EXECUTIVE SUMMARY

Clinical services spot agreements are patient-specific letters of agreement between The University of Texas MD Anderson Cancer Center and out-of-network, non-contracted insurance plans or payors. These agreements are prepared by the Managed Care Department, through coordination with the respective payors, and are typically six months to one year in duration. The agreements outline the financial terms for professional and technical services provided to the patients and include preapproved discounts for each payor type.

According to management, there were more than 3,100 patients with spot agreements in place during FY 2014. The majority (94%) of these agreements were with Medicare Advantage and Managed Medicaid payors. The remaining agreements were with Commercial payors, the Veterans Administration, and other various payors. For FY 2014, the majority (80%) of spot agreement charges were for technical services and totaled approximately $140 million. This represents approximately 3% of the $4.7 billion in hospital gross patient revenue for the year.

The purpose of spot agreements is to allow a wider range of patients to have access to MD Anderson’s services and to ensure the Institution is reimbursed from non-contracted, out-of-network payors at the highest possible rates.

The objective of this engagement was to determine whether the Institution collected the appropriate amounts due for technical services under clinical services spot agreements for FY 2014.

Audit Results:
Based on test work performed, we determined that the Institution is unable to consistently collect the expected amounts due under clinical services spot agreements. Specifically, we noted the following:

- Payments received as of March 2015 for technical services under FY 2014 spot agreements were an estimated $10.8 million less than the contractual amounts, which, according to management, is consistent with the collections trends for other full-service arrangements.
As of June 2015, approximately $48 million in accounts receivable for technical charges under spot agreements were outstanding for more than 90 days. Pre-authorizations for service were not consistently obtained from insurance plans, as required, resulting in approximately $3.4 million in adjustments to technical charges for spot agreement patient encounters.

In addition, we determined that FY2014 spot agreement data used for management’s decision-making erroneously included approximately $15 million in technical charges that were not actually related to spot agreements.

**Management Summary Response:**
Management agrees with the observations and recommendations and has developed action plans to be implemented on or before September 30, 2016.

**Appendix A** outlines the methodology for this project.

The courtesy and cooperation extended by the personnel in Managed Care, Patient Business Services, Clinical Revenue and Reimbursement, and Clinical Leadership are sincerely appreciated.

Sherri Magnus, CPA, CIA, CFE, CRMA  
Vice President & Chief Audit Officer  
September 28, 2015
Observation 1:  
**Contracted Amounts Are Not Consistently Collected**

Each clinical services spot agreement states the payor will pay the Institution, in full, the amount owed based on specific discount and reimbursement rates. Our data analysis showed the Institution is not consistently able to collect the contractual amounts due for technical services provided under the agreements. We analyzed FY 2014 spot agreement financial data and determined that payments received as of March 2015 were an estimated $10.8 million less than the contractual amounts. The inability to collect the amounts due could result in revenue loss for the Institution over time.

Management indicated that contractual reimbursements (including those under spot agreements) are subject to payor rules and policies. As a result of those rules and policies, a portion of gross patient charges may be uncollectible, and reduced payments may occur for reasons such as denials for unallowable services and failure to obtain preauthorizations for service (see Observation 4). The reasons for uncollected amounts may vary by encounter, and management stated that sufficient resources are not available to follow up on the anomalies related to each individual encounter.

According to management, once the Institution’s electronic health record system is implemented in March 2016, spot agreements will be uploaded into the system. When this occurs, information will be readily available for determining whether accurate payments are being received in accordance with agreement terms.

**Recommendation:**
After the implementation of the electronic health record system, management should evaluate processes and tools for monitoring patient accounts to ensure contractual amounts are collected. Management should also reassess staffing levels to determine whether departmental resources are sufficient to support an enhanced monitoring function.

**Management’s Action Plan:**
Responsible Executive: Weldon Gage  
Owner: Miriam Flores  
Due Date: September 30, 2016

*Management will evaluate processes and tools for monitoring patient accounts in the new patient accounting system. It is anticipated that work lists will permit enhanced tracking of AR. In addition, SPOTS will be loaded as a contract so the payment variances will be identified in work queues. Staffing levels will be assessed once the new system is live as it will afford us operational efficiencies. In addition, management will continue on an on-going basis to evaluate processes and tools for monitoring patient accounts.*
Observation 2: **Outstanding Accounts Receivable Balances**

As of June 2015, approximately $48 million in accounts receivable for technical charges under spot agreements were outstanding for more than 90 days. For example, $23.3 million (54%) of hospital receivables for Medicaid spot agreements and $18.6 million (41%) for Medicare were more than 180 days old. Based on the Institution’s accounts receivable aging trends, these payors are typically known as a “slow payors”. In addition, $5.2 million (87%) of hospital receivables for the Veterans Administration and nearly $1 million (58%) for Commercial payors were more than 90 days old.

### Spot Agreements Receivables – Technical Charges (Millions)

<table>
<thead>
<tr>
<th>Payor</th>
<th>Total Accounts Receivables</th>
<th>&gt; 180 days</th>
<th>&gt; 90 days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Managed Medicaid</td>
<td>$43.3</td>
<td>$23.3 (54%)</td>
<td>$5.2 (87%)</td>
</tr>
<tr>
<td>Medicare Advantage</td>
<td>$45.7</td>
<td>$18.6 (41%)</td>
<td>$1 (58%)</td>
</tr>
<tr>
<td>Veterans Administration</td>
<td>$5.9</td>
<td>$5.2 (87%)</td>
<td></td>
</tr>
<tr>
<td>Commercial</td>
<td>$1.7</td>
<td></td>
<td>$1 (58%)</td>
</tr>
</tbody>
</table>

According to management, spot agreements present certain challenges with regard to collections. For example, each spot agreement establishes a relationship with a particular payor for a specific patient. As result, the agreements may create manual billing and collections processes that require additional effort and attention by the Institution and the payors on a case-by-case basis.

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For many payors, the outstanding balances represent more than half of their total accounts receivable. The Managed Care Spot Agreement Policy states that insurance plans/payors must be in good standing before additional spot agreements will be executed. The Institutional Payor Review Policy states the payors will be considered for the “Do Not Accept Designation” (watch list) if they are not in good standing. However, the policy does not clearly state that the Institution will actually forego future agreements with any and all payors who are not in good standing. The increasing age of accounts receivable balances increases the likelihood of bad debt write-offs and revenue losses to the Institution.

**Recommendation**

Management should enhance the collections process to ensure timely payments for services provided under spot agreements. In addition, management should review the Institutional policy to ensure the language will hold payors accountable for untimely payments.

**Management's Action Plan:**
- **Responsible Executive:** Weldon Gage
- **Owner:** Miriam Flores
- **Due Date:** August 31, 2016

*Management will continue to work with all payors to ensure timely payment for services and utilize the appropriate tools within the new patient accounting system to enhance collections. The institutional policy will be reviewed and updated as appropriate.*

**Observation 3:**

**Inaccurate Spot Agreement Data**

Management relies on certain financial data to make decisions relating to payor mix, performance and volume of spot agreement-related activity. This data includes charges, payments and adjustments for spot agreement patient encounters.

During our review, we received patient encounter data for FY2014 that was purported to include technical charges related only to spot agreements. However, based on discussions with management and data validation procedures, we concluded that numerous encounters, with charges totaling approximately $15 million, were not actually related to the agreements.

Based on our discussions, management is aware of data integrity issues that stem from incorrect payor codes being assigned to patient accounts. According to management, the encounters may have been erroneously included in our spot agreement encounter data because the patients' insurance coverage may have changed to in-network, contracted plans during year, and their coverage may not have been appropriately verified and updated in all relevant systems.

Institutional policy states management is responsible for appropriate and effective internal controls to improve management decision making and ensure maintenance and reporting of reliable information. The inaccurate financial data for spot agreements increases the risk that inappropriate decision-making by management could occur.
Recommendation:
Management should develop and implement procedures to validate the accuracy of financial data used for decision making. This should include ensuring insurance coverage information is verified and updated within all relevant systems for all patients.

Management’s Action Plan:
Responsible Executive: Weldon Gage
Owner: Angela Bailey
Due Date: September 30, 2016

Once the Institution’s electronic health record system is implemented in March 2016, the payor/plan structure will make the selection of insurance and coverage information more user-friendly and real-time eligibility will validate the data. Management will monitor the data in the new patient accounting system based on the payor/plan structure established to ensure data quality. Training and updates will take place as required. Continual review of the payor/plan table will be done on a monthly basis and changes communicated to Patient Access, Financial Clearance, Managed Care and Patient Business Services.

Observation 4:
Pre-authorizations for Service Not Consistently Obtained
A pre-authorization allows a patient’s insurance provider to review and determine the medical necessity of a service or drug. In addition, pre-authorizations are often required before services can be performed outside of the local participating provider network. The Institution’s Financial Clearance Policy states that pre-authorization requirements must be verified during the patient intake process. Failure to obtain a pre-authorization may result in the patient’s financial liability for all or part of the cost of services or drugs.

As a result of missing pre-authorizations, there were approximately $3.4 million in adjustments (write-offs) to technical charges for spot agreement patient encounters in FY 2014. According to management, lack of pre-authorizations is a systemic issue that often occurs because same-day/next-day physician orders are issued for patient convenience. These orders allow only a few hours for insurance companies to provide pre-authorizations, when the companies are typically allowed up to 72 hours to respond. When the pre-authorizations are not received timely, medical overrides may be granted to provide the services to the patient, and denials of service and non-payment occur on the backend. Clinical Leadership will be notified of this issue under a separate cover.

Recommendation
Clinical Leadership should coordinate with management to enhance current processes by developing and implementing an initiative to address pre-authorization issues that arise from same-day/next-day physician orders. Leadership should ensure that providers are educated and trained, as appropriate, to ensure compliance with the Institution’s directive regarding pre-authorizations. In addition, after implementation of the electronic health record system, reports should be obtained from the Financial Clearance Center and Patient Business Services to aid in decision-making and promote increased accountability for any noncompliance identified.
Management’s Action Plan:
Responsible Executive: Thomas Buchholz, M.D
Owner: Robert Brigham
Due Date: August 31, 2016

Clinical Leadership will develop and implement an initiative to address pre-authorizations for same-day/next-day service. Providers will be educated and trained, as appropriate, to ensure compliance with the Institution’s directive relating to pre-authorizations. After implementation of the electronic health record system, relevant reports will be requested from the Financial Clearance Center and Patient Billing Services to assist with decision-making and corrective actions for noncompliance.
Appendix A

Objective, Scope and Methodology:
The objective of this engagement was to determine whether the Institution is collecting the appropriate amounts due under clinical services spot agreements. We reviewed technical charges that occurred under these agreements during the period September 2013 through August 2014.

Our procedures included the following:

- Reviewed Managed Care policies and procedures and other documentation to understand processes, guidelines, roles, and responsibilities related to spot agreements
- Conducted interviews and walkthroughs with management and staff in Managed Care and Patient Business Services to understand the processes and controls for creating spot agreements and collecting amounts due
- Performed validation procedures to determine the accuracy, completeness and relevance of financial data for technical encounters that occurred under spot agreements during the audit period
- Reviewed and analyzed financial data for more than 12,800 patient encounters to determine whether actual payments aligned with contractual amounts, as prescribed by Managed Care procedures and discussions with management
- Reviewed the financial data to determine the amounts of various write-offs to total charges, including write-offs for lack of pre-authorizations
- Reviewed reports related to outstanding receivables for spot agreement accounts
- Conducted testing to determine whether services were provided prior to spot agreement effective dates

Our internal audit was conducted in accordance with the International Standards for the Professional Practice of Internal Auditing.

Number of Priority Findings to be monitored by UT System: None
A Priority Finding is defined as “an issue identified by an internal audit that, if not addressed timely, could directly impact achievement of a strategic or important operational objective of a UT institution or the UT System as a whole.”

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