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|  | Whether the Medicare Administrative Contractor (“MAC”) erred in disallowing bad debts claimed by the Provider for indigent patients. |

**A. Facts**

The Providers in this group are appealing the MAC’s adjustments to their fiscal year end 8/31/2015 cost reports that adjusted the Providers’ claimed indigent bad debts. In its preliminary position paper on page 7, the Group states:

During the cost reporting period under appeal, the Providers employed a Charity Care Policy that awarded financial assistance based on the patient’s income relative to the federal poverty level. The Providers confirmed the indigence of certain Medicare patients consistent with its Charity Care Policy. The Medicare Administrative Contractor (the “MAC”) disallowed bad debts claimed by the Providers related to indigent patients, evidently referring to the total resources test set forth in section 312.B of the PRM, which states that providers “should” consider a patient’s total resources in determining indigence.

Based on the respective bad debt reviews performed for each Provider, the MAC determined inpatient and outpatient indigent bad debts were not allowable due to the Providers’ lack of due diligence in establishing an indigence determination as instructed by the Provider Reimbursement Manual (PRM) 15-1, Section 312 and 42 CFR Section 413.89.[[1]](#footnote-1) Specifically for the determination of indigence, the Providers only considered the patients’ income and assets and did not take into account any liabilities or expenses in accordance with the PRM 15-1, Section 312(B). The facts for each Provider are presented separately below.[[2]](#footnote-2)

1. **Participant 1: Bon Secours Richmond County Hospital (Provider Number (“PN”) 49-0094)**

The Provider appealed adjustments 18, 23, 25 and 27. Adjustment 23 and 27 removed all of the Hospital inpatient (IP) and outpatient (OP) indigent bad debts based on extrapolated findings noted during the MAC’s review of the Medicare reimbursable bad debts. Adjustments 18 and 25 removed the Provider’s protested amount for Medicare Bad Debts. See the final audit adjustment report and the bad debt workpapers at **Exhibit C-2**.

The MAC selected a statistical sample of thirteen (13) inpatient accounts and thirteen (13) outpatient accounts for review.[[3]](#footnote-3) The MAC disallowed 100 percent of the inpatient and outpatient indigent bad debts based on the determination that the supporting patient documentation received did not contain any indication of how total resources were used by the Provider to determine indigency.[[4]](#footnote-4)

1. **Participant 2: Bon Secours Maryview Medical Center (PN 49-0017)**

The Provider appealed adjustments 27, 35, 39 and 40. Adjustment 35 and 40 removed all of the Hospital IP and OP indigent bad debts based on extrapolated findings noted during the MAC’s review of the Medicare reimbursable bad debts. Adjustments 27 and 39 removed the Provider’s protested amount for Medicare Bad Debts. See the final audit adjustment report and the bad debt workpapers at **Exhibit C-3**.

The MAC selected a statistical sample of thirteen (13) indigent IP and thirteen (13) indigent OP bad debt accounts for review.[[5]](#footnote-5) The MAC disallowed 100 percent of the IP and OP indigent bad debts due to the following findings: 1) lack of documentation from the Provider to support the indigence determinations were based on the analysis of the patients’ income, expenses, assets and total liabilities[[6]](#footnote-6) and 2) lack of estate verification on deceased patient accounts.[[7]](#footnote-7)

1. **Participant 3: Bon Secours St. Mary’s Hospital (PN 49-0059)**

The Provider appealed adjustments 33 and 37 which removed all of the Hospital inpatient and outpatient indigent and traditional bad debts based on extrapolated findings noted during the MAC’s review of the Medicare reimbursable bad debts. See the final audit adjustment report and the bad debt workpapers at **Exhibit C-4**.

The MAC selected a statistical sample of thirty-five (35) IP accounts and thirty-five (35) OP accounts for review.[[8]](#footnote-8) The MAC disallowed 100 percent of the inpatient and outpatient indigent bad debts due to the following findings: 1) lack of documentation from the Provider to support the indigence determinations were based on the analysis of the patients’ income, expenses, assets and total liabilities[[9]](#footnote-9) and 2) lack of estate verification on deceased patient accounts.[[10]](#footnote-10)

1. **Participant 4: Memorial Regional Medical Center (PN 49-0069)**

The Provider appealed adjustments 29 and 36 which removed all of the Hospital inpatient and outpatient indigent and traditional bad debts based on extrapolated findings noted during the MAC’s review of the Medicare reimbursable bad debts. See the final audit adjustment report and the bad debt workpapers at **Exhibit C-5**.

The MAC selected a statistical sample of thirty-five (35) inpatient accounts and thirty-five (35) outpatient accounts for review.[[11]](#footnote-11) The MAC disallowed 100 percent of the inpatient and outpatient indigent bad debts due to the following findings: 1) lack of documentation from the Provider to support the indigence determinations were based on the analysis of the patients’ income, expenses, assets and total liabilities[[12]](#footnote-12) and 2) lack of estate verification on deceased patient accounts.[[13]](#footnote-13)

**B. Arguments**

Section 1861(v)(1)(A) of the Medicare Act defines “reasonable cost” as “the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs…” The statute authorizes the Secretary to outline the regulations to create methods to determine reasonable costs and the items to be eligible for reimbursement services. The statute states: “[i]n prescribing the regulations referred to in the preceding sentence, the Secretary shall consider, among other things, the principles generally applied by national organizations or established prepayment organizations (which have developed such principles) in computing the amount of payment, to be made by persons other than the recipients of services, to providers of services on account of services furnished to such recipients by such providers…”.

Regulation 42 CFR § 413.20 (a) provides: “*General* - the principles of cost reimbursement will require that providers maintain sufficient financial records and statistical data for proper determination of costs payable under the program… (d) Continuing provider recordkeeping requirements. (1) The Provider must furnish such information to the intermediary as may be necessary (i) to assure proper payment by the program…(ii) to receive program payments, and (iii) to satisfy program over payment determinations. (2) The provider must permit the intermediary to examine such records and documents as are necessary to ascertain information pertinent to the determination of the proper amount of program payment due…”.

42 CFR § 413.24(a) defines the principle of adequate cost data and cost finding. It states, “Providers receiving payment on the basis of reimbursable cost must provide adequate cost data. This must be based on their financial and statistical records which must be capable of verification by qualified auditors.” 42 CFR § 413.24(c) further identifies the importance of supplying adequate cost information to obtain program reimbursement. It states that “adequate cost information must be obtained from the provider's records to support payments made for services rendered to beneficiaries. The requirement of adequacy of data implies that the data be accurate and in sufficient detail to accomplish the purposes for which it is intended. Adequate data capable of being audited is consistent with good business concepts and effective and efficient management of any organization, whether it is operated for profit or on a nonprofit basis. It is a reasonable expectation on the part of any agency paying for services on a cost-reimbursement basis.”[[14]](#footnote-14) **(Exhibit C-6)**

At the center of Medicare's cost reimbursement principles is the rule against cross-subsidization.

The regulatory provision at 42 CFR § 413.89(d) states:

The failure of beneficiaries to pay the deductible and coinsurance amounts can result in the related costs of covered services being borne by other than Medicare beneficiaries. To assure that such covered service costs are not borne by others, the costs attributable to the deductible and coinsurance amounts, which remain unpaid, are added to the Medicare share of allowable costs.

Reference **Exhibit C-7,** Consequently, Providers may receive reimbursement for accounts claimed as Medicare bad debt, if they meet certain criteria.

Under the Secretary’s interpretive authority and longstanding policy, the PRM clarifies these regulatory provisions. In order for bad debts to be allowable under Medicare, the bad debts must meet the provisions of Section 308 of the PRM. Reference **Exhibit C-7** and **Exhibit C-8**. 42 CFR § 413.89(e) and the PRM Section 308 require that:

1. The debt must be related to covered services and derived from deductible and coinsurance amounts (see § 305 for exception).
2. The provider must be able to establish that reasonable collection efforts were made.
3. The debt was actually uncollectible when claimed as worthless.
4. Sound business judgment established that there was no likelihood of recovery at any time in the future.

Per the PRM Section 310, Reasonable Collection Effort, must

… involve the issuance of a bill on or shortly after discharge or death of the beneficiary to the party responsible for the patient’s personal financial obligations. It also includes other actions such as subsequent billings, collection letters and telephone calls or personal contacts with this party which constitutes a genuine, rather than a token, collection effort. …

A. Collection Agencies – A provider’s collection effort may include the use of a collection agency in addition to or in lieu of subsequent billings, follow-up letters, telephone and personal contacts. …

B. Documentation Required – The provider’s collection effort should be documented in the patient’s file by copies of the bill(s), follow-up letters, reports of telephone and personal contact, etc.

Section 310.2, Presumption of Noncollectibility, states, “If after reasonable and customary attempts to collect a bill, the debt remains unpaid more than 120 days from the date the first bill is mailed to the beneficiary, the debt may be deemed uncollectible.”.

Section 312 of the PRM, Indigent or Medically Indigent Patients, states,

In some cases, the provider may have established before discharge or within a reasonable time before admission, that the beneficiary is either indigent or medically indigent. Providers can deem Medicare beneficiaries indigent or medically indigent when such individuals have also been determined to be eligible for Medicaid as either categorically needy individuals or medically needy individuals, respectively. Otherwise, the provider should apply its customary methods for determining indigence of patients to the case of the Medicare beneficiary under the following guidelines:

A. The patient's indigence must be determined by the provider, not by the patient; i.e., a patient's signed declaration of his inability to pay his medical bills cannot be considered proof of indigence;

B. The provider should take into account a patient's total resources which would include, but are not limited to, an analysis of assets (only those convertible to cash and unnecessary for the patient's daily living), liabilities, and income and expenses. In making this analysis the provider should take into account any extenuating circumstances that would affect the determination of the patient's indigence;

C. The provider must determine that no source other than the patient would be legally responsible for the patient's medical bill; e.g., title XIX, local welfare agency and guardian; and

D. The patient's file should contain documentation of the method by which indigence was determined in addition to all backup information to substantiate the determination.

Once indigence is determined and the provider concludes that there had been no improvement in the beneficiary’s financial condition, the debt may be deemed uncollectible without applying the § 310 procedures……

**ii. Indigency Determination**

This issue in dispute is centered on indigent bad debts and whether the Providers’ bad debt policy for determining patient indigence is consistent with Medicare regulations and instructions, specifically the PRM 15-1, Section 312(B) requiring providers to take into account a patient’s total resources, which would include but is not limited to assets, liabilities, income and expenses. The Providers’ process for determining indigence as outlined in their policy is not an actual assessment of a patient’s total resources of assets, income, liabilities and expenses, but rather a general comparison of income and assets to Federal Poverty Guidelines. Reference **Exhibit C-9**. Further, the Providers incorrectly concludes that Section 312 of the PRM 15-1 does not mandate that providers conduct a test of assets, liabilities, income and expenses in order to claim reimbursement for their indigent bad debt. Although Section 312 of the PRM requires that a provider must apply its “customary methods for determining the indigence,” this “customary method” must include an assessment of the patient’s total resources and not an assessment of a patient’s “ability and propensity to pay a debt.”

The Providers contends that hospitals are free to develop and apply their own customary methods for determining patient indigent status and that the federal government does not regulate or impose any requirements on the customary methods hospitals used to determine whether patients receive charity care. The Provider cites *Baptist Healthcare Sys v. Sebelius,* 646 F. Supp. 2d D.D.C 2009 noting that CMS has stated that “a hospital may determine its own individual indigency criteria.” At page 10 of the Group’s Preliminary Position Paper, the Group references a CMS Q&A entitled “Questions on Charges for the Uninsured”, as a source of support for developing its own financial assistance policy and entitlement to Medicare bad debt reimbursement. While the Providers may develop its own “customary method” for determining indigence, the Provider must abide by certain minimum criteria for reimbursement of its Medicare bad debts. As reiterated in Question 11 of the same CMS Q&A noted by the Providers, “if a provider wants to claim Medicare bad debt reimbursement CMS does require documentation to support the indigency determination. To claim Medicare bad debt reimbursement, the provider must follow the guidance stated in the Provider Reimbursement Manual. A hospital should examine a patient’s total resources (emphasis added), which could include, but are not limited to an analysis of assets, liabilities, income and expense, and any extenuating circumstances that would affect the determination.” Reference **Exhibit C-10.**

During the period at issue, the Providers had in place a charity care policy that established provisions for financial assistance to patients who were determined to be indigent under the Providers’ customary methods. As indicated in the Providers’ policy (**Exhibit C-9**), through the financial assistance services for Bon Secours Health System, Inc., patients have access to full charity care write-off for patients whose household income is under 200% of the Federal Poverty Level (“FPL”) and a sliding scale discount for patients whose household income is above 200% of the FPL. The MAC notes that the indigency determinations in dispute appear to be determined by the Providers. In order to qualify for financial assistance and sliding scale discounts, the Providers obtain information from the patient such as total family income, assets, liabilities and current medical debt in order to assess a patient’s indigence. The Providers did not put any emphasis toward consideration of liabilities and expenses in its charity policy. For the inpatient and outpatient indigent patients the MAC reviewed, liabilities and expenses did not factor into the Providers’ decision to approve the patient’s financial assistance applications.

The Group contends that the MAC’s determination disallowing the audited bad debts designated as indigent is flawed because it conflicts with the language of the controlling rules that allow Medicare bad debt reimbursement with respect to Medicare patients who are determined indigent under the hospital’s customary methods. The Group contends that Section 312 of the PRM 15-1, only requires that a hospital must apply its “customary methods for determining the indigence of patients.”

The MAC contends CMS is not dictating the Providers’ policies in this case. The MAC is charged with auditing and verifying the Providers’ information. Section 42 CFR 413.24 puts the burden of providing adequate data on the provider stating in part: “Providers receiving payment on the basis of reimbursable cost must provide adequate cost data. This must be based on their financial and statistical records which must be capable of verification by qualified auditors.” (**Exhibit C-6**)

The MAC is responsible for ensuring that the Providers carried out its due diligence in determining the indigence status of its Medicare patients. The MAC must be furnished auditable information in which to ensure the Provider is in fact following the guidelines established in the Medicare regulations.[[15]](#footnote-15)

The MAC contends that the Secretary has consistently interpreted the manual provisions as requiring providers to comply with all terms in order to receive reimbursement for Medicare bad debt. Sections 310 and 312 of the PRM 15-1 set forth procedures that must be followed and criteria that must be met in order to be in compliance with the regulations. The MAC relies on the Secretary’s interpretation in the administrator’s decision in *Baptist Regional Medical Center vs. Blue Cross Blue Shield Association/National Government Services-Kentucky*, Administrator Decision 2008-D12, February 8, 2008.[[16]](#footnote-16)

According to the Administrator’s decision, Section 312 of the PRM 15-1 does create a mandatory asset test. It is critical that the provider meet all the indigence criteria set forth in Section 312 of the PRM 15-1 and take into account all necessary information needed to properly deem any patient indigent, and thus meet the regulatory requirements that a reasonable collection effort was made and that the debt was uncollectible when claimed as worthless.

Pursuant to the regulation and manual instructions cited above, except in cases where a patient has been determined eligible for Medicaid, providers are required to follow certain procedures in making indigence determination. Those procedures include a) not relying on patient declarations of inability to pay as proof of indigence; b) the application of an asset test – taking into account patient assets, as well as liabilities, income, expenses, to determine indigence; and c) ensuring, after an initial determination that a patient is indigent, that the beneficiary’s financial condition has not improved.

Moreover, Section 312 of the PRM 15-1 compels providers to follow the above-cited procedures to determine indigence and ensures compliance with the requirements of 42 CFR Section 413.89(e), that providers make reasonable collection efforts and ensure that debts are uncollectible before claiming them for Medicare payment. If the Secretary were to excuse providers from attempting to collect debts because such attempts would be futile due to indigence, as provided under Section 312, then it is only reasonable to require – except in the cases of governmental determinations of Medicaid eligibility – that the Provider follow prescribed criteria for verifying indigence and document those procedures in accordance with Medicare documentation rules.

While the MAC notes the Administrator’s decision was not upheld in the United States District

Court for the District of Columbia (*Baptist Healthcare Sys v. Sebelius*, 646 F. Supp. 2d D.D.C

2009), the MAC contends the regulations have not changed to reflect language to the

contrary, despite the Provider’s statements.

**iii. Longstanding CMS Policy codified in the FFY 2020 IPPS Final Rule does not permit a Provider to disregard consideration of Total Resources for the cost reporting period under review.**

In the CMS Proposed Rule for (Federal Fiscal Year) FFY 2021 IPPS (85 FR 32460, 32866-32876, May 29, 2020), CMS proposed to codify the requirements at the PRM 15-1, Section 312(B) that a Provider must follow to determine a beneficiary to be an indigent non-dual eligible beneficiary. Various parts of the rule codified the longstanding policies, which made them applicable to cost reporting periods before, on and after October 1, 2020.

In the proposed rule CMS states:

We are also proposing to amend § 413.89(e)(2) by adding new paragraph (e)(2)(ii)(A) to specify that to determine a beneficiary to be an indigent non-dual eligible beneficiary, the provider must apply its customary methods for determining whether the beneficiary is indigent under the following requirements: (1) The beneficiary’s indigence must be determined by the provider, not by the beneficiary; that is a beneficiary’s signed declaration of their inability to pay their medical bills and/or deductibles and coinsurance amounts cannot be considered proof of indigence; (2) the provider must take into account a beneficiary’s total resources which includes, but is not limited to, an analysis of assets (only those convertible to cash and unnecessary for the beneficiary’s daily living), liabilities, and income and expenses. While a provider must take into account a beneficiary’s total resources in determining indigence, any extenuating circumstances that would affect the determination of the beneficiary’s indigence must also be considered; and (3) the provider must determine that no source other than the beneficiary would be legally responsible for the beneficiary’s medical bill; for example, a legal guardian.

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In this proposed rule, we are proposing that these revisions would be effective for cost reporting periods beginning before, on and after the effective date of this rule because they are clarifications and codifications of longstanding Medicare policies.

(85 FR 32872, May 29, 2020) **(Exhibit C-11)**

During the notice and comment period, stakeholders questioned the requirement that a beneficiary’s total resources be considered when a provider evaluates a beneficiary’s indigence. After consideration of comments, CMS did not finalize its proposal to add new paragraph (e)(2)(ii)(A) (85 FR 58999, September 18, 2020). Instead, CMS introduced new requirements, following the notice and comment period, by adding paragraph (e)(2)(ii)(A), which specifies:

..that in order to conclude that a beneficiary is an indigent non-dual eligible beneficiary, the provider: (1) Must not use the beneficiary’s declaration of their inability to pay their medical bills or deductibles and coinsurance amounts as sole proof of indigence or medical indigence; (2) Must take into account the analysis of both the beneficiary’s assets (only those convertible to cash and unnecessary for the beneficiary’s daily living) and income, (3) May consider extenuating circumstances that would affect the determination of the beneficiary’s indigence or medical indigence which may include an analysis of both the beneficiary’s liabilities and expenses, if indigence is unable to be determined under (ii)(A)(2), (4) Must determine that no source other than the beneficiary would be legally responsible for the beneficiary’s medical bill, such as a legal guardian or State Medicaid program, and (5) Must maintain and, upon request , furnish its Medicare contractor with the provider’s indigence determination policy describing the method by which indigence or medical indigence is determined and all the verifiable beneficiary specific documentation which supports the provider’s determination of each beneficiary’s indigence or medical indigence.

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In the proposed rule, we proposed that our proposals would be effective for cost reporting periods beginning before, on and after the effective date of this rule **because our proposals were clarifications and codifications of longstanding Medicare policies (Emphasis Added)** However, because of the changes to the policies we are finalizing after consideration of public comments, we are finalizing these policies with an effective date for cost reporting periods beginning on or after October 1, 2020.

(85 FR 58999, September 18, 2020**) (Exhibit C-12)**

CMS specifically states that the PRM 15-1, Section 312(B) is its longstanding CMS policy and changed the requirements that a Provider must review income/assets and may consider liabilities/expenses under extenuating circumstances for cost reporting periods **beginning on or after October 1, 2020 (Emphasis Added)**. Therefore, the MAC contends that at the time of its review, and as the cost reporting period reviewed is a cost reporting period that begins prior to October 1, 2020, the MAC followed the interpretation of the Secretary for this issue based on the PRM 15-1, Section 312(B) which requires total resources be analyzed to determine indigence. The MAC would like to again note that the Provider did not submit any documentation for the determination of indigency other than a patient account history with a line entry stating that the patient was approved for assistance.

**C. Conclusion**

The Provider has not exercised due diligence in meeting the criteria set forth in PRM 15–I § 312 in the determination of indigency for the purposes of reimbursement of bad debts by the Medicare program. The MAC respectfully requests the Board uphold the MAC’s adjustments to remove inpatient and outpatient indigent bad debts due to the Provider’s lack of a comprehensive review to determine indigency.

**IV. LAW, REGULATIONS, PROGRAM INSTRUCTIONS**

Laws:

Section 1815(a) of the Social Security Act;Section 1861(v)(1)(A) of the Medicare Act

Regulations:

42 C.F.R. § 413.20 Financial data and reports;42 C.F.R. § 413.24 Adequate cost data and cost finding;42 C.F.R. § 413.89 (2020) Bad debts, charity, and courtesy allowances;85 FR 32460, 32866-32876 May 29, 2020;85 FR 58432, 58989-59006 September 18, 2020

Program Instructions:

CMS PRM 15-1, § 308 Criteria for Allowable Bad Debt;CMS PRM 15-1, § 310 Reasonable Collection Effort;CMS PRM 15-1, § 312 Indigent or Medically Indigent Patients

Case Law:

*Baptist Regional Medical Center vs. Blue Cross Blue Shield Association/National Government Services-Kentucky*, Administrator Decision 2008-D12, February 8, 2008;*Baptist Healthcare Sys v. Sebelius,* 646 F. Supp. 2d D.D.C 2009;*Doctors Hospital vs. BCBSA/CGS Administrators LLC*, PRRB Case #2012-D18, dated September 11, 2012

**V. EXHIBITS**

C-1. Group’s Schedule of Providers

C-2. 49-0094 Final Audit Adjustment Report & MAC Bad Debt Workpapers

C-3. 49-0017 Final Audit Adjustment Report & MAC Bad Debt Workpapers

C-4. 49-0059 Final Audit Adjustment Report & MAC Bad Debt Workpapers

C-5. 49-0069 Final Audit Adjustment Report & MAC Bad Debt Workpapers

C-6. 42 CFR §§ 413.20 and 413.24

C-7. 42 CFR § 413.89

C-8. PRM CMS Pub. 15-1, Sections 308, 310, 312

C-9. Providers’ Charity Care Policy

C-10. CMS’s Questions on Charges for the Uninsured

C-11. 85 Federal Register 32460, 32866-32876, (05/29/2020)

C-12. 85 Federal Register 58432, 58989-59006 (09/18/2020)

1. Reference the workpapers at **Exhibit C-2, C-3, C-4 & C-5**. Detailed workpapers are available but contain PHI. The MAC will submit unredacted documentation under seal, if necessary. [↑](#footnote-ref-1)
2. While the Providers in the group are all appealing the MAC’s adjustments to indigent bad debts, the MAC questions if this issue is appropriate for a group appeal since the underlying facts for each Provider are not identical. [↑](#footnote-ref-2)
3. See **Exhibit C-2, pages 6-7**, for a redacted copy of the MAC’s analysis of the reviewed inpatient and outpatient accounts. Two of the thirteen inpatient sampled accounts related to indigent bad debts. Four of the thirteen outpatient sampled accounts were related to indigent bad debts. [↑](#footnote-ref-3)
4. This error was found in both inpatient indigent samples and all four of the outpatient indigent samples. [↑](#footnote-ref-4)
5. See **Exhibit C-3, pages 7-8**, for a redacted copy of the MAC’s analysis of the reviewed inpatient and outpatient indigent accounts. [↑](#footnote-ref-5)
6. This error was found in seven of the thirteen inpatient samples and eight of the thirteen outpatient samples. [↑](#footnote-ref-6)
7. This error was found in six of the thirteen inpatient samples and five of the thirteen outpatient samples. [↑](#footnote-ref-7)
8. See **Exhibit C-4, pages 3-4**, for a redacted copy of the MAC’s analysis of the reviewed inpatient and outpatient accounts. Nine of the thirty-five inpatient sampled accounts related to indigent bad debts. Ten of the thirty-five outpatient sampled accounts were related to indigent bad debts. The remaining sampled accounts are traditional bad debt accounts, which are being appealed in group case number 20-1927GC for the bad debt zero balance issue. [↑](#footnote-ref-8)
9. This error was found in all nine of the indigent inpatient samples and all ten of the indigent outpatient samples. [↑](#footnote-ref-9)
10. This error was found in three of the ten indigent outpatient samples. [↑](#footnote-ref-10)
11. See **Exhibit C-4, pages 3-4**, for a redacted copy of the MAC’s analysis of the reviewed inpatient and outpatient accounts. Nine of the thirty-five inpatient sampled accounts related to indigent bad debts. Seven of the thirty-five outpatient sampled accounts were related to indigent bad debts. The remaining sampled accounts are traditional bad debt accounts, which are being appealed in group case number 20-1927GC for the bad debt zero balance issue. [↑](#footnote-ref-11)
12. This error was found in seven of the indigent inpatient samples and all seven of the indigent outpatient samples. [↑](#footnote-ref-12)
13. This error was found in two of the nine indigent inpatient samples. There was also an error noted for insufficient documentation relating to a write off date for one of the two disallowed deceased patients. [↑](#footnote-ref-13)
14. See also Section 1815(a) of the Social Security Act, which provides that, “no such payments shall be made to any provider unless it has furnished such information as the Secretary may request in order to determine the amounts due such provider under this part for the period with respect to which the amounts are being paid or any prior period.” [↑](#footnote-ref-14)
15. See also the CMS Administrator Decision *in Doctors Hospital vs. BCBSA/CGS Administrators LLC*, PRRB Case #2012-D18, dated September 11, 2012 stating, “[S]ince Medicare’s inception, providers have been required to maintain and furnish contemporaneous, adequate documentation capable of verification, on audit, to support their claimed costs, including bad debt costs…..The Administrator finds that the burden of proof rests with the provider to maintain and furnish contemporaneous and verifiable documentation.” [↑](#footnote-ref-15)
16. While the MAC notes the administrator’s decision was not upheld in the United States District Court for the District of Columbia (*Baptist Healthcare System v. Sebelius,* 646 F. Supp. 2d 28 D.D.C 2009), but the regulations were not changed until cost reporting periods beginning on/after 10/1/2020. [↑](#footnote-ref-16)