

**Department of Health and Human Services**

**OFFICE OF  
INSPECTOR GENERAL**

**REVIEW OF MEDICARE BAD DEBTS  
AT THE UNIVERSITY OF CALIFORNIA,  
SAN FRANCISCO MEDICAL CENTER**



**JANET REHNQUIST  
INSPECTOR GENERAL**

**JULY 2002  
A-09-02-00057**

# *Office of Inspector General*

<http://oig.hhs.gov/>

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**DEPARTMENT OF HEALTH & HUMAN SERVICES**

**Office of Inspector General**

**Region IX  
Office of Audit Services  
50 United Nations Plaza  
Room 171  
San Francisco, CA 94102**

July 8, 2002

Common Identification Number: A-09-02-00057

Mr. Kenneth Jones, CFO  
University of California, San Francisco Medical Center  
Administration Office  
500 Parnassus, Box 0296  
San Francisco, CA 94143

Dear Mr. Jones:

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), Office of Audit Services' (OAS) report entitled "Review of Medicare Bad Debts at the University of California, San Francisco Medical Center." A copy of this report will be forwarded to the action official noted below for her review and any action deemed necessary.

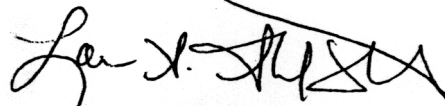
Final determination as to actions taken on all matters reported will be made by the HHS action official named below. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe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

In accordance with the principles of the Freedom of Information Act (5 U.S.C. 552, as amended by Public Law 104-231), OIG, OAS reports issued to the Department's grantees and contractors are made available to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act which the Department chooses to exercise. (See 45 CFR part 5.)

Page 2 – Mr. Kenneth Jones

To facilitate identification, please refer to Common Identification Number A-09-02-00057 in all correspondence relating to this report.

Sincerely,

A handwritten signature in black ink, appearing to read "Lori A. Ahlstrand", written over a horizontal line.

Lori A. Ahlstrand  
Regional Inspector General  
for Audit Services

Enclosures - as stated

**Directly Reply to HHS Action Official:**

Elizabeth Abbott, Regional Administrator  
Centers for Medicare & Medicaid Services, Region IX  
Office of the Regional Administrator  
75 Hawthorne Street, 4th Floor  
San Francisco, CA 94105

cc: Charlotte Canari, Director of Reimbursement,  
University of California, San Francisco Medical Center

**Department of Health and Human Services**

**OFFICE OF  
INSPECTOR GENERAL**

**REVIEW OF MEDICARE BAD DEBTS  
AT THE UNIVERSITY OF CALIFORNIA,  
SAN FRANCISCO MEDICAL CENTER  
(AUDIT PERIOD SEPTEMBER 1, 1999 – MARCH 31, 2000)**



**JANET REHNQUIST  
INSPECTOR GENERAL**

**JULY 2002  
A-09-02-00057**

# *Notices*

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In accordance with the principles of the Freedom of Information Act, 5 U.S.C. 552, as amended by Public Law 104-231, Office of Inspector General, Office of Audit Services, reports are made available to members of the public to the extent information contained therein is not subject to exemptions in the Act. (See 45 CFR Part 5.)

## **OAS FINDINGS AND OPINIONS**

The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed as well as other conclusions and recommendations in this report represent the findings and opinions of the HHS/OIG/OAS. Final determination on these matters will be made by authorized officials of the HHS divisions.





DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Region IX  
Office of Audit Services  
50 United Nations Plaza  
Room 171  
San Francisco, CA 94102

CIN: A-09-02-00057  
July 8, 2002

Mr. Kenneth Jones, CFO  
University of California, San Francisco Medical Center  
Administration Office  
500 Parnassus, Box 0296  
San Francisco, CA 94143

Dear Mr. Jones:

This final report provides you with the results of our review of inpatient Medicare bad debts at the University of California, San Francisco Medical Center (the 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 \$2,993,138 during the Hospital's cost report period ending March 31, 2000. Of the \$2,993,138 bad debts claimed, a net amount of \$2,432,833 did not meet the Medicare reimbursement requirements. Specifically, we found:

- \$2,439,501 that was previously paid through a settlement agreement,
- \$60,000 that was overstated because of a data entry error, and
- \$66,668 that was understated because the net bad debt amount was calculated incorrectly.

We recommend that the Hospital:

- amend its March 31, 2000 cost report by reducing the bad debts claimed from \$2,993,138 to \$560,305, and
- establish procedures to help ensure accuracy of Medicare bad debts claimed on future cost reports.

In written response to our draft report, the Hospital concurred with our findings and recommendations. We summarized the Hospital's comments at the end of the FINDINGS AND RECOMMENDATIONS section of the report. The complete text of the Hospital's comments is included as an APPENDIX to this report.

## INTRODUCTION

### BACKGROUND

Medicare has had a long standing policy that beneficiaries should share in the costs of their own medical care through various deductibles and coinsurance amounts. For example, during Calendar Year 2000, the Medicare patient was liable for a \$776 deductible for each benefit period in which he/she was admitted to a hospital. Also, the patient was liable for \$198 coinsurance per day for the 61<sup>st</sup> through the 90<sup>th</sup> 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. For the amounts the hospitals were unable to collect (bad debts), beginning in 1966 Medicare reimbursed hospitals retrospectively under reasonable cost principles. In 1983, inpatient hospital care was reimbursed under a prospective payment system (PPS). Under Medicare's PPS, bad debts are paid as 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 debts for cost reporting periods beginning during Federal Fiscal Year (FFY) 1998 was reduced 25 percent. For FFY 1999, the amount of allowable bad debts was reduced 40 percent, and for FFY 2000, it was reduced 45 percent. For the FFYs subsequent to FFY 2000, it will be reduced 30 percent.

### Federal Regulations

Hospitals can be reimbursed if bad debts meet Medicare reimbursement criteria. Generally, bad debts must meet the following criteria, as set forth in 42 Code of Federal Regulations (CFR) 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.

***Centers for Medicare & Medicaid Services Guidance.*** The Centers for Medicare & Medicaid Services (CMS) Medicare Provider Reimbursement Manual (PRM), part I, 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.

According to the PRM, part I, section 304, Medicare will reimburse a provider for any allowable bad debts resulting from uncollectible deductibles and coinsurance amounts. Medicaid<sup>1</sup> may pay for a Medicare beneficiary's coinsurance or deductible through Medicaid cost sharing. These beneficiaries and their claims are often referred to as crossovers.

### **The Hospital**

The Hospital provided primary care at two main locations in the city of San Francisco, California: the Parnassus and Mount Zion sites. Also, the Hospital provided services through satellite facilities located in five different cities in California. Over the last three cost reporting periods, the Hospital claimed inpatient bad debts for reimbursement as follows:

<b>Federal Fiscal Year<sup>2</sup></b>	<b>Cost Reporting Period</b>	<b>Total Inpatient Bad Debts Claimed<sup>3</sup></b>
1998	11/1/1997 – 8/31/1998	\$0
1998	9/1/1998 – 8/31/1999	\$497,612
1999	9/1/1999 – 3/31/2000	\$2,993,138

### **OBJECTIVE, SCOPE AND METHODOLOGY**

We performed our audit in accordance with generally accepted government auditing standards issued by the Comptroller General. Our objective was to determine if the Hospital claimed bad debts on its cost report that met Medicare requirements. Our audit focused on bad debts claimed on the Medicare cost report submitted by the Hospital, for the cost reporting period September 1, 1999 through March 31, 2000.

The audit was performed as part of a nationwide audit of Medicare inpatient bad debts. We judgmentally selected the Hospital for review because it claimed the largest amount of bad debts in CMS' Regions IX and X. Also, the Hospital had a substantial increase in bad debts claimed from FFY 1998 to 1999.

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<sup>1</sup> In the State of California, Medicaid is referred to as the Medi-Cal program. In this report, we use the term Medi-Cal to refer to the Medicaid program.

<sup>2</sup> Federal fiscal year is determined by the beginning date of the cost reporting period.

<sup>3</sup> Amounts claimed on the Hospital cost report, Worksheet E, Part A, line 21. The Hospital only claimed inpatient crossover claims as Medicare bad debts. Because of a settlement issue in the State of California, no crossover claims were processed by the State from May 1, 1994 to April 4, 1999. See settlement details on page 5.

To accomplish our objectives, we:

- reviewed criteria related to Medicare bad debts and Medicare’s accounting requirements,
- reviewed the Hospital’s collection and write-off policies and procedures used to accumulate bad debt amounts for the cost report,
- interviewed CMS and California State officials,
- interviewed Hospital and Medicare fiscal intermediary<sup>4</sup> officials,
- examined the Hospital’s Medicare bad debts listing supporting the Medicare cost report, and
- examined the Medi-Cal Remittance Advice used to support the Medicare bad debts listing by the Hospital.

We reviewed the internal controls associated with the Hospital’s process for establishing and writing off bad debts. Also, we reviewed the Medicare fiscal intermediary’s prior audit working papers to identify prior audit findings.

Our fieldwork was performed at the Hospital during February 2002. Additional information was provided by the Hospital and the fiscal intermediary through April 2002.

## **FINDINGS AND RECOMMENDATIONS**

### **BAD DEBTS CLAIMED**

The Hospital claimed bad debts<sup>5</sup> in its March 31, 2000 cost report that did not meet Medicare reimbursement requirements. Of the \$2,993,138 claimed as bad debts, the Hospital included: (1) \$2,439,501 that was previously paid through a settlement agreement, (2) \$60,000 that was overstated because of a data entry error, and (3) \$66,668 that was understated because the net bad debt amount was calculated incorrectly.

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<sup>4</sup> The fiscal intermediary for the Hospital is United Government Services, LLP, located in Camarillo, California.

<sup>5</sup> The Hospital claimed only inpatient crossover (patients that are both Medicare and Medicaid eligible) bad debts in FY 2000. Medicare only and outpatient Medicare bad debts were not claimed because of the costs of processing the claims.

### **Bad Debts Included in Prior Settlement Agreement**

The Hospital overstated bad debts on its March 2000 cost report by \$2,439,501. This overstatement occurred because the Hospital did not ensure that inpatient crossover bad debts claimed in a prior settlement period were excluded from the March 2000 cost report.

***Review of Bad Debts Claimed.*** The Hospital claimed inpatient crossover bad debts in its March 2000 cost report that totaled \$2,993,138. Our review identified \$2,439,501 for claims with service dates from May 1994 to March 1999. Our comparison of the settlement listing provided by the fiscal intermediary to the bad debts log provided by the Hospital indicated that the claims were duplicated. Therefore, the bad debt amount of \$2,439,501 should be deducted from the \$2,993,138 that was claimed.

***Settlement Background.*** From May 1, 1994 through April 4, 1999, Medicare denied reimbursement for bad debts attributable to coinsurance and deductible amounts for all crossover claims. Medicare would allow bad debts after the State determined how much of the crossover coinsurance and deductibles Medi-Cal should pay under the State Plan. However, in order to determine Medi-Cal's portion, CMS expected the State to perform a claim-by-claim comparison. To resolve this issue, the State reprocessed inpatient crossover claims from May 1994 to March 1999. Medicare used this information to determine its portion of the settlement to be paid to the providers for Medicare bad debts. After April 4, 1999, crossover bad debts were to be claimed and documented by the provider and reviewed by the intermediary in accordance with standard Medicare policy.

On April 1, 1999, CMS notified the Hospital that it would receive an initial retroactive lump-sum payment in the amount of \$877,224. On September 8, 1999, CMS made a final settlement payment of \$1,691,002 for a total amount of \$2,568,226. These settlement payments were reported by the Hospital on its August 1999 cost report (Worksheet E, Part A, line 24 "Retroactive Crossover Bad Debt Payment").

### **Reconciliation Bad Debt Log to Cost Report**

The Medicare bad debts log did not reconcile to the March 2000 cost report. The cost report was overstated by \$60,000. Hospital officials informed us that this was a data entry error. To correct the error, the Hospital notified the fiscal intermediary on February 12, 2002 but did not file an amended cost report.

### **Methodology for Calculating Bad Debts**

The Hospital made an error in calculating bad debts. It erroneously deducted some amounts twice. This error caused bad debts claimed to be understated by \$66,668.

**Summary of Results**

Bad debts were overstated by \$2,432,833 in the March 31, 2000 cost report. The following schedule summarizes the results of our audit:

Medicare Bad Debts Claimed	\$2,993,138
Duplication of Settlement	(\$2,439,501)
Reconciliation Error	(\$60,000)
Calculation Error	\$66,668
Allowable Bad Debts	<u>\$560,305</u>

**Recommendations**

We recommend that the Hospital:

- amend its March 31, 2000 cost report by reducing the bad debts claimed from \$2,993,138 to \$560,305, and
- establish procedures to help ensure accuracy of Medicare bad debts claimed on future cost reports.

**HOSPITAL COMMENTS**

In response to our draft report, the Hospital concurred with our findings and recommendations. The Hospital emphasized that this error was inadvertent and caused by confusion between the State’s actions and the fiscal intermediary instructions for implementation of the settlement. Also, the Hospital stated that the error was a “one time event” and is not an ongoing issue for subsequent cost reporting years.

The complete text of the Hospital’s comments is included as an APPENDIX to this report.

\* \* \* \* \*

In accordance with the principles of the Freedom of Information Act (5 U.S.C. 552, as amended by Public Law 104-231), OIG, OAS reports issued to the Department’s grantees and contractors are made available to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act which the Department chooses to exercise. (See 45 CFR Part 5.)

Page 7 – Mr. Kenneth Jones, CFO

To facilitate identification, please refer to Common Identification Number A-09-02-00057 in all correspondence relating to this report.

Sincerely,

A handwritten signature in black ink, appearing to read "Lori A. Ahlstrand". The signature is fluid and cursive, with a large, stylized initial "L" and "A".

Lori A. Ahlstrand  
Regional Inspector General  
for Audit Services

## **APPENDIX**

University of California  
San Francisco



Medical Center

June 24, 2002

Administration  
500 Parnassus Avenue  
San Francisco, CA 94143-0296  
tel: 415/353-2733  
fax: 415/353-2785  
TTY: 415/885-3688

Ms. Lori Ahlstrand  
Regional Inspector General for Audit Services  
Department of Health and Human Services  
Office of Inspector General  
Region IX  
50 United Nations Plaza, Room 171  
San Francisco, CA 94102

**Re: UCSF Medical Center  
Review of Medicare Bad Debts  
PE 3/31/2000  
Common Identification Number A-09-0200057**

Dear Ms. Ahlstrand:

We have received your draft report entitled "Review of Medicare Bad Debts at the University of California, San Francisco Medical Center" and appreciate the opportunity to provide our comments before the final report is issued. We suggest the following changes for your consideration.

1) We believe the draft report does not present sufficient descriptive narrative related to the facts and implementation of the settlement agreement entered into between Beverly Community Hospital Association and California Department of Health Services ("Settlement Agreement") that led to the oversight of the claim in the filed cost report. Specifically, the background narrative of your Review should address the Settlement Agreement as a "one time event". Therefore, this specific error is not an ongoing issue for subsequent cost reporting years.

2) Clearly the error was inadvertent and caused by confusion between the State of California ("State") actions and Medicare Intermediary ("Intermediary") instructions for implementation of the Settlement Agreement. The implementation of the Settlement Agreement called for the State to reprocess claims, for the period May 1, 1994 through April 4, 1999, to determine final Medi-Cal liability before the Intermediary was to issue Medicare settlement amounts. The Intermediary's September 8, 1999 letter indicated that the State had completed the reprocessing and was therefore issuing settlement amounts. In fact, the State reprocessed the claims on a remittance dated December 6, 1999, 3 months after the issued settlement. This delay in claim reprocessing,

Ms. Lori Ahlstrand  
Review of Bad Debts, PE 3/31/00

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06/24/02

coupled with additions to Intermediary instructions for remittances processed after the April 5, 1999 contributed to the error. We believe these issues need to be included in the report.

3) In its September 8, 1999 letter to all Medicare providers, the Intermediary noted that State remittances processed after April 5, 1999 would be reimbursed in accordance with standard Medicare policy on bad debts, because remittances processed after April 5, 1999 were not part of the settlement amounts. UCSF believed that the State had completed its reprocessing before September 1999 as noted in the Intermediary letter that accompanied the settlement. UCSF prepared a log of State remittances processed after April 5, 1999. The log for the fiscal period under review included State processed remittances that began with a remittance dated September 7, 1999 and ended with a remittance dated March 27, 2000. Using State processed remittance dates as a primary basis for reporting bad debt amounts, UCSF inadvertently included the December 6, 1999 remittance that included State reprocessed claims from the Settlement Agreement. We believe this is important information to include in the final report.

Recommendations:

- We agree with the Office of Audit Services' recommendation that UCSF amend the March 31, 2000 cost report to incorporate the reduction of bad debts from the reported \$2,993,139 to the revised amount of \$560,305.
- We have revised our procedures to assure that allowable Medicare bad debts are accurate for future cost report years.

Should you have any questions please do not hesitate to call me at 415-353-2742.

Sincerely,



Ken Jones  
Chief Financial Officer

cc: Elizabeth Abbott, CMS  
Charlotte Canari, UCSF  
Marcia Canning, UCSF  
Harry Cordon, UCSF  
Mark Laret, UCSF  
John Lundberg, UCSF  
James Okura, CMS