services from local public hospitals or Health Department clinics. HHC can then use the information in these regular reports to pressure HMOs to make payments for legitimate HMO services.”

Previous HHC Response: “HHC will begin work to develop and generate such a report as recommended. Additionally, it may be necessary that HHC will have to select, test and procure the requisite systems software that will identify and bill the relevant MMC/HMOs for legitimate non-contracted services rendered to their members.”

Current Status: IMPLEMENTED

Enhancements and edits on HHCs computer system, SMS, enabled its Central Office to prepare such statistical reports for review and analysis. We obtained copies of these “Outpatient Medicaid Managed Care” reports from HHC Central Office for Calendar Year 2001 for contracted and non-contracted plans.

Previous Recommendation #3: “HHC, in conjunction with the City and other local public hospitals or Health Department clinics, should pursue passage of New York State legislation requiring that Medicaid managed care plans reimburse them for legitimate, unreimbursed services provided to their members at the Medicaid fee for service rate. HHC should then use the information developed pursuant to Recommendation #2 above to especially target those HMOs with excessive uncontracted services for which reimbursement has not been received.”

Previous HHC Response: “The Corporation will consult with the New York City MMC and include the contents of this recommendation in HHC’s legislative package for presentation to the New York State Legislature in September 1997.”

Current Status: NO LONGER APPLICABLE

According to HHC officials, there have been regulatory changes affecting MMC billing since the prior audit. First, New York State enacted Prompt Payment legislation, which mandates that the plans must pay for clean claims within 45 days of receipt or pay interest. Also, other changes that the Greater New York Hospitals Association and HHC had lobbied for, such as uniform claims processing or electronic billing, will come to pass with the implementation of the federal Health Insurance Portability and Accountability Act (HIPAA) of 1997. Finally, due to an investigation by the NYS Attorney General, six health plans have recently agreed to correct

their utilization review³ process and must now disclose the clinical standards by which they deny claims.

Previous Recommendation #4: “The President of HHC should appoint a high level individual, to take charge of a task force or committee, which would be responsible for further pursuing the problems and recommendations discussed in this report.”

Previous HHC Response: “The Corporation does not see any benefit to the creation of a special task force to oversee the collection of one particular stream of revenue. The Corporation’s priority is the overall fiscal health of the facilities it operates, with direct responsibility for their performance belonging to the six Network Senior Vice Presidents. Each Network VP is given realistic revenue targets for each payer class, including Managed Care, and is held to those expectations.”

Current Status: IMPLEMENTED

HHC officials created an Ambulatory Care Task Force, consisting of Senior Network Vice Presidents and key Central Office and facility finance staff members, to closely examine operational issues. In addition, collection problems and recommendations are discussed periodically at Finance Committee Board meetings. HHC provided us with copies of Board meeting minutes. There are also various oversight committees, such as a Managed Care Oversight Committee and a Managed Care Policy Committee, to investigate collection problems from HMOs.

We also obtained copies of inter-office memoranda and various reports issued by officials of the Revenue Management Unit showing that they monitor receivables and disseminate information relating to managed care data to the facilities.

In addition, the HHC Revenue Management Unit and Reimbursement Unit have designed Product Line Management (PLM) reports to monitor contract compliance and operational issues and provide data for contract cancellations or renegotiations.

Previous Recommendation #5: “The task force should test the billing process by inputting dummy bills over a period of time to see if bills are actually being mailed out and arriving at their destination.”

Previous HHC Response: “We disagree that this action would be useful or productive. The Corporation, in addition to monitoring HMO revenue targets will ask the Networks to monitor and report on the backlog of manual Managed Care bills, and will continue to seek high-level management follow-up meetings with those MMC/HMOs, such as HIP, that have long histories of being non-responsive to Corporate claims.”

³ Utilization review (UR) is the evaluation of the necessity, appropriateness, and efficiency of the use of health care services, procedures, and facilities. Managed care organizations will sometimes refuse to reimburse or pay for services that do not meet their own sets of UR standards. UR involves the review of patient records and patient bills, but may also include telephone conversations with providers.

Current Status: PARTIALLY IMPLEMENTED

HHC still disagrees that dummy bills would be useful in determining whether bills are actually being mailed. However, hospitals currently electronically bill some HMOs for services provided to their members. This process facilitates the tracking of billed accounts. Furthermore, although inpatient bills to other HMOs were mailed manually, verification of mailing was possible since they were sent by certified mail. We feel that HHC's procedures for inpatient billing comply with the intent of the prior recommendation.

However, although some outpatient bills are electronically processed, it is still difficult to track outpatient bills that are mailed manually to other HMOs, since the bills are not sent by certified mail. According to hospital officials, HHC is still enhancing and testing its technology to bill all HMOs electronically.

Previous Recommendation #6: "Develop formal procedures requiring that hospitals be more aggressive in pursuing collection efforts for payments due from MMC/HMOs. These procedures should:

- "Ensure that HMOs are billed within 30 days of the date of service.
- "Ensure that HMOs that do not pay are billed again within 30 days of the first billing.
- "Define collection efforts to be made in situations where HMOs do not pay after receiving the first two bills from HHC."

Previous HHC Response: "An outpatient Medicaid Managed Care manual was prepared, distributed and implemented in July 1994. This manual improved on the Medicaid Managed Care policy that was in place. Currently we are reviewing and updating our Ambulatory & Managed Care Finance Policy Manual to include all current policies and procedures pertaining to Managed Care."

Current Status: PARTIALLY IMPLEMENTED

HHC's *Third Party Policy-Ambulatory Care* manual (updated in 2000) includes the above-mentioned policies and procedures relating to MMC outpatient accounts. Also, policies and procedures that required clarification have been addressed on an ongoing basis and issued as corporate memos. However, HHC has yet to develop a corporate-wide policy manual for inpatient accounts.

According to the HHC manual, "Managed Care Plans should be billed within 30 days from the date of service and followed up within 60 days from the date of service with a second bill if no response is received from the Plan." Although these procedures are in place, we found instances of noncompliance at our sampled hospitals. These are shown in Table II, following:

Table II
Number (Percentage) of Accounts Billed After 30 Days

Hospital	Inpatient			Outpatient		
	Number of Sampled Accounts	Number (Percent) of Accounts Billed After 30 Days	Range of Days Until Accounts Were Billed	Number of Sampled Accounts	Number (Percent) of Accounts Billed After 30 Days	Range of Days Until Accounts Were Billed
Bellevue	35	11 (31%)	32 to 134	66	8 (12%)	33 to 291
Elmhurst	27	10 (37%)	35 to 186	54	12 (22%)	33 to 91
Kings County	34	11 (32%)	31 to 127	87	24 (28%)	32 to 149

Table III, below, shows the hospitals' follow-up efforts for the accounts in our sample that were not being paid within 30 days.

Table III
Follow-up Efforts for Bills Not Paid Within 30 Days from Bill Date

Hospital	Inpatient		Outpatient	
	Number of Accounts Payment not Received Within 30 Days from Bill Date	Number (Percent) of Accounts Hospital Followed up	Number of Accounts Payment not Received Within 30 Days from Bill Date	Number (Percent) of Accounts Hospital Followed up
Bellevue	18	4 (22%)	32	6 (19%)
Elmhurst	16	6 (38%)	22	3 (13%)
Kings County	21	2 (10%)	15	1 (8%)

As shown above, a significant percentage of patient accounts are not being billed within 30 days and hospital officials are not following up on many patient accounts when payment is not received. HHC needs to ensure that hospitals are complying with its procedures regarding the billing and collecting of patient accounts.

Previous Recommendation #7: “Consider reducing its standard from 30 days to 7 days of the date of service—the non-governmental hospital standard—to increase its chances of securing payments from the MMC/HMOs.”

Previous HHC Response: “Based on the Corporation’s discussions with voluntary

hospitals, they have the same difficulties processing outpatient claims manually as does HHC. While submitting claims faster ensures that payments is received faster, it does not necessarily increase our chances of getting paid when, as documented by the press and the Greater NY Hospital Association, HMOs are routinely delaying and denying claims for questionable reasons.

“Given the high volume of outpatient claims processed at HHC facilities, we are aware of the backlog in HMO claims, and would rather expend our limited resources working with the HMOs and our computer vendors to take steps towards automating our claims processing rather than hiring more staff to send bills out sooner.”

Current Status: NO LONGER APPLICABLE

HHC stated it would not implement this recommendation. Its standard for sending out patient bills remains at 30 days after the date of service. However, the expansion of HHC’s electronic billing capabilities should shorten the time period in which bills are sent to HMOs.

Previous Recommendation #8: “Provide extensive training on SMS and the procedures discussed above to all HHC personnel responsible for billing and collecting amounts owed to HHC from HMOs.”

Previous HHC Response: “The Corporation will arrange refresher training on the SMS Managed Care functions and procedures for all facilities as well as refresher training on billing and bad debt transfer functions. In addition, all Information Systems Departments will be advised to take the SMS training series this summer.”

Current Status: IMPLEMENTED

HHC has provided extensive training to hospital staff members to prepare them for the mandatory managed care enrollment of Medicaid recipients. According to HHC officials, “With the \$20 million in federal and state funding earmarked for managed care training, literally every employee has received an introduction to the basics of managed care and many specialized training courses have been conducted since 1998.” HHC officials provided us with a schedule for Managed Care systems training, including several examples of the general and specialized managed care training schedules and materials that were developed at the facilities.

Previous Recommendation #9: “Closely monitor the hospitals’ compliance with the above-mentioned procedures and determine if the collection rate has significantly improved.”

Previous HHC Response: “The Corporation has already demonstrated improvements in outpatient receivables which has increased by 42 percent in the last four fiscal years ended 6/30/96. We are committed to achieving higher collection targets and will continue our monitoring efforts.”

Current Status: IMPLEMENTED

Based on our testing of a sample of patient accounts, the collection rates have improved, as compared with the collection rate of 14 percent cited in the prior audit, as shown below:

Table IV
Number (Percentage) of Sampled Bills Paid

Hospital	Inpatient			Outpatient		
	Number of Services Provided to Sampled MMC Patients	Number of Services Paid	Percent of Services Paid	Number of Services Provided to Sampled MMC Patients	Number of Services Paid	Percent of Services Paid
Bellevue	35	30	86%	66	28	42%
Elmhurst	27	25	93%	54	32	59%
Kings County	34	29	85%	87	53	61%
Total	96	84	88%	207	113	54%

Previous Recommendation #10: “Program SMS to automatically generate repeated bills to MMC/HMOs for unpaid services.”

Previous HHC Response: “Although this could be done, it is the Corporation’s opinion that repeated billings would be more cost-effective if done selectively. Manual intervention is needed to determine that the billing information is accurate and that the clinical information meets with the MMC/HMOs criteria.”

Current Status: NO LONGER APPLICABLE

SMS does not automatically generate repeated bills to HMOs for unpaid services. HCIs follow up on unpaid accounts to collect payments from insurance companies. HCIs send repeat bills to insurance companies selectively. We feel that this complies with the intent of the original recommendation.

Previous Recommendation #11: “Consider using a private collection agency to pursue collection efforts for amounts owed to HHC by HMOs if HHC’s collection rate does not significantly improve.”

Previous HHC Response: “The Corporation is in the process of developing an RFP to select an outside collection agency for large balance outpatient accounts.”

Current Status : NOT IMPLEMENTED

Hospitals send only non-Medicaid accounts to collection agencies. Hospital officials stated that State law prohibits them from referring Medicaid recipients to collection agencies since HMOs are responsible for payment for their services. However, HHC should consider using collection agencies to pursue payment from the HMOs, since there does not appear to be any prohibition against it.

Previous Recommendation #12: “Require, prior to transferring services to ‘bad debt,’ that hospitals review all relevant billing records to ensure that all required collection efforts were initiated.”

Previous HHC Response: “Billable services that have aged 150 days from dates of services are sent to a prelist/report for review; after 30 days of non-collection status, these accounts are automatically sent to the ambulatory Patient Accounts Managers for a thorough review as per Corporate policy. Bad debt designation is made after this final review is completed. Sr. Network VPs will enforce this procedure.”

Current Status : PARTIALLY IMPLEMENTED

As required by HHC’s *Third Party Policy-Ambulatory Care* manual, bills must be “followed up within 60 days from the date of service with a second bill if no response is received from the Plan.”

To determine the hospitals’ follow-up procedures for outstanding accounts we looked at the accounts in our sample that were outstanding for six months, as well as 10 sampled accounts from each of the hospitals, for patients discharged during Calendar Year 2001 that had outstanding accounts balances as of October 2002. Table V, following, shows the results.

Table V
Status of Accounts Outstanding Over Six Months

Hospital	Inpatient		Outpatient	
	Number of Sampled Accounts Outstanding for More than Six Months	Number (Percent) of Outstanding Accounts that Show Follow-up or Repeat billing	Number of Sampled Accounts Outstanding for More than Six Months	Number (Percent) of Outstanding Accounts that Show Follow-up or Repeat billing
Bellevue	14	14 (100%)	29	13 (45%)
Elmhurst	10	4 (40%)	19	6 (32%)
Kings County	10	3 (30%)	32	2 (6%)

Late posting of initial HMO payments appears to be limiting the HCIs' effectiveness in following up on unpaid accounts. Due to late postings of initial payments, HCIs were not able to determine which accounts were outstanding and needed to be followed up.

Previous Recommendation #13: "Track individual hospital collection rates, and hold them accountable and make them report on why they are not collecting."

Previous HHC Response: "On a monthly basis, the facilities A/R Collection rates are monitored and discussed at each Finance Committee Board meeting."

Current Status: IMPLEMENTED

HHC Central Office prepares reports on individual hospital collection rates to facilitate reviews of the effectiveness of HHC and individual hospital collection efforts. The collection rates are regularly monitored and discussed at Finance Committee Board meetings. Senior Network Vice-Presidents are held accountable for the collection rates at their hospitals.

Previous Recommendation #14: "The high level task force discussed in recommendation #4 should be directly responsible for ensuring that the necessary steps are taken to overhaul the billing system and to implement the recommendations made in this report."

Previous HHC Response: "See responses to recommendations four and five."

Current Status: IMPLEMENTED

HHC officials created an Ambulatory Care Task Force consisting of Senior Network Vice Presidents and key Central Office and facility finance staff members to closely check

operational issues. In addition, collection problems and recommendations are discussed periodically at Finance Committee Board meetings and those of various oversight committees, such as a Managed Care Oversight Committee and a Managed Care Policy Committee.

* * * *

Previous Finding: Sixty-five percent of the total services in the sample were improperly included in the MMC Accounts Receivable. Some of the services should have been included in the strictly Medicaid Accounts Receivable. This would have allowed HHC to bill and collect additional revenue owed from Medicaid. Other services should have been written off, since they were covered under capitation, which is not reimbursable.

- HHC always billed and posted charges greater than the expected amount to be reimbursed by HMOs.
- HHC improperly included 472 services (out of a sample of 1,476 services) in its MMC Accounts Receivable. The services should have been assigned to the HHC Medicaid Accounts Receivable because the patients were Medicaid patients when the services were performed. They were enrolled in MMC plans after the services were performed.
- Hospital staffers inaccurately posted some ancillary charges (laboratory and radiology services) to SMS. Consequently, some ancillary charges, which are not billable, were improperly posted to the MMC Accounts Receivable. This frequently resulting in unnecessary bills to the HMOs.
- Hospital staff members inaccurately recorded on SMS services covered under capitation. When a patient enrolls with an HMO, the HMO receives a monthly capitation fee from Medicaid toward the patient's care. This capitation fee is a monthly advance that is forwarded by the HMO to HHC to cover all contracted services. Therefore these services should not be billed to the HMO.
- Hospital staff members improperly billed the HMO instead of directly billing Medicaid for services referred to as "free access" (these include the Methadone Maintenance Therapy Program, Early Intervention Program, Directly Observed Therapy, and Termination of Pregnancy). Those services are not covered by HMOs and should be billed directly to Medicaid.
- HHC did not always write off ambulance charges in the sample, as required by HHC procedures, which state that ambulance charges are not billable to HMOs.
- HHC did not write off some of the "contractual balances" from the sample, as required by HHC procedures.
- In some cases, HHC hospital staffers incorrectly posted payments and adjustments to the SMS system.

Previous Recommendation #15: “Arrange for SMS to be programmed to indicate the Medicaid reimbursable rate for the appropriate service as opposed to the current practice of posting a different rate to ensure that SMS – and the MMC accounts receivable – reflects the true dollar amount due from the HMOs.”

Previous HHC Response: “As stated before, using posted charges for all payors is standard industry practice and is a generally accepted accounting practice within the industry. It is also more practical given that the insurance status of a patient may appear to be MMC at the time of service, but may at a later point, turn out to be a self-pay or Medicare patient. Using the posted charge to bill can facilitate adjustments required at a later date.”

Current Status: NO LONGER APPLICABLE

HHC is still recording posted charges instead of the expected reimbursement from HMOs. We verified that this is the standard for the hospital industry. Revenue is accrued based on a posted charge of a specific service to represent the cost for a service, including administrative expenses, and must be the same charge for every payer. A managed care company reimburses the hospital for the proportion of the cost based on a reimbursement rate. The difference between the charge and the rate, or the contractual allowance, is the amount of write-off.

Previous Recommendation #16: “Establish a data field in SMS to record the effective date for when a patient enrolls in an MMC plan. This data field should also allow HHC to record dates when a patient transfers from one HMO to another HMO to ensure that the appropriate HMO is billed.”

Previous HHC Response: “There are multiple insurance effective dates already available on the SMS files. The issue is the lack of an automated way of capturing these dates. The Corporation has already explored electronic feeding of enrollment dates from HMOs into the SMS system, but thus far we do not have that capability. The facilities must enter the effective date manually from their enrollment rosters when they register the patient.”

Current Status: IMPLEMENTED

In Fiscal Year 2001, HHC completed its installation in all HHC facilities of a managed care eligibility database, EMEVS (Electronic Medicaid Eligibility Verification System), which enables the staff to verify patients’ Medicaid and insurance eligibility status and identify primary care provider information online. This database is interfaced with the hospital patient registration system, called the UNITY system, of SMS.

Previous Recommendation #17: “Review the computer tapes provided by private vendors on ancillary services to ensure that the information they provide corresponds to the information on SMS.”

Previous HHC Response: “High volumes make it impossible to review a tape and would not only be impractical but would not prove beneficial. We are working with all vendors to ensure that records are formatted properly allowing for ancillaries to post to specific visits as opposed to an open unit causing floating ancillaries. Interfaces for demographic data have been modified to contain financial information.”

Current Status: NO LONGER APPLICABLE

HHC’s computer system, SMS, periodically performs automated “write-offs” or “blasts” for ancillary charges, such as laboratory, radiology, physical therapy, that are provided in conjunction with medical or hospital care, but are not billed by the hospitals to HMOs.

Previous Recommendation #18: “Ensure that HHC’s MMC Accounts Receivable only contains HMO billable services; thus, HHC should:

- (a) “Immediately review its MMC Accounts Receivable and program SMS to write off all services that do not belong on the MMC Accounts Receivable because they are not eligible for any reimbursement, especially the services identified by the auditors – such as ancillary charges, contractual balances, capitated charges, and ambulance charges – to prevent HHC’s Accounts Receivable from being cluttered and inflated by such information.
- (b) “Incorporate, for the long-term, monthly reviews of the MMC Accounts Receivable into HHC’s standard operating procedures. HHC should also program SMS to automatically write off services that do not belong to the MMC Accounts Receivable – such as ancillary charges, capitated charges, and ambulance charges that are not due from HMOs – to prevent HHC’s MMC Accounts Receivable from being cluttered and inflated by such information.”

Previous HHC Response: “The SMS System is already programmed to write-off contractual allowances and ambulance charges.

“Additionally, the SMS System is being programmed to perform year-end blasts on the MMC nonbillable ancillary charges, primary care visits, and other unreimbursable system generated charges.

“The Corporation requested from the MIS department a VOP review that would eliminate any errors in the hospitals’ files that might be preventing automatic write-offs from occurring.”

Current Status: IMPLEMENTED

SMS performs quarterly, automated “write-offs” of ancillary, capitated, ambulance charges and other non-billable charges to correct accounts receivable balances. SMS is also set up so that non-covered plan services are billed directly to Medicaid. According to HHC officials, in May 1998, “SMS performed a variable option file review to eliminate all system-generated errors and corrected MMC A/R balances.”

Previous Recommendation #19: “Conduct periodic reviews of the data contained on SMS to ensure that services specifically covered by Medicaid (even though the patient is MMC-eligible) are billed to Medicaid and not the HMO.”

Previous HHC Response: “The facilities were advised to review and update their files and procedures to ensure that excluded services (MMTP, Family Planning, etc.) are correctly billed to Medicaid.”

Current Status: IMPLEMENTED

The Revenue Management Unit periodically advises facilities to review and update files to ensure that certain services specifically covered by Medicaid (i.e., “carved-out” mental health and substance abuse services such as methadone maintenance and alcoholism rehabilitation) are directly billed to Medicaid.

* * * *

Previous Finding: The following issues did not directly affect HHC’s collection of receivables from HMOs, but they are operational weaknesses:

- HHC did not follow procedures in transferring services to bad debt. The procedures state that once a denial is received from the HMO on a patient’s bill, or if there was no response from the HMO 120 days after the date of service, the patient’s balance should be transferred to “self-pay” and billed to the patient. In addition, 180 days after the service date, the patient’s balance should automatically be written off to bad debt.
- The HHC hospital staff did not routinely obtain authorization numbers from the HMOs for all MMC patients seeking emergency room treatment. Nor did the hospital staff obtain HMO referral slips from the patients seeking non-emergency treatment at the different HHC specialty clinics.

Previous Recommendation #20: “Issue a memorandum to all hospitals reminding them about HHC’s bad debt policies.”

Previous HHC Response: “The Corporation is currently updating and will release its Ambulatory Care Finance policy manual. Bad debt write-off policies will be included in the manual.”

Current Status: NO LONGER APPLICABLE

According to the New York State Department of Health (DOH), hospitals, as Medicaid providers are prohibited from referring Medicaid recipients to a collection agency for unpaid bills when the provider has accepted the recipient as a MMC recipient and submitted the bill to the MMC plan for payment. HHC, as a provider, cannot transfer a MMC patient to “self-pay.” HHC does not have a corporate-wide policy on writing off MMC accounts to bad debt. However, individual hospitals write off any account determined to be uncollectible by transferring it into a “contractual allowance” account.

Previous Recommendation #21: “Routinely monitor HHC hospitals’ adherence to the above policies.”

Previous HHC Response: “The Finance Committee of the Board reviews financial performance indicators and objectives monthly. Additionally, Network Sr. VPs, as well as Executive Directors are held accountable to achieve revenue and expense budget targets.”

Current Status: IMPLEMENTED

As stated earlier, the Senior Network Vice Presidents and the Revenue Management Unit of HHC periodically monitor HHC hospitals’ adherence to its policies and procedures.

Previous Recommendation #22: “Require that hospitals collect and analyze the following information to determine whether the HMOs are properly reimbursing HHC for services provided to their MMC patients. Specifically, HHC’s hospitals should:

- (a) “Obtain valid authorization numbers and referral slips from the HMOs for all emergency room and specialty care visits, and record this information on SMS.
- (b) “Keep a record of all attempts made – on SMS – to obtain these valid authorization numbers and referral slips from HMOs.
- (c) “Where appropriate, post all payment denials and the reasons for such denials received from HMOs on SMS. HHC’s hospitals should also maintain copies of such denials, and record on SMS the services for which pre-authorization was obtained from HMOs and for which no payment or response was received.
- (d) “Conduct monthly analyses of services that were approved by the HMOs for which payments were denied. For these services, the staff should follow up with the HMOs and attempt to obtain reimbursement.
- (e) “Review the above information to identify and take the necessary action against any HMOs that routinely deny payment to HHC after pre-authorizing these

services.”

Previous HHC Response: “The items enumerated in this recommendation are already all incorporated in the Corporation’s Ambulatory/Emergency Care Operating Procedures and policy.

“These policies are all currently being reviewed, will be updated and redistributed in the Corporation’s Ambulatory Care Finance Policy Manual.

“The HHC Mission Statement/Mandate that we must provide medical care to MMC patients who refuses to seek care from their designated HMO providers will not change. We will work with those HMOs to educate their patients where choice rather than emergent care is available and/or needed.”

Current Status: IMPLEMENTED

To determine whether the managed care companies are properly reimbursing HHC for services provided to patients:

- Hospital staff members obtain valid authorization numbers for emergency room visits and referral slips for specialty care clinics, and document their attempts in SMS or patient account folders.
- HHC has procedures in place to ensure that denials of payment from HMOs are investigated. If an admission is denied or not fully paid based on lack of medical necessity, any correspondence received from the HMO are forwarded to the Utilization Review Department or Medical Records Department for their review.
- If, upon review, Utilization Review or Medicaid Records agrees with the HMO, the denial will be accepted. However, if either of these departments disagrees with the plan’s findings, the denial is contested, using the plan’s appeal or dispute resolution process.
- HHC identifies HMOs that routinely and inappropriately deny payment and take the necessary action against them, such as having their contracts terminated.

Recommendations:

HHC has implemented 11 recommendations and partially implemented three recommendations the previous report made; seven are no longer applicable. Of the 22 recommendations the previous report made, one has not been implemented. To address the problems noted in this report, HHC should implement the recommendations that were not fully addressed. We believe that upon implementation of these recommendations, HHC will have corrected the conditions cited in both the previous report and this follow-up report. The recommendations are repeated below, somewhat revised according to the findings of this report.

HHC should:

1. Develop procedures to ensure that outpatient bills are mailed and arrive at their destinations.

HHC Response: “[HHC will] develop certified mail return receipt procedures for bills that are not electronic.”

2. Develop formal collection procedures for inpatient accounts like those for outpatient accounts, as described in the HHC *Third Party Policy-Ambulatory Care Manual*. Ensure that hospitals adhere to these procedures.

HHC Response: “HHC will work on updating policy manuals for Inpatient third party collection.”

3. Consider using private collection agencies to pursue collection efforts for amounts owed to HHC by HMOs.

HHC Response: “Under General Counsel review to determine if our existing contracts permit the agencies to perform these functions.”

4. Require, prior to transferring services to “bad debt,” that hospitals review all relevant billing records to ensure that all required collection efforts were initiated.

HHC Response: “. . . we agree that facilities should review all billing data to ensure appropriate action has been taken. . . .”



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Addendum
Page 1 of 4

Benjamin Chu, M.D., M.P.H.
President

Control No. OIA 02-42

June 5, 2003

Mr. Greg Brooks
Deputy Comptroller, Policy, Audits, Accountancy and Contracts
The City of New York
Office of Comptroller
1 Centre Street, Room 1100 North
New York, New York 10007-2341

RE: DRAFT FOLLOW-UP AUDIT REPORT ON THE COLLECTION PRACTICES AND PROCEDURES OF THE HEALTH AND HOSPITALS CORPORATION RELATED TO MEDICAID MANAGED CARE/HEALTH MAINTENANCE ORGANIZATIONS (Audit # MD02-152F)

Dear Mr. Brooks:

Thank you for the opportunity to respond to the draft audit report concerning the Corporation's billing and collection practices and procedures related to Medicaid Managed Care/Health Maintenance Organizations. I was pleased to read that HHC has made significant improvements since the last report issued in October 1997.

As a Corporation, we are committed to continue to improve our existing processes regarding our billing functions and appreciate your independent appraisal of our systems. Our electronic submission of claims should continue to enhance our review and payment process with HMO companies. The Corporate Facilities, with guidance and assistance from Revenue Management, will take the necessary steps to implement the recommendations cited in the audit report.

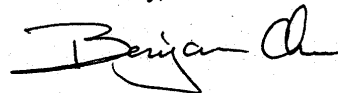
However, the recommendation to use private collection agencies to pursue collection efforts for amounts owed by HMOs for Medicaid patients will be referred to our Legal Department to determine if our existing contracts permit the agencies to perform these functions.

Mr. Greg Brooks
Deputy Comptroller, Policy, Audits, Accountancy and Contracts
June 5, 2003

Attachment I is HHC's response. **Attachment II** is the Audit Implementation Plan, which addresses all the recommendations cited in the report.

Should you have any questions concerning this response, please contact Mr. Alex Scoufaras, Assistant Vice President, Internal Audits at (212) 730-3123.

Sincerely,



Benjamin K. Chu, M.D.

Enclosures

CC: F.J. Cirillo, Senior Vice President, Operations
M. Zurack, Senior Vice President, Finance
J. G. Leon, Senior Vice President, Central Brooklyn Network
P. Velez, Senior Vice President, Queens Health Network
C. F. Perez, Senior Vice President, South Manhattan Network
J. Wool, Network Chief Financial Officer, Queens Health Network
A. Cohen, Network Chief Financial Officer, South Manhattan Network
G. Proctor, Chief Operating Officer/CFO, Kings County Hospital Center
D. Cates, Chief of Staff, Office of the President
A. Scoufaras, Assistant Vice President, Office of Internal Audits
M. Katz, Assistant Vice President, Revenue Management
B. M. Friedman, Inspector General
J. Rubin, Audit Manager, NYC Office of the Comptroller
C. Carino, Audit Supervisor, NYC Office of the Comptroller
M. Eichhorn, Auditor, NYC Office of the Comptroller
R. Bernstein, Senior Auditor, Mayor's Office of Operations
W. Otero, Corporate Assistant Director, Office of Internal Audits

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION
230 West 41st Street • New York, New York 10036**Maxine Katz**
Assistant Vice President
Revenue Management/Operations

DATE: June 2, 2003

TO: Alex Scoufaras
Assistant Vice President
Internal Audits

FROM: Maxine Katz *MK*

SUBJECT: CITY COMPTROLLER'S OFFICE FOLLOW UP AUDIT
ON MEDICAID MANAGED CARE

My office is in receipt of the City Comptroller's Office draft report of Medicaid Managed Care collection practices at Bellevue, Kings County and Elmhurst and we agree with the recommendations and findings with one caveat. We have referred to our General Counsel's office whether or not our existing collection agency contracts allow for the type of follow-up recommended.

I have indicated our implementation timeframes on the Audit Implementation Plan.

Let me know if you have any questions or require additional information.

MK/gl
cc: J. Huey
R. Nunez
W. Otero
M. Zurack

MAYOR'S OFFICE OF OPERATIONS
AUDIT COORDINATION AND REVIEW
AUDIT IMPLEMENTATION PLAN

ATTACHMENT II

PART A

Audit Title: Audit Report on HHC's Collection Practices and Procedures Related to Medicaid Managed Care/HMOs Date: October 6, 1997 Audit Agency: Office of the Comptroller
Agency: NYCHHC (OJA 02-42) Audit Date: MD02-152F OMB Control No: Bureau of Management Audit

RECOMMENDATION WITH WHICH THE AGENCY AGREES AND INTENDS TO IMPLEMENT	METHODS/PROCEDURES	IMPLEMENTATION TARGET DATE	PROGRAM IMPROVEMENTS/DOLLARS SAVINGS INCREASED REVENUE WITH TIME TABLE
<p>Recommendation # 1 HHC should develop procedures to ensure that outpatient bills are mailed and arrive at their destinations.</p>	<p>Develop certified mail return receipt procedures for bills that are not electronic.</p>	<p>12/31/03</p>	
<p>Recommendation # 2 HHC should develop formal collection procedures for inpatient accounts like those for outpatient accounts as described in the HHC Third-Party Policy Ambulatory Care Manual. Ensure the hospitals adhere to these procedures.</p>	<p>HHC will work on updating policy manuals for Inpatient third party collection.</p>	<p>6/30/04</p>	
<p>Recommendation # 3 HHC should consider using private collection agencies to pursue collection efforts for amounts owed to HHC by HMOs.</p>	<p>Under General Counsel review to determine if our existing contracts permit the agencies to perform these functions.</p>	<p>12/31/03</p>	
<p>Recommendation # 4 HHC should require, prior to transferring services to "bad debt," that hospitals review all relevant billing records to ensure that all required collection efforts were initiated.</p>	<p>Although we agree that facilities should review all billing data to ensure appropriate action has been taken, we require General Counsel review as to what action if any may be taken by a collection agency on a Medicaid eligible patient.</p>	<p>12/31/03</p>	