Guam Memorial Hospital Authority
Billing and Collections of
True Self-Pay Accounts

Performance Audit
January 1, 2017 through June 30, 2018

OPA Report No. 19-01
February 2019

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EXECUTIVE SUMMARY
Guam Memorial Hospital Authority
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The Guam Memorial Hospital Authority's (the Hospital) billing and collection practices for true self-pay accounts did not comply with the applicable law, rules and regulations, and policies and procedures, thereby giving the opportunity for patients and/or guarantors to avoid paying their hospital bills. Management allowed non-collection or untimely collection of past due accounts by not instituting rigorous billing and collection systems. From January 1, 2017, through June 30, 2018, the Hospital billed $22.1M, of which 90% or $19.8M remained uncollected. The non-collection may affect the Hospital's ability to provide quality patient care.

Actual Billed Charges Different from Published Fee Schedules
We found that actual patient charges were not on the Hospital's published schedules, and/or incorrect based on updated effective rates. This raised significant concern as to the transparency and accuracy of billings to true self-pay patients.

Credit Arrangement/Payment Agreement at Discharge Not Done
The Hospital did not prioritize making credit arrangements before a patient's discharge. It averaged a patient six months after discharge to return and arrange for a payment plan.

Collections Staff Not Focused on Collecting Delinquent Accounts
About 99% of the time, the Collections Staff perform non-collection tasks, such as entertaining various calls and concerns from patients or visitors. Only 34% of our samples were followed up by telephone calls which were made 49 days after accounts had become delinquent. Still, collections have not progressed.

Delinquent Accounts Not Referred to the Contracted Collection Agency
The Hospital did not refer any delinquent accounts to the contracted Collection Agency, despite the law requirement of referring delinquent accounts after 120 days.

Partial and Interim Bills Not Provided to Patients
The Hospital did not provide partial or interim bills to patients. Billing and Collections Staff expressed concerns with the health and emotional status of the patient, hence being conscious of providing partial or interim bills.

Meanwhile, the Hospital could not provide for our inspection all the signed Legally Enforceable Debt forms and documentation of account referrals for tax refund garnishment. We also noted that the Hospital's Standard Operating Procedures (SOPs) related to the billing and collection of self-pay accounts were outdated for over two decades.

As a result of the audit, we made five recommendations.

Benjamin J.F. Cruz
Public Auditor

Introduction

This report presents the results of our performance audit of the Guam Memorial Hospital Authority's (GMHA) billing and collections for true self-pay accounts. The Office of Public Accountability (OPA) initiated this audit as part of its 2018 annual performance audit plan.

The audit aimed to determine whether GMHA's billing and collection practices for true self-pay accounts were in accordance with applicable law, rules and regulations, and policies and procedures. The scope of this audit was the true self-pay patient accounts from January 1, 2017, through June 30, 2018.

The objective, scope, methodology, and prior audit coverage are detailed in Appendices 1 and 2.

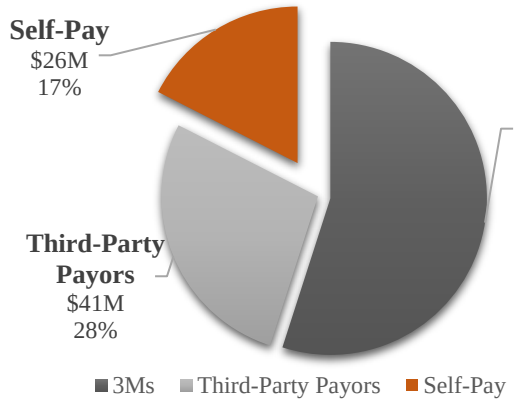
Background

GMHA owns and operates the Guam Memorial Hospital (the "Hospital") which is Guam's only public hospital and is open 24 hours daily. The Hospital is licensed for bed capacity of 161 acute care beds at the main building in Tamuning, and 40 licensed long-term care beds at its Skilled Nursing Facility in Barrigada Heights. The Hospital recognizes that healthcare is a basic human right regardless of the patient's ability to pay.

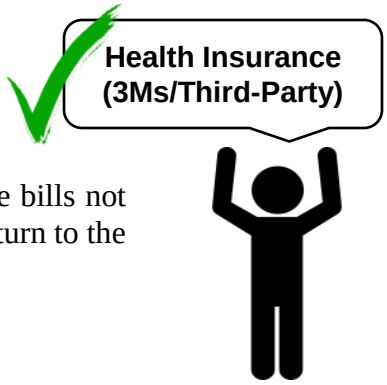
Payer Mix

Chart 1 shows the major categories of the Hospital's payer mix and the total billing per payer type for the past 10 fiscal years. It shows that the 3Ms [Medicare, Medicaid, and Medically Indigent Program (MIP)] dominate the payer mix at 55% or $82 million (M) annually. This was followed by third-party payers or the health insurance companies at 28% or $41M annually. Lastly, the self-pay payers were at 17% or $26M annually.

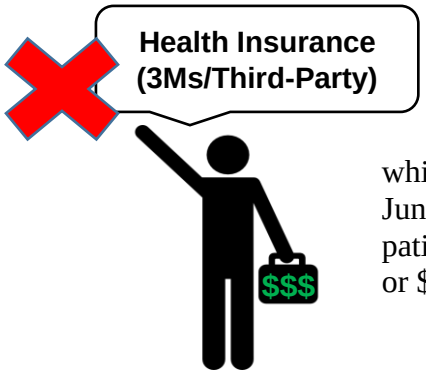
Chart 1. Average Annual Billing per Payer
Fiscal Year (FY) 2008 - 2017



Self-Pay Accounts
Self-pay refers to patients who are underinsured or without health insurance coverage.



Underinsured Self-Pay
The Hospital attempts to collect from the patient's co-insurance and any deductible amounts not yet met according to his/her health insurance coverage. Then, they will collect all other hospital bills from the 3Ms and/or third-party payers. Should there still be bills not covered by the 3Ms and/or third-party payers, the Hospital will return to the patient or guarantor to collect the remaining balance.



True Self-Pay
True self-pay are patients with no health insurance coverage, which was the focus of this audit. From January 1, 2017, through June 30, 2018, the Hospital billed $22.1M to 7,516 true self-pay patients (or 15% of the total patients count). As of August 2018, 90% or $19.8M was still uncollected.

GMHA Departments Involved in Billing and Collections
The Patient Registration Department handles the patient's registration and discharge processes. This department has 22 personnel, which includes the Chief of Admissions and 16 Patient Service Representatives (PSRs).

The Patient Affairs Department handles the Hospital's billing and collection processes. This department has 31 personnel, which includes the Credit & Collection Supervisor and four Collection Agents.

The General Accounting Department has 16 personnel, however, the staff directly involved in the billing and collections include the: (a) Utilization Review Specialist, (b) Quality Improvement (QI) Specialist, (c) Accountant I, and (d) Accountant II.

The Management Information Systems (MIS) Department has nine personnel. They provide data mining support such as customizing various revenue reports, receivable statistics, tax garnishment reports, and collection listings.

Collection Mechanisms Outside of the Hospital
If collection is still not obtained despite the Hospital's efforts of sending customer statements and calling the patient/guarantor, accounts are forwarded either to the contracted Collection Agency or to the Department of Revenue and Taxation (DRT).

a) Contracted Collection Agency – The Hospital has a month-to-month contract with a Collection Agency. The contract states that the Hospital will refer accounts and claims receivable from patients and guarantors over $75, within 270 days of a patient's discharge.

The Contractor shall remit any collections to the Hospital, net of commission, ranging between 20 to 50 percent (%) of amounts collected.

b) DRT – The Hospital refers accounts to DRT for tax refund garnishments for patients/guarantors living in Guam that have a Social Security Number (SSN). The Hospital refers accounts with a minimum balance of $50 because it is charged $25 per account for the actual tax refund garnished. The Hospital collected $4.0M in fiscal year (FY) 2017 and $8.5M in FY 2016 from tax refund garnishments.

Results of Audit

The Hospital's billing and collection practices for true self-pay accounts did not comply with the applicable law, rules and regulations, and policies and procedures, thereby giving the opportunity for patients and/or guarantors to avoid paying their hospital bills. From January 1, 2017, through June 30, 2018, the Hospital billed $22.1M to 7,516 true self-pay patients, of which 90% or $19.8M remained uncollected. By not instituting rigorous billing and collections systems, management allowed non-collection or untimely collection of past due accounts. As a result, uncollected amounts will continue to rise, which may affect the Hospital's ability to provide quality patient care. Our audit found that:

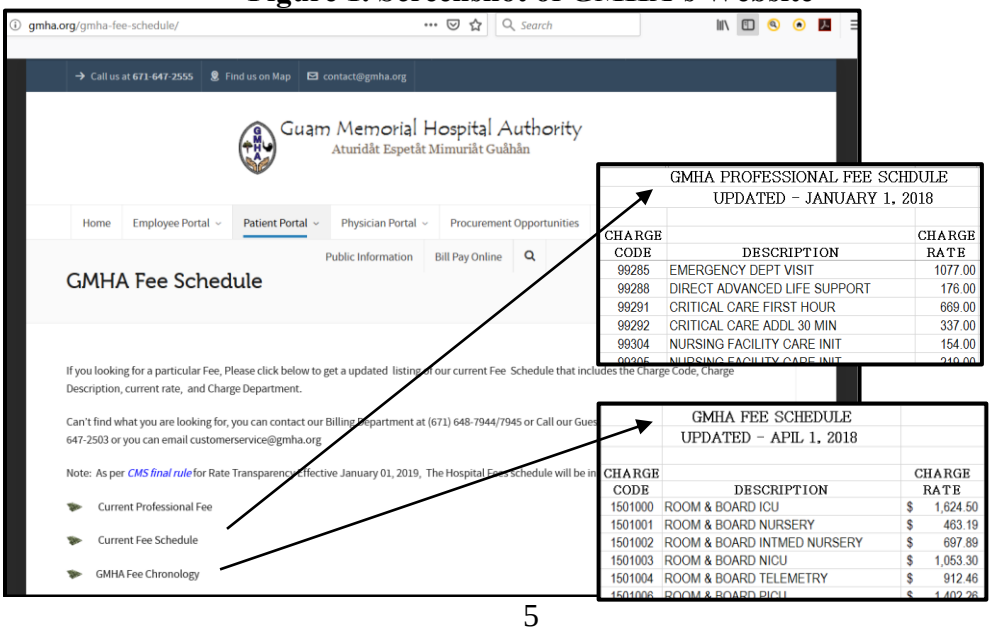
- Charges to patients were not on the Hospital's published fee schedules and/or incorrect based on effective rates;
- Credit arrangements were not done with patients as part of the discharge process;
- Collections Staff were not focused on collecting delinquent accounts;
- No delinquent accounts were referred to the contracted Collection Agency; and
- Both partial and interim bills were not provided to patients.

In addition, the Hospital could not provide for our inspection all the signed Legally Enforceable Debt forms because of a system glitch, and the documentation on account referrals to DRT for tax refund garnishment. We also noted that the Hospital's Standard Operating Procedures (SOPs) related to billing and collections on self-pay accounts were outdated for over two decades.

Actual Billed Charges Different from Published Fee Schedules

According to 26 Guam Administrative Rules and Regulations (GAR) §17104 (a)(1)(a)(1), all patients, regardless of health insurance coverage or other considerations, shall be charged for services received based on the Hospital's fee schedule. Fees for professional services will be determined by the physician and will be billed separately from the Hospital's fees for supplies and services.

Figure 1. Screenshot of GMHA's Website



In our comparison between rates billed to the patients, and the rates based on published fee schedules, we noted variances on several patient accounts tested.

Charges Not in the GMHA Fee Schedule

On 11 patient accounts, we noted certain charges collectively worth $2,483 that were not found in the published fee schedules on the Hospital's website. Although these were not on the website, we verified that the charges were appropriate and properly captured in the Hospital's system. However, the cause of the website not being updated was unclear as the QI Specialist was still checking this issue with the MIS Department. The discrepancy signifies a lack of verification on the completeness of fee schedules before they are updated and posted on the Hospital's website for public access.

Incorrect Charges Based on Effective Rates

On five patient accounts, we noted certain incorrect charge rates when compared with the effective rates published on the Hospital's website. We found that there was an inconsistency between the dates when the new charge rates should have been effected versus the date when the charges were updated in the system.

In one instance, a patient had an emergency visit on February 15, 2018. Based on the Professional Fee Schedule effective January 1, 2018, the patient should have been charged at the new rate of $1,077, however, was charged the old rate of $925 resulting in $152 under billing. Upon inquiry with the QI Specialist, we learned that the system was updated to reflect the new charges in March 2018, or two months after the new rate's effective date. Table 1 shows the five patient accounts charged with the old rates.

Table 1. Sampled Accounts of Charges with Incorrect Charges

Sample No.	Charge Code	Description	Charged Amount at Old Rates	Effective Rates	Over (Under) Billing
3	90935	Hemodialysis	$2,315.25	$2,124.00	$191.25
27	1501001	Room and board	840.26	882.28	(42.02)
41	99285	Emergency Dept. - Professional fee	925.00	1,077.00	(152.00)
42	99283	Emergency Dept. - Professional fee	342.00	365.00	(23.00)
44	99213	Outpatient visit	122.00	128.00	(6.00)
				Net Under Billing	**($31.77)**

This finding was similar to the FY 2017 Management Letter comment from the external auditors stating that the 5% increase for all room and board charges that were effective April 1, 2017, was neither reflected nor effected in the system and was corrected only after the issue was raised as a result of the audit. According to the QI Specialist, the Hospital does not conduct a regular and timely review of the charges billed to patients whenever there are rate changes. A later review is usually only triggered by a complaint or when someone notices an error.

With five of the 50 samples (or 10%) containing incorrect charge rates, the financial impact could be more considering the total billing for true self-pay accounts from January 1, 2017, through June 30, 2018, was $22.1M. We recommend the Chief Financial Officer (CFO) to (a) evaluate whether review and/or corrections should be performed on outstanding patient bills and (b) immediately create a policy on the implementation and review of rate changes.

Credit Arrangement/Payment Agreement at Discharge Not Done

According to 26 GAR §17104 (b)(6)(c), should an uninsured patient be unable to pay the balance at discharge, necessary credit arrangements must be made with the PSR and/or Credit and Collections Staff.

At the time of discharge, the PSRs ask for a future date the patient/guarantor will return to make payment. However, this process does not make up a credit arrangement. In fact, GMHA Policy No. 8350-5, has stricter guidelines about a payment agreement. It states that a payment agreement shall be executed if it is determined that the patient/guarantor cannot pay the total balance in full. It also requires that patients pay a 10% to 30% deposit, depending on the balance owed; otherwise, no agreement shall be executed.

Based on 50 samples, our testing showed that only 37 accounts had future dates the patients/guarantors promised to return to make payment. These future dates ranged from one to 183 days, or as much as six months after the patient had been discharged. Of the 37, only 11 accounts had some payments. However, there were no credit arrangements made, nor were deposits collected.

The GAR mentions both the PSRs and Collections Staff to make necessary credit arrangements, which is not specific as to who is directly in charge. In addition, we find Policy No. 8350-5 contradicting because it requires a deposit. However, if a patient is unable to provide a deposit, then a credit arrangement cannot be executed.

The Patient Affairs Department's reliance on patients/guarantors to return to make credit arrangements immediately gives them the opportunity to avoid making payments. According to the Chief of Admissions, the PSR's focus is on getting the patient's information and releasing patients, and that a patient/guarantor is supposed to make a credit arrangement with the Collections Staff on the future date that was agreed upon. We recommend the CFO to define who is in charge of credit arrangements.

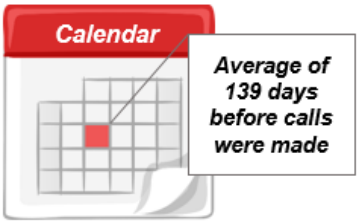
We hear the Hospital's concern regarding the difficulty to collect from patients, especially since it has no leverage to hold them for anything. However, the moment the patient/guarantor walks out of the Hospital, the chances of collecting becomes low. Therefore, we also recommend the CFO to enforce the execution of a credit arrangement before the patient's discharge.

Collections Staff Not Focused on Collecting Delinquent Accounts

According to 26 GAR §17104 (b)(1)(I), once an account becomes delinquent or inactive, the Credit and Collections Representative will make telephone calls to the patient to determine when payment can be expected or if a problem exists with the account. An account is delinquent if it is unpaid after 90 days. Meanwhile, GMHA Policy No. 8350-3 states that the first call to the patient/guarantor should be made within 10 days after the first collection letter is sent and subsequent calls should be made every 15 days until payment is made in full or a payment plan has been put into place.

We found that calls were not regularly performed on delinquent accounts. Of the 50 samples, only 17 (or 34%) patient accounts were followed up by a telephone call. Of the 17 accounts for which calls were attempted, it averaged 49 days after an account had become delinquent before a Collections Staff made an attempted call. This is 139 days or about 5 months after they had discharged the patient. From these 17 attempt calls made, none turned into a successful credit arrangement. For some, the Collections Staff were unable to get an update on the accounts for various reasons such as calling an incorrect phone number, calls not being answered, and more.

Chart 2. Attempted Calls Made



According to one of the Collections Staff, she spends most of her hours handling other tasks such as entertaining various calls and concerns from patients or visitors. Often when she finally gets a hold of the patient/guarantor, she is faced with difficult conversations regarding the patient/guarantor's personal, financial, or emotional difficulties. These conversations can prevent or distract the Collections Staff from focusing on getting status updates or making necessary credit arrangements on delinquent accounts. Therefore, the collection of delinquent accounts have not progressed.

During our interview, the Special Projects Coordinator had shared the Collections Staff's frustrations of how patients can easily change their contact information to avoid receiving calls or statements from the Hospital. In April 2018, the Hospital adopted the AccuReg system, which provides real-time data checks for the legitimacy of information provided by patients including insurance coverage and addresses. However, AccuReg is not an effective tool in checking contact numbers as patients can just easily change them.

If the Hospital can establish credit arrangements with patients/guarantors upon discharge, this should ease some follow-up calls by the Collections Staff. However, we still recommend the CFO to provide formal training and set target collection outputs for the Credit & Collection Supervisor and Collections Staff.

Delinquent Accounts Not Referred to the Contracted Collection Agency

According to 26 GAR §17104 (d)(1), accounts delinquent after 120 days shall be referred to a collection attorney or agency for further action. However, none of the sampled patient accounts were referred to the Collection Agency. The non-referral of accounts further limits the Hospital's ability to progress in the collection of delinquent accounts.

Based on our inquiry with the Special Projects Coordinator, the Hospital has not been referring accounts to the existing Collection Agency because the Hospital is working to issue another Request for Proposal (RFP) for a Call Center/Collection Agency. Note however that one of our sampled patient accounts was delinquent for 450 days.

Due to the prolonged absence of the Credit & Collection Supervisor, the Special Projects Coordinator was tasked to develop an analysis, for recommendation to management, of which delinquent accounts should be referred to the existing Collection Agency. The Special Projects Coordinator stated that the analysis in progress considers the cost-benefit given that they may award a new contract based on the upcoming RFP. The month-to-month contract with the existing Collection Agency, which is valid until October 2019, states that a $25 fee will be charged for any accounts referred by GMHA that is taken back 30 days after the referral date to the Collection Agency.

When inquired about the process of selecting which accounts to be referred to the Collection Agency, we found that GMHA does not have a formal policy in place for this process. Therefore, we recommend the CFO to create a policy on the account referral process to the Collection Agency, including how the analysis should be done and when to refer accounts.

Partial and Interim Bill Not Provided to Patients

According to 26 GAR §17104 (b)(1)(D) and (E), if the patient is hospitalized for over 10 days, he/she will receive a partial bill requesting payment of his/her portion of the account. They shall present to the patient/guarantor for payment an interim bill summarizing all charges keyed in up to the time of discharge. According to the Billing Supervisor, they provide the interim bill to patients every 30 days while the patient is still admitted.

From our 50 samples, nine patients were admitted for over 10 days without being issued partial bills. Only one patient was admitted for over 30 days, but was also not issued an interim bill. We were informed by the Chief of Admissions that the Hospital is concerned with the health and emotional status of the patient, hence being conscious of providing partial or interim bills. The Hospital previously had a Financial Counselor, tasked with speaking to patients and handing them their bills. However, this Financial Counselor had resigned/retired in 1995 and was never replaced.

It is natural for bills to continue to rise as a patient stays longer in the Hospital. Therefore, we recommend the CFO to enforce law requirements of providing partial and interim bills to patients. Considering the recommendation about establishing credit arrangements upon discharge, we also recommend the CFO to assess, based on the current financial condition of the Hospital, whether reinstating a Financial Counselor will help improve the collection process. Financial Counselors not only inform patients of their obligations, but they also relieve physicians and other staff members of the uncomfortable and time-consuming task of discussing finances with patients.

Other Matters

Documents Not Made Available for Inspection

According to 26 GAR §17104 (b)(12)(F), the patient must be informed that the account may be turned over to a collection attorney or agency if not paid within 120 days and that he/she will be liable for collection costs. The Hospital provides a Notice of Legally Enforceable Debt form to patients as part of the admission process.

The form states that:

a) The entire balance of the debt becomes immediately due and payable.
b) Accounts not paid within 60 days will cause the automatic referral of the debt to the DRT for garnishment of tax refunds, or referral to a Collection Agency for further collection efforts.
c) They will impose additional fees for the amount due for services rendered, plus all reasonable legal fees and court costs if referred to an Attorney and/or Collection Agency.

The Hospital staff could not provide for our inspection the signed forms for 23 out of 50 samples (or 46%). According to the Chief of Admissions, the Hospital encountered a system glitch when the signed forms were uploaded to the system. Without these signed forms, the Hospital may not legally enforce collection. Although it was documented in the system that they provided the forms, we questioned the Hospital's storage-keeping practices.

Unable to Determine Accounts Referred to DRT for Tax Refund Garnishment

According to 26 GAR §17104 (b)(1)(L), the Hospital may elect to work with the DRT to withhold income tax refunds for outstanding patient accounts. GMHA could not provide documentation to support whether any of the 50 accounts we sampled have been analyzed for the referral to DRT or not.

Based on our observation, the Hospital's last resort to collect is through account referrals to DRT for tax refund garnishments, as its internal collection efforts for true self-pay accounts were not working effectively. Although we know that GMHA has been receiving collections from outstanding patient accounts through garnished tax refunds, we are also concerned of whether they included all accounts subject to referral in the analysis.

During our interview, the Accountant informed us that they rely on IT personnel for the extraction of patients and guarantors' SSNs, which is primarily DRT's identifier in tax refund garnishments. With that, the Patient Affairs Department could not provide us with information on whether they have referred any of our sampled accounts to DRT. Similarly, the Hospital's management may lack the information it needs to monitor which specific patient accounts were referred to DRT for tax garnishment. This is important when determining recommendations for account write-offs to the Board of Trustees. In March 2017, GMHA had written off $220M in patient receivables. Note that §17104(g) Write-Off Policy states that the Patient Affairs Department shall exhaust all efforts in collecting an account. With the absence of documentation, there was no evidence to support that they have exhausted all efforts to collect from delinquent accounts.

Therefore, we suggest that the CFO consider requiring the Patient Affairs Department to tag which accounts were referred to DRT for tax garnishment in the system and whether there were any collections.

Standard Operating Procedures Last Revised in 1996

The Hospital's SOPs related to billing and collections for self-pay accounts were last revised in 1996. Since they were outdated, we did not test the Hospital's practices based on these SOPs. However, we inspected the following SOPs for informational purposes:

- Policy No. 8350-1, Self-Pay Follow-Up
- Policy No. 8350-2, Processing Walk-in Patients

- Policy No. 8350-3, Telephone Collection
- Policy No. 8350-4, Collection Letters
- Policy No. 8350-5, Payment Agreements
- Policy No. 8350-10, Tax Garnishments

We noted that billing and collection practices differed from the SOP's documented process. For example, Policy No. 8350-5 states that a payment agreement shall be executed if they determine that the patient/guarantor cannot pay the total balance in full. However, it is the Hospital's practice to allow the patients/guarantors an inconsistent amount of days to return to make a credit arrangement. In addition, the policy is unclear when a credit arrangement should be done. The policy also requires that patients pay a 10% to 30% deposit, depending on the balance owed; otherwise, no agreement shall be executed. However, according to the Chief of Admissions, deposits are only required for elective surgeries.

We also noted that they did not follow some SOPs as they were not enforced or may no longer be doable. For instance, Policy No. 8350-3 states that the first call to the patient/guarantor should be made within 10 days after the first collection letter is sent and subsequent calls should be made every 15 days until payment is made in full or a payment plan has been put into place. However, they only called 17 (or 34%) of the sampled patient accounts.

We suggest that the CFO revisit and update the Hospital's SOPs on self-pay billing and collection processes.

Conclusion and Recommendations

The Hospital's billing and collections for true self-pay accounts were not in accordance with the applicable law, rules and regulations, and policies and procedures. Our audit found several variances on charges billed to patients versus the published fee schedules, which raises significant concern as to the accuracy and transparency of billings to true self-pay patients.

We also found that management has been slacking in prioritizing or enforcing collection efforts on the front end. The moment the patient/guarantor walks out of the Hospital, the chances of collecting becomes low. We believe there are higher chances of collection through proactive communication of any financial obligations through partial and interim bills or helping establish credit arrangements before a patient's discharge.

We understand that collection on the front end does not guarantee full collection, even with repeated follow-up efforts by the Collections Staff. Therefore, it is critical for management to determine which patient accounts to refer and when to use the expertise of the contracted Collection Agency.

In current practice, the Hospital only collects less than 10% of accounts referred through garnished tax refunds. However, they could not provide documentation to support the analysis of account referrals to DRT. Similarly, 46% of our sample of Notice of Legally Enforceable Debt forms were not found in the system during our inspection. We caution management to be aware of the importance of proper record-keeping practices.

Lastly, the Hospital's SOPs on self-pay patients' billing and collections were outdated and unclear. We suggest that the CFO revisit and update the SOPs to reflect requirements of the law and rules and regulations on the billing and collection processes for self-pay patients.

We recommend the Hospital's CFO to:

(1) Create a policy on the:
- Implementation and review of rate changes;
- Account referral process to the Collection Agency, including how the analysis should be done and when to refer accounts;

(2) Enforce the execution of
- A credit arrangement before the patient's discharge and define who is in charge of performing them;
- The law requirements of providing partial and interim bills to patients;

(3) Evaluate whether review and/or corrections should be performed on outstanding patient bills;

(4) Provide formal training and setting target collection outputs for the Credit & Collection Supervisor and Collections Staff; and

(5) Assess, based on the current conditions of the Hospital, whether reinstating a Financial Counselor will help improve the collection process.

Classification of Monetary Amounts

	Finding Description	Questioned Costs	Potential Savings	Unrealized Revenues	Other Financial Impact[1]
1	Actual Billed Charges Different from Published Fees Schedules	$ -	$ -	$ -	$ 32
2	Credit Arrangements at Discharge Not Done	$ -	$ -	$ -	$ -
3	Collections Staff Not Focused on Collecting Delinquent Accounts	$ -	$ -	$ -	$ -
4	Delinquent Accounts Not Referred to Contracted Collection Agency	$ -	$ -	$ -	$ -
5	Partial and Interim Bill Not Provided to Patients	$ -	$ -	$ -	$ -
	Total	**$ -**	**$ -**	**$ -**	**$ 32**

[1] Other financial impact are amounts identified in the audit that do not fit the other categories. The $32 represents the net under billing due to the use of incorrect charge rates, which resulted from $191 in overbilling and $223 in under billings for the 50 accounts sampled.

Management Response and OPA Reply

In January 2019, we transmitted a draft report to GMHA. In February 2019, we discussed our findings and recommendations with the GMHA officials. During the exit meeting with GMHA officials, the CEO seemed to generally concur with the findings. However the CEO's official response focused on rationalizing the findings.

1. ***Finding: Credit Arrangement/Payment Agreement at Discharge Not Done***

   GMHA explained that the GAR §17104 (b)(6)(C) applied to a specific class of patients known as "*uninsured parties receiving non-emergency hospital and medical services*." Further, GMHA states that its policy is in fact prescriptive, not mandatory, and that its purpose is to assist patients/guarantors who have limited budgets to make payment on account in a timely manner. GMHA implied that having a signed credit arrangement does not ensure payment.

   OPA Reply: The focus of the finding is to strengthen GMHA's collection efforts on the front end. Even GAR § 17104 (b)(12)(C) mandatorily requires that as part of the discharge process, the PSR or Credit and Collections staff ***must*** have the patient and/or guarantor sign the necessary Payment Agreement or Payroll Deduction form if payment in full is not collected and terms call for extended payments. A Credit Arrangement/Payment Agreement is a detailed plan, which depicts the solution for paying off all outstanding debts that an individual owes. It takes into account the earning of the individual and outlines the terms of repayment, the fees, and other costs and all the rules and requirements pertaining to the debt. Therefore, our finding remains that GMHA does not practice credit arrangement upon patient's discharge.

See Appendix 4 for GMHA's management response.

The legislation creating the Office of Public Accountability requires agencies to prepare a corrective action plan to implement audit recommendations, to document the progress of implementing the recommendation, and to endeavor to complete implementation of the recommendations no later than the beginning of the next fiscal year. We will contact GMHA to provide the target date and title of the official(s) responsible for implementing the recommendations.

We appreciate the cooperation given to us by the staff and management of GMHA during this audit.

OFFICE OF PUBLIC ACCOUNTABILITY

Benjamin J.F. Cruz
Public Auditor

Appendix 1:

Objective, Scope, and Methodology

The objective of our audit was to determine whether GMHA's billing and collection practices for true self-pay accounts were in accordance with applicable law, rules and regulations, and policies and procedures.

The scope of this audit was the self-pay patient accounts from January 1, 2017, through June 30, 2018. We initiated the audit as part of OPA's 2018 annual performance audit plan.

Methodology

The methodology included the review of pertinent laws, rules and regulations, policies and procedures, and other relevant documents pertaining to GMHA's billing and collection processes for self-pay accounts. The work was carried out primarily at the Hospital's Patient Affairs Department located in Tamuning, Guam, and the OPA.

We also:

(1) Researched hotline tips and similar audit reports with the same topic.
(2) Researched other public hospitals regarding best practices in terms of billing and collections policies and procedures.
(3) Conducted interviews and walkthroughs with GMHA officials to gain a general understanding of the billing and collections processes for self-pay patients.
(4) Gained an understanding of the Hospital's Optimum System regarding navigation and access of self-pay patient information.
(5) Identified pertinent law and rules and regulations as audit criteria.
(6) Selected and tested 50 true self-pay accounts.
    a. The 20 samples were the top 20 accounts in terms of dollar value.
    b. The 30 samples were randomly selected throughout the audit period covered.
(7) Compared and analyzed individual charges against appropriate published fee schedules.
(8) Inspected patient accounts through Patient Notes within the Hospitals' Optimum System.
(9) Inquired or interviewed Hospital staff on matters requiring clarification on our testing results.

We conducted our audit in accordance with the standards for performance audits contained in *Government Auditing Standards,* issued by the Comptroller General of the United States of America. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix 2:

Prior Audit Coverage

GMHA FY 2017 Financial Audit (Management Letter)

The independent auditors noted a deficiency involving GMHA's patient receivables in which the 5% increase for all room and board charges effective April 1, 2017, was neither reflected nor effected in the system and was correctly only after the issue was raised by the external auditors.

Other Reports, Studies, etc.

A Final Evaluation Report of GMHA was issued in December 2014 by the U.S. Department of the Interior Office of Inspector General (DOI-OIG). It was found that GMHA's cash flow was negative and its reimbursement rates and fee schedules were out of date. Many of the weaknesses found related to GMHA's inability to generate revenues, collect fees, and secure revenue sources that compensate for the care of uninsured patients. Without enough income, the hospital cannot expand and upgrade its infrastructure, maintain and replace supplies and equipment, or recruit and maintain necessary staffing.

GMHA Management Response

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February 21, 2019

The Honorable Benjamin J.F. Cruz
Public Auditor
Office of Public Accountability
Suite 401 DNA Building
238 Archbishop Flores Street
Hagatna, Guam 96940

Subject: **Draft Audit Report – Guam Memorial Hospital Authority (GMHA) Billing and Collection of True Self-Pay Accounts**

Dear Auditor Cruz:

Buenas yan Saludu! Thank you so kindly for the opportunity to submit the Guam Memorial Hospital Authority's response to the draft performance audit report, received January 30, 2019, of the Hospital's billing and collection of true self-pay accounts.

With respect to self-pay accounts, enforcing collection is a challenge and, at times, futile, thus we direct the hospital's limited resources toward the collection of non-self-pay (private insurance, Medicare, Medicaid and MIP) accounts. The reality is there are thousands of people in our community who simply do not have the financial means to pay for hospital services we provide.

Notwithstanding the lack of resources, GMHA has persisted in its collection efforts, and on some occasions taken extraordinary measures. For example, the Hospital has on occasion leveraged the release of documentation needed to obtain an unofficial live birth certificate as a means to persuade a newborn's mother to make payment or enter into a payment arrangement. These certificates are required for parents to register their newborn in the social security program. This collection method has drawn harsh criticism for the Hospital, but it generated and continues to generate hundreds of thousands in paid services.

In assessing our credit and collection efforts, the ultimate goal is to understand how best GMHA can maximize reimbursement considering the likeliness of an account being paid. We also need to prioritize the allocation of our limited resources on accounts that can yield a higher return on resources invested. To that end, GMHA's Fiscal Services Division reviewed at length each of the findings of the draft performance audit report and offers the following responses:

FINDING: Actual Billed Charges from Published Fee Schedules

GMHA Management Response

> *"We found that some patient charges were not on the Hospital's published schedules, and/or incorrect based on updated effective rates. This raised significant concern as to the transparency and accuracy of billings to true self-pay patients."* - Page 1

> *"According to 26 Guam Administrative Rules and Regulations (GARR) Division 2 Chapter 17 §17104 (a)(1)(a)(1), all patients, regardless of health insurance coverage or other considerations, shall be charged for services received based on the Hospital's fee schedule. Fees for professional services will be determined by the physician and will be billed separately from the Hospital's fees for supplies and services."* - Page 5

Response:

In 1997, GMHA's Board of Trustees adopted what is known as the Physicians Fee Reference (PFR) by *Wasserman Medical Publishers* for the Hospital's professional fees. In 2008, the Board decided that the Hospital adopts the PFR as it is updated annually. The Board required that these adoptions be made each January. However, the annual release of the PFR and processing of the new information do not always align with the prescribed timeline. This along with the Hospital's system limitations has cause delays for implementation. For facility fees, the standing practice of GMHA has been to update all fees annually on April 1. This process began on April 1, 2015.

As a result, the GMHA labeled its fees in a manner that does not reflect when they are actually updated. GMHA will begin a thorough revision of its policies and will implement procedures so that the fee schedule posted on its website will more accurately reflect when a fee becomes effective.

In addition, the GMHA intends to create a Charge Master Description (CDM) unit within the Fiscal Services Division. Many hospitals such as Schneider Regional Medical Center (also a general acute care TEFRA hospital) in the U.S. Virgin Islands have such a unit or department staffed by qualified professionals dedicated to maintaining and updating the hospital's CDM. The GMHA currently relies on a single Quality Improvement Specialist to maintain and update its CDM as other related duty. The creation of a dedicated CDM unit will help improve transparency, accuracy, and timeliness in the process of developing and maintaining the CDM and aligning charges to actual Hospital costs.

FINDING: Credit Arrangement/Payment Agreement at Discharge Not Done

> *"According to 26 GARR Division 2 Chapter 17 §17104 (b)(6)(c), should an uninsured patient be unable to pay the balance at discharge, necessary credit arrangements must be made with the PSR and/or Credit and Collections Staff."* – Page 7

Response:

If the assertion is that this specific policy is not being followed, GMHA would like to clarify how the policy is applied. The GARR regulation, §17104 (b)(6)(C), applies to a very specific class of patients as is clearly noted in its title: *"§17104 (b)(6) Uninsured Parties Receiving Non-Emergency Hospital and Medical Services."* This regulation applies to accounts where GMHA

receives a patient on a non-emergent basis. It should be noted that only a physician can make a determination as to whether a patient's case is emergent or non-emergent.

The draft audit also made a reference to GMHA Policy and Procedure Manual No. 8530-5, stating it "has stricter guidelines" and requires a payment agreement. The policy in question is in fact prescriptive, not mandatory. It states:

> *"POLICY: If a Patient/Guarantor is unable to make full payment of a patient balance when due, periodic, partial payments **may** [emphasis added] be approved in accordance with these guidelines. A Patient/Guarantor financial disclosure statement may be requested to determine appropriate payment arrangements."*

The procedure further reads:

> *"Payment agreements are to be executed **only** [emphasis added] if it is determined that the Patient/Guarantor is unable to pay the total balance in full."*

The procedure requires that the patient is unable to pay in order to avail the payment plan option. The procedure does not impose the payment plan as a means to enforce payment, but rather as a means of assisting the patient guarantor to make payment. This is noted in the purpose statement of the policy:

> *"PURPOSE: To **assist** [emphasis added] patient/guarantors who have limited budgets to make payment on account in a timely manner."*

Policy and Procedure Manual No. 8530-5 further requires a deposit in order for a payment agreement to be executed. The draft performance audit considered this contradictory to what it perceives as the purpose of the policy. However, it would only be contradictory if the policy mandated payment agreements. This is something we will consider when we review and revise our policies.

The draft performance audit also asserts that "credit arrangements" are not done because it does not consider a verbal promise to return to pay (noted as "RPAY" codes) as a credit arrangement. GMHA fiscal staff analyzed the draft audit's sample of 50 self-pay accounts. If the audit author's assertion is that a signed credit arrangement is a superior collection method than a verbal promise, that assertion is not supported by the sample itself. Of the sample, 23 accounts resulted in some form of payment be it partial or full. Of those 23, only 8 are associated with a promissory note while an equal number are associated with an RPAY code. Furthermore, of the 4 accounts that were fully paid, none were associated with a promissory note.

FINDING: Collections Staff Not Focused on Collecting Delinquent Accounts

> *"According to 26 GARR Division 2 Chapter 17 §17104 (b)(1)(I), once an account becomes delinquent or inactive, the Credit and Collections Representative will make telephone calls to the patient to determine when payment can be expected or if a problem exists with the account. An account is delinquent if it is unpaid after 90 days. Meanwhile,*

GMHA Policy No. 8350-3 states that the first call to the patient/guarantor should be made within 10 days after the first collection letter is sent and subsequent calls should be made every 15 days until payment is made in full or a payment plan has been put into place." – Page 7

Response:

Non-compliance with 26 GARR Division 2 Chapter 17 §17104 (b)(1)(I) is the result of staffing shortages in the Patient Affairs Department and the Credit and Collections Department. The draft audit correctly mentioned that Patient Service Representatives and collection staff members spend most of their hours handling other tasks such as entertaining various calls and concerns from patients or visitors as opposed to initiating calls in accordance with the regulation. The GMHA attempted to procure an outsource calling services as part of its engagement with a collection agent but it was ultimately determined to be cost prohibitive. Again this is an allocation of resources dilemma. We simply need to allocate resources where we can get a return on our investment.

Although GMHA concurs that it is not in compliance of 26 GARR Division 2 Chapter 17 §17104 (b)(1)(I), it does not agree with the assertion that its collection staff is not focused on collecting delinquent accounts on the basis that it is not making enough phone calls. GMHA reviewed the draft audit's sample of 50 self-pay accounts, of which 23 accounts resulted in some form of payment. Of those 23 accounts, 5 were associated with a documented call.

FINDING: Delinquent Accounts Not Referred to the Contracted Collection Agency

"According to 26 GARR Division 2 Chapter 17 §17104 (d)(1), accounts delinquent after 120 days shall be referred to a collection attorney or agency for further action. However, none of the sampled patient accounts were referred to the Collection Agency. The non-referral of accounts further limits the Hospital's ability to progress in the collection of delinquent accounts." – Page 8

Response:

GMHA remains committed to pursuing more effective and efficient methods to collect unpaid accounts. It may procure the services of a qualified collection agency in a manner that makes financial sense. GMHA has recently **enlisted the Office of the Attorney General to assist with collections of certain types of delinquent accounts**. We have decided to try this mode of collection as it is deemed to be more effective and impactful at the least cost for the hospital. It is also committed to improving its policies to better determine which accounts are appropriate for referrals for collection or to the Department of Revenue and Taxation for tax refund garnishment.

FINDING: Partial and Interim Bills Not Provided to Patients

"According to 26 GARR Division 2 Chapter 17 §17104 (b)(1)(D) and (E), if the patient is hospitalized for over 10 days, he/she will receive a partial bill requesting payment of

his/her portion of the account. They shall present to the patient/guarantor for payment an Interim Bill summarizing all charges keyed in up to the time of discharge. According to the Billing Supervisor, they provide the interim bill to patients every 30 days while the patient is still admitted." – Page 9

Response:

Rather than enforcing this outdated policy, GMHA will instead recommend its repeal. Serving a bill to a patient who is undergoing hospitalization can have adverse and harmful effects. The policy envisions serving a partial bill upon a patient who may be incapacitated or undergoing certain treatments or procedures as part of their hospitalization. The average stay in an acute care bed at GMHA is 5 days. Patients hospitalized for 10 or more days may indicate a higher level of acuity. Thus, serving such a patient with a partial bill can be more detrimental to the health of that patient and may expose the Hospital to liability.

Further, the mechanics of physically providing an interim bill, on a daily basis to upwards of 60 to 100 patients who have yet to be discharged, requires time and resources the GMHA does not have. This is a management decision to prioritize the allocation of scarce resources to processes that will generate more revenues and collection for the hospital. However, the Hospital will consider the hiring of a financial counselor. In the meantime, Patient Registration staff will be trained, and when feasible, will meet these types of patients to discuss their billings.

FINDING: Documents Not Made Available for Inspection

"According to 26 GARR Division 2 Chapter 17 §17104 (b)(12)(F), the patient must be informed that the account may be turned over to a collection attorney or agency if not paid within 120 days and that he/she will be liable for collection costs. The Hospital provides a Notice of Legally Enforceable Debt form to patients as part of the admission process." – Page 9

"The Hospital staff could not provide for our inspection the signed forms for 23 out of 50 samples (or 46%). According to the Chief of Admissions, the Hospital encountered a system glitch when the signed forms were uploaded to the system. Without these signed forms, the Hospital may not legally enforce collection. Although it was documented in the system that they provided the forms, we questioned the Hospital's storage-keeping practices." – Page 10

Response:

All accounts sampled include signed acknowledgements of GMHA's Terms and Conditions. The Terms and Conditions, presented upon admission, clearly state a patient's obligation to pay, including the obligation to pay legal fees and court costs to an attorney and/or collection agent.

Furthermore, 26 GARR §17104 (b)(12)(F) requires GMHA to inform the patient of his/her responsibility to pay and ***requires the patient*** to (1) agree to terms at time of discharge, and (2) sign the necessary Promissory Note. While the GARR may seek to impose such requirements on

GMHA Management Response

the patient, the hospital cannot legally force patients to sign promissory notes. The Hospital will continue its review of outdated policies and GARR codes that aren't relevant to today's practice.

FINDINGS: Standard Operating Procedures Last Revised in 1996

> *"The Hospital's SOPs related to billing and collections for self-pay accounts were last revised in 1996....We suggest that the CFO revisit and update the Hospital's SOPs on self-pay billing and collection processes."* – Page 11

Response:

The GMHA CFO with the Fiscal Department Supervisors will continue its ongoing review from last year of outdated billing and collection policies and procedure manuals that aren't relevant to today's practice. Upon completion of the review process, it will propose recommendations to the Hospital's Executive Management Council to revise the GARR which would then be forwarded to the GMHA Board of Trustees for final determination.

With immense and sincere gratitude for your time and kind consideration.

LILLIAN PEREZ-ROSADAS, RN, MN
Hospital Administrator/CEO

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Appendix 4:

Status of Audit Recommendations

No.	Addressee	Audit Recommendation	Status	Action Required
1	GMHA Chief Financial Officer	Create a policy on the: • Implementation and review of rate changes; and • Account referral process to the Collection Agency, including how the analysis should be done and when to refer accounts.	OPEN	Please provide target date and title of official(s) responsible for implementing the recommendation.
2	GMHA Chief Financial Officer	Enforce the execution of: • A credit arrangement before the patient's discharge and define who is in charge of performing them; and • The law requirements of providing partial and interim bills to patients.	OPEN	Please provide target date and title of official(s) responsible for implementing the recommendation.
3	GMHA Chief Financial Officer	Evaluate whether review and/or corrections should be performed on outstanding patient bills.	OPEN	Please provide target date and title of official(s) responsible for implementing the recommendation.
4	GMHA Chief Financial Officer	Provide formal training and setting target outputs for the Credit & Collection Supervisor and Collections Staff.	OPEN	Please provide target date and title of official(s) responsible for implementing the recommendation.
5	GMHA Chief Financial Officer	Assess, based on the current conditions of the Hospital, whether reinstating a Financial Counselor will help improve the collection process.	OPEN	Please provide target date and title of official(s) responsible for implementing the recommendation.

Guam Memorial Hospital Authority
Billing and Collections of True Self-Pay Accounts
Report No. 19-01, February 2019

ACKNOWLEDGEMENTS

Key contributions to this report were made by:

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