CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of: **Kindred Healthcare 2005 Bad Debts (Write-off Dates)** **Providers** **vs.** **Wisconsin Physician Service (formerly Mutual of Omaha)** **Intermediary**	**Claim for:** **Cost Reimbursement Determination for Cost Reporting Period Ending:** **Various** **Review of:** **PRRB Dec. No. 2009-D10** **Dated: February** 27, **2009**

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the decision of the Provider Reimbursement Review Board (Board). The review is during the 60-day period in § 1878(f) (1) of the Social Security Act (Act), as amended (42 USC 1395oo (f)). The CMS' Center for Medicare Management (CMM), the Intermediary, and the Providers all submitted comments. The parties were notified of the Administrator's intention to review the Board's decision. Accordingly, this case is now before the Administrator for final agency review.

ISSUE AND BOARD DECISION

The issue is whether Intermediary's adjustments to disallow Medicare bad debts written-off by the Providers and claimed as worthless after the year end date of the terminating cost reports filed for each skilled nursing facility, due to change of ownership was proper.

The Board, reversing the Intermediary's adjustment, held that the Providers were entitled to write off the bad debts at issue. The Board found that Providers incurred bad debts during the time they owned and operated skilled nursing facilities (SNFs,) for

uncollectible Medicare deductible and coinsurance payments related to covered services furnished to dual-eligible beneficiaries. Subsequently, a change of ownership (CHOW) occurred, which required the Providers to file terminating cost reports. The Providers claimed bad debts on those terminating cost reports. The Board noted that some of the bad debts the Providers claimed were written-off after the effective date of the CHOW - which was the fiscal year end date of the terminating cost reports, but prior to the filing of the terminating cost reports. Pursuant to the regulation, at 42 CFR §413.89, and section 310 of Provider Reimbursement Manual (PRM), the Board found that the only mechanism by which Medicare could reimburse allowable bad debt to the terminating Providers was through their terminating cost reports. The Board disagreed with the Intermediary's argument that the automatic assignment of the provider agreement to the new owner upon a CHOW renders the former owner ineligible to receive reimbursement for bad debts relating to dates of service before the CHOW. The Board found this argument inconsistent with CMS policy. The Board determined that, under applicable authority at 42 CFR 412.24(f)(1), there is no distinction between providers terminating their Medicare participation or providers that experience a CHOW to the extent they are required to file terminating cost reports and entitled to the same allowable costs.

Moreover, the Board stated that the language of section 2176 of PRM applies equally to program terminations and CHOWs, and also establishes an exception to the general rule that bad debts are to be claimed in the cost reporting year in which they are deemed as uncollectible. The Board rejected the argument that section 2176 of PRM does not apply to CHOWs. The Board noted the Intermediary's argument that bad debts are recognized in the reporting period in which they are deemed worthless where the Provider continues to be owned by the same legal entity. The Board found that this argument ignored the exception articulated in section 2176 of PRM. The Board found the plain language of the PRM establishes that it applies to both program terminations and changes of ownership. The Board also stated that the fact that this PRM section cites to an outdated regulatory provision at 42 CFR 405.626, does not invalidate the entire policy set forth in that PRM provision. Consequently, the Board determined that with respect to any outstanding costs incurred by the former owner that relate to dates of service prior to the change of ownership, whether they are bad debts or direct administrative costs, CMS' policy is that they should be reimbursed to the former owner through he terminating cost report.

The Board found that the Providers are the proper parties to be reimbursed for bad debts related to services they provided to dually eligible beneficiaries while they operated the skilled nursing facilities. The Board examined the guidance the Intermediary received from CMS on the issue, and concluded that the Intermediary erred in not applying the guidance.

SUMMARY OF COMMENTS

CMM commented, requesting reversal of the Board's decision. For bad debts to be reimbursable, their attempted recovery must comply with requirements set forth in 42 CFR 413.89. The criteria provided in that regulation and section 314 of the PRM clearly control and limit the specific cost reporting period in which a bad debt can be reported, deemed to be worthless, and claimed for Medicare reimbursement. Bad debts are deemed worthless in the cost reporting period under the new ownership. There are no circumstances that permit CMS to supersede or otherwise provide exceptions to the regulation at 42 CFR §413.89(f). CMM contended that it is erroneous and unsupportable to attempt to imply or infer that another provision of the PRM, such as section 2176, or other correspondence, allow for exceptions to the bad debt regulation.

CMM noted that there are two types of situations that occur after a CHOW. Where the provider agreement and number cease to exist, the CHOW is governed by section 2176 of the PRM. This provision is not an exception to the regulation at §413.89(f). Any administrative costs would need to be reported in the terminating cost report, as the former provider no longer exists. However, where the existing provider number and agreement are transferred to the new owner (as occurred in this case), the new owner assumes the assets and liabilities from the former owner. In this type of CHOW, CMS only deals with the new owner. Bad debts related to unpaid deductibles and coinsurance for services rendered under the former ownership, which are determined to be worthless under the new ownership, are reimbursable to the new owner.

The Intermediary commented, requesting reversal of the Board's decision. The Intermediary argued that, under the controlling regulation at 42 CFR 413.89(f), the charge-off of a debt occurs in the period that it is deemed as worthless. Contrary to the Board's decision, the former owner, (the Providers in the group appeal), did not incur the bad debts because they were still collectible at the end of the cost reporting period. In this case, the Medicare provider agreement did not terminate, as it was transferred. The new owner assumed the assets and liabilities of the old owner. Only the new owners may claim bad debts after the CHOW. The Intermediary contended that the Board erroneously interpreted the provisions of section 2176 of the PRM. The Board improperly focused on the old owner's termination of participation, instead of the status of the Medicare provider agreement and number. The Intermediary argued that section 2176 of the PRM applies in circumstances only where the provider agreement and number are terminated.

Further, the Intermediary argued that 42 CFR 405.626, referred to by the Board, has been outdated since 1979. That regulatory provision only applied to situations where there was a terminating provider agreement and number. The Board erroneously interpreted the latest of two conflicting pieces of electronic mail received from CMS as a statement of Medicare policy.

The Providers commented, requesting that the Administrator decline to review the Board's decision. The Providers claimed that the Board's decision is consistent with Medicare regulations and the provisions of the manuals. The evidence in this case shows that the Intermediary is arguing a position that is inapposite with CMS policy on Medicare reimbursement of bad debts after a CHOW. The issue is not whether to reimburse the bad debts; rather, the issue is to whom reimbursement is proper. The policy on Medicare bad debts, generally, and the must bill policy, specifically, are not at issue. The Providers argued that the dispute did not involve the validity of the must bill policy, thus, the must bill policy need not be reviewed to ensure consistent treatment with prior must bill policy challenges.

Moreover, the Providers pointed out that all of the bad debts at issue were for dates of service during which Kindred was still operating the SNFs. The Providers claimed that that they fully complied with this policy by billing the State Medicaid program for dual-eligible coinsurance and deductible amounts and receiving a Medicaid Remittance Advice for each claim before write-off. Pursuant to the regulations and manual provisions, Kindred properly claimed these bad debts on the terminating cost reports it filed for each SNF following the CHOW once the amounts had been written-off as uncollectible. The timing of the write-off and the effective date of the CHOW is immaterial. The general rule states that bad debts are to be claimed in the cost-reporting year in which they are deemed uncollectible.

Further, section 2176 of the PRM establishes an exception to this rule when there is a program termination or a CHOW, as the terminating cost report is the only mechanism by which Medicare can reimburse the seller for allowable bad debts after a CHOW. The Providers argued that the Manual states that the outstanding costs incurred by the seller that relate to dates of service before a CHOW (whether they are bad debts or direct administrative costs) should be reimbursed via the terminating cost report. The Providers claimed that the transfer agreements between Kindred and the buyers reflect this understanding [see Exhibit I-11]. Contrary to the Intermediary's assertions, the parties to each CHOW did not agree to convey "all assets and liabilities." Rather, Kindred and the buyer agreed that Kindred would retain all of its rights to unpaid accounts receivable (including, third party reimbursements) that related to dates of service before CHOW effective date. Further, the Providers asserted that written instructions from CMS support their claims.

DISCUSSION

The entire record, which was furnished by the Board, has been examined, including all correspondence, position papers, and exhibits. The Administrator has reviewed the Board's decision. All comments received timely are included in the record and have been considered.

Under Section 1861(v)(1)(a) of the Act, certain providers are to be reimbursed the reasonable cost of providing services to Medicare beneficiaries. That section defines "reasonable cost" as "the cost actually incurred, excluding therefrom any part of the 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...." The section does not specifically address the determination of reasonable cost, but authorizes the Secretary to prescribe methods for determining reasonable cost, which are found in regulations, manuals, guidelines, and letters. With respect to such payments section 1815 of the Act states that:

> The Secretary shall periodically determine the amount which should be paid under this part to each provider of services with respect to the services furnished by it, and the provider of services shall be paid, at such time or times as the Secretary believes appropriate (but not less often than monthly) and prior to audit or settlement …..the amounts so determined, with necessary adjustments on account of previously made overpayments or underpayments; except 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.

Under reasonable cost reimbursement methodology, the fiscal intermediary makes interim payments to providers based on an estimation of actual costs.[1] Fiscal intermediaries are private entities contracted by CMS to manage Medicare payments issued to providers in accordance with the Social Security Act and the regulations aopted pursuant thereto, and guidelines published by CMS, such as the Medicare Provider

[1] Section 1815(a) of the Social Security Act.

Reimbursement Manual (PRM).[2] After the close of a provider's fiscal year, the provider submits an annual cost report to a fiscal intermediary to account for the cost of services allocated to Medicare. [3] The Intermediary conducts an audit of the report, determines which costs are "allowable" for that period and, if necessary, makes a retroactive adjustment for overpayment or underpayment.[4] Providers are notified of the final determination of program payment and any retroactive adjustment and monies due or owed through issuance of a Notice of Program Reimbursement ("NPR") for that cost reporting period.

Consistent with the requirements of section 1815 of the Act, the regulation sets forth that providers are required to maintain contemporaneous auditable documentation to support the claimed costs for that period. The regulation at 42 CFR 413.20(a) states that the principles of cost reimbursement require that providers maintain sufficient financial records and statistical data for proper determination of costs payable under the program. The regulation at 42 CFR 413.24(a) also describes the characteristics of adequate cost data and cost finding, explaining that 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. The cost data must be based on an approved method of cost finding and on the accrual basis of accounting. Generally, paragraph (b) explains that the term "accrual basis of accounting means that revenue is reported in the period in which it is earned, regardless of when it is collected; and an expense is reported in the period in which it is incurred, regardless of when it is paid."

Along with the documentation requirements for payment, the regulations further explain the reasonable cost principles set forth in the Act.[5] An underlying principle set forth in

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[2] Section 1816 of the Social Security Act, 42 CFR 405.1803(b); 421.5.

[3] 42 CFR 413.20(b). 42 CFR 413.20(b) states that: "Frequency of cost reports. Cost reports are required from providers on an annual basis with reporting periods based on the provider's accounting year. In the interpretation and application of the principles of reimbursement, the fiscal intermediaries will be an important source of consultative assistance to providers and will be available to deal with questions and problems on a day-to-day basis."

[4] Section 1816, 42 CFR 405.1803(a), 413.64(f).

[5] The regulation at 42 CFR 413.1 explains that: "This part sets forth regulations governing Medicare payment for services furnished to beneficiaries" by, inter alia, skilled nursing facilities (SNFs). Paragraph (3) explains that: "Applicability. The payment principles and related policies set forth in this part are binding on CMS and its fiscal

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. This principle is reflected at 42 CFR 413.9(c), which provides that the determination of reasonable cost must be based on costs related to the care of Medicare beneficiaries. However, if the provider's costs include amounts not reimbursable under the program, those costs will not be allowed.

Consistent with this principle, 42 CFR 413.80(a)[6](2003) provides that bad debts are deductions in a provider's revenue and are generally not included as "allowable costs" under Medicare. The regulation at 42 CFR 413.80(b)(1) defines "bad debts" as "amounts considered to be uncollectible from accounts and notes receivable that were created or acquired in providing services. "Accounts receivable" and "notes receivable" are defined as designations for claims arising from the furnishing of services, and are collectable in money in the relatively near future.

However, the regulation at 42 CFR 413.80(d) explains that to ensure that the cost of Medicare services are not borne by others, the costs attributable to the Medicare deductible and coinsurance amounts which remain unpaid are added to the Medicare share of allowable costs. The circumstances under which providers may be reimbursed for the bad debts derived from uncollectible deductibles and coinsurance amounts are set forth at paragraph (e).

In order to receive reimbursement for bad debts under Medicare, providers must meet criteria set forth in the regulation at 42 CFR 413.80(e). This regulatory provision provides:

> 1. The debt must be related to covered services and derived from deductible and coinsurance amounts;
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> 2. The provider must be able to establish that reasonable collection efforts were made;
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> 3. The debt was actually uncollectible when claimed as worthless; and,

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intermediaries, on the Provider Reimbursement Review Board, and on the entities listed in paragraph (a)(2) of this section. (b) Reasonable cost reimbursement. Except as provided under paragraphs (c) through (h) of this section, Medicare is generally required, under section 1814(b) of the Act (for services covered under Part A) and under section 1833(a)(2) of the Act (for services covered under Part B) to pay for services furnished by providers on the basis of reasonable costs as defined in section 1861(v) of the Act.…"

[6] The regulation at 42 CFR 413.80, et seq., has been redesignated to 42 CFR 413.89, et seq. See 69 Fed. Reg. 49254 (Aug. 11, 2004).

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

Further, the regulation, at 42 CFR 413.80(f), explains that:

> 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. [7]

Consistent with the regulatory provisions, section 300, et seq., of the PRM provides guidance with respect to bad debt reimbursement, including bad debt reimbursement involving dual-eligible beneficiaries. Section 310 of the PRM provides in relevant part 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. 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. Section 314 of the PRM explains the accounting period for bad debt recognition:

> Uncollectible deductibles and coinsurance amounts are recognized as allowable bad debts in the reporting period in which the debts are determined to be worthless. Allowable debts must be related to specific amounts which have been determined to be uncollectible. Since bad debts are uncollectible accounts receivable and note receivable, the provider should have the usual accounts receivable records-ledger cards and source documents to support this claim for a bad debt for each account included …. [8]

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[7] See also, e.g., Athens –Limestone Hospital, PRRB. Dec. No. 2001-D40 (where the Board denied bad debts because Provider should have deemed debts worthless and written them off many years earlier when Medicaid remittance advice had been received.)

[8] That provision also explains how bad debts are accounted for where the provider was reimbursed by the program for bad debts for the reporting period in which the amount recovered was included in allowable bad debts, reimbursable costs in the period of recovery are reduced by the amounts recovered. This provision also explains that such

In accordance with section 314 of the PRM, uncollectible Medicare deductible and coinsurance amounts are recognized, and only recognized in the reporting period in which they are deemed worthless.[9] As the court discussed in Palms of Pasadena v. Sullivan, 932 F.2d 982 (D.C. 1991), regarding when a bad debt may be claimed:

> Bad debts relating to Medicare patients can arise when these patients fail to pay their deductible or coinsurance despite the hospital's bona fide attempts at collection….If Medicare does not reimburse providers for these losses, this "could result in the related costs of covered services being borne by other than Medicare beneficiaries." … Medicare therefore steps in and compensates the provider for its losses, but it does so only after the Medicare patients' accounts actually become worthless…. Pursuant to this method, Medicare paid [the provider] a single amount for each bad debt relating to a Medicare patient, regardless of which hospital services gave rise to the debt.
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> The basic effect of these provisions is to bar providers from reporting bad debts on an accrual accounting basis. Rather, some bad debts-those arising from the failure of Medicare patients to pay their deductible or coinsurance amounts-are to be treated as if the provider were on a cash basis. That is, the provider reports (and is then reimbursed for) such Medicare bad debts only in the accounting period when the particular account receivable actually becomes worthless.[10]

These provisions, like that of 42 CFR 413.80(f), ensure the proper recovery of bad debts while safeguarding against double dipping, or duplicative recoveries. In addition, the

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reductions in reimbursable costs should not exceed the bad debts reimbursed for the applicable prior period. Where the provider was not reimbursed by the program for bad debts for the reporting period in which the amount recovered was included in allowable bad debts, reimbursable costs in the period of recovery are not reduced.

[9] Moreover, the section 316 of PRM provides that recoveries of bad debts written-off in a prior period are to be utilized to reduce allowable bad debts in the period in which the unrecovered debts are recovered.

[10] Palms of Pasadena v. Sullivan, 932 F.2d 982, 983 (D.C. 1991) However, while Medicare reimbursement regulation requires health care providers to maintain standard financial records, it does not require the Secretary of Health and Human Services to make reimbursement determinations according to generally accepted accounting principles (GAAP).

period in which a bad debt is claimed can affect the amount of the bad debt to be allowed, either because of the offset of recovered debts, or the affect of certain new provisions affecting the percentage of bad debts which will be paid in a specific cost year.[11] As further explained below, the provision specifically setting forth the cost period in which a bad debt can be reimbursed by Medicare is applicable where a CHOW occurs and the new owner accepts assignment.

Finally, section 322 of the PRM further explains Medicare bad debts under State welfare programs and provides, in part, that:

> 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.[12]

The provisions of the PRM regarding the scope of a reasonable collection effort before reimbursement of bad debts for dual-eligible beneficiaries will be allowed is called "the must bill" policy.[13] The effect of this policy is that a provider must bill the State and receive a Medicaid remittance advice before writing off a debt and deeming it worthless under 42 CFR 413.80.

To determine how CHOWs affect the timing of these recoveries, §1866 of the Act, states that a provider of services shall qualify to participate under Medicare and be eligible for Medicare payment if the provider meets certain conditions and files an agreement with

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[11] See, e. g., 42 CFR413.89 (h) (2008).

[12] See also section 312 of the PRM which explains that: "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: ****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…."

[13] See also CMS Joint Signature Memorandum (JSM) 370, which restates Medicare's longstanding bad debt policy regarding dual eligible beneficiaries.

the Secretary. Section §1866 specifically provides that: "Any provider of services ….shall be qualified to participate under this title and shall be eligible for payments under this title if it files, with the Secretary, an agreement....." [14]

Relevant to this case, the regulations, at 42 CFR 489.18, explain the effect of a change of ownership on a provider agreement. When there is a change of ownership, the existing provider agreement will automatically be assigned to the new owner. Subsection (d) of that regulation further provides that an assigned agreement is subject to all applicable statutes and regulations and to the terms and conditions under which it was originally issued.[15] The Court recognized, in Baptist Health v. Thompson, 458 F. 3d 768 (8th Circuit 2006), that: "In short the Medicare reimbursement system is based on the costs incurred by individual provider hospital without regard to the underlying ownership structure." However, the new owner may decline to accept the existing provider agreement and voluntary terminate the existing provider agreement.[16] In such case, the new owner must apply and meet the conditions of participation outlined in §1819 of the Act and the implementing regulations at 42 CFR 483.100, et seq., along with entering into a new provider agreement and receiving a new separate and distinct provider number.

Consequently, for purposes of the Medicare program, when there is a change of ownership for licensing purposes, and the SNF agrees to accept assignment of the provider agreement, , CMS only has a relationship with the holder of the agreement, the new owner. That entity is entitled to the Medicare payments and also obligated for any Medicare liabilities or civil money penalties, exiting plans of correction of the seller.[17]

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[14] Section 1819 of Act defines a "skilled nursing facility" and the requirements for a skilled nursing facility under Title 18. Consistent with the statute, the regulations at 42 CFR 400.202 defines a Medicare SNF as, inter alia, "a… SNF…that has in effect an agreement to participate in Medicare." Thus, to be eligible for payment a SNF must, among other things, have a provider agreement filed with the Secretary.

[15] 42 CFR 489.18(d).

[16] 42 CFR 489.52.

[17] The Courts directly addressed this issue concerning the effect of automatic assignment of the provider agreement in U.S. v. Vernon Home Health, 21 F.3d 693 (5th Cir.1994). Where the provider accepted automatic assignment of the provider agreement, the Court stated that: "Vernon II could have chosen not to accept the automatic assignment of the provider agreement. Indeed, the government acknowledges that the case would be different if Vernon II had not assumed Vernon I's provider number….. By accepting that assignment, Vernon II agreed (albeit unknowingly) to accept the terms and conditions of the regulatory scheme. Thus, it is liable for the overpayments"

A contractual agreement between the new and old owners cannot invalidate the effect of the regulation. Such a contract is strictly between the parties and does not involve the Medicare program as a party to the contract. It is not Medicare's role to rely on contracts between private parties to determine the recipient of Medicare payments. Rather, in order to ensure responsible oversight of the Medicare program, the statute requires the Secretary make payment in conformity with section 1866 of the Act and 42 CFR 489.18.

The record shows that the Providers involved in this appeal consist of four SNFs operated by subsidiaries of Kindred Health Care.[18] The Providers underwent a CHOW in 2005 for which final cost reports were filed with respective end dates of July 17, 2005, November 30, 2005, and December 31, 2005. The Medicare provider agreements and numbers were transferred to the new owner(s) under an automatic assignment.[19] The Medicare bad debts at issue were those belonging to dually eligible beneficiaries. The bad debts were not written off prior to the end of the respective final cost periods as collection efforts were not completed. The remittance advices from the State Medicaid agencies had not been received showing that the respective State would not cover these costs. Before the filing of the respective final cost reports but after the end of the cost periods, the Providers received the Medicaid remittance advices. The Providers wrote off the bad debts as uncollectible on their final cost reports.

The main support proposed for allowing these bad debts for the Providers' final cost reporting periods are the regulations at 42 CFR 413.24(f)(1) and section 2176 of the PRM. The Administrator finds that the regulation at 42 CFR 413.24(f)(1) merely sets forth the requirements of filing a final cost report whether as a result of a "terminated provider" or a change of ownership and the period for such a report. This regulation, on its face, does not address allowable costs. In addition, the Administrator finds that section 2176 of the PRM[20] is limited to explaining the payment for "Administrative Cost Incurred after Provider Terminates Participation in Program." That provision states that:

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[18] See Joint Stipulation of Intermediary and Providers (Aug. 4, 2008).

[19] See Intermediary Post Hearing Brief (Sept. 18, 2008).

[20] Trans. 166 (September 1976) (explaining that: " 'Administrative costs incurred after provider terminates participation in program' is a new section that includes criteria for the allowability of costs incurred after the effective date of termination of provider participation in the program. Only those direct patient care costs related to the settlement of reimbursement for patient care rendered while the provider was participating in the program are allowable.").

> When a provider terminates its participation in the program, either voluntarily or involuntarily, or a change of ownership occurs (see Health Insurance Regulations section 405.626), administrative costs associated with the preparation and settlement of costs reports with an intermediary and other third parties will be incurred after the effective date of termination. The direct administrative costs that are reasonable and related to the settlement of reimbursement for patient care rendered while the provider was participating in the program and bad debts resulting from coinsurance and deductibles billed to Medicare patients are allowable....However, legal fees and related costs incurred in the sale of the facilities, costs incurred on or after the effective date of termination for the operation or maintenance of closing of the facility are not allowable....[21] (Emphasis added.)

The Administrator finds that section 2176 of the PRM must be read in conjunction with 42 CFR 413.80 and 489.18. By regulation, a Medicare "bad debt" is an amount uncollectible from a specific beneficiary that has met the criteria to be deemed worthless. By regulation a Medicare "bad debt" is charged off in the accounting period in which the account is deemed worthless. Section 2176 cannot provide an exception to, or supersede, or otherwise change the regulation at 42 CFR 413.80. The use of the term "bad debt" in section 2176 is presumed to be consistent with the term bad debt in the regulation. Thus, section 2176 does not support the payment of these costs for cost years before they were determined to be worthless.

Moreover, at the time this PRM provision was issued in 1976, the regulation provided, at 42 CFR 405.626, that a change of ownership invalidated the provider agreement, requiring a new agreement with the new entity. Thus, the PRM refers to an outdated citation at 42 CFR 405.626 that was later changed in the regulation to allow the automatic assignment of the provider agreement under 42 CFR 489.18. Section 2176 of the PRM was drafted long before this regulatory policy was implemented that allowed automatic assignment and never revised. Section 2176 only addresses when the provider terminates from the program, i.e., there is no assignment of the provider agreement.[22] Thus,

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[21] This case is distinguished procedurally from Orange County Medical Center, PRRB Dec. No 94-D36, where the Board allowed certain bad debts after termination of the program, but which was reversed by the Administrator for lack of jurisdiction and, thus, the bad debts were not addressed. The Intermediary in that case argued that, not only was there no jurisdiction, but that the costs were not otherwise allowable.

[22] See Orange County Medical Center, where similarly, the Administrator pointed out that section 2176 of the PRM "must be read together with the regulations and manual sections governing reopening including the requirement for filing timely requests to

regardless, the Administrator finds that, as the provider agreements were automatically reassigned in this case, section 2176 of the PRM does not apply.[23] To allow otherwise when a provider agreement is automatically assigned, would put the Medicare Program at risk of dual demands for the same "bad debts" from two different entities representing the past and present owners claimed in two different reporting periods. In addition, as a general policy, the period in which a bad debt can be claimed can be materially significant because of the offset rules and the regulatory limitations placed on reimbursement of bad debts in specific cost years.

The Administrator finds that providers are required to bill the State and receive remittance advices before dually eligible beneficiaries' bad debts can be deemed worthless and written off. Further, the regulation and manual is unambiguous that 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. This provision is applicable when there is a change of ownership and the provider accepts automatic assignment of the agreement. In this case, the bad debts at issue cannot be determined to be worthless until the Medicaid remittance advices are received by the Providers. The Medicaid remittance advices for these bad debts were not received by the Providers until after the cost reporting periods at issue. Consequently, under the facts of this case, the bad debts cannot be claimed in the Providers' cost reporting periods ending July 17, 2005, November 30, 2005, and December 31, 2005.

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reopen, as laws *pari materia* must be construed in reference to each other." Id. n.7.

[23] In addition, regardless of whether the emails relied upon by the Board were properly included as part of the record, the Administrator finds they are not dispositive of this case as they do not represent CMS policy pronouncements and are contrary to the plain language of the regulation.

DECISION

The decision of the Board is reversed in accordance with the foregoing opinion.

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

Date: **5/1/09**

/s/
Tim Hill
Acting Deputy Administrator
Centers for Medicare & Medicaid Services