CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	**Claim for:**
Faxton-St. Luke's Healthcare Provider	**Provider Reimbursement Determination for Cost Reporting Periods Ending: 2004 & 2005**
vs.	
National Government Services, Inc. MAC	**Review of: PRRB Dec. No. 2015-D25 Dated: September 22, 2015**

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) (1) of the Social Security Act (Act), as amended, 42 U.S.C. §1395oo (f)). The Medicare Contractor (MAC) submitted comments requesting that the Administrator review the Board's decision on Issue No.2.[1] The parties were notified of the Administrator's intention to review the Board's decision. The Center for Medicare Management (CM) submitted comments requesting that the Administrator affirm the Board on Issue No. 1 and reverse the Board's decision on Issue No. 2. Accordingly, this case is now before the Administrator for final administrative review.

ISSUE AND THE BOARD'S DECISION

The issue on review in this case is whether the MAC's adjustment to the Provider's bad debts for indigent patients (Issue No. 2) was proper.[2] Regarding this issue, the Board determined that the MAC's adjustments to these unpaid coinsurance deductibles were improper and should be reversed because the Provider's indigency

[1] The Board separated its decision into two sections.

[2] The first section reviewed the debts for those patients who were non-indigent (Issue No. 1). The Board held that the MAC properly disallowed the Providers' bad debts in this case in relation to the non-indigent. The Administrator summarily affirms the Board's decision regarding the non-indigent patients debts.

determinations of their patients did not violate the requirements set forth by the regulation, nor the Provider Review Reimbursement Manual (PRM).

SUMMARY OF COMMENTS

The MAC commented requesting that the Administrator affirm the Board's decision to disallow the bad debts for the non-indigent patients (Issue No. 1) and reverse the Board's decision on the allowance of bad debts pertaining to the indigent patients (Issue No. 2). In Issue No. 2, the MAC argued that the Board improperly found that the Provider satisfied the indigent determination by accepting documents that do not meet the necessary requirements. Specifically, the MAC stated that the documents the Provider accepted as proof of indigency were non-verified and from a third party (the State). Thus, the MAC alleged that the Provider failed to perform their own due diligence required by the rules and regulations to determine indigency and that the Administrator should reverse the Board's finding and hold that the MAC properly disallowed the bad debts.

The Center for Medicaid Management (CM) commented also asserting that the Board's decision regarding the bad debt adjustments for the non-indigent patients (Issue No. 1) were correct but stating that the reversal of the MAC's adjustments for indigent (Issue No. 2) patients was incorrect. Regarding Issue No. 2 CM asserted that the Provider lacked the documentation necessary for determining indigency set forth in the Provider Review Reimbursement Manual (PRM) §§ 310 and 312. CM argued that the Manual clearly states that a patient's indigency must be determined by the Provider and cannot be determined based upon a patient declaration. In this case CM pointed out that the Provider based their indigency determinations based upon an Application for Eligibility Determination for Uncompensated Care Assistance as well as accepting verbal declarations by patients of their income. CM asserted that the application used was insufficient to establish indigence as it fails to include a review of assets as required by PRM §312 and, also, that the Provider failed to adhere to their own policy by not collecting tax returns and proof of Social Security Income. Accordingly, CM recommended that the Administrator reverse the Board's decision on this issue.

DISCUSSION

The entire record, which was furnished by the Board, has been examined, including all correspondence, position papers, and exhibits. The Administrator has reviewed the Board's decision. All comments received timely are included in the record and have been considered.

Under Section 1861(v)(1)(a) of the Act, providers are to be reimbursed the reasonable cost of providing services to Medicare beneficiaries. That section defines "reasonable cost" as "the cost actually incurred, excluding therefrom any part of the incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included...." An underlying principle set forth in the Act is that Medicare shall not pay for costs incurred by non-Medicare beneficiaries, and vice-versa, i.e., Medicare prohibits cross-subsidization of costs. The section does not specifically address the determination of reasonable cost, but authorizes the Secretary to prescribe methods for determining reasonable cost, which are found in regulations, manuals, guidelines, and letters. With respect to such payments, section 1815 of the Act states that:

> 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 (but not less often than monthly) and prior to audit or settlement …..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 (Emphasis added.)

In addition, consistent with the requirements of section 1815 of the Act, the regulation sets forth that providers are required to maintain contemporaneous auditable documentation to support the claimed costs for that period. The regulation at 42 CFR 413.20(a) states that the principles of cost reimbursement require that providers maintain sufficient financial records and statistical data for proper determination of costs payable under the program. The regulation at 42 CFR 413.24(a) also describes the characteristics of adequate cost data and cost finding, explaining that providers receiving payment on the basis of reimbursable cost must provide adequate cost data. This must be based on their financial and statistical records which must be capable of verification by qualified auditors. The cost data must be based on an approved method of cost finding and on the accrual basis of accounting. Generally, paragraph (b) explains that the term “accrual basis of accounting means that revenue is reported in the period in which it is earned, regardless of when it is collected; and an expense is reported in the period in which it is incurred, regardless of when it is paid.”

Along with the documentation requirements for payment, the regulations further explain the reasonable cost principles set forth in the Act. This principle is reflected at 42 CFR 413.9,[3] which provides that the determination of reasonable cost must be based on costs actually incurred and related to the care of Medicare beneficiaries. Reasonable cost includes all necessary and proper costs incurred in furnishing the services, subject to principles relating to specific items of revenue and cost. The provision in Medicare for payment of reasonable cost of services is intended to meet the actual costs, however widely they may vary from one institution to another. The regulation states that the objective is that under the methods of determining costs, the costs with respect to individuals covered by the program will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by the program. However, if the provider's costs include amounts not reimbursable under the program, those costs will not be allowed.

Consistent with these reasonable cost principles and payment requirements, the regulatory provision at 42 CFR 413.89(a) provides that bad debts, which are deductions in a provider's revenue, are generally not included as allowable costs under Medicare. The regulation at 42 CFR 413.89(b)(1) defines "bad debts" as "amounts considered to be uncollectible from accounts and notes receivable that were created or acquired in providing services. "Accounts receivable" and "notes receivable" are defined as designations for claims arising from the furnishing of services, and are collectable in money in the relatively near future. In particular, 42 CFR 413.89(d) explains that:

> *Requirements for Medicare*. Under Medicare, costs of covered services furnished beneficiaries are not to be borne by individuals not covered by the Medicare program, and conversely, cost of services provided for other than beneficiaries are not to be borne by the Medicare program. Uncollected revenue related to services furnished to beneficiaries of the program generally mean the provider has not recovered the cost of services covered by that revenue. <u>The failure of</u>

---

[3] The regulation at 42 CFR 413.1 explains that: "This part sets forth regulations governing Medicare payment for services furnished to beneficiaries." Paragraph (3) explains that: "Applicability. The payment principles and related policies set forth in this part are binding on CMS and its fiscal intermediaries, on the Provider Reimbursement Review Board, and on the entities listed in paragraph (a)(2) of this section. (b) Reasonable cost reimbursement. Except as provided under paragraphs (c) through (h) of this section, Medicare is generally required, under section 1814(b) of the Act (for services covered under Part A) and under section 1833(a)(2) of the Act (for services covered under Part B) to pay for services furnished by providers on the basis of reasonable costs as defined in section 1861(v) of the Act.…"

> beneficiaries to pay the deductibles and coinsurance amounts could result in the related costs of covered services being borne by others. The costs attributable to the deductible and coinsurance amounts that remain unpaid are added to the Medicare share of allowable costs. Bad debts arising from other sources are not an allowable cost. (Emphasis added.)

The circumstances under which providers may be reimbursed for the bad debts derived from uncollectible deductibles and coinsurance amounts are set forth at paragraph (e). The regulation at 42 CFR 413.89(e) states that to be allowable, a bad debt must meet the following criteria:

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

To comply with section 42 CFR 413.89(e)(2), the Provider Reimbursement Manual or PRM provides further guidance with respect to the payment of bad debts. Section 310 provides the instructions for reasonable collection efforts.

> 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.)

Section 312 of the PRM provides the criteria for indigent or medically indigent patients.

> In some cases, the provider may have established before discharge, or within a reasonable time before the current admission, that the beneficiary is either indigent or medically indigent. Providers can deem Medicare beneficiaries indigent or medically indigent when such individuals have also been determined eligible for Medicaid as either categorically needy individuals or medically needy individuals, respectively. Otherwise, the provider should apply its customary methods for determining the indigence of patients to the case of the Medicare beneficiary under the following guidelines:
>
> A. The patient's indigence must be determined by the provider, not by the patient; i.e., a patient's signed declaration of his inability to pay his medical bills cannot be considered proof of indigence;
>
> B. The provider should take into account a patient's total resources which would include, but are not limited to, an analysis of assets (only those convertible to cash, and unnecessary for the patient's daily living), liabilities, and income and expenses. In making this analysis the provider should take into account any extenuating circumstances that would affect the determination of the patient's indigence;
>
> C. The provider must determine that no source other than the patient would be legally responsible for the patient's medical bill; e.g., title XIX, local welfare agency and guardian; and
>
> D. The patient's file should contain documentation of the method by which indigence was determined in addition to all backup information to substantiate the determination. (Emphasis added.)

Once indigence is determined and the provider concludes that there had been no improvement in the beneficiary's financial condition, the debt may be deemed uncollectible without applying the §310 procedures.

The patient’s Medicaid status at the time of service should be used to determine their eligibility for Medicaid to satisfy the requirement of § 312.

In this case, the Provider is a not-for-profit acute care hospital located in Utica, NY. The MAC denied bad debt reimbursement claims for FYs 2004 and 2005 based upon an audit of a sample of bad debt claims from each fiscal year. Specifically, the MAC

denied claims for two categories of patients: (1) non-indigent patients and (2) indigent patients. The MACs disallowance for the second category of patients is the issue under review in this decision.

The Provider contended that it should have received payment for the unpaid coinsurance and deductibles related to the indigent patients disallowed by the MAC because each case file contained sufficient documentation that the patient was indigent.[4] The MAC determined that the Provider did not sufficiently document the patient's income, assets, and expenses as required by both the Provider's own policy and the PRM.[5] The MAC further contended that the Medicaid application used by the Provider to assist in determining indigency was also insufficient to establish that the patients were indigent.[6]

After a review of the record and the applicable law and Medicare policy, the Administrator finds that the Board incorrectly held that the Provider met all the regulatory requirements and the Manual guidelines for reimbursement of the subject amounts as Medicare bad debts. The Administrator finds that the PRM clearly states that the criteria for establishing indigency and that the Provider did not meet the requirements. In addition, the Administrator notes that Provider also did not follow its own collection policy to establish indigency. Accordingly, the failure to meet these requirements supports the MAC's denial of the bad debt claims.

In order to establish indigency, the PRM §312.A. requires that "the patients indigence must be determined by the provider, not by the patient; i.e., a patient's signed declaration of his inability to pay his medical bills cannot be considered proof of indigence." In this case, the Provider failed to obtain and document the patient's total resources including assets, liabilities income and expenses. Additionally, the Provider permitted the patients to self-testify as to their indigency and did not perform their own due diligence to verify the information, which clearly violates the language of §312.

Additionally, the language in §312(B) states that the "provider should take into account a patient's total resources which would include, but are not limited to, an analysis of assets (only those convertible to cash, and unnecessary for the patient's daily living), liabilities, and income and expenses." The Provider's in-house policy regarding an indigency determination requires patients to complete an application that includes inquiries regarding income, assets and expenses, and requests to supply documentation to support their declarations. The Board found that the Provider demonstrated that it established and substantiated patient income, expenses, and

---

[4] See Provider's Revised Final Position Paper for FY 2004 and 2005 at 5.
[5] See Tr. at 27:19-31:18.
[6] See Tr. at 230:4-232:5.

assets. However, a review of the record shows that the application used by the Provider fails to meet the criteria of §312 and, furthermore, the Provider violated its own indigency policy by failing to obtain tax returns and proof of Social Security Income from patients.

Consistent with PRM §312 the Provider must meet all of the criteria for establishing indigency and consider all necessary information to properly deem any patient indigent, thus, meeting the regulatory requirements that a reasonable collection effort was made and that the debt was uncollectible when claimed as worthless.

In sum, the Medicare bad debt policy relative to determining indigence are not met until all of the relative criteria set forth in the PRM §312 and the regulation at 42 C.F.R. 413.89 have been met. The Administrator finds that the Provider did not meet the indigency requirements and, therefore, the MAC properly disallowed the bad debts in those claims.

DECISION

The Board's decision is reversed regarding the indigent patient bad debt claims.

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

Date: 11/20/15 /s/

Patrick H. Conway, M.D., MSc
Acting Principal Deputy Administrator
Centers for Medicare & Medicaid Services