

CENTERS FOR MEDICARE & MEDICAID SERVICES
Decision of the Administrator

In the case of:

Mesquite Community Hospital

Provider

vs.

**Blue Cross/Blue Shield
Association/Highmark
Medicare Services**

Intermediary

Claim for:

**Determination of Reimbursable
Costs for Cost Reporting
Periods Ending 05/31/00**

Review of:

**PRRB Decision No. 2007-D18
Dated: February 16, 2007**

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the Provider Reimbursement Review Board (Board) decision. The review is during the 60-day period mandated in §1878(f) (1) of the Social Security Act (Act) [42 USC 1395oo (f) (1)], as amended. Comments were received from the Centers for Medicare Management (CMM) and the Intermediary requesting reversal. The Administrator notified the parties of the intent to review the Board's decision. The Provider submitted comments requesting that the Board's decision be affirmed. Accordingly, this case is now before the Administrator for final administrative review.

ISSUE AND BOARD DECISION

The issue is whether the Intermediary's adjustment of the Provider's Medicare bad debts was proper.

The Board reversed the Intermediary's adjustment, stating that the Intermediary's position is based on the fact that no tangible evidence exists that the collection agency ceased its collection activities and returned the accounts to the Provider. The Board concluded that providers may continue to pursue collection activities for debts that have been deemed uncollectible, and to conclude otherwise would violate the cross-subsidization principle. The Board noted that the Intermediary never questioned that the bad debts were attributable to deductibles and co-insurance amounts, or whether reasonable collection efforts were made.

The Board stated that it has consistently held that where a provider satisfies all four criteria of 42 CFR 413.80(e), any presumption regarding collectibility are moot and the bad debt must be reimbursed. The Board found that the term “uncollectible,” means that no payments have been received or are expected to be made on an account based upon the provider’s experience and sound business judgment. The Board concluded that there is no explicit legal requirement that collection efforts must cease before accounts can be deemed uncollectible.

The Board found that the Provider’s practice of performing in-house collection activities for 90 days and then forwarding the accounts to a collection agency for an additional period, and writing off the account balance meets the program requirements. The Provider has demonstrated that it used sound business judgment to establish that there was no likelihood of recovery of these debts at any time in the future.

A conclusive presumption of collectibility arising from an account’s “open” or “active” status at a collection agency contradicts the reality of the collection trade and the regulations. Furthermore, CMS is not disadvantaged, for if the Provider recovers debts from write-offs, such recovery per the PRM at §316 will reduce allowable bad debts. The Board held that a provider may continue collection efforts with respect to debts that have deemed uncollectible for Medicare payment purposes. To hold otherwise, the Board maintains would result in cross-subsidization.

The Board also concluded that the OBRA Moratorium does not apply, noting that the record is inconclusive as to what the Intermediary accepted before August 1, 1987; work papers do not affirmatively establish the Provider’s collection efforts during the relevant timeframe and the collection policies do not provide a detailed explanation of the collection agency’s handling of bad debts, and they do not describe the Provider’s interactions with the agency or clarify when debts at the agency may be written off.

SUMMARY OF COMMENTS

CMM requested the Board’s decision be reversed. This case is similar to others reversed by Administrator.¹ The Administrator’s decision in Battle Creek Health Systems, PRRB No. 2004-D40 was affirmed by the United States District Court.² CMM concluded that debts claimed by the Provider for accounts at a collection agency cannot be claimed as bad debts in accordance with the regulation at 42 CFR 413.80(e) (1999) (redesignated at 42 CFR 413.89) and the Provider Reimbursement Manual. The Board is incorrect to find that bad debts may be claimed even after 120 days while the Provider is engaged in any collection efforts.

¹ See, Odessa Regional Hospital, PRRB Dec. No. 2004-D16, Battle Creek Health

CMM stated that, by virtue of the Provider's admission, there is an approximate collection rate of five percent for Medicare accounts held at the collection agency. It is clear that for a bad debt to be an allowable, it must be uncollectible when claimed as worthless and that sound business judgment established no likelihood of any recovery in the future. If an account is in collection the latter criteria are not met because the account has not been determined to be uncollectible, and it is therefore not worthless and the Provider has not established there is no likelihood of recovery at any time in the future. Contrary to the Board's belief, CMM stated that the PRM at §316 does not infer Medicare anticipates or in any way concurs that providers are to continue collection for accounts to be deemed uncollectible and offset those collections as received. This is in clear conflict with Medicare policy.

The Intermediary requested review, stating that the Provider was still pursuing collection efforts through an external agency at the time the bad debts were deemed to be uncollectible, and, thus, it did not comply with the requirements set forth at 42 CFR 413.80(e).

The Provider requested the Board's decision be affirmed, stating that the case of Battle Creek Health Systems, *supra*, is factually distinguishable and, thus, is not controlling in this appeal. In this case, the Provider issued in-house collection efforts for 90 days and, thereafter, from days 91 through 120, it was forwarded to an outside collection agency; a monthly report was generated detailing collection activities and results, which the Provider reviewed and from which it determined if the accounts were worthless. The collected or active accounts were removed from the bad debt list prior to the account being deemed worthless. The Intermediary's disallowance is based on the fact that the accounts were "housed" at a collection agency and this disallowance is not supported by program policy set forth at 42 CFR 413.80(e). The sound judgment requirement of the regulation should be interpreted as meaning that an account is considered worthless, based on current collection activities, time elapsed and experience.

DISCUSSION

The record furnished by the Board has been examined, including all correspondence, position papers and exhibits submitted by the parties. The Board's decision has been reviewed by the Administrator. All comments received after entry of the Board's decision have been made a part of the record and have been considered.

System/Mercy General Health Partners PRRB Dec. No. 2004-D40, and Foothill Presbyterian Hospital, PRRB Dec. No. 2007-D11.

² See, Battle Creek Health Systems v. Thompson, 2006 WL 839146 (W.D. Mich., March 30, 2006).

Section 1861(v)(1)(A) of the Act requires providers of services to beneficiaries are to be reimbursed the reasonable costs of those services. Reasonable costs are defined as:

The cost actually incurred, excluding therefrom part of the incurred costs 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....

This section does not specifically address the determination of reasonable cost, but authorizes the Secretary to promulgate regulations and principles to be applied in determining reasonable costs. One of the underlying principles set forth in the Act is that Medicare shall not pay for costs incurred by non-Medicare beneficiaries, and vice-versa, i.e., Medicare prohibits cross-subsidization of costs.

These principles are reflected and further explained in the regulations. The regulations at 42 CFR §413.9(c) provides that the determination of reasonable cost must be based on costs related to the care of Medicare beneficiaries.

In addition, Section 1815 of the Act states that:

No such payment 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....

This provision is implemented by the general documentation regulations at 42 CFR 413.20 and 413.24 that require providers to furnish contemporaneous verifiable documentation in support of costs they claim for reimbursement.³

Relevant to this case, the regulation at 42 CFR 413.80(a)⁴ specifically provides that bad debts are reductions in revenues and are not included in allowable costs. However, the regulation at 42 CFR 413.80(a) further provides that bad debts attributable to the deductible and coinsurance amounts of Medicare beneficiaries are reimbursed under the Medicare program.⁵ Bad debts are defined at 42 CFR 413.80(b)(1) as:

[A]mounts considered to be uncollectible from accounts and notes receivable that were created or acquired in providing services. “Accounts receivable” and “notes receivable” are designations for claims arising from the furnishing of services and are collectable ... in the relatively near future.

The regulation at 42 CFR 413.80(d) states that payment for deductible and coinsurance amounts are the responsibility of beneficiaries. However, recognizing the reasonable cost principle set forth at §1861(v)(1)(A) of the Act which prohibits cross-subsidization of allowable costs, the program states that the inability of providers to collect deductibles and coinsurance amounts from the Medicare beneficiaries could result in part of the costs of Medicare covered services being borne by individuals who are not beneficiaries.

To prevent such cross-subsidization, the regulation at 42 CFR 413.80(a)(1999) provides that bad debts attributable to deductible and coinsurance amounts of Medicare beneficiaries are reimbursed under the program if certain criteria are

³ Further, under the Administrative Procedure Act, the proponent of the rule has the burden of proof. See, 5 U.S.C. §556(d). Thus, the provider has the burden to demonstrate that claimed bad debts are allowable.

⁴ Redesignated to 42 CFR 413.89 (2004).

⁵ See also, Section 304 of PRM.

met.⁶ To be reimbursed for bad debts, providers must meet the criteria set forth at 42 CFR 413.80(e), which states that:

- (1) The debt must be related to cover services and derived from deductibles 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 judgments established that there was no likelihood of recovery at any time in the future.

Under the Secretary's interpretative authority, the Provider Reimbursement Manual (PRM) has been issued, which explains the reimbursement regulations. Relevant to this case, Section 310 of the Provider Reimbursement Manual (PRM) states that:

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.

Section 310.A of the PRM further explains, with respect to the use of collection agencies, that:

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. Where a collection agency is used, Medicare expects the provider to refer all patient charges of like amounts to the agency without regard to class of patient. The "like amounts" requirement may include uncollected charges above a specified amount. Therefore, if a provider refers to a collection agency its uncollected non-Medicare patient charges which in amount are comparable to the individual Medicare deductible and coinsurance amounts due the provider from its Medicare patients, Medicare requires the provider to also refer its uncollected deductible and coinsurance amounts to the collection agency.

⁶ While the reasonable cost provision prohibits cross-subsidization, such prohibition relates to the cost shifting of allowable reimbursable Medicare costs for covered services and, thus, cannot be the basis for reimbursing otherwise unallowable costs. See also ,e.g., Community Hospital of Monterey Pensiula v. Thompson, 323 F.3d 782 at 786, 799-800 (9th Cir. 2003)("The cost shifting provisions of the statute must be read together with the provision authorizing the Secretary to refuse to reimburse costs when the provider has failed to "furnish such information as the Secretary may request in order to determine the amounts due such provider.")

The PRM at §310.2 further provides that:

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

Moreover, the PRM at §314 states that uncollectible deductible and coinsurance amounts are recognized as allowable bad debts in the reporting period in which such debts are determined to be worthless and uncollectible. This instruction also explains the burden on the provider to thoroughly document its claimed bad debts:

Since bad debts are uncollectible amounts...the provider should have the usual accounts receivable record ledger and source documents to support its claim...for each account included. Examples of the information that may be retained include...date of bills...date of write-off.

To ensure that providers receive reimbursement for services actually furnished and costs incurred, the Secretary has implemented a number of Medicare documentation principles at 42 CFR 413.9, 413.20 and 413.24. Consistent with these documentation principles as they are relevant to bad debts, §310.B of the PRM provides that:

The provider's collection effort should be documented in the patient's file by copies of the bills, follow-up letters, reports of telephone calls and personal contacts.

The Secretary has also issued instructions for intermediaries to follow when auditing cost reports. The Exhibit 11 of the Intermediary Manual explains that Medicare bad debts for deductibles and coinsurance are reimbursed as "pass-through" costs. Since they have a direct dollar for dollar effect on reimbursement, there is an incentive to claim bad debts before they become worthless. The instruction also discusses that interaction of the 120 day write-off and the use of a collection agency. Specifically, the instruction states that:

If the bad debt is written-off on the provider's books 121 days after the date of the bill and then turned over to a collection agency, the amount cannot be claimed as a Medicare bad debt on the date of the write-off. It can be claimed as a Medicare bad debt only after the collection agency completes its collection effort.

Finally, Congress enacted §4008(c) of the Omnibus Budget Reconciliation Act (OBRA) of 1987⁷ which prohibits the Secretary from making changes in any policy that was in effect on August 1, 1987 regarding reimbursement of bad debts, including, the criteria of what constitutes a bad debt. Subsequently, this provision was amended by §8402 of the Technical & Miscellaneous Revenue Act of 1988⁸ and §6023 of the OBRA of 1989⁹ to provide:

The Secretary may not require a hospital to change its bad debt collection policy if a Fiscal Intermediary in accordance with the rules in effect as of August 1, 1987 with respect to criteria for indigence determination procedures, record-keeping, and determining whether to refer a claim to an external collection agency, has accepted such procedure before that date, and the Secretary may not collect from the hospital on the basis of an expectation of change in the hospital's collection policy.

The Conference Report to the Technical & Miscellaneous Revenue Act of 1988 states that in order for the Moratorium to apply, the Intermediary must affirmatively approve a provider's policy and that such acceptance cannot be inconsistent with the regulations and program instructions. That provision states, in pertinent part, that:

The conferees wish to clarify that Congress intended the actions of the Fiscal Intermediaries occurring prior to August 1, 1987 to approve explicitly hospital bad debt collection practices to the extent such action...was consistent with the regulations, PRRB decisions and program manual and issuances are to be considered an integral part of the policy in effect on that date and thus not subject to change. However, the conferees do not intend to preclude the Secretary from disallowing bad debt payments based on regulations, PRRB decisions, manual and issuances in effect prior to August 1, 1987.¹⁰

In sum, in order to be reimbursed Medicare bad debts, a Provider must show, inter alia, that it has engaged in a reasonable collection effort including that its debts are actually uncollectible when claimed as worthless and that sound business judgment established no likelihood of recovery in the near future. In addition, the moratorium will only prohibit the disallowance of a provider's Medicare bad debts, if the provider can demonstrate that the intermediary explicitly approved of the

⁷ Pub. Law No. 100-203.

⁸ Pub. Law No. 100-647.

⁹ Pub. Law No. 101-239.

¹⁰ H.R. Rep. No. 1104, 100th Cong. 2d Sess. 277 (1988), *reprinted* in 1988 U.S. Code 7 Cong Ad. News at 5337.

hospital's bad debt collection practices and such approval was consistent with the regulations, PRRB decisions and program manual and issuances in effect prior to August 1, 1987.

The record shows that for this cost year, the Intermediary initially conducted an audit of the Provider's bad debts because the bad debts were in excess of 10 percent of the Provider's deductibles and coinsurances and there was a 25 percent increase over the prior year claim of bad debts. This review showed certain pertinent information missing from the Provider's bad debts log including the date of discharge, indigent status, write-off date, break out of deductible and coinsurance and remittance advice date. The Intermediary requested that the Provider revise the bad debt log. When the Provider produced some documentation on the bad debts log the Intermediary found inconsistencies with the write-off dates on the log and the write off dates on the patient detail.¹¹ The write-off discrepancy, it was explained, was due to the Provider sending the bad debt to a collection agency. The Provider acknowledged that it claimed the bad debt prior to accounts being returned as uncollectible from the collection agency.¹²

Applying the foregoing provisions of the Act, regulations, and the instructions to the facts of this case, the Administrator finds that the Intermediary properly disallowed reimbursement for the Medicare bad debts claimed by the Provider. In this instance, the Provider did not establish that the accounts were actually uncollectible when claimed as worthless or that sound business judgment established there was no likelihood of recovery at any time in the future.

The Administrator recognizes that §310.2 of the PRM permits a debt unpaid for more than 120 days from the date the first bill is mailed to the beneficiary to be deemed uncollectible. However, the Administrator finds that the language in this provision implies discretionary rather than mandatory application of this presumption, that is, the debt "may" rather than "shall" be deemed uncollectible. This PRM provision does not suggest that this presumption releases the Provider from meeting the general regulatory documentation requirements set forth at 42 CFR 413.20 and 413.24, or the specific reasonable collection effort and documentation requirements set forth in the 42 CFR 413.80, the PRM and the Intermediary Manual. The presumption only applies where a provider has otherwise demonstrated, through contemporaneous verifiable documentation, that it has engaged in reasonable collection efforts.

The Administrator also finds that the Medicare program reasonably requires that debts have to be returned from such agencies and determined to be uncollectible for

¹¹ Intermediary Exhibit I-9.

¹² Intermediary Exhibit I-10.

there to be a determination of worthlessness. Since Medicare debts have a dollar for dollar effect on reimbursement, there is an incentive to claim bad debts before they become worthless. If a provider continues to attempt collection of a debt either through in-house or through a collection agency, it is reasonable to conclude that it still considers that debt to have value and not to be worthless. Contrary to the Provider's arguments, the Administrator finds that it is reasonable to expect the Provider to demonstrate that it has completed its collection efforts, including outside collection efforts before claiming the debts as worthless. The Provider failed to demonstrate that, once the debt had been sent to a collection agency, consistent collection efforts were used for Medicare and non-Medicare debts, and that the debts were determined to be worthless when claimed.

The Administrator also finds that §316 of the PRM provides only an instruction in the event that a Medicare bad debt is subsequently recovered for reporting such revenue and its reimbursement effect. This is a provision to prevent double dipping by the Provider at the expense of the program. The Administrator finds that the language of this PRM provision in no way infers that Medicare program expects or even anticipates providers to continue to pursue collection activities after claiming bad debts on their cost reports. Therefore, if a provider deems a debt uncollectible after reasonable collection efforts, and, thus worthless, a provider would not be expected to pursue further collection activities. However, if a provider does continue to pursue collection activities, clearly, it does not believe the debt to be worthless and cannot have made a determination that there is no likelihood of any recovery of these debts in the future.

Regarding the Moratorium, the Administrator agrees that the Provider failed to demonstrate that it meets the criteria for allowance of these bad debts under that provision. The record does not demonstrate that, prior to August 1, 1987, the Provider had a policy of writing off bad debts while they were still being pursued by a collection agency.¹³ In addition, the record does not show that the Intermediary "accepted" the Provider's policy prior to August 1, 1987, within the meaning of the statutory Moratorium. Moreover, in addition to the foregoing, the Administrator finds that any acceptance of such a policy by the Intermediary would not have been in accordance with the rules in effect prior to August 1, 1987.

¹³ Intermediary Exhibit I-12 and I-13. Documentation submitted for FYEs 1995 through 1999 is not relevant to the moratorium issue. Further to the extent the prior intermediary may have allowed such bad debts in these years, such allowances were incorrect and contrary to Medicare policy cost years

DECISION

The Board's decision is reversed in accordance with the foregoing decision.

**THIS CONSTITUTES THE FINAL ADMINISTRATIVE DECISION OF
THE SECRETARY OF HEALTH AND HUMAN SERVICES**

Date: 4/18/07

/s/

Herb B. Kuhn
Acting Deputy Administrator
Centers for Medicare & Medicaid Services

DECISION

The Board's decision is reversed in accordance with the foregoing decision.

**THIS CONSTITUTES THE FINAL ADMINISTRATIVE DECISION OF
THE SECRETARY OF HEALTH AND HUMAN SERVICES.**

Date: _____

Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services