|  |  |
| --- | --- |
|  | Whether the MAC improperly disallowed bad debts claimed by the providers in this group appeal because the bad debt expense account in the providers’ financial accounting statements was purportedly not reduced to zero. |

1. **Facts**

This group consists of three providers located in Virginia. All three providers are owned and operated by Bon Secours Mercy Health Inc.

Bon Secours Depaul Medical Center (49-0011) was issued a Notice of Program Reimbursement (NPR) on March 25, 2022, and filed an appeal on September 21, 2022. It appealed adjustments 25 and 32. Adjustments 25 and 32 disallowed traditional bad debts due to various reasons found during review of the inpatient and outpatient claims, including accounts that were claimed on the prior year bad debt listing, accounts that were not reduced to zero, write off dates according to patient account history that were after the FYE, accounts not found on collection agency reports and patient payments that were reported on the patient account history with no amounts. The inpatient and outpatient amounts disallowed were $174,369 and $142,745, respectively.  Reference the MAC’s adjustment report at **Exhibit C-2** and the MAC’s bad debt workpapers at **Exhibit C-5.**

Bon Secours St. Mary’s Hospital (49-0059) was issued an NPR on June 11, 2019, and filed an appeal on December 12, 2019. It appealed adjustments 33 and 37. Adjustments 33 and 37 were for amounts not written off to a bad debt account and reduced to zero and also for disallowed indigent accounts due to insufficient documentation in the determination that the bad debts were due to indigence. The disallowed inpatient and outpatient amounts were $492,902 and $297,947, respectively. Reference the MAC’s adjustment report at **Exhibit C-3** and the MAC’s bad debt workpapers at **Exhibit C-5.**

Bon Secours Memorial Regional Medical Center was issued an NPR on July 10, 2019, and filed an appeal on January 6, 2020. It appealed adjustments 29 and 36. Adjustments 29 and 36 were to disallow bad debts that were not written off to a bad debt account and reduced to zero and indigent accounts disallowed due to insufficient documentation in the determination that the bad debts were due to indigence. The disallowed inpatient and outpatient amounts were $458,121 and $401,352, respectively. Reference the MAC’s adjustment report at **Exhibit C-4** and the MAC’s bad debt workpapers at **Exhibit C-5.**

1. **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, “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.”[[1]](#footnote-1)

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-6.** Consequently, Providers may receive reimbursement for accounts claimed as Medicare bad debts, if they meet certain criteria.

Under the Secretary’s interpretive authority, the Provider Reimbursement Manual (PRM) has been issued to clarify 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**. 42 CFR § 413.89(e) and CMS PRM 15-I, Section 308 require that:

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.

In addition, PRM Section 320.1, Methods of Determining Bad Debt Expenses, explains the Direct Charge off Method,

Under the direct charge-off method, accounts receivable are analyzed and a determination made as to specific accounts which are deemed uncollectible. The amounts deemed to be uncollectible are charged to an expense account for uncollectible accounts. The amounts charged to the expense account for bad debts should be adequately identified as to those which represent deductible and coinsurance amounts applicable to beneficiaries and those which are applicable to other than beneficiaries or which are for other than covered services. Those bad debts which are applicable to beneficiaries for uncollectible deductible and coinsurance amounts are included in the calculation of reimbursable bad debts.

At issue in this appeal is the requirement of Section 320.1. Specifically, the MAC disallowed 100% of the sampled bad debts for a myriad of reasons, but the major one being that the accounts had not been written off to a zero balance. The Providers in this Group contend that the MAC misinterpreted the Providers’ accounting system as indicating that a balance was owed for the bad debts. However, the MAC contends that there should be a zero balance on the accounts if all collection efforts have ceased and the amount is being claimed as a bad debt. The MAC and CMS require that the account be written off in order to document that the Provider did in fact deem the account “worthless” in accordance with PRM Section 308 and 42 CFR § 413.89 before claiming the account as a Medicare bad debt.

The Providers argue that the hospital accounting systems write off the balance and archive the amount in a bad debt sub-ledger for tracking of any potential recoveries. When the Providers send an account to an outside collection agency, the account is moved from its Active Accounts Receivable (“Active AR”) to a “Bad Debt Allowance” account. At that point, the Providers have not yet deemed the accounts uncollectible. It has moved the account to an outside collection agency. It is explained that once a patient account has been returned from the collection agency and efforts have been exhausted, the Provider’s patient accounting system will show a code of 9650 (“Demand Closed Returned”) to indicate all collection efforts have ceased. Reference **Provider’s Preliminary Paper, pg. 4**. This is how the Provider “writes off” its bad debts. However, the bad debt amounts in question are still showing on each patient’s account. This method shows inconsistencies with the examples provided at **Exhibits P-7, P-8 and P-9**. These three accounts did in fact have collection activity after applying code of “9650”, so it is not accurate that the Provider has ceased all collection efforts at that time. The account at **Exhibit P-7** shows the code “9650” on 7/21/2014 and a letter was sent on 8/6/2014 with follow up phone calls after that date. The example at **Exhibit P-8** used the code of “9650” twice, once on 10/2/2013 and again on 10/3/2014 and it shows a demand letter sent 11/8/2013. On **Exhibit P-9** the Demand Close Return code (9650) was used on 11/13/2014 and at that time the collection agency changed and a new collection effort started. These examples show that the MAC did not misinterpret the Providers’ accounting system, the debts were not considered worthless, and collections were still pursued by the Providers and collection agencies even after the accounts were tagged with code 9650.

The Provider also argues that this process removes the patient’s balance from Accounts Receivable and charges it to the expense code of bad debt, but the balance the patient owed will still show up on the patient account if someone pulls it up to view it within the computer system. This is contradictory to PRM 15-1, Section 308, which states sound business judgment established that there was no likelihood of recovery at any time in the future. If the Provider contends that it will likely receive recoveries in the future, then the account is not “worthless” as defined by the regulations and is not yet eligible to be a “bad debt. The rules and regulations specify when an account is deemed worthless **all** collection efforts have ceased. Therefore, the understanding is those accounts would be reduced to zero as the likelihood of collection of any monies has ceased. There should be no balances on these accounts, as all collection efforts are complete and the balances should have been written off from accounts receivable to bad debts on the financial statements. Based on the Medicare audit reviews of bad debts for these Providers and the additional evidence in the Group’s own exhibits included in the Group Preliminary Position Paper, the Providers continued to pursue collections even after the date initially determined to be the write-off date. Requirements 3 and 4 of 42 CFR § 413.89(e) and CMS PRM 15-I, Section 308 have not been met; therefore, the bad debts in question cannot be allowed in the current year.

1. **Conclusion**

The MAC contends that it is responsible for ensuring the Providers carried out due diligence in determining the worthlessness of the claimed bad debt accounts and that the criteria must be met for the bad debts to be allowable and reimbursable by Medicare. The Providers have not reduced accounts deemed worthless to zero balances, making them active accounts and not allowable for Medicare bad debt reimbursement in the current year. The MAC respectfully requests the Board affirm the MAC’s adjustments for each of the Providers, as proposed, and dismiss this case.

LAW, REGULATIONS, AND PROGRAM INSTRUCTIONS

Law:

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

Regulations:

42 CFR § 413.20; 42 CFR § 413.24; 42 CFR § 413.89

Program Instructions:

CMS PRM 15-I, Sections 308-320

V. EXHIBITS

C-1: Final SOP

C-2: MAC’s Final Audit Adjustment Report (49-0011)

C-3: MAC’s Final Audit Adjustment Report (49-0059)

C-4: MAC’s Final Audit Adjustment Report (49-0069)

C-5: MAC’s Bad Debt Workpapers

C-6: 42 CFR § 413.89

C-7: CMS PRM 15-1, Sections 308-320

1. 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-1)