**Whether the MAC’s adjustments to Medicare Inpatient and Outpatient Crossover and Medicare Managed Care Crossover Bad Debts were determined correctly – Additional Crossover Share of Cost Bad Debts.**

**A. Facts None**

Pursuant to audit adjustment numbers 22 and 29 (Exhibit C-2, pages 11, 12 and 13), the MAC adjusted the Provider’s as-filed Medicare bad debts to “reconcile reported bad debts with the Provider’s updated bad debt listings”. These adjustments reduced the Provider’s inpatient crossover and outpatient crossover Medicare bad debts by $32,251 and $14,822, respectively. See Exhibit C-11 for the MAC adjustment workpaper L-G1.

The Provider also included the estimated reimbursement effect of additional allowable inpatient and outpatient Medicare crossover bad debts in its filed Protested Amounts on its cost report. Although the Provider’s filed protested amount documentation includes item 33 related to “[u]nderstated Medicare bad debt payments reported in the filed Medicare cost report pending receipt of bad debt documentation from the State of California (PCSR) and/or the applicable Medi-Cal HMO agency.”, the amounts listed for this item are zero. The only Protested Amount filed related to Medicare Bad Debt payments is item 34 “[u]nderstated Medicare crossover bad debt reimbursement related to share of cost claims”, $142,587 Part A and $111,288 Part B. The MAC adjusted to remove the Provider’s filed Protested Amounts in audit adjustments 21 and 28 (Exhibit C-2). The Provider’s protested amounts detail is included as Exhibit C-3.

According to the Provider’s Final Position Paper (FPP, page 8), the Provider is requesting to include additional crossover bad debts. The Provider is claiming new additional crossover bad debts and is not contesting the MAC’s adjustments made during audit. Therefore, the MAC will limit its response to the new additional crossover bad debts being requested by the Provider.

The Provider asserts that inpatient and outpatient crossover Medicare bad debts were understated due to additional claims that were processed. The Provider contends they have billed their crossover bad debts to the State of California and the State of California processed and remitted payment to the Provider, where applicable, in accordance with the State Plan. The Provider is claiming the unreimbursed portion of the Medicare/Medicaid bad debt after the processing of the claims. The Provider does not include any explanation as to why the debts in question were not claimed as normal inpatient and outpatient crossover Medicare bad debts on the Provider’s filed cost report. The Provider’s Appeal request (Exhibit C-12, pages 6 and 7) and its Final Position Paper indicate that the amounts in contention relate to crossover bad debts for share of cost claims.

The Provider is requesting an additional $63,061 in Medicare inpatient and outpatient crossover bad debts. Per Provider’s Exhibit P-13, this consists of $38,828 of Medicare inpatient crossover bad debts and $24,233 of Medicare outpatient crossover bad debts. The Provider states that “…adequate documentation is available to support the Medicare inpatient and outpatient crossover bad debts enclosed in Exhibit P-13.” (Provider’s FPP, page 9)

The MAC contends the Provider has not demonstrated with convincing evidence that there are additional allowable inpatient and outpatient Medicare crossover bad debts that were not yet reimbursed.

**B. Argument**

The Provider contends that its allowable Medicare Inpatient and Outpatient Crossover bad debts are understated due to the existence of additional crossover bad debts. The Provider’s Appeal request (Exhibit C-12, pages 6 and 7) and its Final Position Paper (FPP) indicate that the amounts in contention relate to crossover bad debts for share of cost claims. The Provider’s FPP states on page 8:

The MAC eliminated the Provider’s protested items which included an amount for additional Medicare inpatient and outpatient crossover bad debts. Specifically, the inpatient and outpatient crossover bad debts were understated related to crossover bad debts with share of cost claims.

The MAC contends the Provider has been properly reimbursed for its Medicare bad debts, as required by the regulations at 42 C.F.R. § 413.89 (Exhibit C-13). When a Medicaid recipient is found to be responsible for a SOC amount, the beneficiary is responsible for this amount. Providers must be able to support whether a proper reasonable collection effort has been applied to these SOC amounts. Bad debt amounts for which the record indicated the patient had an unmet Share of Cost cannot be allowed.

The controlling regulation regarding Medicare bad debts is found at 42 C.F.R. § 413.89 (Exhibit C-13). Specifically, 42 C.F.R. § 413.89(e) defines the criteria for Medicare bad debt reimbursement as follows:

**(e) Criteria for allowable bad debt.** A bad debt must meet the following criteria to be allowable:

(1) The debt must be related to covered services and 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.

(4) Sound business judgment established that there was no likelihood of recovery at any time in the future.

(f) **Charging of bad debts and bad debt recoveries.** The amounts uncollectible from specific beneficiaries are to be charged off as bad debts in the accounting period in which the accounts are deemed to be worthless. In some cases an amount previously written off as a bad debt and allocated to the program may be recovered in a subsequent accounting period; in such cases the income therefrom must be used to reduce the cost of beneficiary services for the period in which the collection is made.

Per this regulation, as applicable to this case, providers must be able to document that reasonable collection efforts were made. Bad debts can only be claimed when an account can be shown to be actually uncollectible when claimed as worthless. Before a debt can be determined to be worthless, all potential legally responsible parties must have been properly billed. Further, bad debts are to be charged off in the accounting period in which the accounts are deemed to be worthless.

The requirements for bad debt reimbursement are discussed further in CMS instructions in CMS Pub. 15, Part 1, Chapter 3. Specifically, Section 312 (Exhibit C-14) states:

In some cases, the provider may have established before discharge, or within a reasonable time before the current 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 eligible for Medicaid as either categorically needy individuals or medically needy individuals, respectively. Otherwise, the provider should apply its customary methods for determining the 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 indigency;

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. (See §322 for bad debts under State Welfare Programs.)

As part of the manual requirements, CMS has a must bill policy for Medicare/Medicaid dual eligible beneficiaries. The must bill policy states that if a patient is determined by the provider to be indigent or medically indigent, the provider does not need to attempt to collect from the patient. However, the provider must make certain that no source other than the patient would be legally responsible for the patient’s medical bill; e.g., title XIX, local welfare agency…, prior to claiming the bad debt from Medicare.

The Provider is required to document the State’s liability for any cost sharing amounts related to unpaid Medicare deductible and coinsurance amounts for dual eligible beneficiaries. The Medicare must-bill policy is an effectuation of this requirement. The must-bill policy is set forth in CMS Pub. 15-1 Sections 310, 312 and 322 (Exhibit C-14).

With respect to beneficiaries who are dual-eligible, Section 1905(p)(3) of the Social Security Act (Act) imposes liability for cost sharing amounts for Qualified Medicare Beneficiaries (QMB) on the States, though Section 1902(n)(2) allows the States to limit that amount to the Medicaid rate and essentially pay nothing toward dual-eligible beneficiaries’ cost sharing if the Medicaid rate is lower than what Medicare would pay for the service.

In those instances where the State owes nothing or only a portion of the dual eligible patient’s deductible or co-pay, the unpaid liability for the bad debt is not reimbursable to the Provider by Medicare until the Provider properly bills the State, and the State refuses payment with a State Remittance Advice. It is required that all Providers have a processed State Medicaid Remittance Advice before allowing dual eligible bad debts.

Item C of CMS Pub. 15, Part 1, Section 312 (Exhibit C-14 and as quoted above) requires that providers must determine that no other source is responsible for the patient’s deductible and coinsurance, including Medicaid. Providers must be able to document this determination. Medicare policies require that providers must bill the Medicaid program and be able to document the response received from the Medicaid program through the Medicaid remittance advice.

Key to this issue is CMS Pub. 15-1, Section 322 (Exhibit C-14). This section addresses dual eligible beneficiaries and state cost sharing plans. This section states in part:

For services that are within the scope of the title XIX plan, States continue to be obligated to pay the full deductible and coinsurance for categorically needy persons for most services, but can impose some cost sharing under the plan on medically needy persons as long as the amount paid is related to the individual's income or resources.

Where the State is obligated either by statute or under the terms of its plan to pay all, or any part, of the Medicare deductible or coinsurance amounts, those amounts are not allowable as bad debts under Medicare. Any portion of such deductible or coinsurance amounts that the State is not obligated to pay can be included as a bad debt under Medicare, provided that the requirements of §312 or, if applicable, §310 are met (emphasis added).

Therefore, where a state has imposed cost sharing, the Provider is expected to collect the amount of cost sharing from the dual eligible beneficiary and not from the Medicare program as a Medicare bad debt. Otherwise, the potential for double-recovery exists as envisioned in CMS Pub. 15-1, Section 316 – once as a Medicare bad debt and then again from the dual eligible beneficiary (Exhibit C-14).

The California Medi-Cal program has a Share of Cost requirement. Details of California’s cost sharing can be found in the Medi-Cal Provider Manual (http://files.medi-cal.ca.gov/pubsdoco/Manuals\_menu.asp). According to the Part 1 section on Share of Cost (Exhibit C-15, page 1):

Some Medi-Cal subscribers (recipients) must pay, or agree to pay, a monthly dollar amount towardtheir medical expenses before they qualify for Medi-Cal benefits. This dollar amount is called Share of Cost (SOC). A Medi-Cal subscriber’s SOC is similar to a private insurance plan’s out-of-pocket deductible.

Generally, a subscriber’s SOC is determined by the county welfare department and is based on the amount of income a subscriber receives in excess of “maintenance need” levels. Medi-Cal rules require that subscribers pay income in excess of their “maintenance need” level toward their own medical bills before Medi-Cal begins to pay.

Providers access the Medi-Cal eligibility verification system to determine if a subscriber must pay an SOC. The message returned by the eligibility verification system includes the SOC dollar amount the subscriber must pay. The eligibility verification system is accessed through the Point of Service (POS) device, Automated Eligibility Verification System (AEVS), state-approved vendor software and the Medi-Cal Web site on the Internet at *www.medi-cal.ca.gov*.

The Medi-Cal Provider Manual clearly indicates that where a SOC exists for a specific beneficiary, the provider must either collect the SOC, or the beneficiary must agree to pay a monthly dollar amount toward his/her medical expenses before he/she qualifies for Medi-Cal benefits.

During the cost reporting period, the Provider rendered covered services to Medicare beneficiaries including dual eligible beneficiaries. Some of the Medicare deductibles and coinsurance imposed on the Medicare beneficiaries remained unpaid. The Provider wrote the unpaid debts off and claimed them on the Medicare cost report for reimbursement. The Provider contends there are additional crossover bad debts that were not previously claimed.

In accordance with CMS Pub. 15-1, Section 310 (Exhibit C-14), the provider must complete reasonable collection efforts and document such efforts in the patient file:

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 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 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. (See §312 for indigent or medically indigent patients.)

A. 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.

The MAC asserts that the regulation 42 C.F.R. § 413.20 (Exhibit C-16) requires providers to maintain sufficient financial records and statistical data to support their reimbursement claims. The word “maintain” generally connotes continuity, and, therefore, a provider is required to have available the necessary documentation at the time it presents its reimbursement claims to the MAC. Further, regulation 42 C.F.R. § 413.24(a) (Exhibit C-6) specifies that such records be verifiable by qualified auditors.

In addition, Medicare regulation 42 C.F.R. § 413.24(c) states:

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.

The Provider has not adequately documented that the bad debts in question meet Medicare requirements for allowable bad debt. The MAC adjustment is in accordance with the Medicare Regulations at 42 C.F.R. § 413.20 and § 413.24(c).

The MAC is willing to work with the Provider on this issue and review any additional documentation that the Provider submits to support that it has properly handled the actual SOC related bad debt amounts. Where a Medicaid recipient is found to be responsible for a SOC amount, the beneficiary is not considered indigent for this amount. In order to claim amounts related to SOC as a Medicare bad debt, the Provider must support that the amount due from the beneficiary was subjected to the reasonable collection efforts described in CMS Pub. 15, Part 1, Section 310.

**C. Conclusion**

If the Provider is unable to provide the additional documentation sufficient to support resolution of this issue, the MAC requests that the Board affirm its position. The MAC adjustment was properly determined in accordance with the above regulations and instructions, including 42 C.F.R. § 413.89 and 42 C.F.R. §§ 413.20 and 413.24, based on documentation submitted by the Provider prior to and during the audit and settlement of the cost report.

For patients with a Share of Cost that had not met Medicaid’s spend-down requirement, the Provider is responsible for meeting the requirements established in 42 C.F.R. § 413.89, as well as CMS Pub. 15-1, Chapter 3. The Provider must establish reasonable collection efforts were made to collect the debt not covered by Medicaid. The Provider has not done so. The MAC requests the Board affirm its adjustments.

V. EXHIBITS

C-1. PRRB Decision in PRRB Case # 17-1920 ENTRY 3

C-2. *Advocate Christ Medical Center, et al. v. Becerra*, No. 1:17-cv-1519 (DC Cir. 2023). ENTRY 3