

**Memorandum**

Date **MAR 12 2002**

From Janet Rehnquist
Inspector General *Janet Rehnquist*

Subject Delinquent Medicare Debt and Compliance With the Debt Collection Improvement Act by the Centers for Medicare and Medicaid Services (A-17-01-02003)

To Thomas Scully
Administrator
Centers for Medicare and Medicaid Services

Attached is our final report on delinquent Medicare debt and compliance with the Debt Collection Improvement Act (DCIA) of 1996 by the Centers for Medicare and Medicaid Services (CMS). The objectives of our review, part of an initiative by the President's Council on Integrity and Efficiency, were to determine whether CMS (1) accurately reported its delinquent Medicare debt to the Department of the Treasury and (2) complied with the collection activities set forth in the DCIA. As of the end of Fiscal Year (FY) 2000, CMS reported about \$8 billion in Medicare delinquent debt on the Treasury Report on Receivables (TROR), the mechanism for informing Treasury about year-to-date debt activity and status.

The CMS has made significant progress in managing debt, especially at the Medicare contractors. However, our review of the TROR identified an estimated \$670 million (absolute value) in misstated and misclassified delinquent Medicare debt (or a net of \$335 million).

- Misstatements on the TROR totaled \$518 million, including \$450 million in reconciliation errors and \$68 million in unsupported or unrecorded transactions.
- Classification errors of \$152 million misstated debt eligible for referral to Treasury.

We also noted that CMS did not have an adequate process for pursuing debt through required demand letters. Letters had not been sent for 126 of the 287 regional office balances tested or for 84 of the 710 Medicare contractor balances tested. In addition, under CMS policies, debt of \$110 million that had been referred to Treasury should be classified as "currently not collectible" (CNC), \$5 million should be written off/closed, and \$48 million reported as CNC should be reviewed and closed accordingly.

In recent years, CMS has collaborated with consultants and the Office of Inspector General to validate the accuracy and completeness of accounts receivable activity. Working within the limitations of a flawed accounting system, this effort has succeeded in improving documentation for receivable balances. However, the lack of a dual-entry,

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integrated financial system continues to impair CMS's ability to adequately support and accurately report debt management activity and balances. While the Healthcare Integrated General Ledger Accounting System, which we fully endorse, will correct many of the problems we noted, the system will not be fully operational until 2007. In the meantime, CMS should take aggressive action to ensure that accurate and timely information is reported on the TROR.

Our report includes specific recommendations to improve supporting documentation, periodic reconciliations, and supervisory review of delinquent debt activities. The CMS concurred with the recommendations in our draft report.

We would appreciate your views and the status of any further action taken or contemplated on our recommendations within the next 60 days. To facilitate identification, please refer to Common Identification Number A-17-01-02003 in all correspondence relating to this report.

We appreciate the cooperation and assistance provided by you and your staff. If you have any questions, please call me or have your staff contact Joseph E. Vengrin, Assistant Inspector General for Audit Operations and Financial Statement Activities, at (202) 619-1157.

Attachment

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**DELINQUENT MEDICARE DEBT
AND COMPLIANCE WITH THE DEBT
COLLECTION IMPROVEMENT ACT BY
THE CENTERS FOR MEDICARE
AND MEDICAID SERVICES**



JANET REHNQUIST
Inspector General

MARCH 2002
A-17-01-02003

EXECUTIVE SUMMARY

BACKGROUND

The Centers for Medicare and Medicaid Services (CMS) relies primarily on Medicare contractors to identify and manage Medicare debt owed to the Federal Government, which results largely from overpayments to providers. Contractors and the CMS central and regional offices use the Provider Overpayment Reporting system or the Physician Supplier Overpayment Reporting system to track most of this debt. In addition, the CMS central office manages other sources of debt, including Medicare premiums, civil monetary penalties, fraud and abuse settlements, and managed care receivables.

Federal regulations require timely and aggressive efforts to collect debt. Under the Debt Collection Improvement Act (DCIA) of 1996, nontax debt owed to the Federal Government that is more than 180 days delinquent must be referred to the Department of the Treasury for collection. Exceptions to the DCIA requirement include debt that is undergoing bankruptcy, appeals, or litigation. The mechanism for reporting year-to-date debt activity and status is the quarterly Treasury Report on Receivables (TROR). The TROR is Treasury's only comprehensive means for periodically collecting data on the status and condition of the Federal Government's nontax debt portfolio. Agencies are required to reconcile the fiscal yearend TROR with the accounts receivable data reported on their financial statements.

As of the end of Fiscal Year (FY) 2000, the CMS TROR included total delinquent debt of about \$8 billion: \$1 billion in debt less than 180 days delinquent and \$7 billion over 180 days.

OBJECTIVE

The objectives of our review, part of an initiative by the President's Council on Integrity and Efficiency, were to determine whether CMS (1) accurately reported its delinquent Medicare debt to Treasury and (2) complied with the collection activities set forth in the DCIA of 1996. To accomplish our objectives, we reviewed Medicare accounts receivable at September 30, 2000, for 8 statistically selected contractors, the 10 CMS regional offices, and the CMS central office.

SUMMARY OF FINDINGS

The lack of a dual-entry, integrated financial system continues to impair CMS's ability to accurately report, support, and classify Medicare debt. We estimate that the absolute value (overstatements plus understatements) of misstated and misclassified CMS-reported non-Medicare Secondary Payer debt¹ as of the fiscal yearend totaled more than \$670 million (or a net of \$335 million). In addition, during the period reviewed, the regional offices and Medicare contractors did not adequately follow CMS policies for pursuing debt through required demand letters or for ensuring that debt was written off/closed or classified as written off/currently not collectible (CNC).

¹ Non-Medicare Secondary Payer debt excludes debt that is owed by insurance companies in cases where Medicare is not the primary payer.

In response to our prior recommendation to centralize debt collection activities, CMS authorized contractors to refer delinquent receivables through the central office to Treasury or a designated debt collection center without regional office involvement, effective April 2001. While the rate of CMS debt referred to Treasury has increased, we believe that CMS should take a more aggressive role to ensure that accurate and timely information is reported on the TROR.

Reporting Debt

Our review identified \$518 million in misstated debt reported on the TROR at September 30, 2000, as follows:

- Misstatements of \$450 million (absolute value) undermined the reliability of debt reported to Treasury on the TROR and debt reported on the financial statements. These errors included \$192 million in incorrect adjustments (of which \$163 million related to unfiled cost reports, which are not considered accounts receivable for financial statement purposes), \$104 million in unreported balances, \$78 million in clerical errors, and \$76 million in duplicated debt.
- An estimated \$68 million in additional misstatements consisted primarily of unrecorded transactions that would reduce debt (e.g., cash collections and writeoffs) and accounts receivable not fully supported by case files.

Collecting Debt

To enhance collections of nonexempt debt (e.g., debt not related to bankruptcy, appeals, and litigation), CMS policy requires fiscal intermediaries to send up to three demand letters, carriers to send up to two, and regional offices to send at least one additional letter. We found that demand letters had not been sent for 126 of the 287 regional office debt balances tested or for 84 of the 710 Medicare contractor debt balances tested.

Classifying and Referring Debt

During FY 2000, CMS referred \$1.7 billion in delinquent debt to Treasury. Although this is a significant increase over prior periods, improvements are still needed to ensure full compliance with the DCIA.

Our analysis found \$152 million in classification errors that misstated debt eligible for referral. These errors included an estimated \$90 million in misclassified balances in the Provider/Physician Supplier Overpayment Reporting systems and an actual \$62 million in debt that should have been classified as DCIA exceptions on the TROR. The \$90 million included an estimated:

- \$41 million primarily classified as debt under appeal that was actually eligible debt,
- \$39 million classified as undergoing appeal when repayment plans were actually in place,
- \$5 million classified as debt eligible for referral that actually was undergoing bankruptcy or appeal proceedings, and

- \$5 million classified as CNC that was actually undergoing bankruptcy proceedings.

Writing Off Debt

Under CMS policy, delinquent debt should be considered for writeoff/CNC when (1) no collection activity has occurred within the past 12 months; (2) the debt is not in bankruptcy, under appeal, or part of a fraud and abuse investigation; and (3) the debt has been delinquent for at least 2 to 6 years. Debt should be considered for writeoff/closed when (1) it has been delinquent over 6 years with no payment, recoupment, or offset activity in the past 12 months or (2) any debt, regardless of age, has had no payment, recoupment, or offset activity in the past 12 months and evidence to support the debt is unavailable.

Our analysis showed that an actual \$110 million in delinquent debt should be classified as CNC and that another actual \$5 million should be written off/closed. In addition, an actual \$48 million reported as CNC should be reviewed and closed accordingly.

CONCLUSION AND RECOMMENDATIONS

The CMS has made significant improvements, particularly at the Medicare contractor level, in managing debt. The majority of the problems we identified were associated with regional office reporting and management of debt. We applaud CMS's decision to authorize the Medicare contractors to refer debt to Treasury, with the central office acting as the control point, and believe that this should help to eliminate some of the problems identified. We also note that, following our review, CMS met its FY 2001 goal to refer \$2 billion in delinquent debt to Treasury and is working to meet its goal of referring 100 percent of eligible debt by the end of FY 2002.

In recent years, CMS has also collaborated with consultants and with the Office of Inspector General to validate the accuracy and completeness of accounts receivable activity. Working within the limitations of a flawed accounting system, this effort has succeeded in improving documentation for receivable balances. However, we believe that the lack of a dual-entry, integrated financial system continues to impair CMS's ability to adequately support and accurately report debt management activity and balances. While we expect that the Healthcare Integrated General Ledger Accounting System (HIGLAS) will correct many of these problems, it will not be fully operational for several more years. In the meantime, we recommend that CMS:

- regularly reconcile summary debt information to supporting records,
- ensure that individual debt balances accurately reflect collections and offsets,
- pursue debt through the required number of demand letters,
- improve the process of assigning status codes to prevent the referral to Treasury of debt that is not eligible for referral and to ensure that eligible debt is referred, and
- review debt balances that need to be written off/closed or classified as written off/CNC.

INTRODUCTION

BACKGROUND

The Medicare program, administered by the Centers for Medicare and Medicaid Services (CMS), consists of two components. Medicare Part A covers medical services provided by hospitals, skilled nursing facilities, home health agencies, and hospices. Medicare Part B covers most physician, durable medical equipment, and outpatient hospital services. The CMS contracts with private insurance companies, referred to as fiscal intermediaries and carriers (contractors), to process and pay Medicare claims submitted by health care providers.

Medicare contractors and the CMS central and regional offices are responsible for managing debt, or accounts receivable, which primarily represents funds owed by providers to CMS due to overpayments. The CMS central office manages additional accounts receivable resulting from civil monetary penalties, fraud and abuse settlements, and managed care debt. Overall responsibility for accounting for, reporting, and collecting Medicare accounts receivable is dispersed among the Medicare contractors and the CMS central and regional offices.

Medicare accounts receivable activity is recorded on the CMS 751 reports, which are used to prepare financial statements. Additional detailed data are recorded on the Provider Overpayment Report (POR) and the Physician Supplier Overpayment Report (PSOR). The CMS uses the 751, the POR/PSOR, and other overpayment information to prepare the quarterly Treasury Report on Receivables (TROR). The TROR is Treasury's comprehensive means for periodically collecting data on the status and condition of the Federal Government's nontax debt portfolio. Agencies are required to reconcile the fiscal yearend TROR with the receivables data reported on their annual financial statements.

Debt Collection Legislation

The Debt Collection Improvement Act (DCIA) of 1996 was designed to maximize collections, minimize the cost of recovery efforts, inform the public of the Government's collection practices, ensure the due process rights of debtors, and encourage agencies to sell their delinquent debt and use other collection tools to increase recoveries. Debt is generally considered delinquent if not fully repaid within 30 days. The act authorizes the Secretary of the Treasury to designate other Federal agencies as debt collection centers. With few exceptions, the act requires Federal agencies to refer to Treasury or another designated debt collection center any nontax debt that has been delinquent for more than 180 days. Exceptions include debt that is undergoing bankruptcy, appeal, or litigation.

As of the end of Fiscal Year (FY) 2000, CMS reported about \$8 billion in delinquent debt on the TROR. Eighty-five percent of this debt (\$7 billion) was over 180 days delinquent.

CMS Policy

The CMS policy requires that when a contractor identifies an overpayment, a demand letter be sent to notify the provider of the existence and amount of the overpayment and to request

repayment. The contractor is to send as many as three overpayment demand letters to the provider within 90 days of the date of determination of the overpayment for Part A and up to two demand letters within 45 days for Part B. Should these recovery efforts fail, the contractor is to refer the overpayment to the respective regional office. That office should attempt to recover the overpayment by sending at least one additional 30-day demand letter to the provider. If the overpayment is not recovered or if repayment arrangements are not made within 60 days, the overpayment should be transferred to the CMS central office for disposition by the CMS Office of General Counsel (OGC), the Department of Justice (DOJ), or Treasury (for offset or cross-servicing). However, it should be noted that most non-Medicare Secondary Payer overpayments are not subjected to these procedures; instead, they are collected by offsetting future claim reimbursement.

During the last 2 FYs, CMS issued several program memorandums that addressed the reporting and movement of delinquent debt. For debts reported as delinquent as of March 31, 1999, Change Request 862 called for a one-time writeoff of delinquent debt in accordance with Office of Management and Budget (OMB) Circular A-129, Policies for Federal Credit Programs and Non-Tax Receivables. This was followed by Change Request 1011, which further defined "currently not collectible" (CNC) debt. In addition, the Medicare contractors are expected to continuously review all debt and quarterly seek approval to reclassify debt as CNC.

As a result, CMS referred to Treasury over 9,000 debts totaling \$2 billion (principal and interest) as of September 30, 2000. This debt included provider overpayments, as well as unfiled cost reports and receivables that CMS had written off as CNC.

OBJECTIVES, SCOPE, AND METHODOLOGY

Objectives

The objectives of our review, which was part of an initiative by the President's Council on Integrity and Efficiency, were to determine whether CMS (1) accurately reported its delinquent Medicare debt to Treasury and (2) complied with the collection activities set forth in the DCIA of 1996. The review covered delinquent debt reported by CMS on the TROR for the period ending September 30, 2000.

Scope and Methodology

We statistically selected 8 contractors, including both fiscal intermediaries and carriers, from the 16 contractors responsible for over 80 percent of Medicare receivables. We validated Medicare debt balances and reviewed debt management activities at the 8 contractors, all CMS regional offices, and the central office.

To review non-Medicare Secondary Payer delinquent debt, we selected a statistical sample of 100 balances at each of the 8 contractors, 450 at the regional offices, and 247 at the central office. We reviewed 1,497 sample items to determine whether a valid receivable existed and whether the requirements of the DCIA were met. To accomplish our objectives, we:

- tested selected sample items to verify reported balances against supporting documentation;
- reconciled balances reported at September 30, 2000, on the 751 reports to the POR/PSOR amounts reported, as appropriate;
- reviewed source documents to confirm the status and location codes recorded in the POR/PSOR;
- reviewed supporting records to verify efforts to recover debt;
- reconciled the central office reported balances on the POR/PSOR and nonprovider accounts receivable to the TROR and/or Financial Accounting Control System (FACS) reports, as appropriate;
- held discussions with and obtained additional documentation from personnel of contractors, regional offices, the central office, OGC, and DOJ; and
- identified debt that had been transferred to DOJ or referred to Treasury and requested confirmation of the balances.

We conducted our review from February through August 2001 in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATIONS

We estimate that the absolute value (overstatements plus understatements) of misstated and misclassified CMS-reported debt as of the end of FY 2000 totaled more than \$670 million (or a net of \$335 million). Our review of CMS debt reported on the TROR identified \$518 million in misstatements (absolute value), including:

- misstatements of \$450 million identified by reconciling debt reported to Treasury on the TROR and debt reported by the central and regional offices on the 751s or FACS reports used for financial reporting purposes and
- an estimated \$68 million in additional misstatements, which consisted primarily of unrecorded transactions that would reduce debt (e.g., cash collections and offsets) and balances not fully supported by case files.

Our analysis also noted \$152 million in classification errors that misstated debt eligible for referral to Treasury. In addition, we identified deficiencies in the processes used by the contractors and the central and regional offices to:

- pursue debt by sending the required number of demand letters,
- classify debt under DCIA requirements, and

- write off debt as required by OMB guidance and CMS guidelines.

REPORTING DEBT

Internal control weaknesses at the central and regional offices have led to inaccurate reporting of debt. We identified \$450 million in reconciliation misstatements (overstatements and understatements combined) that undermined the reliability of debt reported on both the TROR and the CMS financial statements. Further, in testing 1,497 debt balances, we found additional misstatements totaling an estimated \$68 million.

Reconciliation Misstatements

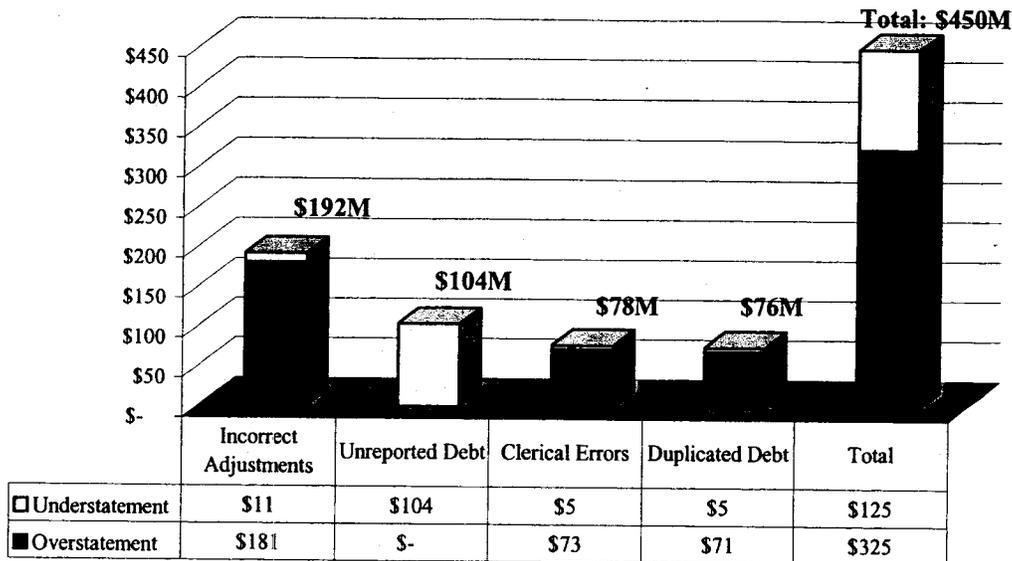
We identified \$450 million (actual, not statistically projected) in reconciliation misstatements by reconciling the debt reported to Treasury on the TROR to the accounts receivable balances reported on the 751s and the FACS reports, which are used for financial reporting. As required by the DCIA of 1996, the TROR should reconcile with receivable information reported by an agency on its financial statements.

The 8 Medicare contractors selected for review showed much improvement in their reporting processes. The immaterial reconciling differences that we identified did not require an adjustment to the TROR and did not contribute to any of the \$450 million in misstatements. However, the processes used by the central and regional offices to report debt and by the central office to consolidate and prepare the TROR did not provide accurate and reliable information for reporting debt to Treasury.

The regional offices used the 751s to certify quarterly to the central office the amount of debt for which they were responsible but applied varying mechanisms to support reported amounts. For example, 2 of the 10 regional offices used the POR/PSOR to report debt, and the remaining offices used automated spreadsheets. The central office used the certified 751s to report debt to Treasury on the TROR, which often required adjustments for amounts reported by the regions.

As illustrated in figure 1, the reconciliation misstatements that we identified included incorrect adjustments, unreported debt, clerical errors, and duplicated debt. Had a strong internal control structure, consistent recordkeeping, and adequate regional and central office coordination been in place, these misstatements might have been prevented or detected.

Figure 1: Types of Reconciliation Misstatements (in millions)



Incorrect Adjustments

The CMS reported \$8 billion, net of adjustments, in delinquent debt on the TROR at September 30, 2000. This included \$5 billion in active debt and \$3 billion in nonactive (CNC) debt. Our reconciliation of the 751s to supporting regional office records and central office adjusting entries disclosed that the TROR included \$192 million in misstated active debt:

- Adjustments totaling \$163 million for unfiled cost reports, which are not considered debt for financial statement purposes, were incorrect. We found that \$141 million of the \$159 million in unfiled cost report debt reported by the regional offices was reported as both delinquent debt and waived debt.² The remaining \$18 million was improperly reported as delinquent debt rather than waived debt. This resulted in an overstatement of \$159 million in debt over 180 days delinquent reported on the TROR. In addition, a \$4 million understatement occurred because the central office made adjustments for unfiled cost reports that were not supported by regional records. (As noted in “Other Matters,” we believe that unfiled cost reports should be consistently reported on both the TROR and the CMS financial statements.)
- Other incorrect central office adjustments amounted to \$29 million. Debt was overstated by \$22 million for duplicate reporting of adjustments that should have been eliminated because the debt was included in both the regional office and the central office records. Debt was understated by \$7 million because balances were eliminated when not warranted by the supporting records.

² Waived debt includes all unfiled cost reports and Medicare Secondary Payer debt.

Unreported Debt

We identified \$104 million in receivables that should have been reported to Treasury by comparing regional debt reported on the 751s with supporting documents, including the POR/PSOR, and by reviewing central office adjusting entries. We found that the two regions that used POR/PSOR to report debt made up 79 percent of the unreported balance. Had the regions reconciled reported amounts to source documents (e.g., case files) before submitting the results to the central office, the appropriate debt balance would have been reported.

Clerical Errors

We found clerical errors of \$78 million at the central and regional offices. These errors most often occurred when consolidating information used to prepare the TROR. For example, \$40 million in regional clerical errors overstated debt. Most of these errors occurred because one regional office submitted two financial reports and the central office used the incorrect report to consolidate debt balances. Also, a \$30 million overstatement of CNC debt resulted from central office errors in transposing items from supporting documents to spreadsheets.

Duplicated Debt

We identified duplicated debt totaling \$76 million at both the central office and the regional offices. The following errors occurred primarily because control procedures were not in place to ensure that debt amounts were not recorded twice when consolidating and reporting debt.

- \$53 million in unfiled cost reports reported as CNC debt on the TROR were also reported in the adjustment for unfiled cost reports sent to Treasury, overstating debt eligible for referral.
- \$14 million in debt balances from four regional offices was reported twice, overstating debt.
- \$5 million in CNC adjustments for one regional office was reported twice, understating CNC debt.
- \$4 million was recorded twice for one region's allocation between the Medicare Part A and Part B trust funds, overstating debt.

Misstated Account Balances

The CMS guidelines require that administrative records be maintained on the total number of debts and the total amount collected. To determine whether CMS adequately maintained records, we reviewed case files and other supporting documents for a sample of 1,497 debt balances. We found such errors as unrecorded transactions that would decrease debt (e.g., collections and writeoffs), inadequate documentation to support reported debt balances, incorrect data entry, and lack of supervisory review before certification. Based on errors in 697 balances,

we estimate that debt reported on the TROR was further misstated by \$68 million (overstated and understated combined). (See appendix A for statistical results.)

- Central office debt balances were misstated by at least an estimated \$47 million. For example, of the 247 sampled transactions, 75 had errors; 60 resulted from unrecorded collections, and 15 were unsupported.
- Regional office debt balances were misstated by at least an estimated \$21 million. For example, of the 450 sampled transactions, 119 had errors; 43 resulted from unrecorded collections or improper reporting, 20 were unsupported, 13 resulted from clerical errors, and 43 resulted from other miscellaneous errors.

These types of errors indicate that the CMS central and regional offices did not maintain adequate debt management records.

COLLECTING DEBT

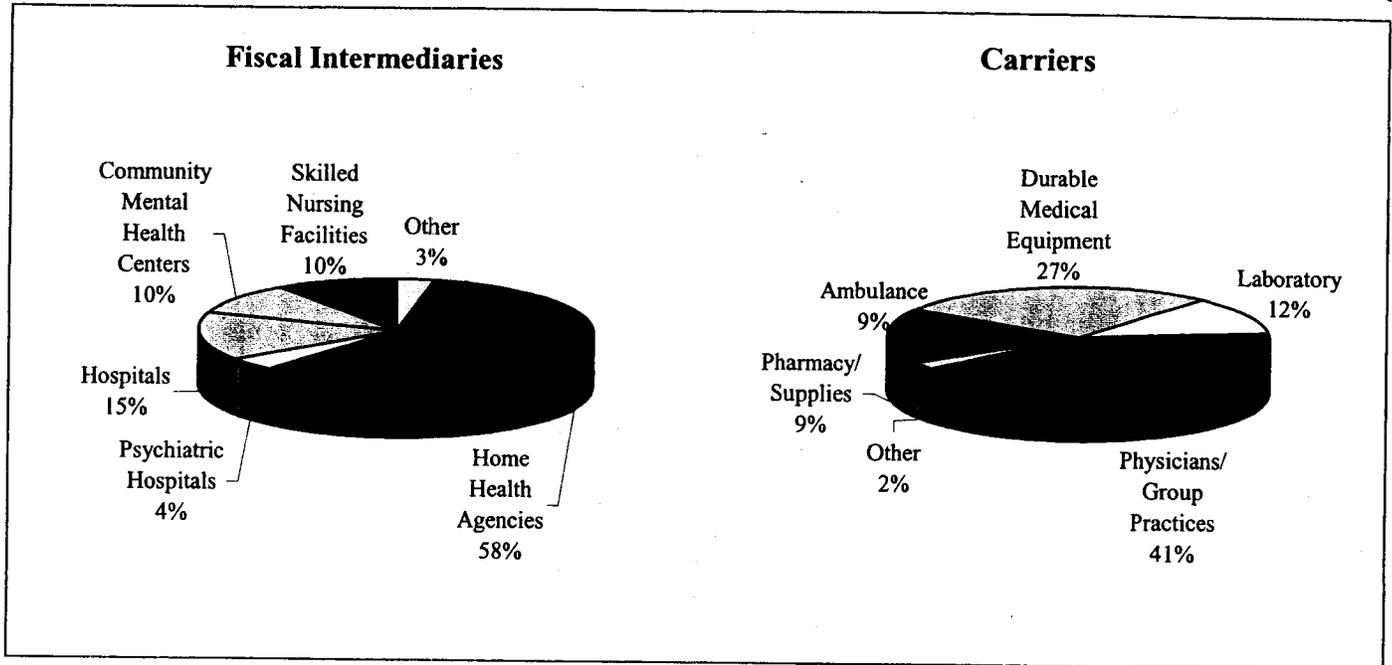
The full cooperation and effort of the Medicare contractors and the regional offices are important in pursuing delinquent debt and in increasing the likelihood of collecting it. To enhance collections of nonexempt debt (debt not related to bankruptcy, appeals, or litigation), CMS policy requires that fiscal intermediaries send up to three demand letters, that carriers send up to two letters, and that regional offices send at least one additional letter.

However, the regional offices and the contractors did not consistently follow these policies and procedures. We found that the regional offices had not sent any demand letters for 126 of the 287 balances tested and that the Medicare contractors had not sent letters for 84 of the 710 debt balances tested.³

As part of our analysis of CMS debt, we noted, as indicated in figure 2, that 58 percent of the debt identified by fiscal intermediaries was owed by home health agencies and 10 percent by community mental health centers. For debt identified by carriers, durable medical equipment suppliers owed 27 percent. These three categories of providers are considered at higher risk of not repaying Medicare debt, requiring a more expeditious and aggressive debt collection process. A periodic analysis of the sources of debt may be beneficial to highlight high-risk providers and prevent the loss of Government funds.

³ To determine whether demand letters had been sent, we tested 997 of the 1,250 contractor and regional office debt balances sampled; we excluded 253 debt balances undergoing bankruptcy, litigation, or appeal.

Figure 2: Debt Incurred by Fiscal Intermediaries and Carriers



CLASSIFYING AND REFERRING DEBT

From the September 1997 effective date of the DCIA through September 30, 2000, CMS referred about \$2 billion in delinquent debt to Treasury. Of this amount, \$1.7 billion was referred in FY 2000. Although this is a significant increase over prior periods, improvements are still needed to ensure full compliance with the DCIA. We note that, following our review, CMS met its goal to refer an additional \$2 billion in FY 2001 and is working to meet its goal of referring 100 percent of eligible debt by the end of FY 2002.

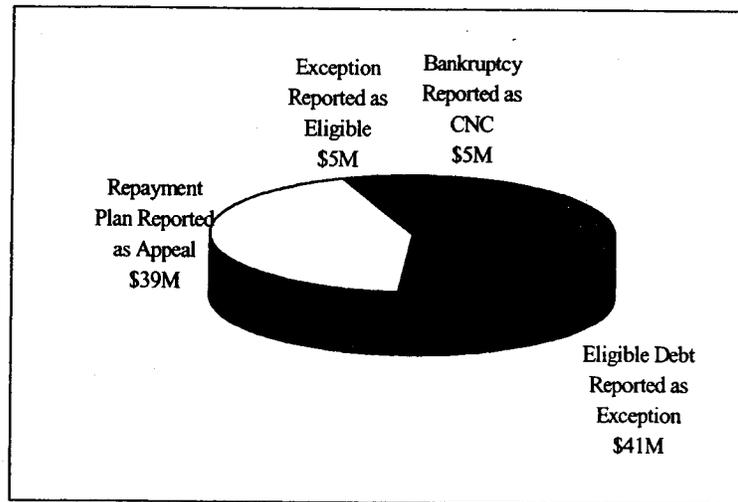
In collecting delinquent debt, CMS receives assistance from Treasury, other designated debt collection centers, DOJ, and the CMS OGC. To ensure the success of these entities' efforts, the Medicare contractors and the CMS central and regional offices must refer accurate and reliable debt information on a timely basis. Otherwise, debt collection efforts could be wasted on debt not eligible for referral, or collectible Medicare dollars could be lost. The CMS guidance for referring debt in accordance with the DCIA requires the use of certain classifications to enable Treasury to capture data of relevance to the Congress and OMB. Examples of these classifications include debt eligible for referral to Treasury and DCIA exceptions, such as debt undergoing appeals, litigation, and bankruptcy. The CMS uses the data field "status code" on the POR/PSOR to identify debt representing DCIA exceptions. These exceptions reduce the debt eligible for referral to Treasury. Misclassifying debt as an exception when it is not may also cause lost collection opportunities at the contractors and the regional offices.

Our review disclosed two types of classification errors that misstated debt eligible for referral to Treasury by \$152 million: misclassified balances on the POR/PSOR totaled an estimated \$90 million, and debt that should have been classified as an exception on the TROR totaled an actual \$62 million.

Incorrect Status Code on POR/PSOR

We found that 126 of the 1,010 contractor and regional debt balances sampled had the incorrect status codes on the POR/PSOR.⁴ Projecting our results, we estimate that these misclassification errors totaled at least \$90 million, as illustrated in figure 3. (See appendix B for statistical results.)

Figure 3: Misclassified Debt (\$90 million)



- Balances of at least an estimated \$41 million in debt eligible for referral were incorrectly classified as an exception, primarily as under appeal. Understating debt eligible for referral to Treasury could preclude future collection efforts and increase the likelihood of lost Government funds.
- Balances of at least an estimated \$39 million had repayment plans in place but were classified as undergoing appeal. These misclassifications overstated CMS delinquent debt.
- Balances of at least an estimated \$5 million were classified as eligible for referral but, in fact, were undergoing bankruptcy or appeal proceedings. These misclassifications overstated debt eligible for referral to Treasury and could undermine the effectiveness and efficiency of Treasury's debt management process by pursuing perceived active debt.
- Balances of at least an estimated \$5 million were undergoing bankruptcy proceedings but were prematurely classified as CNC. Accordingly, debt in bankruptcy over 180 days on the TROR was understated.

Unreported Exceptions

We reconciled each line item on the TROR to supporting documents and found that an actual \$62 million in debt with exceptions had not been included. These errors overstated debt eligible for referral by \$61 million and understated it by \$1 million.

WRITING OFF DEBT

The CMS writeoff policy recommends that delinquent debt be considered for writeoff/CNC or writeoff/closed when certain criteria are present. The key elements of the CNC criteria are

⁴ The 1,010 balances included only those aged over 180 days: 450 regional balances and 560 contractor balances.

(1) no collection activity has occurred within the past 12 months; (2) the debt is not in bankruptcy, under appeal, or part of a fraud and abuse investigation; and (3) the debt has been delinquent for at least 2 to 6 years. The key elements of the writeoff/closed criteria are (1) the debt has been delinquent over 6 years with no payment, recoupment, or offset activity in the past 12 months and (2) the debt, regardless of age, has had no payment, recoupment, or offset activity in the past 12 months, and evidence to support the debt is unavailable.

Our analysis found that at least an actual \$110 million in delinquent debt that had been referred to Treasury should be classified as CNC and another actual \$5 million should be written off/closed primarily because the age and lack of recent collection activity indicate no likelihood of collection. Also, an actual \$48 million reported as CNC debt that had not been closed should be reviewed and closed to prevent Treasury from allocating resources to pursue debt that is not deemed collectible. None of the amounts that we are proposing for writeoff includes debt in bankruptcy, under fraud and abuse investigation, or with an appeal pending at any level. While CMS addressed the issue of significantly aged debt in an April 1999 memorandum, our current review indicates that more emphasis needs to be placed on this effort.

OTHER MATTERS

Debt Reporting Consistency

All institutional providers, such as hospitals, skilled nursing facilities, and home health agencies, are required to file Medicare cost reports within 150 days from the end of their FY. As the final claim for Medicare payment, the reports present the costs incurred in providing medical services to beneficiaries. However, some providers do not submit their cost reports within the required time. These are considered unfiled cost reports.

Before FY 2000, CMS considered unfiled cost reports as accounts receivable, which greatly overstated the receivable balance on the financial statements. Due to a change in accounting policy, with which we concurred, CMS no longer recognizes unfiled cost reports as accounts receivable for financial statement purposes. On the other hand, the CMS TROR as of September 30, 2000, included \$1.6 billion in unfiled cost report debt as part of the total debt eligible for referral to Treasury. We believe that CMS should be consistent in the recognition of debt on its financial statements and the reporting of eligible debt to Treasury.

Incorrect Location Codes

The CMS uses the location code on the POR/PSOR to identify the component currently responsible for managing each debt balance. Once a contractor transfers a debt to a regional office, the region is responsible for collecting and, when appropriate, coordinating with other collectors, such as another region, OGC, DOJ, or a debt collection center. It is imperative that contractors not remove a debt balance until a region or another collector has agreed to accept it as "transferred" and has changed the POR/PSOR location code. Debt will not be included in the CMS balance if it is recorded as a transfer and the involved party has not accepted it.

It is equally important, once that party has accepted the debt, to change the POR/PSOR to the proper location code to prevent duplicate reporting of debt. Of the 450 regional debt balances

we reviewed, 48 had incorrect location codes and 15 of those had a greater potential for being reported twice. In these cases, the regions did not update the POR/PSOR and related reports, such as the 751s, to prevent the potential for duplicate reporting of debt; instead, they used spreadsheets that did not include the correct location codes. As a result, the central office was unable to determine who was managing the debt.

CONCLUSION

The CMS has made significant improvements, particularly at the contractor level, in managing debt. In our opinion, the fragmented responsibility and different methods used for reporting and managing debt among the 10 regional offices contributed to many of the above problems and precluded timely referral of debt balances to Treasury. In our prior report entitled "Safeguarding Medicare Accounts Receivable" (CIN: A-17-99-11999, dated October 28, 1999), we recommended that CMS use a centralized process to eliminate many of the problems we identified in reporting and managing accounts receivable activity. Accordingly, CMS authorized contractors to refer delinquent receivables through the central office to Treasury or a designated debt collection center without regional office involvement, effective April 2001. We applaud CMS's decision to centralize the debt management process and believe that this should help to eliminate some of the problems identified.

We note that the amount of CMS delinquent debt referred to Treasury in FY 2000 increased significantly over prior periods and that documentation for receivable balances has improved in recent years. The latter resulted from CMS's work with consultants and the Office of Inspector General to validate the accuracy and completeness of accounts receivable activity within the limitations of a flawed accounting system. However, we believe that problems still exist because of the lack of a dual-entry, integrated financial system. As reported in previous financial statement audits, this has impaired CMS's ability to adequately support and accurately report debt management activity and balances. While the Healthcare Integrated General Ledger Accounting System, which we fully endorse, will correct many of the problems we noted, the system will not be fully operational until 2007. In the meantime, CMS should take aggressive action to ensure that accurate and timely information is reported on the TROR.

RECOMMENDATIONS

We recommend that CMS:

- Regularly reconcile summary debt information to supporting records by:
 - Using a core system (e.g., POR/PSOR) to track, manage, and report debt.
 - Emphasizing the importance of maintaining, for all debt balances, case folders containing supporting documents (e.g., correspondence, information on provider name changes, and demand letters).
 - Ensuring that debt management records (e.g., POR/PSOR) are reconciled quarterly to financial records (751s and automated spreadsheets) and to supporting documents in case folders.

- Ensure that individual debt balances accurately reflect collections and offsets by regularly coordinating with DOJ, OGC, contractors, and the regional offices and by strengthening coordination between CMS operations and financial reporting.
- Pursue debt through the required number of demand letters.
- Improve the process of assigning status codes to prevent the referral to Treasury of debt that is not eligible for referral and to ensure that eligible debt is referred.
- Review debt balances to identify those that need to be written off/closed or classified as CNC.
- Coordinate with Treasury to develop a policy on reporting unfiled cost reports on the TROR consistent with CMS's treatment of unfiled cost reports on its financial statements.
- Ensure compliance with the CMS debt transfer policy related to the assignment of location codes.

CMS COMMENTS

In response to a draft of this report, CMS agreed with the recommendations and stated that it had already begun to implement them.

**ESTIMATE OF DOLLAR VALUE OF MISSTATED DEBT BALANCES
AT SEPTEMBER 30, 2000**

To determine whether CMS debt was accurately reported to Treasury on the TROR at September 30, 2000, we tested the following samples:

- 450 debt balances reported by the CMS regional offices. We used a simple random sample to select our sample from a population of all reported regional debt balances.
- 247 debt balances reported by the CMS central office. We used two stratified samples to test these debt balances. For the first sample, we randomly selected 50 active POR and 50 active PSOR balances with location codes for DOJ, the central office, OIG, and OGC. We tested a total of 100 debt balances for this stratified sample.

In the second stratified sample, we intended to select 30 balances each for civil monetary penalties, fraud and abuse, and managed care and 60 balances for Medicare premiums (direct billing and State buy-ins). Because the entire population for managed care was 27 balances, we tested 100 percent of the balances for this stratum. We intended to select 30 balances from State buy-in premiums, but none of the debt was delinquent; therefore, we opted to selected 60 items from the direct billing area. We tested a total of 147 debt balances for this stratified sample.

The table below summarizes our statistical projections.

CMS Component	Sample Size	90% Confidence Interval	
		Lower Limit	Upper Limit
Regional Offices	450	\$21M	\$41M
Central Office:			
POR/PSOR	100	\$10M	\$37M
Non-POR/PSOR	147	\$37M	\$84M
Subtotal	247	\$47M	
Total	697	\$68M	

**ESTIMATE OF DOLLAR VALUE OF DEBT MANAGEMENT ERRORS
AT SEPTEMBER 30, 2000**

In addition to determining whether the correct amount for principal was reported, we evaluated the debt management process for the appropriate status codes using the following samples:

- We selected 800 debt balances reported by 8 Medicare contractors. We used a multistage sample based on the probability-proportional-to-size weighted by the dollar value of debt at each contractor location. The first stage consisted of a random selection of 8 contractors from 16 of the largest Medicare contractors. We randomly selected 100 debt balances at the 8 Medicare contractors: 30 balances aged 180 days or less⁵ and 70 balances aged more than 180 days.
- We selected 450 debt balances reported by the CMS regional offices. We used a simple random sample to select our sample from a population of all reported regional debt balances.

We identified debt management errors that misstated debt eligible for referral to Treasury. The table below summarizes our statistical projections.

Debt Management Error	CMS Component	Sample Size	90% Confidence Interval	
			Lower Limit	Upper Limit
Classified as Exception Instead of DCIA Debt	Region	450	\$41M	\$93M
Classified as DCIA Debt Instead of Exception	Region	450	\$5M	\$14M
Classified as Exception Instead of Repayment Plan	Contractor	560	\$39M	\$295M
Classified as CNC Instead of Bankruptcy	Region	450	\$5M	\$60M
Total			\$90M	

⁵ Note: We did not report any errors from the sample of 240 debt balances aged 180 days or less.



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

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2002 FEB -6 AM 10:18

Administrator
Washington, DC 20201

OFFICE OF INSPECTOR
GENERAL

DATE: FEB - 5 2002

TO: Janet Rehnquist
Inspector General

FROM: Thomas A. Scully
Administrator
Centers for Medicare & Medicaid Services

SUBJECT: Office of Inspector General (OIG) Draft Report: *Delinquent Medicare Debt and Compliance with the Debt Collection Improvement Act by the Centers for Medicare & Medicaid Services (CMS) (A-17-01-02003)*

Thank you for the report on our progress in implementing the major provisions of the Debt Collection Improvement Act (DCIA) of 1996. We are continually striving, not only to improve our debt management policies and recover delinquent debt, but also to ensure that taxpayer dollars are spent only for their intended purpose.

We are extremely proud of our work in referring delinquent debt to the Department of Treasury (Treasury). Early on, we developed an aggressive plan to implement the DCIA and have faithfully followed it with great success. During the past 2 years, CMS referred more than \$4 billion in delinquent debt that was more 180 days old. To accomplish this task, we hired additional staff, developed new procedures, and held extensive nationwide training sessions for both CMS staff and more than 50 Medicare contractors. Accomplishments have not come easily as debts needed to be validated, procedures implemented, and systems tested in order to integrate and reconcile our debt with the even larger Health and Human Services (HHS) debt portfolio.

We have created a centralized debt referral system enabling all of our contractors to access one centralized database. This system was then linked with the Department's Program Support Center to ensure an orderly flow of delinquent debt for cross servicing and offset. While referrals began slowly through a number of pilot programs, it was a necessary process that allowed us to identify, work through and resolve issues that inevitably arose before expanding it on a nationwide basis. The training program for our contractors continues on an ongoing basis with monthly teleconferences, annual conferences, and the identification and adoption of best practices. As part of CMS's overall financial management plan, we expect to attain our goal in referring all eligible debt to Treasury by the end of this year.

We appreciate your staff's work and recommendations to improve our referral and reporting processes in a very complex and complicated debt management arena. The CMS agrees with the recommendations in the OIG's report and has already begun work to implement them.

We also agree with your assessment that CMS' challenge continues to be the lack of a financial management system that fully integrates CMS' accounting systems with those of the Medicare contractors. This makes the debt referral process resource intensive. As you are aware, we are committed to also meet this challenge and are in the process of developing an integrated accounting system under our Health Care Integrated General Ledger Accounting System (HIGLAS) project. Our first pilots are scheduled for early next year.

We will continue working to refer all eligible debt to Treasury and increase our efforts to prevent debt from even occurring in our programs.

OIG Recommendation

Regularly reconcile summary debt information to supporting records.

CMS Response

CMS agrees with this recommendation. We have instructed our contractors to regularly reconcile summary debt information to their internal records. We will ensure this process is done through oversight of contractors, regional and central office activities (contractor performance evaluation reviews, A/R consultant reviews, the annual CFO audits, and national training seminars that are sponsored by the Office of Financial Management each year). In addition, during the annual training seminars, we will emphasize the importance of maintaining adequate documentation (i.e., case files, demand letters, Provider Overpayment Reporting system/Physician supplier Overpayment Reporting System ((POR/PSOR)) listings) to support all transactions and balances.

OIG Recommendation

Ensure that individual debt balances accurately reflect collections and offsets.

CMS Response

CMS agrees with this recommendation. CMS has already established weekly meetings to discuss financial reporting requirements and operational issues relative to the Medicare contractors, the CMS regional offices and CMS central office. In addition, we have established a procedure to ensure all new instructions (i.e., program memorandums, joint signature letters and manual updates) are reviewed for financial reporting implications.

CMS has contracted with an outside consultant firm to review the operational processes specific to DOJ and OGC debt balances and accounting activities. The results of this review will be incorporated into new operational procedures.

OIG Recommendation

Pursue debt through the required number of demand letter.

CMS Response

CMS agrees with this recommendation. The issuance of demand letters will be reviewed as part of our oversight processes that are outlined in recommendation #1.

OIG Recommendation

Improve the process of assigning status codes to prevent the referral to The Treasury of debt that is not eligible for referral and to ensure that eligible debt is referred.

CMS Response

CMS agrees with this recommendation. CMS has incorporated a review of the use of these codes in the contractor oversight and evaluation process. In addition, CMS is in the process of enhancing the definitions of the POR/PSOR status codes to ensure consistent interpretation and use of these codes.

OIG Recommendation

Review debt balances that need to be written off/closed or classified as written off/closed or classified as currently not collectible (CNC).

CMS Response

CMS agrees with this recommendation. Instructions were sent to Medicare contractors during FY 2001 formalizing the process for reporting debt that should be classified as write-off/closed or classified as CNC. In addition during the 2nd quarter of FY 2002, instructions will be issued to the regional offices establishing procedures to monitor contractor's performance relative to write-off closed debt.

OIG Recommendation

Coordinate with Treasury to develop a policy on reporting unfiled cost reports on the TROR consistent with CMS's treatment of unfiled cost reports on its financial statements.

CMS Response

CMS agrees with this recommendation. During FY 2001, CMS issued formal instructions to the regional offices and Medicare contractors, which discontinued the recognition and reporting of unfiled cost reports on the CMS financial statements. However, CMS will continue to refer this debt to Treasury and this debt will be reflected on the TROR.

OIG Recommendation

Ensure compliance with the CMS debt transfer policy related to the assignment of location codes.

CMS Response

CMS agrees this recommendation. As discussed in recommendation #4, CMS has incorporated a review of the use of these codes in the contractor oversight and evaluation process. In addition, CMS is in the process of enhancing the definitions of codes used in the POR/PSOR to ensure consistency.

Technical Comments

Overall comment: Since the review of Medicare accounts receivable on September 30, 2000, many changes have been made since then which are not noted in this report. The report refers to the amount of debt that has been referred to Treasury through September 30, 2000 but never comments on our overall strategy/goal to: (1) refer \$2 billion in FY 01; and (2) refer 100 percent of eligible debt by the end of FY 02. In addition, the report refers to policy that has been changed, but makes it sound like current policy.

Executive Summary, Page i, Summary of Findings: The sentence, "While the referral rate for CMS debt transferred to Treasury has improved, we believe that CMS should take a more aggressive role to ensure that...", should state our goals and that we have met them.

Executive Summary, Page iii, Writing Off Debt: The sentence related to debt considered for write off/closed describes the write off/closed criteria during the CMS one-time write off policy at September 30, 1999. For write off/closed of non-Medicare Secondary Payer (MSP) debt, CMS follows the criteria outlined in 42 CFR 405.376.

Introduction, Page 1, Background, third paragraph - The sentence that states: "The CMS uses both the 751 and the POR/PSOR information to prepare the quarterly Treasury Report on Receivables (TROR)." This sentence does not clearly state that the POR/PSOR contains only a portion of the Medicare debt. These systems do not contain any MSP debt, claims adjustments, or beneficiary debt, etc.

Introduction, Page 1, CMS Policy, first paragraph: This paragraph mentions that contractor is to send as many as three overpayment demand letters to the provider within 90 days.....this policy is for non-MSP overpayments. The paragraph does not mention that CMS overpayments are collected at the contractor location through Medicare recoupment. This is a large part of our collection of debt and most of our non-MSP overpayments are collected through Medicare offset, as contractors have an ongoing relationship with the providers/suppliers.

Introduction, Page 2, CMS Policy, third paragraph: "As a result, CMS transferred to Treasury..." CMS does not transfer the debt, but merely refers it to Treasury for cross servicing. The A/R is not transferred to Treasury for financial reporting. The sentence does not mention that MSP debt was included in the \$2 billion.