

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**PROVIDERS DID NOT ALWAYS  
COMPLY WITH FEDERAL  
REQUIREMENTS WHEN CLAIMING  
MEDICARE BAD DEBTS**

*Inquiries about this report may be addressed to the Office of Public Affairs at  
[Public.Affairs@oig.hhs.gov](mailto:Public.Affairs@oig.hhs.gov).*



Amy J. Frontz  
Deputy Inspector General  
for Audit Services

December 2022  
A-07-20-02825

# *Office of Inspector General*

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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.

## Report in Brief

Date: December 2022

Report No. A-07-20-02825

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES  
**OFFICE OF INSPECTOR GENERAL**



### Why OIG Did This Audit

Providers sought reimbursement of nearly \$10 billion for Medicare bad debts on their cost reports with cost reporting periods ending during Federal fiscal years 2016 through 2018. Federal regulations state that Medicare is to reimburse providers 65 percent of deductible and coinsurance amounts for Medicare beneficiaries that remain unpaid (1) after the provider has made a reasonable effort to collect, (2) the debt was uncollectible, and (3) there was no likelihood of future recovery based on sound business judgment ("Medicare bad debts").

Our objectives were to determine whether (1) providers complied with Federal requirements when claiming Medicare reimbursement for Medicare bad debts and (2) providers' policies and procedures for collecting from beneficiaries Medicare deductible and coinsurance amounts that providers claimed as Medicare bad debts complied with Federal requirements.

### How OIG Did This Audit

We randomly selected 67 cost reports in which providers claimed Medicare bad debts. We selected a nonstatistical sample of 148 bad debts and reviewed the providers' documentation of the collection efforts performed.

We reviewed the sampled providers' policies and procedures for collecting Medicare bad debts to ensure that the policies and procedures included reasonable collection efforts.

## Providers Did Not Always Comply With Federal Requirements When Claiming Medicare Bad Debts

### What OIG Found

Providers did not always comply with Federal requirements when claiming Medicare reimbursement for Medicare bad debts. Of the 148 Medicare bad debts in our nonstatistical sample, 86 were associated with beneficiaries whom providers had deemed indigent and for whom, therefore, no reasonable collection efforts were required. Providers did not comply with Federal requirements when claiming 18 of the remaining 62 Medicare bad debts. We identified four additional bad debts for which the amounts that providers claimed did not reflect the amounts owed by the beneficiaries. These 22 bad debts resulted in a total of \$29,787 in unallowable Medicare reimbursement. The Centers for Medicare & Medicaid Services (CMS) inappropriately reimbursed these amounts because the Medicare administrative contractors (MACs) did not concentrate on reviewing bad debts when performing audits of cost reports during our audit period.

For our second objective, the 67 selected providers' policies and procedures for collecting from beneficiaries Medicare deductible and coinsurance amounts that providers claimed as Medicare bad debts complied with Federal requirements. These policies and procedures were similar to the providers' policies and procedures for collecting non-Medicare bad debts.

### What OIG Recommends and CMS Comments

We recommend that CMS consider issuing instructions or guidance to the MACs that require or encourage more review of Medicare bad debts claimed on cost reports, such as defining thresholds beyond which individual Medicare bad debts would trigger an audit, and that directs the MACs to revise their cost report audit work plans accordingly.

CMS concurred with our recommendation and stated that it would consider our findings when issuing future guidance to the MACs regarding the review of Medicare bad debts, taking into account budgetary constraints and competing priorities for the MACs.

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## INTRODUCTION

### WHY WE DID THIS AUDIT

Providers sought reimbursement of nearly \$10 billion for Medicare bad debts on their cost reports with cost reporting periods ending during Federal fiscal years 2016 through 2018 (audit period). Under Medicare Parts A and B, beneficiaries may be responsible for coinsurance and deductible amounts related to claims; however, some beneficiaries may not be able or willing to pay those outstanding amounts. Federal regulations state that Medicare is to reimburse providers 65 percent of deductible and coinsurance amounts (Medicare reimbursable amounts) payable by Medicare beneficiaries that remain unpaid (1) after the provider has made a reasonable effort to collect, (2) the debt was uncollectible, and (3) there was no likelihood of future recovery based on sound business judgment (“Medicare bad debts”).<sup>1</sup>

### OBJECTIVES

Our objectives were to determine whether (1) providers complied with Federal requirements when claiming Medicare reimbursement for Medicare bad debts and (2) providers’ policies and procedures for collecting from beneficiaries Medicare deductible and coinsurance amounts that providers claimed as Medicare bad debts complied with Federal requirements.

### BACKGROUND

#### Medicare Program

Medicare provides health insurance for people aged 65 and over, people with disabilities, and people with permanent kidney disease. Medicare Part A provides inpatient hospital insurance benefits and coverage for extended care services for patients after discharge, and Medicare Part B provides supplementary medical insurance for medical and other health services, including coverage of therapy services. The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program. CMS contracts with Medicare administrative contractors (MACs) to, among other things, process and pay claims submitted by health care providers.

#### Medicare Bad Debts

Under Medicare Parts A and B, beneficiaries may be responsible for coinsurance and deductible amounts related to claims; however, some beneficiaries may not be able or willing to pay those outstanding amounts. Federal regulations state that Medicare reimburses providers 65 percent of Medicare deductible and coinsurance amounts that qualify as Medicare bad debts (42 CFR § 413.89). In order for unpaid Medicare deductible and coinsurance amounts to qualify as

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<sup>1</sup> Bad debts are defined as amounts considered to be uncollectible from accounts and notes receivable that are created or acquired in providing services (*Provider Reimbursement Manual—Part 1*, CMS Pub. No. 15-1, § 302). Throughout this report, we use the terms “Medicare bad debt(s)” and “bad debt(s)” interchangeably as appropriate, depending on their context.

Medicare bad debts eligible for reimbursement, the provider must be able to establish that reasonable collection efforts were made, the debt was actually uncollectible when claimed as worthless, and there was no likelihood of future recovery based on sound business judgment (42 CFR § 413.89(e)).<sup>2</sup>

According to Federal requirements, to be considered reasonable, a provider's efforts to collect Medicare deductible and coinsurance amounts must be similar to the efforts the provider puts forth to collect comparable amounts from non-Medicare patients. The collection effort must involve the issuance of a bill, on or shortly after the discharge or death of the beneficiary, to the party responsible for the beneficiary's personal financial obligations. This effort also includes other actions such as subsequent billings, collection letters, telephone calls, or personal contacts with the responsible party. These actions must constitute a genuine, rather than a token, collection effort (*Provider Reimbursement Manual—Part 1*, CMS Pub. No. 15-1, § 310).

In some cases, providers may have established before discharge, or within a reasonable time before the current admission, that the beneficiary was indigent. Providers can deem Medicare beneficiaries indigent when such individuals have also been determined eligible for Medicaid. Otherwise, providers should apply their customary methods that comport with Medicare guidelines for determining indigence of patients. Once indigence is determined and the provider concludes that there has been no improvement in the beneficiary's financial condition, the debt may be deemed uncollectible without applying reasonable collection efforts (*Provider Reimbursement Manual—Part 1*, § 312).

## **Medicare Cost Reports**

Providers submit cost reports to their MACs annually. Cost reports are based on the providers' financial and statistical records and, among other purposes, serve as the mechanism for providers to claim reimbursement for Medicare bad debts. To support the total amount of Medicare bad debts claimed on their cost reports, providers also submit to their MACs lists of Medicare bad debts, which contain much of the information the MACs need to determine the allowability of the claimed Medicare bad debts (for hospitals, e.g., *Provider Reimbursement Manual—Part 2*, CMS Pub. No. 15-2, § 4004.2, line 12). Providers attest to the accuracy of the data when submitting their cost reports.

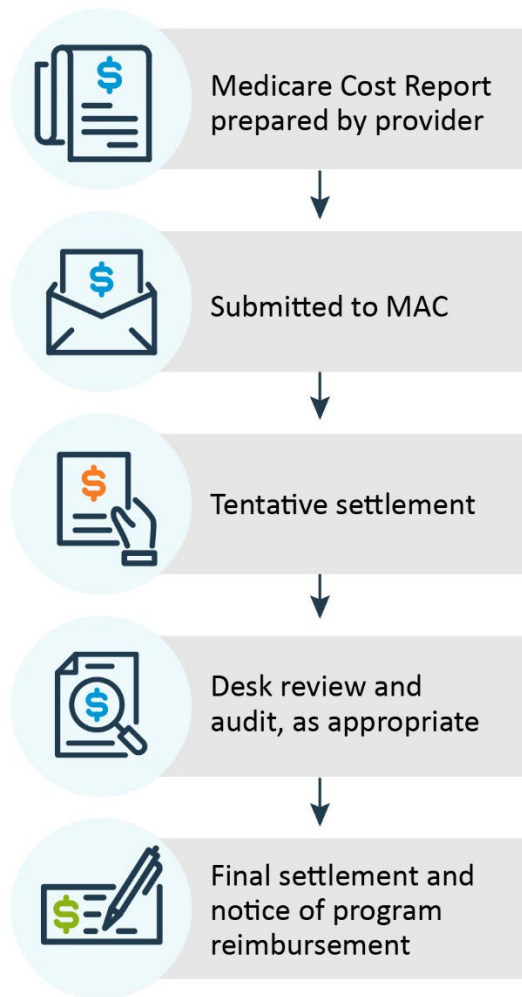
After acceptance of each cost report, the MAC performs a tentative settlement, then performs a desk review of the cost report and conducts an audit, as appropriate, before final settlement. The MAC then issues a Notice of Program Reimbursement to the provider. As the final settlement document, this notice shows whether payment is owed to the provider or to the Medicare program.

The figure on the following page depicts the Medicare cost report submission, review, and settlement process.

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<sup>2</sup> CMS revised 42 CFR § 413.89 after our audit period. 85 Fed. Reg. 58432, 58989-59006, 59023 (Sep. 18, 2020).

**Figure: Medicare Cost Report Process**



### **Medicare Administrative Contractor Cost Report Reviews**

CMS relies on MACs to serve as the primary operational contact between the Medicare fee-for-service program and the health care providers enrolled in the program. MACs perform many administrative activities, including desk reviews and audits of cost reports.

MACs are required to conduct desk reviews of cost reports for all providers that file a Medicare cost report, with the exception of cost reports for hospices and low- or no-Medicare-utilization providers. A desk review is an analysis of the provider's cost report to evaluate its adequacy and completeness and determine the accuracy and reasonableness of the data contained in the cost report. It is a process of reviewing information pertaining to the cost report without detailed verification and is designed to identify issues that may warrant additional review and, where appropriate, to resolve some of those problems or exceptions. A desk review thus aims to determine whether the cost report can be settled without an audit or whether an in-house or field audit is necessary (*Medicare Financial Management Manual*, CMS Pub. No. 100-06, chapter 8, § 20.1).



At its discretion, a MAC may also perform an audit of a Medicare cost report. An audit is an examination of financial transactions, accounts, and reports as they relate to the cost report in order to test the provider's compliance with applicable Medicare laws, regulations, CMS Manual instructions, and directives. The *Medicare Financial Management Manual*, chapter 8, section 40, states that a MAC's audit work plan and selection process, while influenced by budgetary restrictions imposed by CMS and CMS guidance about the types of providers or potential issues to be audited, is generally based on the MAC's professional judgment in determining which provider represents the greatest risk of incorrect payment.

## HOW WE CONDUCTED THIS AUDIT

We used the Healthcare Cost Report Information System (HCRIS) data to identify all cost reports that covered provider cost reporting periods ending during Federal fiscal years 2016 through 2018 and that claimed reimbursement for Medicare bad debts. This resulted in 65,621 cost reports totaling \$15,109,635,025 in Medicare bad debts, with a Medicare reimbursable amount of \$9,821,264,932. From these cost reports, we randomly selected 67 cost reports based on provider type and the dollar amount of bad debt,<sup>3</sup> which resulted in the following provider type counts: 29 hospitals, 18 skilled nursing facilities, 10 renal dialysis facilities, 4 federally qualified health centers, 4 rural health centers, and 2 community mental health centers. Note that the 67 randomly selected cost reports were from 67 distinct providers, and that the Medicare bad debts for these cost report totaled \$21,318,510 (\$13,857,031 Medicare reimbursable).

From the lists of bad debts that providers submitted with the 67 randomly selected cost reports, we selected the largest and smallest bad debts on each list, and judgmentally selected an additional 14 large bad debts from providers whose policies and procedures we considered to be at high risk for error, which resulted in a nonstatistical sample of 148 bad debts totaling \$450,687 (\$292,947 Medicare reimbursable). For our first objective, we reviewed the providers' documentation of the collection efforts performed for the nonstatistical sample of bad debts.

We contacted the individual MACs responsible for reviewing the sampled cost reports to identify what level of review (i.e., desk review or audit) the MACs performed on the Medicare bad debts that the providers reported.

For our second objective, we obtained the sampled providers' policies and procedures for collecting Medicare bad debts and reviewed them to ensure that the policies and procedures included reasonable collection efforts. We also judgmentally selected 15 non-Medicare bad

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<sup>3</sup> The nine groups of cost reports were: (1) hospital cost reports claiming reimbursement less than or equal to \$199,270, (2) hospital cost reports claiming greater than or equal to \$199,335, (3) skilled nursing facility cost reports claiming less than or equal to \$37,120, (4) skilled nursing facility cost reports claiming greater than or equal to \$37,124, (5) renal dialysis facility cost reports claiming less than or equal to \$35,609, (6) renal dialysis facility cost reports claiming greater than or equal to \$35,611, (7) all Federally qualified health center cost reports, (8) all rural health center cost reports, and (9) all community mental health center cost reports.

debts (from 6 of the randomly selected providers) with dollar amounts that were comparable to the dollar amounts for Medicare bad debts in the nonstatistical sample. We then reviewed the associated documentation for the non-Medicare collection efforts to ascertain whether the providers' collection efforts on Medicare bad debts were similar.

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 objectives.

Appendix A contains details of our audit scope and methodology.

## **FINDINGS**

Providers did not always comply with Federal requirements when claiming Medicare reimbursement for Medicare bad debts. Of the 148 Medicare bad debts in our nonstatistical sample, 86 bad debts were associated with beneficiaries whom providers had deemed indigent and for whom, therefore, no reasonable collection efforts were required. Of the remaining 62 Medicare bad debts that providers claimed for reimbursement and that required reasonable collection efforts, providers did not comply with Federal requirements when claiming 18 Medicare bad debts. We identified four additional bad debts for which the amounts that providers claimed did not reflect the amounts owed by the beneficiaries. These 22 bad debts resulted in a total of \$29,787 in unallowable Medicare reimbursement. CMS inappropriately reimbursed these amounts because the MACs did not concentrate on reviewing bad debts when performing audits of cost reports during our audit period. Although Federal regulations and CMS Manuals address provider and MAC responsibilities with respect to collection efforts for Medicare bad debts and audits of Medicare cost reports, our findings suggest that more specific requirements or guidance could provide enhanced, and feasible, stewardship of Federal health care dollars.

With respect to our second objective, the 67 selected providers' policies and procedures for collecting from beneficiaries Medicare deductible and coinsurance amounts that providers claimed as Medicare bad debts complied with Federal requirements. Specifically, we determined that these providers' policies and procedures for collecting Medicare deductible and coinsurance amounts were similar to their policies and procedures for collecting non-Medicare bad debts.

## PROVIDERS DID NOT ALWAYS COMPLY WITH FEDERAL REQUIREMENTS WHEN CLAIMING MEDICARE REIMBURSEMENT FOR MEDICARE BAD DEBTS

### Providers Did Not Always Perform Reasonable Collection Efforts

Federal regulations define bad debts as amounts considered to be uncollectible from accounts and notes receivable that were created or acquired in providing services (42 CFR § 413.89(b)).

Federal regulations specify that bad debt must meet the following criteria to be allowable for Medicare reimbursement: (1) the debt must be related to covered services and be derived from deductible and coinsurance amounts, (2) the provider must be able to establish that reasonable collection efforts were made, (3) the debt was actually uncollectible when claimed as worthless, and (4) sound business judgment established that there was no likelihood of recovery at any time in the future (42 CFR § 413.89(e)).

Federal regulations reduce the amount of the allowable bad debts by 35 percent of the total (42 CFR § 413.89(h)).

The *Provider Reimbursement Manual* states that reasonable collection efforts are not required once indigence is determined; this guidance also specifies the requirements for determining indigence (part 1, § 312).

The *Medicare Financial Management Manual*, chapter 8, provides guidance to MACs on the development of work plans and the selection process to audit Medicare cost reports that providers have submitted.

Of the 148 Medicare bad debts in our nonstatistical sample, 86 bad debts were associated with beneficiaries whom providers had deemed indigent and for whom, under the provisions of the *Provider Reimbursement Manual*, section 312, no reasonable collection efforts were required.<sup>4</sup> Of the other 62 Medicare bad debts that providers claimed for reimbursement and that required reasonable collection efforts, providers were able to establish that reasonable collection efforts were made for 44 Medicare bad debts. However, providers did not comply with Federal requirements when claiming the remaining 18 Medicare bad debts. Of these, we identified 2 Medicare bad debts (both of which were associated with the same provider) for which the provider acknowledged not performing any of the required reasonable collection efforts and an additional 16 Medicare bad debts for which the providers were unable to provide supporting documentation to establish that reasonable collection efforts had been made. These 18 Medicare bad debts totaled \$44,806 and resulted (after the 35-percent reduction mandated by 42 CFR § 413.89(h)) in \$29,124 of unallowable Medicare reimbursement.

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<sup>4</sup> Of these 86 beneficiaries, providers deemed 82 beneficiaries to be indigent based on their Medicaid eligibility. Providers deemed the other four beneficiaries to be indigent after analyzing the beneficiaries' resources.

CMS inappropriately reimbursed the \$29,124 (associated with 18 bad debts) that we identified because the MACs did not concentrate on reviewing bad debts when performing audits of cost reports during our audit period. Specifically, the MACs performed audits that included a review of some individual bad debts on only 2 of the 9 cost reports in which these 18 bad debts were claimed. Neither of these two audits included a review to ensure that providers performed reasonable collection efforts. Moreover, the MACs did not perform a review to ensure that providers performed reasonable collection efforts on any of 67 randomly selected cost reports.

### **Providers Claimed Medicare Bad Debts That Did Not Reflect Amounts Owed by Beneficiaries**

In addition to the 18 bad debts discussed above, we identified 4 bad debts for which the amounts that providers claimed did not reflect the amounts owed by the beneficiaries. For example, one provider stated that the bad debt amount was mis-keyed when the amount was entered on the provider's bad debt list, and that as a result, the provider claimed less than the actual coinsurance amount.

Therefore, the providers claimed inaccurate amounts on their Medicare cost reports: providers overstated two Medicare bad debts by a total of \$1,794 and understated another two by a total of \$774. These four Medicare bad debts thus resulted in a net overstatement of \$1,020 and \$663 in net unallowable Medicare reimbursement. For the remaining 144 Medicare bad debts, the amounts for which the providers requested Medicare reimbursement reflected the amounts of the debts owed by the beneficiaries.

CMS inappropriately reimbursed the \$663 (associated with four bad debts) that we identified because the MACs did not concentrate on reviewing bad debts when performing audits of cost reports during our audit period. Specifically, the MACs performed audits that included a review of some individual bad debts on only two of the four cost reports that had inaccurate amounts.

### **PROVIDERS' POLICIES AND PROCEDURES FOR COLLECTING MEDICARE DEDUCTIBLE AND COINSURANCE AMOUNTS DEEMED TO BE BAD DEBTS COMPLIED WITH FEDERAL REQUIREMENTS**

According to Federal requirements, to be considered a reasonable collection effort, 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. It must involve the issuance of a bill, on or shortly after discharge or death of the beneficiary, to the party responsible for the beneficiary's personal financial obligations. It also includes other actions such as subsequent billings, collection letters, and telephone calls or personal contacts with the responsible party that constitute a genuine, rather than a token, collection effort. The provider's collection effort may include using or threatening to use court action to obtain payment (*Provider Reimbursement Manual—Part 1*, § 310).

With respect to our second objective, the 67 selected providers' policies and procedures for collecting from beneficiaries Medicare deductible and coinsurance amounts that providers claimed as Medicare bad debts complied with Federal requirements. Specifically, we determined that these providers' policies and procedures for collecting Medicare deductible and coinsurance amounts were similar to their policies and procedures for collecting non-Medicare bad debts.

As part of our evaluation of the policies and procedures for these 67 providers, we reviewed the collection efforts related to 15 non-Medicare bad debts from 6 of the same providers included in our sample. We determined that, as directed in section 310 of the *Provider Reimbursement Manual*, the collection efforts for these 15 non-Medicare bad debts were similar in the types and extent of the collection efforts that we had observed for those providers' comparable Medicare bad debts.

The policies and procedures for the 67 providers associated with the randomly selected cost reports described (as depicted in the table below) the following types of possible collection efforts (providers almost always used 2 or more types of collection efforts):

**Table: Types of Collection Efforts Described in Randomly Selected Providers' Policies and Procedures**

Types of Collection Efforts	Number of Providers
Subsequent billings	67
Collection letters	49
Telephone calls	52
Other personal contacts	8
Referral to collection agencies	49
Court action	35

### RECOMMENDATION

We recommend that CMS consider issuing instructions or guidance to the MACs that require or encourage more review of Medicare bad debts claimed in cost reports, such as defining thresholds beyond which individual Medicare bad debts would trigger an audit, and that directs the MACs to revise their cost report audit work plans accordingly.

### CMS COMMENTS

In written comments on our draft report, CMS concurred with our recommendation. CMS also stated that it would consider our findings when issuing future guidance to the MACs regarding the review of Medicare bad debts, taking into account budgetary constraints and competing priorities for the MACs. CMS's comments appear in their entirety as Appendix B.

## OTHER MATTERS

During our audit we noted some instances in which providers complied with Federal requirements (see our first objective) but did not follow their own internal policies and procedures when collecting Medicare coinsurance and deductibles from beneficiaries. Of the 148 Medicare bad debts in our nonstatistical sample, the collection efforts that providers performed did not align with their policies for 29 of the bad debts. For example, one provider's policy included a procedure to contact beneficiaries telephonically to inform them of the amounts due; however, for one of the beneficiaries in our sample, this provider had documentation only of statements mailed to the beneficiary and had no documentation of any phone calls. We identified another example of misalignment in which the provider's policy included offering financial assistance if the beneficiary was unable to pay; however, this provider had no documentation supporting that it had offered financial assistance to the individual. Providers that do not comply with their own stated policies and procedures are at an increased risk that they will not comply with Federal requirements.

## APPENDIX A: AUDIT SCOPE AND METHODOLOGY

### SCOPE

Our audit identified \$15,109,635,025 in Medicare bad debts with a Medicare reimbursable amount of \$9,821,264,932 that multiple types of providers (identified in “Methodology” below) submitted on a total of 65,621 cost reports with provider cost reporting periods ending during Federal fiscal years 2016 through 2018.

This report cites to Federal regulations at 42 CFR § 413.89(e) as well as guidance in the *Provider Reimbursement Manual* and the *Medicare Financial Management Manual*. Among other things, these criteria address the allowability of Medicare bad debt. We reviewed the bad debts in our audit scope from the standpoint of reasonable collection efforts, but the other criteria for allowability of Medicare bad debt were not within the scope of this audit.

We determined that a review of CMS’s internal controls was not significant to accomplishing our audit objectives.

We performed audit work from June 2020 to October 2022.

### METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- obtained HCRIS data for all providers that claimed reimbursement for Medicare bad debts on cost reports that covered provider cost reporting periods ending during Federal fiscal years 2016 through 2018;
- assessed the reliability of the HCRIS data by comparing them to data from cost reports actually submitted by providers;
- randomly selected 67 cost reports based on provider type and the dollar amount of bad debt, which included cost reports for 29 hospitals, 18 skilled nursing facilities, 10 renal dialysis facilities, 4 federally qualified health centers, 4 rural health centers, and 2 community mental health centers;
- contacted the respective MAC for each provider to obtain the list of Medicare bad debts associated with each of the 67 randomly selected cost reports, to determine the extent to which that MAC reviewed those Medicare bad debts, and to obtain the MAC’s workpapers, if applicable;

- selected a nonstatistical sample of the largest and smallest bad debts on each list and judgmentally selected an additional 14 large bad debts from providers whose policies and procedures we considered to be at high-risk for error;
- reviewed the documentation of the collection efforts that providers performed for our sample of individual Medicare bad debts to determine whether the providers complied with Federal requirements when claiming Medicare reimbursement for those bad debts;
- obtained the 67 sampled providers' policies and procedures for collecting Medicare deductible and coinsurance amounts and reviewed those policies and procedures to determine whether they complied with Federal requirements with respect to reasonable collection efforts;
- reviewed the collection efforts the providers performed for a judgmental selection of 15 non-Medicare bad debts; and
- discussed the results of our audit with CMS officials on May 19, 2022.

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 objectives.





## APPENDIX B: CMS COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

*Administrator*

Washington, DC 20201

**DATE:** November 21, 2022

**TO:** Amy J. Frontz  
Deputy Inspector General for Audit Services

**FROM:** Chiquita Brooks-LaSure *Chig B LaS*  
Administrator  
Centers for Medicare & Medicaid Services

**SUBJECT:** Office of Inspector General (OIG) Draft Report: Providers Did Not Always Comply With Federal Requirements When Claiming Medicare Bad Debts (A-07-20-02825)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report. CMS is committed to protecting the Medicare Trust Funds from improper payments, while also ensuring that people with Medicare have access to medically necessary and covered services.

Under the Medicare program, beneficiaries may sometimes be responsible for paying premiums, copayments, deductibles, and coinsurance amounts that are related to the receipt of covered services. As described in the OIG's report, costs that are considered uncollectable from people with Medicare are known as Medicare bad debts. CMS recognizes that an individual's failure to pay a deductible or coinsurance amount could lead to non-Medicare patients bearing the related costs of covered Medicare services, a result that is barred by the statutory prohibition on the cross-subsidization of the Medicare program by non-Medicare patients, as set out at section 1861(v)(1)(A)(i) of the Social Security Act (the Act). To avoid this result, and in accordance with section 1861(v)(1) of the Act and regulations at 42 CFR § 413.89, CMS pays a portion of the uncollectible deductible and coinsurance amounts to certain providers that are eligible to receive reimbursement for Medicare bad debts.<sup>1</sup>

As laid out in 42 CFR § 413.89(e), Medicare bad debts are allowable if: (1) the debt is related to covered services and derived from deductible and coinsurance amounts; (2) the provider can establish that reasonable collection efforts were made; (3) the debt was actually uncollectible when claimed as worthless; and (4) sound business judgment established that there was no likelihood of recovery at any time in the future.<sup>2</sup> To be considered a reasonable collection effort, a provider's effort to collect the Medicare deductible and coinsurance amounts must be similar to the effort the provider puts forth to collect comparable amounts from non-Medicare patients. These efforts must involve the issuance of a bill, and could also include actions such as subsequent billings, collection letters, and telephone calls or personal contacts. In some cases, a provider may have already established that the individual is indigent, and once indigence has

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<sup>1</sup> *Federal Register*: "Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and Final Policy Changes and Fiscal Year 2021 Rates; Quality Reporting and Medicare and Medicaid Promoting Interoperability Programs Requirements for Eligible Hospitals and Critical Access Hospitals; Final Rule (85 FR 58432) (September 18, 2020)"

<sup>2</sup> 42 CFR § 413.89(e)(2) further specifies the different reasonable collection effort requirements for non-indigent beneficiaries, indigent non-dual eligible beneficiaries, and indigent dual-eligible beneficiaries (including qualified Medicare beneficiaries

been determined the debt may be deemed uncollectible without applying the reasonable collection efforts described above.

Providers must submit annual cost reports to their Medicare Administrative Contractor (MAC), which serve as the mechanism to claim reimbursement for Medicare bad debts. Once received, the MACs review the information within the cost report to determine the adequacy, completeness, accuracy and reasonableness of the data contained therein. This process is referred to as a desk review, and is required for all providers filing a Medicare cost report except hospice and low/no Medicare utilization providers. Depending on the results of the desk review, and at the discretion of the MAC, an audit of the cost report may also be conducted. Further, CMS performs annual reviews of the MACs audits and desk reviews via the Quality Assurance Surveillance Plans (QASP) program. These QASP reviews are conducted to ensure MAC work papers are accurate, address the applicable uniform desk review and/or audit steps, and that the overall desk review package meets the criteria identified in Chapter 8 of the Medicare Financial Management Manual and are in compliance with the MAC Statements of Work (SOW).<sup>3</sup>

CMS and the MACs have both desk review and audit programs that cover Medicare bad debts, in which cost reports claiming reimbursement for amounts above a specified threshold may be selected for a review of individual claims and accounts. These thresholds are determined by CMS and are communicated to the MACs to ensure that oversight efforts are appropriately targeted. These reviews may also include a routine review of the reasonable collection efforts of providers to determine whether reasonable collection efforts were made. If a MAC determines that a provider did not supply documentation to support the bad debt claimed, the MAC would disallow the amount from the cost report. For example, MAC reviews of Medicare bad debts submitted for reimbursement during Fiscal Years 2016 - 2018 resulted in approximately \$294 million in recouped savings.

OIG's recommendation and CMS's response is below.

### **OIG Recommendation**

Consider issuing instructions or guidance to the MACs that require or encourage more review of Medicare bad debts claimed in cost reports, such as defining thresholds beyond which individual Medicare bad debts would trigger an audit, and that directs the MACs to revise their cost report audit work plans accordingly.

### **CMS Response**

CMS concurs with this recommendation. CMS will consider the findings in the OIG's report when issuing future guidance to the MACs regarding the review of Medicare bad debts, taking into account budgetary constraints and competing priorities for the MACs.

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<sup>3</sup>CMS, Medicare Financial Management Manual Chapter 8 – Contractor Procedures for Provider Audits. Accessed at: <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/fin106c08.pdf>