CENTERS FOR MEDICARE AND MEDICAID SERVICES
Decision of the Administrator

In the case of:	**Claim for:**
Port Huron Hospital	**Determination for Cost Reporting Period(s) Ending: 06/30/00 and 06/30/01**
Provider	
vs.	
Blue Cross Blue Shield Association/ National Government Services, LLC-WI	**Review of: PRRB Dec. No. 2008-D32 Dated: August 11, 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)). CMS' Center for Medicare Management (CMM) commented, requesting reversal of the Board's decision on Issue No. 1. The parties were then notified of the Administrator's intention to review the Board's decision on Issue No 1. The Intermediary commented requesting reversal of the Board's decision on Issue No. 1. The Provider also submitted comments requesting that the Board's decision be affirmed on Issue No. 1. Accordingly, the case is now before the Administrator for final administrative decision.

ISSUE NO. 1 AND BOARD'S DECISION

Issue No. 1 is whether the Provider was required to submit a claim to the Michigan Medicaid program and to obtain a Medicaid remittance advice in order to receive Medicare reimbursement for Part B bad debts relating to services furnished to patients dually eligible for Medicare and Medicaid.[1]

[1] Issue No. 2, the Provider challenged the Intermediary's sampling methodology. Prior to

The Board, reversing the Intermediary's adjustment, found that a "must bill" policy which was the basis for the Intermediary's adjustment, has no foundation in law and is beyond the requirements of the regulations and Provider Reimbursement Manual (PRM). The Board found that, neither the regulation, nor the PRM require a provider to bill the State. The basic requirement for the reimbursement of deductibles and coinsurance for dual-eligible beneficiaries is demonstration of a reasonable collection effort. The Board found that the Provider in this case has demonstrated uncollectibility by the fact that the patients in question are deemed indigent by virtue of being on Medicaid. Contrary to the Intermediary's argument, the Board found the language in section 312 of the PRM, which appears to be the closest reference to a "must bill" requirement, to be convoluted. Thus, the Board concluded that since the language in the PRM does not support the conclusion that uncollectibility must be established by a billing, the Intermediary improperly denied the Provider's claimed bad debts.

SUMMARY OF COMMENTS

CMM commented, requesting reversal of the Board's decision. CMM argued that the bad debts claimed by the Provider did not comport with the concept of reasonable collection efforts. The Provider failed to bill the State and received no remittance advice (RA). CMM stated that the Intermediary properly disallowed the bad debts at issue. CMM noted that, even if the Provider had followed the must bill policy, the bad debt amounts would have been disallowed if the Part B services were paid for under a fee schedule or reasonable charge methodology payment system. CMM stated that pursuant to the regulation and Medicare policy, a provider must document the liability of a State for any cost-sharing amounts related to unpaid deductibles and coinsurance for dual-eligible beneficiaries.

CMM contended that, to effectuate this requirement, the provider must bill the State in order to determine whether the State is liable for cost-sharing amounts. By billing the State, and having the State process the claims, the Provider would receive an RA for each beneficiary. A provider can then determine the Medicaid status of each beneficiary at the time of service and the State's liability for the payment of deductible and coinsurance amounts. Thus, a provider can affirmatively establish the uncollectibility of the cost-sharing amounts. CMM

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the hearing, the parties entered into a joint stipulation resolving this issue. The Administrator summarily affirms Issue No. 2

argued that it is unacceptable for a provider to write-off a Medicare related dual-eligible beneficiary bad debt as worthless without first billing the State.

CMM pointed out that CMS clearly outlined the "must bill policy" for reimbursement of bad debts associated with dual-eligible beneficiaries in its August 10, 2004, Joint Signature Memorandum (JSM). CMM noted that the JSM restated longstanding Medicare policy that, in those instances where the State owes none or a portion of the dual-eligible copay of a patient, the unpaid liability for the bad debt is not reimbursable to the provider by Medicare until the provider bills the State and the State refuses payment through the issuance of a remittance advice. Even if the State plan limits the liability to the Medicaid rate, by billing the State, a provider can verify the dual-eligible status of a beneficiary and can determine whether the State is liable for any portion of the uncollected cost-sharing amounts.

In addition, CMM argued that with respect to qualified Medicare beneficiaries (QMBs), the statute imposes liability for cost-sharing amounts on the States. However, the statute allows the States to limit that amount to the Medicaid rate, and essentially pay nothing toward dual eligibles' coinsurance amounts, if the Medicaid rate is lower than what Medicare would have paid for the same service. However, CMM argued that in most cases, the State will always be liable to pay for a beneficiary's unpaid deductible amounts. Thus, CMM stated that the State possesses the current and accurate information to determine if a beneficiary is a QMB at the time of service and to determine, as such, the liability of the State for any unpaid QMB deductible and coinsurance amounts. Finally, CMM pointed out that the Ninth Circuit upheld the "must bill" policy.

The Provider commented, requesting that the Board's decision be affirmed. The Provider argued that the policy and legal arguments, as well as references to prior cases, made by CMM are inappropriate and should not be considered. In addition, the Provider claimed that CMM had advanced for the first time an argument in rebuttal to the Provider's position regarding the proper interpretation of a cited circuit court case. Finally, the Provider noted that CMM reiterated arguments presented by the Intermediary, which based on the record before it, the Board properly rejected.

The Intermediary also commented. The Intermediary stated that its arguments to the Board were supported by the circuit court case and a prior Administrator decision. The Intermediary recognized that, although the cited court case and the prior Administrator decision are not binding on a hospital located in Michigan, the facts are substantially similar and support a disallowance of the bad debts. The Intermediary pointed out that, in this case,

by not taking advantage of the opportunity to bill the State's Medicaid program, the Provider did not meet the test of reasonable collection efforts.

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.

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.

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

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.

Consistent with this principle, 42 CFR 413.80(a)[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 413.80(b)(1) 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. . 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. (Emphasis added.)

The circumstances under which providers may be reimbursed for the bad debts derived from uncollectible deductibles and coinsurance amounts are set forth at paragraph (e). The regulation at 42 CFR 413.80(e) states that to be allowable, a bad debt must meet the following criteria:

> 1) The debt must be related to covered services and derived from deductible and coinsurance amounts.
>
> 2) The provider must be able to establish that reasonable collection efforts were made.

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[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).

> 3) The debt was actually uncollectible when claimed as worthless.
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> 4) Sound business judgment established there was no likelihood of recovery at any time in the future.

To comply with section 42 CFR 413.80(e)(2), the Provider Reimbursement Manual or PRM provides further guidance with respect to the payment of bad debts. Section 310 of the PRM provides the criteria for meeting reasonable collection efforts. A reasonable collection effort, *inter alia*, includes:

> 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.... (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 patient's 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. However, section 312.C requires that:

> The provider must determine that no source other than the patient would be legally responsible for the patient's medical bills; e.g., title XIX, local welfare agency and guardian.... (Emphasis added.)

Finally, section 312 also states that:

> 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 [reasonable collection effort] procedures. (See section 322 of the PRM for bad debts under State welfare programs.)

Relevant to this case, section 322 of the PRM notes that:

> Effective with the 1967 amendments, States no longer have the obligation to pay deductible and coinsurance amounts for services that are beyond the scope of the State title XIX plan for either categorically needy or medically needy persons....

> Where the State is obligated either by statute or under the terms of its plan to pay all, or any part of the Medicare deductible or coinsurance amounts, those amounts are not allowable as bad debts under Medicare. Any portion of such deductible or coinsurance amounts that the State is not obligated to pay can be included as a bad debt under Medicare provided that the requirements of §312 or, if applicable, §310 are met. (Emphasis added.)

For instances in which a State payment "ceiling" exists, section 322 of the PRM states:

> In some instances the State has an obligation to pay, but either does not pay anything or pays only part of the deductible, or coinsurance because of a State payment "ceiling." For example assume that a State pays a maximum of $42.50 per day for the SNF services and the provider's cost is $60.00 a day. The coinsurance is $32.50 a day so that Medicare pays $27.50 ($60.00 less $32.50). In this case, the State limits its payment towards the coinsurance to $15.00 ($42.50 less $27.50). In these situations, any portion of the deductible or coinsurance that the State does not pay that remains unpaid by the patient, can be included as a bad debt under Medicare, provided that the requirements of §312 are met. (Emphasis added.)

Section 322 of the PRM concludes by explaining that:

> If neither the title XIX plan, nor State or local law requires the welfare agency to pay the deductible and coinsurance amounts, there is no requirement that the State be responsible for these amounts. Therefore, any such amounts are includable in allowable bad debts provided that the requirements of §312, or if applicable, §310 are met. (Emphasis added.)

The patient's Medicaid status at the time of service should be used to determine their eligibility for Medicaid to satisfy the requirement of Section 312 and to determine the State's cost sharing liability. A patient's financial situation and Medicaid eligibility status may change over the course of a very short period of time. The State maintains the most accurate patient information to make the determination of a patient's Medicaid eligibility status at the time of service and, thus, determine its cost sharing liability for unpaid Medicare deductibles and coinsurance. Thus, CMS issued a Joint Signature Memo (JSM-370) which restated Medicare's longstanding bad debt policy that:

> [I]n those instances where the State owes none or only a portion of the dual-eligible patient's deductible or co-pay, the unpaid liability for the bad debt is not reimbursable to the provider by Medicare until the provider bills the State, and the State refuses payment (with a State remittance advice). Even if the State Plan Amendment limits the liability to the Medicaid rate, by billing the state, a provider can verify the current dual-eligible status of the beneficiary and can determine whether or not the State is liable for any portion thereof.

Relevant to this case, CMS issued a memorandum on August 10, 2004 regarding bad debts of dual-eligible beneficiaries.[3] In order to meet the requirements for a reasonable collection effort with respect to deductible and coinsurance amounts owed by a dual-eligible beneficiary, the long-standing policy of Medicare is that a provider must bill the patient or entity legally responsible for such debt.[4] The memorandum stated that in, Community Hospital of the Monterey Peninsula v. Thompson, the Ninth Circuit upheld the must bill policy of the Secretary.[5] The memorandum also stated that regarding dual-eligible beneficiaries, section 1905(p) (3) of the Act imposes liability for cost-sharing amounts for QMBs on the states through section 1902(n) (2) that allows the states to limit that amount to the Medicaid rate and essentially pay nothing towards dual-eligible cost-sharing if the Medicaid rate is lower than what Medicare would pay for the service.[6] Where the State owes none or a portion of the dual-eligible deductible and coinsurance amounts, the unpaid liability for the bad debt is not reimbursable until the provider bills the State and the State refuses payment, all of which is demonstrated through a Remittance Advice. The memorandum indicated that, in November 1995, language was added to the PRM at section 1102.3L, which was inconsistent with the must bill policy.[7] The Ninth Circuit panel found that section 1102.3L was inconsistent with the Secretary's must –bill policy and also noted that, effective in August of 1987, Congress had imposed a moratorium on changes in Bad Debt reimbursement policies and therefore the Secretary lacked authority in November of 1995 to effect a change in policy. As a result of the Ninth Circuit decision, CMS changed the language in PRM –II Section 1102.3L to revert back to pre-1995 language, which requires providers to bill the individual States for dual-eligibles' co-pays and deductibles before claiming Medicare bad debts (See Change Request 2796, issued September 12, 2003).

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[3] Joint Signature Mem. 370 (Aug. 10, 2004), Intermediary's Final Position Paper (Oct. 25, 2004), Ex. I-2

[4] Id.

[5] Id., citing 323 F.3d 782

[6] Id.

[7] Id.

The CMS JSM also provided a limited "hold harmless provision." This memorandum served as a directive to hold harmless providers that can demonstrate that they followed the instructions previously laid out at 1102.3L, for open cost reporting periods beginning prior to January 1, 2004. Intermediaries who followed the now-obsolete section 11102.3L instructions for cost reporting periods prior to January 1, 2004 may reimburse providers they service for dual eligible bad debts with respect to unsettled cost reports that were deemed allowed using other documentation in lieu of billing the State. Intermediaries that required the provider to file a State Remittance Advice for cost reporting periods prior to January 1, 2004 may not reopen the provider's cost reports to accept alternative documentation for such cost reporting periods. This hold harmless policy affects only those providers with cost reports that were open as of the date of the issuance of the memorandum relating to cost reporting periods before January 1, 2004 and who relied on the previous language of section 1102.3L in providing documentation.[8]

In fulfilling the requirements of sections 312 and 322 of the PRM, Medicare requires a provider to bill the State and receive a remittance advice that documents the Medicaid status of the beneficiary at the time of service, and the State's liability for unpaid deductibles and coinsurance as determined and verified by the State.[9] Accordingly, section 1102.3L of the PRM, Part II (Exhibit 5 to Form CMS-339)[10] requires the submission of the following documentation:

1. Evidence that the patient is eligible for Medicaid, e.g., Medicaid card or I.D. number
2. Copies of bills for Medicare deductibles and coinsurance that were sent to the State Medicaid Agency.
3. Copies of the remittance advice from the State Medicaid Agency showing the amount of the provider's claim(s) for Medicare deductibles and coinsurance denied.

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[8] Id.

[9] The Secretary's "must bill" policy for dual-eligible beneficiaries has been upheld by the Ninth Circuit Federal Court in the decision of Community Hospital of the Monterey Peninsula v. Thompson, 323 F.3d 782 (9th Cir. 2003). In Community Hospital, the court, rendered its decision on a motion for Summary Judgment in favor of the Secretary, and found that the "must-bill" policy was a reasonable implementation of the reimbursement system and not inconsistent with the statute and regulations. Id.

[10] Rev. 6 (April 2006)(changes originally issued pursuant to a Change Request 2796, issued September 12, 2003).

In this case, the Provider claimed payment for Medicare bad debt for services furnished during FYEs June 30, 2000, and June 30, 2001, for services furnished to dual eligible beneficiaries. The Provider maintained that the Michigan Medicaid program established a Medicaid crossover ceiling. In presenting its claim for Medicare crossover bad debts, the Provider calculated the amount of the Medicare deductibles and coinsurance that it determined Michigan Medicaid would have paid had the Provider billed the State Medicaid program.

After a review of the record and the applicable law and Medicare policy, the Administrator finds that the Provider failed to meet all the regulatory requirements and the Manual guidelines for reimbursement of the subject amounts as Medicare bad debts. The Administrator finds that the State Medicaid program provides for the payment of dual eligible beneficiaries' deductible and coinsurance amounts. Thus, in order to determine the State's liability and, likewise, the amount of coinsurance and deductible attributable to Medicare bad debt, the Provider is required to bill the State for these claims.[11] The Administrator finds that, as the Provider did not bill the State for the claims at issue in this case, it has not demonstrated that it has meet the necessary criteria for Medicare payment of bad debts related to these claims.

The policy requiring a provider to bill the State, where the State is obligated either by statute or under the terms of its plan to pay all, *or any part of* the Medicare deductible or coinsurance amounts, is consistent with the general statutory and regulatory provisions relating specifically to the payment of bad debts and generally to the payment of Medicare reimbursement. As reflected in 42 CFR 413.80(d)(1), the costs of Medicare deductible and coinsurance amounts which remain unpaid may be included in allowable costs. In addition, paragraph (e) of that regulation requires, *inter alia*, a provider to establish that a reasonable collection effort was made and that the debt was actually uncollectible when claimed.

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[11] The Administrator notes that by not billing the State, a provider would be claiming amounts for Medicare bad debts which were not verifiable, actual amounts unpaid. Thus, requiring a Provider to bill the State and generate a verifiable tracking document is a reasonable requirement. See, e.g., Tr. pp. 76-79, discussing how the Provider projected the amount Medicaid allegedly would have paid; how the Intermediary would verify the Provider's claim; and how the Medicaid is paid in Michigan. This testimony demonstrates the complexity of any such calculation and demonstrates the difficulty of determining its accuracy.

A fundamental requirement to demonstrate that an amount is, in fact, unpaid and uncollectible, is to bill the responsible party. Section 310 of the PRM generally requires a provider to issue a bill to the party responsible for the beneficiaries' payment. Section 312 of the PRM, while allowing a provider to deem a dually eligible patient indigent and claim the associated debt, first requires that no other party, including the State Medicaid program is responsible for payment. Section 322 of the PRM addresses the circumstances of dually eligible patients where there is a State payment ceiling. That section states that the "amount that the State does not pay" may be reimbursed as a Medicare bad debt. This language plainly requires that the provider bill the State as a prerequisite of payment of the claim by Medicare as a bad debt. Reading the sections together, the Administrator concludes that, in situations where a State is liable for all or a portion of the deductible and coinsurance amounts, the State is the responsible party and is to be billed in order to establish the amount of bad debts owed under Medicare.

The above policy has been consistently articulated in the final decisions of the Secretary addressing this issue.[12] The final decisions of the Secretary have consistently held that the bad debt regulation and 42 CFR §413.20 require providers to bill the Medicaid programs for payment. These decisions have denied payment when there is no documentation that actual collection efforts were made to obtain payments from the Medicaid authority before an account is considered uncollectible and when the provider did not even attempt to bill the State for its Medicaid patients.

Moreover, the must-bill policy concerning dual-eligible beneficiaries continues to be critical because individual States administer their Medical Assistance programs differently and maintain billing and documentation requirements unique to each State program. For instance, an eligibility category known as a Qualified Medicare Beneficiary (QMB), i.e., a dual eligible, which was enacted by the Medicare Catastrophic Act of 1988 represents individuals who meet the definition in Section 1905(p)(1) of the Social Security Act for Medicaid. All QMBs are Medicare beneficiaries, entitled to the full range of Medicare-covered services and Medicare provider options, without regard to whether those services are covered under the Medicaid State Plan, and are eligible for Medicaid payment of their Medicaid cost-sharing expenses.

Section 1905(p)(3) of the Act imposes liability for cost-sharing amounts for QMBs on the States, though Section 1902(n)(2) allows States to limit that amount to the Medicaid rate and

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[12] *See, e.g.*, California Hospitals Crossover Bad Debts Group Appeal PRRB Dec. No. 2000-D80; *See also* California Hospitals at n.16 (listing cases). To the extent any CMS statements may be interpreted as being inconsistent with the "must bill" policy, such an interpretation would be contrary to the OBRA moratorium.

essentially pay nothing toward dual eligibles' cost-sharing if the Medicaid rate is lower than what Medicare would pay for the service. However, in most cases the State will always be liable to pay for a beneficiary's unpaid deductible amounts. The State maintains the most current and accurate information to determine if the beneficiary is a QMB, at the time of service, and the State's liability for any unpaid QMB deductible and coinsurance amounts through the State's issuance of a remittance advice after being billed by the provider.

Consistent with the statute, regulation and PRM, a provider must bill the State and the State must process the bills or claims to produce a remittance advice for each beneficiary to determine their Medicaid status, at the time of service and the State's liability for unpaid Medicare deductible and coinsurance amounts. Thus, it is unacceptable for a provider to write-off a Medicare bad debt as worthless without first billing the State. Even in cases where the provider has calculated that the State has no liability for outstanding deductible and coinsurance amounts, the provider must bill the State and receive a remittance advice before claiming a bad debt as worthless because, as stated above, the State has the most current and accurate information to make a determination.[13]

The Provider also alleged in its Supplemental Position paper and at hearing that it met the criteria of the CMS JSM hold harmless provision. However, the Provider fails to demonstrate that it met several of the necessary criteria. First, the Notices of the Program

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[13] In addition to verifying the validity of the provider's bad debt, submission of the claim to the State and preservation of the remittance advice is essentially a required record keeping criteria for Medicare reimbursement. Under Section 1815 of the Act, no Medicare payments shall be made to any provider unless it has furnished such information as the Secretary may request in order to determine the amounts due such provider. Consistent with the statute, the regulations require that providers maintain verifiable and supporting documents to justify their requests for payment under Medicare. The regulation at 42 CFR 413.20 provides that: "The principles of cost reimbursement require that providers maintain sufficient financial records and statistical data for provider determination of costs payable under the program.... Essentially the methods of determining costs payable under Medicare involve making use of data available from the institution's basis accounts, as usually maintained...." As used in the context of the regulation at §413.20, "maintain" means that the provider is required to keep records and data throughout the cost year and to then make available those records to the intermediary in order to settle the cost report in the normal course of business. The Provider's failure to submit claims to the State, receive and "maintain" the required remittance advices, and furnish such documents to the Intermediary is contrary to this principle.

Reimbursement for the cost reporting periods at issue were respectively dated September 13, 2002 (FYE June 30, 2000) and September 12, 2003 (FYE June 30, 2001) and, thus, were not open at the time of the issuance of the CMS JSM in August 10, 2004. The hold harmless provision set forth in the CMS JSM on August 10, 2004, is specifically limited to "*open* cost reporting periods beginning prior to January 1, 2004." Second, the Provider did not demonstrate that the Intermediary had followed the now-obsolete Section 1102.3L instructions. The Provider points to certain ambiguous language in the audit papers, but does not show the intermediary's reliance on section 1102.3L through the actual payment of dual eligibles' bad debt based on alternative documentation. Third, the Provider did not demonstrate that it had relied on the now obsolete language in providing documentation. For example, the Intermediary workpapers show a note that states "No Medicaid RA or acct history showing reason Medicaid not billed." Thus, the record does not show that the Provider relied on section 1102.3L in filing its claim as supported by the contemporaneous submission of alternative documentation[14] and does not demonstrate that it met the hold harmless provision of the CMS JSM.[15]

In light of the foregoing, the Administrator finds that the Board's decision is incorrect. The Provider had not demonstrated that the bad debts claimed by the Provider were actually uncollectible and worthless when written off on the FYEs 2000 and 2001 cost reports. The Provider did not bill the State and receive a remittance advice as needed to meet the reasonable collection effort requirements of the regulation and manual provisions for the claims at issue in this case.

Moreover, the Administrator finds that the claims at issue appear to be related to Part B claims paid on a charge basis.[16] The Medicare program does not pay the bad debts of beneficiaries relating to services paid on a charge or fee schedule basis. 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

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[14] See ,e.g., Provider Exhibit P-V of Provider's Final Position Paper.

[15] The Provider also did not pursue any claim that its debts were allowable under any interpretation of the OBRA moratorium on bad debts.

[16] See, e.g., Transcript of Oral Hearing (Tr.) pp. 23 (Provider Representative stated that: "The payment at issue is Medicare Part B payment, Outpatient services."); Tr. at 35; Tr. 53-54, (Intermediary Representative stated that: "The beneficiary received services that were covered under Part B. In the main, they would be provided on an outpatient basis and an inpatient basis but billed through Part B and adjudicated as if they were outpatient claims.")

amendments required certain Part B services to be paid under a fee schedule,[17] physician services continued to be paid based on reasonable charge principles throughout the first 25 years of the program. As Medicare Part B payments were not based on "reasonable cost", but rather were based on the reasonable charge or 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 debts by the Medicare program when payment was made by a reasonable charge or fee schedule methodology.

As part of the Omnibus Reconciliation Act (OBRA) of 1989,[18] 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.[19] 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. 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.[20] Among other things, practice expense RVUs were computed by applying historical practice costs percentages to a base allowed charge for each service. Once again, the fee schedules did not provide for reimbursement of bad

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

[18] Pub. Law 101-239.

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

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

debts associated with unpaid coinsurances and deductibles, reflecting the charge-based nature of the payment. The payment for Part B medical and other health services was implemented in regulation at 42 CFR Part 414 (2000), while subpart B of Part 414 addresses physician and other practitioners.

Congress subsequently changed the payment methodology for outpatient services. Section 4541 of the Balanced Budget Act, which added a new section 1833(a)(8) of the Act[21] to specify that the amounts payable for outpatient rehabilitation services will be the amounts determined under section 1834(k) of the Act.[22] Section 4541 of BBA 1997 added the new section 1834(k) to the Act which addresses payment for outpatient rehabilitation services for services furnished on or after January 1, 1999. Section 1834(k)(1)(B) of the Act provides for payment for those services to be made at 80 percent of the lesser of: (1) the actual charge for the services; or (2) the applicable fee schedule. Section 1834(k)(3) defines the applicable fee schedule amount as the amount determined under the physician fee schedule, or, if there is no such fee schedule established for those services, the amount determined under the fee schedule established for comparable services as specified by the Secretary. The Secretary explained that at the time of the enactment:

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[21] Section 1833(a)(8) provides that: "in the case of— (A) outpatient physical therapy services (which includes outpatient speech-language pathology services) and outpatient occupational therapy services furnished— (i) by a rehabilitation agency, public health agency, clinic, comprehensive outpatient rehabilitation facility, or skilled nursing facility, *** (B) outpatient physical therapy services (which includes outpatient speech-language pathology services) and outpatient occupational therapy services furnished— *** (ii) by another entity under an arrangement with a hospital described in clause (i), the amounts described in section 1834(k) of the Act." (Emphasis added.)

[22] In particular, §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— …. (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." (Emphasis added.)

> The physician fee schedule is currently applied to certain outpatient rehabilitation therapy services. It is now the basis of payment for outpatient rehabilitation services furnished by [physical therapist in independent practice] and [occupational therapists in independent practice], physicians, and certain nonphysician practitioners or incident to the services of such physicians or nonphysician practitioners. The physician fee schedule has been the method of payment for outpatient rehabilitation therapy services provided by such entities for several years. Fee schedule payment will now apply when outpatient physical therapy, occupational therapy, and speech language pathology services are furnished by rehabilitation agencies…, SNFs, …hospitals (when such services are provided to an outpatient or to a hospital inpatient who is entitled to benefits under Part A but who has exhausted benefits or is not entitled)….[23] (Emphasis added.)

Consequently, for the cost years in issue, the outpatient Part B services are paid pursuant to a charge or fee schedule for which no Medicare bad debts are paid.[24]

The Medicare program's longstanding policy has been not to pay for bad debts for any services paid under a reasonable charge or fee schedule methodology. Unlike a reasonable cost payment, payment under a fee schedule or charge is not related to a provider's cost outlay for the service and does not involve costs or, likewise, un-recovered "costs." Under a fee schedule or charge basis, Medicare makes payment for a specific service for which there is a predetermined rate which includes a margin for profit and which reflects the price of doing business.[25] As the bad debt provision specifically arises from the reasonable "cost" anti-cross-subsidization provisions, it is not applicable to the reasonable charge/fee schedule methodology set forth in other sections of the Act. Thus, the bad debt provisions found at 42

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[23] 63 Fed Reg. 30818, 30856-57. (Proposed Rule, Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 1999 (June 5, 1998))

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

[25] Generally accepted accounting practices (GAAP) define bad debt expense as an appropriate cost of doing business and, thus, there is presumption that bad debts are implicitly included in such a determination.

CFR 413.80(e), do not apply to services for which Medicare payment is based on reasonable charges or a fee schedule methodology.[26]

The Secretary also explained in a 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."[27] The preamble explained that:

> The concept of Medicare bad debt payments applies only to services reimbursed on the basis of reasonable costs. Medicare has never made payments to account for bad debts for services paid under a fee schedule or reasonable charge methodology, such as services of physicians or suppliers. Under a fee schedule or reasonable charge methodology, Medicare reimbursement is not based on costs and therefore the concept of unrecovered costs is not relevant. Fee schedules which are either charge based or resource-based, relate payments to the price the entity charges. Historically, these prices have reflected the entities costs of doing business including expenses such as bad debt.[28]

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

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

[27] 68 Fed. Reg. 6682 (Feb 10, 2003).

[28] 68 Fed. Reg. 6683.

> 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.[29]

The Secretary explained in the proposed rule that 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.

The Secretary finalized the amendment to the regulations in 2006, as proposed in the February 10, 2003 pronouncement, to clarify that payment of bad debts for covered services paid for under a reasonable charge-based methodology or a fee schedule is not allowable. In response to a commenter that argued that this was a change in policy, the Secretary noted the historical basis for the bad debt policy, stating that:

> During the initial stages of developing the Medicare program in 1966, the issue of "bad debt" arose but was not mentioned explicitly in the statute. However, at that time, based on the intent of the anti-cross-subsidization principle found in the definition of "reasonable cost" at section 1861(v)(1)(A) of the Act, Medicare adopted the policy to pay for the unrecovered costs attributable to uncollectible deductible and coinsurance of Medicare beneficiaries. Accordingly, we believe that this statutory prohibition on cross-subsidization does not apply where services are reimbursed on anything other than the basis of "reasonable costs." [30]

The Secretary again concluded, with respect to payments made pursuant to a fee schedule or reasonable charge methodlogy, that:

> The Medicare program has never allowed payment of bad debts for services paid for on the basis of a fee schedule or reasonable charge methodology.... Under a fee schedule or reasonable charge methodology, Medicare does not share proportionately in an entity's incurred costs but rather makes payment

[29] 68 Fed. Reg. 6685.
[30] 71 Fed. Reg. 69624, 69713 (Dec. 1, 2006).

> for a specific service. The payment is not related to the cost of a service and, thus, does not embody the concept of unrecovered costs due to uncollected amounts of deductibles and coinsurance. Thus, payment of bad debt applies only to services reimbursed on the basis of reasonable cost or to services paid under one of Medicare's prospective payment systems that have a basis in reasonable costs that do not reflect Medicare payment of bad debts during a specified provider base period. Accordingly, when outpatient therapy services began to be paid for on a fee schedule methodology, payment of bad debts associated with these services was no longer available. Therefore, we do not agree with the commenter and we are revising § 413.89(i) and adding new § 413.178(d) as proposed.[31]

In addition, the Administrator notes that Congress also acknowledged the Secretary's proposed rule on "Provider Bad Debt" in enacting its reduction in payments of SNF bad debts under the Deficit Reduction Act (DRA) of 2005.[32] The related conference agreement stated, with respect to "Current Law" on bad debt, that:

> Medicare pays for the costs of certain items outside of the prospective payment system on a reasonable cost basis. Section 1861(v)(1)(A)(I) of the Social Security Act states that the costs for individuals as covered by the Medicare program must not be borne by individuals not covered by the program, and the costs for individuals not covered by the program must not be borne by Medicare. Under this authority the Secretary adopted a bad debt policy in 1966. Under this policy, Medicare reimburses certain providers for debt unpaid by beneficiaries for coinsurance and deductibles. Historically CMS has reimbursed certain providers for 100 percent of this bad debt. SNFs are among the Medicare entities that are currently being reimbursed for 100 percent of beneficiary bad debt.

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[31] Id.

[32] Pub. Law 109-171. Section 5004 of DRA amended section 1861(v)(1) of the Social Security Act to state: "(V) In determining such reasonable costs for skilled nursing facilities with respect to cost reporting periods beginning on or after October 1, 2005, the amount of bad debts otherwise treated as allowed costs which are attributable to the coinsurances amounts under his title for individuals entitled to benefits under part A and ---(i) are not described in section 1935(c)(6)(A)(ii) shall be reduced by 30 percent of such amount otherwise allowable; and (ii) are described in such section shall not be reduced." (Emphasis added.)

> 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.[33] (Emphasis added.)

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

Consequently, in the alternative, the Administrator finds that the bad debts in this case are also properly denied on the basis that they are related to Part B charge based claims and, thus, are not an allowable reasonable cost under 42 CFR 413.80, *et seq*..

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

DECISION

In accordance with the foregoing opinion, the decision of the Board is reversed as to Issue No. 1.

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

Date: **10/14/08** **/s/**
Herb B. Kuhn
Deputy Administrator
Centers for Medicare & Medicaid Services

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