CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	**Claim for:**
Lakeland Regional Medical Center **Provider** **vs.** **BlueCross BlueShield Association/ National Government Services** **Intermediary**	**Provider Reimbursement Determination for Cost Reporting Period Ending: 09/30/2005** **Review of:** **PRRB Dec. No. 2012-D3** **Dated: December 14, 2011**

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 set forth in §1878(f) (l) of the Social Security Act (Act), as amended, 42 U.S.c. §139500 (f)). The parties were notified of the Administrator's intention to review the Board's decision. CMS' Center for Medicare (CM) requested reversal of the Board's decision. The Provider submitted comments requesting affirmation of the PRRB decision. Accordingly, this case is now before the Administrator for final administrative review.

ISSUE AND THE BOARD'S DECISION

The issue is whether the Intermediary's adjustment of the Provider's Medicare bad debts because they were written off while they remained at an outside collection agency, was proper.[1]

[1] The Intermediary disallowed the Medicare bad debts that had been referred to an outside collection agency. The total amount of the disallowance was $434,785 consisting of $218,557 inpatient bad debts and $216, 228 in outpatient bad debts. The percentage of bad debts allowable in FYE 9/30/05 was 70 percent and, therefore, the reimbursement impact of the issue was $304,350.

The Board held that the Intermediary improperly disallowed the Provider's Medicare bad debts in this case. The Board found that that Provider properly claimed uncollected Medicare accounts as bad debts even though those accounts were still held at a collection agency. The Board determined that the Provider had a bad debt policy and procedure wherein the Provider utilized in-house collection efforts, together with external referral of accounts to an outside collection agency. If the Provider determined that the account was uncollectible after completion of the in-house collection efforts, the Provider wrote-off the uncollected amount as a bad debt, but still referred the account to an outside collection agency where it remained unless eventually collected.

The Board noted the Intermediary's argument that the referral to the outside collection agency had the affect of extending the collection effort and, thus, is inconsistent with a determination of worthlessness and potential recovery. The Board concluded that, this view was irreconcilable with the Provider Reimbursement Manual, (which allows the write-off of uncollected accounts after 120 days as bad debts, and then still referring those accounts to an outside collection agency, is allowed by and is consistent with Medicare law and policy. The Board also only found a nonbinding Medicare Intermediary Manual instruction issued in June 2008. The Board disagreed that the "active status of an account was automatic confirmation of the value or collectibility The Board referred to the decision of the District Court of the District of Columbia in *Foothill Hospital-Morris L. Johnston Memorial v. Leavitt*[2] in support of its decision. The Board also found that CMS' policy applying the presumption of collectability to any bad debt held at an outside collection agency violates the Bad Debt Moratorium in this case.[3]

SUMMARY OF COMMENTS

CM submitted comments, requesting reversal of the Board's decision. CM noted that the Administrator has reversed the Board's decision in several similar, prior cases, and that two were ultimately affirmed by the courts. CM argued that the Provider has incorrectly written-off the accounts as bad debts even though collection activities at an outside collection agency were engaged for such

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[2] *Foothill Hospital vs. Leavitt* 558 F.Supp. 2d 1 (D.D.C. 2008).

[3] Omnibus Budget Reconciliation Act of 1987, Pub.L. No. 100-203, § 4008(c), 101 Stat. 1330-55, as amended by the Technical Miscellaneous Revenue Act of 1988, Pub.L. No. 100-647, § 8402, 102 Stat. 3798, and as further amended by the Omnibus Budget Reconciliation Act of 1989, Pub.L. No. 101-239, § 6023,103 Stat. 2176 (*reprinted in* 42 U.S.C. §1395f).

accounts. CM noted that when the criteria set forth at 42 C.P.R. §413.89(e) and the guidance set forth at the PRM are holistically read, the claimed bad debts in this case have not met the regulatory criteria as to be properly reimbursed under the program. CM asserted that in this case, it may appear that the Provider has met the criteria for reimbursement of the claimed bad debts, however, allowing the Provider's bad debts would be erroneously permitting the Provider to select which of the four bad debt criteria with which it will comply. As noted above, CM stated, in support of its arguments, that the reversal of the Board's decision is consistent with two district court decisions.[4]

Moreover, CM argued that longstanding policy under the Medicare program requires that Providers meet the criteria set forth at 42 C.P.R. §413.89 and the guidance at Chapter 3 of the PRM. The intent of Medicare has always been that §310.2 of the PRM be read consistently with the regulatory criteria as well as the guidance set forth in §§308 and 310 of the PRM. Under the Medicare program, a reasonable collection effort is not completed until the entire collection effort of the Provider has ceased. A reasonable collection effort, as described in the regulatory provision and the manual provisions, provides for providers to perform their collection effort either in-house or with the assistance of an outside collection agency or both as long as the collection effort is similar as among Medicare and non-Medicare beneficiaries or patients. In this case, the Provider performed its collection effort on an internal basis for at least 120 days. As such, section 310.2 of the PRM would permit this Provider to cease collection efforts and deem the account as uncollectible. However, the Provider in this case, selected to continue its collection efforts after this timeframe. CM maintained that the provision at section 310.2 never intended a provider to claim an account as uncollectible or worthless on the cost report and then continue collection efforts, whether on an internal or external basis, when there is a chance of recovery.

CM noted that the regulatory provision at 42 C.P.R. §413.89(e)(3) requires that for the uncollected accounts to be claimed as bad debts they must be deemed worthless. Further, the regulatory provision at 42 C.F.R. §413.89(e) (4) means a zero percent chance of recovery on accounts in the future. In this case, the Provider claimed that there is a four to six percent chance of recovery if collection efforts at an outside collection agency are continued. Thus, the debts in this case are not worthless. Under the Medicare program, the Provider can only claim the accounts as Medicare bad debts, once both the in-house and the external collection efforts have ceased. CM also maintained that the Board incorrectly found that CMS'

[4] *Battle Creek Health Systems v. Thompson*, 2006 WL 839146 (W.D. Mich. Mar. 30, 2006), affd. 498 P.3d 401 (6th Cir. 2007); Mesquite Community Hospital v. Leavitt, 2008 WL 4148970 (N.D. Tex. Sept. 5,2008).

policy of applying a "presumption of collectability" to any accounts held at an outside collection agency is in violation of the Bad Debt Moratorium. CM stated that, contrary to the court's decision in Foothill[5], the longstanding policy of the Medicare program does not allow the Provider to deem an account as uncollectible until the entire collection effort has ceased. Finally, CM noted that, to the extent, the $216,228 in outpatient bad debts, involves Part B, no bad debts are permissible.

The Provider commented, requesting affirmation of the Board's decision. The Provider argued that the Board correctly held that bad debts can be considered uncollectible even if they are still at a collection agency. The Provider disagreed with CM's argument that Medicare's longstanding interpretation is that bad debts cannot be claimed it the bad debts have been referred to an outside collection agency. The Provider asserted that the historical documents submitted as exhibits by CM do not support CM's contentions. Further, the Provider argued that CM's argument regarding the Bad Debt Moratorium is contrary to the ruling of the district court in Foothill.[6]

Moreover, the Provider stated that CM's comments, regarding whether certain bad debts related to services paid under a fee schedule, should be rejected. The Provider argued that the evidence in the record shows that the bad debts at issue were not related to services paid under a fee schedule, and that the Intermediary entered into a stipulation. In addition, the Provider asserted that it is improper for CM to raise a new factual issue at this point in the PRRB process. The Provider also noted that the affidavits attached to its comments establish that the outpatient bad debts at issue were not related to services paid under a fee schedule. In particular, the Provider noted that it entered into a contract with Ernst and Young LLP to conduct an in-depth review of the Medicare bad debts and to determine the amount of allowable bad debts that could be claimed on the cost report. As the affidavits show, in preparing the bad debt listing, Medicare rules were followed and any bad debts related to services paid under a fee schedule were excluded.

Finally, the Provider argued that if the Administrator decides to consider this issue, the Administrator should reject CM's concern based on the record, the Intermediary's stipulation and the affidavits submitted by the Provider. Otherwise, the Administrator should remand the case to the PRRB for further proceedings on this issue.

DISCUSSION

[5] 558 F.Supp. 2d 1 (D.D.C. 2008).
[6] *Id.*

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.

Section 1861 (v)(1)(A) of the Social Security Act requires that providers of services to Medicare beneficiaries are to be reimbursed the reasonable cost of those services. Reasonable cost is defined as the "cost actually incurred, excluding there from part of the incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included ..." Id. This component of Medicare law and policy does not specifically address the determination of reasonable cost, but authorizes the Secretary to promulgate regulations and principles to be applied in determining reasonable costs. One of the underlying principles set forth in the Act is that Medicare shall not pay for costs incurred by non-Medicare beneficiaries, and vice-versa. Medicare prohibits cross-subsidization of costs. These reasonable cost principles are reflected and further explained in the regulations. The regulations at 42 C.F.R. §413.9(c) provides that the determination of reasonable cost must be based on costs related to the care of Medicare beneficiaries.

In addition section l8l5(a) of the Act states:

> (a) The Secretary shall periodically determine the amount which should be paid under this part to each provider of services with respect to the services furnished by it, and the provider of services shall be paid, at such time or times as the Secretary believes appropriate..., from the Federal Hospital Insurance Trust Fund, the amounts so determined, with necessary adjustments on account of previously made overpayments or underpayments; except that no such 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 under this part for the period with respect to which the amounts are being paid or any prior period.

Consistent with section l8l5(a) of the Social Security Act, the Secretary has implemented a number of Medicare documentation regulations, including those at 42 CPR §§413.9, 413.20 and 413.24, which require, *inter alia,* that a provider furnish

contemporaneous, auditable, and verifiable documentation in support of a claim for payment.[7]

Relevant to this case, the regulation at 42 C.F.R. §413.89(a) specifically provides that bad debts are reductions in revenues and are not included in allowable costs.[8] However, the regulatory provision at 42 C.F.R. §413.89(a) further provides that bad debts attributable to the deductible and coinsurance amounts of Medicare beneficiaries are reimbursed under the Medicare program.

Generally, bad debts are defined at 42 C.F.R. §413.89(b) (1) as "Amounts considered to be uncollectible from accounts and notes receivable that were created or acquired in providing services." Furthermore, "Accounts receivable" and "notes receivable" are designations for claims arising from the furnishing of services, and are collectible in money in the relatively near future. The regulatory provision at 42 CFR § 413.89(d) states that payment for deductibles and coinsurance amounts are the responsibility of the beneficiaries. However, recognizing the reasonable costs principle at Section 1861 (v)(1)(A) of the Act which prohibits cross subsidization, the regulation at 42 CFR 413.89 states that the inability of providers to collect deductibles and coinsurance amounts from the Medicare beneficiaries could result in part of the costs of Medicare covered services being borne by individuals who are not beneficiaries. Therefore, to prevent such cross-subsidization, Medicare reimburses providers for allowable bad debts. Consequently, providers may receive reimbursement for Medicare bad debt, if they meet all of the criteria set forth in 42 C.F.R. §413.89(e).

> A bad debt must meet the following criteria to be allowable:
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> 1) The debt must be related to covered services and derived from deductible and coinsurance amounts.
> 2) The provider must be able to establish that reasonable collection efforts were made.
> 3) The debt was actually uncollectible when claimed as worthless.
> 4) Sound business judgment established that there was no likelihood of recovery at any time in the future.[9] (Emphasis added).

In addition, 42 CFR 413.89(f) provides that:

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[7] The Administrative Procedure Act provides that the proponent of any action has the burden of proof. 5 U.S.c. §556(d).
[8] Formerly designated as 42 C.F.R. §413.80.
[9] *See also* Section 308 of the PRM.

> (f) Charging of bad debts and bad debt recoveries. The amounts uncollectible from specific beneficiaries are to be charged off as bad debts in the accounting period in which the accounts are deemed to be worthless. In some cases an amount previously written off as a bad debt and allocated to the program may be recovered in a subsequent accounting period; in such cases the income therefrom must be used to reduce the cost of beneficiary services for the period in which the collection is made. (Emphasis added.)

The Provider Reimbursement Manual (PRM) provides guidance in implementing the regulations. Relevant to the issue in this case, Section 310 of the Manual states:

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

Section 310.A of the Manual further explains:

> A provider's collection effort may include the use of a collection agency in addition to or in lieu of subsequent billings, follow-up letters, telephone and personal contacts. Where a collection agency is used, Medicare expects the provider to refer all uncollected patient charges of like amount to the agency without regard to class of patient. The "like amount" requirement may include uncollected charges above a specified minimum amount. Therefore, if a provider refers to a collection agency its uncollected non-Medicare patient charges, which in amount are comparable to the individual Medicare deductible and coinsurance amounts due the provider from its Medicare patient, Medicare requires the provider to also refer its uncollected Medicare deductible and coinsurance amounts to the collection agency. Where a collection agency is used, the agency's practice may include using or threatening to use court action to obtain payment.

A provider is required to demonstrate that it has completed collection efforts for comparable Medicare and non-Medicare accounts, including outside collection, before claiming Medicare debts as worthless. The PRM basically reflects the view that a means of measuring the reasonableness of a hospital's efforts to collect Medicare accounts is to compare them to what the hospital does when its own money, rather than the government's is at stake. The foregoing similar collection effort requirement is separate from section 310.2 ofthe PRM, which provides that:

> If after reasonable and customary attempts to collect a bill, the debt remains unpaid more than 120 days from the date the first bill is mailed to the beneficiary, the debt may be deemed uncollectible.

Section 314 explains the accounting period for bad debts and states that:

> Uncollectible deductibles and coinsurance amounts are recognized as allowable bad debts in the reporting period in which the debts are determined to be worthless. Allowable bad debts must be related to specific amounts which have been determined to be uncollectible. Since bad debts are uncollectible accounts receivable and notes receivable, the provider should have the usual accounts receivable records-ledger cards and source documents to support its claim for a bad debt for each account included. Examples of the types of information to be retained may include, but are not limited to, the beneficiary's name and health insurance number; admission/discharge dates for Part A bills and dates of services for Part B bills; date of bills; date of write-off; and a breakdown of the uncollectible amount by deductible and coinsurance amounts. This proposed list is illustrative and not obligatory. (Emphasis added.)

Section 316.also explains the treatment of the recovery of bad debts stating that:

> Amounts included in allowable bad debts in a prior period might be recovered in a later reporting period. Treatment of such recoveries under the program is designed to achieve the same effect upon reimbursement as in the case where the amount was uncollectible. Where the provider was reimbursed by the program for bad debts for the reporting period in which the amount recovered was included in allowable bad debts, reimbursable costs in the period of recovery are reduced by the amounts recovered. However, such reductions in reimbursable costs should not exceed the bad debts reimbursed for the applicable prior period. Where the provider was not reimbursed by the program for bad debts for the reporting period in which the amount recovered was included in allowable bad debts, reimbursable costs in the period of recovery are not reduced.

Consistent with the Act, the Secretary has also issued guidelines for intermediaries to follow when auditing cost reports. The Intermediary Manual (CMS Pub 13-4) explains that Medicare bad debts for deductible and coinsurance are reimbursed as a pass-through cost. Since they have a direct dollar for dollar effect on

reimbursement, there is an incentive to claim bad debts before they become worthless. The Intermediary Manual (Pub 13-4) provides audit instructions for both IPPS and TEFRA audits set forth at sections 4198 and 4199 provide that:

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

In sum, at the close of each fiscal year, the provider prepares a report showing its costs and the percentage of those costs allocated to Medicare services. The provider, after using reasonable collection efforts, may claim Medicare bad debts in the cost report during "the accounting period in which the accounts are deemed to be worthless." The cost report serves as the basis for the provider's total allowable Medicare reimbursement. The provider files the report with a fiscal intermediary under contract with the Secretary. The intermediary audits certain aspects of the cost report (which may vary year to year on focus and detail of audit) and issues a written "notice of program reimbursement" which determines the total amount reimbursable payable to the provider for Medicare services during the reporting period. 42 C.F.R. §405.l803.

Relevant to certain Medicare bad debt claims, section 4008(c) of the Omnibus Reconciliation Act of 1987 (OBRA),[10] as amended by the section 8402 of the Technical and Miscellaneous Revenue Act of 1988, and section 6023 of OBRA 1989 imposed a "moratorium" on changes to the Medicare bad debt policy in effect on august 1, 1987, as applied to hospitals. Specifically, the moratorium states, in part:

> In making payments to hospitals under [the Medicare Program], the Secretary of Health and Human Services shall not make any change in the policy in effect on August 1, 1987, with respect to payment under [the Medicare program] to providers of service for reasonable costs relating to unrecovered costs associated with unpaid deductible and coinsurance amounts incurred under [the Medicare program] (including criteria for what constitutes a reasonable collection effort, including criteria for indigency determination procedures, for record keeping, and for determining whether to refer a claim to an external collection agency).

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[10] *See* Pub. L. No. 100-203.

> The Secretary may not require a hospital to change its bad debt collection policy if a fiscal intermediary, in accordance with the rules in effect as of august 1, 1987, with respect to criteria for indigency determination procedures, record keeping, and determining whether to refer a claim to an external collection agency, has accepted such policy before that date, and the Secretary may not collect from the hospital on the basis of an expectation of a change in the hospital's collection policy.

In addition, the Conference Report accompanying the 1988 legislative amendment states, "the conferees do not intend to preclude the Secretary from disallowing bad debt payments based on the regulations, PRRB decisions, manuals, and issuances in effect prior to August 1, 1987."

CMS issued additional guidance, by a Joint Signature Memorandum dated May 2, 2009, to clarify longstanding policy concerning reimbursement for a Medicare bad debt while the account is at a collection agency. As a result of this instruction, Medicare contractors are required to disallow Medicare bad debts for accounts at a collection agency where the contractor may heretofore have allowed those bad debts in the past based at least in part on interpretation of language contained in the OBRA 1987. The guidance again emphasized that the longstanding policy of Medicare is that accounts in no case I an unpaid Medicare account that is "in collection", including a collection agency, an allowable bad debt under the regulations. To the extent any Intermediary might have allowed Medicare bad debts for an account at a collection agency, then the application of the policy was not in accordance with the "rules in effect" as of August 1,1987."[11]

In this case, the issue is whether the intermediary properly denied reimbursement for unpaid Medicare beneficiaries' coinsurance and deductible amounts claimed after 120 days from the date the first bill was mailed but which were still remaining at an outside collection agency. The Administrator recognizes that section 310.2 of the PRM permits a debt unpaid for more than 120 days from the date the first bill is

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[11] This issuance was also in response to a May 2, 1990 CMS memorandum clarifying bad debt policy related to accounts at a collection agency. The memorandum properly articulated Medicare longstanding policy that when an account is in collection, a provider cannot have determined the debt to be collectible and cannot have established that there is no likelihood of recovery. However, in light of the Moratorium, the memorandum erroneously stated that it may have been reasonable for an intermediary to interpret that such claims were allowable prior to 1987. That analysis failed to consider that such an interpretation would not have been in accord with the rules in effect as of August 1, 1987.

mailed to the beneficiary to be deemed uncollectible. However, the Administrator notes that the language of that section implies discretionary rather than mandatory application of the presumption, i.e., the debt "may" rather than "shall" be deemed uncollectible. More importantly, that provision must be read consistent with the regulation and manual provisions and thus cannot absolve the Provider from meeting the general regulatory reasonable collection requirements or the specific reasonable collection requirements in the PRM. To meet the requirements embodied at 42 C.F.R. §413.89(e)(2) through (4), a provider must engage in a reasonable collection effort and must demonstrate that the debts were uncollectible when claimed as worthless and that sound business judgment evidences no likelihood of recovery at any point in the future. CMS policy has reasonably held that when a provider sends uncollected amounts to a collection agency, the provider cannot establish reasonable collection efforts have been made, the debt was actually uncollectible when claimed as worthless and that there is no likelihood of recovery.

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

The Administrator also notes that section 316 of PRM provides only an instruction, in the event that a Medicare bad debt is subsequently recovered, for reporting such revenue and its reimbursement effect. This is a provision to prevent double dipping by the Provider at the expense of the Program. The Administrator finds that the language ofthe manual section in no way infers that the Medicare program expects or even anticipates, providers to continue to pursue collection activities after claiming Medicare bad debts on their cost reports. The fact a debt recovered will be offset does not replace the reasonable collection effort requirement. If a provider deems a debt uncollectible after reasonable collection efforts, and, thus worthless, a provider would not be expected to pursue further collection activities. However, if a provider does continue to pursue collection activities, clearly it does not believe the debt to be worthless. The Board suggested this provision makes harmless any premature claiming of unpaid amounts as bad debts, as later collected amounts are offset. However, once the debt is allowed there is no longer any incentive to continue to make collection efforts. Consequently, the Administrator concludes that, under longstanding Medicare law and policy, if a Provider continues collection efforts at an outside collection agency, then the Provider has not complied with the

regulatory criteria set forth at 42 C.F.R. §413.89(e)(3) and (4) and the provisions of Chapter 3 of the PRM.

The Administrator also finds that Bad Debt Moratorium is not applicable in this case. First, CMS has always required that a provider demonstrate that its collection efforts were reasonable and, has always maintained that a debt must be actually uncollectible (that is, not at a collection agency) when claimed as worthless and sound business judgment establishes there is no likelihood of recovery. CMS has also always required similar treatment between unpaid Medicare and non-Medicare claims and that if a provider sends unpaid non-Medicare debts to a collection agency, it must send Medicare unpaid coinsurance and deductibles of comparable amounts. In such instances, the Medicare unpaid amounts may not be claimed until collection activity has ceased for both the Medicare and comparable non Medicare amounts.[12] Thus, inherent in that requirement is that the bad debts cannot be claimed until collection efforts have ceased for all comparable amounts, for both Medicare and non-Medicare. To suggest that, as long as a provider conforms to this requirement of initially sending both Medicare and non-Medicare accounts to collection agency, it can immediately claim the Medicare debts while collection activities continue nullifies the effects, intent and purpose of section 310.A.[13] It would be meaningless to require similar treatment, while concurrently allowing the provider to write off the unpaid coinsurance and deductibles, while the accounts are still at the collection agency.[14] Thus, the issue presented in this case is a logical result of applying the longstanding policy set forth in section 310.A of the PRM.[15]

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[12] For example, in *Humana Hospital,* PRRB Dec. No 92-D41 (FYE 1987), the Administrator reversed the Board's bad debt allowance, where the provider had claimed bad debts at 120 days, sent all bad debts at first to a collection agency but later only had the Medicare debts returned and non-Medicare bad debts sent to a second collection agency. *University Hospital,* PRRB Dec. No. 95-D43 (FYE 1987)*; Hennepin County Medical Center,* PRRB Dec. No. 93-D83 (FYE 12/31/1987).

[13] As the court recognized in *University Health Service* v. *Shalala,* 120 F 3rd 1145 (11th Cir. 1997), the 120 day presumption language of section 310.2, "does not come into effect unless the provider has complied with PRM section 310 in treating identically all Medicare and non-Medicare accounts *and has ceased collection efforts* with regard to all accounts after 120 days." (Emphasis added.)

[14] The provider in *El Centro Regional Medical Center* v. *Leavitt,* Case No. 07cv 1182 WQH (PCL), (S.D. Cal Nov. 24, 2008), also recognized this relationship when it argued:"Plaintiff asserts that the Secretary's requirement that non-Medicare bad debts must be returned from a collection agency in order for the provider to obtain reimbursement for its Medicare bad debts is contrary to the law, regulations,

The Administrator respectfully disagrees with the Foothill court's conclusion that the Intermediary Manual (Pub 13-4), which provides audit instructions for both IPPS and TEFRA audits at sections 4198 and 4199, set forth only new policy. Rather those sections articulated new and existing policy, the latter being the statement that bad debts at a collection agency can be "claimed as a Medicare bad debt only after the collection agency completes its collection effort." The Administrator respectfully points out that the Foothill court's reliance on this specific Trans No. 28 language issuing section 4198 of the Medicare Intermediary Manual ignores other language in the same transmittal that has the same language applicable to the same pass through issue presented in TEFRA cost reports as audit priorities and identified these as "the most significant and recurring issues" It was also left unchanged that the TEFRA provisions were applicable to the first year TEFRA cost reporting period 1983.[16]

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and Manual provisions that govern Medicare reimbursement. Plaintiff further asserts that if the Secretary's intent is that the adjudication in this case be considered part of an ongoing policy that Medicare bad debts can never be recovered when comparable non-Medicare bad debts remain at an outside collection agency, the decision is invalid as a violation of the notice and comment requirements of the Administrative Procedure Act and the Medicare program."

[15] To the extent that the Administrator decision in *Lourdes Hospital* (PRRB Dec Nos. 95-D58, 95-D59, 95-D60) or any other final decision expressed policy that deviated from the existing policy stated above, it was erroneous and contrary to the moratorium and the rules in effect on August 1, 1987. In *Lourdes,* the provider explained, that during the periods under appeal collection efforts ceased and the claims at issue were never in fact collected; "[t]herefore" even if the Board adopts the Intermediary's interpretation of the manual instruction, the provider argues that it should be reimbursed its costs in the subsequent cost reporting period for those Medicare debts which were never collected" In essence, the provider was arguing that if a revised bad debt list were provided applying the rules in effect the amounts would have been allowable in the periods being jointly appealed. The Intermediary, inter alia, also used a ratio method, (because of the lack of accurate provider data on recoveries), that estimated the recovery amounts to be applied and resulted in higher amounts being offset, in certain instances, than the amount originally claimed on the cost report and as it also included the amounts disallowed.

[16] Notably, the TEFRA bad debts audit guidelines are identical to the IPPS bad debt pass through reasonable cost audit guidelines and the transmittal states "Section 4199, TEFRA Review Guidelines—Various exhibits are updated or clarified in accordance with reimbursement principles. Audit in accordance with the quality standards in section 4112." Section 4117 in addressing TEFRA Review Guidelines,

In addition, to invoke a further analysis under the moratorium criteria, a provider must demonstrate that its policy and practice was to claim payment for these same types of bad debts and that prior to August 1, 1987, the intermediary had in fact known of and accepted that policy. This must be done consistent with Medicare documentation rules, which requires verifiable, auditable documentation contemporaneous with the pre-1987 conduct. Hence, declarations or testimony, alone, of the hospital's bad debts policy/practice and the intermediary's alleged acceptance therein, would not be sufficient evidence to support a further analysis of whether the moratorium applies.

The Administrator finds the record in this case lacks documentary evidence to support: 1) the provider's past policy and practice; and 2) an intermediary's acceptance of that past policy. Past cases that were decided on the moratorium issue relied upon extensive documentary evidence provided by pre-August 1, 1987 contemporaneous hospital bad debt policy manuals, pre-august 1, 1987 dated notices of program reimbursements, audit adjustments and evidence of the degree of the intermediary's "investigation and audit" of cost reports prior to August 1, 1987. In this instance, there is no pre-1987 documentary evidence of the treatment

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specifically references the time periods for applying TEFRA Exhibits A (Section 4199-Exhbit A-p 3-76-the bad debt policy) and TEFRA Exhibits B 2-77, et seq. Section 4117 explains that the TEFRA review guidelines shown in TEFRA Exhibit B are provided as mandated review areas “which you must address in the review of the first year TEFRA cost reporting period [1983]. . ..During other TEFRA years, you have flexibility in audit areas.” *(Emphasis added.) Therefore, contrary to the court’s finding the expressed bad debts policy was not a new policy applicable only from 1989In contrast, The Transmittal No. 28 was transmitting new policy with respect to some IPPS issues. For example, regarding the “effective date” of the transmittal, the transmittal states that for "New Policy", the “Effective Date” was “For Prospective Payment System (PPS) cost report audits performed after 10/12/89”, and does not refer to cost reporting periods. Consistent with that, the IPPS Exhibit A shows certain “new policies” to be implemented for IPPS cost reporting periods beginning on or after January 1985 (which likely, were subject to audit at the time the transmittal was released). Transmittal No 19, dated September 1985 added pages 2-31-2-42 involving Section 4118 “Prospective Payment System (PPS) Hospital Audit Guidelines.” Transmittal No 19 dated February 1987 (Rev 19) revised section 4118, 4198 Exhibits and 4199 Exhibits. Transmittal No. 19 removed section 4118.2.

of these bad debts. The Provider relies on testimony evidence[17] that this was the Provider's policy, but provides no documentary support for this allegation. Medicare rules have always required auditable, verification, contemporaneous documentation to support its claim for payment (section 1815, 42 CFR 413.9. 413.20, 413.24).[18] Testimony in this case cannot replace the need for documentation to support the claim that the moratorium bars this disallowance. Testimony here is uncorroborated with contemporaneous documents as to the policy and actual practice and also insufficient to establish that the Intermediary affirmatively audited and accepted such claims after being fully aware of the alleged practice and policy of claiming bad debts.[19]

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[17] A provider witness who was an employee of the Hospital referred to discussions with employees present at the time for support. (See e.g. Transcript of Oral Hearing at 59-60.)

[18] While it is not the Intermediary's burden to prove the moratorium does not apply, the Intermediary supplied audit papers subsequent to moratorium showing it had audited the Provider's manuals, etc., and found no evidence that the Provider met the moratorium criteria. 1-10, I-II. Moreover, the erroneous payment of the bad debts in the 2002- 2004 cost years (after the start of the moratorium and hence not relevant to the moratorium discussion) is shown in the Intermediary workpapers to be a calculation oversight by the auditor, not an acceptance of the practice as the workpapers show the intent was to deny debts still at the collection. Intermediary Exhibit 1-9, Intermediary's Post Hearing Brief at pp 4-5.

[19] The Administrator notes the concern regarding that the claims at issue appear to be related to outpatient claims, which the Provider has contended are not paid under a charge or fee schedule. The Medicare program does not pay the bad debts of beneficiaries relating to services paid on a charge or fee schedule basis. The bad debts here are not otherwise allowable as set forth above and therefore a factual determination of whether they are related to a charge or fee base schedule need not be addressed here. The parties appear to agree that any claims relating to the latter would not be a reimbursable bad debt.

DECISION

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

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

Date: 2/16/12

/s/
Marilynn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services