DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General
Office of Audit Services

OCT 07 2002

REGION IV
Room 3T41
61 Forsyth Street, S.W.
Atlanta, Georgia 30303-8909

CIN: A-04-02-02011

Mr. Lewis Seifert
Vice President of Finance
Florida Hospital
601 East Rollins
Orlando, Florida 33803

Dear Mr. Seifert:

Enclosed are two copies of the Department of Health and Human Services (HHS), Office of Inspector General (OIG), Office of Audit Services' (OAS) final report entitled, *Review of Medicare Bad Debts for Florida Hospital for the Fiscal Year Ended December 31, 1999.* A copy of this report will be forwarded to the HHS action official noted below for review and any action deemed necessary.

Final determination as to actions taken on all matters reported will be made by the HHS action official. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

In accordance with the principles of the Freedom of Information Act, 5 United States Code 552, as amended by the Public Law 104-231, OIG/OAS reports issued to the Department's grantees and contractors are made available to members of the press and the general public to the extent information contained therein is not subject to exemptions in the Act which the Department chooses to exercise (See 45 Code of Federal Regulations Part 5). As such, within 10 business days after the final report is issued, it will be posted on the World Wide Web at http://oig.hhs.gov/

To facilitate identification, please refer to Common Identification Number (CIN) A-04-02-02011 in all correspondence relating to this report. If you have any questions, please contact me or have your staff contact Peter Barbera at (404) 562-7758.

Sincerely yours,

Charles J. Curtis
Regional Inspector General
for Audit Services, Region IV

Enclosures – as stated

Direct Reply to HHS Action Official:

Mr. Dale Kendrick
Associate Regional Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Sam Nunn Atlanta Federal Center
61 Forsyth Street, S.W., Suite 4T20
Atlanta, Georgia 30303-8909

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF MEDICARE BAD DEBTS FOR FLORIDA HOSPITAL FOR THE FISCAL YEAR ENDED DECEMBER 31, 1999

JANET REHNQUIST
Inspector General

OCTOBER 2002
A-04-02-02011

DEPARTMENT OF HEALTH & HUMAN SERVICES

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REGION IV
Room 3T41
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CIN: A-04-02-02011

Mr. Lewis Seifert
Vice President of Finance
Florida Hospital
601 East Rollins
Orlando, Florida 33803

Dear Mr. Seifert:

This report provides you with the results of our review of inpatient Medicare bad debts at Florida Hospital. The objective of our review was to determine if Medicare bad debts claimed by the hospital were in compliance with the Medicare reimbursement criteria.

Our review focused on inpatient Medicare bad debts claimed by the hospital totaling $1,154,650 during the hospital's fiscal year (FY) ended December 31, 1999.

EXECUTIVE SUMMARY

We found that of the $1,154,650 in inpatient Medicare bad debts claimed for reimbursement, $131,698 did not comply with the Medicare reimbursement criteria and was therefore unallowable. In addition, we found that the hospital understated by $93,798 the amount of recoveries of previously written off bad debts that should be offset against the bad debts claimed on the cost report. Furthermore, we noted that the hospital also understated recoveries in the three FYs prior to our audit period by a combined total of $558,807.

The $131,698 was considered unallowable because the hospital did not perform reasonable collection efforts, as defined in the Medicare guidelines. The hospital must demonstrate that reasonable collection efforts were made and the hospital must use similar collection efforts for both Medicare and non-Medicare patients. In general, we found the hospital used significantly more collection efforts for the non-Medicare patient accounts than it did for the Medicare accounts.

The understated recoveries were the result of the hospital estimating bad debt recoveries instead of reporting actual recoveries. Based on our review of FY 1999 recoveries, we conducted a limited review of the amount of recoveries reported in prior years. We found that the recovery amounts were understated by $147,905 in FY 1996, $180,069 in FY 1997, and $230,833 in FY 1998, for a combined total of $558,807.

We recommend that the hospital file an amended cost report for FY 1999 to reduce allowable bad debts by $225,496 ($131,698 unallowable + $93,798 understated recoveries). In addition, we recommend that the hospital review the Medicare bad debt log for the FY 2000 cost report

(already filed with the Medicare fiscal intermediary (FI)) to ensure that Medicare bad debts comply with the reimbursement criteria and that they have been properly reduced by actual recoveries. If appropriate, the hospital should file an amended report for FY 2000.

We also recommend that the hospital establish clear written policies to ensure that Medicare and non-Medicare accounts will be treated consistently and that reasonable collection efforts will be used, in accordance with the Medicare guidelines. In addition, we recommend that the hospital establish procedures for identifying all Medicare recoveries and report actual recoveries instead of using estimates.

We will be forwarding a copy of our report to the Medicare FI along with a recommendation that they make adjustments to reduce allowable Medicare bad debts by $147,905 in FY 1996, $180,069 in FY 1997, and $230,833 in FY 1998. Upon receipt of the adjustments and the revised cost reports, the hospital should make repayment for the difference in reimbursement to the FI.

In written comments to our draft report, the hospital indicated they have been making changes to their systems to ensure they are following the Medicare guidelines for bad debts. In addition, the hospital is working with the FI in filing amended cost reports for the years identified in the audit, which include 1999, 1998, 1997, and 1996. The hospital is also reviewing the Medicare bad debt log for the FY 2000 cost report to ensure that Medicare bad debts were reported appropriately.

The hospital believes that we did not properly consider all collection efforts in our determination that collection efforts for Medicare accounts were not consistent with collection efforts for non-Medicare accounts. In addition, the hospital believes that the non-Medicare accounts that we reviewed were of higher dollar value than the Medicare accounts and thus subject to more collection efforts.

The hospital's complete response is included as Appendix C of the report.

BACKGROUND

Medicare has long had a policy that beneficiaries should share in defraying the costs of inpatient care through various deductibles and coinsurance amounts. For example, during calendar year 2002, the Medicare patient is liable for an $812 deductible for each benefit period in which the patient is admitted to a hospital. The patient is also liable for a $203 a day coinsurance for the 61st through the 90th day of an extended inpatient stay.

Historically, hospitals have been unable to collect a certain percentage of Medicare coinsurance and deductible amounts from program beneficiaries. Under a policy that costs attributable to Medicare beneficiaries are not to be shifted to non-Medicare patients, Medicare reimburses hospitals for these bad debts. This policy was adopted in 1966 when Medicare reimbursed hospitals retrospectively under reasonable cost principles. Beginning in 1983, inpatient hospital

care was reimbursed under a prospective payment system (PPS). Under Medicare's PPS, bad debts are pass-through costs and continue to be reimbursed under reasonable cost principles. Hospitals claim reimbursement for these bad debts by submitting annual Medicare cost reports.

Under Section 1861(v)(1)(T) of the Social Security Act, the amount of allowable bad debt for cost reporting periods beginning during FY 1998 was reduced 25 percent. For FY 1999 the amount of allowable bad debt was reduced 40 percent and for FY 2000 it was reduced 45 percent. For the FYs subsequent to FY 2000 it will be reduced 30 percent.

Bad debts resulting from Medicare deductible and coinsurance amounts that are uncollectible from beneficiaries can be reimbursed to hospitals if the bad debts meet Medicare reimbursement criteria. Generally, bad debts must meet the following criteria, as set forth in 42 Code of Federal Regulations 413.80:

- The debt must be related to covered services and derived from deductible and coinsurance amounts;
- The provider must be able to establish that reasonable collection efforts were made;
- The debt was actually uncollectible when claimed as worthless; and
- Sound business judgment established that there was no likelihood of recovery at any time in the future.

The Medicare Provider Reimbursement Manual (PRM), Section 310.B, requires that the provider's collection effort be documented in the patient's file and PRM, Part II, Section 1102, requires that listings be maintained of beneficiaries whose uncollected accounts were claimed as bad debts.

Allowable bad debts must relate to specific deductibles and coinsurance amounts. Under the terms of PRM, Part I, Section 314, uncollectible deductible and coinsurance amounts are recognized as allowable bad debts in the reporting period in which the debts are determined to be worthless. The specificity required for a bad debt claim is reiterated in the PRM Part II. This Center for Medicare & Medicaid Services (CMS) manual requires that certain beneficiary-specific information [such as names and Medicare health insurance number (HIC)] be sent in by providers claiming reimbursement of bad debts.

OBJECTIVE, SCOPE, AND METHODOLOGY

The objective of our review was to determine if Medicare bad debts claimed by the hospital were in compliance with the Medicare reimbursement criteria. Our audit covered hospital inpatient Medicare bad debts claimed on the cost report for the cost report year January 1, 1999 through December 31, 1999.

To accomplish our objective, we met with staff at the Medicare FI, First Coast Service Options (FCSO) in Orlando, Florida and discussed their role and reviewed their audit work papers and permanent files pertaining to Florida Hospital. We also met with the State Medicaid agency to determine the State's policy regarding Medicaid reimbursement of Medicare deductibles and coinsurance for Medicare patients who also are eligible for Medicaid.

During our review at the hospital we reviewed written policies and procedures for collection of patient balances. We reviewed all 50 bad debt entries greater than or equal to $2,000 and randomly selected 100 entries from the remaining population (for details of the sampling methodology, see APPENDIX A). We performed detailed audit testing on the patient account financial records, Medicare remittance documents, Medicaid remittance documents, and collection activity records for the selected entries. We used the RAT-STATS Variable Appraisal Program to estimate the dollar impact of improper bad debts in the total population (see APPENDIX B for details on the results of our projection). Finally, we obtained a detail of recoveries of previously written off bad debts to determine how much should have been used to reduce current bad debts.

Because of the exceptions noted related to recoveries in FY 1999, we conducted a limited review of the recoveries reported for FYs 1996, 1997, and 1998. For these years, we compared the estimate of recoveries as reported in the cost report to the actual recoveries.

Our review was conducted in accordance with government auditing standards. The review was conducted from December 2001 through June 2002. We performed fieldwork at the State agency in Tallahassee, Florida, at the Orlando office of FCSO, and at the hospital. At the hospital, we relied primarily on substantive testing and as such, an understanding of internal controls of the hospital was not required.

RESULTS

We found that of the $1,154,650 in inpatient Medicare bad debts claimed for reimbursement, $131,698 did not comply with the Medicare reimbursement criteria and was therefore unallowable. In addition, we found that the hospital understated by $93,798 the amount of recoveries of previously written off bad debts, which should be offset against the bad debts claimed on the cost report. Furthermore, we noted that the hospital also understated recoveries in the three FYs prior to our audit period by a combined total of $558,807.

The $131,698 was considered unallowable because the hospital did not perform reasonable collection efforts, as defined in the Medicare guidelines. The hospital must demonstrate that reasonable collection efforts were made and the hospital must use similar collection efforts for both Medicare and non-Medicare patients. In general, we found the hospital used significantly

more collection efforts for the non-Medicare patient accounts than it did for the Medicare accounts. We believe the hospital's collection efforts were inconsistent because the hospital did not have clearly defined collection policies. The policies did not specify the number of contacts to be made, the interval between contacts, or the point at which accounts were to be written off.

The understated recoveries were the result of the hospital estimating bad debt recoveries instead of reporting actual recoveries. Based on our review of FY 1999 recoveries, we conducted a limited review of the amount of recoveries reported in prior years. We found that the recovery amounts were understated by $147,905 in FY 1996, $180,069 in FY 1997, and $230,833 in FY 1998, for a combined total of $558,807.

We recommend that the hospital file an amended cost report for FY 1999 to reduce allowable bad debts by $225,496 ($131,698 unallowable + $93,798 understated recoveries). In addition, we will be forwarding a copy of our report to the FI along with a recommendation that they make adjustments to reduce allowable Medicare bad debts by $147,905 for FY 1996, $180,069 for FY 1997, and $230,833 for FY 1998.

We also recommend that the hospital review the Medicare bad debt log for the FY 2000 cost report (already filed with the FI) to ensure that Medicare bad debts comply with the reimbursement criteria and that they have been properly reduced by actual recoveries. If appropriate, the hospital should file an amended report for FY 2000.

We also recommend that the hospital establish clear written policies to ensure that Medicare and non-Medicare accounts will be treated consistently and that reasonable collection efforts will be used, in accordance with the Medicare guidelines. In addition, we recommend that the hospital establish procedures for identifying all Medicare recoveries and report actual recoveries instead of using estimates.

The following sections provide more details on the results of our review.

COLLECTION EFFORTS NOT CONSISTENT

The hospital did not use the same or similar collection efforts for its Medicare accounts as it did for its non-Medicare accounts. Out of the 150 Medicare bad debts in our sample, 25 accounts received considerably less collection efforts than the typical non-Medicare account. As a result, we estimate that the hospital claimed $131,698 for bad debts, which we considered to be unallowable for reimbursement.

Medicare Accounts Received Less Attention

The regulations state that in order for a bad debt to be allowable, a provider must establish that reasonable collection efforts were made. In defining what is reasonable collection effort, the Provider Reimbursement Manual (PRM-1), Section 310 states that "… a provider's effort to collect Medicare deductible and coinsurance amounts must be similar to the effort the provider puts forth to collect comparable amounts from non-Medicare patients."

We found that the hospital attempted to contact non-Medicare patients an average of about six times prior to writing off an account. However, the hospital only attempted to contact Medicare patients about 4 times on average prior to writing off the 100 accounts under $2,000 in our random sample. This practice was contrary to what we understood the hospital's collection policies to be based on our review of the written policies as well as discussions with hospital personnel.

The hospital had very little written policy addressing how accounts were to be collected. The written policies indicated that all uncollectible accounts, including Medicare and non-Medicare accounts, should be transferred to an outside collection agency normally after insurance or Medicare had paid and the account had gone 60-90 days without activity. In addition, the policy indicated that Medicare accounts must be worked a minimum of 120 days from the date of the first bill.

The hospital also had collection payor profiles, which the business office was supposed to follow. The profile for Medicare patients indicates that, after the first bill is sent, a Medicare patient is to receive a demand letter every 30 days until 120 days from the date of the first bill to the patient, with the last letter notifying the patient that the account is being reviewed for transfer to a collection agency. According to hospital business office personnel, the first bill noted on the profile for a Medicare patient was supposed to be sent after Medicare had paid and the account had been reconciled (business office personnel have checked to ensure that the Medicare payments, deductibles and coinsurance agree with the hospital's records, or differences are reconciled). The account is written off at the time that it is turned over to a collection agency (60-90 days according to the policy, except for Medicare patients which should be at 120 days). If the hospital properly followed the schedule on the Medicare patient collection profile, a Medicare patient would receive, at a minimum, five written contacts demanding payment (the first bill, plus one demand letter every 30 days until 120 days).

In addition to written contacts, according to hospital business office personnel, the patient also may receive phone calls periodically but there is no preset formula as to when those phone calls would be made. The frequency of phone calls was left up to the collector's judgment. Also, a payment by a patient would alter the procedures and no account was to be written off as long as a patient was making payments. In total with written and telephone contacts, a Medicare patient would generally receive in excess of five contacts if the hospital were following its collection procedures.

Contrary to hospital procedures, our review found that Medicare accounts received considerably less attention than the non-Medicare accounts. As stated, the average was about four contacts per Medicare account versus about six contacts per non-Medicare account. Our non-Medicare review was based on 44 similar accounts to the Medicare accounts in our review. Reviewing 44 non-Medicare accounts was adequate to establish the hospital's collection practices. This inconsistent treatment of the Medicare accounts is not in compliance with the definition of reasonable collection effort as set forth in PRM-1 Section 310.

25 Sample Errors Due to Lack of Reasonable Collection Effort

The Medicare guidelines state clearly that a provider must use similar collection efforts for Medicare and non-Medicare patients. To review the Medicare accounts, we established a collection effort benchmark for reasonable collection effort, based on the hospital's collection efforts for non-Medicare accounts. Although our review indicated the non-Medicare average was about six contacts per account, we established a benchmark of four contacts as the minimum acceptable collection effort for Medicare accounts. We did this to be conservative and reasonable, recognizing that 6 contacts was an average and not the minimum followed by the hospital on its non-Medicare accounts.

In reviewing the Medicare accounts, we considered a contact to be any letters sent, phone contacts made, or phone contacts attempted (a note indicating a busy signal was received, or if a message was left). Any account with less than four contacts documented was considered to be an inadequate collection effort, and was treated as an error in our sample. In total, we noted 25 sample items that were errors due to a lack of reasonable collection efforts.

It should be noted that, in addition to making less than four contacts on these patients, the hospital wrote off all but one of the 25 accounts in question prior to 120 days from the date of the first bill to the patient. The Medicare guidelines allow for a presumption of non-collectibility if an account remains uncollected after 120 days of collection effort. That presumption is not afforded to hospitals if an account is less than 120 days from the date of the first bill to the patient. In other words, for accounts that are less than 120 days from the date of first bill, the hospital would need to demonstrate through its efforts that an account was uncollectible and would not be able to presume that it was uncollectible. In the cases of the sample errors, the hospital did not demonstrate that the accounts were uncollectible.

HOSPITAL RECOVERY ESTIMATES NOT ACCURATE

The hospital understated by $93,798 the recoveries of previously written off Medicare bad debts, which should have been used to reduce the total claimed for allowable Medicare bad debts for FY 1999. The total actual recoveries of previously written off Medicare bad debts was $124,229 and the hospital reported only $30,431.

The hospital computed a recoveries offset of $30,431 by taking the FY 1998 Medicare recoveries as a percentage of FY 1998 Medicare bad debts and applying that percentage to the FY 1999 Medicare bad debts. This method does not ensure that the hospital will properly capture all Medicare bad debt recoveries.

The total actual Medicare bad debt recoveries of $124,229 was for all hospital components, including inpatient acute care, outpatient, inpatient psychiatric, inpatient rehabilitation, and skilled nursing. The recoveries were not accounted for by hospital component, and thus could not be properly reported on the cost report. Alternatively, for cost report reporting purposes, we allocated this total between the various components based on the bad debts included on the bad debt log. We determined that, of the $93,798 understated amount, $48,423 related to inpatient acute care, $35,111 to outpatient, $8,650 to inpatient psychiatric, $723 to inpatient rehabilitation, and $891 to skilled nursing services. The following demonstrates how the adjustments were computed for the various hospital components:

Allocation of Recoveries Adjustment

	(1)	(2)	(3)	(4)	(5) (col. 3 - col. 4)
Cost Report Worksheet	**Bad Debts Per Log**	**Percent of Total**	**Allocation of Total Recoveries**	**Recoveries Used By Hospital**	**Computed Adjustment**
E Part A - Inpatient Acute	$1,168,678	50%	$ 62,450	$ 14,028	$ 48,423
E Part B – Outpatient	961,615	41%	$ 51,385	$ 16,274	$ 35,111
E-3 Part I - Psychiatric	161,878	7%	$ 8,650	$ -	$ 8,650
E-3 Part II - Rehabilitation	13,524	1%	$ 723	$ -	$ 723
E-3 Part III - Skilled Nursing	19,100	1%	$ 1,021	$ 129	$ 891
Total	$2,324,795	100%	$ 124,229	$ 30,431	$ 93,798

As previously stated, Medicare reimbursement guidelines require that allowable Medicare bad debts be reduced by recoveries of previously written off Medicare bad debts. Because the hospital did not accurately report the recoveries, the FY 1999 cost report needs to be adjusted as reflected in column 5 of the above table.

OTHER MATTERS

Because of the recoveries exception which we noted in our review of FY 1999, we conducted a limited review of the hospital's recovery offsets in FYs 1996, 1997, and 1998. We noted that for these years the hospital also used estimates for recoveries and did not properly offset actual Medicare bad debt recoveries. We noted that, as in FY 1999, the hospital's estimates were significantly lower than the actual recoveries identified as the following table demonstrates.

Recoveries Adjustments – FYs 1996, 1997 & 1998

	FY 1996	FY 1997	FY 1998	Total
Recoveries Used By Hospital	$ 14,793	$ 12,179	$ 23,617	$ 50,589
Actual Recoveries	162,698	192,248	254,450	609,396
Additional Adjustment Necessary (reduction to bad debts)	$ (147,905)	$ (180,069)	$ (230,833)	$(558,807)

These previously unreported recoveries should be properly reported in the applicable cost reports, in order to return the funds to Medicare.

CONCLUSION AND RECOMMENDATIONS

We found that Medicare bad debts were overstated in FY 1999 by $225,496 due to lack of reasonable collection efforts and the hospital's failure to report actual bad debt recoveries. In addition, we found that the bad debts for FYs 1996, 1997, and 1998 were overstated by a combined total of $558,807 because the hospital failed to properly reduce allowable Medicare bad debts by actual recoveries.

We recommend that the hospital file an amended cost report for FY 1999 to reduce allowable bad debts by $225,496 ($131,698 unallowable + $93,798 understated recoveries). In addition, we will be forwarding a copy of our report to the Medicare FI along with a recommendation that they make adjustments to reduce allowable Medicare bad debts by $147,905 for FY 1996, $180,069 for FY 1997, and $230,833 for FY 1998.

We also recommend that the hospital review the Medicare bad debt log for the FY 2000 cost report (already filed with the FI) to ensure that Medicare bad debts comply with the reimbursement criteria and that they have been properly reduced by actual recoveries. If appropriate, the hospital should file an amended report for FY 2000.

We also recommend that the hospital establish clear written policies to ensure that Medicare and non-Medicare accounts will be treated consistently and that reasonable collection efforts will be used, in accordance with the Medicare guidelines. In addition, we recommend that the hospital establish procedures for identifying all Medicare recoveries and report actual recoveries instead of using estimates.

Auditee's Comments

The hospital has instituted changes to their systems, policies, and procedures to ensure they are following the Medicare guidelines for bad debts. This includes the collection effort that is taken on accounts as well as the timing of that effort.

In addition, the hospital is working with the FI in filing amended cost reports for the years identified in the audit, which include 1999, 1998, 1997, and 1996. Florida Hospital is also reviewing the Medicare bad debt log for FY 2000 cost report to ensure that Medicare bad debts were reported appropriately.

The hospital did not agree with our findings in regards to collection efforts not being the same for some Medicare accounts as for non-Medicare accounts. The hospital believes the regulations specifically state that collection efforts by a collection agency are considered to be valid collection efforts in determining whether an account was worked for 120 days. They believe the collection efforts made by the collection agency for the cases selected for review were not considered in the calculation of the 120 days.

In addition, the hospital believes that the reason for the difference in collection efforts was that our review did not specifically compare the efforts expended on a particular Medicare account with that of a non-Medicare account of equal or similar balance. Since most Medicare account balances are less than $1,000, the effort expended to collect such an account less than $1,000 will be less than the efforts made to collect a greater amount, such as $5,000, regardless of the payer. The hospital contends that these differences were not always considered in the finding of the audit.

OIG's Response

We are pleased that the hospital is taking action to get the cost reports for FYs 1999, 1998, 1997, and 1996 amended. We are also pleased that the hospital has made changes to its systems and policies and procedures based on the Medicare guidelines.

We disagree with the hospital's assertion that the collection agency's efforts should count toward meeting the requirement of 120 days of collection efforts. We evaluated the collection efforts up to the point of write-off, which is when the hospital put the bad debts on the Medicare bad debt log. By placing the uncollected balance on the Medicare bad debt log, the hospital is indicating that the debt is uncollectible and allowable for Medicare reimbursement. The collection agency efforts occurred after the date of write-off and therefore we did not consider them in determining

if a bad debt was allowable. Had the hospital waited until the accounts were returned from the collection agency before writing off the accounts, we would have considered the collection agency's efforts in our review. In addition, we did not treat any accounts as errors on the basis that they were written off prior to 120 days of collection efforts. Instead, we focused on whether or not the number of collection efforts was consistent with non-Medicare accounts.

We disagree with the hospital's statement that we did not review Medicare and non-Medicare accounts with similar balances. In fact, the account balances for the two samples were quite similar. In our random sample of Medicare accounts, the account balances ranged from $3 to $1,983 compared with a range of $25 to $1,502 for the non-Medicare sample. Furthermore, the median account balance in our random sample of Medicare accounts was $764 compared with a median of $701 for the non-Medicare sample. Finally, the average account balance in our random sample of Medicare accounts was $689 compared with $682 for the non-Medicare sample. The hospital suggested that the efforts for a Medicare patient with a balance below $1,000 would be less than the efforts to collect, for example, a $5,000 balance. While that may be true, it is not relevant because, as can be seen from the range, median, and average figures for the samples, there were no such high balances included in the non-Medicare sample. We believe the two samples were similar and the finding is valid.

Sincerely yours,

Charles J. Curtis
Regional Inspector General
for Audit Services, Region IV

SAMPLING METHODOLOGY

OBJECTIVE

The objective of the audit was to determine if Medicare bad debts claimed by Florida Hospital on its FY ended December 31, 1999 cost report met Medicare requirements.

POPULATION

Our population consisted of 1,427 bad debts claimed on the FY 1999 cost report. There were 50 entries that are $2,000 or greater and 1,377 entries that were under $2,000.

The population is shown below:

Strata	Number of Bad Debts	Dollar Amount of Bad Debts
Under $2,000	1,377	$906,021
$2,000 and Over	50	$ 271,047
Total	1,427	$1,177,068*

* The total bad debt amount differs from the total in the executive summary because there were negative entries on the log totaling $(8,391) which were not included in our universe; in addition, the hospital reduced the log total by recoveries of $14,027. The total reductions including negative entries and recoveries were $22,418 which brought the filed total from $1,177,068 down to $1,154,650 (the figure used in the Executive Summary).

SAMPLE UNIT

Each positive entry on the Medicare bad debt log is a Medicare bad debt resulting from unpaid coinsurance and deductible amounts and will represent a sampling unit.

SAMPLE DESIGN

The sample was a stratified sample. All items $2,000 or greater were included in a separate stratum for 100 percent review. We then selected an unrestricted random sample of items with values less than $2,000.

SAMPLE SIZE

We randomly selected 100 bad debts that were less than $2,000, and we reviewed all 50 bad debts that were $2,000 or greater.

ESTIMATION METHODOLOGY

Using the Department of Health and Human Services, Office of Inspector General, Office of Audit Services RAT-STATS Variable Appraisal Program for stratified samples, we projected the amount of bad debts that were not allowable based on not having a reasonable collection effort.

APPENDIX B

VARIABLE PROJECTION

SAMPLE RESULTS

The results of our review are as follows:

Strata	Number of Bad Debts	Sample Size	Value of Sample	Number of Errors	Value of Errors
Under $2000	1,377	100	$ 68,945	24	$ 13,826
Over $2000	50	50	$271,047	1	$ 2,865
Totals	1,427	150	$339,992	25	$16,691

VARIABLE PROJECTION

Point Estimate $193,250

90 Percent Confidence Interval

Lower Limit $131,698
Upper Limit $254,801

FLORIDA
HOSPITAL
601 East Rollins Street
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407/896-6611

August 5, 2002

Mr. Charles J. Curtis
Regional Inspector General for Audit Services, Region IV
Department of Health & Human Services
Room 3T41
61 Forsyth Street, S.W.
Atlanta, GA 30303-8909

Re: Florida Hospital
Common Identification Number A-04-02-02011

Dear Mr. Curtis:

This letter is in response to your report titled Review of Medicare Bad Debts for Florida Hospital. The report provides the results of the review of Medicare bad debts for Fiscal Year ended December 31, 1999. We appreciate the opportunity to provide comments before the final report is issued. Florida Hospital strives to ensure our policies and procedures and our actions are consistent with the requirements of Medicare and Medicaid. It is apparent there will be times when our interpretation of rules and regulations may differ from those of the regulators. There will also be times, as in this instance, where our implementation and interpretation is inconsistent with the interpretation of the regulation.

As a result of the audit, we have been reviewing our systems, policies and procedures, and instituting the changes necessary to ensure we are following the Medicare guidelines for bad debt. This includes the collection effort that is taken on accounts as well as the timing of that effort.

In addition, we are working with our Medicare fiscal intermediary in filing amended cost reports for the years identified in the audit, which include 1999, 1998, 1997, and 1996. We are also reviewing the Medicare bad debt log for fiscal year 2000 cost report to ensure that Medicare bad debts were reported appropriately.

We sincerely appreciate the approach and attitude displayed by your staff. It was truly a cooperative approach to solving a problem rather than affixing blame. We would ask that you consider the following two issues.

In regards to the hospital not having the same collection effort for some Medicare accounts as it does for non-Medicare accounts, we believe the regulations specifically state that collection efforts by a collection agency are considered to be valid collection

efforts in determining whether an account was worked for 120 days. The collection efforts made by the collection agencies for the cases selected for review were not included in the calculation of the 120 days.

The findings indicate Florida Hospital did not apply the same collection efforts to Medicare accounts as was applied to non-Medicare accounts. The review did not specifically compare the efforts expended on a particular Medicare account with that of a non-Medicare account of equal or similar balance. Since most Medicare account balances are less than $1,000, the effort expended to collect such an account less than $1,000 will be less than the efforts made to collect a greater amount, such as $5,000, regardless of the payer. These differences were not always considered in the findings of the audit.

If you have any questions concerning our comments, please contact me.

Sincerely,

Lewis Seifert
Vice President, Finance

LS/kcs

ACKNOWLEDGMENTS

This report was prepared under the direction of Charles J. Curtis, Regional Inspector General for Audit Services. Other principal Office of Audit Services staff who contributed include:

Peter Barbera, *Audit Manager*
Lloyd Myers, *Senior Auditor*
Dicky Sanford, *Auditor*
Bob Julian, Auditor

Technical Assistance
Fran Cowper, Regional Statistical Specialist

For information or copies of this report, please contact the Office of Inspector General's Public Affairs office at (202) 619-1343.