CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	Claim for:
Foothill Presbyterian Hospital **Provider** **vs.** **Blue Cross Blue Shield Association/ United Government Services, LLC** **Intermediary**	**Provider Cost Reimbursement Determination for Cost Reporting Period Ending: 09/30/95** **Review of:** **PRRB Dec. No. 2007-D11** **Dated: November 30, 2006**

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

ISSUE AND BOARD DECISION

The issue is whether the Intermediary's determination of reimbursable Medicare bad debts for beneficiaries without Medicaid eligibility (non-cross-over beneficiaries) is proper.

The Board, reversing the Intermediary's adjustment, held that the Intermediary's adjustment to the Provider's bad debts was improper. The Board found that the Provider attempted to collect accounts through its in-house collection procedures, and if those efforts failed, it determined the debts were uncollectible and had no likelihood of recovery at any time in the future. The Board found that, although the Provider determined that the accounts were uncollectible, the Provider forwarded all

of its debts to an outside collection agency. The Board noted that the Intermediary did not challenge the reasonableness of the Provider's collection effort or its policies. Rather, the Intermediary argued that the referral to the collection agency is inconsistent with the Provider's determination of worthlessness. The Board found that neither the Intermediary Manual (MIM), nor the 1990 memorandum establishes a conclusive presumption that accounts assigned to an outside collection agency have value or are collectible, nor do these policies obviate the sound business judgment rule or any other bad debt reimbursement criteria set forth in the regulation at 42 C.F.R. §413.80.

In this case, the Board found that based on the extensive in-house collection efforts, the Provider's collection efforts met the controlling regulatory requirements. The Board reasoned that the conclusive presumption of collectibility predicated on outside collection account status is contrary to both the reality of the collection trade and the regulations. The Board noted that there is no evidence that providers control the decision making process of their outside collection agencies and, an account that is actually worthless could languish as an "open" or "active account. Thus, the Intermediary's argument violated the prohibition against cross-subsidization. Finally, the Board noted that the record did not contain sufficient information related to the Provider's bad debt policy before 1994 and without this information, it cannot determine if the moratorium provision applies.

SUMMARY OF COMMENTS

CMM commented, requesting reversal of the Board's decision. CMM argued that the Board's decision is incorrect. Medicare policy does not allow a bad debt to be claimed, even after 120 days, while a provider is still engaged in collection efforts, as debts claimed for active accounts at a collection agency cannot be stated as worthless or as having no likelihood of future recovery. Medicare's intent has always been that §310.2 of the Provider Reimbursement Manual (PRM) be read in the context of the bad debt policy set forth in §§308 and 310 of the Manual. That is, until the provider's reasonable collection effort has been completed, both in-house efforts and the use of a collection agency, a bad debt cannot be properly claimed. If an account is in collection, it has not been yet determined to be uncollectible, and a provider cannot have established that there is no likelihood of recovery. Further, CMM noted that the MIM and the June 11, 1990 memorandum confirm the longstanding policy that the bad debt cannot be properly claimed while an account is still in collection at a collection agency as there is still likelihood of future recovery.

DISCUSSION AND EVALUATION

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

Section 1861(v)(1)(A) of the Social Security Act requires that providers of services to Medicare beneficiaries are to be reimbursed the reasonable cost of those services. Reasonable cost is defined as the "the cost actually incurred, excluding therefrom part of the incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included ..." Id. This section does not specifically address the determination of reasonable cost, but authorizes the Secretary to promulgate regulations and principles to be applied in determining reasonable costs. One of the underlying principles set forth in the Act is that Medicare shall not pay for costs incurred by non-Medicare beneficiaries, and vice versa, i.e., Medicare prohibits cross-subsidization of costs.

These principles are reflected and further explained in the regulations. The regulations at 42 CFR §413.9(c) provides that the determination of reasonable cost must be based on costs related to the care of Medicare beneficiaries. Relevant to this case, the regulation at 42 CFR §413.80(a) specifically provides that bad debts are reductions in revenues and are not included in allowable costs. However, the regulation at 42 CFR §413.80(a) further provides that bad debts attributable to the deductible and coinsurance amounts of Medicare beneficiaries are reimbursed under the Medicare program.[1] Bad debts are defined at 42 CFR §413.80(b)(1) as:

> [A]mounts considered to be uncollectible from accounts and notes receivable that were created or acquired in providing services. "Accounts receivable" and "notes receivable" are designations for claims arising from the furnishing of services, and are collectible in money in the relatively near future.[2]

The regulation at 42 CFR §413.80(d) states that payment for deductibles and coinsurance amounts are the responsibility of the beneficiaries. However, recognizing the reasonable costs principle at Section 1861(v)(1)(A) of the Act which prohibits cross subsidization, the program states that the inability of providers to

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[1] See also, Section 304 of PRM.

[2] See also, Section 302 of the PRM.

collect deductibles and coinsurance amounts from the Medicare beneficiaries could result in part of the costs of Medicare covered services being borne by individuals who are not beneficiaries. Therefore, to prevent such cross-subsidization, Medicare reimburses providers for allowable bad debts.[3]

Consequently, Providers may receive reimbursement for Medicare bad debt, if they meet all of the criteria set forth in 42 CFR §413.80(e):

> A bad debt must meet the following criteria to be allowable:
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> (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.[4] (Emphasis added).

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

> To be considered a reasonable collection effort, a provider's effort to collect Medicare deductible and coinsurance amounts must be similar to the effort the provider puts forth to collect comparable amounts from non- Medicare patients.

Section 310.A of the Manual further explains:

> 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. Therefore, if a provider refers to a collection agency its uncollected non-Medicare patient charges, which

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[3] See Id.

[4] See also Section 308 of the PRM.

> in amount are comparable to the individual Medicare deductible and coinsurance amounts due the provider from its Medicare patient, Medicare requires the provider to also refer its uncollected Medicare deductible and coinsurance amounts to the collection agency.

Further, in elaboration on the concept of reasonable collection effort, section 310.2 of PRM, provides:

> 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.

Section 314 of the PRM states that uncollectible deductibles and coinsurance amounts are recognized as allowable bad debts in the reporting period in which such debts are determined to be worthless and non-collectible.[5]

Consistent with the Act, the Secretary has also issued guidelines for an intermediary to follow when auditing cost reports. The Intermediary Manual explains that Medicare bad debts for deductible and coinsurance are reimbursed as a pass-through cost. Since they have a direct dollar for dollar effect on reimbursement, there is an incentive to claim bad debts before they become worthless. Specifically, the instruction states that:

> If the bad debt is written-off on the provider's books 121 days after the date of the bill and then turned over to a collection agency, the amount cannot be claimed as a Medicare bad debt on the date of the write-off. It can be claimed as a Medicare bad debt only after the collection agency completes its collection effort.[6]

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[5] Moreover, to ensure that Providers receive reimbursement for services they actually furnish, the Secretary has implemented a number of Medicare documentation regulations. See 42 CFR §§413.9 and 413.24 and Section 310.B of the PRM.

[6] Intermediary Manual, Part IB , 13-2

In this case, the record reflects that the Provider generally had used in-house collection efforts for a certain period of time and then turned accounts over to a collection agency. The Provider then wrote-off the debts for financial purposes. On audit, the Intermediary disallowed the claimed bad debts that had been forwarded to the collection agency. The Intermediary determined that the Provider failed to demonstrate that the debts in question were uncollectible when claimed as worthless and that there was no likelihood of recovery in the future.

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

The Administrator recognizes that section 310.2 of the PRM permits a debt unpaid for more than 120 days from the date the first bill is mailed to the beneficiary to be deemed uncollectible. However, the Administrator notes that the language of that section implies discretionary rather than mandatory application of the presumption, i.e., the debt "may" rather than "shall" be deemed uncollectible. That manual section does not suggest that this presumption relieves the Provider from meeting the general regulatory documentation requirements or the specific documentation requirements in sections 310.B and 314 of the PRM. Thus, the presumption only applies where a provider has otherwise demonstrated through appropriate documentation that it engaged in reasonable collection efforts.

Further, as the agency explained, since Medicare bad debts have a direct dollar for dollar effect on reimbursement, there is an incentive to claim bad debts before they become worthless. If a provider continues to attempt collection of a debt, either through in-house or a collection agency, it is reasonable to conclude that the provider still considers that debt to have value and that it is not worthless. Thus, the Administrator finds it reasonable to expect a provider to demonstrate that it has completed its collection effort, including outside collection, before claiming debts as worthless.

The Administrator also notes that section 316 of PRM provides only an instruction, in the event that a Medicare bad debt is subsequently recovered, for reporting such revenue and its reimbursement effect. This is a provision to prevent double dipping by the Provider at the expense of the Program. The Administrator finds that the language of the manual section in no way infers that the Medicare program expects, or even anticipates, providers to continue to pursue collection activities after

claiming Medicare bad debts on their cost reports. Thereby, if a provider deems a debt uncollectible after reasonable collection efforts, and, thus worthless, a provider would not be expected to pursue further collection activities. However, if a provider does continue to pursue collection activities, clearly it does not believe the debt to be worthless.[7]

[7] With respect to the moratorium, the Administrator notes that the record is lacking as the Provider's bad debt policy for the applicable period and, thus, the Provider did not demonstrate that the moratorium provision applies in this case.

DECISION

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

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

Date: 2/14/07

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