CENTERS FOR MEDICARE AND MEDICAID SERVICES
Decision of the Administrator

In the case of:	**Claim for:**
Baptist Regional Medical Center	**Determination for Cost Reporting Periods Ending: August 31, 1999 through August 31, 2001**
Provider	
vs.	
BlueCross BlueShield Association National Government Services - Kentucky	**Review of: PRRB Dec. No. 2008-D12 Dated: December 10, 2008**
Intermediary	

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) commented, requesting Administrator's review. The parties were then 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, the case is now before the Administrator for final administrative decision.

BACKGROUND

The Provider is a voluntary nonprofit short-term hospital located in Corbin, Kentucky that offers hospital inpatient/outpatient, psychiatric, and rehabilitation services. The Provider is a member of the Baptist Healthcare System. The Intermediary reviewed the Provider's collection and write-off policies and found that the Provider had established a charitable care policy for determining indigent patients. For an account with a balance due from the patient

under $800, the Provider's policy allowed the patient to disclose information regarding income without further supporting documentation. The policy considered the patient indigent and granted full or 100% charity if the patient's income was less than 125% of the Federal poverty level. For account balances due from the patient of $800 or greater, the policy required patients to disclose information regarding both income and assets, and the Provider determined the amount of debt forgiveness based on both. The Intermediary considered the Provider's charity care write-off practices inconsistent with the requirements of CMS Pub. 15-1, §312 that determinations of indigence include consideration of the patients' total resources (i.e., assets, liabilities and income and expenses) and, accordingly, disallowed all bad debt claims for which the Provider's records did not evidence an asset test.

ISSUE AND BOARD'S DECISION

The issue, set forth by the Board, was whether the Intermediary properly adjusted Medicare bad debt accounts considered indigent by the Provider. The Board focused its decision-making on whether the asset-test guideline at CMS Pub. 15-1, Section 312(B) of the Provider Reimbursement Manual (PRM) must be applied to determine a Medicare beneficiary's indigence. The Board examined CMS Pub. 15-1, §312(B), and concluded that the existing bad debt regulation and manual provision does not create a mandatory asset test and found that the Provider's bad debts should be reimbursed in a manner consistent with the stipulations of the parties.

SUMMARY OF COMMENTS

The Intermediary submitted comments, requesting reversal of the Board's decision. The Intermediary asserted that the Provider did not meet the requirements of CMS Pub. 15-1, §312. The Intermediary asserted that Section 312 of the PRM requires that, in making a determination of indigence, the Provider should take into account the patient's total resources, including assets, liabilities and income. The Intermediary stated that in the case of patient accounts less than $800, no review of patient assets was done as a part of the Provider's indigence determination. In the case of patient accounts over $800, if the account records did not document an asset review, the debts were also disallowed. Therefore, the Intermediary properly disallowed those bad debt claims.

The Intermediary asserted that the Board's ruling is contrary to the Secretary's instructions. The Board improperly concluded that Section 312 of the PRM does not create a mandatory

asset test. The Board was wrong in its interpretation that the requirements of the PRM indicate that the determination of indigence must merely be based on "consideration of the patient's circumstances."

CMM submitted comments requesting reversal of the Board's decision. CMM explained that CMS has consistently interpreted its manual provisions as requiring providers to comply with all their terms in order to receive reimbursement for Medicare bad debts and has issued subsequent interpretive materials that take this position. Sections 310 and 312 of the PRM set forth procedures that must be followed and criteria that must be met in order to be in compliance with the regulations.

CMM asserted that the Provider failed to follow the clearly indicated guidelines. In making determinations that a patient was indigent, the Provider did not apply an asset test, but only an income test, for accounts where the balance due from the patient was under $800. CMM argued that it is critical that the Provider meet the indigency criteria set forth in the PRM in order to take in account all necessary information needed to properly deem any patient indigent and, thus, meet the requirements that a reasonable collection effort was made and that the debt was uncollectible when claimed as worthless.

CMM cited the Federal District Court's decision in *Harris County Hospital District v. Shalala*, 863 F. Supp. 404 (S.D. Tex. 1994), *aff'd*, 64 F.3d 220 (5th Cir. 1995), as the controlling case for reversing the Board's decision. As in the instant case, the bad debt payments to Harris County Hospital were denied by the Intermediary because the Provider failed to apply the asset test to determine if a patient was indigent. As with the instant case, the Board found for Harris County Hospital on the basis that the PRM did not require an asset test to be performed. In that instance, the Administrator reversed the Board's decision and found that the Provider failed to employ an asset test in the Harris County Hospital case. Accordingly, the Administrator's decision in Harris County Hospital District states the correct interpretation of the PRM and should be followed by the Board in the instant case.

The Provider commented, requesting affirmation of the Board's decision. The Provider disagrees with the Intermediary's statement that the Board's decision is contrary to the Secretary's instructions Section 312 of the PRM. The Provider acknowledged the Administrator's historical position on this issue – that an asset test is mandatory under Section 312 of the PRM – but also noted that the CMS' position on bad debts has evolve in recent years and that the decision on review need not cling to positions the Administrator may have assumed in the past.

The Provider asserted that the Administrator's opinions rests on whether Section 312 of the PRM is mandatory, generally turning on the question of whether "should" means the same

as “must” under the PRM instructions. The Provider requested that the Administrator take a fresh look at this issue, and consider that the District Court and Board decisions that state that the word “should” is not mandatory. The Provider asserted that the District Court decisions state that “should” is only mandatory when used as a past tense of “shall.” Accordingly, under the PRM instructions, “should” and “must” mean different things and, therefore, the use of the word “should” in the PRM is not mandatory.

The Provider also asserts that over time, the Secretary has clarified its policy on collection efforts to reflect a less rigid determination of hospital indigence policies and acknowledge that hospitals have flexibility in establishing their own indigency policies. According to the Provider, the Secretary has stated that a collection policy is a decision to be made by the hospital; the only Medicare requirement is that whatever decision the hospital makes, it must be consistently applied if the hospital wishes to seek Medicare reimbursement.

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 were received timely and are included in the record and have been considered. After a review of the record, applicable regulations and manual instructions, the Board’s decision should be reversed.

The Medicare program primarily provides medical benefits to eligible persons over the age of 65, and consists of two parts: Part A [42 U.S.C. §1395(c)-1395(i)], which provides reimbursement for inpatient hospital and related post-hospital, home health and hospice care; and Part B [42 U.S.C. §1395(j)-1395(w)], which is a supplementary voluntary insurance program for hospital outpatient services, physician services and other services not covered under Part A. Medicare providers are reimbursed by the Medicare program through fiscal intermediaries for Part A and carriers for Part B, under contract with the Secretary.

Under Section 1861(v)(1)(a) of the Act, providers are to be reimbursed the reasonable cost of providing services to Medicare beneficiaries. That section defines "reasonable cost" 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 establishing the method or methods to be used, and the items to be included...." The section does not specifically address the determination of reasonable cost, but authorizes the Secretary to prescribe methods for determining reasonable cost, which are found in regulations, manuals, guidelines, and letters.

The principles set forth in the Act are reflected and further explained in the regulations. 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. This principle is reflected at 42 CFR 413.9(c), which provides that the determination of reasonable cost must be based on costs related to the care of Medicare beneficiaries. However, if the provider's costs include amounts not reimbursable under the program, those costs will not be allowed.[1]

Consistent with this principle, 42 CFR 413.89[2] provides that bad debts, which are deductions in a provider's revenue, are generally not included as "allowable costs" under Medicare. The regulation at 42 CFR 413.89 defines "bad debts" as "amounts considered to be uncollectible from accounts and notes receivable that were created or acquired in providing services. "Accounts receivable" and "notes receivable" are defined as designations for claims arising from the furnishing of services, and are collectable in money in the relatively near future.

However, the regulation at 42 CFR 413.89 explains that to ensure that the cost of Medicare services are not borne by others, the costs attributable to the Medicare deductible and coinsurance amounts which remain unpaid are added to the Medicare share of allowable costs. 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
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> 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.

To comply with section 42 CFR 413(e)(2), the Provider Reimbursement Manual or PRM provides further guidance with respect to the payment of bad debts. Section 310 of the PRM

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[1] Further, Section 1815 of the Act and 42 CFR 413.20 and 413.24 require a Provider to support its claim for costs with verifiable, auditable documentation.

[2] The regulation at 42 CFR 413.80 et. seq. has been redesignated to 42 CFR 413.89 et. seq. See 69 Fed. Reg. 49254 (Aug. 11, 2004).

provides the criteria for meeting reasonable collection efforts. Section 310 of the PRM pertaining to a reasonable collection effort, states in part:

> 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 section 312 for indigent or medically indigent patients.) (Emphasis added.)

Moreover, Section 310.B states that the provider's collection effort is to be documented "in the patients file by copies of the bill(s)...." Section 312 of the PRM explains that individuals who are Medicaid eligible as either categorically or medically needy may be automatically deemed indigent.

Section 312 of the PRM, "Indigent or Medically Indigent Patients," states:

> In some cases, the provider may have established before discharge, or within a reasonable time before the current admission, that the beneficiary is either indigent or medically indigent. Providers can deem Medicare beneficiaries indigent or medically indigent when such individuals have also been determined eligible for Medicaid as either categorically needy individuals or medically needy individuals, respectively. Otherwise, the provider should apply its customary methods for determining the indigence of patients to the case of the Medicare beneficiary under the following guidelines:
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> A. The patient's indigence *must* be determined by the provider, not by the patient; i.e., a patient's signed declaration of his inability to pay his medical bills cannot be considered proof of indigence;
>
> B. The provider *should* take into account a patient's total resources which would include, but are not limited to, an analysis of assets (only those convertible to cash, and unnecessary for the patient's daily living), liabilities, and income and expenses. In making this analysis the provider

> *should* take into account any extenuating circumstances that would affect the determination of the patient's indigence;
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> C. The provider *must* determine that no source other than the patient would be legally responsible for the patient's medical bill; e.g., title XIX, local welfare agency and guardian; and
>
> D. The patient's file *should* contain documentation of the method by which indigence was determined in addition to all backup information to substantiate the determination.
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> Once indigence is determined and the provider concludes that there had been no improvement in the beneficiary's financial condition, the debt may be deemed uncollectible without applying the §310 procedures. Emphasis added.

The Secretary has consistently interpreted manual provisions as requiring providers to comply with all terms in order to receive reimbursement for Medicare bad debt and has issued subsequent interpretive materials that take this position. Sections 310 and 312 of the PRM set forth procedures that *must* be followed and criteria that must be met in order to be in compliance with the regulations.

In making determinations that a patient was indigent and hence to justify its failure to bill, and instead deem the account worthless, the Provider did not apply an asset test, but only an income test, for accounts where the balance due from the patient was under eight hundred dollars ($800.00). The Intermediary properly disallowed the claims for bad debt reimbursement filed by the Provider based on these accounts.

The Board improperly reversed the Intermediary's disallowance. Contrary to the Board's finding, Section 312 of the PRM does create a mandatory asset test. It is critical that the provider meet the indigency criteria set forth in §312 of the PRM in order to take into account all necessary information needed to properly deem any patient indigent and, thus, meet the regulatory requirements that a reasonable collection effort was made and that the debt was uncollectible when claimed as worthless.

Pursuant to the regulation and manual instructions cited above, except in cases where a patient has been determined eligible for Medicaid, providers are required to follow certain procedures in making indigency determinations. Those procedures include: not relying on patient declarations of inability to pay as proof of indigency; the application of an asset test-taking into account patent assets, as well as liabilities, income expenses, to determine indigency; and ensuring after an initial determination that a patient is indigent, that the

beneficiary's financial condition has not improved. The Provider's strict compliance with these procedures flows from the plain, mandatory language of Section 312, providing inter *alia*: "indigence *must* be determined by the provider… a patient's signed declaration… *cannot* be considered proof of indigency", "[t]he provider *should* take into account a patient's total resources"; "[t]he provider *must* determine that no other source other than the patient would be legally responsible"; "[t]he patent's file *should* contain documentation"; and "the provider concludes that there has been no improvement in the beneficiary's financial condition." (Emphasis Added).[3]

Moreover, §312 of the PRM compels providers to follow the above-cited procedures to determine indigence ensure compliance with the requirements of 42 CFR 413.89(e), that providers make reasonable collection efforts and ensure that debts are uncollectible before claiming them for Medicare payment. If the Secretary were to excuse providers from attempting to collect debts because such attempts would be futile due to indigency, as provided under §312, then it is only reasonable to require – except in the cases of governmental determinations of Medicaid eligibility – that the provider follow prescribed criteria for verifying indigency and document those procedures in accordance with Medicare documentation rules.

The Provider failed to employ as asset test and did not properly evaluate the indigency status of its patients and, thus, the Intermediary properly disallowed the Provider's claimed bad debts. The Provider's collection and write-off policies, in particular, those that are established as a charitable care policy for indigent patients, fall short of satisfying the

[3] The Administrator notes that the introduction and paragraphs B and D of section 312 of the PRM uses "should" whereas paragraphs A and C use "must." The Administrator finds that within the context of the regulation and the PRM, "should" is synonymous with "must." *The Random House Dictionary of the English Language*, p. 1771 (2d ed. 1987); *Rogets International Thesauraus*, §637.10 (3d ed 1962). The Administrator also notes that the district court in *Harris County Hospital v. Shalala*, 863 F. Supp. 404 (S.D. Texas, 1994); affirmed by *Harris County Hospital District v. Shalala*, 64 F.3d 20, disagreed with the Administrator's interpretation that "should" means "must" within the context of section 312 of the PRM. The District Court in *Harris County*, found, much like the Board in the instant case, that the use of the word "should" is precatory language and only suggests, but does not mandate, the use of an asset test. However, the Administrator also notes that the District Court's decision was affirmed by the Eleventh Circuit Court of Appeals' decision in *Harris County* on grounds other than the definition of "should" and "must." Regardless, the Provider is not located in that judicial district and, therefore, that court holding would not be controlling law.

documentation for patient accounts with balances under $800 constitutes insufficient and improper collection efforts.

In light of the foregoing, the Administrator finds that the Board's decision is incorrect. The bad debts claimed by the Provider were not worthless when written off as Medicare bad debts. The Provider did comply with the required bad debt policies and procedures described above. Accordingly, the Board's decision is reversed.

DECISION

In accordance with the foregoing opinion, the decision of the Board is reversed.

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

Date: **2/8/08** **/s/**

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

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