DEPARTMENT OF HEALTH & HUMAN SERVICES **OFFICE OF INSPECTOR GENERAL**

Office of Audit Services, Region IV
61 Forsyth Street, SW, Suite 3T41
Atlanta, GA 30303

June 10, 2010

Report Number: A-04-09-00057

Ms. Alana Sullivan
Chief Compliance Officer
Erlanger Medical Center
975 East Third Street
Whitehall Building – Suite 513
Chattanooga, TN 37403

Dear Ms. Sullivan:

Enclosed is the U.S. Department of Health & Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of Medicare Part A Bad Debts at Erlanger Medical Center for the Fiscal Year Ended June 30, 2005.* We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this 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.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at http://oig.hhs.gov.

If you have any questions or comments about this report, please do not hesitate to call me at (404) 562-7800, or contact Eric Bowen, Audit Manager, at (404) 562-7789 or through email at Eric.Bowen@oig.hhs.gov. Please refer to report number A-04-09-00057 in all correspondence.

Sincerely,

/John T. Drake, Sr. for/
Peter J. Barbera
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Nanette Foster Reilly
Consortium Administrator
Consortium for Financial Management & Fee for Service Operations (CFMFFSO)
Centers for Medicare & Medicaid Services
601 East 12th Street, Room 235
Kansas City, MO 64106

Department of Health & Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF MEDICARE PART A BAD DEBTS AT ERLANGER MEDICAL CENTER FOR THE FISCAL YEAR ENDED JUNE 30, 2005

Daniel R. Levinson
Inspector General

June 2010
A-04-09-00057

Office of Inspector General

http://oig.hhs.gov

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health & Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC
at http://oig.hhs.gov

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site.

OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) is the Federal agency within the U.S. Department of Health & Human Services that administers the Medicare program and provides Federal oversight of State Medicaid programs for every State in the nation. CMS contracts with Medicare fiscal intermediaries and administrative contractors to, among other things, process and pay claims submitted by Medicare providers. Fiscal intermediary and Medicare administrative contractor responsibilities include determining reimbursement amounts, conducting reviews and audits, and safeguarding against fraud and abuse. Fiscal intermediaries and Medicare administrative contractors use the Medicare cost report for final settlement of Medicare reimbursement due to or from providers.

Section 1813 of the Social Security Act (42 U.S.C. § 1395e) mandates that beneficiaries share in defraying the costs of inpatient care through various deductibles and coinsurance amounts. 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 (defined below) are pass-through costs and continue to be reimbursed under reasonable cost principles. Hospitals claim reimbursement for these bad debts on their annual Medicare cost reports.

Medicare bad debts are amounts considered to be uncollectible from accounts and notes receivable that were created or acquired in providing services for Medicare patients. The Medicare program reimburses hospitals for bad debts associated with uncollectible Medicare deductible and coinsurance amounts if the bad debts meet Medicare reimbursement criteria. Federal regulations (42 CFR § 413.89(e)) provide that, to be eligible for reimbursement, the hospital must show that: (1) the bad debts are related to Medicare covered services and derived from unpaid deductible and coinsurance amounts, (2) reasonable collection efforts were made, (3) the debts were actually uncollectible when claimed as worthless, and (4) sound business judgment established there was no likelihood of recovery at any time in the future. Furthermore, Federal regulations (42 CFR § 413.89(f)) require hospitals to reduce their bad debts by the amount that they recover from previously written off bad debts. Because Federal regulations (42 CFR § 413.89(h)) reduced reimbursement for Medicare bad debts by 30 percent in fiscal year (FY) 2005, Medicare reimbursed 70 percent of the bad debts claimed.

Erlanger Medical Center (Erlanger) is an 819-bed acute care and 50-bed long term care hospital located in Chattanooga, Tennessee. Erlanger includes a Level I trauma center, a teaching center, and a tertiary care services center. On its hospital cost report for July 1, 2004, through June 30, 2005, Erlanger claimed $1,570,958 ($1,099,671 reimbursement) for Medicare inpatient bad debts (bad debts).

OBJECTIVE

Our objective was to determine whether bad debts claimed on Erlanger's FY 2005 hospital cost report were allowable under Medicare regulations and were reduced by bad debt recoveries.

SUMMARY OF FINDINGS

Erlanger properly reported 76 out of 110 bad debts in our sample on its FY 2005 hospital cost report and reduced its bad debts by recoveries received during FY 2005. However, the remaining 34 bad debts in our sample were not allowable under Medicare regulations. Specifically, Erlanger claimed 34 unallowable bad debts totaling $78,116 as follows:

- 33 bad debts totaling $45,273 were for accounts that were still with a collection agency when written off and, therefore, did not meet the definition of uncollectible when claimed as worthless and

- 4 bad debts (3 of which were also included in the 33 bad debts in the previous bullet) totaling $32,843 were for non-covered services and were not derived from unpaid deductible and coinsurance amounts.

Erlanger generally claimed unallowable bad debts because its policies and procedures required accounts to be written off at the time they were referred to a collection agency. Additionally, in some cases Erlanger claimed unallowable bad debts because its patient financial system did not recognize and remove non-covered service charges from patient accounts before transferring the balances to bad debt.

Based on our statistical sample results, we estimated that Erlanger claimed $471,171 for bad debts that were not reimbursable under Medicare regulations. Of this amount, $438,328 related to bad debts that were with a collection agency. A CMS memorandum dated May 2, 2008, entitled *Clarification of Medicare Bad Debt Policy/Bad Debt Policy Related to Accounts at a Collection Agency*, states that Medicare contractors are required to disallow Medicare bad debts for accounts at a collection agency. This same memorandum instructed Medicare contractors not to reopen cost reports to disallow such bad debts prior to May 2, 2008. Therefore, we are not recommending a $438,328 reduction to the bad debt total claimed by Erlanger on its cost report or a refund of the $306,830 in related reimbursement. The remaining balance of $32,843 was unallowable for other reasons specifically related to Erlanger's actions and should be adjusted on Erlanger's cost report. Additionally, three bad debts totaling $22,150 that were not in our sampling frame were duplicate bad debts caused by incorrect adjustments.

RECOMMENDATIONS

We recommend that Erlanger:

- request its fiscal intermediary reopen its 2005 hospital cost report to reduce Medicare bad debts by $54,993 and refund $38,495 in related overpayments,

- review its previously submitted FY 2008 cost report and ensure compliance with CMS's bad debt policy, and

- ensure that cost reports submitted in the future comply with CMS's bad debt policy.

ERLANGER MEDICAL CENTER COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, Erlanger agreed with our findings and recommendations pertaining to overpayments for bad debts that were not derived from Medicare deductible and coinsurance amounts or were duplicate bad debts. However, Erlanger disagreed with our finding regarding patient accounts that were claimed as Medicare bad debts while the accounts were still with a collection agency. Regarding our recommendations that Erlanger review its previously submitted FY 2008 cost report and ensure compliance with CMS's bad debt policy and ensure that cost reports submitted in the future comply with CMS's bad debt policy, Erlanger stated that it would ensure compliance with the laws and regulations governing Medicare bad debt policy. Erlanger's comments (minus attachments) are included as Appendix E.

After reviewing Erlanger's comments, we maintain that our findings and recommendations are valid.

TABLE OF CONTENTS

INTRODUCTION

BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) is the Federal agency within the U.S. Department of Health & Human Services that administers the Medicare program and provides Federal oversight of State Medicaid programs for every State in the nation.

Medicare Fiscal Intermediaries and Administrative Contractors

CMS contracts with Medicare fiscal intermediaries[1] and administrative contractors to, among other things, process and pay claims submitted by Medicare providers. Fiscal intermediary and Medicare administrative contractor responsibilities include determining reimbursement amounts, conducting reviews and audits, and safeguarding against fraud and abuse. Fiscal intermediaries and Medicare administrative contractors use the Medicare cost report for final settlement of Medicare reimbursement due to or from providers.

Medicare Bad Debt Policy

Section 1813 of the Social Security Act (42 U.S.C. § 1395e) mandates that beneficiaries share in defraying the costs of inpatient care through various deductibles and coinsurance amounts. 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 (defined below) are pass-through costs and continue to be reimbursed under reasonable cost principles. Hospitals claim reimbursement for these bad debts on their annual Medicare cost reports.

Medicare bad debts are amounts considered to be uncollectible from accounts and notes receivable that were created or acquired in providing services for Medicare patients. The Medicare program reimburses hospitals for bad debts associated with uncollectible Medicare deductible and coinsurance amounts if the bad debts meet Medicare reimbursement criteria. Federal regulations (42 CFR § 413.89(e)) provide that, to be eligible for reimbursement, the hospital must show that: (1) the bad debts are related to Medicare covered services and derived from unpaid deductible and coinsurance amounts, (2) reasonable collection efforts were made, (3) the debts were actually uncollectible when claimed as worthless, and (4) sound business judgment established there was no likelihood of recovery at any time in the future. Furthermore, Federal regulations (42 CFR § 413.89(f)) require hospitals to reduce their bad debts by the amount that they recover from previously written off bad debts. Because Federal regulations (42 CFR § 413.89(h)) reduced reimbursement for Medicare bad debts by 30 percent in fiscal year (FY) 2005, Medicare reimbursed 70 percent of the bad debts claimed.

[1] Effective October 1, 2005, Congress amended the Social Security Act to require that CMS contract with Medicare administrative contractors instead of fiscal intermediaries (Part A) and carriers (Part B) by October 2011. Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. No. 108-173 § 911, Social Security Act, §§ 1816 and 1842, 42 U.S.C. §§ 1395h, 1395u and 1395kk-1.

Erlanger Medical Center

Erlanger Medical Center (Erlanger) is an 819-bed acute care and 50-bed long term care hospital located in Chattanooga, Tennessee. Erlanger includes a Level I trauma center, a teaching center, and a tertiary care services center. On its hospital cost report for July 1, 2004, through June 30, 2005, Erlanger claimed $1,570,958 ($1,099,671 reimbursement) for Medicare inpatient bad debts (bad debts).[2]

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether bad debts claimed on Erlanger's FY 2005 hospital cost report were allowable under Medicare regulations and were reduced by bad debt recoveries.

Scope

Our review was limited to $1,628,359 that included $1,605,333 in bad debts reported on the bad debt listing supporting Erlanger's FY 2005 hospital cost report[3] and $23,026 in potential duplicate bad debts. We reviewed a sample of 100 bad debts ranging between $500 and $2,999 totaling $87,492 and separately reviewed 10 bad debts valued at $3,000 or more and totaling $72,632. We also reviewed the accuracy and completeness of bad debt recoveries reported by Erlanger during FY 2005.

We limited our review of Erlanger's internal controls to those controls applicable to Erlanger's managing and reporting of its bad debts.

We conducted our fieldwork from December 2008 through February 2009 at Erlanger in Chattanooga, Tennessee.

Methodology

To accomplish our objective, we:

- reviewed applicable Medicare laws, regulations, and guidance;
- held discussions with CMS officials regarding Medicare bad debt program guidance;

[2] On its hospital cost report, Erlanger claimed $1,570,958 in Medicare bad debts, which equaled the $1,638,434 per its bad debt listing reduced by $67,476 in bad debt recoveries.

[3] As explained in Appendix A, our sampling frame of $1,605,333 equaled $1,638,434 minus 69 bad debts totaling $16,668 that were less than $50, minus 4 bad debts totaling $23,026 that were potential duplicates, plus 11 bad debts totaling $6,593 that were negative adjustments.

- evaluated Erlanger policies and procedures regarding the collection of deductibles and coinsurance amounts;

- obtained a list of bad debts claimed in FYs 2004 and 2005;

- tested the lists of bad debts from FYs 2004 and 2005 for duplicate bad debts on the FY 2005 cost report;

- conducted a stratified sample of bad debts as noted in Appendix A;

- validated the population of FY 2005 bad debt write offs;

- reviewed the patient accounting financial records, Medicare remittance documents, Medicaid remittance documents, and collection activity records for the 110 bad debts selected in the sample;

- used the Office of Inspector General, Office of Audit Services (OIG/OAS) statistical software to estimate the number and dollar value of unallowable bad debts for accounts that were with a collection agency when claimed as worthless (Appendix B);

- reviewed the collection agencies' contracts and bad debt invoices for FY 2005; and

- reviewed financial records for bad debt recoveries to determine the accuracy and completeness of bad debt recovery amounts used to reduce bad debts.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

FINDINGS AND RECOMMENDATIONS

Erlanger properly reported 76 out of 110 bad debts in our sample on its FY 2005 hospital cost report and reduced bad debts by bad debt recoveries. However, the remaining 34 bad debts in our sample were not allowable under Medicare regulations. Specifically, Erlanger claimed 34 unallowable bad debts in our sample totaling $78,116 as follows:

- 33 bad debts totaling $45,273 were for accounts that were still with a collection agency when written off and, therefore, did not meet the definition of uncollectible when claimed as worthless and

- 4 bad debts totaling $32,843 were for non-covered services and were not derived from unpaid deductible and coinsurance amounts.[4]

Erlanger generally claimed unallowable bad debts because its policies and procedures required accounts to be written off at the time they were referred to a collection agency. Additionally, in some cases Erlanger claimed unallowable bad debts because its patient financial system did not recognize and remove non-covered service charges from patient accounts before transferring the balances to bad debt. Furthermore, three bad debts totaling $22,150 that were not in our sampling frame were duplicate bad debts caused by incorrect adjustments.

BAD DEBTS NOT UNCOLLECTIBLE WHEN CLAIMED AS WORTHLESS

Federal regulations (42 CFR § 413.89(e)(3)) require that a bad debt be "actually uncollectible when claimed as worthless." Moreover, Federal regulations (42 CFR § 413.89(e)(4)) require that there be "no likelihood of recovery at any time in the future." Accordingly, a May 2, 2008, CMS Joint Signature Memorandum (JSM), entitled *Clarification of Medicare Bad Debt Policy/Bad Debt Policy Related to Accounts at a Collection Agency*, states that Medicare contractors are required to disallow Medicare bad debts for accounts at a collection agency.

The memorandum states that it has been CMS's longstanding policy that when an account is in collection, a provider cannot have determined the debt to be uncollectible and cannot have established that there is no likelihood of recovery under the regulations. That is, until a provider's reasonable collection effort has been completed, a Medicare bad debt may not be deemed as uncollectible. According to CMS, the collection policy supporting the regulation applies to a provider's entire collection effort, both in-house and by use of a collection agency.

Contrary to these regulations, we identified 33 unallowable bad debts totaling $45,273 for accounts that were still with a collection agency when written off. These bad debts did not meet the definition of "uncollectible" when claimed as worthless because they could still have been recovered in the future.

NON-COVERED SERVICES CLAIMED AND DUPLICATES

Federal regulations (42 CFR § 413.89(e)(1)) state that for a bad debt to be allowable, it must be related to covered services and derived from deductible and coinsurance amounts. Four bad debts totaling $32,843 in our sample were not derived from Medicare deductible and coinsurance amounts. Additionally, three bad debts totaling $22,150 were duplicate bad debts caused by incorrect adjustments.

[4] Three of these bad debts were for accounts that were still with a collection agency when written off, that did not meet the definition of uncollectible when claimed as worthless, and that were also included in the 33 bad debts in the previous bullet. A portion of these bad debts was recognized in each bullet, the sum of which was limited to the total bad debt claimed.

CONCLUSION

Our sample review identified 33 unallowable bad debts totaling $45,273 for accounts that were still with a collection agency when written off. Based on our sample results, we estimated that Erlanger claimed 490 such bad debts on its FY 2005 cost report, representing $438,328 in bad debts, and received $306,830 in related reimbursement. However, the May 2, 2008, JSM, stated that Medicare contractors whose practice had been since August 1, 1987, to allow hospitals to claim as bad debts accounts at a collection agency should not reopen cost reports to disallow bad debts that were improperly paid for this reason prior to May 2, 2008.[5] Therefore, we are not recommending a $438,328 reduction to the bad debt total claimed by Erlanger on its FY 2005 cost report or a refund of the $306,830 in related reimbursement. (See Appendix B for details on our sample results and estimates.)

Our review also identified 7 bad debts totaling $54,993 that were unallowable for other reasons specifically related to Erlanger's actions. Four bad debts totaling $32,843 in our sample were not derived from Medicare deductible and coinsurance amounts. (See Appendix C for details on our sample results.) Additionally, three bad debts totaling $22,150 that were not in our sampling frame were duplicate bad debts caused by incorrect adjustments. (See Appendix D for details on our non-sample results relating to duplicate bad debts.)

RECOMMENDATIONS

We recommend that Erlanger:

- request its fiscal intermediary reopen its 2005 hospital cost report to reduce Medicare bad debts by $54,993 and refund $38,495 in related overpayments,

- review its previously submitted FY 2008 cost report and ensure compliance with CMS's bad debt policy, and

- ensure that cost reports submitted in the future comply with CMS's bad debt policy.

ERLANGER MEDICAL CENTER COMMENTS

In written comments on our draft report, Erlanger agreed with our findings and recommendations pertaining to overpayments for bad debts that were not derived from Medicare deductible and coinsurance amounts or were duplicate bad debts caused by incorrect adjustments.

Erlanger disagreed with our finding regarding patient accounts that were claimed in Erlanger's FY 2005 cost report as Medicare bad debt while the accounts were still with a collection agency. Erlanger stated that these accounts were allowable Medicare bad debt

[5] In 1987 the fiscal intermediary for Tennessee allowed bad debt write-offs at the time patient accounts were sent to a collection agency. This practice was continued in Tennessee until May 2, 2008.

given the "bad debt moratorium" and the *Foothill Hospital v. Leavitt*, 558 F. Supp.2d 1 (D.C. 2008) decision.

Regarding our recommendation that Erlanger review its previously submitted FY 2008 cost report and ensure compliance with CMS's bad debt policy, as well as our recommendation that Erlanger ensure that cost reports submitted in the future comply with CMS's bad debt policy, Erlanger stated that it would ensure compliance with the laws and regulations governing Medicare bad debt policy. Erlanger's comments (minus attachments) are included as Appendix E.

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing Erlanger's comments, we maintain that our findings and recommendations are valid. Although we did not make any recommendation pertaining to patient accounts that were claimed in Erlanger's FY 2005 cost report as Medicare bad debt while the accounts were still with a collection agency, Erlanger's disagreement with our finding is not merely academic in light of Erlanger's response to our recommendations regarding the FY 2008 cost report and future cost reports. Erlanger appears to be drawing a distinction between "CMS's bad debt policy," with which it expressly disagrees, and the "laws and regulations governing Medicare bad debt policy," with which it purportedly agrees.

Our finding that patient accounts claimed in Erlanger's FY 2005 cost report as Medicare bad debt while the accounts were still with a collection agency were unallowable was based on Federal regulations (42 CFR §§ 413.89(e)(3) and (4)), which predated the bad debt moratorium. CMS's bad debt policy, expressed in its May 2, 2008, JSM, also is grounded in these regulations. The distinction Erlanger has drawn is not valid.

APPENDIXES

APPENDIX A: SAMPLING METHODOLOGY

POPULATION

The population consisted of Medicare Part A bad debts that were claimed on Erlanger Medical Center's FY 2005 hospital cost report.

SAMPLING FRAME

Erlanger Medical Center provided two Excel files supporting Part A and Part B Medicare bad debts claimed on its 2005 cost report. One file included Part A and Part B crossover bad debts, and the other file included Part A and Part B non-crossover bad debts. We separated the Part A and Part B data from each file and combined the two Medicare Part A bad debt worksheets to create a single Medicare Part A worksheet that comprised 1,825 line items. We removed 4 duplicate Medicare Part A bad debts totaling $23,026. The remaining 1,821 bad debts totaling $1,615,408 represented bad debts claimed on the cost report (excluding an offset for recoveries totaling $67,477). We sorted the bad debts in descending order and separated the 1,821 Medicare Part A bad debts as follows:

- 10 bad debts totaling $72,632 that were $3,000 or greater,
- 1,731 bad debts totaling $1,532,701 that were $500 or greater but less than $3,000,
- 69 bad debts totaling $16,668 that were less than $500, and
- 11 negative amounts for recoveries totaling ($6,593).

To avoid extreme variations in bad debts within our frame, we excluded the 80 bad debts totaling $10,075 that were less than $500. We then created a new excel file containing 1,741 bad debts $500 or greater totaling $1,605,333. This file is our sampling frame.

SAMPLE UNIT

The sample unit was a Medicare Part A bad debt.

SAMPLE DESIGN

We used a stratified random sample. We divided the sampling frame into two strata based on dollar value. Stratum 1 consisted of bad debts $500 or greater but less than $3,000. Stratum 2 consisted of all bad debts $3,000 or greater.

Stratum	No. of Claims in Sampling Frame
1 - $500 - $2,999	1,731
2 - ≥ $3,000	10
Total	**1,741**

SAMPLE SIZE

We randomly selected 100 bad debts $500 or greater but less than $3,000. We reviewed all 10 bad debts that were $3,000 or greater. The total sample size was 110.

Stratum	Sampling Items
1 - $500 - $2,999	100
2 - ≥ $3,000	10
TOTAL	110

SOURCE OF THE RANDOM NUMBERS

We generated the random numbers with the OIG/OAS statistical software.

METHOD FOR SELECTING SAMPLE ITEMS

We consecutively numbered the bad debts that were $500 or greater but less than $3,000 from 1 through 1,731. After generating 100 random numbers, we selected the corresponding frame items.

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to estimate the number and dollar value of unallowable bad debts claimed during fiscal year 2005.

APPENDIX B: SAMPLE RESULTS AND ESTIMATES FOR BAD DEBTS THAT WERE NOT UNCOLLECTIBLE WHEN CLAIMED AS WORTHLESS

SAMPLE RESULTS

Stratum	Frame Size	Value of Frame	Sample Size	Value of Sample	No. of Unallowable Bad Debts	Value of Unallowable Bad Debts
1 - $500 - $2,999	1,731	$1,532,701	100	$87,492	28	$24,099
2 - ≥ $3,000	10	72,632	10	72,632	5	21,174
TOTAL	**1,741**	**$1,605,333**	**110**	**$160,124**	**33**	**$45,273**

ESTIMATES

Estimated Unallowable Bad Debts

Limits Calculated for a 90-Percent Confidence Interval

	Estimated Value of Unallowable Bad Debts	Estimated No. of Unallowable Bad Debts
Point Estimate		
Stratum 1	$417,154	485
Stratum 2	21,174	5
TOTAL	**$438,328**	**490**
Lower Limit	$330,956	365
Upper Limit	$545,700	614

APPENDIX C: RESULTS FOR UNALLOWABLE BAD DEBTS RELATED TO ERLANGER'S ACTIONS

SAMPLE RESULTS

Stratum	Frame Size	Value of Frame	Sample Size	Value of Sample	No. of Unallowable Bad Debts	Value of Unallowable Bad Debts
1 - $500 - $2,999	1,731	$1,532,701	100	$87,492	0	$0
2 - ≥ $3,000	10	72,632	10	72,632	4	32,843
TOTAL	**1,741**	**$1,605,333**	**110**	**$160,124**	**4**	**$32,843**

APPENDIX D: RESULTS FOR UNALLOWABLE BAD DEBTS RELATED TO ERLANGER'S ACTIONS – DUPLICATES

NON-SAMPLE RESULTS

Dollar Value	No. of Potential Duplicates	Value of Potential Duplicates	No. of Duplicates Deemed Unallowable As Bad Debts	Value of Duplicates Deemed Unallowable As Bad Debts
1 - $500 - $2,999	3	$1,919	2	$1,043
2 - ≥ $3,000	1	21,107	1	21,107
TOTAL	**4**	**$23,026**	**3**	**$22,150**

APPENDIX E: ERLANGER MEDICAL CENTER COMMENTS

erlanger

May 10, 2010

By Email via the HHS/OIG Delivery Server

Peter J. Barbera
Regional Inspector General for Audit Services
Office of the Inspector General
Office of Audit Services, Region IV
61 Forsyth Street, SW, Suite 3T41
Atlanta, GA 30303

RE: Report Number: A-04-09-00057 – Review of Medicare Part A Bad Debts at Erlanger Medical Center for the Fiscal Year Ended June 30, 2005 and Report Number: A-04-09-000058 - Review of Medicare Part B Bad Debts at Erlanger Medical Center for the Fiscal Year Ended June 30, 2005

Dear Mr. Barbera-

This letter contains comments from Erlanger Medical Center on the March 30, 2010 and March 31, 2010 drafts reports concerning the Office of Inspector General's (OIG) audits of Medicare Parts A and B bad debts for fiscal year ended June 30, 2005. Erlanger Health System appreciates the brief extension to respond to these reports granted to Erlanger by Eric Bowen of your office as well as the opportunity to provide additional comments to be included in the final report. I understand that this response will be summarized in the body of the final report and also be included in its entirety as an appendix.

General Comments

With respect to being able properly to claim and be reimbursed for Medicare bad debts at the time when accounts were sent to a collection agency, Erlanger Medical Center is covered under the statutory Moratorium for Bad Debt Write-offs ("Moratorium"). Section 4008(c) of the Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203). The Centers for Medicare and Medicaid Services (CMS), has interpreted that Moratorium as applying when an intermediary was allowing the provider to write-off bad debts at the time they were sent to a collection agency prior to August 1, 1987. Under CMS policy, if an intermediary allowed unpaid Medicare accounts as bad debts prior to August 1, 1987

at the time when the accounts were sent to a collection agency, Medicare must continue applying that same principle in all subsequent years and may not disallow Medicare bad debts solely on the basis that the account was at a collection agency.

The determination that the Moratorium applied to Erlanger Medical Center was made by its Fiscal Intermediary (FI) at that time in 2005, as evidenced by the attached work papers from the FI dated July 15, 2005. (The finding that Erlanger was covered by the Moratorium with respect to claiming bad debts when an account was sent to a collection agency was presumably also reached in many prior bad debt audits at Erlanger occurring after Medicare first applied that policy in 1989.)

Irrespective of the FI's finding with respect to Erlanger's 2005 audit, Erlanger would be entitled to the benefit of the Moratorium under the holding in *Foothill Hospital v. Leavitt*, Medicare & Medicaid Guide (CCH) ¶ 302,432 (D.D.C., May 30, 2008). That case involved the same issue--the appealing hospital had claimed bad debts at the time that the accounts were sent to a collection agency. In ruling in favor of the hospital, the court stated:

> The original version of the Moratorium states that "the Secretary of Health and Human Services *shall not make any change in the policy* in effect on August 1, 1987." 42 U.S.C. §1395f note (emphasis added). The plain meaning of this sentence is that the Secretary is prohibited from making any changes in the agency's bad debt policy as it existed as of August 1, 1987.

The court then noted that the Medicare policy requiring accounts to be returned from a collection agency was not published until 1989 with a prospective effective date. Accordingly, the court concluded that an individual provider did not have to prove what an intermediary had allowed for it when it was plain that the agency's national policy in place prior to August 1, 1987 did not bar allowing an unpaid Medicare account as a bad debt at the time that the account was sent to a collection agency. If CMS believes that the *Foothill* case was wrongly decided, it had a right to appeal to the D.C. Circuit. CMS, however, opted not to appeal the *Foothill* decision, and thus, that decision stands as precedent in for the federal district court for Washington, D.C. Any provider can seek judicial review of CMS decisions in Washington, D.C., 42 U.S.C. § 1395oo (f). Accordingly, the precedent in the *Foothill* case applies to Erlanger.

Based both on the FI's conclusion that the Moratorium applies to Erlanger because of what Medicare allowed at Erlanger prior to August 1, 1987, and the court's decision in the *Foothill* case, OIG's conclusion that Erlanger's claim of unpaid Medicare accounts at the time that the accounts were referred to a collection agency was unallowable in any year is erroneous and should be eliminated from the report.

Response to Recommendations

- Erlanger will request a reopening for the FY2005 cost to reduce and refund those errors identified in the audit related to non-covered services mistakenly claimed as allowable bad debts and also those bad debts determined during the audit to have inadequate documentation to support the indigence determinations. The overpayments related to the Part A report total $38,495. The overpayments related to the Part B report total $34,545.

- Erlanger will also review its FY2008 cost report and ensure compliance with the laws and regulations governing Medicare bad debt policy and will also take steps to avoid including claims for bad debts on noncovered services or other nonallowable bad debts in future Medicare cost reports.

If you have any questions regarding this response, please feel free to contact me directly.

Respectfully,

Alana Sullivan

Alana Sullivan
Chief Compliance Officer
Erlanger Health System

Attachment