



Advancing Health in America

Washington, D.C. Office
800 10th Street, N.W.
Two CityCenter, Suite 400
Washington, DC 20001-4956
(202) 638-1100

Dec 17, 2019

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue, S.W., Room 445-G
Washington, DC 20201

RE: Medicare-Medicaid Crossover Bad Debt Accounting Classification

Dear Ms. Verma:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the Centers for Medicare & Medicaid Services' (CMS) efforts to reduce administrative burden for hospitals, especially those with limited resources such as providers in rural and other underserved areas. As part of CMS' Patients over Paperwork initiative, the agency has invited stakeholders to inform the Administration of examples of regulatory burden identified by the field. **To that end, the AHA urges CMS to reconsider its recent guidance to providers requiring them to document Medicare-Medicaid "crossover" bad debt in a manner that is neither standard practice for most hospitals nor consistent with current accounting standards.**

The AHA recognizes the importance of accurately recording bad debt amounts in the Medicare cost report; however, the recent sub-regulatory guidance does not enhance accuracy of cost report data or improve the bad debt reporting process. It does, however, force hospitals to report this bad debt in two different manners – one for CMS and one for the Financial Accounting Standards Board (FASB) – a completely unnecessary regulatory burden. The resources needed to train staff and add technical processes to comply with the guidance are substantial for providers – most notably those that serve the dually eligible population – and do not provide any benefit to them, their patients or CMS.

PREVIOUS MEDICARE-MEDICAID “CROSSOVER” BAD DEBT REPORTING

Medicare-Medicaid “crossover” bad debt includes the unpaid deductible and coinsurance amounts associated with dually-eligible beneficiaries. State Medicaid programs may reimburse providers for none, some, or all of these amounts, in accordance with the state’s Medicaid policy. However, among those states that do contribute to a beneficiary’s cost sharing, the vast majority only will reimburse up to a payment “ceiling,” which has historically been low. The amount that remains outstanding after any payment from Medicaid and/or the beneficiary becomes “crossover” bad debt. Specifically, as discussed in Chapter 3, Section 322 of the Provider Reimbursement Manual, “any portion of the deductible or coinsurance that the State does not pay that remains unpaid by the patient, can be included as a bad debt under Medicare, provided that the requirements of §312 [indigence determination] are met.”

Providers generally write off this crossover bad debt to a contractual allowance account. A contractual allowance is a concept within Generally Accepted Accounting Principles (GAAP) that refers to the difference between a provider's charge and the contractual discounted payment. Crossover bad debt is typically considered to be a contractual allowance because providers are bound by their Medicaid provider agreements (i.e., contracts) to accept the amounts paid by the state plan as payment in full. **According to discussions with our members, Medicare Administrative Contractors (MACs) have historically found this contractual allowance classification to be acceptable, and considered these crossover balances as part of reimbursable bad debt.** On external financial statements, crossover bad debts – and all other uncollectible amounts – are applied as reductions to net patient revenue, in accordance with GAAP.

RECENT CMS GUIDANCE ON CROSSOVER BAD DEBT CLASSIFICATION

In April 2019, CMS released sub-regulatory guidance clarifying the agency’s “longstanding guidance” that providers must write off Medicare-Medicaid crossover bad debts to an expense account for uncollectible amounts (bad debt) and *not to* a contractual allowance amount. This policy, effective for cost reporting periods beginning on or after Oct. 1, 2019, does not affect the amount of reimbursable bad debt. **However, it does create a unique way that “crossover” bad debt must be recorded only for CMS, resulting in substantial, unnecessary administrative burden for providers without any benefit to the accuracy or efficiency of bad debt reporting.** Our members have shared that modifying their documentation practices for these bad debt amounts will require significant resources to train staff and build new electronic processes to link uncollectible amounts from these claims to new adjustment codes. Because a portion of the documentation and adjustment process is automated, providers will have to employ manual interventions in the interim before an additional automated process can be developed, tested and implemented. **For hospitals that serve dually eligible beneficiaries, including providers in rural and other vulnerable communities, utilizing staff and funds to comply with this guidance is particularly difficult and reduces resources that could otherwise be directed to critical operational functions.** Furthermore, this change in

accounting classification does not enhance the accuracy of cost report data nor does it improve the bad debt reporting process for patients, providers or CMS itself. The crossover amounts themselves do not change, and as noted above, MACs have historically accepted as bad debt those crossover amounts adjusted to a contractual adjustment code.

In addition, the guidance does not align with updated accounting standards. In 2014, FASB issued its Accounting Standards Codification Topic 606 (*Revenue from Contracts with Customers*), which directs hospitals and other organizations to report their revenue in external financial statements in accordance with GAAP. Specifically, Topic 606 characterizes most bad debts and uncollectible amounts as “implicit price concessions” rather than bad debt. As such, these amounts must be reported as reductions of net patient revenue, rather than operating expenses, in external financial statements. (Per Topic 606, only those bad debts meeting certain criteria would be reported as operating expenses.) **While the new FASB standard does not specifically govern provider filings with CMS, the inconsistency between these standards – i.e., crossover bad debt as implicit price concession – and the CMS guidance – i.e., crossover bad debt as bad debt expense – will require providers to simultaneously classify crossover balances in different ways in order to comply with both sets of requirements.** This adds even more administrative burden to providers, who now will have to reconcile the differences in internal and external documentation practices.

In light of these concerns, the AHA urges CMS to reconsider its recent guidance to write off Medicare-Medicaid crossover balances to an expense account rather than a contractual allowance account. This guidance is incongruent with FASB standards and common reporting practices, resulting in considerable unnecessary administrative burden to providers who are already grappling with limited resources.

We appreciate your consideration of these issues. Please contact me if you have questions or feel free to have a member of your team contact Erika Rogan, AHA senior associate director for policy, at (202) 626-2963 or erogan@aha.org.

Sincerely,

/s/

Ashley B. Thompson
Senior Vice President
Public Policy Analysis and Development