15. Management Oversight For Revenue Collection Activities

- SCVMC recorded approximately $580 million in gross charges for inpatient and outpatient services in FY 1998-99. However, because the fee setting and recording processes lack management oversight, charges do not accurately reflect the cost of services, are inappropriately recorded, and contribute to charge inequities for unsponsored patients. Specifically:

✓ Operating departments have not conducted cost analyses for the purpose of setting fees for many years. Yet, SCVMC initiated three rate increases since July 1998 that have doubled room rates and increased ancillary service rates by approximately 80 percent.

✓ Internal controls over collection functions are weak, and procedures for charging patients do not exist or are inconsistently applied.

✓ Unsponsored patients who pay the full amount of charges for services receive unequal treatment by the County since Medi-Cal, Medicare, and insurance companies pay only a negotiated portion of charges, and patients qualified for the APD program receive charge discounts based on ability to pay. For example, in December 1999, six unsponsored patients made final payments on bills which reflected total charges, and which exceeded $44,000 for services at SCVMC. In some cases, it took these patients over 10 years to discharge their debt to the County.

- The SCVHHS Finance Department should assume overall management responsibility for all revenue activities at SCVMC. They should establish procedures to ensure that fees are developed using proper cost accounting procedures, conduct periodic comprehensive reviews of rates, establish internal control mechanisms for charge entry and cash collections, and conduct periodic compliance reviews of department charge entry and fee collection processes. In addition, the Board of Supervisors should establish a policy for discounting charges to unsponsored patients.

- By implementing these recommendations, appropriate fee setting and collection procedures would be established, internal controls would be strengthened, and unsponsored patients would be more equitably charged.

Background

In FY 1998-99, SCVMC recorded approximately $580 million in gross revenues for both inpatient and outpatient operations. There are numerous functions in SCVMC that have an impact on the recognition and collection of these revenues. Some of these functions are centralized in the Finance Division of SCVMC. For example, Patient Business Services (PBS) is responsible for invoicing both patients and third party payers and collecting on these invoices. However, many of these functions are decentralized within SCVMC. These activities include the rate setting process, the process to ensure that all services are captured for proper billing to patients, and certain collection processes.

Rate Setting

The current process to establish rates for services provided by SCVMC is fragmented. While the Finance Division has general control over the rate setting process, there is no overall policy in place to review rates to ensure that rates are appropriately being developed. Further, there are no procedures in place to ensure that fees are established using appropriate cost accounting procedures. Additionally, no means has been established to ensure that such rates as the inpatient room rate are based upon operating costs as required by Santa Clara County Ordinance, Section A18-5.

Our inquiries have found that SCVMC has not conducted a comprehensive rate review even though there have been three rate increases implemented by SCVMC since July 1998. Over this 18-month period, SCVMC has doubled inpatient room rates and increased ancillary service rates by approximately 80 percent. The motivation for these three rate increases was the maximization of reimbursements from a state program, SB1255. In each case, the amount of the rate increase that was implemented was an amount that was required to ensure that the usual and customary inpatient charges exceeded a target amount. Additionally, information attached to all three transmittal letters to the Board of Supervisors related to the room rate increases indicated that SCVHHS Finance Department staff had determined that the rate increases bring SCVMC inpatient rates to the community average. We did not audit or review these rate surveys.

After the targeted percentage increase was identified by the Finance Division, the rates were generally increased by applying the desired percentage increase across the board to the current rates in effect. This is true even in areas of SCVMC where the technology related to the performance of a function has changed significantly, such as the pharmacy. In such cases, applying a percentage increase to a rate that was originally developed two or more decades ago does little to ensure that the rate is reflective of the cost of the service. The issue of rate setting in the Pharmacy is discussed below.

Inpatient Pharmacy Fees

For example, inpatient Pharmacy fees are established by Pharmacy Department policy A7170.507. This policy, last revised in April 1994, states that,

> "It shall be the policy of Santa Clara Valley Medical Center Pharmacy Services Division to base its patient charges on the cost of the dose or the unit dispensed or administered plus a uniform fee for service, rather than a percentage mark-up. The schedule of fees will be reviewed at least annually in order to maintain alignment with prevailing community rates for comparable services."

The policy states further that "Inpatient medications will be priced at the indicated fee plus the average wholesale price (AWP)." A fee schedule is then included in the policy, showing 13 separate fees which specify the amounts to be charged for pharmaceutical preparations and compounding procedures performed by the Department. There are wide variations in these fees, which range from a $2.55 fee for an oral/rectal preparation, to a $177.46 fee for an "NICU TPN" preparation.

In August 1999, we requested documentation from the Pharmacy regarding the fees currently charged to patients. We were provided with a listing of inpatient fee categories which corresponded closely with those in effect in FY 1994. However, the amount of the fees on the updated listing had increased substantially. After analyzing the updated fees, we found that each had increased by a standard 70 percent during that period, as shown in the table below.

Table 15.1
Changes In Pharmacy Inpatient Fees
Between April 1994 and September 1999

PREPARATION	4-94 FEE	9-99 FEE	DIFF	% DIFF
Injection Fee	12.82	21.79	8.97	70%
Oral, Rectal	2.55	4.34	1.79	70%
OTC	7.72	13.12	5.40	70%
Rx	12.82	21.79	8.97	70%
IV Solution	27.95	47.55	19.60	70%
Inj-Narcotic	14.11	23.99	9.88	70%
Oral, Rectal Narcotic	3.83	6.51	2.68	70%
TPN/Liter	173.61	295.14	121.53	70%
Irrigation	27.97	47.55	19.58	70%
NICU TPN	177.46	301.68	124.22	70%
CYTO	25.00	42.50	17.50	70%
Compound	18.98	32.27	13.29	70%
Compound/minute	0.83	1.41	0.58	70%

At later interviews with Pharmacy management, we were advised that the individual preparation and compounding fees were developed several years ago based on a cost study performed by the Pharmacy Department. However, the specific year that the cost study was performed could not be recalled by Pharmacy management, and documentation supporting the computation of the different fee amounts was not readily available.

Pharmacy management has acknowledged that each fee had been periodically increased based on standard percentage adjustment factors provided by the SCVHHS Finance Department. It was also confirmed in later discussions with Finance Department staff, evidenced by the 70 percent across-the-board increase implemented for inpatient Pharmacy fees between 1994 and 1999, and by a 30 percent additional across-the-board increase implemented in January 2000.

Accordingly, since 1994, Pharmacy fees have increased an estimated 121 percent without any analysis of the cost basis for individual preparations and compounding procedures. Further, we were advised by hospital administration that an additional inpatient pharmaceutical fee increase will be implemented during FY 1999-00 in order to raise charges to levels which the hospital believes will provide the most favorable reimbursement for the hospital. The amount of this proposed increase was unknown at the time of this report.

Outpatient Pharmacy Fees

Although recent fee increases have not been implemented by SCVMC for Outpatient Pharmacy dispensing services, it is not clear that current fees have any relationship to the cost of services. According to the Pharmacy, an $8.50 dispensing fee is charged for all outpatient prescription medicines, and a 50 percent mark-up on the AWP is charged on all over-the-counter drugs dispensed by the outpatient pharmacies. Yet the Pharmacy has not updated past fee analysis to determine whether these fees fairly recover costs for the hospital.

To justify these outpatient pharmacy fees, we were provided with a 1997 fee study performed by the Pharmacy which showed an average dispensing cost of $4.93 compared with the current fee of $8.50. However, the source and components of the cost and revenue amounts used in this computation were not provided, so we cannot comment on its accuracy. In addition, the computations developed in 1997 do not reflect a variety of significant operating changes that have occurred in the Pharmacy outpatient clinics since that time.

For example, at the Pharmacy Department outpatient clinic locations, the skill mix of staff has changed and automated prescription packaging technology has been introduced during the past several years. Although these changes were intended to reduce costs overall, other changes to employee salaries and benefits, pharmaceutical procurement practices, and the expansion of clinic pharmacy hours may have caused offsetting cost increases which likely reduced or eliminated any savings—and may have increased costs substantially. Therefore, without the benefit of a comprehensive cost analysis, it cannot be determined whether the current $8.50 fee has any relationship to

the dispensing cost per prescription. Such an analysis should be conducted by the Pharmacy to ensure that full costs are being recovered, and that the fee structure fairly apportions costs by preparation and compounding activity.

Over-the-Counter Drugs

The Pharmacy sells various over-the-counter (OTC) drugs to patients. These drugs are based on the AWP for the product, plus a 50 percent mark-up. Therefore, for OTC drugs the dispensing fee established by the Pharmacy has no relationship to cost.

However, interviews with pharmacists at the clinic locations indicate that this pricing methodology frequently results in a pricing structure which in not competitive. Often, sale pricing, as well as standard pricing at large commercial pharmaceutical retailers is well below those being charged by SCVMC. Some pharmacists told us that they advise patients to purchase pain relievers, cough medicines, and other similar products from commercial pharmacies instead of from SCVMC solely because of the pricing structure. As a result, patients must either travel to other locations--which is the antithesis of the stated goals of the decentralized SCVMC pharmacy system--or pay a premium for the OTC product.

Effect of Pricing On SCVMC Finances

We were informed by SCVHHS Finance Department representatives that pharmacy pricing is market based, and that the intent of these pricing strategies is to ensure that fees included on the hospitals Chargè Master List always exceed what SCVMC would otherwise receive on a fee-for-service basis. In the Pharmacy, the hospital reports a cost to charge ratio (i.e., the ratio of total costs to total charges) based on 1998 Medi-Cal cost reports of 0.52:1. This suggests that the hospital charges approximately $2.00 for every $1.00 in Pharmacy costs. However, while this may reflect the general ratio between charges and costs, it does not provide a sound basis for setting individual fees.

In addition to other rate setting methodologies, we have been informed by Financial Management that SCVMC's general process is to make sure that the rates on individual services on the Charge Master List are greater than what SCVMC would receive for the service based upon a fee-for-service comparison. Although a fee-by-fee analysis was not performed for Pharmacy, we found at least five individual fees for lab tests performed by the Department of Pathology and Laboratory Medicine that are set at a rate below what Medi-Cal would otherwise reimburse SCVMC.

We question SCVMC's oversight of the fee setting processes, including the decision in which fees are raised primarily as a means of recovering money from federal/state programs. SCVMC management has stated that, due to contractual agreements, the increases in fees and rates have little or no impact on financial payers. However, they have a real impact on those individuals who must use SCVMC services and have no third party paying for these services.

Inequitable Impact On Unsponsored Patients

The amount of reimbursement expected from unsponsored patients is 100 percent of the gross charges for the services they have received. There are various classes of patients that use SCVMC services. These include patients considered by the County to be medically indigent, patients covered by Medi-Cal, patients covered by Medicare, patients covered by other insurance providers, and patients that are not covered by any third party payer—yet are not considered to be indigent.

The County's indigent program, Ability to Pay Determination (APD), is designed to allow poor and low income County residents to be billed for medical services received or arranged through SCVMC at a level consistent with their ability to pay for these services. The income used in determining a patient's APD status is based upon Federal medical care poverty guidelines. Individuals will not be eligible for APD once their family income exceeds 200 percent of the poverty level. If these individuals are not covered by any other insurance and they require medical services at SCVMC, they will be classified as unsponsored. Thus, many of the unsponsored patients are the working poor. Alternatively, this classification of patient also includes individuals with the means to pay for the services being used. SCVMC does not track financial information in such a manner as to be able to determine the approximate financial make-up of their unsponsored patents.

SCVMC has contractual agreements with most third party payers that result in recovery of less than 100 percent of the gross charges. The result of this is that the amount of the net charges that SCVMC recovers for exactly the same services varies depending on the class of the patient. The average overall reimbursement rate for various classes of patients for FY 1998-99 is identified in Table 15.2 below.

The result is the unequal and unfair treatment of the unsponsored patients of the hospital. These patients, who include the working poor of Santa Clara County who do not qualify for the County's medically indigent program because they have

Table 15.2
Average Percent Of Gross Charges Expected To Be Collected
By Inpatient Class--FY 1998-99

Patient Class	Average % of Gross Charges Reimbursement
Ability To Pay Determination	--*
Medi-Cal	30.05 %
Medicare	50.83 %
Other Insurance	52.59 %

* The medically indigent have no obligation for any inpatient charges. There is a sliding scale for outpatient obligation. Those with income up to 100% of the poverty level have no obligation. Those with income from 101% to 150% of poverty are obliged to pay 10% of the gross charges, those from 151% to 175% of poverty are obliged to pay 20% of the gross charges, and those from 176% to 199% are obligated to pay 30% of the gross charges.

family income exceeding 200 percent of the poverty level, are the only patient class expected to pay 100 percent of the gross charges for medical services at SCVMC. The actual amount of payment that is received from this class of patient is, of course, much lower. On the average, SCVMC collected approximately 7.5 percent of the gross charges for this class in FY 1998-99. However, when these patients do not pay their obligation, the account is referred to the County Department of Revenue (DOR), who performs the delinquent account collection function for SCVMC. DOR makes all attempts at collecting these unpaid accounts, including establishing long-term payment schedules for the patients so they can pay the balance over time. Some of these patients pay 100 percent of the charges they incur. For example, in December 1999, there were six unsponsored patients who made their final payment on total gross charges of more than $44,000. These six patients paid 100 percent of the gross charges they incurred for services at SCVMC, and it took some of them more than 10 years to discharge this debt to the county.

We recommend that the SCVHHS Finance Department establish procedures to ensure that fees are developed using appropriate cost accounting procedures. Further, the Finance Department should establish procedures to ensure a periodic comprehensive review of the rates being charged by SCVMC. Procedures should also be established to ensure that rates throughout SCVMC are set at a level that is based upon the full cost of providing the service. Finally, SCVMC should get Board of Supervisors approval to discount charges to County unsponsored patients that will enable these patients to pay no more than the full cost of the services provided. Although some loss in revenue may occur from those patients who are currently paying 100% of the gross charges, this may be partially or wholly offset by payments made from other patients who are able to pay the discounted amount of gross charges—but would not have paid any of the higher gross charges. We were unable to project the potential impact on revenues with the financial data available from SCVMC, however such lost revenue is estimated to be minimal.

Services Captured For Billing

Each department has its own staff to enter the charges for its services into SCVMC's financial information systems for billing purposes. It is only after the charges are captured in the computer that an invoice can be generated. Although the invoicing process and subsequent collection is the responsibility of PBS, it is important to note that if the charges for services are not appropriately captured, the charges will never be invoiced to the patient and any revenues related to that transaction will be lost.

While this decentralized charge entry makes sense, we found control deficiencies in various activities. The control mechanisms that should be used to ensure that all charges are captured for the billing of services are financial in nature. Many of the individuals that are managing the charge entry function in these departments are not financial specialists. In many cases, they are staff with a technical background that have migrated to administrative functions in the department. Although many of these departments have attempted to develop procedures to control the charge entry function, the procedures are often inadequate. And, the Finance Division has not established procedures related to the charge entry function for these decentralized

departments. Additionally, it does not provide any control function by virtue of the audit of these hospital operations to ensure that all fees are being recorded for billing purposes.

Some of the departments perform procedures to ensure that all of the services performed for the day are properly billed. For example, Diagnostic Imaging compares the Departmental Activity Journal (DAJ) daily to the Diagnostic Imaging Consultation Requests to ensure that all of the exams identified on the request as being performed are appropriately recorded on the DAJ so they will be billed to the patient. Errors identified are researched and corrected. However, another important reconciliation procedure in this Department to ensure that billings are appropriate has not been consistently performed.

Other Departments have reconciliation procedures in place, but they are not adequate to ensure that all billings are captured. For example, the Ambulatory Care Charge Entry unit, which is the unit that enters all of the charge documents prepared in the clinics for patient visits into the system for billing purposes (approximately 496,000 visits and $48.0 million in collected charges in FY 1998-99), does not have adequate procedures to ensure that all of the charge documents produced in the clinics are received by Charge Entry, or to ensure that all of the items on the charge documents are entered into the system.

Additionally, there are no written procedures for the Ambulatory Care Charge Entry function. Although the new Charge Entry supervisor is attempting to implement controls in this area, the procedures that have been established are not adequate. For example, the procedures do not ensure that charge slips have been received for all physicians that have patients scheduled on a particular day. Additionally, although procedures ensure that charge entry staff count the number of charge slips and compare them to the control document, there are not procedures in place to ensure that the control document is correct or to ensure that all missing documents are located. Charge Entry staff informed us that they do not follow up on missing documents if the number of documents on the control slip is only one or two higher than the number of charge documents attached. Since the control slip usually represents one physician's appointments for one day, which totals a maximum of 19 visits at the current expected visits per hour, one missing charge document represents approximately five percent of the total charge documents. Based upon FY 1998-99 statistics, if the Charge Entry staff is allowing one percent of the total number of outpatient visits to fall through the crack, this represents 5,000 visits with total average reimbursement for these visits of approximately $500,000.

Yet other departments do not have controls in place to ensure that all services performed for patients are appropriately charged. For example, the Department of Pathology and Laboratory Medicine does not have appropriate controls in place to ensure that all tests being performed by outside laboratories are being charged to patients—or that they are being charged to patients at the proper price. In this department, we identified the following:

- Because the Department of Pathology and Laboratory Medicine does not perform all laboratory tests required for SCVMC patients, they send some of the

work to outside Reference Laboratories. Since many of these tests are standard tests, Department Management has included these tests on the SCVMC Charge Master List (CML) so they can be billed to patients in the same manner as tests that are performed in-house. Department Management stated that the prices on the CML for tests performed by outside Reference Laboratories are required, by law, to be equivalent to the amount the Reference Laboratory charges SCVMC to perform the test, although an appropriate service fee is also allowed. There were no written procedures for this process, and there are not procedures in place to ensure that all of the tests being performed by these Reference Labs are being charged to patients. We reviewed charges totaling $3,103 to 20 patients from three Reference Lab invoices to ensure that they were properly billed to the patient by SCVMC. Of the total 26 individual lab tests identified for these patients, 11 lab tests ($1,954) were not billed to these patients.

- Additionally, another nine lab tests were billed to patients at an improper amount, resulting in a net overbilling of $121. Since this indicated a problem with the prices being charged to patients for work performed by Reference Labs, we reviewed all items on one invoice for the largest Reference Laboratory. This review identified pricing problems related to these tests. Of the 112 different tests on the Reference Lab invoice, we identified three that were being charged at a lower rate on the CML than the reference lab was charging SCVMC and six that were being charged at a higher rate on the CML than the reference lab was charging SCVMC. All of these pricing errors appeared to relate to a price change implemented by the Reference Lab before it was implemented by SCVMC.

- We also noted that the Department had sent a CML update to the Finance Department so that prices re-negotiated between the Department and the Reference Lab effective 6/1/99 could be properly updated. This update was not sent to Finance until 9/28/99, almost 4 months after the price changes went into effect. A total of 56 prices were affected—25 changes reduced the price on the CML; 30 changes increased the price, and one was not yet on the system. We did not verify all 56 price changes. However, 17 of these prices were on the Reference Lab invoice we reviewed. A comparison of these items found that three of the 17 price changes made on the CML were not to the proper amount being charged by the reference lab, and will result in too much being charged for the test.

We recommend that the Finance Department establish appropriate reconciliation and control procedures for implementation by individual charge entry departments. Further, we recommend that the Finance Department establish audit procedures to ensure that the departments are implementing these procedures and to ensure that all services for patients are appropriately charged.

Collection Processes

Although PBS is responsible for collecting the bulk of the receipts that come into SCVMC, there are other functions in SCVMC that are responsible for certain collections from patients. Examples of decentralization in this function include:

- Pharmacy personnel are responsible to collect payment for certain types of prescription and OTC drugs, as well as co-payments for the Medicare Waiver Program.

- Ambulatory Care Clinic personnel are responsible to collect co-payments and other partial payments for services from certain patients, depending on the patient's insurance carrier.

- Department of Pathology and Laboratory Medicine staff is responsible for the collection of certain invoices that they generate for a particular type of business.

Our review identified a general lack of procedures in this area, with a corresponding deficiency in internal controls. Internal controls are intended to provide management with a reasonable assurance that assets are being properly safeguarded. Additionally, appropriate internal controls will prevent or detect unauthorized acquisition, use or disposition of assets. Examples of issues identified in this area are provided below.

Pharmacy

The Pharmacy Ambulatory Care Formularly lists six prescription drugs which require that the patient pay "cash at the time of receipt" or pay "cash at the time of receipt, or (provide evidence of) guaranteed third party payment" at the time of receipt. The outpatient pharmacies also dispense a number of over-the-counter drugs which are not covered by Medi-Cal, or by other third party payers. Lastly, the outpatient pharmacies are required to collect co-payments from certain patients who participate in the "Medicare Waiver" and other insurance programs. The co-payments for the Medicare Waiver Program are set at a modest level of $3.00 per prescription drug, and are to be collected at the time the prescription is dispensed.

The Pharmacy manages outpatient drug dispensing using the "PCSI" system, which provides the pharmacist or pharmacy technician with information on charges and co-payment fees for each prescription. Non-covered prescription and OTC drug charges are to be noted by the staff person from the electronic formulary maintained in PCSI, and charged to the patient. Co-payment fee requirements, which are determined by patient financial class, are also to be noted by the staff person working the dispensing window, and charged to the patient.

A review of this process indicates that:

- At the clinic sites visited, although Pharmacy staff was generally aware of their duties, the individuals interviewed for this study were not aware of any *formal* policies or procedures for charging patients for non-covered prescription and OTC drugs, accounting for money collected for these drugs, or making deposits. Comprehensive documentation of these activities is not included in the Department's administrative policies and procedures manual (see Section 31).

- Pharmacy staff at the East Valley and Chaboya clinic were aware of policies requiring payment of the Medicare Waiver fee, and the staff at East Valley produced a matrix which displayed these fees. However, this document

provided limited information and was clearly not a component of a more comprehensive policy or procedure prepared by the Pharmacy.

- Pharmacists and technicians at each site indicate that daily collections are low, generally averaging $50 or less each day. We are unaware of any procedures in the Pharmacy to ensure that the daily collection amount is representative of total fees which should be collected.

- When requested, Pharmacy management was unable to produce any records or reports to demonstrate that patient fees are being consistently collected by staff.

We did not conduct an extensive analysis of the financial impact from the lack of comprehensive policies and procedures in these areas. However, we requested that the Pharmacy produce reports to demonstrate whether cash is collected, when appropriate, at the time of receipt for non-formulary drugs, and for Medicare Waiver co-payments.

Based on review of data generated by the Department, we found:

- Patients pay cash or charge for non-formulary drugs, unless Pharmacy staff believes that the drug is covered by a third party payer. However, the third party payer identified by the Pharmacy may not always cover the non-formulary drug or its full cost. For example, between August 1, 1999 and September 30, 1999, the Pharmacy dispensed 123 prescriptions for non-formulary Fexofenadine (Allegra™) to patients receiving services at one of the County's Federally Qualified Health Clinic sites (FQHC). Under FQHC reimbursement regulations, total costs are reimbursed, but are subject to cost report settlement.

- During the same period, the Pharmacy issued over 5,000 prescriptions to patients in financial class G/R (Medicare Waiver Program). Under this grant program, all patient visit charges are billed directly to the federal government, and then adjusted based on final cost report. Yet, based on a sample of over 1,134 prescription records, patients were charged the co-payment amount in only 11.5% of the instances. Unpaid co-payments would potentially have been billed to the patient through PBS. However, because of the low dollar amount of the co-payment, the charge would likely have been written-off.

The loss of revenue would not have been significant in either of these instances. Prescriptions for drugs which require patient payment, and for which no payment or reimbursement is received appear to be relatively few. In addition, we estimate that even if all required patients had paid the Medicare Waiver co-payment during the two month period reviewed, less than $15,000 in additional revenue would have been collected by the hospital. Nonetheless, it is important that collection, accounting and internal control procedures in these areas be established so that theft exposure is minimized.

Ambulatory Care Services

Ambulatory Care Services procedure (Draft 2/98) requires that co-payments, which are partial payments required by the insurance carrier at the point of service, will be

collected when required by patient's insurance group/plan. However, only three of the eleven Ambulatory Care Clinics are collecting any co-payments from patients who have responsibility for these payments. And, even the three clinics that are collecting co-payments are not collecting co-payments from all patients who have this responsibility. Further, not all of the clinics that are collecting these co-payments have the draft procedure that is intended to control this activity.

The Ambulatory Care Services procedure for cash collection requires daily processing of the cash receipts and deposit of these receipts with the Pharmacy for transfer to PBS. Because the volume of the co-payment collection is not currently very high (usually less than $100 per day in each clinic), the clinics are not currently processing and depositing the receipts on a daily basis.

Currently Medical Admitting Clerks (MAC) are "aware" that co-payments are required from several classes of patients (such as Medicare Waiver medical and dental patients and Healthy Family patients). However, there is no comprehensive listing of other insurance plans where co-payments are required. And, as the percentage of SCVMC business related to Insurance Providers increases, the number of patients that should be paying co-payments will increase, making a comprehensive listing more desirable.

Additionally, at the three clinics that are currently collecting co-payments, we were informed by both MACs and Ambulatory Service Managers (ASMs) that the MACs do not aggressively ask for co-payments. The patient is often not asked for the co-payment because the MAC finds it uncomfortable to ask for the money. One ASM stated that asking for the co-payment is contrary to SCVMC's policy of providing service to anyone regardless of the ability to pay. And, while these co-payments are billed to the patient if they are not paid at the point of service, it is important to note that non-payment of these small amounts in the invoicing process will most likely result in a write-off.

Department Of Pathology And Laboratory Medicine

The Department of Pathology and Laboratory Medicine initiated an Outreach Program during fiscal year 1998-99 as part of the reengineering effort, and the Department has taken the responsibility for invoicing the accounts related to this program (see finding related to this issue in Section 16 of this report). Our review of the internal controls related to the invoicing and collection of these accounts found that such controls are not adequate to ensure the proper safeguard of these assets. For example, there is no segregation of duties between the person performing the billing function and the person performing the collection function. Additionally, the same person who performs the billing and collection function is also responsible for receiving the payment. This lack of segregation of duties could expose SCVMC to the unauthorized use of assets.

We recommend that the Finance Department establish appropriate procedures, which encompass reconciliation and internal control issues, for implementation by any departments responsible for collections from patients. A comprehensive listing of co-payments should be developed and kept current, and personnel responsible for the collection of these payments should receive clear instruction related to their responsibility for collection. Further, we recommend that the Finance Department

establish audit procedures to ensure that the departments are implementing these procedures and to ensure that all appropriate collections from patients are being made.

Conclusions

In FY 1998-99, SCVMC recorded approximately $580 million in gross revenues for both inpatient and outpatient operations. The activities to ensure that these charges are based upon the cost of service, appropriately recorded to ensure proper billing and that certain fees and charges are properly collected are decentralized and lack proper controls and management oversight.

The rate setting process is currently fragmented. Although SCVMC has initiated three rate increases since July 1, 1998, which have doubled inpatient room rates and increased ancillary service rates by approximately 80 percent in 18 months, they have no procedures in place to ensure that fees are established based upon appropriate cost accounting procedures, or that inpatient room rates are based upon operating costs as required by Santa Clara County Ordinance, Section A18-5.

The result is the unequal and unfair treatment of the unsponsored patients of the hospital. This results because, while SCVMC has contractual agreements with most third party payers that result in recovery of less than 100 percent of the gross charges, SCVMC's unsponsored patients, who include the working poor of Santa Clara County, are expected to pay 100 percent of the gross charges for medical services at SCVMC. And, while the actual amount of payment that is received from this class of patient is much lower, these patients are pursued for the full gross charges they have incurred. In fact, some of these patients pay 100 percent of the charges they incur. For example, in December 1999, there were six unsponsored patients who made their final payment on total gross charges of more than $44,000. These six patients paid 100 percent of the gross charges they incurred for services at SCVMC, and it took some of them more than 10 years to discharge this debt to the county.

Additionally, there are not adequate controls in place to ensure that all services are captured for proper billing to patients. Finally, although PBS is responsible for collecting the bulk of the receipts that come into SCVMC, there are other functions in SCVMC that are responsible for certain collections from patients. We identified a general lack of procedures in these areas, with a corresponding deficiency in internal controls that are intended to prevent or detect unauthorized use or disposition of assets.

Recommendations

It is recommended that SCVMC Management:

15.1. Direct the Finance Department to establish procedures to ensure a periodic comprehensive review of the rates being charged by SCVMC.

15.2. Direct the Finance Department to establish procedures to ensure that fees are established using appropriate cost accounting procedures, and to ensure that rates are set at a level that is based upon the full cost of providing the service.

15.3. Obtain Board of Supervisors approval for a discount for County unsponsored patients that will enable these patients to pay no more than the full cost of the services provided.

15.4. Direct the Finance Department to establish appropriate reconciliation and internal control procedures for implementation by 1) individual charge entry departments, and 2) departments responsible for collections from patients. Further, the Finance Department should establish audit procedures to ensure that the departments are implementing these procedures and to ensure that all services for patients are appropriately charged and collected.

Costs And Benefits

The cost of implementation of these recommendations should be offset by the benefits to be gained from ensuring that SCVMC rates are established using appropriate cost account procedures, that they are set at a level that is based upon the full cost of providing the services, and that they are properly billed and collected. In addition to the collection of additional revenues related to services that are currently being performed, yet are not being billed, the implementation of these recommendations will result in rates that are more easily justifiable than the current rate structure. Given that these rates are critical to the amount of reimbursement SCVMC receives from federal/state programs, it is important that the rates have a solid basis for justification. Further, implementing a discount for County unsponsored patients that will ensure that these patients pay no more than the full cost of the services provided and will make the cost of these services more equitable.

Response To SCVMC Written Comments On Draft Report

SCVMC partially agrees with recommendations 15.1 through 15.4. Although SCVMC asserts that they are currently performing some of these functions, they agree that the current procedures are often ad hoc and/or need to be updated and enhanced.

We have revised recommendation 15.2 to reflect the fact that rates should be established *based upon the full cost to provide the service* (as required by Santa Clara County Code Section A18-6). This does not limit the setting of rates to the full cost of the service, nor does it prohibit the ability of SCVMC to provide services to the County's uninsured or indigent population at a reimbursement rate that is less than full cost. Since this recommendation does not limit rates to the full cost of the service, the assertion by SCVMC that the implementation of this recommendation may result in the loss of a significant amount of reimbursement is unfounded.