County of Ventura
AUDITOR-CONTROLLER
MEMORANDUM

To: Theresa Cho, MD, Director, Health Care Agency **Date:** November 5, 2024

From: Jeffery S. Burgh

Subject: **AUDIT OF THE HEALTH CARE AGENCY'S REVENUE CYCLE FOR THE VENTURA COUNTY MEDICAL CENTER**

The audit has been completed of the Health Care Agency's (HCA) revenue cycle for the Ventura County Medical Center. The audit was conducted by CliftonLarsonAllen LLP, as commissioned by the Auditor-Controller. The audit report is attached for your reference.

The audit concluded that, overall, HCA had specific policies and procedures that were in line with industry standards. However, HCA did not consistently follow those policies and procedures surrounding key controls over the revenue cycle related to patient admissions and registration, and credit balances. The audit resulted in four recommendations to:

1. Create a policy requiring management review and approval of patient credit balance write-offs.

2. Review accounts before being written off to ensure money is not owed to a patient or other payor.

3. Maintain all documentation to support that insurance eligibility is verified before services are rendered.

4. Obtain Health Insurance Portability and Accountability Act (HIPAA) consent forms before services are rendered.

HCA management initiated corrective action to address the recommendations. Corrective action was planned to be completed in August 2024.

We appreciate the cooperation and assistance extended by you and your staff during this audit.

Attachment

cc: Honorable Kelly Long, Chair, Board of Supervisors
Honorable Janice S. Parvin, Vice Chair, Board of Supervisors
Honorable Matt LaVere, Board of Supervisors
Honorable Jeff Gorell, Board of Supervisors
Honorable Vianey Lopez, Board of Supervisors
Sevet Johnson, Psy.D., County Executive Officer

PERFORMANCE AUDIT OF THE COUNTY OF VENTURA HEALTH CARE AGENCY'S REVENUE CYCLE FOR THE VENTURA COUNTY MEDICAL CENTER

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INDEPENDENT AUDITORS' REPORT

Jeffery S. Burgh, Auditor-Controller
The County of Ventura, California

This report represents the results of our performance audit of the County of Ventura Health Care Agency (HCA) in accordance with County of Ventura contract #8765**.** The performance audit focused on determining whether certain key controls over the HCA revenue cycle for the Ventura County Medical Center (VCMC) were operating effectively and in line with industry standards. As part of our audit, we evaluated HCA's key controls over their revenue cycle related to patient admissions and registration, credit balances, and billing.

We conducted this performance audit in accordance with generally accepted government auditing standards. 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 that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Our work did not include an assessment of the VCMC revenue cycle or other matters not specifically outlined in the enclosed report. The information included in this report was obtained from VCMC on or before January 31, 2024. We have no obligation to update our report or to revise the information combined therein to reflect events and transactions subsequent to November 1, 2024.

CliftonLarsonAllen LLP's policy requires that we obtain a management representation letter associated with the issuance of a performance audit report citing generally accepted government auditing standards. We requested a management representation letter from HCA on November 1, 2024, and received the signed representation letter on November 1, 2024.

CliftonLarsonAllen LLP

CliftonLarsonAllen LLP

Roseville, California
November 1, 2024

Background

The County of Ventura (County) engaged CliftonLarsonAllen LLP (CLA) to conduct a performance audit of the Health Care Agency's (HCA) revenue cycle for the Ventura County Medical Center (VCMC). VCMC is a department of the HCA. VCMC is a hospital system with two public hospital campuses in Ventura and Santa Paula, as well as a broad network of ambulatory care clinics.

This report presents the results of objective analyses carried out by CLA so the County of Ventura Auditor-Controller's Office and those charged with governance and oversight within the County may use the information provided to improve its understanding of current policies and practices and oversee or initiate corrective action regarding internal controls over the revenue cycle for VCMC.

The VCMC admitting department obtains certain patient information including, but not limited to, Insurance eligibility, patient financial responsibility, consent for treatment, and HIPAA consent forms. The VCMC revenue cycle team performs functions such as utilization, coding, and charge reviews, billing, collections, and write-offs. Additionally, the VCMC revenue cycle team evaluates patient credit balances, and will refund patients or payors when it's determined an overpayment occurs.

The health care industry has many unique attributes and risks associated with the revenue cycle. This includes rules and regulations regarding what procedures can be billed to certain payors, and processes and procedures that must take place before billing may occur. There are also additional rules and regulations surrounding the write-off of patient credit balances. Many payments are subject to billing review, retroactive adjustments, or other queries which may occur over a considerable period of time. Individual patients may also be covered by multiple insurers, of which the coordination of benefits may add additional complexity to the billing cycle, that can result in potential overpayments or additional adjustments on patient accounts.

Audit Objectives and Scope

Audit Objectives

The overall objective of this performance audit is to determine whether certain key controls over the HCA revenue cycle for VCMC were operating effectively and in line with industry standards.

As stated in the auditing services proposal, internal controls over the following areas of the revenue cycle for VCMC for fiscal year 2022 were identified as key objectives of the Audit:

- Obtain an understanding of the revenue cycle for VCMC.
- Perform tests of controls to determine the operating effectiveness of key internal controls related to the revenue cycle for VCMC.

Scope

The scope and methodology of our work to address the above audit objectives include the following:

- Perform a walkthrough of one patient account to gain an understanding of the internal controls over the revenue cycle processes at HCA.
- For 8 days in fiscal year 2022, obtain a list of accounts that were removed from accounts receivable using the HCA credit balance script. From those 8 days select a total of 40 accounts and perform the following:
    - Verify that the removed accounts were reviewed and approved by management.
    - Obtain remittance advices for the 40 accounts and other audit support to determine that the script did not remove accounts that were overpayments from patients or payors.
- Obtain a list of credit balance write-offs in May and June 2022 performed by HCA and perform the following:
    - Verify that the write-offs were reviewed and approved by management.
    - For a sample of 40 patient account write-offs obtain the remittance advice and verify that the account was not an overpayment from a patient or a payor.
- Obtain a list of patient payments for 8 days in fiscal year 2022. From those selected days select 40 patient accounts for testing and perform a test of the following controls.
    - Verify for each patient selected that insurance eligibility was checked in accordance with HCA policy. If a patient does not have insurance, verify that the patient was provided the sliding scale fee program or was provided a discount in accordance with the discount payment policy.
    - Verify that the patient financial responsibility policy, consent for treatment, and HIPAA form were provided and signed by each patient in accordance with HCA policy.

Audit Objectives and Scope (Continued)

Scope (Continued)

- For 8 days in fiscal year 2022, obtain a list of patient payments. From those 8 days select a total of 40 accounts and perform the following:
    - Obtain the patient bill or other support to determine when the account was moved from discharged not final billed (DNFB) status to billed status.
    - Obtain support of when the utilization review (UR), coding review, and charge review were performed.
    - Verify that the UR, coding review, and charge review occurred before the patient account status was changed from DNFB to billed.

Audit Results

Overall Audit Objective Results

Based on the procedures performed in response to the audit objectives identified, we observed that HCA did have specific policies and procedures that were in-line with industry standards. We concluded that VCMC did not consistently follow those policies and procedures surrounding key controls over their revenue cycle related to patient admissions and registration, and credit balances.

Strengths

The results of the audit found that VCMC has a number of good practices that are operating effectively. The following are examples of these activities:

Walkthrough

- During our walkthrough procedures, we obtained an understanding of the internal controls structure of the VCMC revenue cycle. Based on the procedures performed we observed that for the most part, the design of the control structure for VCMC was in-line with industry standards.

HCA Credit Balance Script

- Due to inherent flaws in the Electronic Health Record software, credit balances are created when there are certain secondary payors. VCMC runs a script weekly to remove patient credit balances when certain conditions are true.
- When a change is requested to the script, there is a validation process to ensure that the script is running as intended before it is put into production.
- The script is written in a specific way so that it will not adjust any accounts where a patient has made a payment.
- In our testing of 40 patient records that were adjusted using the script, we did not find any instances of the script adjusting a patient account that included an overpayment.

Admissions and Registration

- The design of the control structure for patient admissions and registration is in-line with industry standards.
- In our testing of 40 patient records, we observed that the patient, or guardian, had signed the patient financial responsibility policy for all accounts that were tested.
- In our testing of 40 patient records, we observed that the patient, or guardian, had signed the consent for treatment for all accounts that were tested.

Billing

- The design of the control structure for patient billing is in-line with industry standards.
- In our testing of 40 patient records, we observed that for all accounts where a utilization review (UR) is required, the UR was performed in advance of the account being moved from discharged not final billed (DNFB) to billed.
- In our testing of 40 patient records, we observed that for all accounts where a coding review is required, the coding review was performed in advance of the account being moved from discharged not final billed (DNFB) to billed.
- In our testing of 40 patient records, we observed that for all accounts where a charge review is required, the charge review was performed in advance of the account being moved from discharged not final billed (DNFB) to billed.

Observations and Recommendations

Summary of Observations

As a result of our procedures, we identified instances where the internal controls surrounding the revenue cycle for VCMC were not operating effectively. A summary of our observations are outlined below:

- CLA observed that patient credit balances were written off without a formal review and approval process.
- CLA observed that for 12 of the 42 patient credit balances tested, these accounts were written off when they represented a liability to a patient or payor.
- CLA observed that for 3 of the accounts tested in our procedures over admissions and registration VCMC was unable to provide support that insurance eligibility was verified before services were provided.
- CLA observed that for 1 of the 40 accounts tested in our procedures over admissions and registration VCMC was unable to provide support that the patient signed the HIPAA consent form before the patient visit.

Detailed Recommendations

The following pages provide the detail of our recommendations as well as the applicable responses from the HCA. The recommendations are intended to raise the internal control effectiveness with standard industry practices.

Recommendation 1.01
Topic: Credit Write-Offs
Subtopic: Policies

Condition	Criteria
CLA observed that for 42 of the 42 credit balance write-offs tested from May and June 2022, HCA was unable to provide support that the write-offs were reviewed and approved.	Patient credit balance accounts can be created either from HCA excluding charges that were billed, inputting multiple contractual allowances, or by an overpayment from a payor and/or patient. When writing off credit balance accounts, there is a risk that HCA could write off a credit balance that was the result of an overpayment, which should be refunded to the patient and/or payor.

Cause	Effect
The HCA credit balance policy states the Patient Accounts Manager shall routinely report the status of credit balances and overpayments to the CFO and the Compliance Committee for review. Any unusual patterns or occurrences will be investigated in accordance with the Compliance Policy. There does not appear to be a policy that states that HCA shall review and approve the write-off of individual credit balances.	Credit balances owed to a payor and/or patient represent liabilities of HCA. By writing off these accounts, HCA is removing liabilities from their accounts. A review and approval process over these write-offs would help ensure accuracy and that these potential liabilities are not written off.

Recommendation
We recommend that HCA create a policy that the write-offs of credit balances be reviewed and approved by Management to ensure accuracy of patient credit balance write-offs.

Management Response
HCA agrees with the policy and put in a request in Cerner that there is a supervisory review in the system that will happen. Looking at hard copy reports in the meantime.

Management Response Timeline
In July 2024, HCA implemented a new policy, accompanied by a manual review process and reporting system.

Recommendation 1.02
Topic: Credit Write-Offs
Subtopic: Overpayments

Condition	Criteria
CLA observed that for 12 of the 42 credit balance write-offs tested from May and June 2022, the credit balance was created by a patient and/or payor overpayment of $290 of the total $7,344 credit balances tested.	Credit balances that are created by overpayments represent liabilities to the payor or patient. By writing off these accounts the payor and/or patient is not refunded money owed to them. As the account is no longer in a credit balance status, the billing department would be unaware of the potential refund.

Cause	Effect
The credit balance write-off did not review every patient account individually, however appeared to write it off in a lump sum.	Credit balances owed to a payor and/or patient represent liabilities of HCA. By writing off these accounts, HCA is removing liabilities from their accounts. CLA observed that at the time of our procedures, 8 of the 12 accounts had been refunded to a patient subsequent to the write-off.

Recommendation
We recommend that every account be reviewed before being written-off to ensure money is not owed to a payor and/or patient.

Management Response
HCA agrees with the recommendation to review credit balances to determine the appropriate action steps.

Management Response Timeline
In response, we implemented a policy to address this and ensure credit balances are reviewed in July 2024.

Recommendation 2.01
Topic: Enrollment
Subtopic: Insurance Eligibility

Condition	Criteria
CLA observed for 3 of the 40 selections tested, HCA was unable to provide support that insurance eligibility was verified before services were provided in accordance with HCA policy.	HCA policy is that insurance eligibility is verified before procedures are provided, except in the case of emergencies where services may be required by law regardless of a patient's ability to pay.

Cause	Effect
The insurance eligibility form was not filed properly.	By not verifying insurance eligibility prior to services being performed, HCA does not know which payor to bill, if any, or if the patient has coverage for services that are provided.

Recommendation
We recommend maintaining all supporting documentation in the electronic health records system if possible to support that the policies and procedures are being properly followed.

Management Response
HCA agrees with this recommendation and have made the necessary work flow change processes.

Management Response Timeline
HCA implemented new technology to ensure verification occurs pre-visit and stores the data in the EHR in August 2024.

Recommendation 2.02
Topic: Enrollment
Subtopic: HIPAA Consent Form

Condition	Criteria
CLA observed for 1 of the 40 selections tested, the HIPAA consent form was not signed nor did the form indicate that verbal consent was obtained in accordance with HCA policy.	By not obtaining or identifying consent, the patient does not indicate that they were informed of their patient rights under HIPAA.

Cause	Effect
The Agency did not obtain a signed form in accordance with policy, however did obtain a signed form on a subsequent patient visit.	The notices included in the patient information booklet are protections for HCA against certain actions that patients can have against HCA. Obtaining the evidence that the patient was informed of these rights is beneficial in instances where a patient may bring forward a complaint or lawsuit that they were not informed of certain policies or procedures.

Recommendation
We recommend that HCA obtain consent from all patients in line with their policy before services are rendered.

Management Response
HCA agrees with this recommendation.

Management Response Timeline
We have implemented procedures to ensure that consent is obtained prior to rendering services in July of 2024.