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Dear Ms. Kovach and Ms. Dyer,

In recent months, many hospitals in North Carolina, South Carolina, Virginia, and West Virginia have experienced increased focus and scrutiny of their Medicare bad debts by Palmetto GBA (Jurisdiction M Medicare Administrator Contractor (MAC)) and its subcontractors. Although it is not unusual for Palmetto GBA to pull samples from a bad debt log to test whether the claimed bad debt meets the regulatory requirements for reimbursement, these reviews have been of a different nature and tenor. Specifically, these reviews are applying new documentation requirements related to zero balance adjustments and Medicare/Medicaid crossover adjustment codes. We have reached out to Scott Neely, Provider Audit and Reimbursement Manager at Palmetto GBA, on numerous occasions to discuss these additional requirements. Mr. Neely suggested that we request additional guidance and clarification from CMS so that our members can better understand these additional requirements that are beyond the requirements currently set forth in the Provider Reimbursement Manual 15.1.

- Zero Balance Adjustment – We have received reports from several members that they are experiencing Medicare Cost Report bad debt denials based on the new zero-balance policy requiring that the accounts receivable (AR) balance on all Medicare bad debt accounts be equal to zero before placing the account on the Medicare bad debt log. This new requirement is in direct contradiction to how a majority of provider accounting systems are set up and places an unnecessary and overly burdensome expectation on providers. A majority of hospital accounting systems write off the balance and archive the amount in a bad debt sub-ledger for tracking of any potential recoveries. This removes the account from the hospital's Accounts Receivable ledger and removes the accrued balance of the account from the hospital's bad debt allowance. Auditors could potentially verify this by requesting a detail listing of accounts receivable that ties to the balance sheet and it would not include these accounts since they are written off from the balance sheet and income statement as uncollectible. While these sub-ledgers no longer have impact on the hospital's income statement or balance sheet, they serve a needed function by allowing hospitals to measure collection efforts, track account aging and collection activities and monitor future payments on bad debt accounts.

- Medicare/Medicaid Crossover Adjustment Code – A majority of providers surveyed utilize a Medicaid contractual adjustment code for any remaining balance or patient balance after a claim has processed with payment or zero payment from Medicaid. This is common practice across the industry; many

providers' accounting and billing systems adjudicate claims in this manner. This process has always been acceptable in the past until recent guidance has been presented informally at various events throughout the region indicating dual eligible Medicare/Medicaid accounts must be written off to a bad debt adjustment code in order to be claimed as an allowable Medicare bad debt. Restated, crossover bad debts will only be allowed if they are written off to an Expense account and will be disallowed if written off to a Contractual Account. The Program Reimbursement Manual (PRM) Chapter 3, Section 320.1 is cited as the basis of this change. We are not sure whether Palmetto GBA's new interpretation requires the account to be written off as a Bad Debt Adjustment and appear on the income statement as such in the Revenue Deductions section or written off as an expense in the Expense section of the hospital's income statement.

Regular Medicare Bad Debt Guidance

Under the Medicare program, beneficiaries are responsible for various deductibles and coinsurance amounts depending upon the type of services provided. See 42 U.S.C. §§ 1395e, 1395l. Medicare regulations define bad debts as "amounts considered to be uncollectible from accounts and notes receivable that were created or acquired in providing services." 42 C.F.R. § 413.89(b)(1). Under the regulations, "bad debts attributable to the deductibles and coinsurance amounts are reimbursable under the Medicare program." The regulations specify four criteria for reimbursable bad debts: (1) they must be "related to covered services and derived from deductible and coinsurance amounts;" (2) the hospital must make "reasonable collection efforts;" (3) the debts must be "actually uncollectible when claimed as worthless;" and (4) "sound business judgment established that there was no likelihood of recovery at any time in the future;" see also PRM (CMS Pub. 15-1), Part I, Chapter. 3, § 308.

PRM Pub. 15-1, Chapter 3

According to PRM Pub. 15-1, Chapter. 3, § 310, 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. The PRM states that a provider should issue a bill "on or shortly after discharge or death of the beneficiary to the party responsible for the patient's personal financial obligations."

Additionally, as referenced in PRM Pub. 15-1 Chapter. 3, § 312, 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. Section 322 further clarifies, 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. Section 322 Medicare Bad Debts under State Welfare Programs, specifically addresses crossover bad debts and § 320 only has potential relevance to "regular" bad debts. Section 322 describes allowable crossover bad debts without reference to any particular accounting treatment or reference to § 320.1.

Section 320.1 refers to § 300 (general principle that unpaid deductibles and coinsurance are reimbursable) and § 302.2 (allowable bad debts must meet the criteria in § 308 – reasonable collection effort, worthless when claimed, sound business judgment). Section 302.2 needs to be read in connection with the definition of bad debts in § 302.1 which are "amounts considered to be uncollectible", not amounts considered to be uncollectible only if accounted for in a particular fashion. None of this read collectively gives any indication that some accounting treatments might preclude unpaid Medicare deductible or coinsurance from being allowable bad debts, particularly since all the relevant categories (bad debt expense, charity, contractual allowances) are deductions from revenue that are excluded from allowable costs in the cost report.

Section 320.1 deals with the Direct Charge Off accounting method. Section 320.2 deals with the Reserve Method and states that the specific unpaid deductibles and coinsurance charged against the reserve are includable in reimbursable bad debts. It doesn't seem reasonable that one accounting treatment would exclude bad debts and the other would not. Both of these sections (320.1 and 320.2) are differentiating that inclusion of bad debts by use of an estimated aggregate reserve method are not allowable as a Medicare Bad Debt. There is no indication in either of these sections for the specific accounting treatment of the account balance maintained in an uncollectible sub-ledger after written off from active accounts receivable as a bad debt expense. The bad debt sub-ledger is utilized for accounting purposes and is not reflected on the financial statements because the accounts have been deemed worthless. However, if there is a potential future recovery from an estate settlement, third party, or patient payment, there is a record of accounting in order to apply the recovery.

Providers Had No Notice of the MAC's New Interpretation of the Bad Debt Rules

Guidance in the PRM does not specify either of the requirements being imposed in order to claim a bad debt as Medicare allowable bad debt. Even if the disallowance of the Provider's Medicare bad debt for these issues were not contrary to the plain language of the Medicare bad debt rules, the implied new interpretation of the bad debt rules should not be applied retroactively to disallow the costs at issue because the Providers did not have fair notice at the time of the different view of the law.

Due process requires administrative agencies to afford regulated parties fair notice of the requirements imposed upon them under agency rules. Before the MAC can properly apply a requirement, the Provider must first be afforded fair notice of that interpretation with "ascertainable certainty." Gen. Elec. Co., 53 F.3d at 1329; see also Loma Linda Univ. Med. Ctr., 408 Fed. Appx. 383 (D.D.C. 2010) (reversing a CMS disallowance of reimbursement for a hospital's indirect medical education costs because the agency had not afforded the hospital with adequate notice, with ascertainable certainty, of the agency's current interpretation of the Medicare part A claims filing regulations). MAC's have consistently held that the account balance is irrelevant to its eligibility as a Medicare bad debt and they have accepted the Medicare/Medicaid Crossover adjustment as a Medicaid contractual to represent no further collection since meeting the indigent criteria. Accordingly, because Providers did not have notice of the new interpretation of the bad debt rules at the time it incurred the costs, the new interpretations should not be applied retroactively to penalize Providers.

Conclusion

To enforce the position that an account must be zero balance or written off with specific adjustment code is inconsistent with both the text and purpose of the Medicare statute and CMS bad debt rules. Additionally, it is in direct contradiction to how a majority of provider accounting systems are set up and places an unnecessary and overly burdensome standard of expectation on providers. Again, any account previously written off as uncollectible by either means of coding, no longer has an AR balance either on the hospital financial reports or

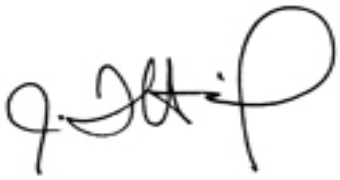
in the hospital's AR ledgers. Lastly, providers had no notice of the MAC's new interpretation and therefore this requirement should not be applied retroactively.

There has been indication for some time of pending updates and clarifications to the PRM sections pertaining to bad debts. The provider community seeks clarification and guidance on many of these issues but that clarification is given, it is difficult to comply with informal changing guidance and audit standards being applied retroactively. Additionally, a similar area CMS may already be considering in the PRM language pertains to the AICPA in the midst of a transformational discussion that relates to the reporting of net revenue. These changes will be effective for periods beginning after December 2018 for all providers. The difference between contractual adjustments, charity care, and bad debt will continue to transform into categories of implicit and explicit price concessions. These implications should also be considered in areas that may necessitate changes in the PRM for rules written over 30 years ago.

We respectfully request clarification from CMS or the establishment of work group with the hospital associations, Palmetto GBA and CMS representatives to discuss these issues as these are significant changes from what has been common practice in the industry and accepted on prior audits. Please contact Ronnie Cook (rcook@ncha.com/919-677-4225), Barney Osborne (bosborne@scha.org/803-744-3544), Jay Andrews (jandrews@vhha.com/ 804-965-1229) or Carol Haugen (chaugen@wvha.org/304-353-9721) if you have any questions. We look forward to our continued discussions.

Sincerely,

Stephen J. Lawler
President
North Carolina Healthcare Association



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