



San Mateo Medical Center Billings and Collections

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Summary

The San Mateo Medical Center (SMMC) suffered financial losses in fiscal year 2002 of \$9 million. Internal and external audits for that period identified specific issues with billings and collections practices including the timeliness of billing and lack of controls to ensure billings for all services. When these audits became available in spring of 2003, the Grand Jury recommended that the billings and collections practices be investigated to ensure that the financial interests of the County were being adequately served.

The Grand Jury concluded that the billings and collections practices at SMMC are not fully serving the financial interests of the County at this time. SMMC has made substantial improvements over the past 18 months in its billings and collections practices. It has increased management focus, introduced performance measures and targets, implemented systems improvements, and developed more disciplined processes. These changes have helped build a platform upon which additional advances can be made. However, a significant gap still exists between SMMC's performance and what could be achieved assuming best practices.

The Grand Jury further concluded that by setting aggressive targets in key areas; tracking performance and rewarding achievement; by designing and implementing initiatives with cross-departmental participation; and by focusing on continuous process and system improvement, SMMC could capture nearly \$13 million in incremental revenue annually and increase cash flow by an additional \$5 million based on fiscal year 2003 performance.

Key recommendations of the Grand Jury include:

- Benchmarking performance against comparable medical centers by October 1st, 2004.
- Developing and publishing a strategic plan by October 31st, 2004, for billings and collections that includes:
 - aggressive targets for accuracy of registration information, timeliness of billings, accuracy of submissions of billings to insurance providers, and magnitude of write-offs by insurance provider
 - initiatives to reach targets that include integrated plans for training, tie-in with performance evaluation, tracking and systems changes.

- Ensuring the “Revenue Committee”, a group of representatives from the revenue producing departments of SMMC, regularly meet and review progress against targets and assess effectiveness of on-going initiatives.
- Analyzing the performance of SMMC’s collections agency, Revenue Services, by October 1st, 2004, and experimenting with moving patient account balances to that service more quickly.
- Establishing a pre-registration pilot program during FY ’05.
- Evaluating the use of incentive or bonus programs for employees based on achieving billings and collections goals.
- Making payment easier for patients and their families by providing accurate directions to a conveniently located Cashier’s Office.



San Mateo Medical Center Billings and Collections

Issue

Do the billings and collections practices and performance at the San Mateo Medical Center adequately serve the financial interests of the County?

Background

The San Mateo Medical Center (SMMC) is a public, county-supported hospital and network of clinics providing emergency, medical/surgical, locked psychiatric, long term care, imaging, pharmacy, and laboratory services. As a county hospital, SMMC must accept every patient for whom services are available, regardless of the patient's ability to pay. For providing this mandated care for the uninsured and indigent population of San Mateo County, a portion of SMMC's costs are subsidized by the County. The County is also responsible for any additional financial shortfall.

SMMC experienced financial losses in fiscal year 2002 (July 2001 through June 2002) of \$9 million. Financial performance dropped during construction and transition into a new building and ongoing conversion to new computer systems. Internal and external audits for that period identified specific issues with billings and collections practices including the timeliness of billing and lack of controls to ensure billings for all services. When these audits became available in spring of 2003, the Grand Jury recommended that the billings and collections practices be investigated.

The focus of this investigation was to identify opportunities for improvement in billings and collections practices that could impact "net patient service revenue" to SMMC either by (a) increasing the amount of revenue that can be collected and/or (b) collecting that revenue more quickly. The "net patient service revenue" is the estimated net realizable amount to be collected from patients, third party payors, and others for services provided by SMMC.

The Grand Jury reviewed financial data, selected documented procedures, and recent financial and systems audits of SMMC. Interviews were conducted to explore, compare and analyze methods of billing and collecting for the services provided with SMMC senior management and financial officers and staff, MediCal personnel, Revenue Services personnel, and senior management at another California county hospital and one local private hospital.

This document is organized as follows:

Findings

Section 1: The Financial Opportunity

Section 2: The Billings and Collections Process

Section 3: The Billings and Collections Performance

Section 4: Improvements Implemented by SMMC

Conclusions

Recommendations

Findings

During fiscal year 2003 (FY '03), SMMC had approximately 46,000 total patient care days, 194,000 clinic cases, and 32,000 Emergency Room visits. Total revenues were \$141.8 million with net income of \$6.2 million after the County's contribution of \$51.2 million.¹ Of the \$141.8 million in total revenue, approximately 42% or \$59.2 million was from net patient services revenue (referred to as net revenue in the balance of the document).²

SECTION 1: The Financial Opportunity

While SMMC has made progress improving its billings and collections practices since FY '02 (see Section 4), the Grand Jury found that additional opportunities exist for improvement. These improvements can impact financial performance, allowing SMMC to collect more revenue and to collect that revenue more quickly.

Collect More Revenue

For FY '03, SMMC had \$59.2 million in net revenue from \$173.8 million in total charges for services delivered³ or only 34 cents on every \$1 charged. A number of factors contribute to the difference between the total charges and the net revenue. These factors include contractual discounts, charity, bad debt, administrative losses, and insurance denials. See Chart 1: Estimated Breakdown of Total Charges.⁴

¹ The County's contribution includes a county subsidy (\$26.6 million) and funds from the sales tax (\$3.7 million), the realignment subsidy – vehicle license fees (\$12.4 million), and the tobacco settlement (\$8.5 million). During FY '03, SMMC repaid \$25.3 million to the County for previous advances. This was possible because of strong cash flow in FY '03 in large part due to a one-time MediCal adjustment and increased collections of Senate Bill (SB) 1732 and 855 reimbursements.

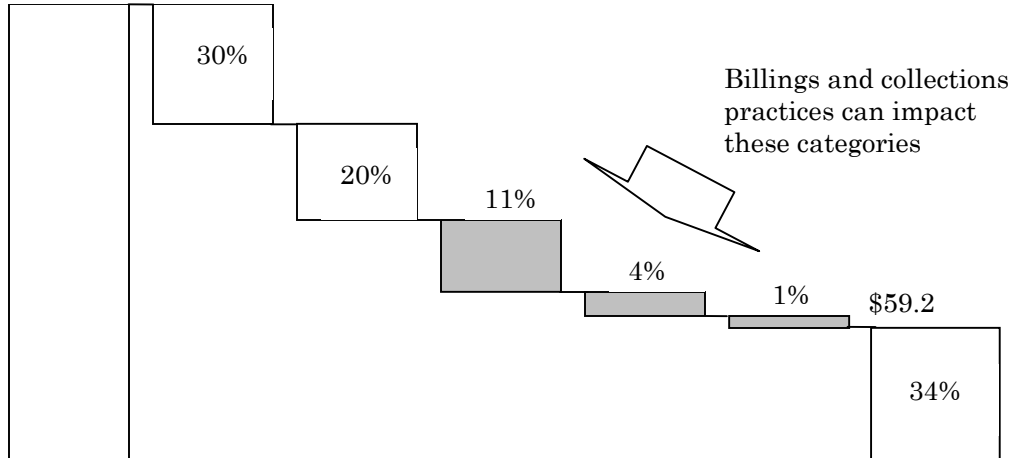
² The balance of the revenue was from pharmacy, sales of drugs and medical supplies, SB-855 state aid program revenues, and other non-operating revenue sources.

³ Referred to as “gross charges” by SMMC.

⁴ The methodology used to estimate the \$ amount of each factor was to (a) calculate the total \$'s for each factor using the monthly percentages on the Monthly Patient Financial Services Key Indicators and multiplying by the relevant three-month gross revenue averages from the CORE report, and then (b) apply those relative percentages across the factors to the difference between the amount of total charges and the net revenue.

CHART 1: Estimated Breakdown of Total Charges for FY '03

100% = \$173.8 million



\$ Total Net	Contract	Charity	Bad Debt	Admin	Insurance
(\$ Millions)					
173.8	51.1	34.9	18.8	7.3	2.5

Source: Financial Reports from SMMC

Explanation for each category of uncollectible revenue or “write off”:

- **Contract Discounts** - 30% of the total charges are not expected to be collected due to contractual agreements with third parties who pay on behalf of the patients based on negotiated discounts or reduced charges.
- **Charity** - 20% of the total charges are classified as Charity when a patient is deemed incapable of paying and no third party coverage can be identified. In that case, the County “reimburses” SMMC for the services through its indigent care subsidization program.
- **Bad Debt** - nearly 11% of total charges are considered bad debt when a patient is deemed capable of paying but SMMC is unable to collect. Assuming SMMC reached its target of 5% of total charges as bad debt, \$10.1 million additional net revenue could be realized.
- **Administrative Losses** - approximately 4% of total charges are adjustments made by SMMC for the difference between charged and reimbursed amounts associated with a patient’s account. These may include charges for services that are not covered as well as charges entered after the claim has been submitted (i.e., late charges). SMMC estimates that about 30% of these losses, or \$2.2 million, could be “avoided” based on a decrease in late charges and timelier follow-up.
- **Insurance Denials** -- more than 1% of total charges are insurance denials that occur when a service is billed but the insurance company or government program refuses

to pay. Denials include Utilization Review denials because the payor did not consider the patient in need of certain services. Denials can also be the result of the provider not getting authorization prior to delivering services. SMMC estimates that 15 to 20% of total insurance denials, or \$0.4 million to \$0.5 million, could have been avoided had prior authorization been obtained.

SMMC does not expect to collect the 30% of total charges classified as contractual discounts or the 20% classified as charity. This analysis assumes that SMMC is doing a thorough job seeking insurance coverage for incoming patients and that all “charity” is in fact for patients who cannot get coverage and who do not have the resources to pay for the services. The classification of such accounts is an area that has not been audited by the Controller’s office.

With improvements in its billings and collections practices, SMMC could collect some portion of the 16% of total charges classified as bad debt, administrative losses and insurance denials. Based on SMMC’s own estimates, approximately \$12.7 million in additional net revenue could be realized, an increase of 21% over the net revenue for FY ’03.

Collect Revenue More Quickly

If SMMC could accelerate the billings and collections process, it would experience three benefits:

- ensure greater likelihood of ultimate bill payment,
- reduce the cost of collection, and
- make more cash available for other uses.

Once a patient has received services, SMMC begins the billings and collections process. At any given time, a certain amount of revenue has been recorded but has not yet been collected; this amount is categorized as accounts receivable. An industry standard benchmark for measuring the effectiveness of managing accounts receivable is gross accounts receivable days (gross AR days or just AR days in this report). This number is the total dollars in accounts receivable divided by the average daily gross revenue.⁵ One way to think about this number is as the average length of time it takes for a bill to be paid. Ideally, AR days should be as low as possible while ensuring optimal collections.

As of January 31st, 2004, accounts receivable for SMMC were approximately \$63 million. This represents 97 AR days⁶. If AR days were reduced to the current SMMC target of 74 days, approximately \$5 million in additional cash would be made available while increasing the likelihood of collecting more revenue at a reduced cost.⁷

⁵ Average daily gross revenue is calculated by taking the total gross billed services for the most recent 3 months and dividing by the number of days in those 3 months.

⁶ Average daily gross revenue of the most recent three months for this period was approximately \$0.65 million. The accounts receivable balance of \$63 million excludes \$3.6 million classified as bad debt. Including this amount would increase gross AR days to 102.

⁷ Assumes 34% of gross receivables is collected.

SECTION 2: The Billings and Collections Process

The standard process for SMMC billings and collections is described below and is diagrammed in Appendix A. This process does not include all of the potential complexities but does serve as a useful framework for discussing opportunity areas.

The billing cycle begins when a patient registers. During registration, personal information is collected and insurance coverage is checked. If the patient has insurance, SMMC checks to see if the service or procedure is covered and seeks authorization (if necessary) for the treatment. If no insurance can be identified for the patient within 5 days, SMMC's Community Advocates work to check for eligibility in other programs.

Once the services are delivered, the internal billing process begins. The necessary information is collected and the bill or claim is prepared. The bill or claim is then transmitted either electronically or by mail to the primary payor of the patient. The primary payor is the first entity that is responsible for paying for all or some portion of the treatment. This payor can be an insurance company, a government program or the patient in the event that no insurance or program has been identified. If the bill is being sent to a payor who is an entity paying on behalf of the patient, the bill is called a claim. After the primary payor has processed the claim, SMMC reconciles its accounts and sends a claim for any balance of the services to the secondary payor, if necessary. In some cases, these claims may be denied by the primary or secondary payor in which case SMMC may reprocess the claim and/or appeal the denial. Any unpaid balance is then billed directly to the patient.

If SMMC has not received payment from the patient after some specified period of time depending upon the type of account, the account is transferred to a collections agency. This agency receives a percentage of the recovered funds as compensation. SMMC classifies funds transferred to the collections agency as bad debt.

Siemens' Assessment

In April of 2003, Siemens Medical Solutions Health Services⁸ conducted an assessment of the revenue cycle at SMMC. Some of its key findings and opportunities included:

- Inefficiencies exist due to a lack of optimal system utilization. This results in manual processes and decreased productivity. Siemens identified many areas that could be enhanced by better utilization of existing systems.
- Staff members in Patient Financial Services have less-than-adequate knowledge of system functions and how their tasks are interrelated with other hospital departments.

⁸ Siemens is a multi-national company that sells and services computer systems; they are the major systems provider to SMMC. Their "Revenue Cycle Optimization Assessment" reviewed existing patient access and business office processes and system settings to improve business outcomes associated with the revenue cycle.

- Opportunities exist to incorporate automatic eligibility and pre-registration for all patients with scheduled services.
- A Data Quality Audit program should be implemented for the Admitting and Registration department to facilitate data integrity and ensure accountability of all registration areas.
- Management does not perform daily data analysis to track department and staff performance.

Throughout this Grand Jury investigation, SMMC was in the midst of a significant effort to improve its systems and processes with particular focus on addressing the first two issues above and the automated eligibility portion of the third. SMMC hopes this effort will lead to cleaner and faster submissions, more categorized patients, and improved ability to reconcile services with billings. The Grand Jury was not able to assess at this time of the investigation the effectiveness of these efforts.

Revenue Committee

A cross-functional task force named the “Revenue Committee” was formed in February 2004. This committee plans to meet regularly to track all services provided by SMMC with the goal of capturing more revenue. The committee includes representation from in-house staff from the revenue producing departments.

Registration

According to the Siemens assessment, 85% of clinic services are scheduled; however, only a small percentage is pre-registered. In most cases, this does not allow SMMC time to determine insurance coverage and/or authorization before the patient receives services. By pre-registering patients, SMMC could reduce the amount of bad debt, insurance denials and/or administrative losses. SMMC is considering implementation of a pre-registration process, but no specific plan or timeline has been developed.

Registration at the time of service is done locally at the hospital and each of the clinics by personnel from different departments. This has caused problems in establishing accountability. Registration accuracy is not currently measured, but the belief within SMMC is that accuracy is significantly below 90%. Industry benchmarks for this process range from 95 to 97%. Inaccurate or missing information during the registration phase causes billings and collections problems later.

Systems do not highlight account status by patient upon registration. A patient with an outstanding bill is provided services without identification of the outstanding charges or discussion of how they plan to settle existing balances. In addition, the current systems do not identify co-pay amounts upfront for all patients; therefore, those patients may not be billed for co-pays for 30 to 60 days after receiving services. The Siemens assessment report highlighted the need to do everything possible to collect payments up front and/or arrange for future payment. According to the assessment, “it has been well documented in the healthcare industry that 50 percent of the self-pay balances will never be recovered once the patient has left the facility.” Self-pay balances include all of the full-pay accounts as well as the portions of the other payor categories that are the patient’s responsibility (e.g., co-pays, deductibles).

Seeking Insurance Eligibility and Service Authorization

Checking for insurance eligibility is currently a major problem area. Automating eligibility determination can speed up the billing process and improve collections. This automation is a focus of the current systems improvement effort.

Accounts for individuals who are identified as eligible for MediCal but who have not completed the application process are sent to a private company specializing in completing these applications. The company is currently pursuing \$8 million in receivables and will receive 20% of any reimbursed amounts.

Waiting for service authorizations from some payors causes delays in the billing process particularly with MediCal/Health Plan of San Mateo. In some cases, SMMC is not aware that MediCal/Health Plan of San Mateo is waiting on receipt of an authorization in order to process the claim. MediCal/Health Plan of San Mateo expressed willingness to work with SMMC to create automated reports that flag accounts waiting for authorization and/or eligibility determination.

Internal Billing

SMMC is matching its target of 9 days to prepare bills or claims once a patient is discharged. The benchmark for other medical centers ranges from 4 to 6 days.

Once a claim to a payor has been prepared, it is passed through software that checks for errors based on the rules established by the payor. SMMC does not currently track the accuracy of submissions; however, it estimates that only 40 to 70% of initial submissions are “clean”, i.e., have no errors. Those with errors must be re-worked before being sent out. SMMC is currently targeting 90% for “clean” submissions and has a number of initiatives underway to more fully automate this process and reduce the amount of manual processing and re-processing that occurs. The benchmark for other medical centers for “clean” submissions is 98%.

External Billing

Once a claim or bill is prepared and sent to the payor or patient, the external billing process begins. During the external billing process, insurance denials and administrative losses occur. Some insurance denials are accepted, some require re-work while others are appealed. Records are kept of the denials, but no official process is in place to evaluate the causes of these denials or losses on a regular basis.

Collections

After exhausting its own bill collection efforts, SMMC outsources outstanding collections to Revenue Services, a group within the County’s Employee and Public Services department that provides collection services for County entities. SMMC transfers accounts to Revenue Services on a variable schedule by payor, e.g., full pay accounts are transferred when they become 60 to 90 days past due. Revenue Services then pursues the accounts through letters and phone calls only giving up on accounts when contact information cannot be found or where the likelihood of collection is deemed to be zero.

Revenue Services advised that currently 20 to 25% of the accounts it receives from SMMC have inaccurate patient contact information obtained at the time of registration; many of the patients it contacts are unaware of their payment obligation; and SMMC is keeping accounts longer, sending only the very difficult to collect, e.g., half of the accounts want to pay but cannot, the other half can pay but do not want to. Revenue Services emphasized the importance of obtaining accurate information and educating patients at registration that they might be financially responsible for a portion (or all) of the bill. Currently Revenue Services meets with SMMC bi-weekly to discuss progress with accounts.

SMMC was not able to provide data on the effectiveness of the collections performance of Revenue Services, although the overall cash collected is tracked monthly. The two agencies have different perceptions of how much is collected on a pre-collect basis (after sending 1 letter); SMMC believes “quite a bit” is collected while Revenue Services stated that almost nothing is collected on that basis. According to Revenue Services, it recovered approximately 50% of the receivables classified as bad debt (requires phone contact) over the past 4 months, i.e., average monthly receivables of approximately \$1 million were transferred to Revenue Services and it arranged payments on accounts totaling \$500,000. In most cases the \$500,000 will be received over a period of time. What is not clear is why there is not more cash on a monthly basis coming into SMMC from Revenue Services given the 50% collection rate.

SECTION 3: The Billings and Collections Performance

Comparison of Gross AR Days Performance

SMMC tracks its gross AR Days on a weekly basis. See Chart 2: Breakdown of Gross AR Days.

CHART 2: Breakdown of Gross AR Days for Week Ending 2/1/04

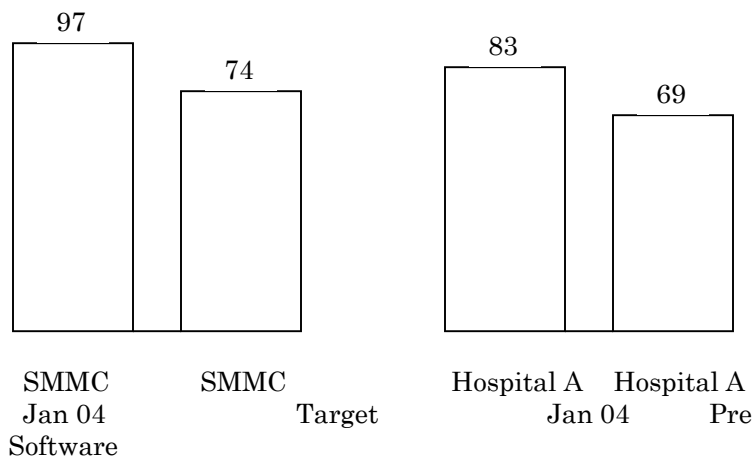
Category	ACTUAL	TARGET
In-house	11	11
Discharged, Not Billed		
Registration	0	1
Medical Records	3	5
Billing	6	3
Total Discharged, Not Billed	9	9
Final Billed		
0 to 30 days	13	16
31 to 60 days	13	10
61 to 90 days	11	10
91 to 120 days	6	5
121 to 150 days	8	5
151 to 180 days	5	5
>180 days	22	3
Total Final Billed	77	54
GRAND TOTAL	97	74

Receivables are tracked from the date of service. In-house AR days are those days for long-term care patients and for in-house patients prior to discharge. The discharged, not billed days reflect the time to prepare the bill internally. The final billed days start once the bill has been sent and are tracked based on the number of days the bill has been outstanding.

For the week ending February 1, 2004, SMMC had gross AR days of 97, 23 days over its established target of 74 days. An industry benchmark and SMMC's target for "% of Gross AR days over 90 days" is 20%. Currently SMMC has 41 AR days in accounts over 90 days, or 43% of its total AR days. Most of the "extra" AR days are in the over 180 days category which consists of some accounts where MediCal eligibility is being sought.

The Grand Jury compared gross AR days of SMMC to a comparable county hospital (Hospital A). See Chart 3: Gross AR Day Comparison.

Chart 3: Gross AR Day Comparison



SMMC's target of 74 days appears reasonable when compared to the range for AR days of Hospital A of 69 to 83 days. Interestingly, the comparable county hospital's AR performance has deteriorated recently with the conversion to a new accounting system. The hospital is currently focusing its efforts to address this problem.

Billings and Collections Performance by Payor or Financial Class

In identifying specific opportunities for improvement, it is critical to understand the billings and collections performance by payor group or financial class. See Chart 4: Billings and Collections Performance by Payor Group or Financial Class.

CHART 4: Billings and Collections Performance by Payor Group or Financial Class

Primary Payor Groups	For FY 2003		As of 1/31/04	
	\$ MM in Total Charges	% of Total Charges	% Net Revenue	Gross AR Days
MediCal *	66.2	38.1	49.0	97+
WELL	35.0	20.1	0.8	Not Applicable
Medicare	32.8	18.9	48.8	135
Undetermined	14.1	8.1	41.0	265
Indigent	6.6	3.8	0.0	Not Applicable
Insurance/Com	5.6	3.2	50.4	204
Full Pay	5.4	3.1	1.7	143

* AR days for MediCal do not include MediCal pending accounts which are currently in the Undetermined category.

SMMC tracks “\$ total charges” and “net revenue” by payor but does not track any of the “write off” categories by payor, i.e., contract discount, charity, bad debt, administrative losses and insurance denials. SMMC does not track AR days by payor, but days can be calculated from existing data.

MediCal

MediCal is a federal and state program which provides health care benefits to those on welfare or to the medically needy and is SMMC’s largest payor constituting 38% of total charges. MediCal/Health Plan of San Mateo⁹ pays fully and promptly (within 15 to 30 days) when eligibility, authorization and the submitted claim are in order. However, if those items are not in order, claims can be denied and/or payment delayed.

- SMMC has experienced delays in payment when trying to confirm coverage for some MediCal patients which can take up to 210 days.
- SMMC has also experienced delays receiving authorization for treatment, as previously discussed.
- MediCal/Health Plan of San Mateo estimates that approximately 90% of SMMC’s claims are “clean” when they initially receive them for processing. This is below the best practice benchmark of 98%.
- In FY ’03, denials (refusal to pay) for MediCal were approximately 2.3% of total charges. This is a dramatic improvement over FY’02, when denials were 7% of total charges. While SMMC tracks denials, they do not have any published action plan for reducing the occurrence of denials moving forward.

MediCal/Health Plan of San Mateo (as well as Medicare) sends payment directly to a lock box (account at a bank) so that cash can be immediately deposited into a bank account.

WELL

The San Mateo Medical Center WELL (Wellness, Education, Linkage, and Low Cost) Program was established in July 1996 to provide medical care to County residents who are medically indigent with eligibility criteria based on income at or below 200% of the Federal Poverty Level. WELL is SMMC’s second largest payor or financial class constituting 20% of total charges. Patients enrolled in the WELL Program pay an annual flat fee and are also responsible for co-payments for selected services. While this number is not regularly tracked, analysis done by SMMC indicated that approximately 40% of those payments were collected in FY ’03. The balance of the charges is classified as “charity.”

⁹ San Mateo County contracts with the Health Plan of San Mateo for its MediCal reimbursement instead of directly with the state. In late March 2004, the San Mateo County Board of Supervisors issued a 90-day notice to the Health Plan of San Mateo that the County intends to stop doing business with it. By contracting with the Health Plan and not directly with the state, the County is unable to access certain federal money. Regardless of the future of the Health Plan, SMMC will still accept MediCal patients.

Medicare

Medicare is a federal program providing insurance to persons 65 years of age or over and to persons receiving disability benefits under Social Security. Medicare is SMMC's third largest payor constituting 19% of total charges.

Assuming eligibility has been established and the claim submitted properly, Medicare pays promptly within 15 days. In FY '03, denials for Medicare were essentially 0%. Some portion of the Medicare billings is classified as bad debt due to the patients' failure to pay deductibles, co-pays, and/or payments for uncovered services.

Undetermined

The Undetermined financial class includes patients for whom no initial insurance information was captured at the time of registration as well as the MediCal pending accounts.

This category currently constitutes 8% of total charges. Eventually these accounts should be assigned to a more specific category. SMMC is focusing its efforts on minimizing the number of accounts in this category with additional training of registration staff and system improvements. MediCal pending is currently within this category.

Indigent

The Indigent financial class includes patients who are not eligible for MediCal, Medicare, or the WELL program and do not have the financial means to pay for medical services.

Per SMMC's charter, these patients are serviced but no attempt is made to collect payment.

Insurance/Commercial

This financial class is made up of patients who have coverage from commercial insurance payors such as Kaiser and Blue Shield. In the case of the "Healthy Kids" program, the Health Plan of San Mateo is the insurance carrier.

"Healthy Kids" is a County program to provide affordable insurance coverage for children residing in San Mateo County and living in families with incomes up to 400% of the federal poverty level who are ineligible for full-scope MediCal. There is a small monthly premium charged to the families.

While SMMC collects over 50% in net revenue from this class overall, the AR days of 220 are very high.

Full Pay

The Full Pay financial class includes patients who have no third party coverage and are deemed responsible for and capable of making their own payments. This category constitutes 5.4% of total charges with a very low revenue collection rate of 1.5%.

- SMMC estimates that over 90% of the total charges are written off as bad debt but this number is not tracked.
- SMMC has introduced an incentive-based program to help reduce the level of bad debt with the Full Pay category. The program provides a 50% discount to patients if

they pay within 30 days of discharge. SMMC has not yet determined the effectiveness of this program.

Other Observations

The Grand Jury obtained additional information relevant to the investigation.

Organization of Patient Financial Services

Patient Financial Services has primary responsibility for billings and collections. Currently, there are 63 staff members in the department with responsibilities for Admitting and Pre-Admitting, ER registration, the Community Access Program, Physicians Billing, Patient Pre-billing and Post-billing, and Training.

Two functions critical to the billings and collections process reside in other departments: clinic registration resides in the Clinic Division and insurance coding resides in Medical Records for in-patients and is the responsibility of the doctors at the clinics. Up until a few years ago, Medical Records was part of Patient Financial Services. Recently, SMMC decentralized the insurance coders assigning them on-site at the clinics.

Incentives or Bonuses

In discussions with SMMC staff, the potential of introducing incentives or bonuses for employees tied to achieving billings and collections goals generated interest. One of the staff had previously worked at a medical center where bonuses were utilized with success. At Revenue Services, a bonus plan is used to help motivate employees.

Upcoming Audits

The Controller's office is interested in conducting an audit of the billings and collections practices at SMMC but decided to delay to FY '04 or '05 to give SMMC an opportunity to implement system improvements. The Controller's office also expressed interest in conducting a benchmarking analysis of comparable medical centers.

Accepting Private Insurance

SMMC has contracted with Blue Shield, a private commercial insurance carrier, in order to improve its revenue situation by broadening the client base; however, this is likely to negatively impact AR days because commercial insurance companies are notoriously slow payors.

Making Payments at SMMC

If a patient wants to make a payment in person after receiving services, he/she must go to the Cashier's office at the hospital. The Grand Jury found the Cashier's office to be inconveniently located and very difficult to find. Neither the directory in the Lobby nor the Information Desk correctly reflected the current location of the office.

Comparison to Other Hospitals

The Grand Jury interviewed two other hospitals in order to identify best practices that might be applied to SMMC: a county hospital (Hospital A) and a private hospital (Hospital B).

Hospital A

Hospital A is a county hospital about three to four times the size of SMMC with a comparable patient base (indigent and low income), service offering, and payor mix. The hospital's management places a high priority on managing the revenue cycle and has invested significant resources in upgrading its systems. Interestingly, its recent system conversion has initially resulted in a degradation of performance in billings and collections as reflected in the increase in average AR days from 69 to 83. They are actively addressing this problem.

Hospital A has implemented processes and procedures over the past one to two years that have contributed to improvements in their billings and collections performance.

- Creation of an organization-wide focus on billings and collections that includes monthly meetings of a wide cross-section of department representatives to address specific issues and identify improvement areas – includes utilization review, medical records, admission/registration, and revenue producing departments.
- Introduction of a rigorous stratification and prioritization of account collections by payor. This allows the hospital to focus scarce resources where the greatest return is possible.
- Experimentation with an upfront discounted flat fee of \$5 to 30 for self-pay patients to ensure participation in payment, collect more cash, and reduce cost of collection.
- Negotiated payment timeframes of 60 to 90 days with commercial insurance providers where possible.

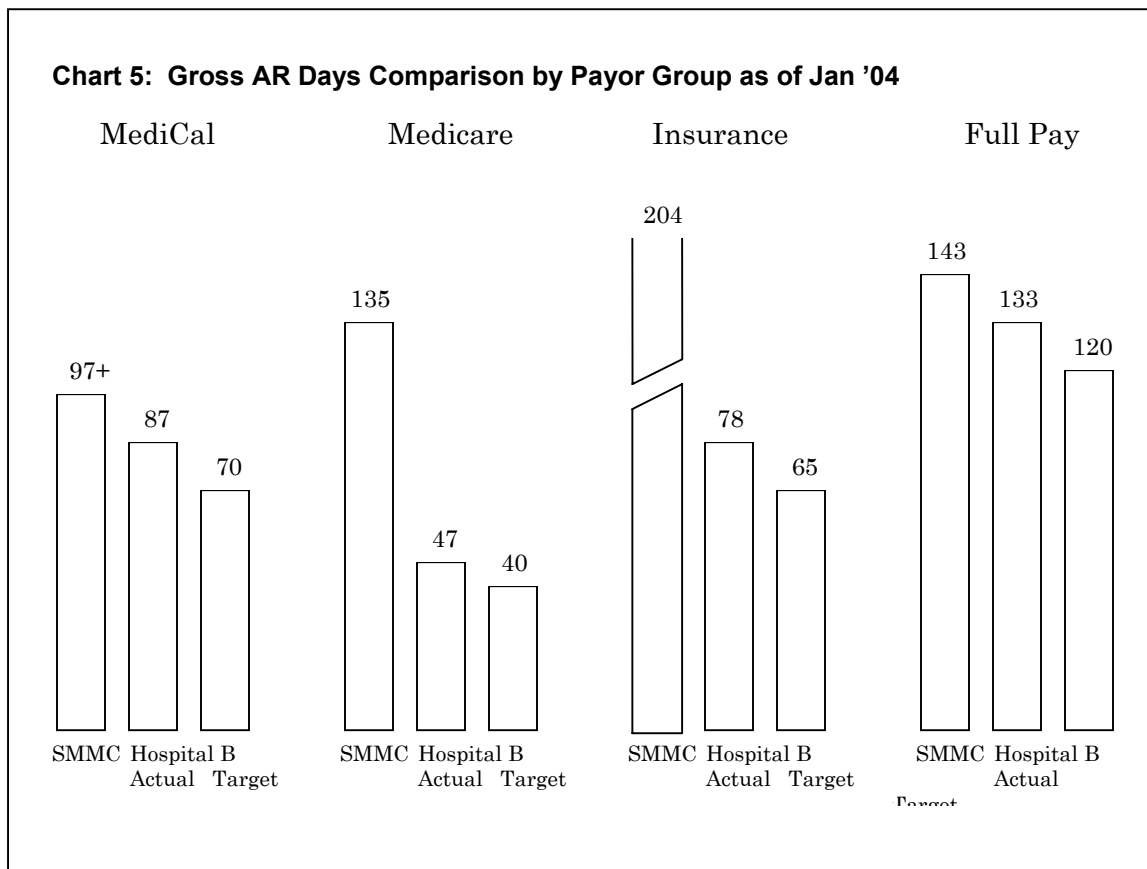
Hospital A's challenges include managing a complex set of service delivery points and retaining insurance coders who can manage the complexity of claims processing for MediCal and Medicare.

Its focus areas moving forward include getting the right insurance codes in the system, establishing insurance eligibility early in the process, and managing late charges for services rendered from departments.

Hospital B

Hospital B is a private hospital approximately two times the size of SMMC. Although private, this hospital does manage Medicare and MediCal patients. The actual and target AR days by payor for Hospital B are significantly lower than those for SMMC. See Chart 5: Gross AR Days Comparison by Payor Group. It should be noted that AR days for MediCal of 97 are understated for SMMC as this number does not include the AR days for MediCal pending accounts which SMMC is currently tracking within another payor category.

Chart 5: Gross AR Days Comparison by Payor Group as of Jan '04



Some of the highlights of its billings and collections practices include:

- Detailed performance measures and more aggressive targets than SMMC
 - AR days target for each payor;
 - Registration accuracy at 97%;
 - Clean submissions at 98%.
- Regularly monitoring unbilled accounts category, total cash collected, and credit balance accounts
- Ongoing analysis of administrative losses and insurance denials by payor
- Training and integration with MBO's (management by objectives included in performance evaluation) to ensure accuracy of registration at admissions
 - Improved from 20% to nearly 97% accuracy;
 - Tracks admission error on a daily basis;
 - Provides monthly reports on errors by department and by registrar.
- Maintaining a strong focus on continuous process improvement, e.g., a four –page Accounts Receivable 2003 Plan outlines numerous steps to improve billings and collections by payor.
- Outsourcing accounts receivable collections for self pay accounts to third party. The third party charges 7% of the collections as a fee and resolves 87% of the

outstanding accounts. Accounts are sent to collections after 90 to 120 days. The collections agency recovers 23 to 30% of the outstanding funds.

- Pursuing aggressive collections practices (e.g., utilizing four different collections agencies and not giving up on accounts easily).

The hospital's focus moving forward is on collecting more pre-pays at admission or prior to discharge. Currently they collect less than 5% of patient billings upfront.

SECTION 4: Improvements Implemented by SMMC

Through interviews and review of materials provided, the Grand Jury identified specific changes made in the last eighteen to twenty-four months in the billing and collection practices at SMMC that helped contribute to improved financial results. These changes included elevating the attention placed on billings and collections within the organization, setting targets and measuring progress against those targets, and implementing system improvements. Examples of these changes are:

- New management has increased the emphasis on billings and collections and specifically focused on “collecting cash and controlling the revenue cycle”.
- Some performance measures have been established and targets set for overall billings and collections performance including gross AR days, total cash collected, cost per \$ collected, and percentages for each uncollectible or “write off” category.
- Standardized reports have been developed that track progress in managing the revenue cycle including a “Weekly Accounts Receivable Monitor Report” and a “Monthly Patient Financial Services Key Indicators.”
- Opportunities for systems improvements have been identified and are currently being implemented.
- There has been an increased focus on initial categorization of patients to increase the percentage of patients for whom some form of insurance can be secured.

These changes have resulted in some recognized improvements in the overall billings and collections performance at SMMC.

- MediCal staff reported that over the past one to two years, SMMC moved from the bottom third of contracting entities to the top third in terms of timeliness and accuracy of claims submission.
- According to Revenue Services, SMMC is identifying more MediCal eligibility up front and sending fewer of those accounts to Revenue Services for collections.
- SMMC collected additional cash during FY '03 by successfully appealing denials and reversing administrative losses from previous years that were assumed to be uncollectible. One of the appealed denials was for \$500,000.

Conclusions

Currently, the billings and collections practices at SMMC are not fully meeting the financial interests of the County.

SMMC has made significant improvements over the past 18 months in its billings and collections practices. It has increased management focus, introduced performance measures and targets, implemented systems improvements, and developed more disciplined processes. These changes have helped build a platform upon which additional advances can be made. However, a significant gap still exists between SMMC's performance and what could be achieved assuming best practices.

When comparing SMMC to other hospitals and to optimal billing cycles (e.g., shortest billing cycle if no delays experienced by either SMMC or the payor), further improvements in billings and collections are possible, e.g.,

- benchmarking performance against comparable medical centers;
- creating more cross-functional participation in setting priorities, publishing strategies, and implementing policies;
- ensuring on-going improvement by setting aggressive targets in key areas, tracking performance and rewarding achievement;
- developing specific initiatives by payor group;
- collecting more payment directly from patients by capturing accurate information at registration and seeking payment more quickly in the billing cycle;
- better facilitating patients making payments by locating the Cashier's office in an easy to find place in the hospital and providing clear and accurate directions that will lead one to the office; and,
- focusing on continuous process and systems improvement.

These improvements could help SMMC capture nearly \$13 million in incremental revenue annually and to increase cash flow by an additional \$5 million.

Recommendations

1. The County Controller should:
 - 1.1 by October 1st, 2004, conduct a benchmark analysis of comparable medical centers for billings and collections best practices and performance.
 - 1.2 by January 1st, 2005, perform an audit of SMMC's billings and collections practices and performance. This audit should include a review of the "categorization" process to ensure that insurance coverage is being sought for patients where possible.

2. The Board of Supervisors should direct SMMC's "Revenue Committee" to:
 - 2.1 meet at least monthly on an on-going basis;
 - 2.2 review administrative losses, insurance denials, bad debt, collections by Revenue Services, and unbilled accounts on monthly basis'
 - 2.3 assess new billings and collections initiatives on monthly basis;
 - 2.4 invite third parties to meetings on an ad hoc basis to provide outside perspective, e.g., patients, payors, billings and collections staff from other hospitals.
3. The Board of Supervisors should direct the Chief Financial Officer of SMMC to develop a billings and collections strategic plan by October 31st, 2004, and to provide quarterly updates on the progress to the strategic plan to the County Manager. The plan should include input from the "Revenue Committee", incorporate the benchmark analysis from the Controller's Office, and include:
 - 3.1 Specific targets established or revised for:
 - AR days by payor and overall based on benchmark information;
 - % of total charges for each "write off" category by payor and overall based on benchmark information;
 - AR days for internal billing (4 to 6 days) and aged-receivables based on benchmark information;
 - Registration accuracy at 97%;
 - "Clean submissions" at 98%;
 - Upfront payment collection at 10% (increased when pre-registration is implemented).
 - 3.2 Details for initiatives to reach targets that include integrated plans for training, tie-in with performance evaluation, tracking, and systems changes.
 - 3.3 Required changes to reporting and tracking:
 - track AR days, bad debt, denials, and administrative losses by payor group;
 - track registration accuracy by registrar and create daily/ monthly reports;
 - track upfront cash collections by registrar and create daily/monthly reports;
 - track Revenue Services performance including ability to credit back collections from Revenue Services to the appropriate payor category;
 - separate MediCal pending from Undetermined category;
 - separate Healthy Kids from Insurance/Commercial category;
 - provide ability to move accounts out of Undetermined category.

- 3.4 Systems changes to support up front payment collection:
 - 3.4.1 ability to flag past due accounts of patients registering for additional services;
 - 3.4.2 ability to provide estimates of co-pays and attempt to collect at the time of registration.
- 3.5 A review of systems and process changes implemented during FY '04.
- 4. The Board of Supervisors should direct the Patient Services Department of SMMC to conduct an analysis of the collections performance of Revenue Services by October 1st, 2004, that includes:
 - 4.1 characteristics of transferred accounts (e.g., self-pay accounts versus co-pays for MediCal, \$ size, days outstanding);
 - 4.2 characteristics of accounts that are successfully collected upon;
 - 4.3 pre-collect and bad-debt collection rates;
 - 4.4 qualitative feedback from Revenue Services on changes SMMC could make to enhance collectibility of accounts.
- 5. The Board of Supervisors should direct SMMC to assess the effectiveness of the “50% discount to patients for payment in 30 days” by October 1st, 2004, and to modify and/or experiment with other ideas, e.g., providing 50% discount if payment made at or before discharge and 30% if made within 30 days, or charging an upfront flat fee (\$10 to 30) for selected services.
- 6. The Board of Supervisors should direct SMMC to investigate or experiment with moving full pay accounts and self pay account balances more quickly to Revenue Services.
- 7. The Board of Supervisors should direct SMMC to work with MediCal/Health Plan of San Mateo by October 1st, 2004, to develop automated reports to flag accounts waiting for information or authorizations prior to payment, assuming the contract with the Health Plan is still in place.
- 8. The Board of Supervisors should direct SMMC to pilot a pre-registration function during FY '05 with full deployment during FY '06.
- 9. The Board of Supervisors should direct SMMC to experiment with incentives or bonuses for employees tied to achieving billings and collections goals.
- 10. The Board of Supervisors should direct SMMC to consider organizational changes to provide improved accountability for the billings and collections process, i.e., move Medical Records and/or Clinic Registration into Patient Financial Services.
- 11. The Board of Supervisors should direct SMMC to immediately ensure the directory and the Help Desk staff correctly reflect the location of the Cashier’s Office at the hospital. All signs leading to the Cashier’s Office should be in English and Spanish.

12. The Board of Supervisors should direct SMMC to immediately identify a more convenient location for the Cashier's Office and to develop a plan and timeline for the move.



COUNTY OF SAN MATEO
Inter-Departmental Correspondence

County Manager's Office

DATE: July 19, 2004

BOARD MEETING DATE: July 27, 2004

TO: Honorable Board of Supervisors
FROM: John L. Maltbie, County Manager
SUBJECT: 2003-04 Grand Jury Responses

Recommendation

Accept this report containing responses to 2003-2004 Grand Jury recommendations on the following: Sexual Assault Cases in San Mateo County; Grand Jury Whistleblower Recommendation; San Mateo Medical Center Billings and Collections; and San Mateo County Purchasing Division.

Discussion

The 2003-2004 Grand Jury issued reports on Sexual Assault Cases in San Mateo County on April 29, 2004; Grand Jury Whistleblower Recommendation on May 3, 2004; San Mateo Medical Center Billings and Collections on May 27, 2004; and the San Mateo County Purchasing Division on June 10, 2004. The County is mandated to respond to the Grand Jury within 90 days from the date that reports are filed with the County Clerk and Elected Officials are mandated to respond within 60 days. The report pertaining to Sexual Assault Cases requires direct responses from the Sheriff and the District Attorney. Reports pertaining to Medical Center Billings and Collections and the Purchasing Division require direct responses from the Controller's Office. Combined responses from the County and the Controller's Office have been prepared for the Purchasing Division and Medical Center Billings and Collections.

Vision Alignment

This response to the Grand Jury's findings and recommendations keeps the commitment of responsive, effective and collaborative government through goal number 20: Government decisions are based on careful consideration of future impact, rather than temporary relief or immediate gain.

San Mateo Medical Center Billings and Collections

Findings:

We generally agree with the Grand Jury findings and are encouraged by the number of times that the Grand Jury acknowledged the improvements that have been made in billings and collections at the San Mateo Medical Center over the past 18-24 months. SMMC converted to the Siemens Patient Accounting System in September 1999. The impact of this conversion cannot be underestimated. Unfortunately fully adequate system testing was cut short due to the impending Y2K deadline in January 2000. It is acknowledged that the Patient Accounting System was not fully operational resulting in backlogs in claims processing and follow-up.

Patient Financial Services staff has been working with the Information Services Department's Health Applications Unit and Siemens consultants to essentially redesign the Patient Accounting System. SMMC is continually reviewing processes and reporting for further improvement. Over the past year SMMC has reviewed and updated key Master Files and Profiles to ensure optimum settings to increase cash collections and revenue. SMMC views this process as an ongoing task. Major changes have already been implemented to assure optimal use of the Patient Accounting system. System changes include developing statement protocols so that patient statements are generated within a specified number of days after discharge and transferred to Revenue Services when payment is not received within the specified timeframe. SMMC has implemented the Siemens' Receivable Management Workstation, an online collection tool that automates the assignment and presentation of accounts to billers for follow-up. In addition to sharing knowledge on optimizing use of the Siemens system, the Siemens consultants have offered their observations on best practices at other health care facilities. PFS management and supervisors have used this information to make improvements in its workflow processes. Cash collections have steadily increased as improvements are implemented.

SMMC continuously monitors its own performance through weekly and monthly reports of key indicators including cash collections and monthly adjustments. Two key indicators are reported monthly to the SMMC Board of Directors, Net AR days and cost to collect per dollar of cash collections. Other indicators will be reported as they are developed.

Recommendations:

1. The Controller should:

- 1.1 By October 1, 2004, conduct a benchmark analysis of comparable medical centers for billings and collections best practices and performance.**

Response: Concur. Controller's study will commence on or before October 1, 2004.

- 1.2 By January 1, 2005, perform an audit of SMMC's billings and collections practices and performance. This audit should include a review of the "categorization" process to ensure that insurance coverage is being sought for patients where possible.**

Response: Concur. Controller's study will commence on or before January 1, 2005. The Controller's Audit Division is currently performing a study, the primary purpose of which is to determine if patients are properly classified as indigents. This study was requested by the County Manager's Office as part of a larger study being directed by the Controller's Office to determine the most cost effective approach to satisfy the County's legal obligation to provide indigent health care.

2. The Board of Supervisors should direct SMMC's Revenue Committee to:

- 2.1 Meet at least monthly on an on-going basis;**

Response: Concur. The Revenue Committee has been meeting on a bi-weekly basis and will meet at least monthly in the future.

- 2.2 Review administrative losses, insurance denials, bad debt, collections by Revenue Services, and unbilled accounts on a monthly basis;**

Response: Concur in part. The Revenue Committee in its current format is not the forum to discuss these issues. It is the responsibility of Patient Financial Services management in collaboration with the Revenue and Reimbursement Manager to review these areas against budgeted targets monthly.

- 2.3 Assess new billings and collections initiatives on a monthly basis;**

Response: Concur. The charter of the Revenue Committee is to bring together clinical and financial managers to discuss revenue improvement initiatives for the revenue cycle. PFS managers continuously assess new billings and collections initiatives and routinely notify the Reimbursement Manager of these initiatives. In addition, PFS staff works with clinical managers on new initiatives as evidenced by the recent implementation of the Ron Robinson Senior Care Center and the Burlingame Long Term Care facility that included active PFS involvement.

- 2.4 Invite third parties to meetings on an ad hoc basis to provide outside perspective, e.g., patients, payers, billings and collections staff from other hospitals.**

Response: Concur in part. The Revenue Committee in its current format is not the forum to discuss these issues. PFS Managers and Supervisors regularly attend trainings and seminars with third parties, including payers, billings and collections staff from other hospitals. In addition, ad hoc meetings are held as appropriate to discuss specific issues.

1. **The Board of Supervisors should direct the Chief Financial Office of SMMC to develop a billings and collections strategic plan by October 31, 2004, and to provide quarterly updates on the progress to the strategic plan to the County Manager. The plan should include input from the “Revenue Committee,” incorporate the benchmark analysis from the Controller’s Office, and include:**

Response: Disagree. The Chief Financial Officer and the Director, Patient Financial Services annually develop a strategic plan to improve revenue cycle operations and develop key performance metrics. These metrics are developed based on projected improvements related to system application maximization, the reimbursement environment and regulatory requirements. Actual performance against metrics is already presented monthly to the SMMC Board of Directors.

3.1 Specific targets established or revised for:

3.1.1 AR days by payer and overall based on benchmark information;

Response: Disagree. SMMC currently monitors overall AR days and AR days by high volume payers (e.g., Medicare and Medi-Cal). We disagree with the notion that AR days should be compared by payer against a benchmark because AR days can be highly volatile and subject to manipulation. According to Zimmerman & Associates, traditional indicators (e.g. AR Days) lack industry standardization and do not correlate to optimized performance. The calculation of AR days is based on patient discharge date. AR days begin to accrue at the time that the patient leaves SMMC whether or not the patient has health insurance. Therefore, when an uninsured patient receives Medi-Cal eligibility, the aging of the account is not readjusted to reflect the fact that the patient just got Medi-Cal. For example, if an uninsured patient is discharged on 12/8/03 & Medi-Cal eligibility is approved on 4/19/04 then the account is already 130+ days old when the Medi-Cal claim submission process is initiated.

3.1.2 % of total charges for each “write off” category by payer and overall based on benchmark information;

Response: Concur. SMMC currently monitors overall percentage of charges for each write off category by payer.

3.1.3 AR days for internal billing (4 to 6 days) and aged-receivables based on benchmark information;

Response: Concur. SMMC already monitors AR days on a weekly basis for internal billing and aged-receivables and is always focused on reducing days as external factors allow. See response to 3.1.1 for discussion of AR days based on benchmark information.

3.1.4 Registration accuracy at 97%;

Response: Concur in part. Patient Accounting reviews admissions and emergency department registrations on a daily basis and communicates errors to the admitting staff. This is an on-going process and to date the errors have been reduced. Registration accuracy is difficult to measure as information at the time of registration may be different from the information available at the time of billing. Either the patient provided inaccurate information or the information was accurate when asked but later changed. Staff will evaluate the current baseline accuracy rate and develop a registration accuracy target that will be higher than the baseline and will increase incrementally as the target is reached.

3.1.5 “Clean submissions” at 98%;

Response: Concur. SMMC uses DSG, a claims processing software system. DSG utilizes all edits for Medicare, Medi-Cal and insurance claims. Claims do not pass edit for submission to a payer unless they are clean. In addition, staff has met with Siemens, DSG and InfoIMAGE, the vendor that produces SMMC’s patient statements, to review claims processing edits and have made improvements in insuring clean submission. These efforts will be on going to assure continued improvement.

3.1.6 Upfront payment collection at 10% (increased when pre-registration is implemented).

Response: Concur. Payments for co-pays are already collected upfront and posted to patients’ accounts at the time of receipt. SMMC staff will be working on developing a target and it will probably be greater than 10%.

3.2 Details for initiatives to reach targets that include integrated plans for training, tie-in with performance evaluation, tracking, and systems changes.

Response: See response to recommendation 3.0 above. The Patient Services Training Coordinator reports to the Director, Patient Financial Services, and is responsible for orientation of all new registration staff, as well as the on-going training of existing registration staff throughout the Medical Center. This includes training on the use of the Siemens system and enhancements, as well as registration processes such as identification of patient financial status. The Patient Services Training Coordinator also prepares a bi-weekly newsletter, The Elixir, which is distributed to all registration staff. The Elixir includes information on new programs, system changes and general information affecting the registration and billing process. Performance standards for billing and collection targets are included in the evaluations of Patient Financial Services staff.

3.3 Required changes to reporting and tracking:

3.3.1 Track AR days, bad debt, denials and administrative losses by payer group;

Response: Concur. SMMC currently tracks AR days, bad debt, denials and administrative losses by financial class.

3.3.2 Track registration accuracy by registrar and create daily/monthly reports;

Response: Concur. PFS will work with ISD to develop monitoring reports. However, tracking of accuracy is somewhat subjective based on information available/disclosed to the registrar at time of registration.

3.3.3 Track upfront cash collections by registrar and create daily/monthly reports;

Response: Disagree. SMMC currently monitors upfront cash collections by site and has created weekly reports to monitor collection activity.

3.3.4 Track Revenue Services performance including ability to credit back collections from Revenue Services to the appropriate payer category;

Response: Concur. SMMC currently monitors Revenue Services performance. Collections on accounts in pre-collect status are posted directly to patients' accounts.

3.3.5 Separate Medi-Cal Pending from Undetermined category;

Response: Concur in part. SMMC will attempt to separate Medi-Cal Pending from the Undetermined category through ad hoc reporting. Establishing a new financial class for the Medi-Cal Pending accounts would entail major system modifications to both the Patient Management and Patient Accounting systems, as well as all ancillary systems that receive patient information. Extensive testing would also need to be done to assure that all pathways have been modified correctly. The cost/benefit of undertaking this modification will have to be evaluated.

3.3.6 Separate Healthy Kids from Insurance/Commercial category;

Response: Disagree. Healthy Kids is an insurance program and there is no need to distinguish it as a separate financial category. Healthy Kids has a distinct payer plan within the Insurance category so reporting and tracking of Healthy Kids revenue can be monitored on an ad hoc basis.

3.3.7 Provide ability to move accounts out of Undetermined category.

Response: Concur. SMMC currently does move accounts out of the Undetermined category and to other financial categories as appropriate when changes in patients' financial status occur.

3.4 Systems changes to support up front payment collection:

3.4.1 Ability to flag past due accounts of patients registering for additional services;

Response: Concur in part. As a Section 17000 safety net provider, SMMC cannot turn patients away on the basis of their payment history. However, staff will review ability to flag past due accounts in conjunction with the implementation of pre-registration services.

3.4.2 Ability to provide estimates of co-pays and attempt to collect at the time of registration.

Response: Concur. SMMC currently collects co-payments at the time of registration and posts these payments directly to the patients' accounts.

4. The Board of Supervisors should direct the Patient Services Department of SMMC to conduct an analysis of the collections performance of Revenue Services by October 1, 2004, that includes:

4.1 Characteristics of transferred accounts (e.g., self-pay accounts versus co-pays for Medi-Cal, \$ size, days outstanding);

Response: Concur. The Siemens system currently generates reports on the characteristics of transferred accounts including financial class and dollar amount.

4.2 Characteristics of accounts that are successfully collected upon;

Response: Concur. SMMC currently receives a monthly report from Revenue Services of accounts that are successfully collected upon.

4.3 Pre-collect and bad debt collection rates;

Response: Concur. SMMC will work with Revenue Services to develop a report to calculate pre-collect and bad debt collection rates.

4.4 Qualitative feedback from Revenue Services on changes SMMC could make to enhance collectibility of accounts.

Response: Concur. PFS staff currently meets with Revenue Services management on a bi-weekly basis. SMMC receives continuous feedback from Revenue Services on status of patients' accounts. The one area that would possibly increase account collectibility is verification of patient address. SMMC is currently installing Siemens HDX eligibility verification software that includes linkage to the Equifax and other address databases. To the extent that this database is up-to-date then SMMC registration will be updated with current address information. HDX implementation will be in August 2004. Revenue Services evaluates the collectibility of transferred accounts and the applicability of charity care adjustments after evaluation of patients' resources.

- 5. The Board of Supervisors should direct SMMC to assess the effectiveness of the “50% discount to patients for payment in 30 days” by October 1, 2004, and to modify and/or experiment with other ideas, e.g., providing 50% discount if payment made on or before discharge and 30% if made within 30 days, or charging an upfront flat fee (\$10 to \$30) for selected services.**

Response: Concur in part. It is difficult to “modify and/or experiment” with patient payment options as these options are linked to system programs that must be updated to accommodate new billing programs. In addition, any changes require adequate patient notification and continuous experimentation will result in patient confusion. Since the Center for Medicare and Medicaid Services (CMS) recently ruled that discounts are acceptable, SMMC is in the process of implementing a 50% prompt pay discount offered to self-pay patients for payment made in 30 days. SMMC will evaluate the effectiveness of the discount in a reasonable period of time. SMMC has offered this discount informally to self-pay patients and it has been well received. SMMC is currently reviewing and developing additional discounts for charity care patients.

- 6. The Board of Supervisors should direct SMMC to investigate or experiment with moving full pay accounts and self pay account balances more quickly to Revenue Services.**

Response: Disagree. Statement protocols have been implemented through Siemens that assure that patients are sent statements at a specified number of days after their discharge/visit. If payment is not received then accounts are automatically transferred to Revenue Services at Day 54. This allows time for the patients to pay SMMC directly, take advantage of the 50% prompt pay discount if applicable and reduces the commission that the SMMC pays for collection on self-pay accounts. Transferring accounts to Revenue Services more quickly would not give SMMC time to process its internal collection cycle or the patient to submit payment and would result in higher commission fees.

- 7. The Board of Supervisors should direct SMMC to work with Medi-Cal/Health Plan of San Mateo by October 1, 2004, to develop automated reports to flag accounts waiting for information or authorization prior to payment, assuming the contract with the Health Plan is still in place.**

Response: Disagree. The Health Plan of San Mateo currently processes claims as either pending or denied if accounts need additional information. A biller works the pending/denied claims to provide the necessary documentation. Receiving a report in advance would not change the processing of these claims.

- 8. The Board of Supervisors should direct SMMC to pilot a pre-registration function during FY '05 with full deployment during FY '06.**

Response: Concur. SMMC understands the benefits of performing pre-registration for clinic patients and have assessed the number of staff required to support a full-time pre-registration unit based on the number of annual clinic visits. It has been determined that a minimum of 16 FTEs is needed to support a pre-registration unit. Given budget

constraints, SMMC has been unable to move forward with implementation of a pre-registration unit.

- 9. The Board of Supervisors should direct SMMC to experiment with incentives or bonuses for employees tied to achieving billings and collections goals.**

Response: Concur. SMMC will work with EPS to explore the possibility of creating an incentive/bonus program for collections staff.

- 10. The Board of Supervisors should direct SMMC to consider organizational changes to provide improved accountability for the billings and collections process, i.e., move Medical Records and/or Clinic Registration into Patient Financial Services.**

Response: Disagree. The current organizational structure provides accountability for the billings and collection process. Patient Financial Services is responsible for both Patient Access and Patient Accounting. Moving additional departments into Patient Financial Services would not improve accountability for the billings and collections process. For example, both Medical Records and Clinic Registration support dual functions, i.e., clinical and financial, that would not necessarily benefit from transferring organizational responsibility to Patient Financial Services. Patient Financial Services management/supervisory staff regularly meets with their counterparts in Medical Records and the Outpatient Clinics to discuss issues impacting billings and collections. There is additional operational benefit to be gained by moving these departments into PFS. In fact it would be counterproductive as PFS managers would necessarily assume operational responsibility for clinical areas that are out of context within Patient Finance and would therefore dilute the managers' effectiveness.

- 11. The Board of Supervisors should direct SMMC to immediately ensure the directory and the Help Desk staff correctly reflect the location of the Cashier's Office at the hospital. All signs leading to the Cashier's Office should be English and Spanish.**

Response: Concur. This recommendation has already been implemented. Written directions in English/Spanish to the Patient Payment Unit located on the 3rd Floor of the Administration Building have been provided. These directions are given to patients asking where to make payments.

- 12. The Board of Supervisors should direct SMMC to immediately identify a more convenient location for the Cashier's Office and to develop a plan a timeline for the move.**

Response: Disagree. Patient Payments has already been moved from the Cashier's Office to the Patient Accounting area located on 3rd Floor of the Administration Building. In addition, payments can be made at any clinic location.

August 9, 2004

Honorable Jonathan E. Karesh
Judge of the Superior Court
Hall of Justice & Records
400 County Center
Redwood City, CA 94063

Dear Judge Karesh:

Below are the Controller's responses to the Grand Jury's recommendations regarding the San Mateo Medical Center Billings and Collections Report.

1.1 The County Controller should by October 1, 2004, conduct a benchmark analysis of comparable medical centers for billings and collections best practices and performance.

Controller concurs. Our study will commence on or before October 1, 2004.

1.2 The County Controller should by January 1, 2005, perform an audit of SMMC's billings and collections practices and performance. This audit should include a review of the "categorization" process to ensure that insurance coverage is being sought for patients where possible.

Controller concurs. Our study will commence on or before January 1, 2005. The Controller's Audit Division is currently performing a study, the primary purpose of which is to determine if patients are properly classified as indigents. This study was requested by the County Manger as part of a larger study being directed by my office to determine the most cost effective approach to satisfy the County's legal obligation to provide indigent health care.

Sincerely,

Tom Huening
Controller

APPENDIX A: FLOW CHART FOR BILLINGS AND COLLECTIONS

