YAP STATE
DEPARTMENT OF HEALTH SERVICES

Internal Controls over the Accounting and Reporting of Program Income

Office of the Public Auditor
State of Yap
Federated States of Micronesia

OFFICE OF THE PUBLIC AUDITOR
STATE OF YAP
FEDERATED STATES OF MICRONESIA
P.O. BOX 927, Colonia, Yap 96943
Phone: (691) 350-3416 Fax: (691) 350-4987 Email: audityap@mail.fm

EXECUTIVE SUMMARY

The Office of the Yap State Public Auditor has issued the final report on its audit of *Internal Controls over the Accounting and Reporting of Program Income* for the Department of Health Services. The audit was requested by the Director of Health Services.

The Fiscal Procedures Agreement (FPA) of the Amended Compact of Free Association requires FSM governments to seek opportunities to earn income to defray government program costs by establishing fees for services in the areas of public utilities, health services, and government-owned or operated commercial enterprises. Accordingly, the Department of Health Services had in place a schedule establishing fees for services provided by the Yap Hospital to outpatients, inpatients, and medical referral patients.

The primary responsibility of the Department of Health Services is to provide health care to the people of the State. Accordingly, the Department of Health Services cannot refuse services to anyone because of outstanding bills or because of his inability to pay for the health care. Therefore, fees to be collected at the hospital have to be easily identified, easily assessed (billed) and collected in a timely manner by the hospital personnel in the normal course of performing their health care functions. In addition, to be equitable, methods should be in place to ensure that patients are billed the same fees for the same services. Moreover, controls must be in place to ensure that once services are billed to patients, funds collected are properly accounted for and deposited to the State Treasury in a timely fashion.

Below is a summary of our findings and recommendations relating to our review of the accounting and reporting of program income at the Hospital:

(1) We recommended that DHS revise and simplify its existing fee schedule.

We found that the existing fee schedule was not comprehensive; some charges billed to patients were not listed on the fee schedule. Moreover, there existed a disparity in health care cost charged to dispensary patients, outpatients, and inpatients. Exemptions to fees were not adequately documented increasing the chances of billing errors. The fee schedule was not easy to enforce. It had too many variations in fees for medication, surgical procedures and medical supplies that were proving too difficult and time-consuming for nurses and other hospital staff to track services received by each patient in order to allow preparation of invoices.

(2) We recommended that the DHS revise and number its existing hospital forms to accommodate accounting information needed for proper assessment and collection of fees.

We found that the patient "encounter form" was the primary record available to document the number of patients seen by the hospital and the type of services received. DHS had begun utilizing the form to assess fees to patients, but because the forms were not numbered, DHS could not ensure that all forms were accounted for at the end of the day. Moreover, because the forms were primarily health care forms, the accounting information necessary to show the full cost of the services received by the patient and the ultimate collection of the fees billed were not available on the forms.

(2) **We recommended that the accounting office improve accounting for program income to ensure that all services billed have been collected or otherwise have been recorded to the patients' receivable account.**

We had difficulty tracing encounter forms to cash receipts and receivable accounts. Likewise, information was not available on patients' receivable accounts to allow tracing the outstanding bills back to the encounter or billing forms. Even though the Hospital had taken steps at the time of our review to improve its accounting, fees associated with each patient visit could not be readily traced to accounting records to determine whether the patient paid the bill in cash in full, or whether a balance remained to be paid by the patient or by insurance.

(3) **We recommended that DHS improve accounting and collection of its receivables.**

We found that DHS maintained three types of receivable listings: outstanding bills for inpatients, medical referral patients and insurance payments. The lists were not integrated, but were independently maintained by different staff members. Consequently, it was difficult to determine what a particular patient owed in total to the hospital without going through all three lists. Moreover, collection on accounts was poor because the hospital had little means to enforce collection. We suggested that they concentrated on collecting as much from patients as soon as possible by offering discounts for early payments. We also recommended that they send out regular reminders to patients with outstanding balances to settle their accounts.

(4) **We recommended that DHS purchase an accounting software for its accounting of program income to allow monthly and fiscal year reports and that were reconcilable to State Finance records.**

(5) At the time of our review, the only accounting ledger maintained by DHS for program income was a cash receipt ledger. The accounting office was only required to prepare a daily cash summary for transmittal of deposits to the State Treasury. No attempt was made to accumulate the daily reports into monthly summaries of collection for reconciliation with Finance records. Moreover, the cash receipts journal and daily report represented only the cash portion of the total program income. No report was given to the Finance on total program income earned each fiscal year because such information was not available.

We also offered other recommendations to DHS to improve controls over the safeguarding of cash and ensuring proper segregation of duties, among other things.

We met with the Director and pertinent staff members of the Department of Health Services to discuss our findings and recommendations. The Department has initiated many of the recommendations contained in the report. A memo from the Deputy Director of Health Services to relevant staff members regarding the audit findings and recommendations are attached as part of this report.

We thank the Director and the staff of the Yap Hospital for the courtesy and cooperation extended to us during our audit.

Respectfully submitted,

Gertrude Gootinan

Gertrude Gootinan,
Yap State Public Auditor

YAP STATE DEPARTMENT OF HEALTH SERVICES
Internal Controls over the Accounting and Reporting of Program Income

Table of Contents

PART ONE

Introduction

Why did we do this audit?

1.1 In August 2005, Mark Durand, the Director of Health Services requested the assistance of the Public Auditor's Office to review policies and procedures for the collection of program income for weaknesses and provide recommendation if necessary.

1.2 Subsequently, our office internal discussion proved this area to be of interest for review based on the negative public perception of the hospital services and prior audit inquiries of the hospital accounting records.

1.3 It is part of the Public Auditor Office sphere of responsibility to review systems and programs that provide services to the public for economy.

Purpose of the audit

1.4 The objective of our audit was to:

Evaluate the accounting and reporting policies and procedures for program income and offer recommendations to strengthen internal controls in order to maximize the collection of program income. The objective of our audit was not to provide an opinion on internal controls over financial reporting of program income. Accordingly, we express no such opinion.

Auditing standards we followed

1.5 The audit was performed, as applicable, in accordance with standards for performance audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States. Accordingly, we included such tests of the records and documents of DHS related to program income and applied other auditing procedures that we considered necessary in the circumstances.

Audit scope

1.6 Detailed transactions selected for review were limited to the three-month period of June, July, & August 2005.

1.7 The audit covered the billable service areas below:

- outpatient services
- inpatient services
- medical referral program.
- dispensary service was covered to show indirect effects on collection of revenue.

How did we carry out the audit?

1.8 **To understand what should be happening**:

- We obtained an understanding of billing, collection and reporting of program income by interviewing the Director of Health Services, as well as key personnel in areas involved with revenue collection and management.
- We reviewed existing (formal & informal) policies, procedures, and considered best-practices.
- We obtained copies of and reviewed billing and collection forms in current use.

1.9 **To understand what was actually happening**:

- We tested a sample of transactions in the billing and collection of program income.
- We obtained and analyzed receivable listings and summary reports of program income collected within the past year.
- We conducted surprise cash-counts at two collection points to assess the risk of fraud and improper accounting of program income.
- We conducted other tests and performed other analysis that we deemed to be necessary under the circumstances.

What the audit did not cover:

1.10 We did not review policy & procedures of those areas not related to collection of program income.

1.11 We did not review the entire Medical Referral Program, but limited our review to areas related to billing and revenue collection.

PART TWO

Background

About the Department of Health Services

2.1 The Department of Health Services (DHS) is the sole primary health care provider in the State of Yap, Federated States of Micronesia. The Yap Memorial Hospital operated by the DHS is located in Colonia, Yap. DHS also operates two community dispensaries on Yap Proper and eighteen in the outer islands.

2.2 Primary funding for the operation of the Department of Health Services is derived from Compact II Health Services Sector Grant. Certain divisions, most especially the Division of Public Health, also administers certain program specific grants from the U.S. Department of Health and Human Services, passed-through the FSM National Government. From time to time, the Department also receives grants from other organizations such as the World Health Organization or other U.N.-affiliated programs.

About program income

The Director of Health Services wishes to improve the billing and collection of program income because:

2.3 "Program Income" as defined by the Fiscal Procedures Agreement (FPA) of the Amended Compact of Free Association includes "(1) earnings from the use or rental of real or personal property acquired with Compact funds; (2) the sale of commodities or items fabricated under a sector grant; (3) and fees assessed in the areas of public utilities, health services, and government-owned or operated commercial enterprises.

2.4 The FPA requires the FSM governments to seek opportunities to earn income to defray government program costs by establishing fees for services in the areas of public utilities, health services, and government-owned or operated commercial enterprises. Program income earned shall remain with the programs in which they are earned to offset operational and capital costs not covered by Compact funds.

2.5 On a local level, the competition for limited funds under the Compact has translated to a reduction of funds available for the operation of the Department of Health Services. One of the first programs that have been slated for cuts has been the medical referral program. The Department is looking for ways to maintain the program through other means. Funds generated through the billing of hospital services to patients is being evaluated as a potential source of funds to allow continuation of the medical referral program.

A history of "user-fees" at the hospital

2.6 During the Trust Territory Government, the Yap Hospital did not make any serious attempts to charge user fees for any of the services it provided to the general public

2.7 During the first years of the Compact of Free Association in the 1980s, the State of Yap began encouraging departments providing services to the general public to begin assessing user fees.

2.8 The Executive Budget Review Committee implemented the policy by allocating a portion of each relevant department's annual budget to "reimbursement"; meaning that a portion of the department's budget was to be derived from user fees collected from the general public. It was during this time that the hospital began charging a small fee for doctor consultation and prescriptions, and hospital stays.

The types of hospital services billed to patients (users)

At present, the hospital charges fees to patients receiving certain services in the following areas:

2.9 Outpatient services:
"Outpatients" are those patients who received health services without hospitalization. Depending on the type of services received the patient is usually charged one or more of the following fees: doctor consultation, x-ray, lab analysis, prescriptions, dental care, physical examination, and medical supplies, and surgical or other medical procedures, if required

2.10 Inpatient services:
Patients who were admitted overnight to the hospital ward are considered "inpatients". This type of patient is usually charged a fee for the following: x-ray, lab analysis, medication, room & board, medical supplies, non-medical supplies, and prescriptions. Similarly with outpatients, inpatients are also subject to fees associated with any surgical or other medical procedures that may have been required.

2.11 Medical Referral Program:
Non-insured patients referred off-island for further treatment under the hospital medical referral program is expected to pay a down payment of $500 (or $1,500 if alcohol/drug related injuries) along with 3.5% of the total medical bill from the treatment hospital. The rest of the treatment cost is paid by the DHS through the State Finance.

Who bills and collects hospital program income:

2.12 Staff of the Business Office:
The Business Office is responsible for maintaining financial records for the hospital. The office is staffed with three employees, a supervisor, an accountant, and an insurance & vital statistician. The Business Office is the primary collection point of user fees for DHS services. It is tasked to perform fee assessment, fee collection, receipt issuance, and accounting.

2.13 Pharmacists and his assistants:
This is the other collection point of fees for services. It is also where most patients obtain their medicine, formulary and over-the-counter drugs. The pharmacist manages daily operation, assisted by three pharmacy assistants. During evening & weekend hours this office receives cash payments and issues receipts to patients, in addition to filling patients' prescriptions.

2.14 Nurses at the Nurse Station:
The nurse station is responsible for handling after-hours outpatients for the Business Office and the Pharmacy. It is also responsible for providing care to inpatients and also to maintain logs and other reports to track medication, medical supplies and services provided to inpatients. The Business Office depends on such logs to prepare billing forms for inpatients.

2.15 Supply & Procurement Officer:
This office is responsible for replenishing the pharmacy and dispensaries with needed medicinal supplies, as well as releasing certain on-demand supplies to the nurse station such as oxygen. It also releases medical supplies on charge-account basis for some public and private entities.

2.16 Medical Referral Program Coordinator:
The Department of Health Services started this program to subsidize the referral of uninsured patients off-island for further treatment. The program employed a coordinator responsible for managing the program; specifically, taking care of referral logistics, billing and collection, among other things. In July 2005, the Department of Health Services signed a memorandum of understanding with MiCare (Insurance Management Provider) to extend logistical support to uninsured Yap State patients referred to Manila.

2.17 Doctors and Aides at the Public Health clinics:
The division of Public Health organizes medical clinics for the public. Most of the time these clinics are free to the general public, although occasionally, some clinics require a small fee from attending patients. Fees charged to patients attending Public Health clinics are processed by Finance and Pharmacy as regular outpatient transactions.

Methods of payment

2.18 Cash payment:
Cash payment is usually made at the Business Office or the Pharmacy (after normal working hours) for either current expenses or outstanding debt. Payments are receipted and recorded on the cash receipts journal.

2.19 Account receivables:
Patients who may be unable to immediately settle their medical expenses incur an interest and penalty free debt to the hospital. Sometimes a promissory note is executed to allow the patient or his family to pay the hospital bill in installments.

2.20 Insurance coverage:
Patient with insurance coverage pays a $2 co-payment for each visit and the cost of non-covered services received, such as over the counter drugs and medical supplies. The insurance pays the hospital for the rest of the patient medical cost, except for fees waived in exchange for specific MiCare services, as stipulated in the adopted agreement.

PART THREE

SUMMARY OF FINDINGS

Procedures Necessary To Collect Program Income:

The decision or policy to begin charging patients for certain services was only the first of several steps that should have been taken by hospital management to ensure its successful implementation. Other policies and procedures should have been developed to ensure the efficiency and effectiveness of the processes of billing and collecting program income. Before the hospital could collect program income, management should have developed guidelines and procedures to explain to those charged with the responsibility:

3.1 How to determine and identify billable services

3.2 How to determine the correct rate to apply for each billable service

3.3 How to track patients who received billable services

3.4 How to ensure that 100% of all patients who received billable services were accurately invoiced and accounted for

3.5 How to ensure that nonbillable (free) services were not invoiced

3.6 How to ensure that all amounts invoiced were timely collected

3.7 How to ensure that all amounts collected were accurately recorded and timely deposited to the State Treasury

3.8 How to ensure that deviations from established policies and procedures would be timely identified and corrected by employees in the normal course of performing their duties.

3.9 How to ensure that the processes of tracking, billing and collecting program income were carried out as much as possible by existing personnel, yet not impede the hospital staff's primary function of providing health care to patients.

Successful billing and collection of program income required that:

3.10 Policies and procedures for each of the steps related to charging and collecting program income must be set in writing to ensure consistency of implementation and lessen the risk of misunderstanding and errors.

3.11 Methods for consistent tracking and invoicing of each billable service must be formulated and new forms or accounting tools be developed, if no existing tools could be used to accommodate the new processes.

3.12 Controls to safeguard collections against theft and loss must be instituted to ensure that all collections are properly accounted for and deposited to the Treasury.

3.13 Personnel to be responsible for tracking billable services, invoicing them and collecting income must be identified and the additional duties be added to their job descriptions and communicated to them.

We found that:

3.14 Only the fee schedule had been set in writing. Directives and internal memos were also available explaining certain parts of the fee assessment and collection process, but there were no comprehensive written policies and procedures for the billing and collection of program income to which employees could easily refer. Our attempts to obtain documentation to help us understand the process found employees reciting their own understanding of verbal instructions they had received from management.

3.15 Forms in use to track billable services were forms originally developed by the hospital for other purposes. Although we found some forms were tailored to accommodate some of the accounting information required for assessing fees to patients, certain vital information critical to the correct assessment of fees were lacking on other forms.

3.16 Accounting procedures were not formulated to ensure accurate information on program income was accumulated, analyzed, and reported to management. Accordingly, there was no coordinated supervisory review to ensure that all billable services were invoiced and collected by the department.

3.17 Reliance was placed on the medical and clinical staff to document services provided to patients, however, careful consideration was not given to the process to ensure that the additional responsibility did not unnecessarily hinder their primary responsibility of providing health care to patients.

We believe that the weaknesses above existed because:

The procedures currently in place for collecting program income were generally the same procedures instituted by the hospital back in the 1980's when it first began charging fees for its services. At that time, maximizing collections was not a primary objective. Therefore, no review and evaluation of the revenue billing and collection process was conducted to ensure that all billable services were invoiced and all collections were deposited and accounted for. In fact, our overall conclusion on the existing procedures for collecting program income is that controls are inadequate to ensure that fees for all billable services are collected and deposited.

Our recommendation:

In order to maximize its collection of program income, the Department of Health Services must conduct a comprehensive review of the steps necessary to collect program income and institute controls to ensure that billable services are tracked, invoiced and collected. These steps must be set in writing for easy reference by those who are charged with the responsibility to bill and collect program income. In the rest of this report, we have tried to address internal control weaknesses specific to each area of the process of tracking, billing and collecting income and attempted to provide recommendations that when implemented we hope may resolve some of the problems cited.

PART FOUR

IDENTIFYING AND COSTING BILLABLE SERVICES

In order for the Department of Health Services to assess fees to patients, it must first decide which services to bill to patients and set the appropriate fee for each service. The Department of Health Services has in place a schedule listing fees for outpatient services, surgical, x-ray and lab procedures, inpatient room and board, and medical supply usage fees for outpatients and another one for inpatients. The fee schedule is updated regularly. The one in current use was adopted in April 2005. It would appear therefore that those charged with the responsibility to track services and assess related fees would have no difficulty determining which services to include on the patients' invoice. Unfortunately, we found this was not entirely true.

Criteria for an effective fee schedule:

4.1 **The fee schedule must be comprehensive.** It should cover all fees and charges imposed by the hospital on patients, or to a third party on behalf of patients.

4.2 **The fees should be equitably applied to all users.** Great disparities between fees for different users without justification encourage users to avoid payment.

4.3 **Exemptions to the fees should be kept at the minimum.** Such exemptions must be clearly explained and documented to minimize the risk of billing errors.

4.4 **Each fee must be relatively easy to enforce.** Consideration must be given to the units of measurement (flat rate, per dose, per unit) and methods for tracking the units and whether the personnel assigned to the tasks would be willing and able to perform them effectively and consistently.

We found that:

4.5 ***The current fee schedule is not comprehensive.*** Fees and other charges for medical referral patients are not included on the Fee Schedule.

4.6 ***There exists a big disparity in prescription costs to dispensary patients, outpatients and inpatients.*** Prescription drugs obtained at the community dispensaries are free to patients. Outpatients are charged a flat rate of $2.00 on all types of medication. In contrast, inpatients are charged at $1.00 per dose, even for a nonprescription drug like Tylenol.

4.7 ***Exemptions to the fee schedule were not adequately documented:***

- The current fee schedule charges a $2 consultation fee to outpatients. Patients attending certain clinics were not required to pay the $2. Those free clinics were not identified on the

fee schedule or elsewhere in writing; neither is there a mechanism for differentiating patients attending free clinics from those who should be paying the doctors fee.

- The fee schedule requires outpatients to pay a $2 flat rate for each type of medication prescribed by the doctor per visit. Yet, certain medications were free such as "*Vermox*" for intestinal worms. We were also told that certain medications that would normally be assessed a fee sometimes could be given away for free if the doctor renders a certain diagnosis.

4.8 ***Insufficient information is provided to allow verification of fees charged.***

- **Doctor's fees for Day and Night**: We found that the fee schedule required a different fee for visits during the day and night, yet the forms used for tracking services did not require the time of the visit to be recorded.

- **FSM and Non-FSM Rates**: The fee schedule requires different rates for "Local/FSM" and "Others", yet did not specify whether it meant "citizens" or "residents", neither did it provide basis or guidelines for determining citizenship or residency of patients.

- **Alcohol and Non-alcohol Related Medical Referrals**: Fees for medical referral patients are higher if the reason for the referral is alcohol related. Yet, it is not documented how the "alcohol-related" referrals were to be identified.

4.9 ***Employees' abilities to effectively assess fees were not adequately considered.*** Terminology used for certain surgical procedures such as "simple", "total" or "radical" may be medical terms that only the doctors fully understand. Non-medical employees of the Business Office are responsible for costing services provided by the doctors and assessing fees. Unless management requires the doctors to note the procedures or conditions exactly as written on the fee schedule in legible writing to allow the Business Office staff to accurately prepare the bill using the correct rate for the right procedure, the risk of billing errors will be high.

4.10 ***Inpatient fees for medical supplies were established without adequate consideration of the cost-effectiveness of tracking the patient's use of the supplies.*** (For additional discussion refer to *Part 6: Communicating the Charges to the Patients – Outpatients* on page 16).

The lack of written procedures on how to implement the fee schedule contributed to much of the difficulties of assessing and collecting the different fees. Consequently,

4.11 We were unsuccessful in our attempt to trace inpatient billings to the services recorded by the nurses in patients files selected for testing. Because of the difficulties of tracking the units of medical supplies and prescriptions used by patients, we found documentation of such usage to be unreliable.

4.12 Our attempt to verify outpatient fees and services as documented on the Encounter Forms to the payments received by the Business Office were hindered by the lack of documented exceptions to the doctors' fees and prescription charges.

4.13 Pharmacy employee admitted that some outpatients, when they find out that the doctor had prescribed to them a medication available at the community dispensary, do not bother to pay the fees and fill their prescriptions at the hospital. They instead choose to fill their prescription at the dispensary for free.

Our recommendations:

We feel it is important for DHS management to conduct a comprehensive review and evaluation of the existing fee schedule against the points raised above.

4.14 One objective of such a review is to attempt to simplify the tracking and billing of the items on the schedule. For example, a way to simplify tracking and billing of inpatient medicine and medical supplies is to use a flat rate, instead of the current practice of billing for each individual dose or item.

4.15 Another objective is to rethink the methods for tracking each charge to ensure that the methods are cost-effective and that the tasks are assigned to the appropriate personnel.

4.16 The third objective of the review might be to ensure the rate structure is fair to all patients. If the review results in changes to the bill, the revised bill should be made available to the general public to allow patients the opportunity to point out billing errors to the cashier and thus help ensure proper billing of the items on the fee schedule.

4.17 A comprehensive implementation guide addressing the concerns raised in this report should be formulated and adopted for ready reference by those who are assigned the responsibility to assess and collect hospital fees.

PART FIVE

TRACKING PATIENTS RECEIVING BILLABLE SERVICES

Once a fee schedule is established, the process of tracking the types of services provided to each patient begins. When the fee schedule applies across the board to all patients, the process is made simpler. However, when the fee schedule does not apply to certain types of patients or services, successful implementation of the fee schedule becomes dependent on the ability of the DHS personnel to correctly match patients with the appropriate billable services received.

5.1 Medical Referral Patients:

5.1.1 There are two types of patients who may be referred off-island for treatment – those who are insured and those without health insurance coverage.

5.1.2 Some of the costs of services provided to the insured patient before the point of referral may be billable. However, once the decision is made for off-island referral, the cost of treatment of the insured patient becomes the sole responsibility of the insured patient and MiCare.

5.1.3 For uninsured patients, the billing process while treatment is ongoing at the Yap State Hospital follows the procedures for outpatients or inpatients, whatever the case may be. Once the decision is made by the medical referral committee to refer the uninsured patient off-island for further treatment, the billable charges for the uninsured medical referral patient is reduced to two items – the flat fee of $500 or $1,500 and 3.5% of the total cost of treatment that may be billed by the referral hospital.

5.2 Inpatients:

5.2.1 According to the DHS Fee Schedule, every inpatient is a paying patient. The reason is that almost every service provided to the inpatient is billable under the Fee Schedule. These include the room and board, medical supplies and medication dispensed to the patient while under hospital care.

5.2.2 Records of patient admittance maintained by the nursing staff are adequate to allow an independent person to determine at any point in time the list of patients who should be invoiced by the hospital.

5.3 Outpatients:

5.3.1 For outpatients, it is an entirely different matter. Not all services provided to outpatients are billable under the current fee schedule.

5.3.2 As we discussed in Part Four, in order to enforce the fee schedule, it is important to distinguish those patients receiving free services from those who should be paying a fee.

Currently, the hospital tracks patients receiving billable services as follows:

5.4 Every person who visits the hospital or community dispensary seeking medical attention, whether alone, or as a participant in an ongoing clinic, is required to obtain and fill out an "Encounter Form". At the hospital the forms are obtained and completed at the Record Room window. The Record Room staff inserts the completed form into the patient's chart and forwards the chart to the Outpatient Department.

5.5 At the Outpatient Department or clinic, a nurse or medical aide takes and records the patient's vital statistics onto the form and forwards the form and patient chart to the patient's doctor.

5.6 After his examination, the doctor records the diagnosis and prescriptions, if any, onto the form. Then the patient is given the Encounter Form for presentation to the Business Office (Finance) window for payment of required fees.

5.7 At the Business Office, the cashier reviews the form, consulting her copy of the fee schedule, if necessary, and then informs the patient the total amount due. She notes on the Encounter Form the total amount received from the patient and then issues the patient a cash receipt, a copy of which is retained in her cash receipt book. The cashier then stamps the Encounter Form, as an indication to Pharmacy that the Business Office has received all fees associated with the visit and that the patient is allowed to receive his prescription.

5.8 The patient takes his copy of the receipt, if any, and the stamped Encounter Form to Pharmacy as proof of payment and a record of the doctor's prescription for the patient. The copy of the cash receipt is kept by the patient, but the Encounter Form is surrendered to the Pharmacy staff who prepares the patient's prescription.

5.9 The forms are retained at the Pharmacy until the next business day when the forms are forwarded to the Record Room for posting onto a *Diagnosis Database*.

How DHS tracks patients receiving free and/or billable services:

5.10 As we discussed in Part Four, not all exemptions to the Fee Schedule are documented. We found that under the current set-up, the cashiers at the Business Office are solely responsible for ensuring that free services are not billed to patients and that fees for billable services are assessed and collected.

5.11 Upon presentation of the Encounter Form to the cashiers window, the cashier reviews the services received, assesses fees on the billable items on the encounter form, without indicating such on the encounter form and asks the patient to render payment on the portion not covered by insurance. The amount of the cash payment is noted on the encounter form and the supporting cash receipt.

5.12 If any services rendered to the patient are free of charge, such items are not marked as such on the encounter form. Our tests of encounter forms found that shortages between what should have been charged and the amount of cash collected were explained as the nonbillable services received. Due to the lack of proper documentation, only an independent person with sufficient knowledge of the fee schedule and its exemptions could possibly determine how the cash payments were calculated.

What is wrong with the current system?

5.13 **No reliable records of paying outpatients are currently maintained by the hospital**. One may argue, "what about the cash receipts?" One can rely on the cash receipts as a true record of all payments received by the hospital only in the absence of the risk of human errors and greed. But since errors and dishonesty are an inherent part of human nature, controls need to be in place to mitigate the risks involved in the handling of cash.

Our findings and recommendations:

The only available records of patients visiting the hospital are the Encounter Forms. The Encounter Form was intended as a medical form. Its adoption for accounting purposes began as part of enforcing the Fee Schedule. If DHS wishes to continue to use the Encounter Form as an unofficial outpatient invoice, the following concerns and recommendations need to be considered:

5.14.1 Finding: *The Encounter Form did not differentiate between free and billable services.*

Consequently, it was difficult to determine in a given day, how many patients should have made payments at the Business Office. Moreover, of those patients who made payments at the business office, it was difficult to determine that the total amount due DHS was collected and reported by the Business Office.

Recommendation: The Director should consider using special Encounter Forms for the Public Health Free Clinics and dispensaries to distinguish the patients of those free clinics from the regular outpatients who receive billable services at the Hospital.

5.14.2 Finding: *The Encounter Form is not pre-numbered.*

Pre-numbered forms are accounting tools to ensure that all transactions in each business cycle are counted and recorded. When utilized in this manner, the Encounter Form can serve the same purpose as a job order form that an auto repair shop might use to track billable service.

Recommendation: To ensure that the hospital maintains reliable records of all patients receiving billable services, we recommend that DHS adopt the use of a special pre-numbered encounter form for paying outpatients.

5.14.3 Finding: *The Encounter Form is a one-copy form.*

Another accounting tool to ensure the availability of reliable data is the use of multiple copy forms. Currently, the one copy of the Encounter Form is kept in the Record Room. Even though the Business Office uses the form as the basis for the payments received from patients, no copy is maintained at the Business Office. Consequently, discrepancies between what should have been charged to the patients as documented on the Encounter Form and what was actually charged as evidenced by the cash receipts were not readily obvious. Moreover, if pre-numbered forms were utilized for outpatients receiving billable service, a record of all paying patients could be maintained that could be matched against the number of cash receipts issued by the Business Office.

Recommendation: If the special pre-numbered Encounter Forms are adopted for paying outpatients, the Form should be prepared in sets of three; the original for the Record Room and the second copy for the Business Office to be stapled to the corresponding cash receipt and the third copy should be provided to the patient.

PART SIX

COMMUNICATING THE CHARGES TO THE PATIENT

- In a business enterprise, the cost of a service provided to a customer is communicated to the customer via an invoice or billing statement. The billing statement serves several purposes:

    - It ensures that all chargeable services are billed to customers and that no customers are receiving services for free.
    - It provides assurance to management that services are billed at established rates.
    - It establishes a sale amount that the entity could record as revenue.
    - It communicates the cost of the service to the customer to ensure that he does not pay more or less than the amount owed.
    - It serves as additional verification of actual cash payments received.
    - It establishes an amount owed to the entity that can be used to collect receivables.

How the DHS communicates fees to patients:

The existing billing procedures are different for outpatients, inpatients, and medical referral patients. The differences are due to the types of fees and nature of services involved in providing medical care to the three different groups of people. We will, therefore, separately describe the different procedures, the deficiencies we noted for each procedure and our recommendations below.

OUTPATIENTS:

As described in Part Five, the Medical Encounter Form is currently used by DHS as the unofficial invoice for outpatients. However, as an invoice, the Encounter Form is used by DHS primarily to allow the Business Office to assess and collect fees from patients. It is not intended to communicate the total bill to the patient, nor to serve as a permanent record of the total charges billed to the patient.

Why the Encounter Form is Ineffective as a Billing Statement

We found that the Encounter Forms currently lacks important information to meet the needs of patients and DHS management. The Encounter Form in its present format:

6.10 **Did not allow fees and other billable charges to be separately listed in a format that could be verified against the fee schedule or other hospital policies.**

6.11 **Did not state the total income due to DHS from services provided to each patient.**

6.12 **Made no references to the cash payment made or receivable accounts.**

6.13 **Did not identify free services and note that fees for such were zero.**

6.14 **A copy was not provided to the patient; neither was a copy kept at the Business Office.**

A case study for further illustration:

6.15 A patient covered under the MICARE insurance program visits the hospital for a minor ailment. He completes an encounter form at the Record Room window and is processed as previously described in Part Five.

6.16 The doctor prescribes three types of medicine on the Encounter Form for the information of the Pharmacy staff who will later fill the prescriptions after the patient had cleared all fees associated with his visit at the cashier's window.

6.17 Let's say the visit occurred during a weekday before 5:00 p.m. According to the Fee Schedule, the patient should be charged $2 for the doctor's visit, and $2 each for the three prescriptions the doctor had ordered. Therefore, a potential total of $8 in income is due to the hospital for this patient's visit. As he proceeded to the cashier's window, the patient reviews the Encounter Form and expects to be liable only for the $2 insurance co-payment.

6.18 At the cashier's window in the Business Office, the patient hands over the form to the cashier and waits impatiently for her to inform him of the amount owed. She reviews the form and noted that one of the prescriptions was an over-the-counter drug not covered by insurance. She asks the patient for $4. He appeared surprised but did not comment. He hands over the four dollars. The cashier notes the $4 on the left hand corner of the Encounter Form, stamps the form "paid", and prepares a cash receipt for $4, a copy of which she gives to the patient.

6.19 The patient leaves the cashier's window heading for Pharmacy with the Encounter Form knowing only that he had paid $4 for something.

6.20 The Encounter Form eventually will be permanently filed in the Record Room. DHS management reviewing *cash receipts* for the day will note that our patient had visited the hospital and had paid $4. Management will not know that the total amount owed by or on behalf of the patient for his visit was actually $8.00, instead of the $4 noted on the cash receipt.

6.21 A review of the same patient's encounter form by management may fail to note:

- that the patient is insured, therefore, part of his bill should be collected from the insurance program;
- that he visited the hospital during the day, therefore, he appropriately paid the $2 doctors fee instead of the $5 for after-hour visits;
- that one of the prescriptions was an over-the-counter drug not covered by insurance;
- that he had paid $4; and
- that the MICARE insurance program still owed $4 to the hospital for his visit.

Our Recommendation:

6.22 Unless DHS can modify the Encounter Form to include the information cited above, the adoption of an entirely different form to serve as the billing statement should be seriously considered. The form should be simple enough to be completed by the Business Office in as little time as filling out a cash receipt. As with all other accounting forms, the billing statement should be pre-numbered and should be issued in duplicates – one copy for the patient and the other copy for the Business Office. It should contain enough information to allow it to be traceable to the Encounter Form and to any related cash receipts or accounts receivable ledgers.

INPATIENTS:

Billing procedures:

Communicating the fees charged by the Hospital to inpatients is also a challenge, not because of deficiencies in the billing form as previously described for outpatients, but it is a challenge because of the difficulties of tracking the services provided to the patient while under hospital care.

6.23 Tracking of services is crucial to the process of charging fees for services provided to the patient. Because the basic fees established for inpatients were chargeable at small units of measurements (per dose of medication, per cup, per needle, per psi), an efficient system to effectively track each service by the unit used was necessary for accurate inpatient billing. Unfortunately, such a system was not developed.

6.24 Instead, the shift nurses at the ward were tasked to track services provided to inpatients for billing and accounting purposes. This is in addition to the primary responsibility of providing patient care and recording clinical data.

6.25 Several forms & charts were adopted for the nursing staff to track services provided for each inpatient, along with recording clinical information. The forms included the following: supply sheet, medication chart, prescription log, PRN log or "on need basis" medicine log, and IV fluid order log.

6.26 The nurses were required to maintain the above logs and submit them to the Business Office upon discharge of the patient.

6.27 The cashier at the Business Office reviews the logs in the patient's medical file to identify chargeable supplies and services. A billing statement is prepared and then kept on file for the patient.

Problems with Existing Procedures and their Impact

6.28 **Unreliable Maintenance of Logs**:

- It appeared that no guidelines were provided to the nursing staff on how to maintain the logs. The methods used to record dispensing of medical supplies and medicine to inpatients was not standardized on the forms in use.

- Our review of one supply sheet found that sometimes lines were used to keep score of how many each a type of supply was used, whereas other times actual numbers were used. The log used to record administration of drugs, were initialed to show administration of a single dose of medicine, but we also found asterisks, lines and other notation on the page without adequate explanation.

- We expected that if two people separately prepared a billing statement for the same patient using the same logs, they each would come up with two very different amounts.

6.29 **Forms were not devised to meet the specifics of the fee schedule:**

- Medical supplies were billed per unit such as "per psi" for oxygen, "per cc" for syringes, etc., yet the supply sheet for recording the use of medical supplies would not allow more than one number to fit in each of the little squares provided on the form.

- The Business Office staff admitted to us that on several occasions they had almost erroneously billed oxygen to the patients by the tank, instead of by "psi" because of inadequate recording of usage by unit.

6.30 **Units billable per the fee schedule were not necessarily the units in common use.**

- As an example, a patient used a combination of "5 and 3 cc" syringes during a ten-day period.

- To be able to calculate the cost of the syringes after the patient is discharged, the number of slashes representing each 5 cc syringe needed to be counted, then multiplied by 5cc to obtain a subtotal of the 5-cc syringes.

- The same would be done for the 3-cc syringes. The total 3-cc syringes would be added to the total 5-cc syringes, then divided by 50cc because the fee schedule specified the rate for assessing the cost of syringes in units of 50-cc.

- Having converted the 5cc and 3cc to 50 cc's, the rate of twenty cents per 50cc could then be applied and the cost of the syringes to the patient could finally be determined.

6.31 **Inadequate information is provided on patient billing statements to allow independent verification.**

- After tracking the above minute details on logs later filed with the patient medical file and transmitted to Finance for preparation of the "Billing Summary", no attempt was afterward made to allow the patient to verify the accuracy of his bill. The cost of the medical supplies and medications are shown as lump sums only on the billing form.

- Moreover, even when costing the medications and supplies, the Business Office did not attempt to leave a trail of their calculations, whether on the same logs in the patient file or on a different sheet of paper to allow an independent person to trace the billed amount back to the patient file.

THE PROBLEMS ABOVE CONTRIBUTED TO MAKING THE TRACKING AND BILLING OF INPATIENT SERVICES INEFFICIENT, UNRELIABLE, AND TIME-CONSUMING. THEREFORE, THE RISKS OF BILLING ERRORS WERE HIGH.

Our Recommendation

6.32 Management must evaluate inpatient fee assessment strategy to perhaps consider instituting a flat rate for supplies and medication, consistent with assessing a flat fee for outpatient. The current tracking and billing process for inpatient services needs to be evaluated not only for its effectiveness but to also address the problems cited above. The various forms currently in use should be re-evaluated to streamline the recording task for the nursing staff.

MEDICAL REFERRAL PATIENTS

6.33 In general, tracking medical referral patients or the services they were provided was not a problem. The Medical Referral Coordinator keeps adequate records to allow management to determine which patients were referred off-island for treatment at a given period of time. Fees chargeable to medical referral patients as per current hospital policy are 3.5% of total treatment cost as billed by the treatment hospital, in addition to a flat fee of $500. For alcohol-related referrals, the flat fee is increased to $1,500 and is required to be paid upfront.

6.34 The medical referral program allows 90 days for the treatment hospital to submit a statement of expenses. Once all the statement of expenses, including the professional fee vouchers, has been received the program Coordinator prepares a billing summary for the patient. The summary includes the down payment of either $500 or $1,500 plus the 3.5% of medical expense. A copy of the bill summary is forwarded to Finance office to record incoming payments.

Our expectations:

6.35 We expected the billing statement for medical referral patients to be comprehensive, to allow verification by an independent person, and to be prepared with timeliness and accuracy.

Our findings:

6.36 In general, billing summaries for medical referral patients prepared by the program coordinator were not sufficient billing statement of medical expenses. We noticed they were not prepared with timeliness, even after the 90 days allowance.

6.37 We found invoices and bill summaries from the health care providers not dated upon receipt by the program coordinator. We reviewed records of 26 patients discharged between November 2004 to September 2005 and discovered only 13 with invoices from the health care provider. Moreover, we discovered that patient discharged in the last quarter of 2004 and first quarter of 2005 had their bill summaries prepared 5 months later on average. It also appears the medical referral coordinator backdated some bill summaries prepared for the DHS finance.

6.38 We found that some billing summaries failed to include the flat fee. Records were inadequate to allow us to determine whether the fee had already been paid or had been inadvertently omitted from the billing statement.

6.39 We tested a sample of referral patient's billing summaries to ensure costs were accurately billed to patients and that receipts were properly recorded. Of 13 billing summaries reviewed, we were unable to trace the total amount billed to six patients to the invoices from the treatment hospital.

The above conditions occurred because:

6.40 The 90-day allowance period for the treatment hospital to provide invoices, along with limited means for DHS to verify expenses billed, made it difficult for DHS to bill the patients with timeliness and with accuracy.

6.41 The medical referral coordinator was not required to provide backup documentation for the patient billing summary, either in the form of copies of the actual invoices from the treatment hospital or a summary sheet detailing the costs claimed by the treatment hospital.

Our Recommendation:

6.42 We recommend that DHS work with the treatment hospitals to submit invoices to DHS within 30-days after treatment. The Medical referral patient should then be required to prepare a billing statement for each returned patient as quickly as possible. The billing statement should contain details of valid expenses traceable to the original treatment hospital invoice.

PART SEVEN

ACCOUNTING FOR PROGRAM INCOME

As discussed in Part Six, the timely and accurate preparation of patient invoices provides hospital management with data on total program income for outpatient services, inpatients, and medical referral patients. To properly accumulate and accurately report on program income, at least three basic accounting ledgers are necessary to track total services billed, record payments received and allow follow up on outstanding payments. These three ledgers or journals are as follows:

The Invoice Journal (Register) – lists all invoices issued by the hospital.

7.1 Information required is date, invoice number, patient name, hospital number, invoice amount, program income accounts to be credited (i.e., doctors fee, lab tests, medical supplies, prescriptions, room & board, etc.), reference to cash receipt number or patient receivable account.

7.2 It is very important that invoices be pre-numbered to allow separate and speedy identification of all bills issued to patients and to ensure that 100% are recorded in the invoice journal.

7.3 If DHS prefers to have different types of invoices for outpatients, inpatients, and medical referral patients, then the three different sets of invoices need to be pre-numbered and recorded in three separate invoice registers.

7.4 The invoices should be prepared on self-carbon sheets in muti-page sets, either in duplicates or triplicates as the need may be. One copy of the invoice must be reserved for the Business Office. The original always is reserved for the person billed.

Cash Receipt Journal – lists all cash payments received by the hospital as evidenced by official cash receipts.

7.5 Information required to be maintained are date, cash receipt number, payee, amount paid, referenced invoice, revenue or receivable account to be credited.

7.6 Payments received must be referenced to the originating invoice by number.

7.7 Therefore, a factor for consideration by hospital management is to ensure that if it decides to utilize three distinct invoices for the three billing areas, that the numbering system be devised to easily distinguish invoices for one area from the others. This will result in easier referencing/tracing of payments to original invoices by number.

Accounts Receivable Ledgers – provides a listing of invoices that have not been fully paid (are outstanding), usually maintained by billing name.

7.8 The maintenance of an accounts receivable ledger becomes necessary when payments are not immediately received upon presentation of invoices to patients.

7.9 In the absence of prior unpaid balances, total invoices issued, less payments received on same invoices should equal total receivable from patients for a point in time.

How The DHS Recorded Program Income

Current procedures at the hospital for recording, accumulating and reporting program income is insufficient to ensure that all applicable fees billed to customers are recorded and reported because:

7.10 **No invoice register existed**. The hospital did not have any lists in place that would serve the purposes of the Invoice Register for outpatient fees. We were provided some lists for inpatients and medical referral fees, however, the lists were intended to show amounts remaining to be paid by customers rather than an actual listing of all billing summaries issued for each of the areas during a given period of time.

- *Outpatient Fees* – Current accounting procedures for program income do not allow recording of total services billed to patients as explained in Part 6.15-21. Moreover, the encounter forms currently being used as outpatient invoices were not pre-numbered, making it difficult to account for all encounter forms issued to paying patients during a given period of time.

- *Inpatient Fees* – The lack of a numbering system on the patient billing summaries made it difficult to account for 100% of fees billed to inpatients during a given period of time.

- *Medical Referral Fees* – The billing summaries issued to medical referral patients were also not pre-numbered with the same impact on the accounting for such fees as the others.

- *Insurance billings* – For insurance billing purposes, the hospital has begun attempting to maintain lists of fees charged to outpatients and inpatients. However, because of the deficiencies of the current accounting procedures for program income, the lists were unreliable.

7.11 **A cash register journal was being maintained**. The Business Office issues official pre-numbered cash receipts each time payment is received from patients.

- The cash receipt is a single copy which is given to the payer.

- Payment information written on the receipt is automatically carbon-transferred to an underlying journal page.

- On the journal page, the cashiers attempt to identify the payment by type of fees or services, or specify the account to be credited.

- Because of deficiencies in the invoicing process as explained in Part Six, receipts were not adequately referenced to original invoices.

- Consequently, it was hard to determine whether payments received represented full or only partial payment of invoices.

7.12 **Accounts receivable ledgers were not reliable**. The hospital currently maintains accounts receivable information on insured outpatients for insurance billing purposes and account receivable information on certain outpatients and medical referral patients. However,

- Due to the lack of an invoice register and insufficient information provided on past payments, the existing listings of outstanding payments for inpatient and medical referral patients were not reliable.

- Because total charges per outpatients were inadequately documented on encounter forms, it was difficult to determine whether amounts receivable from insurance were accurate.

Cause of the deficiencies:

7.13 DHS had primarily relied on the State Finance to record program income. Prior to the adoption of GASB 34 in fiscal year 2003, the State Finance was not required to report on accounts receivable, but recorded revenue only on a cash basis. Accordingly, DHS management did not require the Business Office to account for 100% of all program income that were billed to patients and to follow through to ensure that 100% of the total billed were subsequently collected.

7.14 Accordingly, the only records that DHS consistently maintained on program income were information related to payments received. Cash receipts issued on a daily basis by the Business Office were tallied and corresponding cash collections were submitted to the State Treasury for deposit to the bank and recording in the relevant state revenue account. Information relating to unpaid patient accounts were not required to be submitted to Finance, therefore, DHS did not maintain accurate records of receivable balances.

Our recommendations:

7.15 We recommend that the Director of DHS require the Business Office to establish and maintain the journals described in the first part of this Section. We recommend that an accounting software such as *Quickbooks* be utilized to simplify the bookkeeping tasks. Otherwise, the journals could be created on spreadsheets such as Microsoft Excel. In whatever form the lists were to be maintained, the following should be the objectives of each:

7.15.1 **Invoice Register** – Reporting by fiscal period, an accurate list of patient invoices would provide management with information relating to total income earned by the hospital through services provided to patients. Properly classified by type of fees, referenced to cash receipts and accounts receivable ledgers, management could readily determine: what type and how much of fees and services were billed per patient and in total for the accounting period? Of the total billed, how much was collected? Of the unpaid balance: who was expected to settle the payment, insurance or the patient, or had the payment been waived as per the current arrangement with MICARE for certain outpatient fees and services?

7.15.2 **Cash Receipts Journal** – We saw no immediate need to revise the current form of the cash receipt book and journal. However, there was a need to properly reference cash receipts to original invoices and to enable tracing of payments on accounts to specific receivable accounts.

7.15.3 **Accounts Receivable Ledgers** – In theory, an accounts receivable is created each time an invoice is issued to a patient. The account is settled (the balance reduced to zero) when full payment on the invoice is receipted. Therefore, whether a paper trail of the receivable needs to be established depends on the length of time between issuance of the invoice and receipt of full payment on the account.

A. Outpatients Services –

Uninsured Outpatients: Our understanding of the outpatient fees and services saw no need in general to establish receivable accounts for uninsured outpatients. The fees associated with outpatient services were required to be paid immediately upon presentation of the invoice (billed amount) to the patient. The control in place to ensure that payment is received was the requirement that Pharmacy would not fill prescriptions ordered by doctors for patients until clearance was received from the Business Office.

We expected that the only situations in which uninsured outpatient accounts receivable may need to be established were on occasions where lab tests or other more expensive services might result in a bill that the outpatient could not afford to pay at the time of his visit to the hospital. In such a case, the Business Office might require the patient to sign a promissory note to settle his bill at a later date. If this happens, the Business Office should immediately create a receivable ledger for the patient onto which is documented the unpaid invoice number and amount and the repayment plan agreed to with the patient. All related cash receipts should be posted to the ledgers until the balance is reduced to zero.

Insured Outpatients: Each insured outpatient who visits the hospital is responsible for a $2 insurance co-payment and any costs associated with his visit not covered by MICARE. All other costs associated with his visit should be claimed by DHS against MICARE. DHS had begun attempting to track insured outpatient fees and services in order to properly bill for the insurance portion. However, because of the lack of proper invoices for outpatients, the information on the receivable ledgers for the insurance program could not be verified for accuracy. We expect that with our recommended changes to improve the outpatient billing form that the insurance receivable ledgers should be improved.

B. **Inpatient Services –**

Our review found that almost every inpatient invoice resulted in the establishment of an accounts receivable because invoices were prepared long after patients were discharged. Since January 2006, DHS has adopted a policy of requiring patients to settle their bill immediately after being discharged. As with outpatients, any accounts that could not be settled immediately by the patient should be established as an accounts receivable. A file should be established for the receivable account. In the file, a copy of the promissory note should be maintained along with a simple ledger for recording the total invoice amount and subsequent cash receipts. Invoices and cash receipts should be referenced by number to allow independent tracing back to the source documents.

C. **Medical Referral Services –**

A medical referral patient receivable file should be established as soon as the medical referral committee has approved outside referral. The first item in the file should be the medical referral fee of $500 or $1,500. Since the fee of $1,500 is required to be paid upfront, early establishment

of the file would document that the fee had been assessed and paid. A separate invoice can be issued for the fee. When bills from the treatment hospital begin arriving after the patient's return, another invoice(s) can be prepared for the final bill and recorded in the same patient receivable account. In this manner, amounts owed by each patient can be tracked in one file for ready access.

D. Unrecorded Revenues and Expenses –

Prior to the new Memorandum of Understanding (MOU) adopted in the summer of 2005 between Health Services and MiCare, a co-payment was required of the outpatient and the insurance was billed for the rest of medical expenses. In the new agreement Health Services agreed to not bill MiCare for the following covered fees: doctor's fee, lab tests, and x-rays. In exchange, MiCare extended its management expertise & services to Yap State uninsured patients referred to the Phillipines. The MOU did not waive prescription expenses therefore implying it was still covered by MiCare. The outpatient pays a co-payment of $2 along with "non-covered" services, such as over-the-counter drugs and medical supplies. MiCare is billed periodically for prescription and everything else not waived in the agreement. The fees that the hospital has agreed not to bill to MiCare are still income and should be accumulated and reported along with other program income. Moreover, the cost of services provided by MiCare are actual expenses of DHS that should be recorded and reported by the Department of Health Services.

Our Expectation

We expected that DHS would have procedures in place to track the value of services waived and likewise would require MiCare to provide a cost of services provided to uninsured referral patients in exchange for the waived fees.

Our Findings

The MOU contains a clause obligating Health Services, in case of suspension of the agreement, to continue providing free doctor, lab, and x-ray services to outpatients until it equal the value of services provided by MiCare to uninsured Yap State referral patients. Therefore, we expected Health Services to have a system of maintaining a running balance of this income less expenses applied which could be reported as part of the periodic billing between MiCare and DHS. But such a running balance was not available.

Our Recommendation

Once DHS revises the encounter form or adopt a billing form for outpatients to allow recording of all costs associated with the outpatient visit, it would be possible to track fees waived for insured patients. In the sample invoice register attached to this report as Exhibit A, we have attempted to show how DHS would track payment of all fees associated with each outpatient invoice, in addition to accounting for the payments and receivable balances. DHS management should require MiCare to report periodically to DHS the cost of services provided to uninsured Yap State referral patients to allow DHS to record these expenses.

PART EIGHT

REPORTING AND MONITORING

In order to know whether policies and procedures were achieving the objectives for which they were designed, management must have in place a system for comparing goals and expectations against actual results in order to evaluate the effectiveness of its policies and procedures.

Reporting Financial Results

8.1 One of the primary objectives of an accounting system is to provide management with the financial results that will enable them to evaluate whether policies and procedures were operating as intended. Investigating unexplained variances between expected and actual financial results, or historical data against current data can provide management with insights about the effectiveness of existing policies and procedures.

Our Expectation

8.2 We expected that DHS management from the time it began enforcing its fee schedule to require periodic financial information on the collection of program income that was adequate to show:

- ✓ Total fees assessed (invoiced) by type by fiscal year
- ✓ Total fees collected by type by fiscal year
- ✓ Total fees outstanding (receivable) as of the end of each fiscal period aged to show number of days or fiscal periods outstanding.
- ✓ Estimated allowance for bad debts on the receivable balance outstanding as of fiscal year-end.

Our Findings

8.3 We found the Business Office was not required to provide financial information to management on total program income invoiced to patients. Instead, information provided on program income represented only the cash collection that consisted of only a portion of the total income that should have been earned by the hospital each time a patient received health services at the hospital. Even so, the information was not required to be compared by fiscal period. Rather, the financial reports on collections were intended only to show that amounts collected were deposited to the State Finance and Treasury.

8.4 Collections were submitted to Finance and Treasury without classification as to type of receipts, i.e., doctors fees, prescriptions, medical supplies, lab tests, etc. Accordingly, the State Finance merely recorded the deposits from the hospital in one revenue account called "hospital collections". Therefore, if collections decreased from one year as compared to the prior years, management would not be able to readily determine which type of fee had suffered a reduction in collection.

8.5 Consequently, we determined that existing progress and financial reports prepared by the Business Office were insufficient to be useful as a decision-making tool for management. For instance, the monthly report issued by Finance was nothing more than a categorized summary of financial activity for the month. It would not be useful for in-depth comparative analysis that management could use to make informed decisions.

Our Recommendation

8.6 We recommend that the fiscal officer be required to assist the Business Office staff gather and record financial data relating to program income in a manner consistent with generally accepted accounting principles.

8.7 Management should also require that GAAP financial statements be prepared by the Business Office on a periodic basis, but especially at the end of each fiscal period.

8.8 Since the State Finance and Treasury has the ultimate task of recording program income on the State's financial management system, the fiscal officer should be required to periodically obtain such information for reconciliation with DHS own records to ensure that the Health Services Sector Grant is properly credited for the program income collected by DHS.

Utilizing Existing Information Systems

8.9 In order for a policy to be implemented effectively, it must be supported by a system of efficient procedures. Procedures can be made effective and efficient only if periodic evaluations and adjustments are conducted. With this in mind, together with the knowledge of deficiencies at the hospital, we examine methods employed for gathering data, as well as the information usability.

Our Expectation

8.10 In order to gauge the effectiveness of the fee collection policy, we had to determine how much fees was collected in comparison to what should have been collected. Hence, we expected the hospital would have readily available the following or at least be able to compile them with some reliability, presuming a good information system exist.

a) Existence of a useful information system

b) Number of patients that sought medical care for a fee (and those for free), including medical referral patients

c) Number of fee payments

d) Number of prescriptions (pharmacy & dispensaries)

Our Findings

8.11 We learned the hospital had in recent years been using a database program to amass and organize data of its activities. The database was part of an initiative by the US Government under the Bio-terrorism Act to track pandemics around the world to keep tabs on potential threats. So even though the hospital have been accumulating relevant information, the format of the data being accumulated was not tailored to meet the needs of the Department of Health Services. We came across the following during our review.

a) Although the department maintains a database with some pertinent information, it was not being utilized to its full potential.

b) Even with the assistance of the Data System Coordinator, we were unable to determine with certainty how the number of paying and nonpaying patients for a given period.

c) The number of payments on the cash receipt journal (CRJ) did not agree with the monthly reports. So we tried to determine how many encounter forms entered into the database with a fee, as well as those without a fee. We learned the database was not set up to distinguish transaction with a fee from those without. Therefore, the database was not useful as a secondary support to the cash receipt journal. Not being able to verify the accuracy of payments on the cash receipt journal indicates the risk exists for payments to go unrecorded or prescriptions to be given out for free.

d) Pharmacy has a database in which is listed all patients and their prescriptions. The number of patients for a given period should agree with the number of payments made at the Business Office, if we make the assumption that all prescriptions were charged a fee. However, our comparison of the two sets of records found a large discrepancy; too large even to be attributable to patients who might have been prescribed free medication. The variance showed that Pharmacy had more records of patients than the Business Office had for the same period. The conclusions we reached were that: (1) patients were paying for their fees and the Business Office was not recording the payments or (2) patients were obtaining prescriptions without paying the required fees.

Had DHS performed a similar analysis of the two sets of records previously, the discrepancy would have been identified and investigated. The bottom line was the Department of Health Services was not utilizing existing information systems to evaluate the results of its operations.

Our Recommendation

8.12 We recommend that Health Services take advantage of the existing database to centralize and improve the usability of available information. For instance, transition effort must be taken toward computerization in all areas, especially Finance, to make it easier to organize raw data into useful information for monitoring and evaluation purposes.

PART NINE

INTERNAL CONTROL CONSIDERATIONS

Internal controls consist of a set of policies and procedures designed by management to ensure that goals and objectives are achieved. Proper accounting controls include policies and procedures designed to reasonably allow employees within the normal course of performing their duties to discover errors and timely correct them and to mitigate the risk of fraud. However, properly designed control procedures are expected to provide only reasonable, rather than absolute assurance, of detecting errors or fraud. The best control procedures may not be cost-effective to implement. Therefore, in attempting to design control policies and procedures, management must take into consideration the cost versus the benefit of each policy and procedure and choose from among the most cost-effective to implement. Management should also not expect to eliminate the risks of fraud entirely since collusion between employees could render the best control procedure virtually ineffective. What is important for internal controls is management's periodic evaluation of control policies and procedures to determine whether they are operating as intended.

Some of the accounting controls that we have mentioned in the previous sections of this report are the use of pre-numbered multiple-copy accounting forms. Other controls that we will address in this section are :

- Requiring accounting transactions to be documented on authoritative official source documents such as cash receipts and invoices;
- Ensuring appropriate segregation of duties; and
- Safeguarding cash.

General Operations

Pharmacy not requiring the receipt as proof of payment

9.1 The pharmacy is responsible for filling prescription for the patient. Since the policy took effect to charge fees for services, the pharmacy was required to verify proof of payment before dispensing medicine. The patient usually pays for prescription at Finance during regular hours. A receipt is usually prepared for the patient upon payment. The supporting encounter form is stamped "paid," for the patient to present to the pharmacy to get prescription.

Our Expectation

9.2 We expected the pharmacy staff to require the receipt as proof of payment at the Business Office.

Our Findings

9.3 During the early phase of our audit, we observed staff at the Pharmacy window asking for the encounter form to verify if it was stamped "paid" before filling prescription. The payment receipt was hardly requested. Our discussion with the staff about proper controls made it obvious the payment receipt was not required at the Pharmacy window to get prescriptions. We found it surprising to hear the staff wonder why the receipt was significant when a stamped "paid" encounter form was readily available. The question showed a lack of understanding of proper accounting controls as it relates to the receipting of cash.

Our Recommendation

9.4 We recommend to the Pharmacy supervisor to instruct the staff to require the receipt as proof of payment without exception before filling prescriptions for patients, instead of relying on the "paid;" stamp. Management should consider eliminating the task of stamping encounter forms all together. The cash receipt is a better evidence of payment as the form can be traced to actual collections of cash to the Business Office.

Cash/Change fund not securely maintained

9.5 There were two collection points at the Department of Health Services. The business office was responsible for collecting & receipting payments between 7:30am – 4:30pm on weekdays. The Pharmacy was responsible for collecting & receipting payments between 4:30pm – 9:00pm on weekdays and weekends. Each one maintained a change fund of its own. The Business Office maintained a change fund of $100, which was usually kept in a desk drawer accessible by two keys. The Pharmacy usually maintained a change fund of $80, kept in a pad-lock cabinet drawer accessible by a single key mounted on the wall above. All four staffs at the Pharmacy had a key to the office.

Our Expectation

9.6 We expected cash/change fund to be maintained securely with access restricted only to the cashier.

Our Findings

9.7 Our observation of the Business Office maintenance of the change fund / cash collection made us note the following: The fact that two keys in possession of two individuals with access to the change fund takes away controls to restrict access to cash. The Business Office was not using an office safe to secure cash overnight but usually kept it in a desk drawer next to a plexi-glass window, risking it being burglarized.

We also observed the Pharmacy maintains its cash without adequate controls. The cabinet drawer had a single key, which was usually mounted on the wall directly above the cabinet making it accessible to anyone in the pharmacy. We were informed the Pharmacy employees all had keys to the pharmacy.

Our Recommendation

9.8 Both the Pharmacy and Finance should restrict access to cash (change fund & collection) as much as possible by having proper controls in place to prevent access and misuse of cash. The number of keys to cash drawer should be limited to one, with a back up key maintained by the Director. Finance should also make use of the safe-deposit for over night safe keeping of cash.

After hours @ Pharmacy - no segregation of duties

9.9 Before Finance office close for the day (4:30pm), a staff would take the cash receipt journal to the Pharmacy. The pharmacy then takes on the responsibilities of assessing fees, collect & record payment, prepare payment receipts, stamp encounter forms, and enter information in the database to process prescription's labels, and fill/dispense prescriptions. A pharmacy staff takes care of all these between 4:30pm – 9:00pm on weekdays and 7:30am –9:00pm on weekends. Normally, the pharmacy designated an individual to work in the evening and another to work on weekends.

Our Expectation

9.10 Segregation of duties must exist as a control measure to lessen and perhaps prevent misuse of fund and improper recording of collections. We expected the number of prescriptions dispensed to patients at the Pharmacy to reflect the number of payments recorded on the cash receipt journal.

Our Findings

9.11 We found inconsistencies between the pharmacy database in comparison to record room database and variance between the listing of prescriptions dispensed in comparison with the number of payments on the cash receipt journal. We found the Pharmacy prescribed more medicine than payments recorded on the cash receipt journal. Moreover during substantive testing of pharmacy records, we were also unable to locate 3 encounter forms in the record room database, along with 2 encounter forms "stamp-paid" by the Pharmacy but unrecorded on the cash receipt journal. These numbers came from a representative sample, which projected an estimated 390 prescriptions unrecorded on the cash receipt journal if the entire population (total number of prescriptions for 3 months, June, July and August) was to be considered. A significant figure that seems validated by the derived variance of 411.

The risk exists at the Pharmacy for payments to go unrecorded or the recording to be manipulated for the purpose of pilfering cash. The opportunity exists for someone to accept payment from a patient and not record it on the cash receipt journal, dispense medicine and simply throw away the encounter form to go undetected. We could not locate many encounter forms at record room for the audit period, which makes the database unreliable to verify the cash receipt journal authenticity.

Our Recommendation

9.12 Management should look into hiring another person to work at Finance in the evening and weekends or alternate the hours of existing staff so that someone will be available to work the evening & weekend shift. This will ensure that receipt of payments is centralized at Finance allowing the Pharmacy to focus on filling prescriptions. Ideally, the Business Office should be open 24 hours for 7 days a week or at least when the hospital is open.

Change fund used as loan fund

9.13 Change funds at Finance and Pharmacy were meant to be used for the purpose of giving out change to the patients. Neither office maintained a petty cash fund.

Our Expectation

9.14 Change fund must be used only for that purpose, to give changes to the patients for payments made to the hospital.

Our Findings

9.15 There were indications that change funds at Finance and the Pharmacy were used for petty cash, on occasion at least. We found the Pharmacy had less cash in its change fund than it what we expected during a surprise cash count we conducted. The Pharmacist acknowledged the staff borrowed money sometimes from the change fund for personal use to reimburse later. So he paid the shortage as reimbursement to bring the balance current.

The Pharmacy had been maintaining a log of its daily activity for the last 3 years. Our analysis of collections and change fund balance recorded shows the Pharmacy was consistently short of the $80 in change fund it should maintain. In addition, sometimes the amount of cash collected one day was not the same as the amount deposit the next day. In fact, $292.75 was the total shortage of cash for the period of June until August, which was basically money taken out. During the same period $305.75 was the total overage of cash, which was money replaced

Finance doesn't have a secondary log of daily activities beside the Cash Receipt Journal, which limit our understanding of cash movement to what was recorded therein.

Based on our understanding of what was recorded and the possibility of what could have gone unrecorded, the risk exists to misuse the change funds.

Our Recommendation

9.16 Management should instruct supervisors & staff of each area to refrain from using the change/collection fund as a personal loan fund. Clear written procedures of handling cash must also be put in place to lessen the chance of undetected abuse of funds. Management must also consider establishing a petty cash fund to be used by various sections of the hospital for other office expenses if the need exists.

MEDICAL REFERRAL PROGRAM

9.2 Receiving bill statement from Health Care Provider

9.2.1 In the past referral patient with insurance coverage was handled differently than patient without insurance. Insured patients was handled by MiCare dealing with the treatment hospital, and uninsured patient without insurance was handled by Yap Department of Health Service (DHS) dealing with the treatment hospital.

A new arrangement effective in July 2005 by way of an MOU between MiCare and DHS made it so both insured and non-insured patients are handled by MiCare dealing with the health care providers in the Philipines, in exchange for certain services DHS waived billing MiCare for. The new arrangement was intended to control, if not eliminate questionable expenses (professional fee & others) and ensure logistic support for all referral patient. Invoices for insured medical

referral patients are the responsibility of the patients and MiCare. In constrast, invoices for uninsured patients are the responsibility of Yap State DHS.

Accordingly, statement of accounts including invoices from the health care provider flow to Yap in the following sequence of events. The health care provider submits invoices to MiCare office in Manila, which validate and forward the material to MiCare Office in Pohnpei. The Pohnpei office would then forward the statement of account to DHS with its own billing statement, expecting a payment within 30 days. Payments from the hospital is made payable to MiCare and presented to the insurance representative in Yap to deposit.

When DHS receives the invoices from the treatment hospital, the medical referral coordinator reviews and prepares billing statements for uninsured patients for their 3.5% contribution. Then the bills are forwarded to the Yap State Finance for payment.

Our Expectation

9.2.2 To allow Yap State Finance to timely bill referred patients for their 3.5% contribution and request payment from Finance to the health care providers in a timely fashion, we expected the billing statement from the health care providers for non-insured referral patient to reach Yap hospital not more than 30 days after treatment.

Our Findings

9.2.3 Before the new agreement, billing statements from the treatment hospital was generally delayed to reach the Department of Health Services (DHS). That has improved somewhat since the new MOU with MiCare, although not significantly, considering that MiCare's role should be to pass on the information to DHS, especially billing statements for non-insured patients. We discussed the cause of the delay with MiCare representative and it appears MiCare is preparing its own billing statement, instead of passing on the ones from the health care providers.

Our Recommendation

9.2.4 We recommend the Medical Referral Program Coordinator clarify with MiCare the procedures of receiving billing statements or at least convey its expectation. If MiCare needs to prepare its own billing statement to submit to DHS, then it should be traceable to the original statement of accounts from the health care providers. In fact, the original statement of accounts should accompany any billing statement prepared by MiCare. DHS management should negotiate the reduction of the 90 days allowance for the health care provider to submit statement of accounts.

9.3 Validating Expenses

9.3.1 Prior to the MOU with MiCare, the Department of Health Services (DHS) had direct billing arrangements with the health care providers. The medical referral program coordinator had the responsibility to verify expenses claimed by the treatment facility, even though it was rarely done.

After the MOU was adopted, the statement of expenses from the treatment hospital flowed through MiCare to eventually reach DHS, with MiCare's own billing statement. The responsibility to verify expenses remained the same. According to a MiCare representative, the treatment hospital usually provides a statement of account to their office in Manila. Separately, certain doctors

submit their professional fee vouchers to the same office. MiCare then determines the amount of professional fees based on a "unit-cost" for professional services commonly used in the Philipines. From this arrangement, it appears that the physicians who personally bill MiCare, were subcontracted by MiCare.

Our Expectation

9.3.2 We expected the DHS to have a mechanism in place to validate the claim of expenses from the treatment hospital to ensure that Yap State is invoiced only for valid costs related to the treatment of uninsured patients from Yap State.

Our Findings

9.3.3 In the past, statement of accounts and professional fee vouchers for uninsured patients came to Department of Health Services (DHS) directly from the treatment hospital. With the new agreement, statement of account and professional fee vouchers arrives to DHS through MiCare. Our understanding is that MiCare validates all expenses claimed including professional fees before passing them on to DHS.

We reviewed 18 medical referral files to discover most had questionable claims of professional fees, the hospital paid anyway. Albeit, these cases in general occurred prior the new arrangement (MOU). We found claims of professional fees hand-written on non-authoritative vouchers and others on legitimate looking vouchers untraceable to the statement of account furnished by the health care providers. We also found vouchers with names of physicians we could not connect to the statement of account. We did find some professional fees that appeared valid – the name on the voucher matched the physician's name on the statement of account from the health care provider.

9.3.4 We concluded after discussions with DHS staff that the medical referral coordinator was not required to ask the treatment hospital to substantiate 100% of expenses claimed against DHS for uninsured patients before submitting the bills to Finance for payment.

Our Recommendation

9.3.5 The hospital should consider reducing the number days (which is currently 90 days) requiring invoices from the treatment facility. It must define and explicitly convey to the insurance and health care providers its intolerance for questionable costs and require a certain level of acceptable documentation of expenses. The coordinator must verify expenses before preparing the bill summary. A claim of professional fees via a voucher must be traceable to the type of services the doctor provided in the statement of account prepared by the health care provider. Private doctors who provided consultation services must present their claims in a voucher with authenticity traceable to the statement of service, and to his/her private practice.

Moreover, since it appears MiCare is responsible to validate professional fees under the terms of the new agreement and seems to have a working relationship with the doctors, it is in the best interest of Health Services to independently verify claimed expenses.

COLLECTION OF ACCOUNTS RECEIVABLE

Medical referrals

9.4 The medical referral regulations & policies set the rate for medical referral services, along with the terms of the Memorandum of Understanding (MOU) with MiCare. The program account receivables is usually the $500 ($1500 for alcohol & drug related injuries) plus 3.5% of treatment cost the patient was supposed to pay.

Our Expectation

9.4.1 We expected the hospital would have an effective plan to reduce its account receivable and collection responsibility would be clearly assigned. We expected management to make sure the staff members performs their duties to effect collections.

Our Findings

9.4.2 The Department of Health Services (DHS) lacks an effective plan to collect account receivables related to the medical referral program. Consequently the Department of Health Services (DHS) had accumulated a significant amount of account receivables for the medical referral program that dated as far back as 1990. The total account receivable outstanding from 1990 to 1998 was $86,613.69. In addition, there was $36,554.31 outstanding for FY01, FY02, and FY03. We learned that collection responsibility was not clearly defined & assigned, due to the lack of job descriptions. Initially, management did not have readily available a job description for the program coordinator, however, one was later furnished which indicated the coordinator was responsible for account receivable collection.

We found that Health Services lack a plan to collect its account receivables. As a matter of fact, the bill summary prepared by the coordinator is usually turned over to Business Office for the patient, with no requirement that the Business Office contact the patient. As a result, the patient rarely gets a copy of the bill. Neither were there any follow-up attempts to obtain payment from patients.

The above condition exist due to the confusion of roles and responsibilities by the staff, coupled with ineffective management to make sure the responsibility was assigned and carried out accordingly.

Our Recommendation

9.4.3 Management must make sure that every staff understand their responsibility by having a job description on file, read and endorsed by the staff. Management must also spearhead the effort to come up with an effective collection plan to collect account receivables related to the referral program, and to ensure it is executed. Perhaps the responsibility to collect all account receivables can be consolidated for one person to do.

INPATIENTS

9.5 Many people who are hospitalized do not have the financial means to immediately settle their hospital bills upon discharge from the hospital. Moreover, it is the hospital's policy that patients would not be refused medical care because of unpaid bills. If the patient was deceased, cultural considerations make it difficult for staff to collect from the deceased patient's family. Therefore, it was expected that there would be long standing inpatient accounts at the hospital.

Our expectations:

9.5.1 We expected that DHS would have considered the above difficulties of collecting inpatient accounts and formulated policies and procedures to ensure that amounts billed could be collected.

Our findings:

9.5.2 Beginning in January 2006, the Department of Health Services required inpatients to settle their hospital accounts or sign a promissory note to pay in future installments immediately upon discharge from the hospital. Previously, no such policy existed. Instead, billing statements for inpatients were not always prepared in time to be presented to the patient after discharge. Consequently, most patients left the hospital without having seen a copy of their bill. The Business Office was not required to deliver the bill to the patients. We found that bills were prepared and filed without evidence of effort to collect from patients. Consequently, for the months of June, July and August 2005, the hospital billed 152 inpatients a total $16,932.97. Only 22 of the patients paid a combined $2,820 or sixteen percent of the total billed.

Our recommendations:

9.5.3 By requiring inpatients to settle their accounts upon their discharge from the hospital or to sign a promissory note to settle the accounts at a future date, the Department of Health Services has taken the first step to address the above problems. We recommend that DHS also require the Business Office to send out monthly statements to patients with outstanding accounts at the hospital and/or run monthly radio announcements reminding people with unpaid bills to come to the hospital to settle their accounts. In addition, other means of collecting on accounts should be investigated such as requiring that returning patients with outstanding bills pay a certain percentage of the old bills in addition to the current amount billed before receiving their prescription. Incentives to ensure timely collection of accounts should also be considered such as offering discounts to patients who pay in full within 15 to 30 days after the invoice date.

PART TEN

RELATED MATTERS FOR CONSIDERATIONS

10. Supply lack of inventory controls & monitoring of the dispensaries

10.1 The Department of Health Services (DHS) subsidized dispensaries with medicine to support health care at the community level and to strengthen preventive measures. There are 18 dispensaries located among the outer islands of Yap and 2 located on the main island.

10.1.1 All dispensaries have managers responsible for daily operation of the station. Each station receives medicine and medical supplies from Yap State Hospital through Supply & Procurement division, per requisition basis. The manager usually prepares a requisition of needed items based on a listing of standard stock a dispensary must have.

10.1.2 Since most of the dispensaries are located on remote islands, DHS had designated an individual the responsibility to oversee inventory & monitoring of the dispensaries. Therefore, daily contact via two-way radio occur between the dispensary managers and this individual, to place requisitions, as well as reporting activities & progress for each station. Replenishment is usually prepared for the next vessel trip to the outer islands. Beside the daily report of the dispensary progress, the same individual is suppose to travel to the outer islands for actual inventory count and inspection. The dispensaries give away medicine "free of charge" to patients.

Our Expectation

10.2. Since fees for medicine accounts for a significant percentage of program income annually, the Department of Health Services should have in place proper controls to curb outflow of medicine "free of charge," without compromising the availability of medicine to the needy.

Our Findings

10.3 We learned that Supply & Procurement Office had sketchy information of the dispensary's activities, including the lack of inventory records. Actual inventory count & monitoring of the dispensaries had been sporadic and without reliable records.

10.3.1 Therefore we decided to review available records to compile and establish the status of each dispensary for the audit period, before we could determine its impact on revenue collection at the hospital. Due to the lack of inventory records, we considered the monthly requisition as replenishment of medicine used the month before, to estimate how much medicine the dispensaries use on a monthly basis, to compare with how much the hospital pharmacy dispense monthly. Requisitions from the 18 dispensaries at the outer islands we obtain revealed that 3,372 patients received medical care within the 3 months period auditing. The total cost of drug requisitions for the same period was $76,480.12.

10.3.2 By comparison, the Pharmacy dispensed medicine to 3,487 patients within the same period, at a cost of $21,022.99. Clearly more medicine was dispensed at the dispensaries than the Pharmacy at a ratio of 4 to 1, despite the lower number of patients. The cost disparity was even more compelling. The dispensary gave away medicine at an average cost of $22.68 worth for each patient, while the hospital Pharmacy dispensed medicine at an average cost of $6.03 per patient for the same period. The disparity appears unreasonable, especially without justification.

10.3.4 A recent inventory count of 8 dispensaries in the outer islands, came up with significant amount of expired medicine with a range in value of $.30 to $10,530.

Our Recommendation

10.4 Supply & procurement division must institute adequate inventory controls.

10.4.1 If the current policy must continue with medicine "free of charge," then procedures and controls must be in place to ensure the dispensaries only get what is needed. Regular inventory count on-site and monitoring must be performed. Otherwise, management should evaluate charging fees for medicine at the dispensary in a way that would complement the hospital's revenue generating policy, without compromising access and affordability to medicine at the community level.

Recd on 5-29-06

5.29-06

P1/4

THE STATE OF YAP
DEPARTMENT OF HEALTH SERVICES
P.O. BOX 148, COLONIA, YAP
FEDERATED STATES OF MICRONESIA 96943

5/30/06

Cable GovYap
Tel: (691) 350-2215
Fax: (691) 350-3443

Date: May 25, 2006

All the concerns and comments from key DHS personnel regarding memo dated May 7, 2006 have been incorporated - recommendations and procedures to address problem areas which needs to be corrected as identified by the May Audit reported. Some if not most of the recommendations are implemented or being implemented. However, a committee comprises of supervisors of Business Office, Medical Record, Pharmacy, Chief of Public Health, OPD, Chief of Medical Staff and Quality Assurance need to meet with me discuss and follow up to make sure everybody concern understand the procedures and make sure the system is in place and working as intended and as presented in this document and at the same time implement the remaining procedures.

Note that procedures with "*" can be implemented immediately. The others may still need more work in terms of computer software or administrative systems etc...

The recommendations and procedures will be limited to the following areas as delineated in the audit:

- Outpatient Services areas
- Inpatient services areas
- Medical Referral Program
- Dispensary Services (CHC)

* There may be a need to revise the Policy and Procedures Manual in some areas to reflect the desired revisions.

Outpatient Service

Fee Schedule – Fees schedule must be updated to include all different categories of chargeable and "free" of charge items and services. Business office and Pharmacy must use the Fee Schedule as bases of all charges at all times. Any items or services lacking must be brought to the attention of the Fiscal officer & Assistant Director to work with concerned individuals to establish the charge immediately.

Encounter Form – Encounter Forms Procedures

- * Two copies of encounter forms with pre-number must be developed and used for all outpatient services. The form must have a section to identify "free" of charge item and services for free services only. At the time of the clinic, or when the doctor sees patient, one copy remains at public health or with the doctor. These copies will be collected by business office personnel on the following working day. The business officer staff verifies the

encounter form number and passes on the information on to data entry staff to be entered into the system.

- * For after hours, a pile of numbered encounters will be signed out from medical record at 4:30pm- and maintain a log of each after hours patients who registers for care and # of encounter assigned to each, than record room make sure all records has been collected and what missing (this figures can be reported in monthly report for record room) and than the encounter form collected to the business office for entry into the system.

- * For charge items and services, the same encounter form is used. Thus, encounter forms must show the categories of charges that patients pay for including insured patients. Insurance number must be included too. The patient pays at the business office (or pharmacy after working hour). One copy will be given to patients and one copy remains at the business office. All pharmacy encounter forms will be picked up by business office staff on the following working day. Business office verifies encounter form numbers, the number of "free" services, and total of collection. These totals must be recorded and maintained by business office. This figure should be totaled up at the end of the month and inserted into monthly outpatient totals to reflect possible outpatient collection verse the actual collection. Any missing encounter forms should be noted. The business office staff is responsil le to find out what happened to it and the Fiscal Officer must approve dismissal of such encounter form and note justification on file. Business office staffs follow up with record room and pull out chart of patients with missing encounter forms and find out what charges was made and bill patients accordingly if needed. The second copy of the encounter forms of itemized receipt must be given to patient at time of payment.

Note: What important is to be able to track and get the accurate number of visits and diagnoses into the data system- and possible daily collection for out patient verse actual collected and also bill and collect any missing encounter form that should have been paid by patient and not paid.

- * For CHC, all encounter forms will be pre-numbered by WCHC Operation Managers and staff starting from number 1...to what the number end at the end of each month. Than a new count for the following month starting from 1... A log should be maintained to track all encounter forms sent to each sites, number and month. The Operation Manger will be responsible for make sure all encounter forms are numbered correctly and sent to CHC sites. Operation Manager will collect the encounter forms as scheduled returned them back to WCHC Office. Any missing encounter forms must be justified by Site Supervisor. Patient chart must be checked if the patient owes. The CHC nurse is responsible to inform the patient to pay and collection. Upon payment by patient, receipt should reflect the receipt # and months which the payment is for. Operation manager will update this information on his log. This information must be included in the monthly report.

Inpatient Services

Problems that surface in the audit have to do with discrepancy of inpatient billing. This is taken care of by the flat fee rate charge for inpatient billing. Much of the improvement has been done according the Business Office Manual. Several weak areas addressed below.

- * Inpatient Fee Schedule must be reviewed to ensure all the "other services" that need to be charged are comprehensive, accurate and are in the inpatient Fee Schedule.

- * Business office should track and account for inpatient collections and charges on a daily basis. Computer program is critical in tracking and updating the inpatient MOU billings. Monthly reports for inpatients should reflect the total monthly inpatients collection possible and portion collected MOU collection and unpaid balance. Business office staff should follow-up on unpaid bills as specified under Business Office Manual. Any uncollected bills after one year should be moved to "write off" account. Patients' names, dates, and charges should be noted in the write off account. Perhaps, letter should be sent to patient and MOU signers that such patient is not eligible for off island referral unless payment of past bill is paid in full.

Implementing the above mentioned, it is complex due to different dates of payment and different categories of patients' account and information that needs to be tracked for both for inpatients and outpatients. Patients account should be able to record and track at least the following information:

Patients Data:

a. Date
b. Invoice number
c. Patient Name
d. Hospital Number
e. Invoice Amount

Classification: Revenue Account Coding Information:

a. Doctors Fee
b. Prescription (flat fee charges)
c. Lab. Test
d. Surgical Procedures
e. Delivery
f. Oxygen
g. Others

Payment Information

a. Receipt Number
b. Amount

Billing Information

a. Patient Account Number
b. Amount
c. Insurance Account / number
d. Amount
e. Insurance Amount waived.
f. System to track and bill MOU accounts

(Note: It is very difficult to maintain patient bill and payment record manually. Thus, a program should be sought to do the job easily and accurately. The scenario is at a click of a computer button, patients', account status can be obtained alone with payment, billing information and patient bill forms.) (Need computer program and staff training)

* The monthly *financial statement* should provide all related revenue, billing information for outpatients and inpatients information. See monthly report attached.

Medical Referral Program

With the medical referral policy and procedures in place, much of the medical referral problems noted in the audit are resolved.

- Delay in receiving bills from off island hospitals are a problem. Perhaps, we must cut a deal with these hospitals to submit bill to our medical referral within 30 days of patient discharge or we will not pay the bill. This will help improve payment of referral bills, reporting and budgeting. (For Director to consider)

- Programmer should assist medical referral coordinator to automate most of the medical referral data. Most of the data are captured on a spread sheet. Developing forms on the computer to input data and provide needed reports will certainly improve the program management. (Need programmer if not ok at the present)

Dispensary Services

During the time of the audit, no charge was done at the dispensaries. However,* effective March 13, 2006 collections commence at the CHC Sites.

The medical supply inventory should be programmed to capture the costs of medical supplies sent and used at the CHC by sites. The inventory report should provide cost information on a monthly basis. (Need good inventory program and training of staff).

Thank you.