

AUDITOR'S REPORT

HARRIS HEALTH SYSTEM INSURANCE VERIFICATION AND FOLLOW-UP



July 30, 2015

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BARBARA J. SCHOTT, C.P.A.
HARRIS COUNTY AUDITOR

July 30, 2015

Mr. George Masi
President and Chief Executive Officer
Harris Health System
2525 Holly Hall
Houston, Texas 77054

RE: Harris Health System Insurance Verification and Follow-up for the four months ended August 31, 2014

The Audit Services Department performed procedures relative to the Harris Health System (Harris Health) Insurance Verification and Follow-up. The objective of the engagement was to evaluate critical process controls for identifying available resources for payment of patient services. Procedures were performed to selectively test manual and automated controls for:

- Identifying patients that were eligible for Medicaid or the Children's Health Insurance Program (CHIP).
- Assisting the patients that may be eligible apply for Medicaid or CHIP coverage.
- Following-up to ensure that patients completed the Medicaid or CHIP application process.
- Identifying insurance coverages that patients were enrolled in but that the patient did not report to Harris Health.
- Verifying that patient services provided or scheduled were within the patient's coverage period.
- Updating the patient accounting system for changes identified through verification procedures performed.

The engagement process included providing you with engagement and scope letters and conducting an entrance and exit conference with your personnel. The purpose of the letters and conferences were to explain the process, identify areas of concern, describe the procedures to be performed, discuss issues identified during the engagement, and solicit suggestions for resolving the issues. A draft report was provided to you and your personnel for review.

The enclosed Auditor's Report presents the significant issues identified during our procedures, recommendations developed in conjunction with your staff, and any actions you have taken to implement the recommendations. Less significant issues and recommendations have been verbally communicated to your staff.

Mr. George Masi
President and Chief Executive Officer

We appreciate the time and attention provided by you and your staff during this engagement.

Sincerely,

A handwritten signature in blue ink, appearing to read "Barbara J. Schott", with a long horizontal flourish extending to the right.

Barbara J. Schott
County Auditor

cc: Harris Health System Board of Managers
District Judges
County Judge Ed Emmett
Commissioners:
 R. Jack Cagle
 El Franco Lee
 Jack Morman
 Steve Radack
Devon Anderson
Vince Ryan
William J. Jackson

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OVERVIEW

To ensure Harris Health receives insurance payments that are available for services provided to patients, processes have been implemented in the Patient Access Management and Patient Financial Services areas to:

- Identify patients that may be eligible for federal or state programs but have not enrolled.
- Monitor and assist patients enrolling in federal or state programs.
- Verify the accuracy of health insurance coverages reported by patients.
- Identify health insurance coverages that the patients may not have reported to Harris Health.

Uninsured patients that may be eligible for federal or state programs are identified when they apply for the Harris Health System Financial Assistance Program (Financial Assistance). Applications are processed through the eligibility application system (NSI/Chassis) which also identifies possible eligibility for insurance programs such as Medicare, Medicaid, and CHIP.

Patients admitted to Harris Health hospitals (inpatients or observation patients) that do not have insurance and have not completed a current Financial Assistance application are visited at bedside by a Financial Counselor. The Financial Counselor accesses NSI/Chassis through a mobile workstation and completes an application for Financial Assistance by interviewing the patient or their family members. Patients that are determined to be potentially eligible for a federal or state program are then helped to complete the necessary program enrollment forms by the Financial Counselor.

Indigent patients that come to Harris Health could in some cases be eligible for Medicaid or the CHIP programs. As a result, caseworkers from the Texas Department of Health and Human Services Commission (HHSC) are available at Harris Health locations to help enroll patients. Financial Counselors send completed enrollment forms to the HHSC caseworkers for processing. The HHSC caseworkers forward the forms that they receive to the Texas Medicaid & Healthcare Partnership, the state contractor that certifies Medicaid and CHIP eligibility and enrollment.

Inpatient/observation patient enrollments are monitored by Medicaid Pending Representatives or Medicaid Pending Specialists using on-line reporting screens (work queues) available through the Harris Health patient information system (Epic). Work queues are established to monitor whether:

- Eligible patients have provided all of the necessary information to complete their enrollment.
- Completed enrollment forms were sent to HHSC caseworkers, and received by the Texas Medicaid & Healthcare Partnership.
- Texas Medicaid & Healthcare Partnership has timely responded to enrollment forms submitted to them.

- Patient accounts in Epic have been updated to reflect current enrollment and certification status.

Employees that schedule or register outpatients review information in Epic or NSI/Chassis to identify patients that have not completed a current Financial Assistance application. Depending on the location, the outpatients without current applications may be requested to complete and return an online or paper application, or directed to a Harris Health Eligibility Center where they can receive assistance completing an application.

If the application process determines they are eligible, outpatients are responsible for enrolling themselves in federal or state programs and must apply and provide documentation of enrollment or denial to Harris Health within 60 days after they are determined to be eligible. If the documentation is not provided, the outpatients are billed as self-pay patients for services already received, and are no longer eligible for Financial Assistance.

In some cases, Harris Health assigns patient accounts to outside vendors to determine eligibility or to enroll patients in federal or state programs. Automatic processes in Epic timely transmit information for the accounts assigned to the vendors for:

- Inpatients/observation patients that are discharged before a Financial Counselor visit.
- Inpatients/observation patients determined to be eligible that have not completed program enrollment.
- Patients that receive emergency services and are classified as self-pay in Epic.
- Patients that are eligible for the Supplemental Social Security Program.

Automated processes are also used to verify the accuracy of insurance coverage recorded in Epic for patients that schedule their services in advance. If discrepancies are identified during verification, they are investigated by Patient Access Management Staff who correct the information in Epic before patients receive services. Insurance not verified before services are provided is verified when patients arrive for services, either electronically or by telephone.

If patients have insurance but do not disclose that information to Harris Health, there are automatic processes through Epic to identify the insurance by searching for matches of demographic data in Epic with the demographic data from certain insurance providers (Medicaid, Medicare, etc.).

Patient Financial Services also uses an outside contractor (eScan) to electronically search for insurance not reported. Information from Harris Health's records is automatically transmitted to eScan before and after patients receive Harris Health services and eScan searches a wide range of sources for possible insurance matches. Most patients' accounts in Epic are automatically updated for insurance identified by eScan. Insurance Verification Representatives investigate and update insurance not automatically updated by eScan and/or confirm any coverage that is automatically updated before the insurance is billed.

RESULTS

Based on procedures performed, the processes implemented by Patient Access Management and Patient Financial Services to ensure that Harris Health receives insurance payments available for services provided to patients are adequate in achieving the objectives of:

- Identifying patients that may be eligible for Medicaid or CHIP.
- Assisting patients that may be eligible apply for Medicaid or CHIP coverage.
- Following-up to ensure that patients complete the Medicaid or CHIP application process.
- Identifying insurance coverages that patients are enrolled in but did not report to Harris Health.
- Verifying that coverage periods for insurance identified cover the patient services scheduled or provided.
- Timely updating patients' accounts in Epic for changes in coverage status.

Although the above objectives are being achieved, opportunities to improve controls were identified related to processes for timely updating the patients' accounts in Epic for coverage identified and reported to Harris Health by eScan.

These issues are discussed in greater detail in the attached Issues and Recommendations matrix.

ISSUES AND RECOMMENDATIONS

Subject	Background	Issue	Recommendation	Management Response
<p>Confirming Insurance Discovered by eScan</p>	<p>eScan automatically uploads possible insurance matches to patients' accounts. Insurance Verification Representatives access the accounts, confirm the matches are correct, and (if correct) update patients' accounts before billing.</p> <p>At the request of Patient Financial Services Management, eScan provides a weekly electronic file of matches so that Insurance Verification Representatives can identify whether any matches were missed and not confirmed.</p>	<p>Controls do not ensure that all matches on the electronic file sent by eScan are confirmed by Insurance Verification Representatives. Two out of 25 transactions tested for July 8, 2014, were identified where possible insurance coverages were not confirmed and uploaded after three months.</p> <p>Not ensuring all matches on the weekly electronic file are timely confirmed increases the risk that insurance coverages are not timely billed, which could result in delayed payments or lost revenue.</p>	<p>Patient Financial Services Management should ensure Insurance Verification Representatives are trained to identify missed matches using the eScan electronic file. In addition, monitoring procedures should be implemented to identify and investigate matches that are not timely confirmed and uploaded to patients' accounts.</p>	<p>PFS Management agrees. Employees were re-educated as soon as the issue was identified. Also, we now have a tool – as provided by eScan – that allows us to run real-time reports that give us complete transparency to any cases whereby the coverage has been identified but has not been loaded. Per our new processes, this report is run every Monday and the missed cases are audited for additional training opportunities and/or system load issues.</p>

RISK ASSESSMENT AND SUMMARY OF RECOMMENDATIONS

The risk matrix below presents the assessed level of risk or exposure identified during our procedures. Inherent risk relates to factors that because of their nature cannot be controlled or mitigated by management. Inherent risk includes factors such as legislative changes, number and dollar amount of transactions processed and/or complex nature of transactions. Control risks relate to factors that can be influenced or controlled by management. Controls such as policies and procedures, electronic or manual approvals, system security access, and separation of job responsibilities may be instituted by management in order to mitigate control risk. Control risk is assessed during the planning phase in order to establish the nature, timing, and extent of testing and at the conclusion of the engagement in order to incorporate actions taken to implement our recommendations. The overall risk considers a combination of inherent and control risks.

Inherent Risk:	Control Risk:		Overall Risk:
<input checked="" type="checkbox"/> High <input type="checkbox"/> Moderate <input type="checkbox"/> Low	Prior to Procedures	After Procedures	<input type="checkbox"/> High <input checked="" type="checkbox"/> Moderate <input type="checkbox"/> Low
	Adequate	Adequate	
Type of Procedures: Audit			
Purpose: To evaluate critical process controls for identifying available resources for payment of patient services.			
Outstanding Audit Recommendations:			
Priority Rating:	Audit Recommendations: Insurance Verification		
1	Ensure Insurance Verification Representatives are trained to identify missed matches using the eScan electronic file. Implement monitoring procedures to identify and investigate matches that are not timely confirmed and uploaded to patient's accounts.		
Priority Rating	<ol style="list-style-type: none"> 1. Implement immediately (30 – 90 days) – Serious internal control deficiencies; or recommendations to reduce costs, maximize revenues, or improve internal controls that can be easily implemented. 2. Work towards implementing (6 – 18 months) – Less serious internal control deficiencies, or recommendations that can not be implemented immediately because of constraints imposed on the department (i.e., budgetary, technological constraints, etc.). 3. Implement in the future (two – three years) – Recommendations that should be implemented, but that can not be implemented until significant and/or uncontrolled events occur (i.e., legislative changes, buy and install major systems, requires third party cooperation, etc.). 		