PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION

ON THE RECORD
2014-D11

PROVIDER –
Cooper Hospital/University Medical Center

Provider No.: 31-0014

vs.

INTERMEDIARY
BlueCross BlueShield Association/
Novitas Solutions, Inc.

DATE OF HEARING -
September 5, 2012

Cost Reporting Periods Ended -
December 31, 2003; December 31, 2004

CASE NOs.: 07-0847 and 07-0306

INDEX

ISSUES:

ISSUE 1
Whether a provider's collection effort on inpatient and outpatient bad debts must include personal telephone calls to patients to comprise a reasonable collection effort.

ISSUE 2
Whether the Intermediary incorrectly determined that the regulations affirmatively preclude a write off of bad debts prior to 120 days after the first bill is sent.

ISSUE 3
Whether days associated with patients covered under the New Jersey Charity Care Program should be included in the numerator of the Medicaid proxy of the Medicare disproportionate share hospital ("DSH") calculation pursuant to 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II).

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the amount of Medicare reimbursement due a provider of medical services.

The Medicare program was established under Title XVIII of the Social Security Act, as amended ("Act"), to provide health insurance to the aged and disabled. Title XVIII of the Act was codified at 42 U.S.C. Chapter 7, Subchapter XVIII. The Centers for Medicare & 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 to organizations known as fiscal intermediaries ("FIs") and Medicare administrative contractors ("MACs"). FIs and MACs[1] determine payment amounts due the providers under Medicare law, regulation and interpretative guidelines published by CMS.[2]

Providers are required to submit cost reports annually, with reporting periods based on the provider's accounting period. A cost report shows the costs incurred during the relevant accounting period and the portion of those costs allocated to the Medicare program.[3] Each 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").[4] A provider dissatisfied with the intermediary's final determination of total reimbursement (*i.e.*, the NPR) may file an appeal with the Provider Reimbursement Review Board ("Board") provided it meets the following conditions: (1) the provider must be dissatisfied with the final determination of the intermediary; (2) the amount in controversy is $10,000 or more for an individual appeal (or $50,000 for groups); and (3) the appeal must be filed with the Board within 180 days of the receipt of the final determination.[5]

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[1] FIs and MACs are hereinafter referred to as intermediaries.
[2] *See* 42 U.S.C. §§ 1395h, 1395kk-1; 42 C.F.R. §§ 413.20, 413.24.
[3] *See* 42 C.F.R. § 413.20.
[4] *See* 42 C.F.R. § 405.1803.
[5] *See* 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835.

BAD DEBTS

Payment for deductibles and coinsurance amounts are the responsibility of Medicare beneficiaries.[6] However, in order to ensure that costs attributable to covered services furnished to Medicare beneficiaries are not borne by individuals who are not covered by the Medicare program, 42 C.F.R. § 413.89(d)[7] specifies that bad debts attributable to Medicare deductibles and coinsurance are reimbursable as allowable costs. To be considered allowable, § 413.89(e) specifies that a bad debt must meet the following criteria:

> (1) The debt must be related to covered services and derived from deductible 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 judgment established that there was no likelihood of recovery at any time in the future.

The Provider Reimbursement Manual, CMS Pubs. 15-1 and 15-2 ("PRM 15-1 and 15-2") provides additional guidance on allowable bad debts. In particular, PRM 15-1 §§ 300-334 provides general guidance relating to Medicare coverage of bad debts. During the time at issue, PRM 15-2 § 1102.3(L)[8] provided guidance on completing the bad debt portion of CMS Form 339, a cost report questionnaire, and required the provider to attach certain information with the as-filed cost report such as the provider's bad debt collection policy and a listing of bad debts being claimed.

In § 4008(c) of the Omnibus Budget Reconciliation Act of 1987,[9] Congress enacted a noncodified statutory provision that became known as the "Bad Debt Moratorium." In 1988, in § 8402 of the Technical and Miscellaneous Revenue Act of 1988, Congress retroactively amended the Bad Debt Moratorium.[10] In 1989, in § 6023 of the Omnibus Budget Reconciliation Act of 1989, Congress again retroactively amended the Bad Debt Moratorium.[11] As a result of these subsequent changes, the Bad Debt Moratorium, as amended, reads:

> In making payments to hospitals under title XVIII of the Social Security Act [this subchapter], the Secretary of Health and Human Services shall not make any change in the policy in effect on August 1, 1987, with respect to

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[6] *See* 42 C.F.R. § 413.89(d).

[7] On August 11, 2004, 42 C.F.R. § 413.80 was redesignated as 42 C.F.R. § 413.89. 69 Fed. Reg. 48916, 49254 (Aug. 11, 2004).

[8] Pursuant to revisions made by PRM 15-2, Ch. 11, Transmittal 6 (April 2006), the 339 instructions relating to bad debts were relocated from § 1102.3(L) to § 1102.3(I).

[9] Pub. L. No. 100-203, 101 Stat. 1330, 1330-55 (1987).

[10] Pub. L. No. 100-647, 102 Stat. 3342, 3798 (1988).

[11] Pub. L. No. 101-239, 103 Stat. 2106, 2167 (1989).

> payment under title XVIII of the Social Security Act to providers of service for reasonable costs relating to unrecovered costs associated with unpaid deductible and coinsurance amounts incurred under such title (including criteria for what constitutes a reasonable collection effort, including criteria for indigency determination procedures, for record keeping, and for determining whether to refer a claim to an external collection agency). 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 indigency determination procedures, record keeping, and determining whether to refer a claim to an external collection agency, has accepted such policy before that date, and the Secretary may not collect from the hospital on the basis of an expectation of a change in the hospital's collection policy.[12]

MEDICARE DISPROPORTIONATE SHARE ("DSH")

Part A of the Medicare program covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the inpatient prospective payment system ("IPPS").[13] Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[14]

The statutory provisions addressing the IPPS are located in 42 U.S.C. 1395ww(d) and they contain a number of provisions that adjust payment based on hospital-specific factors.[15] This case involves the hospital-specific DSH adjustment specified in § 1395ww(d)(5)(F)(i)(I). This provision requires the Secretary to provide increased IPPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[16]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[17] The DPP is a proxy for utilization by low-income patients and determines a hospital's qualification as a DSH. It also determines the amount of the DSH payment to a qualifying hospital.[18]

The DPP is defined as the sum of two fractions expressed as percentages.[19] Those two fractions are referred to as the "Medicare/SSI" fraction and the "Medicaid" fraction. The Medicare/SSI fraction is defined in § 1395ww(d)(5)(F)(vi)(I) as:

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[12] Reprinted at 42 U.S.C. § 1395f note entitled "Continuation of Bad Debt Recognition for Hospital Services."
[13] *See* 42 C.F.R. Part 412.
[14] *See id.*
[15] *See* 42 U.S.C. § 1395ww(d)(5).
[16] *See also* 42 C.F.R. § 412.106.
[17] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.106(c)(1).
[18] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (F)(vii)-(xiv); 42 C.F.R. § 412.106(d).
[19] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).

> [T]he fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were entitled to benefits under part A of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were entitled to benefits under part A of this subchapter, ...

The Medicare/SSI fraction is computed annually by CMS, and intermediaries use CMS' calculation to compute the DSH payment adjustment as relevant for each hospital.[20]

Similarly, the Medicaid fraction (also referred to as the Medicaid proxy) is defined in § 1395ww(d)(5)(F)(vi)(II) as:

> [T]he fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were *eligible for medical assistance under a State plan approved under subchapter XIX of this chapter*, but who were not entitled to benefits under part A of this subchapter, and the denominator of which is the total number of the hospital's patient days for such period.[21]

The intermediary determines the number of the hospital's patient days of service for which patients were eligible for medical assistance under a State plan approved under Title XIX of the Act (*i.e.*, 42 U.S.C. Chapter 7, Subchapter XIX) but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period.[22]

The Medicaid fraction is the only fraction at issue in this case. However, resolution of the Medicare DSH issue also involves the interpretation of a similar Medicaid DSH provision in Title XIX of the Act and its application to the Medicare DSH Medicaid fraction. The details of the Medicaid DSH provisions are discussed in more detail below.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Cooper Hospital/University Medical Center ("Provider") is located in New Jersey and participates in the New Jersey Charity Care Program ("NJCCP") which provides medical assistance to uninsured low-income patients not eligible for other medical assistance programs, including Medicaid. The Provider initiated appeals from the NPRs for fiscal years (FYs) 2003 and 2004 dated September 22, 2006 and May 24, 2006 respectively.

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[20] 42 C.F.R. § 412.106(b)(2)-(3).
[21] (Emphasis added.)
[22] 42 C.F.R. § 412.106(b)(4).

For FYs 2003 and 2004, the Provider is challenging the disallowance of its Medicare bad debts by the Riverbend Government Benefits Administrator, Highmark Medicare Services ("Intermediary"). The Intermediary disallowed the Provider's bad debt claims using a sampling methodology. Issues 1 and 2 pertain to the bad debts disallowed by the Intermediary.

For FY 2004, the Provider is also challenging the Intermediary's refusal to include NJCCP days in the Medicaid fraction of the Providers' Medicare DSH calculations. Issue 3 pertains to these NJCCP days. The parties agree that resolution of this issue hinges on the meaning of the phrase "patients who for such days were eligible for medical assistance under a State plan approved under subchapter XIX [*i.e.*, Title XIX of the Act]" as used in 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II) to describe the Medicaid fraction. This phrase identifies those days that are to be counted in the Medicaid proxy of the Medicare DSH adjustment.

Title XIX of the Act provides for federal sharing of state expenses for medical assistance for low-income individuals under the Medicaid program provided the state Medicaid program meets certain provisions contained in Title XIX. The state must submit a plan describing the state Medicaid program and seek approval from the Secretary. If approved, the state may claim federal matching funds, known as federal financial participation ("FFP") under Title XIX for the services provided and approved under the state Medicaid program.

PARTIES' CONTENTIONS:

ISSUE 1 – BAD DEBTS COLLECTION EFFORT:

The Provider contends that Medicare rules and regulations do not mandate that a reasonable collection effort must include telephone calls to each patient who owes the provider money. The controlling regulation, 42 C.F.R. § 413.89(e)(2), requires only that there be "reasonable collection efforts." While CMS did not define "reasonable collection efforts" in the regulation, CMS did expand on the regulatory requirement in PRM 15-1 § 310 as follows:

> 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 Provider asserts that § 310 specifies only one element that is clearly and absolutely mandated to be part of "reasonable collection efforts," namely, that a bill be sent to every patient on or shortly after discharge.[23]

[23] *See* Provider's Final Position Paper at 4-5 (Case No. 07-0306).

The Provider explains that, upon discharge, a patient's insurer is sent a summary of charges using the UB-92 claim form. After receiving payment or an explanation of benefits from the payer, the Provider issues a statement advising the patient of the amount he or she owes the Provider. The Provider contends that, through an effective and highly automated internal computerized system, the Provider generates and sends three additional statements (each thirty days apart) to each patient with an unpaid balance. This internal process is uniformly applied to all patients, regardless of payer or amount of balance due.[24]

The Provider notes that § 310 lists telephone calls among the examples of "other actions" that may be used as part of a genuine collection effort; however, neither the regulation nor the PRM guidance specifically mandate that telephone calls are a necessary or essential element of a "reasonable collection effort." Similarly, the Provider asserts that "subsequent billings" and "collection letters" are optional under the PRM guidance.[25]

In support of its case, the Provider points to the decision of the CMS Administrator in *Lourdes Hospital v. Blue Cross Blue Shield* ("*Lourdes*").[26] In that case, the CMS Administrator gave the following summary of the necessary elements for a "reasonable collection effort":

> The Provider's collection policy included, *inter alia*, the following. The Provider made inquiries of patients' financial resources and insurance information at the time of admission. Upon discharge, patients were notified of their total charges, and an itemized bill was sent to each patient approximately five days after discharge. At least three additional statements were sent after the initial billing. At the end of the billing cycle, which was less than 120 days, the Provider wrote or charged off as a bad debt every outstanding account, both Medicare and non-Medicare, for which there was no payment activity. Thereafter, the Provider forwarded both the Medicare and the non-Medicare accounts to a collection agency. On its respective cost reports for the cost years at issue, the Provider claimed the accounts that were charged off as bad debts. The Provider submitted sample copies of the actual billing statements which document the collection efforts.[27]

The Provider's internal collection efforts include a bill and three overdue debt statements and, thus, are as extensive as those summarized in the *Lourdes* decision. The Provider contends that "telephone calls" were notably absent from the above description of a "reasonable" collection effort.[28]

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[24] *See id.*
[25] *See id.*
[26] CMS Administrator Decision (Oct. 25, 1995) , *reversing,* PRRB Dec. Nos. 1995-D58, 1995-D59, & 1995-D60 (Aug.31, 1995) (copy included as Provider Exhibit P-5 (Case 07-0306)).
[27] *Id.* at 5.
[28] *See* Provider's Final Position Paper at 5-6 (Case No. 07-0306).

Similarly, in *Methodist Hosp. of Dyersburg v. BCBS of Tennessee* ("*Methodist Hospital*"),[29] the PRRB upheld a bad debt collections process (and automated "dunning" system) as reasonable and compliant with 42 C.F.R. § 413.89(e) notwithstanding the fact that this process did not include telephone contacts. The Provider asserts that the bad debt collection process outlined in the *Methodist Hospital* decision is comparable to the Provider's own internal bad debt collection process.[30]

The Provider also notes that, during the time at issue, it was transitioning to a new Patient Accounts Policy and Procedure. However, the Provider recognizes that the revised written policy issued on December 31, 2003 had never been formally adopted and implemented,[31] and that the bad debt claims at issue are to be reviewed using the formal written policy that had been issued on March 15, 2002.[32] The March 15, 2002 policy states that telephone calls are to be made as part of the internal bad debt collection effort.[33]

Notwithstanding, the Provider also asserts that, sometime before 2004, it modified that written policy to discontinue the internal practice of making telephone calls to each patient who owed money. The Provider contends that it made a business decision that such telephone calls were not required by the Medicare rules and regulations, or the PRM 15-1, and that it was not a cost effective tool for enhancing patient collections.[34] This operational modification in the Provider's policy was communicated orally to the Provider staff, who were instructed that telephone calls were not necessary or required by Medicare regulations.[35]

The Provider contends that, in modifying its Medicare bad debt collections policy to discontinue the internal practice of making telephone calls, the Provider aligned its internal Medicare bad debt collections policy to the internal non-Medicare bad debt collections policy. The Medicare rules principally stress parity between a provider's Medicare and non-Medicare bad debt collection efforts. The Provider asserts that, during FY 2004, its internal collection efforts for non-Medicare patients did not include telephone calls. The fact that the Provider does not have an internal policy of making telephone calls in pursuit of non-Medicare bad debt collections, where it receives no third-party indemnity for bad debt, is strong evidence that such phone calls have not proven to be a particularly cost effective tool for enhancing patient collections.[36]

The Provider contends that not following the written internal policy of making telephone calls is not legally significant because the Medicare rules and regulations refer only to engaging in a reasonable collection effort and that this may occur without adhering strictly to an internal

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[29] PRRB Dec. No. 2000-D56 (May 30, 2000), *review declined*, CMS Administrator (July 21, 2000) (copy included as Provider Exhibit P-6 (Case No.07-0306)).
[30] *See* Provider's Final Position Paper at 6 (Case No. 07-0306).
[31] *See* Intermediary Exhibit I-5 (Case No. 07-0306) (copy of the unadopted bad debt collection policy dated Dec. 31, 2003).
[32] *See* Intermediary Exhibit I-2 (Case No. 07-0306) (copy of the bad debt collection policy dated Mar. 15, 2002).
[33] *See* Provider's Final Position Paper at 6-7 (Case No. 07-0306).
[34] *See* Provider Exhibit P-8 (Case No. 07-0306) (copy of memo prepared by Mike Rose, former Vice-President of Finance).
[35] *See* Provider Exhibit P-4(Case 07-0306) at ¶ 13 (Declaration of Robert Perry); Provider's Final Position Paper at 7 (Case No. 07-0306).
[36] *See* Provider's Final Position Paper at 7-8 (Case No. 07-0306).

policy, which may on its face exceed what is actually required by that standard. The Provider cites other cases[37] to support its position that the reasonable collection effort standards do not require it to adhere to its Patient Accounts Policy and Procedure. The Provider further explains that, to the extent the Provider's internal policy lists elements (*e.g.*, phone calls) that go above and beyond what is necessary to constitute a reasonable collection effort under the Medicare rules, a failure to adhere to that policy equally for Medicare and non-Medicare patients alike should not in and of itself be a proper, substantive basis for disallowing the bad debt that the Provider actually incurred in treating Medicare patients. Doing so would result in inappropriately "shifting" the cost of those patients to others, in violation of the statutory definition of "reasonable cost" as delineated at 42 U.S.C. § 1395x(v)(1)(A).[38]

The Provider further contends that, in addition to the internal efforts used to collect unpaid accounts, the Provider refers Medicare and non-Medicare accounts that remain unpaid thirty days after the fourth statement has been sent to the patient to an outside collection agency. Upon referral of these unpaid accounts, the collection agency uses additional collection efforts, such as making telephone calls and sending additional statements, to collect the debts. These efforts taken together with the internal policy of billing and follow up demand letters constitute "additional collection efforts" that are "optional" under the PRM 15-1 § 310.[39]

In responding to the Provider's contentions, the Intermediary agrees that the Patient Accounts Policy and Procedure that had been effective since March 15, 2002 met the definition of reasonable collection efforts as defined in 42 CFR 413.89(e). The Intermediary made this finding during its audit of the Medicare bad debts for FY 2004. The Provider's March 15, 2002 written bad debt collections policy in effect during the time at issue includes the following statements:

> COLLECTION EFFORT
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> - Four statements must be sent to the Medicare beneficiary for each account whose balance represents a true patient balance. The HIS automatically produces four patient statements, 30 days apart, for unpaid balances and automatically "writes off" the amount which qualifies for bad debt the month following the 4th statement. The account will then transmit to a collection agency at the end of that month.
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> - Additionally, in an effort to provide a genuine collection effort, *a minimum of two phone calls will be placed* to the patient on account balances >$500.00 for outpatients and >$1,000.00 for inpatients. *These calls must be documented in the HIS.* Memos should reflect the name of the individual to whom the

[37] *See, e.g., Detroit Receiving Hosp. v. Shalala*, 194 F.3d 1312 (6th Cir. 1999); *American Farm Lines v. Black Ball Freight Serv.*, 397 U.S. 532 (1970).
[38] *See* Provider's Final Position Paper at 7-8 (Case No. 07-0306).
[39] *See id.* at 9-10.

> caller spoke, as well as the outcome of the call requesting payment. The patient should also be advised that their account will be referred to a collection agency if left unpaid. To be considered a reasonable collection effort, the effort to collect Medicare deductibles and co-insurance amounts must be similar to the effort put forth to collect comparable amounts from non-Medicare patients.[40]

As part of its audit of FYs 2003 and 2004, the Intermediary selected a sample of both inpatient and outpatient Medicare bad debts to review and determine if the Provider had adhered to its bad debt collections policy. As a result of the review, the auditors informed the Provider that the bad debts were being disallowed due to lack of reasonable collection efforts, primarily the nonexistence of telephone calls.[41]

The Intermediary agrees with the Provider that PRM 15-1 § 310 includes telephone calls as one of the collection tools that can be used to determine whether the Provider made a reasonable collection effort. In fact, the Provider itself defined in its bad debt collection policy the criteria for a reasonable collection effort. In particular, this policy specifies that a minimum of two phone calls would be placed to the patient on account balances greater than $500.00 for outpatients and greater than $1,000.00 for inpatients and that these telephone calls would be documented in the Provider's internal computerized system. The Intermediary notes that, as stated in that policy, the Provider believed that the inclusion of telephone calls as part of their collection effort would make the effort a "genuine, rather than token" effort. Thus, the Intermediary asserts that the accounts that failed due to "unreasonable" collection efforts were those accounts in which the Provider failed to comply with its own policy. If the Provider had adhered to their policy, which included statements as well as telephone calls on certain dollar value accounts, the failed accounts would have been allowed per 42 C.F.R. § 413.89(e).[42]

In addition to the lack of telephone calls, the Intermediary reduced the Medicare inpatient and outpatient bad debts for the following reasons:

- Failure to document secondary insurance;
- Failure to support deductible and/or coinsurance balance;
- Offset of Medicare recoveries;
- Denial of claimed charges by Medicare; and
- Account was a non-Medicare bad debt.

Thus, the failure to make telephone calls in compliance with the company's written collection policy is only one reason why the bad debts at issue were denied.[43]

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[40] Intermediary Exhibit I-2 at 2 (Case No. 07-0306) (italics emphasis added).
[41] *See* Intermediary's Final Position Paper at 3-4 (Case No. 07-0306).
[42] *See* Intermediary's Final Position Paper at 5-6 (Case No. 07-0306).
[43] *See id.* at 7.

ISSUE 2 – BAD DEBTS WRITTEN OFF WITHIN 120 DAYS OF THE FIRST BILL.

The Provider contends that it does not typically treat Medicare patient bad debts as uncollectible until sometime after the fourth statement is sent, at which point the debts have been uncollected for over 120 days and are "deemed" uncollectible pursuant to PRM 15-1 § 310.2.[44]

The Provider contends that it may have internally written off some accounts before 120 days had elapsed from the first bill; however, that was the exception to the rule because, in virtually every other case involved, far more than 120 days elapsed prior to Provider actually claiming the debt as worthless in its cost report submission. According to the Provider, the legal issue presented on appeal is not whether a debt was worthless at the time it was written off internally, but rather at the time it was claimed as worthless on the Medicare cost report.[45]

The Provider challenges the Intermediary's interpretation of the PRM and uses the following hypothetical to illustrate why the Intermediary's interpretation is flawed. Assuming the calendar year and the cost year are the same, a provider bills patient A and patient B on January 1st. After engaging in identical collection efforts for both claims, the provider does an internal write-off of patient A's claim on 119th day and does an internal write-off of Patient B's claim on 121st day. Both claims remained unpaid at the time they were claimed on the Medicare cost report on May 31st of the following year. As per the Provider, the Intermediary would take the position that, in the hypothetical, the provider's write-off of patient A's claim was inappropriate, while the write-off of patient B's claims was proper even though the provider engaged in the same collection efforts for both claims and both claims remained unpaid at the time they were claimed on the cost report. The Provider contends that claims may be written off within 120 days of discharge because the instructions for the Form CMS-339 in PRM 15-2 § 1102.3(L), as revised on September 12, 2003, specify that a provider:

> Must be prepared to demonstrate that the debts were actually worthless if it elects to claim [] Medicare bad debts in 120 days or less from the first bill.[46]

In the *Lourdes* decision, the Administrator found that, even before the passage of 120 days, the debts were properly treated as worthless after the issuance of a bill and three follow-up demands under a collections system virtually identical to the Provider's bad collections process. In the *Methodist Hospital* decision, the PRRB similarly approved claims for bad debts that were written off prior to 120 days after the first bill.[47]

The Provider asserts that the Bad Debt Moratorium is relevant to this case. The Provider characterizes the Bad Debt Moratorium as a Congressional prohibition on CMS from adopting more restrictive policies for bad debts after August 1, 1987 than were applied prior to that date. Specifically, the Provider asserts that, to the extent the Intermediary (or the Administrator) reverses the approach taken for many years and adopts a more stringent policy that simply

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[44] *See* Provider's Final Position Paper at 10 (Case No. 07-0306).
[45] *See id.* at 10-11.
[46] PRM 15-2, Ch. 11, Transmittal 5 (Sept. 12, 2003) (copy included as Provider Exhibit P-9 (Case No. 07-0306)).
[47] *See* Provider's Final Position Paper at 10-12 (Case No. 07-0306).

deemed all debts "collectible" before the expiration of 120 days from the first bill, irrespective of the actual collections effort that precedes the write off, then that policy reversal would violate the Bad Debt Moratorium.[48]

> In responding to the Provider's contentions, the Intermediary relies on the presumption of noncollectibility located at PRM 15-1 § 310.2. The Intermediary recognizes that the Provider asserts that it generally does not treat Medicare patient bad debts as uncollectible until sometime after the fourth statement is sent, at which point the debts would have gone uncollected for over 120 days and would be "deemed" uncollectible pursuant to § 310.2. Contrary to the Provider's position, the Intermediary asserts that the results of its audit demonstrate that there were accounts that did not meet the § 310.2 criteria because only 120 days or less transpired before the debts associated with Issue 2 were written off.[49]

Further, for these accounts, the Intermediary contends that the Provider again failed to follow its collection policy. Specifically, the Intermediary contends that the Provider's failure to follow its own collection policy of sending four statements (each thirty days apart) caused the accounts to be written-off in less than 120 days. The Intermediary did not find any evidence in the Provider's account file to document why four statements were not generated for these accounts and, more generally, why these accounts were written-off prematurely. The Intermediary asserts that these premature write offs did not comply with PRM 15-1 § 310.2 and the Provider's own collection policy.[50]

> The Intermediary also points to the fact that there was confusion among the staff as to which Patient Accounts Policy and Procedure was in existence during the time covered by the audit (*i.e.*, FY 2004). However, the Provider's general counsel later clarified as follows:
>
> > During the on-site audit for Fiscal Year 2004, a question arose as to Policy No. C11R3 entitled "Bad Debt/Compliance Policy" dated 12/31/03 (hereinafter, "Rev. 03"). Upon further review, it does not appear that Rev.03 was effectively adopted and implemented. Therefore, we ask that you base your audit findings only on Policy No. C11R2 entitled "Bad Deb/Compliance Policy" dated 03/15/02.[51]

Thus, the Provider has represented that the written policy dated December 31, 2003 was not in effect during FY 2004.[52]

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[48] *See id.* at 12.
[49] *See* Intermediary's Final Position Paper at 8 (Case No. 07-0306).
[50] *See id.* at 8-9.
[51] *See* Intermediary Exhibit I-6 (Case No. 07-0306).
[52] *See* Intermediary's Final Position Paper at 5, 7 (Case No. 07-306).

ISSUE 3 – STATE CHARITY CARE PROGRAM PATIENT DAYS EXCLUDED FROM MEDICARE DSH CALCULATION:

The Provider contends that the Medicare statute and regulations require the inclusion of the NJCCP days in the Medicare DSH calculation because the charity care program was a part of the New Jersey State Medicaid Plan and CMS reviewed and approved that plan. The Provider also contends that the charity care funding relies on Medicaid dollars for which the State receives federal matching funds. The Provider argues that the term "medical assistance" is broad in scope and includes all services and payments for services made under the state Medicaid plan, including Medicaid DSH payments. Thus, the NJCCP must be considered "medical assistance under a State plan," and all days related to providing care for charity care patients must be included in the Provider's own DSH calculations. The Provider asserts that, although patients in the Medically Indigent ("MI") and General Assistance Unemployable ("GAU") programs do not qualify for Medicaid, these claims are paid through the Medicaid DSH funds. Accordingly, MI and GAU program patients should qualify for medical assistance under a state approved plan.[53] In this regard, the Provider relies primarily on various PRRB decisions.[54]

In a supplemental filing, the Provider presented a new legal argument based on the recent federal district court decision in *Nazareth Hosp. v. Sebelius*, 938 F. Supp. 2d 521 (E.D. PA 2013) ("*Nazareth*"). The new legal argument alleges that the Secretary violated the Equal Protection Clause of the Constitution by treating similarly situated hospitals differently, depending on whether they are located in a § 1115 waiver state. [55]

The Intermediary counters that days of care paid for by State programs for low income patients who are not eligible for Medicaid – even if those State programs are cited in the State Medicaid plan approved by CMS – cannot be included in a provider's DSH calculations. The Intermediary reasons that, because the New Jersey State Medicaid Plan provides that patients who are eligible for the NJCCP cannot be eligible for Medicaid, NJCCP days must be excluded from the Medicaid proxy of the Medicare DSH calculation. In order to be included in the Medicaid proxy, a State program must be covered as "medical assistance" as defined under 42 U.S.C. § 1396d(a)[56] (*i.e.*, the patient days must be Medicaid eligible, not merely low income days that Medicaid permits to be counted solely for the Medicaid DSH adjustment).[57]

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[53] *See* Provider's Final Position Paper at 12-17 (Case No. 07-0306).

[54] *See Arizona 96-99 DSH Group v. Blue Cross Blue Shield Ass'n*, PRRB Dec. No. 2007-D29 (May 4, 2007), *rev'd*, CMS Administrator Dec. (July 6, 2007); *Good Samaritan Reg'l Med. Ctr. v. Blue Cross Blue Shield Ass'n*, PRRB Dec. No. 2007-D35 (May 17, 2007), *rev'd*, CMS Administrator Dec. (July 13, 2007); *Ashtabula Cnty. Med. Ctr. v. BlueCross Blue Shield Ass'n*, PRRB Dec. No. 2005-D49 (Aug. 25, 2005), *rev'd*, CMS Administrator Dec. (Oct. 11, 2005); *Washington State Medicare DSH Group II v. BlueCross Blue Shield Ass'n*, PRRB Dec. No. 2007-D5 (Nov. 22, 2006), *rev'd*, CMS Administrator Dec. (Jan. 19, 2007). These PRRB decisions are included as Provider Exhibits P-13 and P-14, P-11, P-12(Case No. 07-0306)).

[55] *See* Provider's Supplemental Position Paper at 10 (Case No. 07-0306).

[56] The Intermediary characterizes the services and eligibility requirements set out in 42 U.S.C. § 1396c(a) as "traditional" Medicaid coverage.

[57] *See* Intermediary's Final Position Paper at 11-16 (Case No. 07-0306).

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Board has considered Medicare law and guidelines, the parties' contentions and the evidence presented at the record hearing. Set forth below are the Board's findings and conclusions.

ISSUE 1 – BAD DEBTS COLLECTION EFFORT:

PRM 15-1 § 310 provides the following guidance to providers on satisfying the bad debt criteria in 42 C.F.R. § 413.89(e)(3) for "establish[ing] that reasonable collection efforts were made":

> *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. (see § 312 for indigent or medically indigent patients.)
>
> A. Collection Agencies.—*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 uncollected patient charges of like amount to the agency without regard to class of patient. The "like amount" requirement may include uncollected charges above a specified minimum amount. . . .
>
> B. Documentation Required.—*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.[58]

In other words, the guidance recognizes that a provider's actual "collection effort" or "effort to collect" (*i.e.*, the "[i]t"[59]) may be something more, less or equal to what may be "considered a reasonable collection effort." Further, § 310 describes how the actual "collection effort" or "effort to collect" can be considered "reasonable." In this regard, § 310(A) further describes how providers may use a collection agency as part of their actual "collection effort" and

[58] (Emphasis added.)

[59] Note that the noun "[i]t" as used in the second and third sentences of PRM 15-1 § 310 refers to the noun "a provider's effort to collect" as used in the first sentence of § 310 and that the only reference to reasonable collection effort is in the introductory phrase "[t]o be considered a reasonable collection effort . . . ."

§ 310(B) describes what documentation is required to document the provider's actual "collection effort."

Significantly, § 310 makes clear that it is up to the provider to make a business decision on how much and what types of actual "collection effort" it will expend to collect debts. These business decisions ultimately determine whether the provider's actual "collection effort" is less than, equal to, or greater than the minimum needed to establish that it is "reasonable." These business decisions also include what tools the provider will use as part of its actual "collection effort" (*e.g.*, whether or not the provider will engage a "collection agency" to assist in that effort).

Regardless of where the provider sets the bar for its actual "collection effort" (*i.e.*, below, equal to, or above the minimum), § 310 specifies that, in order for a collection effort to be considered reasonable, the provider's actual "collection effort" for Medicare accounts must be similar to that used for non-Medicare accounts. As a result, if a provider makes a business decision to set its collection process somewhere above the minimum needed to establish a reasonable collection effort, then the provider is effectively raising the bar for the actual "reasonable collection effort" standard that that provider must meet. This means that the actual "reasonable collection effort" standard applied varies from provider to provider and determining the standard to be applied to a particular provider necessarily depends on what business decisions the provider has made in setting its debt collection process.

The business decisions that a provider makes in setting its debt collection process and procedure are reflected in the provider's written debt collection policy. As part of the normal cost report audit process and procedure, intermediaries request to receive a copy of the provider's written bad debt collection policy for handling Medicare and non-Medicare patient accounts. This requirement is memorialized in the CMS Form 339 which is submitted with the as-filed cost report. Specifically, during the time at issue, this form asked whether the provider's bad debt policy had changed from the prior year and, if so, to submit a copy.[60]

The hospital audit program in effect prior to the Bad Debt Moratorium confirms that the Medicare program expected hospitals to maintain and make available during audit a written bad debt collections policy at least since December 1985. Specifically, as part of the audit of a hospital, the hospital audit program required the intermediary to review the hospital's bad debt policy to test the hospital's internal controls and adherence to Medicare bad debt policies.[61]

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[60] *See* PRM 15-2, Ch. 11, § 1102 and Exhibit 1.

[61] *See* Medicare Intermediary Manual, Part 4, CMS Pub. No. 13-4 ("MIM 13-4"), Ch. 5, § 4499 Exhibits 1, 15, and 21 (as revised by MIM 13-4, Ch. 5, Transmittal 16 (Dec. 1985)) (stating, for example, in § 1.15 that ; "the auditor should request . . . [p]olicies and procedures relating to the determination and collection of bad debts"; in § 15.01 "[t]he auditor should review the provider's policies and procedures to obtain an understanding of the method used to determine bad debts, bad debt collection effort and the method used to record the recovery of bad debts previously written off"; and in § 21.05(A)(1) "[r]eview the provider's 'bad debt' policy and determine whether its application to both Medicare and other patients is consistent"). This hospital audit program was designed for use by both intermediaries and CPA firms to test the hospital's internal controls and adherence to Medicare policies. *See* MIM 13-4, Ch. 5, § 4402 (as revised by MIM 13-4, Ch. 5, Transmittal 16 (Dec. 1985)) (stating that "the audit program was designed so that an intermediary or CPA could express an opinion as to whether or not the provider is adhering to Medicare Reimbursement Principles as explained int ehh Provider Reimbursement Manual, HCFA Pub. 15-1"); MIM 13-4, Ch. 5, § 4499 Exhibit 1 at § 1 (stating that "The Audit Program was developed to assist an intermediary or CPA firm in determining if the correct amount of reimbursement was made to the provider for the cost report

Further, the hospital audit program is derived from 42 C.F.R. §§ 413.20 and 413.24 for the purpose of testing hospital internal controls and adherence to Medicare policies.[62] In this regard, the Board notes that maintaining a written bad debt collections policy is consistent with 42 C.F.R. §§ 413.20(a) and (d) and 413.24(c) to ensure adequate and sufficient cost information is maintained. Specifically, 42 C.F.R. § 413.20(a) specifies in pertinent part:

> (a) *General.* The principles of cost reimbursement require that providers maintain sufficient financial records and statistical data for proper determination of costs payable under the program.

Similarly, 42 C.F.R. § 413.24(c) specifies in pertinent part:

> (c) *Adequacy of cost information.* Adequate cost information must be maintained from the provider's records to support payments made for services furnished to beneficiaries. The requirement of adequacy of data implies that the data be accurate and in sufficient detail to accomplish the purposes for which it is intended. Adequate data capable of being audited is consistent with good business concepts and effective and efficient management of any organization, whether it is operated for profit or on a nonprofit basis. It is a reasonable expectation on the part of any agency paying for services on a cost-reimbursement basis. In order to provide the required costs data and not impair comparability, financial and statistical records should be maintained in a manner consistent from one period to another. However, a proper regard for consistency need not preclude a desirable change in accounting procedures if there is reason to effect such change.

Further, maintaining a written bad debt collections policy is also consistent with PRM 15-1 § 310. In order to have similar treatment across Medicare and non-Medicare accounts, it necessarily means that there is consistency in this treatment across Medicare and non-Medicare debts. The Medicare program's expectation that the provider maintain a policy and procedure for its bad debt collection effort is reflected in the use of the word "customary" in PRM 15-1

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being audited. Also, the audit program was designed so that an intermediary or CPA [firm] could express an opinion as to whether or not the provider is adhering to Medicare Reimbursement Principles as explained in the Provider Reimbursement Manual, HCFA Pub. 15-1."); MIM 13-4, Ch. 5, § 4499 Exhibit 21 at ¶¶ 21.01, 21.05(A)(1) (as revised by MIM 13-4, Ch. 5, Transmittal 16 (Dec. 1985)) (stating in § 21.01 "the scope of an audit of the balance sheet accounts for Medicare purposes is dependent upon the. . . effectiveness of the internal controls" and in § 21.05 "[r]eview the provider's 'bad debt' policy and determine whether its application to both Medicare and other patients is consistent"). *See also, e.g., Buckeye Home Health Serv. Inc. v. Blue Cross of Central Ohio*, PRRB Dec. No. 1983-D108 (July 14, 1983), *review declined*, CMS Administrator (Sept. 1, 1983) (PRRB decision issued prior to the Bad Debt Moratorium where bad debts were disallowed due to the Provider's failure to follow its bad debt collection policy).

[62] *See* MIM 13-4, Ch. 5, § 4499 Exhibit 1 at §§ 1, 1.04(B)(15), 1.15 (as revised by MIM 13-4, Ch. 5, Transmittal 16 (Dec. 1985)) (citing to 42 C.F.R. §§ 405.406, and 405.453 which were later relocated to 42 C.F.R. §§ 413.20 and 413.24 as authorities for the hospital audit program which includes among other things, review of the written bad debt collection policy). *See also supra* note 61.

§ 310.2. This section according to its title provides for a "presumption of noncollectibility" if certain conditions are met:

> *If 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.[63]

Thus, in order to obtain the benefit of this presumption, a provider must make both "reasonable *and* customary attempts to collect"[64] for 120 days prior to writing a bad debt off.

The Provider has confirmed that, during the time at issue, it had in place a written bad debt collections policy and procedures with an issue date of March 15, 2002 ("2002 Collection Policy").[65] The 2002 Collection Policy specified that "[a]ll patient balances will meet the criteria for bad debt write off using the criteria below prior to the actual bad debt write off."[66] Before an account could be written off, the criteria for collection efforts required the Provider to issue four statements to the Medicare beneficiary and make a minimum of two telephone calls on account balances greater than $500 for outpatients and greater than $1000 for inpatients "in an effort to provide a genuine collection effort."[67] In connection with the four statements, the policy states that the internal electronic accounting system "automatically produces four patient statements, 30 days apart, for unpaid balances and automatically 'writes off' the amount which qualifies for bad debt the month following the 4th statement."[68]

The Provider admits that it did not follow the policy for certain debts by not making the telephone calls required by that policy prior to writing off such debts.[69] However, the Provider contends that not following its written internal policy is not legally significant because, even without the telephone calls, the collection effort was both reasonable and customary. Also, the Medicare rules and regulations only refer to engaging in a reasonable collection effort and this may occur without adhering strictly to an internal policy. The Board disagrees.

With regard to the bad debts at issue for Issue 1, it is undisputed that:

1. The Provider's collection efforts for these bad debts failed to comply with the 2002 Collection Policy because the Provider did not make the telephone calls as required by that policy.

2. The Provider wrote off these bad debts more than 120 days after issuance of the first bill in reliance on the "presumption of noncollectibility" provided in PRM 15-1 § 310.2.

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[63] (Emphasis added.)
[64] (Emphasis added.)
[65] *See* Intermediary Exhibit I-2 (Case No. 7-0306).
[66] *See* Intermediary Exhibit I-2 (Case No. 7-0306).
[67] *Id.* at 2.
[68] *Id.*
[69] *See* Provider Exhibit P-4 (Case No. 07-0306).

The Intermediary made adjustments to the inpatient and outpatient bad debts on the FY 2003 and 2004 cost reports to remove those bad debts for which the Provider failed to make the telephone calls that were required under the 2002 Collection Policy.

The Provider also has failed to supply any supporting documentation to validate why the Provider did not adhere to the 2002 Collection Policy. The Declaration of the Director of Patient Financial Services further supports that the Provider strayed from the 2002 Collection Policy and, hence, any potential applicability of the Bad Debt Moratorium is moot. The Provider's statements further acknowledge that there was lack of consistency in following a collection policy:

> It is my understanding that sometime before 2004 Cooper had operationally modified its internal policy to discontinue the practice of making personal phone calls to each patient who owed Cooper.
>
> It is my understating that the operationally modified policy was communicated orally to Cooper staff, in which they were advised that phone calls were not necessary or required by Medicare regulations or manuals.[70]

It is apparent that the Provider's lack of internal controls related to the collection policies and procedures has led to a breakdown in the collection process. By not maintaining and following its written bad debt collection policy, the Provider failed to establish its adherence to Medicare bad debt policies consistent with 42 C.F.R. §§ 413.20(a) and 413.24(c).[71] Accordingly, the Intermediary's adjustment to remove those bad debts for which the Provider's collection efforts failed to comply with the 2002 Collections Policy is affirmed.

ISSUE 2 – BAD DEBTS WRITTEN OFF WITHIN 120 DAYS OF THE FIRST BILL:

The Board finds that the evidence presented by the Provider in the position papers and the exhibits fails to establish that each bad debt "was actually uncollectible when claimed as worthless" pursuant to the bad debt criteria at 42 C.F.R. § 413.89(e)(3).[72] The Board further finds that the Provider fails to meet the presumption of noncollectibility in PRM 15-1 § 310.2.

The Provider has conceded that its internal written policy required internal attempts to collect for 120 days prior to writing off.[73] Notwithstanding, the Provider contends that this noncompliance is a technicality and not significant. The Board disagrees.

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[70] *See* Provider Exhibit P-4 at 2 (Case No. 07-0306).

[71] *See supra notes* 60-64 and accompanying text.

[72] *See also* PRM 15-1 § 308.

[73] For example, in the Provider's 2004 Final Position Paper at page 10-11 (Case No. 07-0306), the Provider makes the following statement regarding its inconsistent internal collections practice:

> Cooper may have internally written off some debts before 120 days had elapsed from the first bill, in virtually every case involved, far more than 120 days had elapsed prior to Cooper's actually "claiming" the debt as worthless in its cost report submission.

PRM 15-1 § 310.2 specifies that:

> *If 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.

Thus, in order to obtain the benefit of this presumption, a provider must make both "reasonable *and customary* attempts to collect" for 120 days prior to writing a bad debt off. The Provider failed to follow its customary attempts, *i.e.*, its written policy.

The instructions for the Form CMS-339 in PRM 15-2 § 1102.3(L) further clarifies when a provider can elect to claim the Medicare bad debts in 120 days or less from the first bill. Specifically, these instructions, as revised on September 12, 2003, specify that the provider:

> [M]ust be prepared to demonstrate that the debts were actually worthless if it elects to claim [] Medicare bad debts in 120 days or less from the first bill.[74]

These instructions confirm that, if the Provider writes off a debt prior to 120 days of collection efforts, then the Provider does not get the benefit of the "presumption of noncollectibility" and must demonstrate that the debts were actually worthless. Contrary to this instruction, the Provider failed to document the basis for writing off the bad debts prior to 120 days. This is further evidence that the Provider lacked internal controls related to its internal collection policies and procedures.[75] Accordingly, the Board finds in favor of the Intermediary's adjustment for inpatient and outpatient bad debts.[76]

ISSUE 3 – STATE CHARITY CARE PROGRAM PATIENT DAYS EXCLUDED FROM MEDICARE DSH CALCULATION:

The evidence establishes that charity care beneficiaries of the NJCCP are not eligible for Medicaid and that the services provided under the NJCCP are not matched with federal funds except under the Medicaid DSH provisions.

The Medicaid DSH provisions are similar to the Medicare DSH provisions. 42 U.S.C. § 1396r-4(a) mandates that a state Medicaid plan under Title XIX of the Act must include a

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[74] PRM 15-2, Ch. 11, Transmittal 5 (Sept. 12, 2003).

[75] *See* Board's findings and determination on Issue 1 for a discussion of the Board's other findings on the Provider's lack of internal controls. The Provider's reliance on the Administrator's decisions in *Lourdes* and the Board's decision in *Methodist Hospital* is misplaced. Where other providers have opted to set the bar for their bad debt collection policies in order to comply with PRM 15-1 § 310 is not relevant to the Provider's noncompliance with its own bad debt collection policy. Pursuant to PRM 15-1 § 310, the Provider exercised its discretion to set the policy for its debt collection efforts and it failed to follow that policy.

[76] While the Board reaches the same conclusion as the Intermediary, the Board disagrees with the Intermediary's position that collection activity must be for more than 120 days in order to be reasonable under PRM 15-1 § 310. These manual provisions specify that provider collection efforts must be for more than 120 days in order "[t]o be considered a reasonable collection effort." Rather, § 310.2 allows providers to get the benefit of a presumption of noncollectibility if certain conditions are met. In particular, in order to qualify for that presumption, the collection effort is required, among other things, to be for more than 120 days.

provision for a payment adjustment to hospitals which serve a disproportionate number of low income patients (*i.e.*, it requires a Medi*caid* DSH adjustment for hospitals that is independent of the Medi*care* DSH adjustment at issue in this case). The Medicaid DSH adjustment is eligible for FFP even though the particular patient days counted for Medicaid DSH are not directly eligible for FFP because they do not qualify as "traditional Medicaid" services described in 42 U.S.C. § 1396c(a).

The question for the Board is whether the NJCCP as a state funded program not otherwise eligible for Medicaid coverage and included in the New Jersey State Medicaid Plan solely for the purpose of calculating the Medi*caid* DSH payment constitutes "medical assistance under a State plan approved under [T]itle XIX" for purposes of the Medi*care* DSH adjustment, specifically in the Medicaid fraction component.

In prior decisions on similar state-funded programs, the Board has interpreted the Medicare statutory phrase "medical assistance under a State plan approved under [T]itle XIX" to include any program identified in the approved state plan (*i.e.*, it has not limited the days counted to traditional Medicaid days).[77] Subsequent to those decisions, the U.S. Court of Appeals for the District of Columbia ("D.C. Circuit") issued its decision in *Adena Reg'l Med. Ctr. v. Leavitt*, 527 F.3d 176, (D.C. Cir., 2008),[78] and concluded that the days related to charity care beneficiaries eligible for the Ohio Hospital Care Assurance Program (HCAP) should not be included in the Medicaid proxy of the Medi*care* DSH calculation.[79] Like the NJCCP, HCAP patients could not qualify for Medicaid but the HCAP days were included in the Medicaid DSH calculation. The D.C. Circuit pointed out that 42 U.S.C. § 1396r-4(c)(3)(B) "permits the states to adjust DSH payments 'under a methodology that' considers *either* 'patients eligible for medical assistance under a State plan approved under [Medicaid] or ... low-income patients,' 42 U.S.C. § 1396r-4(c)(3)(B), such as those served under the HCAP."[80]

Upon further review and analysis of § 1396r-4, the Board continues to find that the term "medical assistance under a state plan approved under [T]itle XIX" excludes days funded by only the state and charity care days even though those days may be counted for Medicaid DSH purposes. Title XIX describes how hospitals qualify for the Medicaid DSH adjustment. Specifically, § 1396r-4(b) establishes two distinct categories of low-income patients that are used to calculate a Medicaid DSH payment. The two categories, identified as the "Medicaid inpatient utilization rate" and the "low-income utilization rate," are defined in subsection (b)(2) and (b)(3), in pertinent part, as follows:

> (b)(2) For purposes of paragraph (1)(A), the term "medicaid inpatient utilization rate" means, for a hospital, a fraction (expressed as a percentage), the numerator of which is the hospital's number of inpatient days attributable to patients who (for such days) were *eligible for medical assistance under a State*

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[77] *See, e.g., Ashtabula County Med. Ctr. v. Blue Cross Blue Shield Ass'n,* PRRB Dec. No. 2005-D49 (Aug. 10, 2005), *rev'd*, CMS Administrator Decision (Oct. 11, 2005).
[78] *Cert. denied*, 129 S. Ct. 1933 (2009).
[79] *Adena*, 527 F.3d at 180.
[80] *Adena*, 527 at 180 (brackets, ellipses, and citation in original; footnote and italics emphasis added).

> *plan approved under this title* [*i.e.*, Title XIX of the Act] in a period ... , and the denominator of which is the total number of the hospital's inpatient days in that period. ...
>
> (b)(3) For purposes of paragraph (1)(B), the term "low-income utilization rate" means, for a hospital, the sum of –
> (A) the fraction (expressed as a percentage)-
> (i) the numerator of which is the sum (for a period) of (I) the total revenues paid the hospital for *patient services under a State plan* under this title ... and (II) the amount of the *cash subsidies for patient services received directly from State and local governments*, and
> (ii) the denominator of which is the total amount of revenues of the hospital for patient service (including the amount of such cash subsidies) in the period; and
> (B) a fraction (expressed as a percentage)-
> (i) the numerator of which is the total amount of the hospital's charges for inpatient hospital services which are attributable to charity care in a period, less the portion of any cash subsidies described in clause (i)(II) of subparagraph (A) in the period reasonably attributable to inpatient hospital services, and
> (ii) the denominator of which is the total amount of the hospital's charges for inpatient hospital services in the hospital in the period. ...[81]

Subsection (b)(2) specifically uses the term "eligible for medical assistance under a State plan," the exact language from the Medicare DSH statute at issue in this case. That phrase describes the days included in the "Medicaid inpatient utilization rate" for the Medicaid DSH adjustment.

It is the second category, the "low-income utilization rate," that clarifies what is and what is not included in "medical assistance under a State plan." Subsection (b)(3) defines the term "low-income utilization rate" to include three components. In paragraph (A)(i)(I) of this subsection, there is the first component consisting of "services [furnished] under a State plan under this title [XIX]," the same category of patients described in the Medicaid utilization rate. In paragraphs (A)(i)(II) and (B)(i), there are the second and third components consisting of "cash subsidies for patient services received directly from State and local governments" and "charity care" respectively. If Congress had intended the term "eligible for medical assistance under a State plan" (the only category of patients in the Medicaid utilization rate) to include the state funded hospital days and charity care days, the subsections adding those types of days in the "low income utilization rate" would have been superfluous.

Based on the above, the Board concludes that, because the NJCCP is funded by "state and local governments" and, thus, is included in the low income utilization rate but not the Medicaid inpatient utilization rate, NJCCP patient days do not fall within the Medicaid DSH statute definition of "eligible for medical assistance under a State plan" at 42 U.S.C. § 1396r-4(b)(2).

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[81] (Emphasis added.)

Statutory construction principles require the Board to apply the meaning Congress ascribed to the term "eligible for medical assistance under a State plan" used in the Medicaid statute to the same phrase used in the Medicare statute.[82] NJCCP patient days, therefore, cannot be included in the Medicare DSH statutory definition of "eligible for medical assistance under a State plan" at 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II). Accordingly, the Intermediary's adjustments properly excluded NJCCP patient days from the Provider's Medicare DSH calculations for FY 2004.

Finally, the Board recognizes that, by letter dated in its March 8, 2013, the Provider filed a motion requesting permission to reopen the record for the on-the-record hearing in order to submit new legal argument based on the recent federal district court decision in *Nazareth Hosp. v. Sebelius*, 938 F. Supp. 2d 521 (E.D. PA 2013) ("*Nazareth*")[83] and to develop that legal argument for application to the Provider. The new legal argument alleges that the Secretary violated the Equal Protection Clause of the Constitution by treating similarly situated hospitals differently, depending on whether they are located in a § 1115 waiver state. The Provider noted that the *Nazareth* court had remanded the case back to the Administrator to address, among other things, the following three questions:

> The three questions: "How were plaintiff hospitals compensated for inpatient services in Pennsylvania's General Assistance program in FY 2002? Were costs of inpatient services arising from Pennsylvania's GA program the same or different from those incurred in Section 1115 demonstration projects in other states? Were GA inpatients in Pennsylvania hospitals the same or different from hospital inpatient populations in other states via a Section 1115 demonstration project, and if so, how?"[84]

The Provider suggested that allowing it to develop the administrative record would avoid unnecessary delay and waste of time and financial resources as the Provider would not later need to request the District Court to remand the appeal back to the Board to enable it to develop the record on this constitutional argument. Similarly, in its April 9, 2013 letter to supplement its motion, the Provider described the following as an area to be developed: "What remains is an analysis of New Jersey's Charity Care system ["NJCCP"] to demonstrate that the same legal analysis applies to Cooper." The Provider also requested that it be permitted to submit an expert report.

By letter dated May 2, 2013, the Board gave the Provider 30 days in which to supplement the record with this new legal argument and to develop the record on that new legal argument. However, the Board denied the Provider's request to file an expert report "since the [P]rovider has not established the expertise required under PRRB Rule 34." The Provider did not later seek to cure this defect. Rather, on June 24, 2013, the Provider filed the Provider's Supplemental

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[82] *See Atlanta Cleaners & Dyers, Inc. v. U.S.*, 286 U.S. 427, 433 (1932).

[83] Subsequent to the Provider's 2013 filing, the Third Circuit reviewed the district court's decision in Nazareth and reversed it. *See Nazareth Hosp. v. Secretary U.S. Dep't of Health and Human Servs.*, No. 13-2627, 2014 WL 130413 (3rd Cir. Apr. 2, 2014).

[84] 938 F. Supp. 2d at 527n.14 (citing to "July 11, 2012 order (doc. No. 40 at 2)").

Position Paper with four exhibits marked P-1 to P-4 for Case No. 07-0306 to develop the record on the new legal argument.

As these new legal arguments concern violations of the Constitution, the Board does not have the legal authority to rule on them pursuant to 42 C.F.R. § 405.1867. However, Board hearings are where the record is developed and set for any subsequent review on appeal and the Board must review the sufficiency of that record and make findings as relevant.

At the outset, the Board notes that Provider Exhibit P-2 of the Provider's Supplemental Position Paper is a report that was prepared for and submitted to the *Nazareth* court (hereinafter referred to as "Provider's P-2 Report") as it pertained to the Pennsylvania GA program for 2002. In particular, the report states that it "focuses on the second question" posed by the court. As previously noted, the Board denied the Provider's request to submit an expert report due to its noncompliance with Board Rule 34 and the Provider failed to subsequently cure that defect with the Board.[85] Accordingly, the Board is accepting the Provider's P-2 Report into the record for this case but refuses to recognize it as a report prepared by an expert due to the noncompliance with Board rules.

In reviewing the record for the additional legal argument, the Board notes that the Provider's P-2 Report specifically identifies New Jersey as having a § 1115 waiver program that was approved on April 14, 2011 and expired on December 31, 2013 and covered childless adults up to 24 percent of the federal poverty limit ("FPL").[86] Further, the only description in the record of the benefits furnished under the NJCCP is included at Provider Exhibit P-3 of the Provider's Supplemental Position Paper which describes certain medical assistance using a sliding scale up to 300 percent of the FPL. However, that description is dated March 13, 2013 which coincides with the existence of the New Jersey § 1115 waiver program identified in the Provider's P-2 Report and is close to ten years subsequent to the time period at issue (*i.e.*, the Provider's FY 2004). Further, the Board notes that the Provider's Supplemental Position Paper asserts that "[t]he provisions setting forth approved payments for DSH hospitals explained at § 4.19A (pages I-260 through I-300 of P-4 [of Provider's Supplemental Position Paper]), include a detailed description of the NJCCP (pages I-262 through I-263 of P-4 [of Provider's Supplemental Position Paper])."[87] However, the cited materials for the "detailed description of the NJCCP" are excerpts from the New Jersey State Plan that have a CMS-approval date of December 6, 2012 and an effective date of July 1, 2011 and, thus, were not in effect during the time at issue. Based on these gaps in the record, the Board concludes that the Provider has failed to develop the record for the on-the-record hearing to answer the three questions that the *Nazareth* court had posed on remand where references to the Pennsylvania GA program for 2002 are substituted with the NJCCP for 2004.

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[85] Provider's P-2 Report appears to have been accepted into the *Nazareth* record on remand from the *Nazareth* court to the CMS Administrator to answer one of the three questions. *See* 938 F. Supp. 2d at 527. The Board notes that the Board was not involved in this remand and that the *Nazareth* court did not refer to the report as an expert report in its decision. *See generally* 938 F. Supp. 2d at 521-542. Further, while the report itself "summarized" the "credentials and expertise" of the preparer, neither was the report proffered to the Board as an expert report nor was it submitted in accordance the process and procedure for expert reports delineated in Board Rules 28 and 34.

[86] It is unclear whether New Jersey implemented this § 1115 waiver program and, if so, how that program related to the NJCCP that also appears to have been in place at the same time.

[87] Provider's Supplemental Position Paper at 5.

DECISION AND ORDER:

ISSUE 1-BAD DEBTS COLLECTION EFFORT

The Intermediary's adjustments to remove from the cost reports for fiscal years 2003 and 2004 those inpatient and outpatient bad debts for which the Provider's collection efforts failed to include the telephone calls that were required under the 2002 Collections Policy are affirmed.

ISSUE 2-BAD DEBTS WRITTEN OFF WITHIN 120 DAYS OF THE FIRST BILL.

The Intermediary's adjustments to the cost reports for fiscal years 2003 and 2004 to remove inpatient and outpatient bad debts written off within 120 days of the first bill are affirmed.

ISSUE 3-DSH-NEW JERSEY CHARITY CARE PROGRAM

The Intermediary's adjustments to exclude New Jersey Charity Care Program days from the numerator of the Provider's Medicaid proxy as used in the cost reports for fiscal years 2003 and 2004 comply with 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II) and, accordingly, are affirmed.

BOARD MEMBERS PARTICIPATING:

Michael W. Harty
John Gary Bowers, CPA
Clayton J. Nix, Esq.

FOR THE BOARD:

Michael W. Harty
Chairman

DATE: JUN 18 2014