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March 22, 2018

John Jay Shannon, M.D.
Chief Executive Officer
Cook County Health & Hospitals System
1900 W. Polk Street, Suite 220
Chicago, Illinois 60612

M. Hill Hammock
Chairman, Board of Directors
Cook County Health & Hospitals System
1900 W. Polk St., Room 211
Chicago, Illinois 60612

Re: IIG17-0421 (Bad Debt Expense)

Dear Dr. Shannon and Chairman Hammock:

This letter is written in accordance with the Code of Ordinances, Cook County, Illinois ch.2, art. IV, sec. 2-289(c)(2) (2007) (the "Ordinance") in connection with a review of bad debt expense generated during the course of operations at the Cook County Health and Hospitals System ("HHS"). This statement is made to apprise you of the completion and results of this review.

Background

During a Finance Committee Meeting of the Cook County Board of Commissioners on January 17, 2018, HHS senior management stated that the gross accounts receivable was $426 million, but the net realizable value was $90 million. HHS senior management uses bad debt expense and contractual allowances in its calculations to reach the net realizable value of accounts receivable. Additionally, senior management explained that the bad debt expense was comprised of charges for healthcare services rendered to patients who were uninsured and have no ability to pay. We initiated this review to assess the circumstances surrounding the creation of bad debt expense at HHS.

The amount of revenue owed to the hospital for healthcare services provided to patients is known as accounts receivable. HHS, however, will not be able to fully collect from many patients. These uncollectible patient accounts are referred to as bad debt expense. During our review, we obtained HHS reports utilized for tracking bad debt expense, accounts receivable, and "Bad Encounters." Additionally, we interviewed 13 department heads and managers responsible for operating the Revenue Cycle, Managed Care, and Health Information

Management departments. These departments are collectively responsible for patient scheduling, patient registration, financial assistance, accounting, coding, and billing for HHS. We also conducted limited site visits of the call center and central registration operations.

After careful consideration of all the information, we concluded that uninsured patients do, as anticipated, generate a large volume of bad debt expense for HHS. However, we also determined that bad debt expense also includes expenses associated with care provided to insured patients.

In addition to uninsured patients, HHS provides healthcare services to patients with insurance coverage from private insurance companies and government programs such as Medicaid and Medicare (collectively "Payors"). HHS must follow certain rules and protocols in order to receive payments from these Payors. Otherwise, claims submitted to Payors for healthcare services provided to their members could be denied or rejected ("Denials").[1] Our review identified a large volume of Denials that eventually became "write-offs."[2]

HHS' failure to follow the Payors' stipulations has resulted in Denials of a minimum of $108,483,963 in 2016 and $66,284,824 in 2017.[3] This form of bad debt expense is separate and apart from the bad debt expense associated with uninsured patient care. HHS wrote off $317,244,262 and $336,691,270 for patients under CareLink (a financial assistance program for uninsured and underinsured patients with limited or no income to cover the costs of medical care) in 2016 and 2017, respectively. After isolating the bad debt expense associated with Payor Denials, we sought to identify the key operational deficiencies that generate large volumes of write-offs associated with the Denials.[4] We have highlighted the primary deficiencies causing the large volume of Denial write-offs:

- Our review revealed that Denials cannot be attributed to only one area or department at HHS. In fact, Denials are attributed to scheduling, patient registration, and coding in connection with patients. Physicians and nurses also contribute to Denials due to erroneous patient scheduling and inadequate or inaccurate documentation related to coding.

- HHS clerks fail to fully and correctly obtain, verify, and input patient demographic and insurance information during the patient scheduling, pre-registration, and registration stages.

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[1] Rejected claims refer to claims that can be corrected and resubmitted for reimbursement if done timely. However, rejected claims become Denials when they become stale.

[2] We analyzed the accounts receivable and identified journal entries that appeared to be claim denials over $1 million.

[3] We reviewed the 2015 accounts receivable and identified similar write-offs for Denials totaling over $91 million.

[4] Although the write-offs associated with CareLink and charity care may include administrative deficiencies of a similar nature as those experienced in Denial administration, they are not the primary focus of this review.

- Physicians and nurses contribute to Denials when they fail to obtain new Financial Identification Numbers ("FINs") when scheduling patient appointments. The duplication of FINs are referred to as "Bad Encounters." These Bad Encounters are similar to generating duplicate invoices triggering Payor denial of claims.

- HHS fails to obtain prior authorization and prior certification for certain medical procedures that Payors require as a stipulation for payment. Additionally, HHS fails to timely submit claims to Payors for insured patients pursuant to Payor requirements.

OIIG Review

Bad Debt Expense

Bad debt expense is a managerial estimate used in the calculation of the net realizable value of accounts receivable (fair market value of assets). The write-off of bad debts occurs when patient accounts are found to be uncollectible and removed from the books as an asset. Importantly, actual write-offs could exceed the estimated bad debt expense.

Bad debt expense can be estimated periodically and an allowance account will be created. This method basically absorbs the bad debt expense before write-offs actually occur in order to present the net realizable value for accounts receivable purposes.

Bad Debt Expense (Allowance Method)

T.1

Bad Debt Expense	*Allowance for Uncollectible Accounts*
$108,000,000 (Debit)	$108,000,000 (Credit)

During the subsequent year, senior management will write off patient accounts and reduce the allowance for uncollectible accounts. In the chart below, as an example, HHS had write-offs for "Medicaid Denied, Untimely Filing" during 2017.

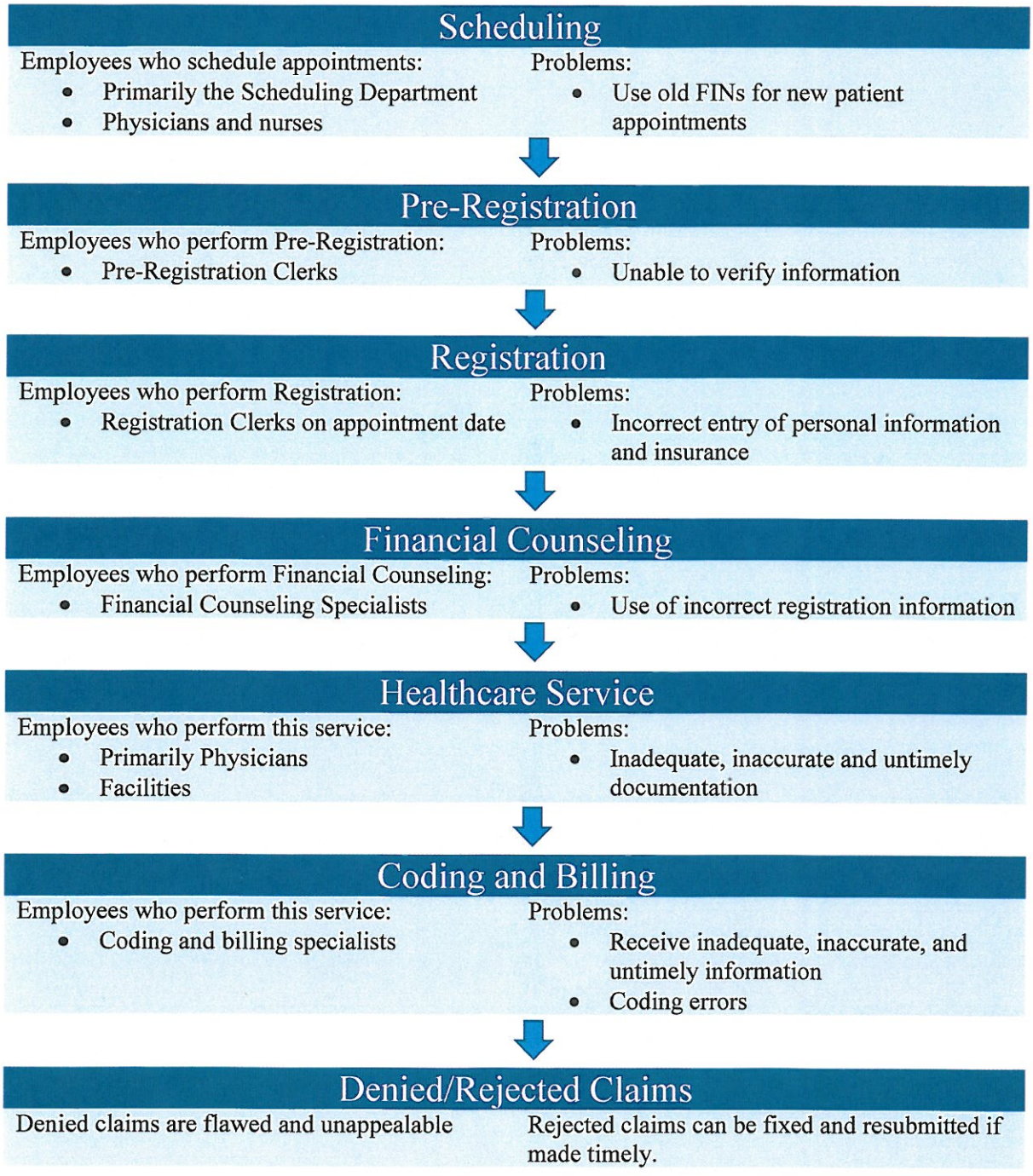
T.2

Allowance for Uncollectible Accounts	*Accounts Receivable*
$6,008,636 (Debit)	$6,008,636 (Credit)

Alternatively, senior management could use the direct method for recognizing bad debt expense. Pursuant to this method, senior management does not create an allowance account (as shown in T.1). Rather, senior management will write-off accounts when it determines patient accounts are uncollectible (as shown in T.2). Senior management may deem accounts uncollectible based on length of time the patient accounts have been outstanding. Senior management may also establish other criteria when designating patient accounts uncollectable based on prior professional experience with patient accounts. Thus, management has the discretion to use the allowance, direct, or a combination of these methods to recognize bad debt. HHS recognizes both methods.

Denials

Throughout the course of this review, it became apparent that Denials cannot be fairly attributed to one area or department within HHS. In fact, Denials are attributed to scheduling, patient registration, and coding in connection with rendering healthcare services to patients. Physicians and nurses also contribute to Denials due to erroneous patient scheduling and inadequate or inaccurate documentation for coding.



We reviewed the accounts receivable for HHS (AR – Transaction Summary) and identified write-offs associated with Payors for 2016 and 2017.[5] In 2017 alone, there were at least 20 journal entries for Denials totaling over $66 million ($108,483,963 for 2016). We listed below the charges that exceeded $1 million and comprised a majority of the Denials for HHS during 2017.

Description	**Number of Transactions**	**Amount**
No Attending CNTR SIG	70,217	$2,335,355.58
No Referring Doctor	7,694	$1,790,356.03
Untimely Filing	4,312	$1,902,401.61
Non Covered Service	29,905	$5,257,766.12
Untimely Filing (MCAID)	11,816	$6,008,636.47
Non Covered Service (MCAID)	3,415	$1,663,610.01
Untimely Filing (Commercial)	2,275	$1,334,630.28
Untimely Filing (Managed Care)	9,044	$2,490,740.71
No Pre-Certification (Managed Care)	4,583	$1,969,645.46
No Primary Care Physician Referral (Managed Care)	7,325	$3,388,825.61
Non Covered Services (Managed Care)	62,596	$1,498,538.99
Case Management	2,274	$4,755,036.89
Patient Access	24,692	$9,834,310.25
Coding	13,176	$5,067,763.78
Untimely Filing (Physician Billings)	43,300	$9,896,354.81
Non Covered Service (Physician Billings)	18,114	$3,254,921.75
Grand Total		**$62,448,894.35**

HHS' Revenue Cycle Director has generally explained that the Denials "are driven by wrong insurance, Bad Encounters, wrong registrations, no pre-authorizations, and no attending physician signatures." These are "'front-end' problems [that create Denials], and the 'back-end' problems [causing Denials] are coding and billing." This office then analyzed reports and interviewed department heads and managers to develop the circumstances surrounding front-end and back-end operations.

Patient Scheduling

We received statements from various HHS department heads and managers who identified the failure to properly schedule patient appointments as a central operational inefficiency resulting in a significant number of claim Denials. A site manager for patient registration specifically explained, "Patients should receive a new financial identification number (FIN) with each visit because the FINs are similar to unique invoices. The insurer will

[5] On January 12, 2018, HHS issued a Request for Proposal (#H18-0007) seeking a vendor for accounts receivable factoring. HHS required the vendor to purchase all outstanding accounts receivable greater than 60 days without recourse. HHS received no proposals in response to this RFP.

not pay the invoice because they have already paid a bill with that FIN. The insurer [would] not know there were new services." HHS refers to this problem as "Bad Encounters."

This site manager further explained, "Bad Encounters happen when clerks draw on old FINs to schedule new appointments. For example, there is a record for a discharged patient and a clerk schedules a new appointment on this old record."

The Director of Operations of Patient Support is responsible for managing the Patient Call Center that receives calls from patients for healthcare appointments. The Director explained that during scheduling there is a screen that provides an opportunity to select an old encounter (old appointment) or a new encounter. The scheduler needs to click the button for an old or new encounter. The Director further stated "It makes a scheduler's life easier to use an old encounter. The scheduler has to click two more buttons to use a new encounter. I do not think people are malicious; I believe staff in other departments need to be educated because they do not know how these habits are affecting the finance department."

The Director informed us that although the physicians and nurses are not assigned to the Scheduling Department, they are able to schedule appointments for patients. The Director stated his department is not the problem because they have been properly trained to correctly schedule patient appointments. He explained, "I saw a person's name from the Surgery Department 15 times on the Bad Encounters Report. These individuals are not trained schedulers." OIIG investigators received statements from other department heads and managers who corroborated the Director's statements. Additionally, Bad Encounters can be resolved at the registration stage. However, this creates an increased burden on the registration department.

Patient Registration

We identified $9.8 million in write-offs attributed to Patient Access for 2017. According to the Revenue Cycle Director, this journal entry for Patient Access represents write-offs that stem from problematic patient registrations. Patient registration is both a hospital-based and ambulatory clinic function at HHS. That is, Patient Access may refer to that portion of patient registrations performed at Stroger and Provident Hospitals, with the clinics performing the remainder and majority of patient registrations.

The Ambulatory and Community Health Network ("ACHN") is headed by one of the Chief Operating Officers ("COO") at HHS. The ACHN COO stated that the patient registration process at the clinics is primarily a standardized practice for HHS. The COO explained that the patient registration process starts with scheduling an appointment. The pre-registration staff may contact patients before their appointment to verify demographic information and insurance coverage. On the appointment day, patients will appear at the clinics or hospitals and check in with a registration clerk. The registration clerk will complete a process to register the patient. The registration process includes selecting from a menu of items to gather relevant information. The COO explained, "The key to appropriate and effective billing is to get patient registrations correct. The two are linked. It is essential to

obtain accurate information because registration is the front-end and billing is the back-end. Billing has to be cleaned up. The challenge for healthcare entities is accurate registrations."

The Training & Quality Control department is primarily responsible for training Patient Access and ACHN employees on scheduling, patient registration and insurance verification. The department has a System Manager and four staff members responsible for training 250-300 registration clerks. The Manager also trains doctors, nurses, and department managers and supervisors on the proper methods to register patients.

The Manager explained, "Clerks are not putting in the information into the system correctly. If it gets input correctly, we get paid." She said the reason for incorrect input is because some employees cannot identify the correct information. The Manager explained further that employees must be trained repeatedly. Moreover, the employees do not receive discipline because of a lack of accountability. The Manager also stated there is an insufficient number of trainers to meet the current demand at HHS.

A different registration site manager stated, "Another problem with registration is a lack of understanding of insurance rules and regulations." She said Medicaid and Medicare rules have changed and require healthcare providers to use managed care insurers as the primary insurers. This site manager also said, "Registration mistakes will affect the billing and coding capabilities. Incomplete information causes problems with the ability of the billing and coding departments [to function]."

Coding Healthcare Charges

Health Information Management ("HIM") is the department responsible for coding charges for "Facilities" and "Physician Billings." We identified over $5 million in write-offs attributed to "Coding" for 2017.

HIM receives coded charges through a computer system (Cerner) representing physician services. Physician services are described according to the International Statistical Classification of Diseases and Related Health Problems (ICD-10) codes. These codes require physicians to be very specific in documenting the healthcare services being provided. For example, it is insufficient for a physician to document treatment for a broken bone. Rather, the physician is required to identify the particular bone being treated.

HHS physicians have also not fully embraced the necessity of accurate coding to ensure the proper ICD-10 code is attached to each patient service. Moreover, many physicians do not have access to software that can transform a physician's patient service description into useable codes. In these cases, coders must code the physician services with ICD-10 codes which result in a failure to capture the extent of services provided. As for Facilities charges, the coders do not need to refer to ICD-10 codes. The coders review the physician's narratives on the account to determine the Facilities charges. These coded charges are sent to the billing department via Siemens (HHS computer information system). Nonetheless, wrong coding will always result in charges being denied.

The HIM department head has described the many problems that coders encounter in their jobs. For example, coders cannot code charges when medical records are incomplete. The medical record becomes complete when all healthcare services are included (with sufficient detail), the patient has been discharged and the physicians have signed off on the medical record. The department head said there are bills that are not issued until 18 months after discharge because of the lack of documentation, insufficient detail and the failure to obtain physician sign off. As outlined below, this, in itself, may trigger a Payor Denial.

Billings

HHS wrote off $21.6 million or 33% of the $66 million due to untimely filed medical charges in 2017. The Revenue Cycle operations include the Patient Financial Services ("PFS") department. PFS is responsible for preparing and submitting patient bills to Payors. The PFS Director explained, "[w]hen I get a 'clean bill' (no issues, no system holds, designated insurer, diagnosis, and charges), I can begin the billing process through the Siemens Envision System."

The Director explained, however, HIM delays in coding charges affect the billing department's ability to submit bills to Payors. Further, the Director explained that some claims arrive in the department too late to be submitted for payment pursuant to the Payor's claim limitations period.

The Director said that Denials are sent in files electronically from Payors to HHS. The files are referred to as Electronic Remittance Advices ("ERA") which is similar to an Explanation of Benefits form provided to individual patients. Through the ERA, Payors describe the basis for reimbursement but also all Denials such as "no prior authorization."

The Director further explained, "Patient registrations cause the biggest problems associated with Denials. These problems include wrong insurance eligibility, wrong primary insurer (e.g., Medicaid instead of Aetna), wrong policy number, wrong name, wrong date of birth, and no insurance company address. Coding and lack of physician documentation are also problems." If PFS staff cannot resolve the Denial, a write-off will be proposed to the Chief Financial Officer for the subject medical charges.

Managed Care

During our review, we identified $11.6 million in write-offs attributed to Managed Care. Of this amount, HHS incurred $10.2 million in lost revenue due to Managed Care failing to obtain pre-certifications (prior primary care physician referral) and pre-authorizations from insurers. A department head interviewed stated, "I do not think the organization has a good handle on this process. Payors require documentation for non-emergency services but physicians go ahead and perform treatment. When patients are [receiving] services and have insurance, it is a standard rule to obtain pre-authorization." The department head stated further that Managed Care could monitor this process through HHS' computerized information system.

CareLink

During our review, we learned that some patients seek charity care despite having insurance coverage because of their interest to obtain a lower co-pay which is available at HHS. A department head explained, for example, "We do not have a policy for turning away patients. There are insured patients with non-emergencies who should go down the street. Sometimes these patients get their prescriptions filled at HHS to by-pass a $25 co-pay at [a private pharmacy]. Prescriptions are much cheaper at HHS" (e.g., $4 at HHS vs. $20 at a private pharmacy).

Additionally, the department head stated there are insured patients who receive CareLink because HHS is "out of network" for their insurance coverage. The department head stated, "When these insured patients use HHS for non-emergencies, their debt 'ends up' in uncollectible debt. These patients should also go down the street too."

OIIG Conclusions and Recommendations

These matters are of significant importance because HHS has experienced $174.8 million in denied claims in 2016 and 2017 that are unrelated to the costs associated with charity related care. Our review revealed that these claim denials are primarily attributed to clerical and process errors made during patient appointment scheduling, patient registration, and coding healthcare charges. Additionally, we received reliable statements suggesting the existence of a significant number of registration clerks, coders, and billers who do not possess adequate self-motivation or the required skill sets and knowledge base to perform their respective job responsibilities. Moreover, there are medical professionals who fail to properly schedule patient appointments thereby creating problems with patient registrations. HHS also experiences large revenue losses due to physicians failing to complete patient medical files in a timely fashion.

Accordingly, in consideration of all of the foregoing, we respectfully request that consideration be given to the following recommendations for remedial action.

1. HHS should heighten its focus on claim denial prevention and require additional personnel to provide quality control measures at the different stages of the Revenue Cycle. HHS should assess the current quality review process and implement modifications that will identify problems before they are submitted to Payors for payment. This should include expanding on the practices currently being used in patient registration and training. The increase in personnel costs should be minimal compared to the amount of claim denials HHS experiences each year. This includes implementing system restrictions to prevent personnel from creating duplicate Financial Information Numbers.

2. HHS should expand and enforce the performance standards for all employees who participate in or affect the revenue cycle process. HHS management and supervisors should hold employees accountable for their actions and institute the appropriate

discipline, training, or preferably a combination of both for repeated errors that result in revenue loss. HHS should fill open positions in the Revenue Cycle Department with qualified new hires. Moreover, current employees without the necessary skill set or self-motivation to meet the minimal performance standards should be replaced.

3. HHS should re-evaluate its current policy that provides non-emergency healthcare services to insured patients whose insurance companies will not pay HHS. Similarly, HHS, while always mandating the delivery of appropriate medical care, should seek to better align and/or educate its medical providers with the guidelines prescribed by Payors for the selection of reimbursable medical treatments.

4. Senior management should emphasize to physicians and other medical professionals the importance of accurately completing patient medical records in a timely fashion. This should include implementing additional oversight measures and the imposition of discipline for routine failures to meet these deadlines.

5. HHS should ensure that physicians and nurses receive the necessary training to appropriately schedule patient appointments. It should also work closer with the Managed Care Department to avoid claim denials based the absence of pre-certifications, pre-authorizations, and non-covered services provided to insured patients.

I hope this information proves helpful. If you have any questions or would like to discuss this matter further, please do not hesitate to contact me. In accordance with Section 2-285(e) of the OIIG Ordinance, we respectfully request notification within 45 days of any action taken in response to these recommendations. Thank you for your time and consideration to this issue.

Very truly yours,

Patrick M. Blanchard
Independent Inspector General

Via Electronic Mail Delivery

cc: Honorable Toni Preckwinkle
Honorable Members of the Cook County Board of Commissioners
Cook County Health and Hospitals System Board of Directors
Mr. John Keller, Chief of Staff, Office of the President
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