FRESENIUS MEDICAL CARE

June 2, 2014

Ms. Martha Frisone, Chief
Certificate of Need Section
Division of Health Service Regulation
809 Ruggles Drive
Raleigh, NC 27603

Re: Public Written Comments
CON Project ID # J-10282-14

Dear Ms. Frisone:

The attached Public Written Comments are forward for consideration by the CON Project Analyst conducting the respective review. If you have any questions regarding these comments please feel free to contact me.

Respectfully,

Jim Swann
Director of Operations, Certificate of Need

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Raleigh, North Carolina 27612

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Public Witten Comments
CON Project ID # J-10282-14
DVA Healthcare Renal Care Inc., d/b/a East Durham Dialysis
Prepared and Submitted by Jim Swann
FMC Director of Operations, Certificate of Need

The application submitted by DVA Renal Healthcare Renal Care, Inc. (DVA) presents the CON Section with an incomplete picture, inaccurate information, and an application which is not conforming to the CON Review Criteria and Rules for End Stage Renal Disease Treatment facilities. The application should be not be approved, or conditionally approved. The following information identifies multiple failures within the application.

1. The applicant fails to conform to CON Review Criterion 3 and should be denied.

   The applicant has provided only 23 letters of support from in-center dialysis patients, and no letters of support from home patients. The CON Section has historically relied upon patient letters of support as evidence of patient interest in a new dialysis facility. The Section has found other applications non-conforming to Criterion 3 in the absence of sufficient letters of support. The Section has historically not relied upon an applicant's assertion that other patients support the project but did not supply letters of support. In this case the applicant asks the Section to assume its assertion that 28% of the patients who would not sign letters of support would transfer their in-center care upon completion of the project.

   Equally as important, the applicant has not provided any evidence of support for its projections of home patient population to be served. First, the applicant has suggested that two patients would transfer their care. However the applicant has not provided letters of support from these patients. The applicant has not provided even the representation that the patients offered a verbal commitment (though BMA suggest that is not sufficient to meet the burden of proof historically used by the Section). The applicant goes further to suggest that one new PD patient per year will somehow appear at the facility. The applicant offered no methodology. The applicant offered nothing but a speculative guess that somehow a patient would desire to use the facility.

   It is incumbent upon the applicant to provide the CON Section with an application that is reasonable and credible. The applicant has simply failed to provide sufficient evidence of a patient population willing to transfer their care to the proposed new facility. In multiple other CON reviews the Agency has determined that the absence of sufficient numbers of patient letters, or patient letters with sufficient information (such as residence location) was enough of a reason to determine an application to be non-conforming to Criterion 3.

2. The application should be found non-conforming to CON Review Criterion 5. Because the applicant has not provided reasonable and credible projections of a patient population to be served, the resultant projections of revenues and expenses

must be determined to be unreliable. If they are unreliable, then the application cannot be found conforming to CON Review Criterion 5.

3. The applicant has indicated in Section X of the application, on page 49) that the Medicare Allowable Charge for dialysis is $240. The applicant also notes that Medicare reimbursement is only 80% of the allowable rate. The applicant has followed this by indicating its intent to write off the 20% billable to "Medicare only" patients. BMA suggests this is not appropriate and not consistent with Medicare guidelines.

   Beyond the above issue, BMA notes that Medicare has indeed proposed a 12% cut in drug payments for ESRD care (See Exhibit 1). This reduction for dialysis treatment was announced on November 22, 2013, and is scheduled to go into effect beginning in 2016.

   The applicant's parent company commented on November 25, 2013 about *"the bad news"* (See Exhibit 2).

   Thus it is clear that the applicant was aware of the projected decrease in reimbursement as related to dialysis treatment. Consequently the applicant should have projected lower Medicare allowable rates for 2016 and forward. As a result of using the current Medicare allowable and failing to use a lower rate for future years, the applicant has overstated revenues to be earned by the facility. The application is therefore not based upon credible information and should be found non-conforming to CON Review Criterion 5.

4. The applicant has provided a floor plan which indicates eight PD training rooms. The applicant has proposed to serve only four PD patients by the end of Operating Year 2. The applicant proposes a facility which is overly developed and is not conforming to CON Review Criterion 12.

   BMA suggests that the Analyst should not assume that the applicant provided a floor plan drawn by an outside agency, and therefore the applicant is not solely responsible. The applicant included the plan within the application. The applicant further provides an attestation which indicates that the application is accurate. If the applicant did not propose to include eight PD training rooms the applicant had ample opportunity prior to submission of the application to reform the floor plan or have it redrawn to present a more accurate picture of the proposed facility. In this case the applicant should be found non-conforming to CON Review Criterion 12.

5. The applicant has also indicated that it would write off the 20% required co-pay for Medicare patients (application, Page 49, Note 3). This is not an acceptable practice and the applicant may be in violation of Medicare claims processing procedures.

   CMS guidelines for write-offs require the provider to make reasonable efforts to collect the amounts due. A bill must be forwarded to the responsible party. A "token, collection effort" is not sufficient. In other words the provider has a responsibility to make collection efforts. The very idea of proposing to simply write the 20% co-payment off without first seeking to collect seems contradictory to the Medicare laws. See excerpts from CMS regarding bad debt at Exhibit 3.

   Given the absolute failure by the applicant on this matter, BMA suggests the financial projects of the applicant are not credible and the application should be found non-conforming to CON Review Criterion 5.

6. Given the many failures within the application, the application is clearly not the best alternative and fails to conform to CON Review Criterion 4.

SUMMARY:

BMA suggests the application fails on multiple levels and should not be approved. BMA suggests the applicant fails to conform to CON Review Criteria 3, 4, 5 and 12.

For these reasons, the application should be denied.

Exhibits:
1) News article, Medicare cuts to dialysis reimbursement
2) DaVita article, re: reduction to reimbursement
3) Excerpts from Medicare Provider Reimbursement Manual

CMS retains 12% cut in drug payments for ESRD care, approves new QIP measures

By Mark E. Neumann
November 25, 2013
No Comments
KEYWORDS ESRD bundle Email / Print / Reprints / | / Text Size+
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The Centers for Medicare and Medicaid Services issued its much-anticipated **final rule** Nov. 22 that updates 2014 payment rates for dialysis facilities paid under the end-stage renal disease Prospective Payment System (PPS). The agency also approved final changes to the ESRD Quality Incentive Program for performance year 2014, which will impact dialysis clinic payments in 2016.

Despite more than 1,000 comments protesting the proposed cut by the dialysis industry, patients, renal association groups, and even members of Congress, the agency decided to keep a 12% reduction in the drug utilization adjustment to the base rate, but implement it over a three- to four-year transition period.

(Where Medicare and the ESRD Program are headed)

CMS released a proposed rule in July that called for a 12% reduction in payments for injectable drugs based on a 30%+ drop in utilization—primarily in the prescribing of anemia drugs—from 2007 to 2012. The agency proposed to temper the cut with a 2.6% payment increase for 2014 based on the annual Medicare market basket review of costs of providing care to dialysis patients.

Congress required CMS to implement a payment reduction as part of the American Taxpayer Relief Act passed by Congress in 2012, but Congress left it up to the agency to determine the amount of the cut.

CMS said it would implement the first portion of the cut in 2014—a 3.3% reduction to the drug payment adjustment—but dialysis clinics won't see a change in the overall payment for patients for 2014 and 2015 because of other offsets, the agency said.

The cuts will still have an impact on the bottom line for dialysis clinics, said Kidney Care Council and Kidney Care Partners in prepared statements released on Friday in response to the final rule. "Today's Medicare ruling substantially reduces funding needed for patient care and interferes with the ability of our physicians, nurses, and clinical teams to do the very best for their patients," said KCC chairman Tom Weinberg. Ultimately, the payment cut of $29.93 per dialysis treatment "contradicts the unified voice of patients, clinicians, providers, facilities, and members of Congress to correct the total amount of the reduction" originally proposed in July, said Weinberg. "Phasing in a cut of this magnitude only delays the harm."

(Mineral and bone disease testing attestation in the ESRD QIP: A tale of two cities)

According to Kidney Care Partners, a coalition of patients, physicians, nurses, providers, and manufacturers, the rule deals a "significant blow to an already fragile system" by ultimately reducing Medicare payments to a level that will not cover the cost of care for individuals on dialysis. "Phasing in this cut does not solve the problem," said KCP chairman Ron Kuerbitz. "Instead, it only delays the inevitable harm that will come as a result of failing to cover the cost of care. Simply put, this model is unsustainable."

As a result of the rule, KCP said, providers and physicians will face difficult choices regarding staffing, facility hours, quality improvement interventions, and ultimately whether an entire facility can be kept open to service a community. In turn, Medicare beneficiaries could face reduced access to care.

"Our community worked with Congress to establish a sustainable bundled payment system," said Kuerbitz. "It is troubling that, as we celebrate the 40th anniversary of the Medicare dialysis benefit, this rule appears to be a step backwards. We appreciate those in Congress on both sides of the aisle who support their constituents living with kidney failure, and we will continue to work with them to ensure that these, and all Americans with kidney failure, have access to the highest quality care in the years to come."

Details of the final rule include:

The ESRD payment base rate: This remains the same from CY 2013 to CY 2014 at $239.02. CMS said the rate reflects the CY 2013 ESRD PPS base rate of $240.36 adjusted by the ESRD market basket (3.2%) minus the productivity (0.4%) increase, the wage index budget neutrality factor of 1.000454, and the home dialysis training add-on budget neutrality adjustment factor of 0.999912. That brings the base rate up to $247.18, but then CMS makes a 3.3% cut in the portion of the CY 2014 drug utilization adjustment that is being transitioned for 2014, or $8.16, to arrive at a final CY 2014 ESRD PPS base rate of $239.02 ($247.18 - $8.16 =$239.02).

The wage index: No changes

The outlier policy: Outlier services fixed dollar loss amounts are updated for 2014 for adult and pediatric patients, along with Medicare Allowable Payments (MAPs) for adult patients for CY 2014 using 2012 claims data. Based on the use of more current data, the fixed-dollar loss amount for pediatric beneficiaries would increase from $47.32 to $54.01 and the adjusted average outlier services MAP amount would decrease from $41.39 to $40.49 as compared to CY 2013 values. For adult beneficiaries, the fixed-dollar loss amount would decrease from $110.22 to $98.67 and the adjusted average outlier services MAP amount would decrease from $59.42 to $50.25. The 1% target for outlier payments was not achieved in CY 2012. "We believe using CY 2012 claims data to update the outlier MAP and fixed dollar loss amounts for CY 2014 will increase payments for ESRD beneficiaries requiring higher resource utilization in accordance with a 1% outlier policy," CMS said in the final rule.

The self-dialysis and home dialysis training add-on adjustment: Medicare is increasing this add-on adjustment by 50% for both peritoneal dialysis and home hemodialysis training treatments. In CY 2014, the nursing time accounted for in the training add-on adjustment will increase from one hour to 1.5 hours per training treatment, resulting in an increase of $16.72, for a total training add-on adjustment of $50.16 per training treatment.

The 50% increase in payment, however, is one of the offsets the agency is using to keep the 2014 base rate the same as 2013. "We note that the increase to the training add-on adjustment will be made in a budget neutral manner in that we have applied a training add-on budget-neutrality adjustment factor of 0.999912 to the base rate."

The final rule also ends the four-year transition period for dialysis clinics that chose not to move directly into the new bundled payment system when it took effect in January 2011. Dialysis facilities were paid a blended payment with a portion of payments based on the composite rate methodology and a portion based on the new

PPS rate. In 2014, the final year of the four-year transition period, all dialysis facilities will be paid 100% of the ESRD PPS rate for dialysis services.

(SDO perspective on the bundle cuts: Dialysis patients face fewer options)

QIP measures finalized

The final rule also includes new reporting and clinical measures as part of the ESRD Quality Incentive Program. For the ESRD QIP Payment Year (PY) 2016 program (which will rely on measures of dialysis facility performance during 2014), CMS is finalizing 11 measures addressing infections, anemia management, dialysis adequacy, vascular access, mineral metabolism management, and patient experience of care. Performance scores will be calculated by weighting clinical measures at 75% of the total performance score and weighting the reporting measures at 25%.

More details on Provider Call

On Jan. 15, CMS will hold a National Provider Call to help facilities and other stakeholders in the ESRD community understand the final rule. The discussion will be recorded and made available at www.cms.gov/live.

Dowload the final rule.

Find more articles about the ESRD bundle

Mr. Neumann has been executive editor of Nephrology News & Issues since 1989.
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DaVita HealthCare Partners Inc. Comments on the Final CMS ESRD Rates and Provides Initial 2014 Operating Income Guidance

November 25, 2013 05:00 AM Eastern Standard Time

DENVER--(BUSINESS WIRE)--DaVita HealthCare Partners Inc. (NYSE: DVA) today commented on the final Centers for Medicare and Medicaid Services (CMS) Medicare ESRD rule for 2014 and announced initial 2014 operating income guidance.

Final CMS Rule

LeAnne Zumwalt, Group Vice President said, "On the dialysis rule, the bad news is that CMS appears to have accepted the premise that the language in the American Taxpayer Relief Act of 2012 required it to make a partial rebasing of the bundle. This could unfairly result in cuts of nearly $30 per treatment over a three to four year period by looking only at pharmaceutical economics. This means that Medicare dialysis rates will be flat in 2014 and 2015 in an environment of increasing expenses.

"The good news is that Medicare rates will not be decreased next year, when most thought rates would be down. In addition, we get to work with Congress and CMS on trying to mitigate future cuts, and CMS has a number of appropriate reimbursement levers to pull to offset cuts a few years out if it chooses to do so, since Medicare reimbursement already fails to cover the full cost of caring for Medicare patients."

Guidance

Given the issuance of the final CMS rule, the company is now in a position to provide initial 2014 guidance and expects 2014 enterprise operating income to be in a range of $1.675 to $1.850 billion.

The company expects 2014 operating income for our dialysis services and related ancillary business to be in the range of $1.425 to $1.540 billion. The primary reasons for a likely year-on-year decline in operating income are Medicare patient expense increases, commercial rate and mix pressures, and health care exchange dynamics.

The company expects 2014 operating income for HealthCare Partners (HCP) to be in the range of $250 to $310 million. The primary reason for a substantial expected year-on-year decline in HCP operating income in 2014 is the previously announced Medicare Advantage rate cuts, which the company will have limited ability to offset.

These projections and the underlying assumptions involve significant risks and uncertainties, including those described below and actual results may vary significantly from these current projections.

Capital Markets Day

The company will discuss its outlook in more detail at its upcoming Capital Markets Day in New York City on Monday, December 9, 2013, at 9:30 a.m. Eastern Time.

This meeting is being broadcast live by conference call and webcast. You can access the webcast at the DaVita HealthCare Partners investor relations web page. You can join this call on:

Monday, December 9, 2013
Starting at 9:30 a.m. EST
Dial in number: 800-399-4406
Webcast: www.davita.com/investors

The event will be held at the New York Palace Hotel, 455 Madison Avenue, New York, NY 10022. If you plan to attend, please register with us by emailing your name and company affiliation to Kelly.Perez@davita.com.

If you are joining the presentation by conference call, please refer to the "DaVita HealthCare Partners Capital Markets Call" and provide the operator with your name and company affiliation. Investors who are unable to listen live will be able to access the presentation and an audio replay via our web site at www.davita.com/investors. There will be no telephone replay.

About DaVita HealthCare Partners

DaVita HealthCare Partners, a Fortune 500® company, is the parent company of DaVita and HealthCare Partners. DaVita is a leading provider of kidney care in the United States, delivering dialysis services to patients with chronic kidney failure and end stage renal disease. As of September 30, 2013, DaVita operated or provided administrative services at 2,042 outpatient dialysis centers in the United States serving approximately 166,000 patients, and at 66 centers in ten countries outside of the United States. HealthCare Partners manages and operates medical groups and affiliated physician networks in California, Nevada, Florida, Arizona and New Mexico in its pursuit to deliver excellent-quality health care in a dignified and compassionate manner. As of September 30, 2013, HealthCare Partners provided integrated care management for approximately 760,000 managed care patients. For more information, please visit DaVitaHealthCarePartners.com.

Forward Looking Statements

This release contains forward-looking statements within the meaning of the federal securities laws, including statements related to our guidance and expectations for our 2014 consolidated and dialysis services and related ancillary businesses operating income and HCP's 2014 operating income. Factors that could impact future results include the uncertainties associated with the risk factors set forth in our SEC filings, including our annual report on Form 10-K for the year ended December 31,

2012, our quarterly report on Form 10-Q for the quarter ended September 30, 2013 and subsequent quarterly reports to be filed on Form 10-Q, or our current reports on Form 8-K. The forward-looking statements should be considered in light of these risks and uncertainties.

These risks and uncertainties include, but are not limited to, and are qualified in their entirety by reference to the full text of those risk factors in our SEC filings relating to:

- *the concentration of profits generated by higher-paying commercial payor plans for which there is continued downward pressure on average realized payment rates, and a reduction in the number of patients under such plans, which may result in the loss of revenues or patients,*
- *further reduction in government payment rates under the Medicare End Stage Renal Disease program or other government-based programs,*
- *the impact of health care reform legislation that was enacted in the United States in March 2010,*
- *the impact of the Center for Medicare and Medicaid Services (CMS) 2014 Medicare Advantage benchmark structure,*
- *the impact of the American Taxpayer Relief Act,*
- *the impact of the sequestration that went into effect on April 1, 2013,*
- *the impact of disruptions in federal government operations and funding,*
- *changes in pharmaceutical or anemia management practice patterns, payment policies, or pharmaceutical pricing,*
- *legal compliance risks, including our continued compliance with complex government regulations and current or potential investigations by various government entities and related government or private-party proceedings, including risks relating to the resolution of the 2010 and 2011 U.S. Attorney Physician Relationship Investigations,*
- *our ability to maintain contracts with physician medical directors, changing affiliation models for physicians, and the emergence of new models of care introduced by the government or private sector, that may erode our patient base and reimbursement rates,*

- *our ability to complete any acquisitions, mergers or dispositions that we might be considering or announce, or to integrate and successfully operate any business we may acquire or have acquired, including HCP, or to expand our operations and services to markets outside the United States,*
- *risks arising from the use of accounting estimates, judgments and interpretations in our financial statements,*
- *the risk that the cost of providing services under HCP's agreements may exceed our compensation,*
- *the risk that further reductions in reimbursement rates, including Medicare Advantage rates, and future regulations may negatively impact HCP's business, revenue and profitability,*
- *the risk that HCP may not be able to successfully establish a presence in new geographic regions or successfully address competitive threats that could reduce its profitability,*
- *the risk that a disruption in HCP's healthcare provider networks could have an adverse effect on HCP's business operations and profitability,*
- *the risk that reductions in the quality ratings of health maintenance organization plan customers of HCP could have an adverse effect on HCP's business, or*
- *the risk that health plans that acquire health maintenance organizations may not be willing to contract with HCP or may be willing to contract only on less favorable terms.*

We base our forward-looking statements on information currently available to us at the time of this release, and we undertake no obligation to update or revise any forward-looking statements, whether as a result of changes in underlying factors, new information, future events or otherwise.

Contacts

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Manuals

Return to List

Details for title: 15-1

Publication # 15-1

Title The Provider Reimbursement Manual - Part 1

Downloads

Chapter 1 -- Depreciation [ZIP, 141KB]
Chapter 2 -- Interest Expense [ZIP, 77KB]
Chapter 3 -- Bad Debts, Charity, and Courtesy Allowances [ZIP, 22KB]
Chapter 4 -- Cost of Educational Activities [ZIP, 17KB]
Chapter 5 -- Research Costs [ZIP, 11KB]
Chapter 6 -- Grants, Gifts and Income From Endowments [ZIP, 4KB]
Chapter 7 -- Value of Services of Nonpaid Workers [ZIP, 35KB]
Chapter 8 -- Purchase Discounts and Allowances, and Refunds [ZIP, 56KB]
Chapter 9-Compensation of Owners [ZIP, 38KB]
Chapter 10 -- Cost to Related Organizations [ZIP, 18KB]
Chapter 11 - Allowance In Lieu Of Specific Recognition Of Other Costs - RESERVED [ZIP, 5KB]
Chapter 12 - Return On Equity Capital Of Proprietary Providers - RESERVED [ZIP, 5KB]
Chapter 13 - Inpatient Routine Nursing Salary Cost Differential - RESERVED [ZIP, 5KB]
Chapter 14 -- Reasonable Cost of Therapy and Other Services [ZIP, 89KB]
Chapter 15 -- Change of Ownership [ZIP, 12KB]
Chapter 21 -- Costs Related to Patient Care [ZIP, 833KB]
Chapter 22 -- Determination of Cost of Services [ZIP, 94KB]
Chapter 23 -- Adequate Cost Data and Cost Finding [ZIP, 188KB]
Chapter 24 -- Payment to Providers [ZIP, 114KB]

300. PRINCIPLE

Bad debts, charity, and courtesy allowances are deductions from revenue and are not to be included in allowable costs; however, bad debts attributable to the deductibles and coinsurance amounts are reimbursable under the Program.

302. DEFINITIONS

302.1 Bad Debts.--Bad debts are amounts considered to be uncollectible from accounts and notes receivable which are created or acquired in providing services. "Accounts receivable" and "notes receivable" are designations for claims arising from rendering services and are collectible in money in the relatively near future.

302.2 Allowable Bad Debts.--Allowable bad debts are bad debts of the provider resulting from uncollectible deductibles and coinsurance amounts and meeting the criteria set forth in Section 308. Allowable bad debts must relate to specific deductibles and coinsurance amounts.

302.3 Charity Allowances.--Charity allowances are reductions in charges made by the provider of services because of the indigence or medical indigence of the patient.

302.4 Courtesy Allowances.--Courtesy Allowances are reductions in charges by the provider in the form of an allowance to physicians, clergy, members of religious orders, and others as approved by the governing body of the provider, for services received from the provider. Reductions in charges made as employee fringe benefits, such as hospitalization and personnel health programs are not considered courtesy allowances.

302.5 Deductible and Coinsurance Amounts.--Deductible and coinsurance amounts are amounts payable by beneficiaries for covered services received from providers of services, excluding medical and surgical services rendered by physicians and surgeons. These deductibles and coinsurance amounts, including the blood deductible, must relate to inpatient hospital services, post-hospital extended care services, home health services, out-patient services, and medical and other health services furnished by a provider of services.

304. BAD DEBTS UNDER MEDICARE

Bad debts resulting from deductible and coinsurance amounts which are uncollectible from beneficiaries are not includable as such in the provider's allowable costs; however, unrecovered costs attributable to such bad debts are considered in the Program's calculation of reimbursement to the provider.

The allowance of unrecovered costs attributable to such bad debts in the calculation of reimbursement by the Program results from the expressed intent of Congress that the costs of services covered by the Program will not be borne by individuals not covered, and the costs of services not covered by the Program will not be borne by the Program. Payment for

deductibles and coinsurance amounts is the responsibility of the beneficiaries. However, the inability of the provider to collect deductibles and coinsurance amounts from beneficiaries of the Program could result in part of the costs of covered services being borne by others who are not beneficiaries of the Program. Therefore, to assure that costs of covered services are not borne by others because Medicare beneficiaries do not pay their deductibles and coinsurance amounts, the Medicare Program will reimburse the provider for allowable bad debts, not to exceed the total amount of unrecovered costs of covered services furnished to all beneficiaries. In the determination of unrecovered costs due to bad debts, the Medicare Program is considered as a whole without distinction between Part A and Part B of the Program.

305. EFFECT OF THE WAIVER OF LIABILITY PROVISION ON BAD DEBTS

A. Beneficiary Liability.--The waiver of liability provision of the law protects a beneficiary from liability for payments to a provider for noncovered services when (l) the services are found to be not reasonable and necessary or to involve custodial care (i.e., excluded from coverage under section l862(a)(l) or (9) of the Social Security Act), and (2) the beneficiary did not know or could not reasonably be expected to have known that the services were not covered. Where the beneficiary had knowledge that the services were not covered, liability will remain with the beneficiary.

B. Provider Not Accountable.--The program will reimburse the provider for the services if the provider did not know and could not reasonably be expected to have known that the services were not covered and the beneficiary had no knowledge as described n paragraph A. If the provider has such knowledge, it will assume accountability for the noncovered services. Where neither the provider nor the beneficiary is found accountable, the provider's charges for the services and the patient days are recorded as Medicare charges and Medicare patient days. The provider is entitled to collect from the beneficiary the amounts that would have represented the deductible and coinsurance amounts. If these amounts are not collected, they can be reimbursed under the Medicare bad debt provision (see 304) since the effect of the waiver of liability provision is to reimburse the provider as it would have been reimbursed had the services been covered.

C. Provider Accountable.--Where the provider is found accountable, any bad debts the provider experiences from such a program decision (i.e., those charges the provider cannot collect from the beneficiary) cannot be reimbursed under the Medicare bad debt provision as defined in §302. Provider costs attributable to these noncovered services furnished a beneficiary where the beneficiary's liability to the provider has been waived must be included in a provider's total costs for cost report purposes. The provider's charges for the services and the patient days must be shown as non-Medicare charges and non-Medicare patient days. The provider is nevertheless entitled to collect from the beneficiary the amounts that would have represented the deductible and coinsurance amounts had the services been covered. If these

amounts are not collected, however, they cannot be reimbursed under the Medicare bad debt provision since they apply to services held to be not covered. (See §306 below.)

306. BAD DEBTS RELATING TO NONCOVERED SERVICES OR TO NONBENEFICIARIES

If a beneficiary does not pay for services which are not covered by Medicare, the bad debts attributable to these services are not reimbursable under the Medicare program. Likewise, bad debts arising from services to non-Medicare patients are not reimbursable under the program.

Services which are not covered are defined generally in the following Health Insurance Manuals:

CMS-Pub. 10	Hospital Manual - §260
CMS-Pub. 11	Home Health Agency Manual - §§230 and 232
CMS-Pub. 12	Skilled Nursing Facility Manual - §240

308. CRITERIA FOR ALLOWABLE BAD DEBT

A debt must meet these criteria to be an allowable bad debt:

1. The debt must be related to covered services and derived from deductible and coinsurance amounts. (See §305 for exception.)

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.

310. REASONABLE COLLECTION EFFORT

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.

When a collection agency obtains payment of an account receivable, the full amount collected must be credited to the patient's account and the collection fee charged to administrative costs. For example, where an agency collects $40 from the beneficiary, and its fee is 50 percent, the agency keeps $20 as its fee for the collection services and remits $20 (the balance) to the provider. The provider records the full amount collected from the patient by the agency ($40) in the patient's account receivable and records the collection fee ($20) in administrative costs. The fee charged by the collection agency is merely a charge for providing the collection service, and, therefore, is not treated as a bad debt.

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.

312. 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.

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. (See §322 for bad debts under State Welfare Programs.)

314. ACCOUNTING PERIOD FOR BAD DEBTS

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

316. RECOVERY OF BAD DEBTS

Amounts included in allowable bad debts in a prior period might be recovered in a later reporting period. Treatment of such recoveries under the program is designed to achieve the same effect upon reimbursement as in the case where the amount was uncollectible.

Where the provider was reimbursed by the program for bad debts for the reporting period in which the amount recovered was included in allowable bad debts, reimbursable costs in the period of recovery are reduced by the amounts recovered. However, such reductions in reimbursable costs should not exceed the bad debts reimbursed for the applicable prior period.

Where the provider was not reimbursed by the program for bad debts for the reporting period in which the amount recovered was included in allowable bad debts, reimbursable costs in the period of recovery are not reduced.

320. METHODS OF DETERMINING BAD DEBT EXPENSE

320.1 Direct Charge-Off.--Under the direct charge-off method, accounts receivable are analyzed and a determination made as to specific accounts which are deemed uncollectible. The amounts deemed to be uncollectible are charged to an expense account for uncollectible accounts. The amounts charged to the expense account for bad debts should be adequately identified as to those which represent deductible and coinsurance amounts applicable to beneficiaries and those which are applicable to other than beneficiaries or which are for other than covered services. Those bad debts which are applicable to beneficiaries for uncollectible deductible and coinsurance amounts are included in the calculation of reimbursable bad debts. (See §§300, 302.2, 314, and 316.)

320.2 Reserve Method.--Bad debt expenses computed by use of the reserve method are not allowable bad debts under the program. However, the specific uncollectible deductibles and coinsurance amounts applicable to beneficiaries and charged against the reserve are includable in the calculation of reimbursable bad debts. (See §308.)

Under the reserve method, providers estimate the amount of bad debts that will be incurred during a period, and establish a reserve account for that amount. The amount estimated as bad debts does not represent any particular debts, but is based on the aggregate of receivables or services.

322. MEDICARE BAD DEBTS UNDER STATE WELFARE PROGRAMS

Prior to 1968, title XIX State plans under the Federal medical assistance programs were required to pay the Part A deductible and coinsurance amounts for inpatient hospital services furnished through December 31, 1967. Any such deductible or coinsurance amounts not paid by the State were not allowable as a bad debt.

Effective with the 1967 Amendments, States no longer have the obligation to pay deductible and coinsurance amounts for services that are beyond the scope of the State title XIX plan for either categorically or medically needy persons. For example, a State which covers hospital care for only 30 days for Medicaid recipients is not obligated (unless made part of the State title XIX plan) to pay all or part of the Medicare coinsurance from the 61st day on. For services that are within the scope of the title XIX plan, States continue to be obligated to pay the full deductible and coinsurance for categorically needy persons for most services, but can impose some cost sharing under the plan on medically needy persons as long as the amount paid is related to the individual's income or resources.

Where the State is obligated either by statute or under the terms of its plan to pay all, or any part, of the Medicare deductible or coinsurance amounts, those amounts are not

allowable as bad debts under Medicare. Any portion of such deductible or coinsurance amounts that the State is not obligated to pay can be included as a bad debt under Medicare, provided that the requirements of §312 or, if applicable, §310 are met.

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

If the State is not participating under title XIX, but State or local law requires the welfare agency to pay the deductible and coinsurance amounts, any such amounts are not includable in allowable bad debts. If neither the title XIX plan nor State or local law requires the welfare agency to pay the deductible and coinsurance amounts, there is no requirement that the State be responsible for these amounts. Therefore, any such amounts are includable in allowable bad debts provided that the requirements of §312 or, if applicable, §310 are met.

324. PROVIDER-BASED PHYSICIANS--PROFESSIONAL COMPONENT NOT A BAD DEBT

The professional component of a provider-based physician's remuneration is not recognized as an allowable bad debt in the event the provider is unable to collect the charges for the professional services of such physicians. Bad debts are recognized only if they relate to a provider's "allowable"

costs. "Allowable" costs pertain only to covered services for which the provider can bill on its own behalf under Part A and Part B. They do not pertain to costs of services the provider might bill on behalf of the provider-based physician. Technically, the professional component is a physician charge, not a provider cost. Thus, considering physician reimbursement as a provider cost in determining allowable bad debts would not be in conformance with the law.

326. APPLYING COLLECTIONS FROM BENEFICIARIES

When a beneficiary or a third party on behalf of the beneficiary makes a partial payment of an amount due the provider, which is not specifically identified as to which debt it is intended to satisfy, the payment is to be applied proportionately to Part A deductibles and coinsurance, Part B deductibles and coinsurance and noncovered services. The basis for proration of partial payments is the proportionate amount of amounts owed in each of the categories.

328. CHARITY, COURTESY, AND THIRD-PARTY PAYER ALLOWANCES--COST TREATMENT

Charity, courtesy, and third-party payer allowances are not reimbursable Medicare costs. Charges related to services subject to these allowances should be recorded at the full amount charged to all patients, and the allowances should be appropriately shown in a revenue reduction account. The amount reflecting full charges must then be used as applicable to apportion costs and in determining customary charges for application of the lower of costs or charges provision.

Example - The provider entered into an agreement with a third-party payer to render services at 25 percent below charges. Accordingly, for an X-ray service with a charge of $40, the provider billed the third party payer $30. The charge of $40 would be used to apportion costs and the $10 allowance would be recorded in a revenue reduction account.

331. CREDIT CARD COSTS

Reasonable charges made by credit card organizations to a provider are recognized as allowable administrative costs. Credit card charges incurred by a provider of services represent costs incurred for prompt collection of accounts receivable. These charges have come to be recognized as a substitute for the costs that would otherwise be incurred for credit administration (e.g., credit investigation and collection costs).

332. ALLOWANCE TO EMPLOYEES

Allowances, or reduction in charges, granted to employees for medical services as fringe benefits related to their employment are not considered courtesy allowances. Employee allowances are usually given under employee hospitalization and personnel health programs.

The allowances themselves are not costs since the costs of the services rendered are already included in the provider's costs. However, any costs of the services not recovered by the provider from the charge assessed the employee are allowable costs.

332.1 Method for Including Unrecovered Cost.--The unrecovered cost of services furnished to employees as fringe benefits may be included in allowable costs by treating the amount actually charged to the employees as a recovery of costs. Where the cost of the service exceeds the amount charged to the employee, the amount charged to the employee would be applied as a reduction in the costs of the particular department(s) rendering the services. If costs should be apportioned by the RCCAC Method, all charges related to employees' services would be subtracted from the total charges used to apportion such costs, so that unrecovered costs relating to employees' allowances would be apportioned between Medicare patients and other patients. Likewise, where an average cost per diem is used to apportion costs, the days applicable to the employees who received the allowances should be removed from the total days used to apportion costs.

Where the amount charged to an employee exceeds the costs of the services provided, there is no unrecovered cost and, therefore, no cost of fringe benefit. In this case, the amount charged to the employee is not offset against the department costs and the charges for the services given to the employee are not deleted from the total charges. The services furnished to employees are treated the same as services furnished to any other patients.

A. Example (Where Departmental Costs are Equivalent to 90% of Charges).-

	Gross Charges	Costs
Other than Employees		
Medicare----------	$ 900	
Non-Medicare----------	1,800	
	$2,700	
Employees	300	
Total----------	$3,000	$2,700
Computation of employee fringe benefit (30% discount):		
To be collected--70% of $300		($210)
Cost applicable to service provided (90% x $300)		270
Unrecovered Cost----------		$ 60
Total charges----------	$3,000 Total costs	$2,700
Less: Employee charges----------	300 Employee payment (Amount charged)	210
Adjusted charges----------	$2,700 Adjusted cost	$2,490

Payment by Medicare--900/2700 x $2,490 = $830

The unrecovered cost of $60 remains in the departmental costs and is apportioned among the users of the department other than employees.

B. Example (Where Departmental Costs are Equivalent to 50% of Charges).--

	Gross Charges	Costs
Other than Employees		
Medicare----------	$ 900	
Non-Medicare----------	1,800	
	$2,700	
Employees----------	300	
Total----------	$3,000	$1 500
Computation of employee fringe benefit (30% discount):		
To be collected--70% of $300		($210)
Cost applicable to service provided (50% x $300)		150
Excess of amount charged to employees over cost		$ 60
Unrecovered Cost----------		None
Payment by Medicare (900/3,000 x $1,500)--		$ 450

334. EXAMPLES: COMPUTATION OF BAD DEBTS REIMBURSABLE UNDER THE PROGRAM

334.1 Computation under Part A.-- Under Part A, deductible and coinsurance amounts are subtracted from the program's share of allowable costs in determining the amount reimbursable. Therefore, any uncollectible deductible and coinsurance amounts under Part A represent unrecovered costs to the provider. Bad debts reimbursable under the program are included in Medicare reimbursement under part A as follows:

Cost of covered services for Medicare patients----------		$160,000
Deductible and coinsurance billed to Medicare patients (from provider's records)----------	$8,500	
Less: Allowable bad debts for deductible and coinsurance less amount recovered in excess of costs under Part B----------	1,500	7,000
Balance due provider for covered services----------		$153,000

(See § 334.2, Example C, for offset to allowable bad debts.)

334.2 Computation Under Part B.-- Under Part B, the amount reimbursable by the program (exclusive of bad debts) is determined by applying 80% to the reasonable cost of covered services furnished to beneficiaries, after application of the deductible provisions. The remaining 20% of the reasonable cost should be recovered from the beneficiary through the coinsurance amount of 20% of the charges. Where the provider's charges exceed costs, coinsurance amounts contain an amount in excess of costs. Where charges are lower than costs, coinsurance amounts are less than the equivalent percentage of costs. Since the program reimburses the provider for the unrecovered costs resulting from beneficiaries' allowable bad debts, a calculation must be made to determine whether or not there are any such unrecovered provider costs and whether and to what extent the provider may be reimbursed for bad debts in order to offset any such unrecovered costs.

Where the provider recovers an amount in excess of the total Part B costs of the Medicare program reimbursement by the program, together with deductibles and coinsurance amounts collectible from beneficiaries, allowable bad debts under Part A are reduced by the amount of this excess.

The cost reports provide a special schedule for making this calculation.

The following examples illustrate the method to be used and the results that could be obtained under the different conditions.

A. Example: Provider Charges Higher Than Costs--Part B Services.--

1.	Total gross charges, all patients	$180,000
2.	Total program charges	45,000
3.	Percent of program charges	25%
4.	Total cost of covered services	$150,000
5.	25% of cost applicable to beneficiaries	$ 37,500
6.	Less: Deductibles billed to beneficiaries	2,000
7.	Net Cost	$ 35,500
8.	80% of net cost applicable to program	$ 28,400
9.	Less: Amount received or receivable from *contractor* or SSA	25,560
10.	Balance due provider or program	$ 2,840
11.	Add: Reimbursable bad debts (line 20 below)	2,500
12.	Balance due provider or program (line 20 plus 11)	$ 5,340

Computation of Reimbursable Bad Debts

13.	Total costs applicable to Part B	$ 37,500
14.	Less: 80% of net costs applicable to Part B	28,400
15.	Balance of costs to be recovered from beneficiaries	$ 9,100

16.	Deductible and coinsurance to beneficiaries ($2,000 plus $8,600)	$ 10,600
17.	Less: Uncollectible deductible and coinsurance	4,000
18.	Net deductible and coinsurance billed to beneficiaries (if line 18 is equal to or greater than line 15, do not complete lines 19 and 20)	$ 6,600
19.	Unrecovered costs from program ($9,100 minus $6,600) (line 15 less line 18)	$ 2,500
20.	Reimbursable bad debts (lesser of line 17 or line 19	$ 2,500

B. Example: Provider Charges Lower Than Costs--Part B Services.--

1.	Total gross charges, all patients	$180,000
2.	Total program charges	45,000
3.	Percent of program charges	25%
4.	Total cost of covered services	$200,000
5.	25% of cost applicable to beneficiaries	$ 50,000
6.	Less: Deductibles billed to beneficiaries	$ 2,000
7.	Net Cost	$ 48,000
8.	80% of net cost applicable to program	$ 38,400
9.	Less: Amount received or receivable from *contractor* of SSA	34,560
10.	Balance due provider or program	$ 3,840
11.	Add: Reimbursable bad debts (line 20 below)	4,000
12.	Balance due provider or program (lines 10 plus 11)	$ 7,840

Computation of Reimbursable Bad Debts

13.	Total costs applicable to Part B	$ 50,000
14.	Less: 80% of net costs applicable to Part B	38,400
15.	Balance of costs to be recovered from beneficiaries	$ 11,600
16.	Deductible and coinsurance billed to program ($2,000 plus $8,600)	$ 10,600
17.	Less: Uncollectible deductible and coinsurance	4,000
18.	Net deductible and coinsurance billed to beneficiaries (if line 18 is equal to or greater than line 15 do not complete lines 19 and 20)	$ 6,600
19.	Unrecovered costs from program ($11,600 minus $6,600) (line 15 less line 18)	$ 5,000
20.	Reimbursable bad debts (lesser of line 17 or line 19)	$ 4,000

C. Example: Provider Charges Higher than Costs--Part B Services Collections by Provider Exceed Costs).--

1.	Total gross charges all patients	$180,000
2.	Total program charges	45,500
3.	Percent of program charges	25%
4.	Total cost of covered services	$150,000
5.	25% of cost applicable to beneficiaries	$ 37,500
6.	Less: Deductible billed to beneficiaries	2,000
7.	Net Cost	$ 35,500
8.	80% of net cost applicable to program	$ 28,400
9.	Less: Amount received or receivable from intermediary or SSA	**25,560**
10.	Balance due provider or program	$ 2,840
11.	Add: Reimbursable bad debts (line 20 below)	-0---
12.	Balance due provider or program (lines 10 plus 11)	$ 2,840

Computation of Reimbursable Bad Debts

13.	Total costs applicable to Part B	$ 37,500
14.	Less: 80% of net costs applicable to Part B	28,400
15.	Balance of costs to be recovered from beneficiaries	$ 9,100
16.	Deductibles and coinsurance billed to beneficiaries ($2,000 plus $8,600)	$ 10,600
17.	Less: Uncollectible deductible and coinsurance	1,000
18.	Net deductible and coinsurance billed to beneficiaries	$ 9,000
19.	Unrecovered costs from program (line 15 less line 18)	$ (500)
20.	Reimbursable bad debts (less of line 17 or line 19)	-0---

* Amount collected in excess of costs in transferred to computation of reimbursable and bad debts under part A and reduces allowable bad debts under Part A. (See § 334.1.)