CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	Claim for:
HCA 01 Outpatient Therapy Bad Debts	Cost Reporting Periods Ending: 2001
Provider vs.	
Wisconsin Physician Services	Review of: PRRB Dec. No. 2010-D11 Dated: January 28, 2010
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 section 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 Providers submitted comments, requesting that the Administrator affirm the Board's decision. Accordingly, this case is now before the Administrator for final agency review.

ISSUES AND BOARD'S DECISION

The issue is whether the Intermediary properly disallowed reimbursement for the Providers' uncollected coinsurance and deductible amounts relating to outpatient therapy services, paid under the Medicare Part B fee schedule, and claimed as a bad debt for the Providers respective cost reporting periods ending 2001.

A majority of the Board noted that section 1861(v)(1)(A) of the Social Security Act provides a prohibition of cost shifting (anti cross subsidization) which was adopted in regulation and resulted in bad debt policy. The regulation at 42 CFR 413.80 provided the criteria for the payment of bad debt. The cost based outpatient therapy payment

was replaced by a fee-based system. Prior to the Balanced Budget Act of 1997 the payments for outpatient therapy services were made using salary equivalent guidelines. The Board stated that CMS asserted that the physician fee schedule mechanism included all costs including bad debt, and traditionally did not allow the recovery of bad debt for these service covered by the physician fee schedule. Beginning in July 1, 1999, the BBA mandated that outpatient therapy be paid under a prospective system.

A majority of the Board concluded that, while the Balance Budget Act of 1997 shifted the basis of payment for outpatient rehabilitation services from reasonable cost to 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 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 bad debt policies remain unchanged. 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.

The Board majority also found significant the fact that CMS has not been able to support that the physician fee schedule includes reimbursement to physicians or other providers for uncollected coinsurances and deductibles pursuant to the Providers' request. This conclusion is also supported by the Board' review of the physician fee schedule methodology. The Board concluded that, if the Court in *Abington Crest Nursing and Rehabilitation Center v. Leavitt*, 575 F. 3d 717 (D.C. Cir. 2009), had the benefit of discovery, it would have seen that CMS cannot offer any factual support for the assertion that Medicare fee schedule payments reimburse providers for bad debt. The Board concluded that Medicare had an obligation to reimburse bad debts for services regardless of the payment methodology. The Board found that 42 CFR 413.80 was a mandate for the paying of the bad debt. Therefore, the Intermediary improperly disallowed the Providers' bad debt arising from outpatient therapy services under the Part B fee schedule.

One member of the Board dissented. The Board member questioned whether there was a law regulation or CMS ruling that bound the Board and, if not, whether CMS' interpretation of the law is reasonable. The Board member examined the reasonable cost provision at section 1861(v)(1)(A) of the Social Security Act, the bad debt regulation at 42 CFR 413.80 and the controlling law on outpatient therapy services at section 1834(k) of the Act.

The dissenting Board member found that bad debts are paid when a provider is reimbursed reasonable costs and that physicians paid on a fee schedule have never been reimbursed for Medicare bad debts. There was a change of methodology relating to outpatient therapies from reasonable costs to the lesser of charges or the physician fee schedule. There is nothing in the statute that indicates that bad debts are to be paid when a provider is reimbursed under a fee schedule. Consequently, the dissenter further examined CMS' policy for Medicare bad debts and whether it was consistent with the statue and regulation.

The dissenting Board member identified three documents: an April 10, 2000 CMS letter, section 3645 of Pub 13-3 (2003), and the February 10, 2003 proposed rule. Nothing in this evidence indicated that the Intermediary adjustment was inconsistent with CMS' longstanding bad debt policy. The Board member did not find that the issue of whether the physician fee schedule included a component for bad debt was relevant. The Board member found his decision was based on CMS' consistent policy of not paying bad debts to providers paid based on the physician fee schedule. There is no evidence that CMS has changed this policy. The bad debt regulation did not change as the regulation and statute that the Board majority relies on is not applicable to bad debts when a provider is not paid based on reasonable cost.

SUMMARY OF COMMENTS

CMM commented requesting that the Administrator review and reverse the Board's decision. CMM stated that the Board properly found that the Congress changed the basis of payment for outpatient rehabilitative services from a reasonable cost to a fee-based payment under Part B. However, the Board was incorrect to conclude that, congressional silence on the payment of bad debts demonstrated its intent that the bad debt policy should remain unchanged. The Board seems to be suggesting that the Medicare policy is to reimburse bad debts for services paid under a fee schedule. However, CMM stated, the longstanding policy under Medicare has been not to pay for bad debts for any services paid under a charge-based or fee schedule.

The bad debt regulation and Chapter 3 of the Provider Reimbursement Manual provide that the unrecovered costs attributable to uncollectible deductibles and coinsurances of Medicare beneficiaries are considered in calculating Medicare payment to providers reimbursed on the basis of reasonable costs. To determine which costs are subject to the Medicare bad debts reimbursement, the prohibition on cross subsidization under section 1861(v)(1)(A) of the Act must be considered. CMM stated that the prohibition on cost shifting is not implicated when services are paid under other than a reasonable costs basis. Allowing reimbursement for bad debts is a feature of the reasonable cost payment principle and of the prospective payment

systems when they are based on costs and where the base period, upon which the prospective rates are based, do not include Medicare bad debts.

The payment of bad debts has never been applied to services paid under a prospective system based on a fee schedule or reasonable charge methodology. Under a fee schedule, Medicare makes payment for a specific service. The payment is not for the provider's cost outlay or unrecovered costs. CMM stated that it believed that Congress is well aware of this point and that it could have mandated that bad debts for fee schedule services be paid under Medicare, but it has never done so. In 2006, the Secretary published a final rule that embodied this longstanding policy.

The Board erred in suggesting that the Court in *Abington* would have ruled differently as the court clearly held as it did, because the Secretary was reasonable to interpret the reasonable cost provisions under which the bad debt regulation is implemented as not controlling under the fee schedule payment methodology. CMM stated that it agreed with the dissenter's opinion that properly noted three documents setting forth the policy.

The Intermediary commented, requesting reversal of the Board's decision.

The Providers commented, requesting affirmation of the Board's decision. The Providers stated that the Board's decision was the result of carefully and thoroughly reviewing the parties' arguments and factual record and relevant precedent including the rulemaking record and statutory authority associated with the establishment of the outpatient therapy fee schedule and other forms of Medicare payment. The Providers laid out the legal background for the payment of bad debts. The Providers pointed out that inpatient hospital services, inpatient psychiatric services, long term care, etc., as all providing for the payment of bad debt, even though the various prospective payment systems are not designed to cover the costs of individual providers.

The Providers noted that when Congress has seen fit to eliminate bad debt payments, it has done so expressly through statutory enactment as it has done with certified registered nurse anesthetists and others. In this case, no Medicare statute, regulation, or manual operatives during the relevant fiscal years precludes the Providers from being reimbursed for their claimed bad debts. The statutory basis governing outpatient therapy services makes no mention of bad debt. Thus, there is no statutory basis to preclude reimbursement of bad debts for outpatient therapy services.

The providers argued that it is also arbitrary for CMS to reimburse bad debts for some services paid under a prospective basis, but not others. The Providers stated that CMS proposes that the bad debts are paid through the fee schedule. However it is not logical for CMS to allow bad debts under one prospective payment system, but not

under another. The courts have also rejected such reasoning in the past. Furthermore, the Providers argued that there does not appear to be any factual support for CMS' contention that the fee schedule payment accounts for provider bad debts. One part of the reasoning behind CMS' policy with respect to bad debts is that fee schedules provide some compensation to providers for bad debts. The Providers stated that they went though exhaustive efforts but did not receive any documentation from CMS to support the contention that when CMS calculated the fee schedule, it did in fact consider providers' unrecovered costs associated with uncollectible deductibles and coinsurances. Finally, the Providers stated that the current bad debt regulation cannot be applied to the present case. The Providers' claimed that if the bad debt policy at 42 CFR 413.80 only applied to cost reimbursed services, CMS' action, in amending the regulation, would not have been necessary. The Providers fully believed that it was acceptable and appropriate to claim reimbursement for bad debts related to outpatient therapy services. Therefore, the Intermediary's adjustment should be reversed.

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 section 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 section 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, under reasonable cost, the Medicare program prohibits cross-subsidization of costs, a principle also referred to as the "anti-cross 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 413.80[1] 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) 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 cost.

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.

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

(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.

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,[2] physician services continued to be paid based on reasonable charge principles throughout the first 25 years of the program. This methodology provided that the reasonable charge for a physician's service was the lowest of: 1) The physician's actual charge; 2) the physician's customary charge, or 3) the prevailing charge in the locality for similar services.[3] As Medicare Part B payments were not based on reasonable costs under section 1861(a)(1)(A) of the Act, 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 section 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.

The concepts and methodology underlying the physician fee schedule were enacted as part of the Omnibus Budget Reconciliation Act (OBRA) of 1989[4] and OBRA

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[2] Statutory amendments earlier 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.

[3] *See e.g.* 56 Fed. Reg. 59501, 59504. (The customary is the median charge for physicians for the service for the period July through June data collection period that precedes the current calendar year. The median, or midpoint, of the data serves as the customary charge, The prevailing charge limit for a particular service in a locality is an amount set high enough to cover the full customary charges of the physicians whose billings have accounted for at least 75 percent of the charges in the locality for that service. Since 1975, changes in the prevailing limits from year to year have been constrained by statute to the amount of inflation in medical costs as measured by the Medicare Economic Index (MEI).)

[4] Pub. Law 101-239.

1990.[5] As part of the Omnibus Reconciliation Act (OBRA) of 1989[6], section 6102 of OBRA 1989 amended Title XVIII of the Act by adding new section 1848 called "Payment for Physicians Services." The primary change required the replacement of the reasonable charge payment mechanism with a fee schedule for physician services. 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 for all physician services.[7] 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] Under the formula set forth in section 1848(b)(1) of the Act, the payment amount for each service paid under the physician fee schedule is the product of three factors: (1) a nationally uniform relative value for the service; (2) a geographic adjustment factor (GAF) for each physician fee schedule area; and (3) a nationally uniform conversion factor or CF for the service. The CF converts the relative values into payment amounts. For each physician fee schedule service, there are three relative values: (1) an RVU for physician work; (2) an RVU for practice expense; and (3) an RVU for malpractice expense. For each of these components of the fee schedule there is a geographic practice cost index (GPCI) for each fee schedule area. The GPCIs reflect the relative costs of practice expenses, malpractice insurance, and physician work in an area compared to the national average for each component

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[5] Pub. Law 101-508.

[6] Pub. Law 101-239.

[7] The physician work RVUs, established for the implementation of the fee schedule in January 1992, were developed with extensive input from the physician community. A research team at the Harvard School of Public Health developed the original physician work RVUs for most codes in a cooperative agreement with the CMS. In constructing the code-specific identifiers for the original physician work RVUs, Harvard worked with panels of experts, both inside and outside the Federal government, and obtained input from numerous physician specialty groups.

[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 e.g.* 56 Fed. Reg. 59502 (Final rule for "Medicare Program; Fee Schedule for Physician Services")(Nov. 25, 1991).

Among other things, practice expense RUVs were initially computed by applying historical practice costs percentages to a base allowed charge for each service. The final rule, published on November 25, 1991[9] set forth the fee schedule for payment for physicians' services beginning January 1, 1992. 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 addressed physician and other practitioners.

Initially, only the physician work RVUs were resource-based, and the practice expense (PE) and malpractice RVUs were based on average allowable charges. In particular, under the formula specified at section 1848(c)(2)(C) of the Act, the practice expense and malpractice RVUs were based initially on historical data for practice expenses weighted by specialty, "applied to estimated 1991 average allowed charges under the customary, prevailing and reasonable charge methodology."[10] In addition, as noted, the total payment involves a conversion factor or CF. The statutory formula for the payment amount under the fee schedule multiplies a relative value for a service by a geographical adjustment factor for a fee schedule area by a conversion factor or CF. The CF is a multiplier that transforms relative value for service into payment amounts and is a single national value that applies to all services paid under the fee schedule. The base CF was required to produce total payments under the fee schedule that were the same as total payments that were expected in 1991 under the customary prevailing and reasonable charge methodologies.[11] After a transition period, the statute provided for future updates of the CF with the default mechanism also provided for in the Act.

Section 121 of the Social Security Act Amendments of 1994[12], enacted on October 31, 1994, amended section 1848(c)(2)(C)(ii)[13] of the Act and required the Secretary

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[9] 56 Fed. Reg. 59502.

[10] 56 Fed. Reg. 59509 (1991). ("Consistent with section 1848(c)(2)(C) of the Act, we are computing practice expense and malpractice RVUs by applying historical practice cost percentages to a base allowed charge for each service. 56 Fed. Reg. at 59510.)

[11] 56 Fed Reg. at 59512 (1991).

[12] Pub. Law 103-432

[13] Section 1848(c) states regarding the physician work and practice expense components that: "(c) Determination of Relative Values for Physicians' Services.—(1) Division of Physicians' Services Into Components.—In this section, with respect to a physicians' service: (A) Work component defined.—The term "work component" means the portion of the resources used in furnishing the service that reflects physician time and intensity in furnishing the service. Such portion shall—(i) include activities before and after direct patient contact, and (ii) be defined, with respect to

to develop resource-based practice expense RVUs for each physician's service beginning in 1998 to consider general categories of expenses (such as office rent and wages of personnel, but excluding malpractice expenses) comprising practice expenses.

In developing these new practice expense RVUs, section 4505(d)(1) of the Balanced Budget Act of 1997 required the Secretary to utilize, to the maximum extent practicable, generally accepted accounting principles that recognize all staff, equipment, supplies, and expenses, not just those that can be tied to specific procedures, and use actual data on equipment utilization and other key assumptions. The indirect costs for most services are imputed from direct practice expense costs based on physician fee schedule work RVUs and converted to dollars using the Medicare CF. That is, there are no specific indirect cost components in that part of the practice expense cost pool.[14]

Section 4505(a) of the Balanced Budget Act of 1997 (BBA)[15] amended section 1848(c)(2)(C)(ii) of the Act to delay implementation of the resource-based PE RVU

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surgical procedures, to reflect a global definition including pre-operative and post-operative physicians' services. (B) Practice expense component defined.—The term "practice expense component" means 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) comprising practice expenses." Regarding the computation of the physician RVUs, section 1848(c)(2)(C) states that: "(C) Computation of relative value units for components.—For purposes of this section for each physicians' service—….. (i) Work relative value units.—The Secretary shall determine a number of work relative value units for the service based on the relative resources incorporating physician time and intensity required in furnishing the service. (ii) Practice expense relative value units.—The Secretary shall determine a number of practice expense relative value units for the service for years before 1999 equal to the product of— (I) the base allowed charges (as defined in subparagraph (D)) for the service, and (II) the practice expense percentage for the service (as determined under paragraph (3)(C)(ii)), and for years beginning with 1999 based on the relative practice expense resources involved in furnishing the service. (D) Base allowed charges defined.—In this paragraph, the term "base allowed charges" means, with respect to a physician's service, the national average allowed charges for the service under this part for services furnished during 1991, as estimated by the Secretary using the most recent data available."

[14] *See,* e.g., 65 Fed. Reg. 65379 (November 1, 2000).

[15] Pub. Law 105-33.

system until January 1, 1999. In addition, section 4505(b) of the BBA provided for a 4-year transition period from charge-based PE RVUs to resource-based RVUs. The resource-based PE RVUs for each physician service were published in a final rule, published November 2, 1998[16] effective for services furnished in 1999. Based on the requirement to transition to a resource-based system for PE over a 4-year period, resource-based PE RVUs did not become fully effective until 2002.[17]

[16] 63 Fed. Reg. 58814. Initially, the resource-based system was based on two significant sources of actual practice expense or "PE" data: the Clinical Practice Expert Panel (CPEP) data; and the AMA's Socioeconomic Monitoring System (SMS) data. The CPEP data were collected from panels of physicians, practice administrators, and nonphysicians (for example, registered nurses (RNs)) nominated by physician specialty societies and other groups. The CPEP panels identified the direct inputs required for each physician's service in both the office setting and out-of-office setting. CMS refined and revised these inputs based on recommendations from the RUC. The AMA's SMS data provided aggregate specialty-specific information on hours worked and practice expense or PEs. Separate PE RVUs are established for procedures that can be performed in both a nonfacility setting, such as a physician's office, and a facility setting, such as a hospital outpatient department. The difference between the facility and nonfacility RVUs reflects the fact that a facility typically receives separate payment from Medicare for its costs of providing the service, apart from payment under the physician fee schedule. The nonfacility RVUs reflect all of the direct and indirect PEs of providing a particular service.

[17] Section 212 of the Balanced Budget Refinement Act of 1999 (BBRA) (Pub. Law 106-113) directed the Secretary to establish a process under which the Secretary accepts and uses, to the maximum extent practicable and consistent with sound data practices, data collected or developed by entities and organizations to supplement the data we normally collect in determining the PE component. A May 3, 2000 interim final rule (65 Fed. Reg. 25664) set forth the criteria for the submission of these supplemental PE survey data. The criteria were modified in response to comments received, and published in the *Federal Register* at 65 Fed. Reg. 65376 as part of a November 1, 2000 final rule. The physician fee schedule final rule published in 2001 and 2003, respectively, (66 Fed. Reg. 55246 and 68 Fed. Reg. 63196) extended the period during which supplemental data would be accepted through March 1, 2005. Not applicable here, in the Calendar Year (CY) 2007 physician fee schedule final rule with comment period (71 Fed. Reg. 69624), the revised the methodology for calculating PE RVUs beginning in CY 2007 and provided for a 4-year transition for the new PE RVUs under this new methodology.

Outpatient therapy services, prior to the Balanced Budget Act of 1997, were paid pursuant to section 1861(v) of the Act, under the reasonable cost methodology.[18] Congress subsequently changed the payment methodology for certain services including outpatient therapy services. Section 4541 of the Balanced Budget Act of 1997[19] amended and added new paragraph section 1833(a)(8) of the Act[20] and amended 1834(k) of the Act.[21]

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[18] When these services were provided under arrangement, the services were paid under the section 1861(v)(5) salary equivalency guidelines.

[19] Pub. Law 105-33.

[20] Section 1833 provides that: "(a) Except as provided in section 1876 and subject to the succeeding provisions of this section, there shall be paid from the Federal Supplementary Medical Insurance Trust Fund, in the case of each individual who is covered under the insurance program established by this part and incurs expenses for services with respect to which benefits are payable under this part, amounts equal to— ****

(8) 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."

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

"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— ….

The Secretary noted the change in the law with respect to the payment of outpatient therapy services from reasonable cost to a fee schedule basis in a January 30, 1998 Final Rule which set forth a chart of the BBA provisions and the effective dates by provider type.[22]

The Providers argued that 42 CFR 413.80 establishes the requirement for claiming allowable bad debts and that the Balanced Budget Act of 1997 did not alter this section. A majority of the Board concluded that there while the BBA shifted the basis of payment for outpatient therapy services from reasonable cost to fee-based, it did not change the applicability of 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 outpatient therapy services. 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 uncollectible coinsurance and deductibles for any services paid under a reasonable charge or fee schedule methodology.

Unlike a reasonable cost payment, payment under a reasonable charge/fee schedule is not related to a provider's cost outlay for the service and does not involve costs or, likewise, unrecovered "costs." Under the reasonable charge/fee schedule, Medicare makes payment for a specific service for which there is a predetermined rate which includes 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 section 1848 of the Act. Thus, the bad

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

[22] 63 Fed. Reg. 5106 at 5108.

debt provisions, found at 42 CFR 413.80(e), do not apply to services for which Medicare payment is based on reasonable charges or fee schedule methodology.[23]

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 section 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 section 1848 of the Act. Among other things, section 1848 was outside the scope of the controlling statutory authority for bad debt payment of section 1861(v)(1)(A) of the Act and was derived from a reasonable charge methodology that is assumed to account for the cost of doing business and is not intended to pay for a provider's unrecovered costs.[24] Likewise, the transition from the charge based to the resource based fee schedule did not change the underlying premise that the payment was not to

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[23] 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 providers than suppliers for furnishing the same service. We believe that doing so would be antithetical to the payment under a fee schedule." 67 Fed. Reg. at 9117.

[24] 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.

reimburse a provider its reasonable cost for the service. 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.[25] The Administrator finds that this CMS' policy prohibiting the payment of Medicare uncollectible coinsurance and deductibles 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 opposite. The Secretary explicitly stated that this rule was a confirmation/clarification of a longstanding 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 section 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."[26] 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

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

[26] 68 Fed. Reg. 6682 (Feb 10, 2003).

> have reflected the entities costs of doing business including expenses such as bad debt.[27]

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.[28]

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 how this longstanding 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 skilled nursing facility bad debts under the Deficit Reduction Act (DRA) of 2005.[29] 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.

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

[27] 68 Fed Reg. 6683.
[28] 68 Fed Reg.6685.
[29] Pub. Law 109-171.

> 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.
>
> 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 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.[30]

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 reimbursement of bad debts is 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 it had set forth 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.

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

Finally, the Providers contended that CMS was not able to demonstrate, as shown through the Providers' FOIA request, that there were any documents showing that uncollectible "coinsurance" and "deductibles" were included under the resource based fee schedule. The Providers thus maintained that if these amounts were not used to compute the fee schedule payment that this fact would have been determinative of the issue in *Abington*.[31] However, the Administrator finds that Medicare has historically never paid for uncollectible deductibles and coinsurance under a reasonable charge/fee schedule methodology. The statutory basis for the "bad debt" payment arises under section 1861 and the reasonable cost methodology. The fee schedule is not intended to reimburse providers their "unrecovered' costs, whether charge based or resource based. Thus, whether the physician fee schedule methodology specifically provided for these "unrecovered costs" is not determinative of the issue in this case, nor is the results of the Providers' FOIA request determinative of the issue in this case.

However, even assuming, *arguendo*, it would be relevant whether bad debt was a factor in the resource base fee schedule payment, on its face, the payment involved in this case is the lesser of "the actual charge" or the fee schedule and, thus, the payment continues to involve a charged based factor. Furthermore, inter alia, for the resource-base value fee schedule methodology used for the cost reporting period in this case, the "prior" charged-based fee schedule methodology acted as a basis for aggregate expenditures.[32] Specifically, in moving away from the charged-based fee schedule payment to the implementation of the resource-based fee schedule, the initial conversion factor (to be updated annually) was to ensure that the estimated aggregate payments for 1992 would result in the same aggregate amount of payments as made in 1991 under the charge-based fee schedule.[33] In addition, the

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[31] The Providers' FOIA request, for which no documents were produced, related to uncollectible "coinsurance" and "deductibles" within the physician fee schedule. As CMS has repeatedly stated that the physician fee schedule does not pay providers for unrecovered costs such as uncollectible coinsurance and deductibles it is not unreasonable that no documents were identified. CMS produced documents for the Providers' inquiry requesting documents involving the bad debts within the physician fee schedule. The Providers did not submit the documents released under FOIA into the administrative record due to the Board declining their offer to provide them.

[32] CMS also discussed at length at 63 Fed. Reg. at 58894-95 the impact of the implementation of the resource based practice expense and does not note any adverse affects due to "bad debts."

[33] In addition, the statutory methodology for computing the practice expense initially relied upon the charge methodology and was used in part through the transition period that included the 2001 cost year. Further, the indirect costs for most services are imputed from direct practice expense and thus there are no specific indirect cost

implementation of the resource-based practice expense required a budget neutral transition and the total Medicare expenditures for calendar year 1999 were required to be the same as the amount that would have been paid under the prior charge-based method of paying practice expenses.[34] Consequently, while the Providers seek to identify a discrete coinsurance and deductible component in the resource based fee schedule payment, it is evident that, overall, the charge-based methodology was the basis for the determination of aggregate payments for the future resource-based methodology. As these statutory provisions affecting aggregate resource based fee schedule payments are based on updated historical payments made under the charge methodology (a methodology for which no bad debt is paid), these provisions, in the least, indirectly ensure the continued recognition of providers' historical cost of doing business.[35]

In sum, the Intermediary properly denied payment for the bad debts that are the subject of this appeal.[36]

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components in that part of the practice expense cost pool. That is, direct practice expense costs and physician work serve as the proxy to the indirect costs. Finally, in the preambles promulgating the resource based payment methodology, the only tangentially related reference is to uncompensated care (but not bad debts) in regard to the effects of the Emergency Treatment and Labor Act (EMTALA) on emergency room physicians who are obligated under law to treat any patient regardless of the patient's ability or willingness to pay for treatment. The Secretary recognized that this may have induced the emergency room physicians to significantly and unavoidably (as they were required to treat such patients) overstate patient cares hours to cause an inaccurately low practice expense per hour for emergency room specialty and, therefore, the Secretary made an adjustment as a proxy to the practice expense component which would have otherwise have been paid to that specialty.

[34] 63 Fed. Reg. 58895 (Nov 2, 1998).

[35] Because of the significant complexity of the methodology and the underlying data and the many multiples of components that comprise the methodology upon which the fee schedule is based (some of which was collected/processed by third parties), were a court to determine that this line of inquiry was critical to the resolution of the issue and not otherwise satisfied by the plain language of the statute, a remand to the agency would be requested for the opportunity to address this issue in depth.

[36] Even assuming, *arguendo*, that such bad debts were found to be allowable, the Provider would still be required to demonstrate that, inter alia, that the requirements of 42 CFR 413.80(e) were otherwise met. Although the stipulation (as memorialized in the Board's decision) suggests that the parties agreed that reasonable collection efforts were used, as the claims were listed as a protested item on the cost report, it is unlikely that these bad debts were audited beyond the legal determination that they were fee schedule bad debts.

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: 3/24/2010

/s/
Charlene Frizzera
Acting Administrator
Centers for Medicare & Medicaid Services