CENTERS FOR MEDICARE & MEDICAID SERVICES

Decision of the Administrator

In the case of:	Claim for:
Extendicare 99 Uncollect Co-In Dual Elig Group **Provider** **vs.** Blue Cross /Blue Shield Association United Government Services, LLC - WI **Intermediary**	Provider Cost Reimbursement Determination for Cost Reporting Period Ending: 12/31/99 Review of: PRRB Dec. No. 2006-D40 Dated: July 27, 2006

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

BACKGROUND

Extendicare Health Services, Inc., is a health service company that owned and/or operated all of the 24 Medicare-certified skilled nursing facilities (SNFs) that comprise the Providers participating in this group appeal. In this case, the Providers claimed reimbursement for bad debts related to uncollectible deductibles and coinsurance arising from therapy services provided to patients that were dually eligible for Medicare and Medicaid, also known as Qualified Medicare Beneficiaries

(QMBs),[1] that were paid under Medicare Part B fee schedule for fiscal year (FY) 1999 cost reports. In particular, commencing July 1, 1998, Congress mandated that the Medicare program shift its reimbursement for Part A covered SNF services from a cost based system to a prospective payment system. In addition, Congress provided that therapy services that SNFs provide would be reimbursed under the Medicare Part B fee schedule if the Medicare eligible patient was not in a covered Part A stay at the time therapy services were rendered. The uncollected bad debts for coinsurance and deductibles at issue in this case are related to the Part B services provided to such Medicare eligible patients not in a covered Part A stay.

The Intermediary audited the Providers' cost reports and disallowed the bad debts claimed for therapy services render to QMBs that were subject to payment under the Medicare Part B fee schedule. The Intermediary disallowed the claimed bad debts on the grounds that the implementation of the Part B fee schedule render the payment system no-cost-base. Therefore, the Intermediary concluded that the unpaid deductibles and coinsurance are not reimbursable as a "cost" attributable to providing services to Medicare beneficiaries.

ISSUE AND BOARD'S DECISION

The issue before the Administrator is whether the Intermediary properly disallowed bad debts related to uncollectible deductibles and coinsurance arising from therapy services, paid under the Medicare Part B fee schedule, where the Medicare eligible patient was not in a covered Part A stay at the time therapy services were rendered and provided to patients that were dually eligible for Medicare and Medicaid (Qualified Medicare Beneficiaries or QMBs).[2]

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[1] To be covered by Part B, a Medicare-eligible person must pay limited cost-sharing in the form of premiums, and deductible and coinsurance amounts. Where a Medicare beneficiary is also a Medicaid recipient, (i.e., "dually eligible"), a State Medicaid agency may enter into a buy-in agreement with the Secretary. Under such an agreement, the State enrolls the poorest Medicare beneficiaries, those eligible for Medicaid, in the Part B program by entering into an agreement with the Secretary and by paying the Medicare premiums and deductibles and coinsurance for its recipients as part of its Medicaid program.

[2] Providers' Exhibit P-1. The Providers allege that statutes in some of the States where the participating facilities are located (Pennsylvania and Washington) prohibit the payment of Medicare deductible and coinsurance under their State Medicaid Programs. The Providers did not explain the status of such claims under the State Medicaid Program, in the remaining States (Florida and Texas) where two Providers

A majority of the Board held that the Intermediary's adjustment to the Providers' uncollectible deductibles and coinsurance arising from therapy services paid under the Part B fee schedule was improper. A majority of the Board concluded that, while the Balance Budget Act (BBA) of 1997 shifted the basis of payment for SNF outpatient rehabilitation services from reasonable cost to a fee-based, it did not change the existing bad debt policy articulated at 42 CFR. 413.80 et. seq. The Board majority determined that, if Congress intended to change the bad debt policy with respect to SNFs providing services payable under the Part B fee schedule, Congress would have statutorily done so as it had for certain other services paid under a fee schedule. Congress' silence demonstrated its intent that the existent SNF bad debt policies remain unchanged. Finally, the Board majority noted a February 10, 2003 Proposed Rule, where CMS proposed to eliminate bad debts arising from any service reimbursed under a fee schedule. The Board stated that if CMS believed that the bad debt policy articulated in 42 CFR. 413.80 applied only to cost reimbursed services, the change articulated in the Proposed Rule would be unnecessary.

One member of the Board dissented. The dissenting Board member concluded that since there was no bad debt reimbursement policy articulated in the regulations governing reimbursement determined under a fee schedule, 42 CFR 414, Medicare had established the maximum amount it would pay for certain services. Therefore, no additional payment would be made for bad debts. The dissenting Board member noted that when Medicare sets a fee schedule as the basis for paying for a given service, it no longer shares proportionately in the cost of providing those services. Therefore, the cost reimbursement principles, including the bad debt regulation at 42 CFR 413.80 were not applicable.

SUMMARY OF COMMENTS

CMM commented requesting that the Administrator review and reverse the Board's decision. CMM argued that, although bad debts are reimbursable for services paid on the basis of a prospective payment system, payment for bad debts has never applied to services paid base on a fee schedule or reasonable charge methodology. CMM explained that, under a fee schedule Medicare does not share proportionately in a provider's incurred costs; instead, Medicare makes payment for specific services.

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in this case are located. In addition, no evidence (as opposed to allegations) was submitted in the record regarding the treatment of the coinsurance and deductibles for QMBs by any of the various State Medicaid plans in which the Providers are located.

The fee payment is not related to a specific provider's cost outlay for the services and does not include the concept of un-recovered costs.

Moreover, CMM argued that Medicare consistently has applied the bad debt policy to only cost reimbursement or cost-base prospective payment system. CMM cited to examples where bad debts are not reimbursable for services paid on a fee schedule basis. Thus, CMM concluded that the bad debt provision does not apply to deductible and coinsurance amounts for services paid on a fee schedule system.

The Intermediary commented, requesting reversal of the Board's decision. The Intermediary argued that because the Providers are not being reimbursed on a cost basis, actual costs are not reduced by the amount of co-pays and deductibles. Therefore, it is not necessary to include bad debts related to therapy on the cost report. The fee schedule payment is not related to a specific provider cost and does not include the concept of un-recovered costs.

The Providers commented, requesting affirmation of the Board's decision. The Providers maintained that the Board majority correctly held that the Providers' claims for bad debt reimbursement were within the terms of the regulation and that the Providers' have demonstrated that they have met every requirement specified in the regulations that's necessary to obtain bad debt reimbursement. The Providers also argued that the policy of not allowing bad debt claims based upon coinsurance and deductibles for services payable under a fee schedule is inconsistent with the governing regulations. The Providers maintained that the focus should be on lost revenue traceable to services provided to Medicare beneficiaries, instead of the type of payment structure (i.e., fee schedule) that Medicare has in place. Furthermore, the policy of not allowing bad debts claimed based upon coinsurance and deductibles for services payable under a fee schedule has never been articulated in the Federal statutes or the governing regulations. The Providers agreed with the Board majority's determination that Congress' silence on bad debts with respect to SNFs providing services payable under the Part B fee schedule demonstrated Congress' intent to leave the existing SNF bad debt policy in place.

DISCUSSION

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

The Medicare program primarily provides medical benefits to eligible persons over the age of 65, and consists of two parts: Medicare Part A [Sections 1811 through 1821 of the Social Security Act], which provides reimbursement for inpatient hospital and related post-hospital, home health and hospice care; and Medicare Part B [Sections 1831 through 1841 of the Social Security Act], which is a supplementary voluntary insurance program for hospital outpatient services, physician services and other services not covered under Part A. The original statutory provisions for Medicare Part A payments, established, inter alia, the principles of reasonable cost reimbursement under §1861(v) (1) (a) of the Act. Section 1861(v)(1)(a) of the Act states that providers are to be reimbursed the reasonable cost of providing services to Medicare beneficiaries. Section 1861(v)(1)(a) of the Act, defines "reasonable costs" as the cost actually incurred, excluding therefrom any part of the incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations established the method or methods to be used, and the items to be included…." Section 1861(v)(1)(a) of the Act, does not specifically address the determination of reasonable cost, but authorizes the Secretary to prescribed methods for determining reasonable costs, which are found in regulations, manuals, guidelines and letters.

One of the underlying principles set forth at §1861(v)(1)(A) of the Act regarding reasonable cost Part A payments is that:

> The necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this title will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs….

That is, the Medicare program prohibits cross-subsidization of costs, a principle also referred to as the "anticross subsidization" principle. As stated above, the principles set forth in the Act are further reflected and explained in the regulations

Consistent with this principle, 42 CFR 413.89[3] provides that bad debts, which are deductions in a provider's revenue, are generally not included as "allowable costs" under Medicare. Notably, the regulation at 42 CFR 413.80(d)(2000) explains the principle underlying the payment of bad debts. In particular, 42 CFR 413.80(d) explains that:

> *Requirements for Medicare.* Under Medicare, costs of covered services furnished beneficiaries are not to be borne by individuals not covered by the Medicare program, and conversely, cost of services provided for other than beneficiaries are not to be borne by the Medicare program. Uncollected revenue related to services furnished to beneficiaries of the program generally means the provider has not recovered the cost of services covered by that revenue. The failure of beneficiaries to pay the deductibles and coinsurance amounts could result in the related costs of covered services being borne by others. The costs attributable to the deductible and coinsurance amounts that remain unpaid are added to the Medicare share of allowable costs. Bad debts arising from other sources are not an allowable costs. (Emphasis added.)

The circumstances under which providers may be reimbursed for the bad debts derived from uncollectible deductibles and coinsurance amounts are set forth at paragraph (e). The regulation at 42 CFR 413.80(e) states that to be allowable, 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 there was no likelihood of recovery at any time in the future.

The Provider Reimbursement Manual (PRM) provides further guidance with respect to the payment of bad debts. Relevant to this case, §322 of the PRM, Medicare Bad Debts under State Welfare Programs, states that:

> Where the State is obligated either by statue or under the terms of its plan to pay all, or any part, of the Medicare deductible or coinsurance amounts, those amounts are not allowable as bad debts under

[3] Recodified at 42 CFR 413.89 without significant change in the language.

> Medicare. Any portion of such deductible or coinsurance amounts that the State is not obligated to pay can be included as bad debt under Medicare provided that the requirements of §312 or, if applicable, §310 are met.[4]

In contrast to Medicare Part A payments, for Medicare Part B payments, the original statutory provisions established the principles of reasonable charge payments for physician services and other services under Part B. The primary provisions governing the reasonable charge payment methodology were set forth in sections 1833 and 1842(b) of the Act. While statutory amendments required certain Part B services to be paid under a fee schedule,[5] physician services continued to be paid based on reasonable charge principles throughout the first 25 years of the program. As Medicare Part B payments were not based on reasonable costs, but rather were based on reasonable charges or a fee schedule, notably there was no corresponding prohibition against cross subsidization under the Part B reasonable charge or fee schedule methodologies. Plainly, the Part B reasonable charge and fee schedule payment methodologies were not controlled by the provisions of §1861(v)(1)(A) of the Act. Consequently, there was also no provision for the payment of bad debt by the Medicare program when payment was made by a reasonable charge or fee schedule methodology.

As part of the Omnibus Reconciliation Act (OBRA) of 1989[6], §6102 of OBRA 1989 amended Title XVIII of the Act by adding new §1848 called "Payment for Physicians Services." The primary change required the replacement of the reasonable

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[4] Section 312 of the PRM explains that individuals who are Medicaid eligible as either categorically or medically needy may be automatically deemed indigent. However, §312.C requires that: "The provider must determine that no source other than the patient would be legally responsible for the patient medial bill; title XIX, local welfare agency and guardian…." Finally, §312 also states that: "[O]nce indigence is determined, and the provider concludes that there had bee no improvement in the beneficiary's financial condition, the debt may be deemed uncollectible without applying the §310 [reasonable collection effort] procedures." (See §322 for bad debts under State Welfare Programs.) See also the effects of a State payment "ceiling" at §322 of the PRM.

[5] Statutory amendments earlier on in the program required certain Part B services such as radiologists services, durable medical equipment (DME) and clinical laboratory services be changed from a reasonable charge payment methodology to a fee schedule methodology.

[6] Pub. Law 101-239.

charge payment mechanism with a fee schedule for physician services.[7] Section 1848(b)(1) of the Act requires that:

> [B]efore January 1 of each year beginning with 1992, the Secretary shall establish, by regulation, fee schedules that establish payment amounts for all physician services furnished in all fee schedule areas for that year….

Section 1848 requires that the fee schedule include national uniform relative values (RUVs) for all physician services. The relative value of each service must be the sum of relative value units (RVUs) representing physician work, practice expenses net of malpractice expenses and the costs of professional liability insurance.[8] Among other things, practice expense RUVs were computed by applying historical practice costs percentages to a base allowed charge for each service. Once again, the fee schedules did not provide for reimbursement of bad debts associated with unpaid coinsurances and deductibles reflecting the charge-based nature of the payment. The payment for Part B medical and other health services was implemented in regulation at 42 CFR Part 414 (2000), while subpart B of Part 414 addresses physician and other practitioners.

Congress also subsequently changed the payment methodology for SNF services. Section 4433 of the Balanced Budget Act (BBA) of 1997[9] mandated the implementation of a per diem prospective payment system for SNFs covering all costs (routine, ancillary and capital) of covered SNF services furnished to beneficiaries under Part A of the Medicare program effective for cost reporting periods on or after July 1, 1997. Section 4432(b)(3) of the Balance Budget Act of 1997 also added paragraph (9) to §1888(e) of the Act to provide that with respect to services covered under Part B that are furnished to a SNF resident, the amount of payment for the service shall be the amount provided under the fee schedule for such item or services.[10] Section 4432 is read in conjunction with §4541 of the Balanced

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[7] Congress also enacted the Omnibus Budget Reconciliation Act of 1990 (Pub. Law 101-508), which contained several modifications and clarifications to the OBRA 1989 (Pub. Law 101-239) provisions establishing the physician fee schedule.

[8] Section 1848(c) (1)(B) of the Act defines practice expense component as the portion of the resources used in furnishing the service that reflects the general categories of expenses (such as office rent and wages of personnel, but excluding malpractice expenses.) See also, generally, 56 Fed. Reg. 59502 (Final rule for "Medicare Program; Fee Schedule for Physician Services")(Nov. 25, 1991).

[9] Pub. Law 105-33.

[10] Section 1888(e)(9) of the Act provides: "Payment for certain services.- In the case of an item or service furnished to a resident of a skilled nursing facility or a part of a

Budget Act which added a new §1833(a)(8) of the Act[11] to specify that the amounts payable for outpatient rehabilitation services furnished by a SNF will be the amounts determined under §1834(k) of the Act. Relevant to this case, §1834(k) of the Act provides that payments in 1999 and thereafter shall be based on the physician fee schedule set forth at §1848 of the Act.[12]

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facility that includes a skilled nursing facility … for which payment would (but for this paragraph) be made under Part B in an amount determined in accordance with section 1833(a)(2)(B), the amount of the payment under such part shall be the amount provided under the fee schedule for such service or item."

[11] Section 1833(a)(8) provides that:

''in the case of—

(A) outpatient physical therapy services (which includes outpatient speech-language pathology services) and outpatient occupational therapy services furnished—

(i) by a rehabilitation agency, public health agency, clinic, comprehensive outpatient rehabilitation facility, or skilled nursing facility,

(ii) by a home health agency to an individual who is not homebound, or

(iii) by another entity under an arrangement with an entity described in clause (i) or (ii); and

(B) outpatient physical therapy services (which includes outpatient speech-language pathology services) and outpatient occupational therapy services furnished—

(i) by a hospital to an outpatient or to a hospital inpatient who is entitled to benefits under part A but has exhausted benefits for inpatient hospital services during a spell of illness or is not so entitled to benefits under part A, or

(ii) by another entity under an arrangement with a hospital described in clause (i), the amounts described in section 1834(k) of the Act."

[12] In particular, section 1834(k) of the Act provides as follows:

''k) Payment for outpatient therapy services and comprehensive outpatient rehabilitation services.—

(1) In General.—With respect to services described in section 1833(a)(8) or 1833(a)(9) for which payment is determined under this subsection, the payment basis shall be—….

(B) for services furnished during a subsequent year, 80 percent of the lesser of—

(i) the actual charge for the services, or

(ii) the applicable fee schedule amount (as defined in paragraph (3)) for the services

…

(3) Applicable Fee Schedule Amount.—In this subsection, the term "applicable fee schedule amount" means, with respect to services furnished in a year, the amount determined under the fee schedule established under section 1848 such services furnished during the year or, if there is no such fee schedule established for such

In implementing these various SNF payment provisions, the regulation at 42 CFR 413.1(g)(2)(2000) provides, regarding the payment for services furnished in SNFs that:

> The amount paid for services other than those described in 411.15(p)(2) of this chapter—
> (i) That are furnished in cost reporting periods beginning on or after July 1, 1998, to a resident who is in a covered Part A stay, is determined in accordance with the prospectively determined rates for SNFs established under section (e) of the Act as set forth in subpart J of this part.[13]
> (ii) That are furnished on or after July 1, 1998, to a resident who is not in a covered Part A stay, is determined in accordance with any applicable Part B fee schedule, or for a particular item or service to which no fee schedule applies, by using the existing payment methodology utilized under Part B for such item or service. (Emphasis added.)

In this case, the Providers' claimed an amount for bad debts for uncollected Medicare deductible and coinsurance for therapy services render to QMBs that were payable under the Medicare Part B fee schedule. In particular where therapy services continued to be necessary for a SNF resident beyond the point in time that their stay is covered by Part A Medicare the services were billable to Medicare Part B. That is, the services at issue were those provided to a resident who was not in a covered Part A stay and for which payment is determined in accordance with the applicable Part B fee schedule.[14]

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services, the amount determined under the fee schedule established for such comparable services as the Secretary specifies." (Emphasis added.)

[13] With respect to the prospective portion of a SNF's payment, 42 CFR 413.35 (2000) explains that: "(a) *Method of payment.* Under the prospective payment system, SNFs receive a per diem payment of a predetermined rate for inpatient services furnished to Medicare beneficiaries. The per diem payment is made on the basis of the Federal payment rate described in 413.37 …….(b) Payment in full. The payment rates represent payment in full (subject to applicable coinsurance as described in subpart G of part 409 of this chapter) for all costs (routine, ancillary and capital-related) associated with furnishing inpatient SNF services to Medicare beneficiaries…."

[14] Providers' Position Paper, p.6.

The Providers argued that 42 C.F.R. §413.80 establishes the requirement for claiming allowable bad debts and that the BBA of 1997 did not alter this section. A majority of the Board concluded that while the BBA of 1997 shifted the basis of payment for SNF outpatient rehabilitation services from reasonable cost to a feebased, it did not change the existing bad debt policy articulated at 42 CFR 413.80 et. seq.

Applying the law to the facts of this case, the Administrator finds that the Intermediary properly denied the Providers' claimed Medicare bad debts relating to uncollectible deductibles and coinsurance arising from therapy services provided to patients who were not in a covered Part A stay and for which payment was determined in accordance with the Part B fee schedule. The Administrator finds that the BBA of 1997 changed the basis of payments from reasonable cost to a fee schedule for these services. Medicare's longstanding policy has been not to pay for bad debts for any services paid under a reasonable charge or fee schedule methodology.

Unlike a reasonable cost payment, payment under a fee schedule is not related to a provider's cost outlay for the service and does not involve costs or, likewise, un-recovered "costs." Under a fee schedule, Medicare makes payment for a specific service for which there is a predetermined rate which includes a margin for profit and which reflects the price of doing business. While 42 CFR 413.80. et. seq., does not address bad debt payment to providers paid under a fee schedule individually for each type of fee schedule payment, the bad debt provision arises from the reasonable "cost" anti-cross-subsidization provisions which is not controlling under the reasonable charge/fee schedule methodology set forth at §1848 of the Act. Thus, the bad debt provisions found at 42 CFR 413.80(e) do not apply to services for which Medicare payment is based on reasonable charges or a fee schedule methodology.[15]

[15] This policy is also consistent with the policy articulated for the "Fee Schedule for Payment of Ambulance Services" 67 Fed. Reg. 9100, 9117 (Feb 27, 2002). As noted in the preamble to the final rule, the Secretary stated that: "A few commenters stated that the regulations do not address the issue of bad debts for ambulance services. Medicare has traditionally paid for hospitals bad debts for uncollected beneficiary deductibles and copayments. The commenters believe that Medicare should be responsible for payment of reasonable cost associated with bad debts for ambulatory services. …. *Response*: There is no provision under the fee schedule for payment of bad debts. The law requires that the program pay 80 percent of the lower of the fee schedule and or the billed charge and that the beneficiary is liable for the Part B coinsurance and unmet Part B deductible amounts. Furthermore, sharing in bad debt for providers and not for independent suppliers would result in greater program payments to provider than suppliers for furnishing the same service. We

Moreover, the Administrator does not agree with the Board's conclusion regarding Congress' action in explicitly prohibiting bad debts in certain instances (e.g., physician assistants, CRNA) where payment is made outside of the reasonable cost methodology. The Board concluded that congressional silence with respect to the payment of the services at issue in this case is evidence of Congress' affirmative intent that bad debts should be paid. The Administrator notes that congressional silence is not generally a persuasive canon of statutory construction. In addition, Congress has been inconsistent with respect to specifically stating that bad debts are, or are not allowed, making congressional silence even less persuasive. Bad debts were not even specifically mentioned as an allowable costs under §1861 of the Act, rather the Secretary, in implementing the reasonable cost provisions and its prohibition against cross- subsidization, has implemented such a policy under 42 CFR 413.80.

Congress also did not specifically prohibit the payment of bad debts under §1848 of the Act. Among other things, §1848 was outside the scope of the controlling statutory authority for bad debt payment of §1861(v)(1)(A) of the Act and was derived from a reasonable charge methodology that is assumed to account for bad debts.[16] Thus, the Administrator finds that congressional silence regarding the prohibition on the payment of bad debts in enacting the fee schedule for the services at issue is not dispositive of this issue. Rather, when Congress does not specifically speak on a matter, the question for the courts is whether the agency's answer is based on a permissible construction of the statute.[17] The Administrator finds that this CMS' policy prohibiting the payment of bad debts under a reasonable charge/fee schedule methodology is consistent with the controlling language of the Act.

In addition, the Board misconstrues the meaning of the Secretary's publication of his policy, in a proposed rule, that bad debts were not allowable for services paid under a reasonable charge/fee schedule methodology. The Board argues that this is substantive evidence that CMS was aware that the existing regulation allowed for these bad debts, otherwise such a change would not have been necessary. However, the plain language of the proposed rule shows just the oppose. The Secretary explicitly stated that this rule was a confirmation/clarification of a longstanding

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believe that doing so would be antithetical to the payment under a fee schedule." 67 Fed. Reg. at 9117.

[16] Congress also has not specifically prohibited the payment of bad debts with respect to durable medical equipment, but such a policy has been adopted by the Secretary.

[17] See, e.g., Chevron USA v. Natural Resources Defense Council, 467 U.S. 837 (1984).

policy. The Secretary prefaced the "Provider Bad Debt" proposed rule with an explanation that bad debt policy originated from the "anti-cross subsidization" principle that is part of the definition of "reasonable cost" as defined under §1861(v) of the Act. Moreover, while hospital payments moved for the most part for example, to a prospective payment basis, CMS continued to pay bad debts because, inter alia, the bad debts incurred during the inpatient PPS base period were not included in the calculation of the prospective rates.

The Secretary further explained in the proposed rule that consistent with the principles articulated under reasonable cost bad debt rules, "this proposed rule would clarify that bad debts are not allowable for entities paid under reasonable charge or fee schedule methodology."[18] The preamble explained that:

> The concept of Medicare bad debt payments applies only to services reimbursed on the basis of reasonable costs. Medicare has never made payments to account for bad debts for services paid under a fee schedule or reasonable charge methodology, such as services of physicians or suppliers. Under a fee schedule or reasonable charge methodology, Medicare reimbursement is not based on costs and therefore the concept of unrecovered costs is not relevant. Fee schedules which are either charge based or resource-based, relate payments to the price the entity charges. Historically, these prices have reflected the entities costs of doing business including expenses such as bad debt.[19]

In summarizing the provisions of the proposed rule, the Secretary stated that:

> C. *Confirmation of Bad Debt Policy for Services paid Under a Charge-based Methodology or Fee Schedule.*
>
> This proposed rule would amend language in the existing bad debt regulations to clarify that bad debts are not recognized or reimbursed for any services paid under a reasonable charge-based methodology or fee schedule. This clarification is not a change of policy.[20]

Consequently, contrary to the Board's conclusion, the rule is not evidence that the Secretary understood that such a policy was inconsistent with the regulations, thereby requiring notice and rulemaking. Rather, the Secretary explained in proposed rule

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[18] 68 Fed. Reg. 6682 (Feb 10, 2003).
[19] 68 Fed Reg. 6683.
[20] 68 Fed Reg.6685.

how this long standing policy was *consistent* with the existing regulation at 42 CFR 412.80 on bad debts and, therefore, did not require notice and rulemaking.

Notably, Congress acknowledged the Secretary's proposed rule on "Provider Bad Debt" in enacting its reduction in payments of SNF bad debts under the Deficit Reduction Act (DRA) of 2005.[21] Section 5004 of DRA amended section 1861(v)(1) of the Social Security Act to state:

> (V) In determining such reasonable costs for skilled nursing facilities with respect to cost reporting periods beginning on or after October 1, 2005, *the amount of bad debts otherwise treated as allowed costs which are attributable to the coinsurances amounts under his title for individuals entitled to benefits under part A* and—
> (i) are not described in section 1935(c)(6)(A)(ii) shall be reduced by 30 percent of such amount otherwise allowable; and
> (ii) are described in such section shall not be reduced. (Emphasis added.)

The related conference agreement stated that with respect to "Current Law":

> Medicare pays for the costs of certain items outside of the prospective payment system on a reasonable cost basis. Section 1861(v)(1(A)(I) of the Social Security Act states that the costs for individuals as covered by the Medicare program must not be borne by individuals not covered by the program, and the costs for individuals not covered by the program must not be borne by Medicare. Under this authority the Secretary adopted a bad debt policy in 1966. Under this policy, Medicare reimburses certain providers for debt unpaid by beneficiaries for coinsurance and deductibles. Historically CMS has reimbursed certain providers for 100 percent of this bad debt. SNFs are among the Medicare entities that are currently being reimbursed for 100 percent of beneficiary bad debt.
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> Effective beginning with cost reports starting FY 2001, Medicare began reimbursing hospitals for 70 percent of the reasonable costs associated with beneficiaries bad debts. In 2003 CMS issued a proposed rule (42 CFR part 413, Medicare Program Provider Bad Debt Payments) in which its described its intent to reduce reimbursement of bad debts for certain providers, including SNFs, by 30 percent. Within the rule, CMS explained that it believed that reducing the amount of

[21] Pub. Law 109-171.

> Medicare debt reimbursement would encourage accountability and foster an incentive to be more efficient in bad debt collection efforts. It also stated that it believed that Medicare bad debts policy should be applied consistently and fairly among all providers eligible to receive bad debt reimbursement.[22] (Emphasis added.)

Congress specifically adopted that provision of the proposed rule that represented a new policy on reducing SNF bad debts, while reaffirming that part of the proposed rule which explained that bad debts are limited to reasonable cost reimbursement under Part A. If Congressional silence must be attributed a "meaning", as the Board has earlier attempted to do, it is more appropriately attributed under the circumstances set forth here. Congress was aware of the Secretary's proposed rule on "Provider Bad Debt." Congress spoke on the new debt reduction proposal set forth in that rule. Congress did not express any congressional intent contrary to that set forth as CMS' longstanding bad debt policy on reasonable charge based/fee schedule methodology. Thus, to the extent congressional silence is relevant, the legislation enacted by Congress under DRA shows that Congress felt no need to act upon, or modify, the Secretary's long standing stated policy on the prohibition of the payment of bad debts under a reasonable charge/fee schedule methodology.[23]

In sum, the Intermediary properly denied payment for the bad debts that are the subject of this appeal.[24]

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[22] House Report 109-362, 109 H. Rpt. 362 (109th Congress, 1st Sess.) (Dec 19, 2005).

[23] In fact, the only reasonable reading that may be given to Congress' specific language adopting and addressing the reduction of SNF bad debts within the context of "the coinsurances amounts under his title for individuals entitled to benefits under part A" is that Medicare does not pay bad debts to SNFs for coinsurances that result from Medicare eligible individuals not in a covered Part A stay under 42 CFR 413. (g)(2)(ii).

[24] Even assuming, *arguendo*, that such bad debts were found to be allowable, the Provider would still be required to demonstrate that, inter alia, Medicare was responsible for the bad debts of the QMBs under section 322 of the PRM and that the requirements of 42 CFR 413.80(e) were otherwise met.

DECISION

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

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

Date: 9/12/06 /s/

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