PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

2004-D40

PROVIDERS –
Battle Creek Health System
Mercy General Health Partners

Provider Nos.: 23-0075 and
23-0004

vs.

INTERMEDIARY –
BlueCross BlueShield Association/
United Government Services, LLC

DATE OF HEARING –
September 9, 2003

Cost Reporting Period Ended - June 30, 1999

CASE NOs.: 02-0431 and 02-0364

INDEX

ISSUES:

1. Was the Intermediary's adjustment to the Provider's TEFRA rate proper?

2. Did the Intermediary properly conclude that the Provider failed to make reasonable collection efforts and document such efforts with respect to certain bad debts claimed by the Provider?[1]

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Governing Statutes and Regulations:

The Medicare program was established to provide health insurance to the aged and disabled. 42 U.S.C. §§1395-1395cc. The Centers for Medicare and Medicaid Services (CMS—formerly the Health Care Financing Administration (HCFA)) is the operating component of the Department of Health and Human Services (DHHS) charged with administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted out to insurance companies known as fiscal intermediaries. Fiscal intermediaries determine payment amounts due the providers under Medicare law and under interpretive guidelines published by CMS. Id.

At the close of its fiscal year, a provider must submit a cost report to the fiscal intermediary showing the costs it incurred during the fiscal year and the proportion of those costs to be allocated to Medicare. 42 C.F.R. §413.20. The fiscal intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider and issues the provider a Notice of Program Reimbursement (NPR). 42 C.F.R. §405.1803. A provider dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board (Board) within 180 days of the issuance of the NPR. 42 U.S.C. §1395oo(a); 42 C.F.R. §405.1835.

From the Medicare program's inception until 1983, hospitals were reimbursed the lower of their reasonable costs or customary charges for services provided to Medicare beneficiaries. 42 U.S.C. §1395f(b)(1). The statute at 42 U.S.C. §l395x(v)(1)(A) defines reasonable costs as "the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services . . . ."

Congress ultimately amended the reasonable cost payment system because it was concerned that while being reimbursed the reasonable costs of covered services,

[1] This decision encompasses two cases heard by the Board: Battle Creek Health System, PRRB Case Nos. 02-0431 and Mercy Health Partners, PRRB Case No. 02-0364. The only issue in the Mercy General case is whether the Intermediary's adjustment to the Provider's Medicare bad debts was proper. The parties and the Board have agreed to incorporate Battle Creek Health System record pertaining to the Medicare bad debts issue on the record of Mercy General Health Partners. Therefore, the Board's decision regarding the Medicare bad debts issue in the Battle Creek Health system case will also apply to the Mercy General Health Partners case.

providers had no incentive to provide services efficiently or otherwise limit their costs. Congress first modified the law by enacting 42 U.S.C. §1395ww(a), which established limits on operating costs and authorized the Secretary of the Department of Health and Human Services (Secretary) to promulgate regulations to establish prospective limits on the costs recognized as reasonable in furnishing patient care.

In 1982, Congress enacted the Tax Equity and Fiscal Responsibility Act (TEFRA), again modifying the reasonable cost reimbursement methodology in order to create incentives for providers to render services more efficiently and economically. TEFRA imposed a ceiling on the rate-of-increase of inpatient operating costs recoverable by a hospital. The TEFRA ceiling amount, or target amount, is calculated based upon the allowable Medicare operating costs in a hospital's base year (net of certain other expenses including capital and medical education costs) divided by the number of Medicare discharges in that year. The TEFRA target amount is updated annually based on an inflation factor. If a provider incurs costs below the applicable TEFRA target amount in a given cost reporting year, it is entitled to reimbursement for its reasonable costs plus an additional incentive payment. Because the TEFRA target amount serves as a ceiling, a provider may not be reimbursed for its costs above the applicable TEFRA target amount for a particular year.

In 1983, Congress enacted the Social Security Amendments, P. L. No. 98-21, which created the Prospective Payment System (PPS) for hospital inpatient operating costs. After the implementation of PPS, only providers and units within providers exempt from PPS that continued to be paid under the reasonable cost system were subject to the TEFRA rate-of-increase limit.

BACKGROUND OF THE PROVIDER:

The Provider is an acute care hospital located in Battle Creek, Michigan. United Government Services, LLC (UGS, the Intermediary) audited the Provider's cost report for the period ended June 30, 1999 and issued an NPR on September 29, 2001. The Provider was dissatisfied with the adjustment made by the Intermediary to its hospital-based psychiatric unit's TEFRA target rate and its disallowing certain Medicare bad debt claims. The Provider requested a hearing before the Board and met the jurisdictional requirements of the Medicare regulations at 42 C.F.R. §§405.1835 – 405.1841.

The Provider was represented by Chris E. Rossman, Esquire, of Honigman Miller Schwartz and Cohn LLP. The Intermediary's representative was James R. Grimes, Esquire, of the Blue Cross Blue Shield Association.

TEFRA TARGET RATE:

FACTS:

The Provider operates a psychiatric unit (the "Unit") that is reimbursed under TEFRA and is, therefore, subject to TEFRA's rate-of-increase limits. Under TEFRA rate-of-

increase limits, a hospital's (or PPS-excluded unit's) initial TEFRA rate is base on its own cost experience in a base year. Applicable regulations provide that the base year for a newly established PPS-excluded unit is the first cost reporting period of at least 12 months following the unit's certification to participate in the Medicare program.

The initial TEFRA target rate for the Provider's psychiatric unit was established by its fiscal intermediary, United Health Care (UHC). UHC incorrectly based the computation of the Unit's initial target rate on the cost report for the nine-month period ended June 30, 1994. The rate should have been computed using the data contained in the cost report for the fiscal year ended June 30, 1995 — the correct base year.

The error went undetected until the Provider's subsequent fiscal intermediary, United Government Services (UGS), discovered the mistake during its review of the 1999 cost report. UGS computed a revised initial target rate based on the cost data in the June 30, 1995[2] cost report, updated the rate according to the prescribed annual percentage increases, and settled the 1999 cost report using the updated target rate. This resulted in a decrease in Medicare reimbursement of approximately $354,000.[3]

PARTIES' CONTENTIONS:

The Intermediary contends that it could not knowingly continue to apply an incorrect TEFRA target rate, because doing so would clearly violate Medicare regulations that require that reasonable cost reimbursement be based on the actual cost incurred in providing services to Medicare beneficiaries. Furthermore, the Intermediary could not perpetuate an error that it knew resulted in a windfall to the Provider. Finally, the Intermediary avers that it was not necessary to reopen the 1995 cost report in order to use 1995 as the Provider's TEFRA base year because the total amount of Medicare reimbursement related to the 1995 cost report remained unchanged.

The Provider contends that the Intermediary's adjustment to the Provider's 1999 TEFRA rate contradicts Section 1886 of the Act and the regulations found at 42 C.F.R. §413.40(c)(4)(ii) which require that each year's TEFRA rate equal the previous year's rate times the applicable percentage increase. In addition, the Provider maintains that the adjustment violates PRM §2931.1 which states that an intermediary's final determination may be reopened by the intermediary only within 3 years of the date of such notice, except in the case of fraud or similar fault. The record in this case does not include any assertion or evidence of fraud or similar fault.

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[2] The Provider's initial TEFRA target amount per discharge, as established by UHC using 1994 as the base year, was $6,669.02. Using 1995 as the base year resulted in an initial TEFRA target amount of $4,838.15 per discharge. (Provider's Final Position Paper, pg. 7)

[3] The Provider's 1995 through 1998 cost reports were not reopened by the Intermediary, so Medicare reimbursement for those years was not impacted by the change in base year at issue in this case.

ISSUE 2 – MEDICARE BAD DEBTS:

The Intermediary disallowed a portion of the Medicare bad debts claimed by the Provider on the basis that the Provider failed to comply with all of the requirements set forth in 42 C.F.R. §413.80(e), in particular, the third and forth criteria set forth therein: "(3) the debt was 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." The reduction in allowable bad debts based on this finding totaled $207,763 with a Medicare reimbursement effect of $155,822.[4] [5]

The Intermediary found that the Provider pursued internal collection efforts for Medicare and non-Medicare debts for a period of less than 120 days, then wrote off the debts for financial purposes and referred the accounts to a collection agency. The Provider included as bad debts on its cost report any Medicare account that was at least 120 days old by the end of the cost reporting period. These bad debt claims included debts that had been referred to the collection agency. The Intermediary concluded that the debts that were sent to the collection agency but not returned to the Provider as uncollectible did not meet the requirements of 42 C.F. R. §413.80, because they had never been determined to be uncollectible, and collection efforts continued after the accounts were written off.

PARTIES' CONTENTIONS:

The Intermediary maintains that the worthlessness of the receivables envisioned under criteria 3 and 4 of C.F.R. §413.80(e) requires a scrutiny of each receivable and the facts surrounding the debt and the debtor. To provide some administrative ease in establishing a reasonable collection effort and the non-collectibility of debts, the instructions at CMS Pub. 15-1 §310.2 provide for a presumption of worthlessness after collection efforts on an account have been pursued for at least 120 days after the date the first bill is mailed to the beneficiary.

The Intermediary contends that the Provider's bad debt write-off policy resulted in some individual accounts being written off less than 120 days after the first bill was sent and then the accounts were sent to the collection agency. Therefore, the Provider is not entitled to the presumption contained in CMS Pub. 15-1 §310.2 because collection efforts were not pursued for at least 120 days before the debts were "deemed" worthless.[6] The Intermediary asserts that the fact that bad debts were sent to a collection agency is evidence that the Provider did not consider the accounts to be worthless. Under the regulations, the Provider has the burden of establishing that a debt is actually uncollectible when claimed as worthless, and that there is no possibility of recovery at any time in the future. In this case, the Provider assigned the bad debts to a collection

[4] For cost reporting periods beginning during FY 1998, bad debt reimbursement was limited to 75% of the allowable amount.

[5] For Mercy General Health Partners the adjustment of allowable bad debts reduced its Medicare reimbursement by $327,829.

[6] See Intermediary's proposed decision page 2.

agency and never reviewed them again. The Provider cannot then establish that the bad debts were ever determined to be actually uncollectible. As a result, the Intermediary maintains that the Provider is not entitled to Medicare reimbursement for debts that had not been deemed worthless at the time of write-off.

In its defense, the Provider contends that it complied with the requirements set forth in 42 C.F.R. §413.80(e) which must be met in order for bad debts to be reimbursable under the Medicare program.[7] The record in this case established by uncontroverted evidence that (i) the debts at issue were related to Medicare covered services and derived from Medicare deductible and coinsurance amounts; (ii) the Provider undertook reasonable collection efforts to collect the debts; (iii) the debts were actually uncollectible when claimed as worthless by the Provider; and (iv) the Provider exercised sound business judgment when establishing that there was no likelihood of recovery at any time in the future.

The Provider's witness testified that no account was ever claimed as a bad debt on the cost report until it had been at the collection agency for at least 120 days.[8] Therefore, it followed reasonable collection efforts and is entitled to rely on the presumption set forth in CMS Pub. 15-1 §310.2,[9] which states:

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

In conclusion, the Provider maintains that it complied with the statutory and regulatory requirements governing the allowability of Medicare bad debt claims; therefore, the Intermediary's adjustment should be reversed.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board, after consideration of the Medicare law and Program instructions, parties' contentions and evidence presented, finds and concludes the following:

ISSUE 1 - TEFRA RATE:

The Board finds that the Intermediary properly determined the Provider's June 30, 1999 TEFRA target rate using the fiscal year ended June 30, 1995 base year data and subsequent annual percentage increases.

Since the Board finds no specific regulation that addresses the type of error that occurred in this case, it turns for guidance to the overarching reasonable cost reimbursement principles enunciated in 42 C.F.R. §413.9 which state in relevant part:

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[7] See Provider's proposed decision page 4.
[8] Tr. 109:12-17
[9] See Provider's proposed decision page 4.

> [a]ll payments to providers of services must be based on the reasonable cost of services covered under Medicare and related to the care of Medicare beneficiaries.

It is undisputed that the Provider's TEFRA base year should have been the fiscal year ended June 30, 1995. The question then becomes whether it was necessary for the Intermediary to reopen the then final 1995 cost report in order to use its data to establish the initial TEFRA target rate.

Notwithstanding the Provider's contention to the contrary, the Board finds that it was unnecessary to reopen the 1995 cost report in order to establish the correct TEFRA base year. Moreover, the Board agrees with the Provider that the Intermediary was precluded from reopening the 1995 cost report settlement because the cost report was final. The 1995 cost report was not reopened, and the amount of reimbursement due the Provider for 1995 was not changed. Finally, the Board notes that the Intermediary elected not to reopen and amend the settlements of the other cost reports impacted by the re-basing of the base year, so the Provider was not adversely impacted in any year prior to 1999 when the error was detected and properly corrected.

ISSUE 2 - BAD DEBTS:

The Board finds that the Intermediary's adjustment reducing the Provider's bad debt claims due to inadequate collection efforts was improper.

The Intermediary disallowed a portion of the Provider's Medicare bad debts, claiming that the Provider failed to comply with the requirements of 42 C.F.R. §413.80(e) which set forth the criteria that must be met in order for bad debts to be reimbursable. The Intermediary's sole basis for the disallowance was the Provider's use of an outside collection agency as part of its collection efforts. The Intermediary concluded that the Provider was not entitled to claim Medicare reimbursement for any bad debts until such time that the collection agency ceased its collection activities and returned the account to the Provider. The Board finds the Intermediary's position without merit.

The Medicare program reimburses providers for unrecovered costs attributable to bad debts resulting from deductible and co-insurance amounts which are uncollectible from Medicare beneficiaries. Pursuant to 42 C.F.R. §413.80(e), bad debts must meet the following criteria to be allowable:

> (1) The debt must be related to covered services and derived from deductible and co-insurance 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.

The Board notes that the Intermediary has never questioned that the bad debts claimed by the Provider relate to covered services provided to Medicare beneficiaries and that they were derived from deductibles and co-insurance. Furthermore, evidence presented at the hearing clearly established that the Provider undertook reasonable collection efforts in accordance with the above-quoted regulation, and there is no evidence in the record to the contrary.[10] The Intermediary's witness conceded that the Provider undertook reasonable collection efforts for the bad debts at issue[11] and, but for the referral of the accounts to an outside collection agency, the Provider would be entitled to claim these bad debts on its 1999 Medicare cost report.[12]

The Board is unable to reconcile the Intermediary's position with CMS Pub. 15-1 Section 310.2 that allows a provider to seek Medicare bad debt reimbursement for accounts that remain uncollected after a provider has engaged in reasonable and customary collection efforts for a period of a least 120 days. The Intermediary claims that the Provider must wait to claim a debt as uncollectible until either the collection agency returns the account to the Provider and the Provider determines a date certain as to the worthlessness of the account, or the collection agency makes a determination that an account is worthless.[13]

According to CMS Pub 15-1 §310.2, a provider's use of a collection agency may be "in addition to or in lieu of" collection efforts undertaken by the provider itself. Thus, the Board finds that the Intermediary's argument that the Provider's use of an outside collection agency obligated the Provider to engage in its collection efforts for a period greater than the 120 days set forth in CMS Pub 15-1 §310.2 is not supported by the applicable Medicare regulations or manual instructions.

CMS Pub 15-1 §316 indicates that when a provider, in a later period, recovers amounts previously included in allowable bad debts, the provider's reimbursable costs in the period of recovery are reduced by the amounts so recovered. Thus, it is reasonable to infer that the Medicare program expects that providers will continue to pursue collection activities with respect to debts that have been deemed uncollectible for Medicare reimbursement purposes.

Under Medicare law, regulations, and program instructions, the Provider is entitled to Medicare reimbursement for the bad debts at issue in this case.

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[10] Tr. at 80:17 – 84:19; Tr. 90:19 – 92:10

[11] Tr. at 166:3 – 166:16; Tr. at 176:4 – 176:23; Tr. 182:18 – 21; Tr. 188:17 – 189:25.

[12] Tr. 179:8. In response to a Board member's question, the Intermediary's witness indicated that the Provider would have been entitled to claim bad debts had they not used a collection agency.

[13] Tr. at 159:14 – 160:4.

DECISION AND ORDER:

ISSUE 1 – TEFRA RATE

The Intermediary's adjustment establishing the cost report ended June 30, 1995 as the base year for the purpose of computing the TEFRA target rate used to settle the Provider's June 30, 1999 cost report was correct. The Intermediary's adjustment is affirmed.

ISSUE 2 – BAD DEBTS

The Intermediary's adjustment disallowing Medicare bad debts due to inadequate collection efforts was improper and is reversed.

BOARD MEMBERS PARTICIPATING:

Suzanne Cochran, Esquire
Dr. Gary Blodgett
Martin W. Hoover, Jr., Esquire
Elaine Crews Powell, CPA
Anjali Mulchandani-West

DATE: September 16, 2004

FOR THE BOARD

Suzanne Cochran, Esquire
Chairman