PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION
On the Record

2024-D19

PROVIDER-
Bon Secours Memorial Regional Medical Center

Provider No.:
49-0069

vs.

MEDICARE CONTRACTOR –
Palmetto GBA c/o National Government Services, Inc.

RECORD HEARING DATE –
May 1, 2023

Fiscal Year Ending –
08/31/2014

CASE NO. –
17-1846

CONTENTS

ISSUE STATEMENTS

1. Whether the Provider is entitled to receive reimbursement for its Medicare Managed Care ("Medicare Part C") costs incurred through its nursing and allied health ("NAH") program, based on the requirements in 42 C.F.R § 413.87, when the Provider submitted no-pay bills to the Medicare Contractor in the UB-92 format but the claimed costs in those bills were not captured in the Provider's Statistical and Reimbursement Report ("PS&R") data[1] for the Provider's fiscal year ("FY") 2014?[2]

2. Whether the Medicare Contractor erred in disallowing Medicare bad debts claimed by the Provider for allegedly not having 120 days of continuous collection efforts?[3]

DECISION

After considering the Medicare law and regulations, the arguments presented, and the evidence admitted, the Provider Reimbursement Review Board ("PRRB" or "Board") finds:

1. The Medicare Contractor properly adjusted the Provider's NAH Medicare Part C payment for FY 2014 to exclude the Medicare Part C data associated with the no-pay bills at issue; and

2. The Medicare Contractor properly disallowed the Medicare bad debts at issue for FY 2014.

INTRODUCTION

Bon Secours Memorial Regional Medical Center (the "Provider" or "Bon Secours") is a general short-term hospital located in Mechanicsville, Virginia.[4] The Medicare Contractor[5] assigned to Bon Secours for these appeals is Palmetto GBA c/o National Government Services, Inc. ("Medicare Contractor").

Bon Secours offers nursing educational programs and/or allied health professional education ("NAH") programs. Bon Secours contends that, for FY 2014, it met the requirements in 42 C.F.R. § 413.87 and was underpaid for its Medicare Part C Managed Care ("Part C")[6] costs

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[1] The PS&R Report is a series of reports which capture statistical and reimbursement data for Medicare claims. *See* https://www.cms.gov/medicare/audits-compliance/part-a-cost-report/provider-statistical-reimbursement-report-psr (last visited May 14, 2024).
[2] Stipulations (hereinafter "Stip.") at ¶ 1.4 (Feb. 28, 2022).
[3] *Id.* at ¶ 1.5
[4] Medicare Contractor's Final Position Paper (hereinafter "Medicare Contractor's FPP") at 2 (Jul. 5, 2019).
[5] CMS's payment and audit functions under the Medicare program were historically contracted to organizations known as fiscal intermediaries ("FIs"), but these functions are now contracted with organizations known as Medicare administrative contractors ("MACs"). The term "Medicare contractor" refers to both FIs and MACs as appropriate and relevant.
[6] Medicare Part C Managed Care costs are incurred under what is referred to as the Medicare Advantage Program (formerly known as the Medicare+Choice Program or M+C) which provides an alternative to the traditional Medicare "fee for service" program and allows Medicare beneficiaries to enroll in a health maintenance organization ("HMO"), preferred provider organization ("PPO") or other private managed care plans. If an individual with Medicare enrolls in a Medicare Advantage plan, the Secretary makes payments to the plan instead of making

incurred through its NAH program.[7] Additionally, Bon Secours maintains the Medicare Contractor "improperly disallowed $68,637.63 in bad debt expenses based on its determination that [Bon Secours] did not maintain 120 days of continuous collection efforts."[8]

Bon Secours timely appealed the Medicare Contractor's final determination and has met the jurisdictional requirements for a hearing before the Board. On May 1, 2023, the Board approved a record hearing for the above-captioned case. Bon Secours was represented by Daniel J. Hettich, Esq. of King & Spalding LLP. The Medicare Contractor was represented by Edward Lau, Esq. of Federal Specialized Services, LLC.

STATEMENT OF FACTS AND RELEVANT LAW

A. Nursing and Allied Health Education Programs

The NAH issue centers on whether the Medicare Contractor properly calculated Bon Secours' NAH payment for FY 2014. Bon Secours alleges the Medicare Contractor failed to include all of its Part C patient days in the calculation of its NAH payment for 2014.[9]

From the inception of the Medicare program in 1965, certain medical education expenses have been reimbursed on a reasonable cost basis.[10] Both the House and Senate Committee reports, accompanying the 1965 legislation,[11] suggest that Congress favored including medical educational expenses as allowable medical education costs under the Medicare program. The following statements from Congressional committee reports address the reimbursement of medical education costs as allowable expenses under the Medicare program and reflect Congressional inclination regarding reimbursement of medical education expenses:

> Many hospitals engage in substantial educational activities, including the training of medical students, internship and residency programs, the training of nurses, and the training of various paramedical personnel. Educational activities enhance the quality of care in an institution, and it is intended, until the community undertakes to bear such education costs in some other way, that a part of the net cost of such activities (including stipends of trainees as well as compensation of teachers and other costs) should be considered as an element in the cost of patient care, to be borne to an appropriate extent by the hospital insurance program.[12]

Significantly, these reports specifically list nursing and paramedical (*i.e.*, NAH) education expenses as a type of medical education activity that "should be considered as an element in the

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payments to other providers under Parts A or B. *See* 42 U.S.C §§ 1395w-21-1395w-29.
[7] Provider's Optional Response Paper (hereinafter "Provider's Response") at 1 (Aug. 12, 2019).
[8] *Id*. at 7.
[9] Provider's Final Position Paper (hereinafter "Provider's FPP") at 1 (Jun. 12, 2019).
[10] *See* 42 U.S.C. § 1395x(v)(1)(A); 42 C.F.R. § 405.421 (1966); 57 Fed. Reg. 43659, 43661 (Sept. 22, 1992).
[11] Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286 (1965).
[12] S. Rep. No. 89-404, at 36 (1965); H.R. Rep. No. 89-213, at 32 (1965).

cost of patient care, to be borne to an appropriate extent by the hospital insurance program [i.e., the Medicare program]."[13]

In 1999, Congress enacted the Balanced Budget Refinement Act ("BBRA") and, in § 541(a), added 42 U.S.C. § 1395ww(1) to provide for additional payments to be made to qualifying hospitals to cover the costs of Medicare Managed Care patients associated with approved NAH programs.[14] This statutory provision describes the methodology for determining the additional payments and sets forth the rules for determining an additional payment amount for any qualifying hospital that receives payments for its costs of operating approved NAH education programs under 42 C.F.R § 413.85. The Secretary implemented BBRA § 541(a) at 42 C.F.R. § 413.87 to set forth the qualifying conditions that must be met in order for a hospital to receive an additional payment amount associated with Part C Managed Care utilization.[15]

In 2000, Congress passed the Benefits Improvement and Protection Act ("BIPA") and, in § 512(a), amended 42 U.S.C. § 1395ww(l)(2)(C) to change the formula for determining NAH Part C Managed Care payments by adding consideration of a provider's Part C Managed Care utilization.[16] Specifically, for cost reporting periods beginning on or after January 1, 2001, hospitals operating NAH programs could receive additional payment amounts if: (i) the hospital received reasonable cost Medicare payment for a NAH program in its cost reporting period ending in the federal fiscal year two years prior to the current calendar year; (ii) the hospital is receiving reasonable cost payments for its NAH program in the current calendar year; and (iii) the hospital has a Part C Managed Care utilization greater than zero in its cost reporting period ending in the fiscal year that is two years prior to the current calendar year.[17] Accordingly, in the final rule published on June 13, 2001, the Secretary implemented BIPA § 512(a) by revising 42 C.F.R. § 413.87.[18]

On February 3, 2003, CMS issued Program Memorandum, Transmittal A-03-007 ("PM A-03-007"), which outlined the Medicare contractor and standard system changes needed to process NAH education supplemental payments for Part C Managed Care enrollees.[19] PM A-03-007 updated the 1998 Program Memorandum under Transmittal A-98-21 ("PM A-98-21"),[20] which explained the methodology for processing direct graduate medical education ("DGME") and indirect medical education ("IME") payments associated with Part C Managed Care enrollees effective January 1, 1998. PM A-03-007 effectively instructed hospitals that operate a NAH program and qualify for additional payments related to their Part C enrollees under 42 C.F.R. § 413.87(e), to submit their Part C claims to their regular Medicare contractor to be processed as no-pay bills in UB-92 format, *with condition codes 04* ***and*** *69*, so that the Part C inpatient days can be accumulated on the PS&R report type 118 for purposes of calculating the Part C NAH payment through the cost report process.

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[13] *Id*.
[14] Pub. L. 106-113, Appendix F § 541(a), 113 Stat. 1501A-321, 1501A–391 (1999).
[15] *See* 65 Fed. Reg. 47026, 47051-52 (Aug. 1, 2000) (initial codification of 42 C.F.R. § 413.87).
[16] Pub. L. 106-554, Appendix F § 512(a), 114 Stat. 2763A-463, 2763A-533 (2000).
[17] *Id.*
[18] 66 Fed. Reg. 32172, 32195-96 (June 13, 2001) (revising 42 C.F.R. § 413.87(c)(1)-(2)).
[19] Program Memorandum, CMS Pub. 60A, Transmittal A-03-007 (Feb. 3, 2003) (available at: https://www.cms.gov/regulations-and-guidance/guidance/transmittals/downloads/a03007.pdf (last visited May 14, 2024).
[20] Program Memorandum, HCFA Pub 60-A, Transmittal A-98-21 (Jul. 1, 1998) (NOTE: CMS was formerly known as the Health Care Financing Administration or "HCFA").

The cost report instructions for Worksheet E, Part A are located in the Provider Reimbursement Manual, CMS Pub. 15-2 ("PRM 15-2"), § 4030, and they explain that the NAH Managed Care payment, for Line 53, is obtained from the provider's Medicare contractor.[21] On May 23, 2003, CMS issued Program Memorandum, Transmittal A-03-043 ("PM A-03-043"), distributed to the Medicare contractors, explaining the required steps to calculate the hospital's NAH payment.[22] Included in Step 1 of these steps was a specific instruction to obtain the number of Part C inpatient days from the PS&R, report type 118.[23] The Transmittal notes that, "subject to the rules concerning time limitation for submitting provider claims at §3600.2 of the Intermediary Manual [CMS Pub. 13], additional documentation to revise the [Medicare contractor's] determination may be submitted by the provider, but will be subject to audit by the [Medicare contractor]."[24]

B. Bad Debts

The bad debts issue centers on whether the Medicare Contractor properly disallowed payments based on the finding that Bon Secours did not maintain adequate support demonstrating 120 days of continuous collection efforts. Bon Secours contends it is required to use reasonable collection efforts and that the Medicare Contractor's basis for the adjustment to require "'120 days of continuous collection efforts,' or even specify the frequency with which a hospital must attempt collection" is not based in CMS regulations or program guidance.[25]

The Medicare regulations governing bad debts are located at 42 C.F.R. § 413.89. Subsection (a) states the general rule that "[b]ad debts . . . are deductions from revenue and are not to be included in allowable cost." However, in order to ensure that Medicare-covered costs are not shifted to individuals who are not covered by the Medicare program, subsection (d) specifies that bad debts attributable to Medicare deductibles and coinsurance are reimbursable as allowable costs.

Bad debts must meet the following criteria specified in 42 C.F.R. § 413.89(e) (2013) to be allowable:

> (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.

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[21] Ex. C-2.
[22] Program Memorandum, CMS Pub. 60A, Transmittal A-03-043 (May 23, 2003) (available at: https://www.cms.gov/regulations-and-guidance/guidance/transmittals/downloads/a03043.pdf (last visited May 14, 2024). *See also* Ex. C-3.
[23] Ex. C-3 at 2.
[24] PM A-03-043 at 2. (At the time of publication, "FI" stood for Fiscal Intermediary, now referred to as Medicare contractors.)
[25] Provider's FPP at 1.

Additional guidance on the Medicare bad debt requirements is located in Chapter 3 of the Provider Reimbursement Manual, CMS Pub. 15, Part 1 ("PRM 15-1"). PRM 15-1 § 308 mirrors 42 C.F.R. § 413.89(e) in outlining the four criteria that must be satisfied in order for bad debts to be eligible for reimbursement by Medicare. PRM 15-1 § 310 provides guidance as to what constitutes reasonable collection efforts.

PRM 15-1 § 310 through 310.2 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. It must involve the issuance of a bill on or shortly after discharge or death of the beneficiary to the party responsible for the patient's personal financial obligations. It also includes other actions such as subsequent billings, collection letters and telephone calls or personal contacts with this party which constitute a genuine, rather than a token, collection effort. The provider's collection effort may include using or threatening to use court action to obtain payment. (See § 312 for indigent or medically indigent patients.)
>
> A. Collection Agencies. —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 practices may include using or threatening to use court action to obtain payment.
>
> B. Documentation Required. —The provider's collection effort should be documented in the patient's file by copies of the bill(s), follow-up letters, reports of telephone and personal contact, etc.
>
> 310.1 Collection Fees.—Where a provider utilizes the services of a collection agency and the reasonable collection effort described in § 310 is applied, the fees the collection agency charges the provider are recognized as an allowable administrative cost of the provider.
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> 310.2 Presumption of Noncollectibility.—*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.[26]

Significantly, in the FY 2021 IPPS Final Rule, the Secretary codified certain longstanding policies related to "reasonable collection efforts" into the Code of Federal Regulations and did so on a *retroactive basis*.[27] As a result of these revisions, 42 C.F.R. § 413.89(e)(2) states the following in pertinent part:

> (2) The provider must be able to establish that reasonable collection efforts were made.
>
> (i) *Non-indigent beneficiary*. A nonindigent beneficiary is a beneficiary who has not been determined to be categorically or medically needy by a State Medicaid Agency to receive medical assistance from Medicaid, nor have they been determined to be indigent by the provider for Medicare bad debt purposes. To be considered a reasonable collection effort for nonindigent beneficiaries, all of the following are applicable:
>
> (A) A provider's collection effort or the effort of a collection agency acting on the provider's behalf, or both, to collect Medicare deductible or coinsurance amounts must consist of all of the following:
>
> (1) Be similar to the collection effort put forth to collect comparable amounts from non-Medicare patients.
>
> (2) For cost reporting periods beginning before October 1, 2020, involve the issuance of a bill to the beneficiary or the party

[26] (Bold and italics emphasis added.)

[27] 85 Fed. Reg. 58432, 58989-59006, 59023-25 (Sept. 18, 2020). *See also id*. at 58994 ("We are finalizing our proposal to amend § 413.89(e)(2) by adding a new paragraph (e)(2)(i)(A)(5)(*ii*), effective for cost reporting periods **beginning before**, on, and after **the effective date of this rule**, to specify that a provider's reasonable collection effort requirement for a nonindigent beneficiary must also start a new 120-day collection period each time a payment is received within a 120-day collection period." (emphasis added)); *id*. at 58996 ("Therefore, we proposed to amend § 413.89(e)(2) by adding a new paragraph (e)(2)(i)(A)(*6*) to specify the requirements a provider must follow in order to document the provider's reasonable collection effort for nonindigent beneficiaries. Because these are clarifications of codifications of longstanding Medicare bad debt policy, these policies would be effective for cost reporting periods **beginning before**, on and after **the effective date of the final rule**. . . . After consideration of the public comments we received, we are finalizing our proposal to amend § 413.89(e)(2) by adding a new paragraph (e)(2)(i)(A)(6) to specify the requirements a provider must follow in order to document the provider's reasonable collection effort for nonindigent beneficiaries. Specifically, providers must maintain and, upon request, furnish verifiable documentation to its contractor that includes all of the following: (*i*) The provider's bad debt collection policy which describes the collection process for Medicare and non-Medicare patients, (*ii*) The patient account history documents which show the dates of various collection actions such as the issuance of bills to the beneficiary, follow-up collection letters, reports of telephone calls and personal contact, etc.; and (*iii*) The beneficiary's file with copies of the bill(s) and follow-up notices." (bold and underline emphasis added)).

responsible for the beneficiary's personal financial obligations on or shortly after discharge or death of the beneficiary.

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(5)(i) Last at least 120 days after paragraph (e)(2)(i)(A)(2) . . . . of this section is met before being written off as uncollectible under paragraph (e)(3) of this section.

(ii) Start a new 120-day collection period each time a payment is received within a 120-day collection period.

(6) Maintaining and, upon request, furnishing verifiable documentation to its contractor that includes all of the following:

(i) The provider's bad debt collection policy which describes the collection process for Medicare and non-Medicare patients.

(ii) The patient account history documents which show the dates of various collection actions such as the issuance of bills to the beneficiary, follow-up collection letters, reports of telephone calls and personal contact, etc.

(iii) The beneficiary's file with copies of the bill(s) and follow-up notices.

(B) A provider that uses a collection agency to perform its collection effort must do all of the following:

(1) Reduce the beneficiary's account receivable by the gross amount collected.

(2) Include any fee charged by the collection agency as an administrative cost.

(3) Before claiming the unpaid amounts as a Medicare bad debt, cease all collection efforts, including the collection agency efforts, and ensure that the collection accounts have been returned to the provider from the agency.[28]

C. Stipulations

The Parties agreed Stipulations which set forth, in pertinent part, the following facts and principles of law for purposes of the appeal:

I. **Background**

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[28] *Id*. at 59024.

1.4 The first issue in this appeal is whether the provider is entitled to receive reimbursement for its Medicare Managed Care costs incurred through its nursing and allied health ("NAH") program based on the requirements in 42 C.F.R § 413.87 when the Provider submitted no-pay bills to the MAC in the UB-92 format and that the claimed costs were not captured in the Provider's PS&R data.

1.4.1 On January 17, 2017, the MAC issued an NPR for the Provider's FYE August 31, 2014.

1.4.2 In the audit adjustment report accompanying the NPR, the MAC in adjustment number 13, decreased the amount reported on the as-filed cost repot from $1,739,701 to value of $1,619,601 for NAH Part C payment of Line 53 of Worksheet E Part A.

1.4.3 The initial appeal request was filed on July 14, 2017 with the NAH issue.

1.5 The second issue in this appeal is whether the MAC erred in disallowing Medicare bad debts claimed by the Provider for allegedly not having 120 days of continuous collection efforts. The adjustments related to that issue are adjustments 16 and 21.

1.5.1 The Provider filed a Request to Add the bad debt 120 days of continuous collection efforts issue to the case on September 13, 2017.

1.6 The total amount in controversy of the appeal exceeds the minimum threshold of $10,000.

II. Facts Related to the Provider's Appeal

2.1 The first issue is the Provider's NAH Part C payment determinations for calendar-years 2013 and 2014 insofar as they overlap with the Provider's cost reporting period spanning September 1, 2013 through August 31, 2014.

2.1.1 One of the principal data points for determining a provider's NAH Part C payment for a given calendar-year is the number of inpatient days attributable to Part C beneficiaries during the provider's cost reporting period ending in the federal fiscal year that is two years preceding the payment year.

2.1.2 For the purposes of the Provider's NAH Part C payment determination for calendar-years 2013 and 2014, the

applicable Part C days are those from the Provider's fiscal years ending ("FYEs") August 31, 2011 and 2012.

2.1.3 During the periods, the Provider has submitted to the MAC UB-04 CMS 1450 ("UB-04') forms reflecting Part C days during FYEs August 31, 2011 and 2012.

2.1.4 The UB-04 forms submitted by the Provider reflected the use of condition code "04" to designate it as an "informational only bill" (a "Shadow Bill").

2.1.5 For FYEs August 31, 2011 and 2012, the Provider's Shadow Bills using condition code 04 were used by the MAC for purposes of calculating the Provider's Part C days in the Medicare fraction of the DSH calculation, and such days were included in the Provider's MedPAR file.

2.1.6 During the period at issue in this appeal, the number of Part C days indicated on the Provider's MedPAR filed was 3,373 Part C length of stay days (including 3,357 Part C covered days) for FY 2011 and 4,129 Part C days for FY 2012.[29]

2.1.7 The Shadow Bills did not use condition code "69" to designate the shadow bill as one for a teaching hospital.

2.1.8 The absence of condition code 69 on the Provider's Shadow Bills caused the NAH Managed Care data of 3,373 Part C length of stay days (including 3,357 Part C covered days) for FY 2011 and 4,129 Part C days for FY 2012 to be omitted from the Provider's PS&R report type 118.

2.1.9 The MAC relied on the Provider's PS&R report type 118 and the Provider's FYE 08/30/2012 cost report to calculate the Part C days for the Provider's Part C NAH payment.

2.2 For the second issue regarding the bad debt expenses, the MAC disallowed payments based on finding that the Provider did not maintain adequate support to document 120 days of continuous collections efforts in a sample of inpatient bad debt accounts:

2.2.1 The MAC audited a sample consisting of thirteen inpatient bad debt accounts that the Provider had claimed as Medicare bad debts in the reporting period under appeal.

[29] The Providers' MedPAR data indicate a total of 3,373 days corresponding to Part C beneficiaries' length of stay and 3,357 days as Part C covered days for 2011. For purposes of these stipulations of fact, the parties present both amounts for consideration by the Board as it relates to the 2011 data. Note: The preceding text is included as footnote 1 in the Stipulations.

2.2.2 For three of those accounts, the MAC determined that the Provider did not maintain support to document 120 days of continuous collection efforts prior to writing off the accounts, and that Provider failed to follow its own Bad Debt Policies for the remaining sampled accounts, *see* MAC Exhibit C-1 and Provider Exhibit P-7 for basis of the MAC disallowance.

The MAC also contends that Sample Rec. #103 was written off by the Provider on September 8, 2014, which is after the Provider's FYE of August 31, 2014.

2.2.3 The MAC applied an extrapolated adjustment to the Provider's allowable Medicare bad debt expenses based on three accounts.

2.3 On June 12, 2019, the Providers filed a final position paper in OH CDMS. The Provider submitted MedPAR data as an exhibit to its Final Position Paper. The exhibit indicates 3,373 Part C length of stay days (including 3,357 Part C covered days) for FY 2011 and 4,129 Part C days for FY 2012.

2.4 On July 5, 2019, the MAC filed a final position paper in OH CDMS.

2.5 On August 12, 2019, the Provider filed an optional response paper in OH CDMS.

DISCUSSION, FINDINGS OF FACT, AND CONCLUSIONS OF LAW

A. Issue 1 – Nursing and Allied Health Education Programs

At the outset, the Board notes that a decision on the same NAH issue for Bon Secours but for other fiscal years (specifically FYs 2010-2013) was issued in PRRB Decision 2023-D32 on September 15, 2023. As the FY 2014 appeal had two distinct issues, it was not consolidated into that previous decision cover the earlier fiscal years.

As shown above, the Medicare Contractor and Bon Secours have stipulated in the appeal that, while Bon Secours used condition code "04" on the Part C bills at issue to designate them as no-pay or information-only bills, Bon Secours *failed* to use condition code "69" to designate those no-pay bills *as pertaining to a teaching hospital* (whether DGME or NAH). The Parties also have stipulated that the absence of condition code 69 on the no-pay bills at issue caused the NAH Managed Care data associated with those no-pay bills to be omitted from Bon Secours' PS&R Report Type 118 for the fiscal year under appeal.[30]

[30] *See* Stip. at ¶¶ 2.1.7 and 2.1.8.

Similar to the preamble to the final rule published on May 12, 1998 (the "1998 Final Rule") and PM A-98-21 for DGME, PM A-03- 007, plainly instructed Bon Secours to bill claims for Part C Managed Care enrollees for NAH program. Specifically, the PM instructs Hospitals operating an NAH program to submit the M+C claims to be processed as a no-pay bill using the UB-92 format on the form CMS-1450[31] *with condition codes 04* ***and*** *69* so that the M+C inpatient days could be accumulated on the PS&R (report type 118) for purposes of calculating the Part C NAH payment on the relevant cost report.[32] The Medicare Contractor argues that Bon Secours "must file a UB-04 claim form through the claims processing system in order to calculate the [NAH] payment for [Part C Managed Care] enrollees", and that Bon Secours' claims "must be timely submitted as required by 42 C.F.R. §424.44."[33] The Medicare Contractor further states that "the requirement to bill [no-pay claims] for [Part C Managed Care] enrollees was communicated *before* the finalization of [Bon Secours'] FYE 8/31/2012 cost reporting period."[34] The Medicare Contractor notes "[t]he method of receiving payment for DGME for [Part C] enrollees was specifically addressed by CMS in the Federal Register dated May 12, 1998."[35] The Medicare Contractor contends that it used the best available data when reviewing and calculating Bon Secours' NAH payment.[36]

In its Final Position Paper, Bon Secours argues that PM Transmittal A-03-043 provides "specific steps for [Medicare contractors] to follow in calculating the additional [NAH Part C Managed Care] payment amount."[37] The Medicare Contractor argues that "CMS identifies the data source for the [Medicare Contractor's] calculation of NAH [Part C] Manage[d] Care payments as the PS&R report type 118."[38] However, the Medicare Contractor notes that Bon Secours' PS&R reports type 118 "reflected a different number of [Part C] days as a result of the no-pay claims than what [Bon Secours'] records indicated."[39] The Medicare Contractor notes that Bon Secours "should have been aware" of this difference.[40]

Bon Secours states it submitted a total of 4,129 Part C days for services in FY 2012.[41] The Medicare Contractor argues that it is "the Provider's responsibility to seek to have the [Part C] days corrected on its FYE 8/31/2012 cost report via a reopening. The [Part C] days reported on Worksheet S-3, Column 4, Line 2 for the FYE 8/31/2012 should include PS&R Report Type 118 hospital days to be used in the [NAH] payment calculation for FYE 8/31/2014."[42] While the Medicare Contractor did not scope NAH for review, based on CMS thresholds, the Medicare

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[31] When PM A-03-007 was issued, the form CMS-1450 used a UB-92 format and was also referred to as the UB-92. The form CMS-1450 was later revised to update the UB-92 format, replacing it with a UB-04 format and, as a result, it is now also known as the UB-04. *See* Medicare Claims Processing Manual, CMS Pub. 100-04, Transmittal 1254 (May 24, 2007) available at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1254CP.pdf (last visited May 14, 2024); https://www.cms.gov/medicare/coding-billing/electronic-billing/institutional-paper-claim-form (last visited May 14, 2024).
[32] CMS Transmittal A-03-007 at 1.
[33] Medicare Contractor's FPP at 9.
[34] *Id.* at 13.
[35] *Id.* at 14.
[36] *Id.* at 8.
[37] Provider's FPP at 5.
[38] Medicare Contractor's FPP at 8.
[39] *Id.*
[40] *Id.*
[41] Stip. at ¶ 2.1.6.
[42] Medicare Contractor's FPP at 8.

Contractor notes that the PS&R report is integral to the cost report preparation, audit, and settlement processes and, to that end, providers have access to the PS&R for those purposes.[43] Accordingly, for FY 2012, for example, Bon Secours could have used the PS&R report type 118 in preparing its FY 2012 cost report to identify the issue and then pursued correction by re-billing the claims, and revising the FY 2012 cost report, through an amended cost report, or a reopening, as necessary.

The Medicare Contractor cites to the Administrator's decisions in *Santa Barbara Cottage Hosp. v. BlueCross BlueShield Ass'n* and *Sutter 98-99 Managed Care (CIRP) Grp. v. BlueCross BlueShield Ass'n,* in which the Administrator held that the "pre-existing methodology requires that claims be made to the intermediary in order to generate a payment."[44] Further, "the requisite claims were reasonably required to be submitted to the Intermediary pursuant to 42 CFR § 424.30, § 424.32, and § 424.44."[45] The Medicare Contractor requests that the Board affirm the adjustment as the Medicare Contractor appropriately included the correct number of Medicare Part C days based on the data included in the PS&R.[46]

Bon Secours contends that "it met the requirements of 42 C.F.R. § 413.87 and should receive full reimbursement for its Medicare Managed Care costs incurred through its [NAH] program."[47] Bon Secours states it did, in fact, treat Medicare managed care patients[48] and did submit "no-pay" or "shadow" bills for FYs 2011 and 2012; but that, "[f]or reasons unknown and beyond the Provider's control, not all of the shadow bills that [it] submitted during its FYEs August 31, 2011 and August 31, 2012 were reflected in [PS&R Reports] for that period."[49] Accordingly, Bon Secours maintains that the Medicare Contractor "improperly omitted certain of the Provider's [Part C] days on Worksheet S-3 Part 1, Column 6, Line 2 on the Provider's cost report, despite proper shadow billing"[50] resulting in an underpayment.

Bon Secours asserts that it is ultimately the Medicare Contractor's responsibility to calculate the NAH Part C Managed Care payments correctly.[51] In this regard, Bon Secours notes:

> The regulations do not specify the data source from which the [Medicare contractor] or CMS will obtain information regarding a provider's Medicare Managed Care days in order to calculate the payment. CMS stated in rulemaking that it will use "the best available cost reporting data . . . from HCRIS" to determine these payments. 66 Fed. Reg. 32172, 32179 (June 13, 2001) (regarding

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[43] *Id.* at 9. *See also* https://www.cms.gov/data-research/statistics-trends-and-reports/provider-statistical-reimbursement-report (CMS webpage describing the importance of the PS&R report and providers' access to it). *See also* PRM 15-2 § 104 (describing how Medicare contractors can provide copies of the PS&R).
[44] *Id*. at 18 (citing Santa *Barbara Cottage Hosp. v. BlueCross BlueShield Ass'n,* Adm'r Dec. at 13 (Nov. 16, 2007), *reversing* PRRB Dec. 2007-D78 (Sept. 28, 2007)).
[45] *Id*. at 18-19 (citing *Sutter 98-99 Managed Care (CIRP) Grp. v. BlueCross BlueShield Ass'n,* Adm'r Dec. at 20 (Aug. 16, 2011), *reversing* PRRB Dec. 2011-D34 (June 16, 2011)).
[46] *Id*. at 20.
[47] Provider's Response at 1.
[48] *Id.*
[49] Provider's FPP at 2.
[50] *Id* at 3.
[51] *Id.* at 5.

> use of best available cost report data). PS&R data is mentioned nowhere in the regulation or rulemaking.[52]

Bon Secours contends that, because the PS&R report type 118 did not accurately capture its Part C days, the Medicare Contractor is required to use *other auditable data* to accurately calculate its NAH Part C Managed Care payment.[53] However, according to Bon Secours, "the [Medicare Contractor] severely underestimated this calculation on line 53 of Worksheet E, Part A in its audit of the Provider's cost report."[54]

In support of its contention that the Medicare Contractor should have used other auditable data, Bon Secours points to the instructions in PM A-03-043. Bon Secours recognizes that PM A-03-043 directs Medicare contractors to "obtain the number of [Part C] inpatient days from the . . . [PS&R] report type 118" but notes that it also specifies that "additional documentation to revise the [Medicare contractor's] determination *may* be submitted by the provider, but will be subject to audit by the [Medicare contractor]."[55] Bon Secours cites to Board decisions where the Board directed the Medicare Contractor to consider such other "additional documentation" outside of the PS&R report:

1. *Campbell's Provider Care, Inc*., PRRB Dec. 2001-D22 (May 2, 2001) in which the Board allowed the provider "to submit evidence of inaccurate PS&R data."[56]

2. *Santa Barbara Cottage Hospital*, PRRB Dec. 2007-D78 (Sept. 28, 2007), in which the Board "held that the failure to capture a provider's Medicare Managed Care data being on the PS&R report was of no consequence when the provider could demonstrate through records that it had billed for its Managed Care enrollees."[57]

Accordingly, Bon Secours maintains that, consistent with PM A-03-043 and these Board decisions, it has supplied alternative auditable documentation of its no-pay billing and corresponding remittance from the Medicare Contractor.[58] Further, Bon Secours asserts that this alternative auditable documentation should be used to adjust its NAH Part C Managed Care payment for FY 2014.[59]

Lastly, Bon Secours argues the Medicare Contractor's required use of the PS&R Report type 118 (at the exclusion of the other auditable data) violates the Notice and Comment required by both the Administrative Procedure Act and the Medicare Act. Specifically, "[b]ecause the [Medicare Contractor's] policy to use PS&R report 118 data at the exclusion of other auditable data proffered by the Provider did not undergo notice-and-comment rulemaking, it cannot be enforced in a way that deprives the Provider of its due NAH Part C payment."[60] Accordingly, Bon

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[52] *Id*.
[53] *Id.* at 8.
[54] *Id.* at 9.
[55] *Id*. (citing to PM A-03-043 at 2) (emphasis added).
[56] *Id.*
[57] *Id*. at 10. (NOTE: The Provider's citation to "05-1327 et al" reflects the PRRB case number, not the decision number, which was PRRB Dec. 2007-D78. The cited date of September 28, 2007 is correct.).
[58] *Id.*
[59] *Id.* at 10-11.
[60] *Id*. at 11-12.

Secours requests that the Board instruct the [Medicare Contractor] to correct its PS&R report type 118 to reflect the correct amount in its MEDPAR-validated data.[61]

42 U.S.C. § 1395ww(1) provides for additional payments to hospitals that operate NAH programs. The statutory provision was implemented at 42 C.F.R § 413.85 which allows for additional payments associated with Medicare + Choice utilization *if qualifying conditions are met under § 413.87(c)*. Bon Secours contends that it has "met the requirements of 42 C.F.R. § 413.87 and should receive full reimbursement for its [Part C] Managed Care costs incurred through its [NAH] program."[62] Section 413.87(e) specifies that the additional payment amount is determined according to the following steps:

> (e) *Calculating the additional payment amount for portions of cost reporting periods occurring on or after January 1, 2001.* For portions of cost reporting periods occurring on or after January 1, 2001, subject to the provisions of §413.76(d) relating to calculating a proportional reduction in [Part C Managed Care] direct GME payments, the additional payment amount specified in paragraph (c) of this section **is calculated according to the following steps**:
>
> (1) *Step one*. Each calendar year, determine for each eligible hospital the total –
>
> (i) Medicare payments received for approved nursing or allied health education programs based on data from the settled cost reports for the period(s) ending in the fiscal year that is 2 years prior to the current calendar year; and
>
> (ii) Inpatient days for that same cost reporting period.
>
> (iii) [Part C] inpatient days for that same cost reporting period.
>
> (2) *Step two*. Using the data from step one, determine the ratio of the individual hospital's total nursing or allied health payments, to its total inpatient days. Multiply this ratio by the hospital's total [Part C] inpatient days.
>
> (3) *Step three*. CMS will determine, using the best available data, for all eligible hospitals the total of all –
>
> (i) Nursing and allied health education program payments made to all hospitals for all cost reporting periods ending in the fiscal year that is 2 years prior to the current calendar year;
>
> (ii) Inpatient days from those same cost reporting periods; and
>
> (iii) [Part C] inpatient days for those same cost reporting periods.

[61] *Id.* at 12-13.
[62] Provider's Response at 9.

> (4) *Step four*. Using the data from step three, CMS will determine the ratio of the total of all nursing and allied health education program payments made to all hospitals for all cost reporting periods ending in the fiscal year that is 2 years prior to the current calendar year, to the total of all inpatient days from those same cost reporting periods. CMS will multiply this ratio by the total of all [Part C] inpatient days for those same cost reporting periods.
>
> (5) *Step five*. Calculate the ratio of the product determined in step two to the product determined in step four.
>
> (6) *Step six*. Multiply the ratio calculated in step five by the amount determined in accordance with paragraph (f) of this section for the current calendar year. The resulting product is each respective hospital's additional payment amount.

The Board finds the intent of the regulation is to *accurately* provide reimbursement to *all* providers who participate in approved NAH programs. The methodology formulated by CMS takes into account the data provided by each provider to calculate the *total reimbursement for* ***all*** *of the participating providers* ***with qualifying NAH programs***. The Board notes the importance of providers submitting accurate information to CMS for accurate reimbursement.

The cost report instructions for Worksheet E, Part A at PRM 15-2 § 4030 state: "Line 53--Enter the amount of nursing and allied health managed care payments if applicable."[63] Importantly, the cost report instructions reference PM A-03-043. On May 23, 2003, CMS issued PM A-03-043 which describes the steps to calculate the hospital's NAH payment and, in particular, states:

> Step 1: Determine for each eligible hospital the—
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> ****
>
> Total [Part C] inpatient days for that same cost reporting period. (If applicable, ***obtain*** *the number of [Part C] inpatient days from the Provider Statistics and Reimbursement Report (PS&R), report type 118*. [Part C] encounter days associated with providers and units excluded from the IPPS issued by CMS may be added to the inpatient days from report type 118.[64]

PM A-03-043 clearly states Medicare contractors are to *obtain* the number of Part C inpatient days from the PS&R report type 118. The PS&R system accumulates statistical and reimbursement data based on claims submitted by providers on the form CMS-1450 (also previously known as UB-92 and currently known as the UB-04[65]). Along with the PS&R

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[63] This is the cost report instruction for Line 53 of Worksheet E, Part A on the form CMS-2552-10, used for FY 2011 and after. Similar instruction existed for Line 11.01 of Worksheet E, Part A for the form CMS-2552-96, used for FY 2010.

[64] (Italics and bold emphasis added, and underline emphasis in original.)

[65] *See supra* note 31.

Summary Report, the Medicare Contractor uses the standard Remittance Advice ("RA") which explains the reimbursement claim decisions including the reasons for payments and adjustments of processed claims. Hospitals that operated an NAH program were instructed to submit the Part C Managed Care claims as a no-pay bill using the form CMS-1450 with condition codes 04 ***and*** 69 so that the Part C inpatient days could be accumulated on the PS&R (report type 118) to calculate the Part C NAH payment on the cost report.[66]

On May 23, 2003, PM A-03-043 was issued to provide further clarification regarding the calculation of the NAH payment and, in that Program Memorandum, Medicare contractors were instructed to obtain the data from the PS&R report type 118. However, Bon Secours failed to use condition code "69" to designate the no-pay bill as one for a teaching hospital and rather only used condition code 04 to note it was an information-only bill (*i.e.*, no-pay or shadow bill).[67] The absence of condition code "69"on Bon Secours' no-pay bills caused the NAH Managed Care Part C days at issue to be omitted from Bon Secours' PS&R report type 118 because both condition codes 04 and 69 were required in order to make it to this PS&R report type.[68] The Medicare Contractor relied on Bon Secours' PS&R report type 118, and the cost report at issue, to calculate the Part C days for Bon Secours' Part C NAH payments for FYE 08/30/2014.[69]

Bon Secours contends that "the PS&R report 118 is erroneous and that the [Medicare Contractor] is *required* to use other auditable data to accurately calculate the Provider's [Part C] Medicare Managed Care Days for NAH payment."[70] Bon Secours claims it "has supplied examples of its shadow billing and corresponding remittance from the [Medicare Contractor] that demonstrates [Bon Secours'] practice of shadow billing for its Medicare Managed Care days."[71] Bon Secours also cites to previous Board decisions which permit the Medicare Contractor's use of the PS&R report "unless the provider furnishes proof that inaccuracies exist"[72] and argues that the Board has previously held that the PS&R data is not always the best evidence available and may be disputed with contrary evidence.[73] Additionally, it notes that, in the past, the Board "held that the failure to capture a provider's Medicare Managed Care data being on the PS&R report was of no consequence when the provider could demonstrate through records that it had billed for its Managed Care enrollees."[74]

However, the Board finds that, in these cases and under the circumstances, the Medicare Contractor did use the best available data by relying on the PS&R Report type 118 for determining Bon Secours' NAH payment for each respective fiscal year. The preamble to the 1998 Final Rule, as well as PMs A-98-21 and A-03-007, all plainly instruct teaching hospitals (including Bon Secours) to bill claims for Part C enrollees using condition codes 04 ***and*** 69. As conceded in the Parties' Stipulations at ¶ 2.1.7, Bon Secours did not submit no-pay bills in a UB-92 format using

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[66] Medicare Contractor's FPP at 4.
[67] Stip. at ¶¶ 2.1.4 and 2.1.7.
[68] Stip. at ¶ 2.1.8.
[69] Stip. at ¶ 2.1.9.
[70] Provider's FPP at 8-9 (italics emphasis added).
[71] *Id.* at 10.
[72] *Id*. at 9 (citing to CMS Pub. 13 § 2242 (2012) and *Research Med. Ctr. v. Wisconsin Physicians Serv.*, PRRB Dec. 2012-D12 (Mar. 9, 2012)).
[73] *Id*. (citing to *Campbell's Provider Care, Inc. v. Blue Cross Blue Shield Ass'n*, PRRB Dec. 2001-D22 (May 2, 2001)).
[74] *Id.* at 10 (citing to *Santa Barbara Cottage Hosp. v. Blue Cross Blue Shield Ass'n*, PRRB Dec. 2007-D78).

the condition code 69. As a result, (as made clear in PM A-03-007), the Part C days at issue were omitted from the PS&R report type 118 and were not reconciled on the cost reports at issue. Bon Secours had ample notice to properly bill the claims in accordance with the PM A-03-007 and, per PM A-03-043, and knew the Medicare Contractor would base the NAH Part C payment on the PS&R report type 118. Moreover, Bon Secours could have sought a correction of the Part C days, through a reopening of the cost report, but failed to make the request of the Medicare Contractor.

Bon Secours' argument that the no-pay bills associated with the Part C days at issue were not reflected on the PS&R Type 118 "[f]or reasons unknown and beyond the Provider's control"[75] rings hollow. On February 3, 2003, (three months prior to the publication of Transmittal A-03-043, which Bon Secours has cited), CMS published PM A-03-007, which states in pertinent part:

> [T]his transmittal modifies Transmittal A-98-21 to permit these non-IPPS hospitals and units to submit their M+C claims to their respective intermediaries to be processed as no-pay bills so that the M+C inpatient days can be accumulated on the Provider Statistics & Reimbursement Report (PS&R) (report type 118) for DGME payment purposes through the cost report.
>
> ****
>
> [T]his transmittal also applies to all hospitals that operate a nursing or an allied health (N&AH) program and qualify for additional payments related to their M+C enrollees under 42 CFR 413.87(e). These providers would similarly submit their M+C claims to their respective intermediaries to be processed as no-pay bills ***so that the M+C inpatient days can be accumulated on the PS&R (report type 118) for purposes of calculating the M+C N&AH payment through the cost report.*** (The instructions for calculating this payment will be explained in a separate transmittal).
>
> …. hospitals that operate an approved N&AH program ***must*** *submit claims* to their regular intermediary in UB-92 format, *with condition codes 04* ***and*** *69 present* on record type 41, fields 4-13, (Form Locator 24-30). ***Condition code 69*** has recently been modified by the National Uniform Billing Committee to indicate that the claims, in addition to being submitted for operating IME and DGME payments to IPPS hospitals may now be submitted as *no-pay bills … for purposes of calculating* the DGME and/or ***N&AH payment*** *through the cost report*.
>
> ****
>
> Provider Education
>
> [Medicare contractors] must notify, through their Web sites and their next regularly scheduled bulletins, ***all*** hospitals that either

[75] *Id*. at 2.

> operate only GME program(s), only N&AH education program(s), or operate both GME and N&AH education programs, within 30 business days after receipt of the electronic copy of this PM of the above reporting requirements. Electronic billing associations and clearinghouses must be notified within 30 business days as well. Include the following information in this notice:
>
> Teaching hospitals that operate GME programs (see 42 CFR §413.86) and/or hospitals that operate approved N&AH education programs (see 42 CFR §413.87) ***must*** *submit separate bills for payment for M+C enrollees*. The M+C inpatient days are to be recorded on PS&R report type 118. For services provided to M+C enrollees by hospitals that do not have a contract with the enrollee's plan, non-IPPS hospitals and units are entitled to any applicable DGME and/or N&AH payments under these provisions. Therefore, such hospitals and units should submit bills to their intermediary for these cases in accordance with the instructions otherwise described in this transmittal. In addition to submitting the claims to the PS&R report type 118, hospitals must properly report M+C inpatient days on the Medicare cost report, Form 2552-96, on worksheet S-3, Part I, line 2 column 4, and worksheet E-3, Part IV, lines 6.02 and 6.06.

Thus, *prior to the Program Memorandum to which Bon Secours has cited*,[76] CMS had already issued instructions specifying that claims must be billed with Code 69 to be reported on the PS&R report type 118 for NAH payment calculation purposes. Similarly, Medicare contractors were to notify providers with NAH programs of this new requirement. The May 2003 Program Memorandum is the "separate transmittal" referred to in PM A-03-043 as the instructions for calculating the NAH payment. The word "must" in that Program Memorandum is not "suggestive" or "permissive," but a requirement.

Bon Secours' citation to PRRB Dec. 2007-D78 argues that the Board found that "the PS&R report was of no consequence when the provider could demonstrate through records that it had billed for its Managed Care enrollees."[77] However, Bon Secours fails to mention that the Administrator reviewed and reversed the Board's decision on this issue.[78] The Board also notes that the cases in that 2007 decision related to DGME (as opposed to NAH) for cost reports/appeals for 1998 through 2001. Similarly, the other PRRB Decision cited by Bon Secours (PRRB Dec. 2001-D22) related to a home health agency and its cost reporting period ended December 31, 1995. Notably, these cases involve cost reporting periods that took place *prior to* the issuance of PM A-03-007 in February 2003, which confirmed that NAH programs must submit no-pay bills for Part C days using condition codes 04 ***and*** 69. The instructions in the Program Memorandum make clear that claims made after the effective date must be billed with condition codes 04 and 69 for purposes of calculating any additional NAH payment.

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[76] *See id*. at 5
[77] *Id*. at 10.
[78] *Santa Barbara Cottage Hosp. v. BlueCross BlueShield Ass'n,* Adm'r Dec., *reversing* PRRB Dec. 2007-D78. The Board also notes that PRRB Dec. 2007-D78 was not a unanimous decision.

Finally, unlike DGME, PM A-03-043 makes clear that the additional Part C payments are made from a defined pool that is divided between all qualifying NAH providers and, as a result, a NAH provider's PS&R report type 118 is used not just relative to that NAH provider's payment but also relative to payment for all other NAH providers. Accordingly, the Board finds that these Decisions are distinguishable and do not provide support for Bon Secours' contentions.

Finally, 42 C.F.R. § 413.87(e), as quoted above, indicates that the additional payment for NAH, related to Part C patients/days, is calculated *at a national level*. CMS is using managed care payments, total inpatient days, and Part C days "for **all** eligible hospitals"[79] to determine each hospital's ratio of the payment pool, which "may not exceed $60 million in any calendar year."[80] Bon Secours' failure to bill the days with the condition code 69, so that those days would be properly reported on PS&R report type 118, not only affects Bons Secours, but ***all*** NAH providers participating in the calculation. Allowing additional days to be included only for Bon Secours, when they were not properly billed, would affect all NAH providers negatively, even though those providers did bill their days correctly. The issue is not simply that the days can be proven to have been billed, albeit incorrectly, but also that it alters the payment calculation and pool for the *entire* community of NAH hospitals. Thus, CMS' reliance upon PS&R report type 118 for all providers, in terms of Part C days, is both consistent and proper, as the providers have been notified that these claims must be billed with codes 04 and 69 for this very purpose. There is nothing in the record of these cases that demonstrates that Bon Secours was not able to, or somehow prevented from, correctly billing the days at issue; thus, the years of incorrect billing were not "beyond the Provider's control. . . ."[81] Rather, Bon Secours failed to bill in the proper fashion for discharges in its FY 2012.

As further evidence that the failure to bill with codes 04 and 69 was not beyond its control, the Board notes that Bon Secours could have corrected these claims any time within the one-year billing requirements. Bon Secours is responsible for their actions, *and* the detrimental results of those actions.

B. Issue 2 – Bad Debts

Bad debts are reimbursable under the Medicare Program if they meet the following criteria pursuant to 42 C.F.R. § 413.89(e):

> (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

[79] 42 C.F.R. § 413.87(e)(3).
[80] 42 C.F.R. § 413.87(f)(3).
[81] Provider's FPP at 2.

While the regulation does not define "reasonable collection efforts,"[82] PRM 15-1 contains interpretive guidelines on that regulation.[83] In particular, PRM 15-1 § 310 provides guidance regarding the Secretary's interpretation of "reasonable collection efforts," as quoted above.

Section 310.B explains that a "provider's collection effort should be documented in the patient's file by copies of the bill(s), follow-up letters, reports of telephone and personal contact, etc." Section 310.2 further states that "[i]f 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 patient/ beneficiary, the debt may be deemed uncollectible." As thoroughly explained in prior decisions on this issue of the reasonableness of bad debt collection efforts, the Board has interpreted this "reasonable *and customary*" language to require a provider both to have a written debt collection policy memorializing the process for its "collection effort," and to follow that written policy in its debt collection process.[84]

Additionally, the federal regulations at 42 C.F.R. § 413.20(d)(1) and 42 C.F.R.§ 413.24(c) require that auditable, verifiable documentation is available for review to assure proper payment by the Medicare program.

Bon Secours appealed Audit Adjustments Nos. 16 and 21 which both state: "[t]o adjust Traditional Bad Debts for not having 120 days for continuous collection efforts, lack of documentation and for not considering total resources when determining indigence for Indigent Bad Debt accounts."[85] The Medicare Contractor "audited a sample consisting of thirteen inpatient bad debt accounts that the Provider had claimed as Medicare bad debts . . ."[86] Per the parties' agreed-upon stipulations, "[f]or three of those accounts, the MAC determined that the Provider did not maintain support to document 120 days of continuous collection efforts prior to writing off the accounts, and that the Provider failed to follow its own Bad Debt Policies."[87]

A summary of the Medicare Contractor's disallowed accounts:

> Account Sample 1
> The MAC found the Provider made three attempts then sent the account to the collection agency and one attempt was made by the collection agency. There were only 113 days of collection efforts from the first bill. Additionally, the MAC found this account to be

[82] *District Hospital Partners, L.P., et al. v. Sebelius*, 932 F. Supp. 2d 194, 200 (D.D.C. 2013) (citing *GCI Health Care Ctrs., Inc. v. Thompson*, 209 F. Supp. 2d 63, 69 (D.D.C. 2002)).
[83] *Battle Creek Health Sys. v. Leavitt*, 498 F.3d 401, 404 (6th Cir. 2007).
[84] *See, e.g., Marian Health Ctr. v. Blue Cross & Blue Shield Ass'n*, PRRB Dec. 85-D110 (Sept. 23, 1985), *declined review*, CMS Adm'r (Oct. 29, 1985); *Cooper Hosp. v. Blue Cross Blue Shield*, PRRB Dec. 2014-D11 (June 18, 2014), *declined review*, CMS Adm'r (Aug. 20, 2014). *See also Methodist Hosp. v. Wisconsin Physician Serv.*, PRRB Dec. 2014-D18 (Aug. 26, 2014), *declined review*, CMS Adm'r (Oct. 14, 2014); *St. John Health 2004-2005 Bad Debt Moratorium CIRP Grp. v. National Gov't Servs.*, PRRB Dec. 2014-D19 (Aug. 27, 2014), *rev'd on other grounds*, CMS Adm'r (Oct. 23, 2014); *HMA 2004-2006 Bad Debt Grp. Appeals v. Wisconsin Physician Serv.*, PRRB Dec. 2014-D30 (Sept. 25, 2014), *declined review*, CMS Adm'r (Oct. 28, 2014); *Momence Meadows Nursing & Rehab. Ctr., LLC v. National Gov't Servs.*, PRRB Dec. 2018-D23 (Feb. 12, 2018), *declined review*, CMS Adm'r (Apr. 6, 2018).
[85] Ex. P-8, C-1 at 9 and 11.
[86] Stip. at ¶¶ 2.2.1.
[87] *Id.* at ¶¶ 2.2.2.

> written off in the incorrect fiscal year (September 8, 2014, when the Provider's cost reporting period ended on August 31, 2014).
>
> Account Sample 2
> The MAC found the Provider made three attempts then sent the account to the collection agency and one attempt was made by the collection agency. There were only 101 days of collection efforts from the date of first bill.
>
> Account Sample 3
> The MAC found the Provider made two attempts and sent the account to the collection agency and three attempts were made in November and December 2013. However, the Provider wrote the account off in May 2014. The MAC found this was not a continuous effort as the account went five months with no active collection attempts by the collection agency.[88]

The Medicare Contractor contends:

> Per the Provider's Bad Debt policy in place at the time it does not appear the Provider followed its own policies as there was not sufficient collections efforts on the three accounts disallowed. Per the Provider's Bad Debt Policy there is a series of letters sent to the patient then the account is placed at the collection agency for a minimum of six months. The three accounts did not have 120 days in collection efforts in total so it did not follow its own policy."[89]

Bon Secours argues the Medicare Contractor "improperly disallowed $68,637.63 in bad debt expenses based on its determination that the Provider did not maintain 120 days of continuous collection efforts for some bad debt accounts."[90] In contrast, Bon Secours maintains the following:

> i) the MAC has not adequately explained how it identified the three accounts for which it claims the Provider did not have 120 days of continuous collection efforts, (ii) the MAC's defines "collection efforts" more narrowly than the program guidance, (iii) the Provider did maintain 120 days of continuous collection efforts, (iv) the MAC's disallowance is predicated on a standard that does not exist in the regulations or program guidance, and (v) the Provider employed reasonable collection efforts in attempting to collect on the three accounts on which the MAC based its statistical sampling.[91]

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[88] Summary analysis based on Medicare Contractor's FPP at 24-25.
[89] Medicare Contractor's FPP at 24.
[90] Provider's FPP at 14.
[91] *Id.*

Bon Secours contends that there is no regulation or manual that provides a specific timeframe between collection letter or telephone calls to be considered a reasonable collection effort.[92] However, the Medicare Contractor also argues that Bon Secours did not follow its own policy regarding collections efforts. The Medicare Contractor maintains that "it is only reasonable to require that the Provider follow the prescribed criteria to maintain adequate documentation to support the accounts, adhere to its own Bad Debt policies, exert collection efforts that are in accordance with CMS regulations and document that verification accordingly."[93] The Medicare Contractor found that all three accounts did not maintain 120 days of continuous collections efforts.

The Board finds Bon Secours has not established that "reasonable collection efforts" were made as required by 42 C.F.R. § 413.89(e). Significantly, PRM 15-1 § 310 makes clear that in order for a debt collection policy to be reasonable, the provider must, at a minimum, issue a bill, as well as subsequent or follow-up bills, and collection letters which may or may not threaten a lawsuit. Section 310 also requires the provider to make telephone calls or other personal contacts and *may* include the use of a collection agency in lieu of any of the preceding efforts, or subsequent to its prior efforts to collect a bill. It is up to the provider to make a business decision on how much and what types of actual "collection effort" it will expend to collect debts and what tools the provider will use as part of its actual "collection effort" including whether the provider will engage certain third parties referred to as "collection agencies" to assist them in that effort. Finally, regardless of where the provider sets the bar for its actual "collection effort" § 310 specifies that, in order for a collection effort to be considered reasonable, the provider's actual "collection effort" for Medicare accounts must be similar to that used for non-Medicare accounts and that there is consistency in this treatment across Medicare and non-Medicare debts.[94]

Thus, it is the provider's business decision to develop what is its reasonable ***and*** *customary* collection effort for Medicare deductibles and coinsurance mediated only by the CMS' requirement that this effort be similar to and consistent with its efforts to collect comparable amounts of non-Medicare debt. The business decisions that a provider makes in setting its *customary* debt collection process and procedures are reflected in the provider's written debt collection policy. As part of the normal cost report audit process and procedure, intermediaries request a copy of the provider's written bad debt collection policy for handling Medicare and non-Medicare patient accounts. This requirement is memorialized in the CMS Form 339 which is submitted with the as-filed cost report.[95]

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[92] *See generally* Provider's Response at 2.

[93] Medicare Contractor's FPP at 22.

[94] Prior to the Bad Debt Moratorium, CMS gave the following example of the § 310 requirement for similar treatment in the context of collection fees:

> [T]he allowability of collection fees has been clarified. When a collection agency is used by a provider, the collection fees are allowable costs only if all uncollected charges of like amount, without regard to class of patient (Medicare or non-Medicare), are referred to a collection agency.

PRM 15-1, Transmittal 210 (Sept. 1978) (emphasis added) (revising provisions addressing collection agency fees and moving those provisions from § 318 to § 310.1).

[95] *See* PRM 15-2, Ch. 11, § 1102.

The hospital audit program in effect prior to the Bad Debt Moratorium confirms that the Medicare program expected hospitals to maintain and make available during audit a written bad debt collection policy at least since December 1985.[96] Specifically, as part of the audit of a hospital, the hospital audit program required the intermediary to review the hospital's bad debt policy to test the hospital's internal controls and adherence to Medicare bad debt policies:

> 15.01 The Auditor should review the provider's policies and procedures to obtain an understanding of the method used to determine bad debts, bad debt collection effort and the method used to record the recovery of bad debts previously written off. After reviewing bad debt policies and procedures, the auditor should determine that only uncollectible deductible and coinsurance amounts are included in the calculation of *reimbursable* bad debts.[97]

Further, the hospital audit program is derived from 42 C.F.R. §§ 413.20 and 413.24 for the purpose of testing hospital internal controls and adherence to Medicare policies. The Medicare program's expectation that the provider maintain a policy to memorialize the process for its actual "collection effort" is reflected in the use of the word "customary" in the Presumption of Noncollectibility delineated in PRM 15-1 § 310.2. In order to obtain the benefit of this presumption, a provider must follow its own policies for its "reasonable ***and*** *customary* attempts to collect"[98] for more than 120 days prior to writing off a bad debt. Indeed, very recently in the FY 2021 IPPS Final Rule, the Secretary memorialized these longstanding policies by codifying them, *on a retroactive basis*, into the Code of Federal Regulations at 42 C.F.R. § 413.89(e)(2)(i)(A)(5)-(6) as quoted above.

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[96] *See* Medicare Intermediary Manual, Part 4, CMS Pub. No. 13-4 ("MIM 13-4"), Ch. 5, § 4499 (as revised by MIM 13-4, Ch. 5, Transmittal 16 (Dec. 1985)) (stating, for example, in § 1.15 that: "the auditor should request... [p]olicies and procedures relating to the determination and collection of bad debts"; in § 15.01, "[t]he auditor should review the provider's policies and procedures to obtain an understanding of the method used to determine bad debts, bad debt collection effort and the method used to record the recovery of bad debts previously written off"; and in § 21.05(A)(1), "[r]eview the provider's 'bad debt' policy and determine whether its application to both Medicare and other patients is consistent"). This hospital audit program was designed for use by both intermediaries and CPA firms to test the hospital's internal controls and adherence to Medicare policies. *See* MIM 13-4, Ch. 5, § 4402 (as revised by MIM 13-4, Ch. 5, Transmittal 16 (Dec. 1985)) (stating that "the audit program was designed so that an intermediary or CPA could express an opinion as to whether or not the provider is adhering to Medicare Reimbursement Principles as explained in the Provider Reimbursement Manual, HCFA Pub. 15-1"); MIM 13-4, Ch. 5, § 4499 (stating that "The Audit Program was developed to assist an intermediary or CPA firm in determining if the correct amount of reimbursement was made to the provider for the cost report being audited. Also, the audit program was designed so that an intermediary or CPA [firm] could express an opinion as to whether or not the provider is adhering to Medicare Reimbursement Principles as explained in the Provider Reimbursement Manual, HCFA Pub. 15-1."); MIM 13-4, Ch. 5, § 4499 at ¶¶ 21.01, 21.05(A) (1) (as revised by MIM 13-4, Ch. 5, Transmittal 16 (Dec. 1985)) (stating in § 21.01 "the scope of an audit of the balance sheet accounts for Medicare purposes is dependent upon the... effectiveness of the internal controls" and in § 21.05 "[r]eview the provider's 'bad debt' policy and determine whether its application to both Medicare and other patients is consistent"). *See also, e.g.*, *Buckeye Home Health Serv. Inc. v. Blue Cross of Central Ohio*, PRRB Dec. No. 1983-D108 (July 14, 1983), *review declined*, CMS Adm'r (Sept. 1, 1983) (PRRB decision issued prior to the Bad Debt Moratorium where bad debts were disallowed due to the Provider's failure to follow its bad debt collection policy).

[97] MIM 13-4, Ch. 5, § 4499, Exhibit 15 at § 15.01 (as revised by MIM 13-4, Ch. 5, Transmittal 16 (Dec. 1985)) (note that Chapter 5 is entitled "Hospital Audit Program").

[98] (Emphasis added.)

Here, there is no evidence in the record of Bon Secours' internal/in-house collection efforts and policy documenting its *customary* collection practices which were applied from the time of billing *until the debts were sent to outside collection agencies*. Bon Secours asserts that it made certain collection efforts but fails to either produce any evidence in support of those assertions or establish that those efforts met and complied with its bad debt collection policy, *i.e*., were in compliance with its *customary* collection process and, as such, did not discriminate between Medicare and non-Medicare accounts. While Bon Secours' policies for referring bad debts to primary, secondary and tertiary collection agencies after internal collection efforts are in the record at Exhibit C-9, it is not apparent what Bon Secours did internally to collect bad debts, and there is no evidence that Bon Secours followed its *customary* internal/in-house collection policy prior to sending these debts to a collection agency.[99] In this respect, the Board notes that Bon Secours' outsourcing policy specifically states referrals are made only to a primary collection agency "after *established* internal collection procedures have been ***exhausted***"[100] and here the record does not establish that the internal customary collection procedures were "exhausted" for the bad debts at issue *prior to* their referral to a collection agency. Similarly, the Board notes that, per Bon Secours' Bad Debt Policies at Exhibit C-9, "Primary Bad Debt accounts are placed for six (6) months."[101] Six months is in excess of 180 days, therefore, if bad debts have been written off in less than 120 days, Bon Secours has not followed its own policy. Thus, Bon Secours did not exercise due diligence in the criteria set forth in PRM 15-1 § 310.

Finally, the Board notes that, as shown in the Medicare Contractor workpapers at Exhibit P-7, one (1) of the three (3) bad debts at issue was also denied because Bon Secours failed to establish that it was written off during the fiscal year at issue. Bon Secours acknowledges this denial reason in the Stipulations at ¶ 2.2.2, but did not address this denial reason in either its final position paper or its response and indeed entered no evidence into the record to counter the Medicare Contractor's finding. As such, the Board concludes that Bon Secours does not dispute this denial reason.[102]

In summary, for both the NAH Part C Manage Care issue and the bad debt issue, the Board finds Bon Secours has failed to meet "its burden of production of evidence and burden of proof by establishing, by a preponderance of the evidence, that [it] is entitled to relief on the merits of the matter at issue."

DECISION

After considering Medicare law and regulations, the arguments presented, and the evidence admitted, the Board finds:

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[99] *See, e.g., Cooper Hosp. v. BlueCross BlueShield Ass'n*, PRRB Dec. No. 2014-D11 (June 14, 2014) (affirming disallowance of bad debts due to the provider's failure to follow its collection policy), *declined review*, CMS Adm'r (Aug. 20, 2014).

[100] Ex. C-9 at 1 (emphasis added).

[101] *Id*. at 2.

[102] Similarly, the Provider did not challenge the extrapolation of the bad debt sample, but rather only contested the denial reason "1" which stated "Not 120 days continuous collection efforts." Ex. P-7.

1. The Medicare Contractor properly adjusted Bon Secours' NAH Part C Managed Care payment for FY 2014 to exclude the Medicare Part C data associated with the no-pay bills at issue; and

2. The Medicare Contractor properly disallowed the Medicare bad debts at issue for FY 2014.

Board Members Participating:

Clayton J. Nix, Esq.
Kevin D. Smith, CPA
Ratina Kelly, CPA

For the Board:

6/27/2024

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: PIV