

bad debts, as it has long paid Medicare bad debts of other types of providers or entities that were paid on a reasonable-cost basis. By contrast, "free-standing" or independent ESRD facilities were paid on a reasonable charge basis and were expected to absorb any Medicare bad debt as part of that charge. When we developed the composite payment rate system, which is used to pay both hospital-based and free-standing ESRD facilities, we based payment on the results of audits of ESRD facilities' reported costs, exclusive of Medicare bad debts. For this reason, we decided it was appropriate to separately recognize these bad debts at the end of the facility's fiscal year. Under the authority granted us in section 1881(b)(7) of the Act, we considered two options for paying these bad debts. One option was to include the bad debt allowance in the calculation of the composite rate. The other option was to reimburse an ESRD facility's bad debts in a special payment at the end of the facility's cost accounting period. We decided that this latter option was preferable because it would allow us to pay each facility the exact amount of its allowable bad debts. We concluded that, under the statute, we could pay an ESRD facility for its bad debts incurred from providing services to Medicare beneficiaries, and thereby avoid indirectly passing on these bad debts to individuals not covered by Medicare. Similarly, we determined that it would be appropriate to cap the total bad debt payment at a facility's unrecovered costs. In this way, the combination of the composite rate payments and our payment, if any, for Medicare bad debts would not exceed the facility's total allowable cost of providing services to Medicare beneficiaries.

In 1994, a group of providers of outpatient renal dialysis services challenged our regulation at § 413.178(a), which caps reimbursement for an ESRD facility's bad debt at costs. The plaintiffs argued, among other things, that we had provided inadequate justification for the reimbursement cap and were unable to demonstrate that the cap was consistent with the statute, as required by the Administrative Procedure Act (APA) (5 U.S.C., 706(2)(A)). The U.S. District Court for the District of Columbia upheld our regulation as an acceptable exercise of our discretion under the APA. On appeal, however, the D.C. Circuit Court overturned the District Court's ruling and found that our explanation, relying on the statutory provisions relating to cross-subsidization discussed above, was inadequate justification for the rule

and inconsistent with a prospective rate scheme (*Kidney Center of Hollywood et al. v. Shalala*, 133 F.3d 78,88 (D.C. Circuit 1998)). The Circuit Court ordered that the final rule be vacated and remanded the case to us with the instruction that we either more adequately justify the rule or jettison it altogether.

#### *D. Legislation Affecting Bad Debt Reimbursement for Hospitals*

##### 1. Omnibus Reconciliation Act of 1987

In 1987, the Congress enacted section 4008(c) of the OBRA of 1987 and later amended it in sections 8402 of the Technical and Miscellaneous Revenue Act of 1988 and section 6023 of OBRA of 1989. The provision, as amended, prohibits us from making "any change in the policy in effect on August 1, 1987, regarding reimbursement to hospitals for Medicare bad debts." This legislation is collectively referred to as the moratorium on changes to the Medicare bad debt policy for hospitals. Since its enactment, the moratorium has precluded us from making any changes to bad debt policy for hospitals, although the Congress has authorized subsequent changes through legislation. The moratorium does not apply to entities other than hospitals. Since the inception of the Medicare program, bad debt reimbursement for entities other than hospitals has been and continues to be at our discretion. According to *Kidney Center of Hollywood, et al. v. Shalala*, the Secretary's discretion on this matter is broad as long as it is authorized by statute and is rationally justified. Therefore, we believe any changes made to bad debt policy for these other entities can be implemented by regulation.

##### 2. Balanced Budget Act of 1997

From 1989 to 1996, provider and entity cost report data showed an alarming growth in bad debt payments in the Medicare program. For hospitals alone, from 1990 to 1994, total Medicare bad debt payments grew 165 percent, from \$415 million to \$1.1 billion. During this period, the inpatient bad debts grew 140 percent, from \$270 to \$650 million, and Part B (primarily outpatient) bad debts tripled, from \$140 to \$430 million. In 1997, with increasing concern over the rapidly expanding payout for bad debts under Medicare, the Congress responded with section 4451 of the Balanced Budget Act (BBA) of 1997 (Pub. L. 105-33). Section 4451 of the BBA amended section 1861(v)(1) of the Act by adding section 1861(v)(1)(T). The legislation required that, in determining reasonable costs for

hospitals, the amount of bad debts otherwise treated as allowable costs (attributable to deductibles and coinsurance amounts) should be reduced by 25 percent for fiscal year (FY) 1998, by 40 percent for FY 1999, and by 45 percent for subsequent years.

##### 3. The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000

As a response to concerns from Medicare hospitals that the fiscal impact of this provision of the BBA was too harsh, the Congress enacted section 541 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (Pub. L. 106-554) (BIPA). This eased the reduction in hospital bad debt reimbursement from 45 percent to 30 percent. Although the Congress decreased the reduction of bad debt reimbursement for hospitals, the BIPA did not address the issue for other providers.

#### *E. Impact Using Prospective Payment Systems on the Role of Bad Debt in Medicare Payment Systems*

The introduction of the PPS has changed the context for Medicare's bad debt policy. The PPS for inpatient hospital services was introduced in 1983 out of a notion that cost reimbursement systems provided an incentive for providers to incur costs. The costs were passed along to Medicare automatically and provided no incentive for prudent and efficient management of hospital resources. This methodology provided no opportunity for hospitals to earn profit through efficiency. The DRG payments were intended to provide a context in which the hospitals that achieved savings through efficiency and innovative practices could profit from their efforts. In fact, the result of this change in payment system was that hospital Medicare margins (a rough measure of the extent to which payments exceeded actual costs) rose immediately and have continued to exceed pre-PPS levels.

In this context, making separate payments for uncollected Medicare deductible and coinsurance amounts is no longer an appropriate expression of Medicare's responsibility for reimbursement, especially in a marketplace where commercial insurers do not make similar adjustments in their payments. In fact, the availability of additional payment when debts are not collected provides an incentive to the provider to forego effective collection efforts in return for the certainty of Medicare payments. If Medicare did not recognize these payments, there would be a greater incentive for the hospitals