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I. Background

A. Bad Debt Reimbursement

In 1966, the Health Insurance Benefits Advisory Committee (HIBAC) (authorized by section 1867 of the Social Security Act, repealed 1984) recommended that Medicare cover the unpaid deductible and coinsurance amounts that arose in connection with the provision of covered services to beneficiaries (herein referred to as Medicare bad debt). This recommendation was meant to avoid cross-subsidization that might occur if hospitals or other entities tried to recoup Medicare bad debt from other payers. The HIBAC believed that under the statute, the Congress had intended to avoid cross-subsidization by meeting the cost of the bad debts that accrued to a provider where these amounts were otherwise uncollectible. The reasoning behind this view flowed from section 1861(v)(1)(A)(i) of the Act, which states that the costs for individuals covered by the Medicare program must not be borne by individuals not covered by the program, and the costs for individuals not covered by the program must not be borne by Medicare. We refer to this statutory provision as the prohibition on cross-subsidization. The Secretary agreed with the HIBAC recommendation and the bad debt policy was adopted in 1966. This anti-cross subsidization principle is now part of the definition of "reasonable cost" as defined in section 1861(v) of the Act.

Under section 2145 of the Omnibus Budget Reconciliation Act (OBRA) of 1981 (Pub. L. 97-35), the Congress mandated a prospective payment system (PPS) for paying providers of various services covered by Medicare. Hospitals became the first provider-type to receive Medicare reimbursement under this law

with the establishment of a PPS for inpatient hospital services in 1983. PPS replaced the retrospective cost-based reimbursement methodology previously in effect. Under this reimbursement system, Medicare payment for Part A inpatient operating costs is made on the basis of a prospectively determined rate per type of discharge, as determined by the classification of each patient case into a diagnosis-related group (DRG).

Shortly after implementation of PPS, in a Priority Audit Memorandum dated July 9, 1985, the Office of Inspector General (OIG) recommended that, in light of this new payment system, we should discontinue the reimbursement of inpatient hospital bad debts. After a thorough evaluation, we rejected the OIG's recommendation to discontinue paying bad debt for hospitals, concluding that the payments continued to be appropriate for the reasons discussed below. We also evaluated and rejected a second option suggested by the OIG to include a bad debt component in the DRG rates. We decided that this proposal would limit a hospital's incentive to collect the deductible and coinsurance amounts from the beneficiary and would address only the inpatient side. We also felt that because every facility incurred varying amounts of bad debt, the inclusion of bad debt in the DRG rates would be inequitable.

Therefore, in accordance with our regulations, we have continued to recognize bad debt for entities receiving payment under a PPS, such as for inpatient hospital services (42 CFR 412.115(a)), where Medicare payment policy, before PPS, recognized payment of those bad debts and where the prospective payments were derived from costs that did not reflect base period Medicare bad debts. That is, the prospective rates used to reimburse entities for services furnished to Medicare patients have basis in cost and are calculated using cost data reported by the entities on a base year cost report. They are then updated for inflation to the year in which payments are to be made. However, the bad debts incurred during that base period were not included in the calculation of the prospective rates. The bad debts for these entities are claimed at the end of each fiscal year, and allowable amounts are reimbursed separately.

Entities currently eligible to receive bad debt payments include hospitals, skilled nursing facilities (SNFs), critical access hospitals, rural health clinics, end-stage renal disease (ESRD) facilities, federally qualified health clinics, community mental health clinics, health maintenance organizations (HMOs)

reimbursed on a cost basis, competitive medical plans (CMPs) and health care pre-payment plans.

The general bad debt policy is set forth in regulations at § 413.80 and the Provider Reimbursement Manual (PRM) (CMS Pub. 1501), Part 1, Chapter 3). Bad debt policy for ESRD Facilities is set forth in a separate regulation at § 413.178 and is further discussed below.

B. Reasonable Charge/Fee Schedules

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

C. End-Stage Renal Disease Bad Debt Reimbursement

Medicare pays ESRD facilities a prospectively determined composite rate. Under the payment rules authorized by sections 1881(b)(2) and (b)(7) of the Act as amended by OBRA of 1981, we pay 80 percent of a prospectively set rate for outpatient dialysis services. The Medicare beneficiary is responsible for the remaining 20 percent as a copayment, as well as any applicable deductible amounts set forth in § 413.176. If the ESRD facility makes reasonable collection efforts, as described in the PRM (CMS, pub. 15-1) Part I, (Section 310) but is unable to collect the coinsurance or deductible, we consider the uncollected amount to be a "bad debt" as described in §§ 413.178(b) and 413.80(b)(1) and (e).

At the end of the year, Medicare recognizes a facility's Medicare bad debts. However, under our current regulations, bad debt payments are capped so that total Medicare reimbursement (composite rate plus bad debt payments) does not exceed the total cost to serve Medicare patients.

Although section 1881 of the Act does not require Medicare to pay for an ESRD facility's Medicare bad debt, Medicare for many years (before the composite payment rate system) paid hospital-based ESRD facilities for their Medicare