CENTERS FOR MEDICARE & MEDICAID SERVICES

Decision of the Administrator

IN THE CASE OF:	CLAIM FOR:
El Centro Regional Medical Center, **Provider** **vs.** **Blue Cross Blue Shield Assn./ United Government Services LLC-CA** **Intermediary**	**Provider Reimbursement Cost Reporting Periods Ending: 12/31/98 and 12/31/99** **REVIEW OF:** **PRRB Dec. No. 2007-D21** **Dated: February 23, 2007**

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 60-day period mandated in §1878(f)(1) of the Social Security Act (Act) [42 USC 1395oo(f)(1)], as amended. Comments were received from the Center for Medicare Management (CMM), and the Intermediary requesting reversal. The Administrator notified the parties of the intention to review the Board's decision. Comments were also received from the Provider, requesting affirmation of the Board's decision. Accordingly, this case is now before the Administrator for final administrative review.

ISSUE AND BOARD'S DECISION

The issue involves whether the Intermediary properly disallowed the Provider's regular Medicare bad debts.

The Board, reversing the Intermediary's adjustment, held that the Intermediary improperly disallowed the Provider's regular Medicare bad debts. The Board found the Provider's in-house collection policy complied with program requirements, and noted that the disallowances were based on the Provider contracting an outside collection agency which did not utilize similar efforts to recover Medicare and non-Medicare accounts. The Board found that the Provider

Reimbursement Manual instructions require similar collection efforts be applied to Medicare and non-Medicare accounts, but these instructions do not apply to outside collection agencies. The Board noted that the manual instructions only require that when a provider uses a collection agency, it must refer all like amounts of Medicare and non-Medicare receivables to outside collection agency. The Board also noted that the manual provisions pertaining to use of an outside collection agency does not address that agency's practices, but rather explains the fundamental requirement that Medicare expects all like patient charges of like amount be forwarded to an agency without regard to class of patients. Thus, the Board found that the Provider met this requirement and that Medicare and non-Medicare accounts were subject to the same collection activities.

Moreover, the Board determined that the Provider's policies were established to assure that Medicare accounts would be at least 120 days old from the date the Provider first billed the beneficiary, that reasonable collection efforts were made, and that the debts were actually uncollectible when claimed as worthless. The Board found that, contrary to the Intermediary's argument, Medicare accounts were not routinely returned to the Provider after 30 or 60 days, but remained at the collection agency as long as collection efforts seemed warranted. In addition, the Board found persuasive the Provider's testimony, including that of an expert in usual and customary collection practices. Thus, the Board concluded that since the Provider established that reasonable collection efforts were made and that the debts were actually uncollectible when claimed as worthless, the Provider's Medicare bad debts were allowable.

COMMENTS

CMM commented, requesting reversal of the Board's decision. CMM argued that the Board erred in finding that Medicare policy permits an inconsistent collection effort for Medicare and non-Medicare accounts. CMM noted that the clear intent of Medicare policy is that similar collection efforts for Medicare and non-Medicare unpaid amounts be made through the entire collection process, including collection efforts made while at the collection agency. Referring to a prior Administrator decision for support, CMM asserted that the relevant provisions of the Provider Reimbursement Manual clearly apply to the collection efforts of a collection agency. CMM noted that the Board distinguished this current case from the referenced prior case because the collection agency was contractually obligated by the provider to have a different collection effort for Medicare and non-Medicare patients. However, CMM argued that regardless of whether the collection practices differ pursuant to a contract or for other reasons, a dissimilar collection effort by a collection agency does not meet the provisions of the manual and results in the disallowance of bad debts.

The Intermediary commented, requesting reversal of the Board's decision. The Intermediary argued that under the relevant manual section, the Provider must treat Medicare and non-Medicare accounts similarly until the end of the collection effort.

The Provider commented, requesting affirmation of the Board's decision. The Provider argued that it established reasonable collection efforts and that its debts were actually uncollectible when claimed as worthless. The Provider pointed out that its in-house collection policy complied with program requirements; it referred all uncollected patient charges of like amounts to an outside collection agency, and the actual efforts at this outside collection agency routinely exceeded far beyond 60 days. Further, the Provider maintained that it presented compelling evidence to demonstrate that Medicare and non-Medicare accounts were subject to the same collection activities. All collection efforts at the outside collection agency were similar for Medicare and non-Medicare patients, and the only distinction between them occurred at the time the outside collection agency returned the claims, after the outside collection agency had made reasonable efforts at collection and had determined the Medicare accounts were "uncollectible."

Moreover, the Provider argued that, although non-Medicare claims for which there was no likelihood of recovery were not returned, sound business judgment reflected the economics of the modern collection process. Namely, it is financially beneficial for the outside collection agency to retain these debts that only had little likelihood of recovery. Modern collection practices rely on regular computerized database searches incurring immaterial cost per claim. Thus, the Provider reasoned even without a likelihood of recovery, the minimal effort to maintain a claim in the "one-in-a-million" recovery category is justified just in case of a change in the debtor's financial circumstances or location information.

Conversely, the Provider argued that business experience with Medicare claims show that they are more likely to be paid early and they tend to be lower in amount, on average. Thus, holding Medicare claims for years at a time does not make economic sense following sound business practices. Finally, the Provider asserted that the years-long periods of inactive status associated with non-Medicare claims in the expectation that a small portion may become active would never be accepted by the Medicare program as "active" collection of Medicare claims.

DISCUSSION

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)(2000)[1] 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.[2] 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.[3]

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 collect deductibles and coinsurance amounts from the Medicare

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[1] Redesignated at 42 CFR 413.89 (2004).

[2] See also, Section 304 of PRM.

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

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.[4]

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.[5] (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. (Emphasis added.)

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 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

[4] See Id.

[5] See also Section 308 of the PRM.

> uncollected Medicare deductible and coinsurance amounts to the collection agency. Where a collection agency is used, the agency's practice may include using or threatening to use court action to obtain payment.

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.[6]

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.[7]

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

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[6] 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, 413.20 and 413.24 and Section 301.B of the PRM.

[7] Intermediary Manual, Part IB, 13-2.

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 record reflects that the Provider engaged in in-house collection efforts for both its Medicare and non-Medicare charges for approximately 90 days and then accounts of like amounts were transferred to an outside collection agency. For the Provider's Medicare accounts, the collection agency's policy required continued collection efforts for an additional period of time (30-60 days at which time they were reviewed and only the Medicare accounts were returned, as uncollectible. The Provider then wrote-off the Medicare accounts and claimed them as Medicare bad debts. The Provider acknowledged that non-Medicare accounts were retained by the collection agency, but claimed that while at the collection agency the accounts were treated the same, thus, it met the regulatory requirement to claim the debts at issue as uncollectible. However, despite this claim, the record shows that the collection agency retained non-Medicare accounts and continued collection procedures, including such procedures as legal action and skip tracing.[8]

From a sample, the Intermediary also noted differences in the collection efforts at the collection agency between Medicare and non-Medicare accounts. With respect to the non-Medicare accounts sampled, the collection agency used skip tracing, the threat of legal action, attaching interest to unpaid balances and liens. However, from the Medicare accounts sampled, the Intermediary found no evidence that these types of actions were used.[9] In addition, the record shows that the Provider's collection letters differed between Medicare and non-Medicare accounts. The non-Medicare collection letters were stronger in tone and assessed greater penalty for non-payment.[10]

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

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[8] See Intermediary Exhibit I-11 —Collection Procedures for Medicare Accounts (Effective 4-99) and Collection Procedures for Non-Medicare accounts. The Administrator notes that the pursuant to these procedures Medicare accounts are returned to the Provider between 30-60 days, if the debt is not satisfied, and that accounts will be reported to local and national credit agencies. However, in the case of non-Medicare accounts, the collection agency continues with its collection efforts, including skip tracing and possible legal action.

[9] See Intermediary Exhibit I-7. See also Discussion on sampling at Hospital San Francisco, Admin. Dec. 2003-D57

[10] See Intermediary Exhibit I-6.

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 similar collection efforts by continuing to purse Non-Medicare accounts of comparable amounts. Thus, the presumption only applies where a provider has otherwise demonstrated through appropriate documentation that it engaged in similar, reasonable collection efforts for all accounts, both Medicare and Non-Medicare.

Moreover, the Administrator is not persuaded by the Provider suggestion that further collection efforts for Medicare accounts are not feasible. The Provider has elected to have Medicare accounts returned for "write-off" approximately at the 120-day presumption point when Medicare debts may be claimed. However, there is nothing in the record to show that engaging in similar collection efforts for Medicare accounts as the Provider has elected to pursue for non-Medicare accounts would not result in a similar recovery. Further, as the CMS explained, since Medicare bad debts have a direct dollar for dollar affect on reimbursement, there is an incentive to claim bad debts before they become worthless. Thus, as the PRM instructs, Medicare anticipates a provider to pursue Medicare accounts and non-Medicare account of comparable amounts similarly, including collection efforts by an outside collection agency. Thus, the Administrator finds it reasonable to expect a provider to demonstrate that it has completed its collection effort for both Medicare and non-Medicare comparable accounts, including outside collection, before claiming Medicare 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 for comparable non-Medicare bad debts after claiming comparable 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 for like non-Medicare accounts, clearly it does not believe the debts of similar amounts to be worthless.

Further, the Administrator finds that the requirement set forth in the PRM at §§310, et seq., which consistently interprets the regulation at 42 C.F.R. §413.80(e)(1)-(4), mandates that when a collection agency is used, a provider's effort to collect the deductible and coinsurance amounts must be similar to the effort put forth to collect comparable amounts from non-Medicare patients throughout the entire collection process, both at the time prior to when the accounts are referred to the outside

collection agency and while at the collection agency, and when returned for "write-off." The reasonable collection effort incorporates and provides the burden of providers to document their collection efforts for all similar Medicare and non-Medicare bad debts claim as Medicare is a guarantor. As has been stated in past decisions, the undisputed purpose of this requirement is to ensure that a provider treat similarly those accounts for which the provider has no guarantor as those for which the government acts as guarantor. This prevents Medicare from being used as a payer for unpaid bills that might yet be paid.

In sum, after a review of the record and applicable law and policy, the Administrator finds that these bad debts were properly disallowed under 42 CFR 413.80(e)(2) through (4) and section 310 of the Manual.

DECISION

The decision of the Board in this case is reversed consistent with the foregoing opinion.

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

Date: 4/30/07

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