NEW YORK CITY HEALTH AND HOSPITALS CORPORATION

COLLECTION PRACTICES FOR INPATIENT BILLS

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Luis R. Marcos, M.D.
President
New York City Health and Hospitals Corporation
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New York, NY 10013

Dear Dr. Marcos:

The following is our audit report addressing collection practices for inpatient bills at three acute care hospitals of the Health and Hospitals Corporation: the Harlem Hospital Center, the Jacobi Medical Center, and the Kings County Hospital Center.

This audit was performed pursuant to the State Comptroller’s authority as set forth in Article V, Section 1 of the State Constitution; Article II, Section 8 of the State Finance Law; and Article III of the General Municipal Law. The major contributors to this report are listed in Appendix A.

March 30, 2001
New York City Health and Hospitals Corporation
Collection Practices for Inpatient Bills

Scope of Audit

The New York City Health and Hospitals Corporation (HHC) operates New York City’s municipal hospital system, which includes 11 acute care hospitals as well as other healthcare facilities. For the fiscal year ended June 30, 1999, HHC hospitals reportedly billed $739 million for inpatient services. When payment for a bill cannot be collected, the bill may be referred to one of several private collection agencies. For the year ended June 30, 1999, about 30,000 HHC inpatient accounts, totaling $218 million, were referred to collection agencies. A total of $53.5 million of this amount was collected by the agencies.

Our audit addressed the following question about collection practices for inpatient bills at three HHC hospitals (the Harlem Hospital Center, the Jacobi Medical Center, and the Kings County Hospital Center) for the period July 1, 1997 through March 31, 2000:

- Can improvements be made in hospital collection practices that would result in greater collections of inpatient revenue?

Audit Observations and Conclusions

We found that many of the unpaid bills the hospitals referred to collection agencies could have been collected by the hospitals instead. If improvements were made in hospital collection practices, payments on unpaid bills would have been received in a more timely fashion, collection agency fees would have been reduced and net revenues to the hospitals would have been increased.

According to HHC guidelines, hospitals should ensure that all reasonable efforts to collect bills have been made before accounts are referred to a collection agency. To evaluate the adequacy of the collection practices at the three hospitals, we compared the actions taken by the hospitals in unsuccessfully trying to collect on certain accounts to the actions taken by collection agencies in successfully collecting on the accounts. We found that, for 71 of 100 randomly selected accounts that we evaluated, the successful actions taken by the collection agencies were the kinds of actions that the hospitals’ collection staff were expected to take and frequently entailed nothing more than thorough or persistent efforts to confirm the patient’s eligibility for Medicaid. We conclude that the hospitals could have collected the 71 accounts, and therefore could have expedited the collection of $385,000 in unpaid bills and saved the $83,900 in fees that were paid to the collection agencies for these accounts. (See pp. 5-9)

During the year ended June 30, 1999, the fees paid by HHC to collection agencies for inpatient collections totaled $11.7 million, of which about 70 percent ($8.2 million) related to collections made from Medicaid. HHC
hospitals contain units dedicated to determining whether patients are eligible for Medicaid coverage and payment is relatively easy to collect once this eligibility has been determined. If collection practices at the other eight HHC acute care hospitals are similar to the practices at the three hospitals addressed by our audit, improvements in collection practices could lead to significant reductions in the multi-million dollar fees paid to collection agencies. (See p. 9)

Once an inpatient account has been deemed uncollectible, the hospital should promptly refer the account to a collection agency. However, for the accounts we sampled at the Jacobi, Harlem and Kings County hospitals, we found that an average of 49 days, 33 days and 31 days, respectively, elapsed between the date the hospital classified the account as uncollectible and the date the hospital transferred the account to the collection agency. Such delays further impair the collectibility of unpaid accounts. (See p. 10)

We made two recommendations to address the deficiencies in collection practices which we identified in this report.

Comments of HHC Officials

HHC officials acknowledged there is room for improvement in hospital collection practices for inpatient billings and agreed with our recommendation that hospitals improve collection efforts before unpaid bills are referred to collection agencies. HHC officials did not agree with our recommendation that hospitals transfer uncollectible accounts to collection agencies in a more timely fashion. A complete copy of HHC’s response is included as Appendix B to this report. State Comptroller’s Notes, addressing matters contained in HHC’s response, are included as Appendix C.
Contents

Introduction

- Background .......................................... 1
- Audit Scope, Objective and Methodology ................. 3
- Response of HHC Officials ............................... 4

Collection Practices ........................................ 5
- Recommendations ....................................... 10

Appendix A  Major Contributors to This Report

Appendix B  Response of Health and Hospitals Corporation Officials

Appendix C  State Comptroller’s Notes
**Introduction**

**Background**

The New York City Health and Hospitals Corporation (HHC) was created in 1970 to operate New York City’s municipal hospital system, which provides comprehensive medical, mental health and substance abuse services to City residents regardless of their ability to pay. HHC operates the largest municipal hospital system in the nation, with about three times as many beds as its nearest counterpart. HHC’s facilities include 11 acute care hospitals, 4 long-term care facilities, 6 Diagnostic and Treatment Centers, 7 Communicare Centers (which are community-based facilities that provide preventive care for all members of a family), 46 Child Health Clinics and 6 Oral Health Clinics.

For the fiscal year ended June 30, 1999, HHC reported that its emergency rooms handled nearly 1 million health emergencies, its clinics treated about 5 million patients, and its hospitals provided care to about 216,000 inpatients. During this year, about $4.1 billion in total revenue was reported by HHC, and the amount billed for inpatient services reportedly totaled about $739 million.

The inpatient billing and collection practices of HHC’s 11 acute care hospitals are overseen by the HHC Central Office. Before a bill can be generated for inpatient services, the hospital must determine what services were provided to the patient, and who will pay for these services (Medicaid/Medicare, a private insurance company, or the patient). This information then must be entered into HHC’s automated accounting and billing system. The information relating to medical services is determined by the hospital’s Medical Record Department. Once the medical services are identified, the appropriate billing rates can be applied to these services.

The information relating to the payor is determined by the hospital’s Patient Accounts Department, as one of the Department’s Hospital Care Investigators (HCIs) interviews the patient upon admission to the hospital, and another HCI subsequently verifies the information received from the patient and obtains any additional information that is needed to identify the most likely payor for the services provided to the patient. Since many of the inpatients at HHC hospitals are covered by Medicaid, each hospital has a Medicaid Assistance Program Unit, which processes Medicaid applications for hospital inpatients and records the services provided to Medicaid recipients on New York State’s Medicaid system. This Unit, which is operated by the New York City Human Resources Administration, can help the hospitals promptly determine whether patients are covered by Medicaid and facilitate prompt payment for the services provided to these patients. According to HHC officials, their
bills to Medicaid are usually paid within two weeks of billing.

After the bill is issued, the account is monitored by another HCI in the Accounts Receivable Unit of the Patient Accounts Department. If payment cannot be obtained within a reasonable amount of time (generally 120 days), the account is to be classified as uncollectible and is generally referred to a private collection agency. If the account is found to be uncollectible before 120 days have passed (e.g., if mail addressed to the patient is returned unopened), it may be referred to a collection agency as soon as it is determined to be uncollectible. A number of collection agencies contract with HHC, and accounts are referred to the agencies on the basis of the surname on the account (each collection agency is assigned a portion of the alphabet). The collection agency is generally given about nine months to collect on an account, though accounts may be kept open longer if collection is still considered possible by the agency. The payors contacted by the collection agencies are instructed to remit payment to HHC, and the agencies are paid 21.8 percent of the collected amount by HHC.

For the fiscal year ended June 30, 1999, about 30,000 HHC inpatient accounts, totaling $218 million, were written off as uncollectible and referred to collection agencies. The agencies, which collected $53.5 million of this amount, were paid $11.7 million for their services.

As is the practice in the hospital industry, the amounts billed by HHC for inpatient services are often greater than the amounts insurers are willing to reimburse for the services. As a result, when HHC receives payment on a bill for inpatient services, it often receives less than the full amount billed for the services. Accordingly, the amount billed by HHC for inpatient services routinely overstates, to some extent, the amount of revenue HHC is likely to receive for the services, even if payment is received for every service provided. Despite this overstatement, in our report, we describe HHC inpatient accounts in terms of their full billed amounts, and not in terms of the amounts that are likely to be paid by insurers, because the accounts are described in HHC records in terms of their full billed amounts, and not in terms of the amounts that are likely to be paid by insurers.
Audit Scope, Objective and Methodology

We audited selected collection practices for inpatient bills at three HHC acute care hospitals for the period July 1, 1997 through March 31, 2000. The three hospitals addressed by our audit were the Harlem Hospital Center, the Jacobi Medical Center, and the Kings County Hospital Center. We selected these hospitals because statistics showed that two of them (Harlem and Kings County) had high percentages of their inpatient bills collected by collection agencies, while one (Jacobi) had among the lowest percentages of inpatient bills collected by collection agencies. The objective of our performance audit was to determine whether improvements can be made in these practices that would result in greater collections of inpatient revenue. To accomplish this objective, we interviewed officials and reviewed records at the three hospitals and at the HHC Central Office.

In particular, for each of the three hospitals, we reviewed records relating to 35 randomly selected accounts that had been collected by collection agencies during the 1998 and 1999 calendar years. The objectives of this review were to (1) identify the actions taken by the hospitals in unsuccessfully trying to collect on these accounts, (2) identify the actions taken by the collection agencies in successfully collecting on the accounts, and (3) evaluate whether the actions taken by the collection agencies could reasonably have been taken by the hospitals before the accounts were referred to the agencies for collection.

We conducted our audit in accordance with generally accepted government auditing standards. Such standards require that we plan and perform our audit to adequately assess those operations of HHC which are included in our audit scope. Further, these standards require that we understand HHC’s internal control structure and compliance with those laws, rules and regulations that are relevant to the operations which are included in our audit scope. An audit includes examining, on a test basis, evidence supporting transactions recorded in the accounting and operating records and applying such other auditing procedures as we consider necessary in the circumstances. An audit also includes assessing the estimates, judgments and decisions made by management. We believe our audit provides a reasonable basis for our findings, conclusions and recommendations.

We use a risk-based approach to select activities for audit. We therefore focus our audit efforts on those activities we have identified through a preliminary survey as having the greatest probability for needing improvement. Consequently, by design, we use finite audit resources to identify where and how improvements can be made. We devote little audit effort to reviewing operations that may be relatively efficient or effective. As a result, we prepare our audit reports on an “exception
basis.” This report, therefore, highlights those areas needing improvement and does not address activities that may be functioning properly.

Response of HHC Officials

Draft copies of this report were provided for review and comment to HHC officials. Their comments have been considered in preparing this report and are included as Appendix B. Appendix C contains State Comptroller’s Notes, which address matters contained in HHC’s response.

Within 90 days after final release of this report, we request the President of the Health and Hospitals Corporation report to the State Comptroller, advising what steps were taken to implement the recommendations contained in this report, and where recommendations were not implemented, the reasons therefor.
Collection Practices

Once a bill has been issued for the services provided to an inpatient, the account should be monitored by the Accounts Receivable Unit of the hospital’s Patient Accounts Department. If payment cannot be collected by the hospital, the bill may be referred to one of the private collection agencies under contract to HHC. According to HHC guidelines, the Patient Accounts Department should “. . . ensure that all reasonable efforts to collect have been made by the hospital prior to collection agency referral.” Reasonable efforts include “. . . timely interviews and follow-up regarding a patient’s ability to pay the hospital bill, determinations of third party health insurance eligibility, documentation of efforts, and aggressive pursuit with insurance payors.”

To evaluate the adequacy of the collection practices of the three hospitals addressed by our audit, we selected for review inpatient accounts that were unable to be collected by the hospitals and had been referred to collection agencies, and had been collected by the agencies during the 1998 and 1999 calendar years. For each hospital, we randomly selected 35 such accounts (105 accounts in total). We compared the actions taken by the hospitals in unsuccessfully trying to collect on these accounts to the actions taken by the collection agencies in successfully collecting on the accounts, and evaluated whether the actions taken by the collection agencies could reasonably have been taken by the hospitals before the accounts were referred to the agencies for collection.

In conducting our review, we examined the collection activities documented in the files submitted to HHC by the collection agencies, and the collection activities of the HCIs documented in the records maintained by the three hospitals’ Patient Accounts Departments. Since the collection agency files for 5 of the 105 accounts selected for review either were not provided to us by HHC until after our audit field work was completed or did not adequately document the actions taken by the collection agencies, our review of collection practices did not include these five accounts.

We found that, for 71 of the remaining 100 accounts, the successful actions taken by the collection agencies could reasonably have been taken by the hospitals before the accounts were referred to the agencies for collection. We therefore conclude that, if the hospitals had been more active in pursuing the collection of these accounts, all 71 accounts could have been collected by the hospitals. The results of our review are summarized in the following table:
As is shown in the table, most of the accounts at each hospital could have been collected by the hospital’s Patient Accounts Department. In the 29 accounts that could not have been collected by the hospitals, the actions taken by the collection agencies in obtaining payment from patients or insurers (such as visiting the patients in their homes or threatening legal action if payment was not made) could not have been taken by the hospitals, because the HCIs are not allowed to take these actions (for example, according to HHC guidelines, the HCIs are required to stay at the hospital when they follow up on unpaid bills). However, in the other 71 accounts, the actions taken by the collection agencies were the kind of actions that HCIs are expected to take when following up on unpaid accounts, and frequently entailed nothing more than thorough or persistent efforts to confirm the patient’s eligibility for Medicaid. For example:

- In one account, the patient was discharged from the Harlem Hospital Center on October 18, 1998. There was no indication in the Patient Account Folder that staff from the Patient Accounts Department tried to contact the patient until December 14, 1998, when an HCI telephoned the patient and was told by a friend of the patient that the patient was out of the country. On February 26, 1999, mail sent to the patient by the hospital was returned to the hospital as undeliverable because the addressee was not known. No further follow-up activities are documented in the Patient Account Folder, and the account was classified as uncollectible on March 4, 1999. There was no indication in the Patient Account Folder that an attempt was ever made to process a Medicaid application for the patient. According to the file submitted by the collection agency, the agency obtained the necessary medical information from the hospital, verified the patient’s address and completed a Medicaid
application for the patient. The patient was ruled eligible for Medicaid, Medicaid was billed, and the hospital was paid $1,229 by Medicaid.

- In another account, the patient was discharged from the Jacobi Medical Center on March 11, 1998. The initial investigation by the Patient Accounts Department showed that the patient did not have any insurance, and the HCI offered to help the patient prepare a Medicaid application. According to the records, the patient’s mother was contacted by telephone twice during April 1998 in an unsuccessful effort to complete the Medicaid application. On April 27, 1998, the bill was sent directly to the patient. On June 1, June 26, July 14, and August 5, 1998, the HCI tried to phone the patient, but the patient’s telephone number was disconnected. There was no indication that the HCI tried to call the patient’s mother again after April. On September 20, 1998, the account was transferred to a collection agency. According to the collection agency notes, the agency first tried to contact the patient at the disconnected telephone number, but later phoned the patient’s mother, who was cooperative and provided the documents needed to complete the Medicaid application. Medicaid was billed, and on February 16, 1999, the hospital was paid $18,250 by Medicaid.

- In another account, the patient (a 24-month old baby) was discharged from the Kings County Hospital Center on February 1, 1999. According to the Patient Account Folder, when the patient’s mother was interviewed, she stated that she was covered by Medicaid but did not have her identification card. The HCI made several attempts to contact the mother, and checked the Medicaid system for eligibility. According to notes in the Folder, the patient’s mother was eligible for Medicaid, but the child was not eligible. Consequently, the bill was sent directly to the mother. However, the mother did not respond to the bill and could not be contacted. On July 20, 1999, the account was transferred to the collection agency, whose investigator contacted Medicaid and secured an eligibility number for the patient on August 24, 1999. Medicaid was billed, and on September 8, 1999, the hospital was paid $4,611 by Medicaid.

- In another account, the patient was discharged from the Jacobi Medical Center on October 5, 1998. The initial investigation by the Patient Accounts Department showed that the patient did not have any insurance, and the HCI offered to help the patient prepare a Medicaid application. An appointment with the patient was set for October 14, 1998, but the patient did not keep the appointment. On
October 21, 1998, another call was placed to the patient, but no one answered the telephone. On November 5, 1998, it was decided to make the account self-pay, and the patient was billed directly for $5,600. On February 8, 1999, the patient was telephoned, but the person who answered stated that the patient did not live at that residence. According to documentation in the Patient Account Folder (a printout from the New York State Welfare Management System), the patient was eligible for Medicaid. However, Medicaid was not billed. The account was transferred to the collection agency on April 20, 1999. According to the collection agency notes, the investigator saw the printout indicating Medicaid eligibility in the Patient Account Folder, and billed Medicaid. On May 10, 1999, 20 days after the account was transferred to the collection agency, the hospital was paid $3,710 by Medicaid.

We analyzed the 71 accounts that could have been collected by the three hospitals, if the hospitals had been more active in pursuing collection, to determine which parts of the hospitals’ collection process were in need of improvement. We concluded that, in 54 of the 71 accounts, improvements were needed in the actions taken by HCIs in attempting to identify the party to be billed (Medicaid/Medicare, a private insurance company, or the patient), and in all 71 accounts, improvements were needed in the actions taken by HCIs in following up on the bill after it had been issued.

Our analysis of the 71 accounts is summarized by the following table:
The fees paid to the collection agencies for collecting the 71 accounts totaled about $83,966 (21.8 percent of the $385,167 collected on the accounts). Therefore, if the hospitals had been more active in pursuing the collection of the accounts and had made the collections instead of referring the accounts to the collection agencies, they would have saved a total of $83,966 on these 71 accounts alone.

In addition, if collection practices at the other eight HHC acute care hospitals are similar to the practices at the three hospitals addressed by our audit, improvements in these practices could lead to significant reductions in the fees paid by HHC to collection agencies for inpatient collections. During the year ended June 30, 1999, these fees totaled $11.7 million, of which about 70 percent ($8.2 million) related to collections made from Medicaid. Since HHC hospitals contain units dedicated to determining whether patients are eligible for Medicaid, and since payment is relatively easy to collect once this eligibility has been confirmed, a significant portion of the $8.2 million in fees might be saved if hospital collection practices were improved.

Moreover, if the three hospitals addressed by our audit had been more active in pursuing the collection of the 71 accounts and had made the collections (which totaled $385,167) themselves instead of referring the accounts to the collection agencies, they would have collected the $385,167 much sooner. Any such acceleration of the collection process would be advantageous to HHC’s cash flow.

We note that improvements could be made in hospital collection practices if collection agency files were routinely reviewed to identify the practices that were effective for the agencies. Such reviews were not conducted at the three hospitals addressed by our audit.

Once an account is determined to be uncollectible by a hospital’s Patient Accounts Department, it should be transferred promptly to the appropriate collection agency. However, when we analyzed the processing times for the

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Accounts That Could Have Been Collected</th>
<th>Deficiencies in Identifying Party To Be Billed</th>
<th>Deficiencies in Following Up on Bill</th>
</tr>
</thead>
<tbody>
<tr>
<td>Harlem</td>
<td>25</td>
<td>19</td>
<td>25</td>
</tr>
<tr>
<td>Jacobi</td>
<td>21</td>
<td>20</td>
<td>21</td>
</tr>
<tr>
<td>Kings County</td>
<td>25</td>
<td>15</td>
<td>25</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>71</strong></td>
<td><strong>54</strong></td>
<td><strong>71</strong></td>
</tr>
</tbody>
</table>
105 accounts that were selected for review, we found that all three hospitals were not as prompt as they could have been in transferring these accounts to collection agencies, as follows:

- At the Jacobi Medical Center, an average of 49 days elapsed between the date the account was classified as uncollectible and the date the account was transferred to the collection agency.

- At the Harlem Hospital Center, an average of 33 days elapsed between the date the account was classified as uncollectible and the date the account was transferred to the collection agency.

- At the Kings County Hospital Center, an average of 31 days elapsed between the date the account was classified as uncollectible and the date the account was transferred to the collection agency.

Such processing delays may make unpaid accounts even more difficult to collect, as patients may become more difficult to locate and insurers’ time limits (such as the two-year limit imposed by Medicaid) may be more likely to be exceeded.

### Recommendations

1. Develop an action plan for improving the effectiveness of Patient Accounts Departments in collecting on unpaid bills for inpatient services. As part of this plan, ensure that the Departments adequately follow up on unpaid bills, and routinely review the files submitted by collection agencies to identify effective collection practices.

2. Transfer accounts to the appropriate collection agency as soon as possible after they are classified as uncollectible.
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1. According to HHC’s guidelines, hospital personnel should ensure that all reasonable efforts are made to collect bills before they are referred to a collection agency. HHC defines reasonable efforts to include follow-up regarding a patient’s ability to pay, determinations of third party health insurance eligibility and aggressive pursuit with insurance payors. While obtaining Medicaid can be a complex process, our findings illustrate that collection agency personnel were effective in securing Medicaid eligibility for HHC patients by taking such reasonable actions as phoning the patient’s mother for information, contacting the Medicaid office to obtain an eligibility number, and using eligibility information available in the Patient Account Folder.

2. The objective of our audit was to determine whether improvements could be made in hospital collection practices. Our findings demonstrate that improvements can be made and these improvements would increase HHC’s revenue by reducing collection agency fees and improving cash flow. Further, our methodology, which involved a random selection of accounts collected by collection agencies, was appropriate and directly supportive of our audit objective. We note that HHC officials agree hospitals can improve their collection efforts prior to referring accounts to collection agencies.

3. Our audit does not suggest that HHC not use collection agencies to support and enhance collection practices. The major finding of our audit is that HHC personnel can do a better job of collecting inpatient bills before they are referred to collection agencies. Additionally, our report recognizes actions taken by collection agencies in obtaining payment from patients or insurers that could not have been taken by hospital personnel.

4. We met with Jacobi Medical Center officials on November 16, 2000 to discuss our preliminary audit findings. At the meeting, we agreed to reduce the number of accounts to which we took exception to 21 from 25. However, we did not agree that Jacobi staff could have collected only seven of the 21 accounts before they were referred to collection agencies. We continue to maintain that Jacobi staff could have collected all 21 accounts.

5. As stated in Note 4, we revised our preliminary audit findings based on our meeting with Jacobi officials. One of the four cases we eliminated was the one that required 1,062 days for the collection agency to obtain payment. It should be noted the collection agencies managed to collect all 21 accounts, even though Jacobi staff held 13 of the 21 accounts for a longer time period than the collection agencies took to collect them.
6. As stated in our report, the Jacobi, Harlem and Kings County hospitals took an average of 49, 33 and 31 days, respectively, to transfer accounts to a collection agency after they were deemed uncollectible. Jacobi Medical Center staff did not transfer 10 of 34 accounts to collection agencies for at least 60 days after they were deemed uncollectible. Such delays make unpaid accounts more difficult to collect. Hence, we maintain that HHC officials should implement our recommendation to transfer accounts to a collection agency as soon as possible after they are classified as uncollectible.

7. We amended our report accordingly.

8. As stated in our report, the collection agency obtained the required information to process the Medicaid application, and the hospital was subsequently paid $1,229.