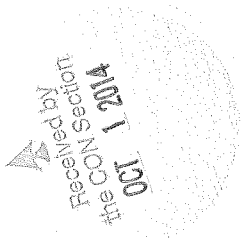
FRESENIUS
MEDICAL CARE

October 1, 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 # N-10319-14
CON Project ID # N-10321-14
CON Project ID # N-10323-14

Dear Ms. Frisone:

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

Respectfully,

Jim Swann
Director of Operations, Certificate of Need

3717 National Drive, Suite 206
Raleigh, North Carolina 27612

Phone 919-896-7230
FAX 919-896-7233

Public Witten Comments
CON Project ID # M-10323-14
Total Renal Care of North Carolina, LLC. d/b/a Sampson County Home Dialysis
Prepared and Submitted by Jim Swann
FMC Director of Operations, Certificate of Need

The application submitted by Total Renal Care of North Carolina, LLC (TRC) employs an unrealistic and unsupported growth rate for the projected population to be served. This results in overstated revenues and questionable financial projections. The application should be found non-conforming to CON Review Criterion 3 and 5.

Additionally, the applicant seeks to duplicate existing and approved health services. BMA is providing home therapies through its FMC Roseboro facility. BMA has CON approval to develop a home dialysis program at the BMA Clinton facility; that project is nearly complete at this time and should be certified soon. Both of these programs will have more than sufficient capacity for patients desiring to dialyze at home. Thus the applicant is proposing to duplicate existing health services and is non-conforming to CON Review Criterion 6.

The application should be not be approved, or conditionally approved. The following information identifies multiple failures within the application.

1. TRC has represented that the home patient population of North Carolina is increasing at a rate of 11.37% across the state, and that the home patient population is growing significantly faster than the ESRD patient population of the state.

   The reality of this is that the home patient population is comprised of two modalities: Peritoneal Dialysis and Home Hemodialysis. Both modalities are a subset of the entire ESRD patient population of the state. Indeed the ESRD patient population on the whole is increasing at a rate of 3.17% as represented by TRC. On this point we can agree.

   In a practical sense, there are three modalities within the ESRD patient population: traditional In-center dialysis, home peritoneal dialysis, and, home hemodialysis. The overwhelming majority of patients in North Carolina are traditional in-center dialysis patients. The July 2014 SDR reports that as of December 31, 2013 there were a total of 15,574 ESRD patients residing in the 100 counties of North Carolina. Of these, 1,955, or 12.55% were home patients.

   As noted above the home patient population however is comprised of two home modalities, peritoneal dialysis and home hemodialysis. It has been BMA experience that the home hemodialysis patient population is the fastest growing modality within the ESRD patient population.

   The TRC application has aggregated both home modalities and has therefore inflated the growth of the peritoneal patient dialysis population.

In CON Project ID # M-10115-13, BMA addressed the growth of the two home modalities. BMA includes Assumption # 3 from the BMA application, page 15 for reference:

3. *Within the most recent years, the growth of the home patient population has increased at a rate greater than the ESRD patient population as a whole. For example, based upon SEKC zip code reports for the periods indicated below, BMA has calculated changes within the ESRD patient population.*

	IC	Home HD	Home PD	IC PD	Other	Total
3/31/2012	12836	277	1420	2		14535
12/31/2009	12128	123	1186	1	6	13444
12/31/2007	11704	59	1115		6	12884
Raw Change 2007 - 2012	1132	218	305			1651
% of Change 2007 - 2012	0.096719	3.694915	0.273543			0.128143
Annualized Change	0.022757	0.869392	0.064363			0.030151

a. *The overall growth of the ESRD patient population from December 31, 2007 through March 31, 2012 averaged slightly over 3% annual growth. This figure is calculated by dividing the percentage of change for the period (51 months) by 51 and then multiplying by 12 to annualize.*
b. *During this time, the in-center hemo-dialysis patient population increased by an average of 2.28% annually. This figure is calculated in the same manner as the annualized change discussed in a) above.*
c. *During the same period of time, the PD patient population grew at a rate of 6.44% annual. This figure is calculated in the same manner as the annualized change discussed in a) above.*
d. *However, the home hemo-dialysis patient population increased at significantly higher rate of 86.94%. This figure is calculated in the same manner as the annualized change discussed in a) above.*
e. *BMA assumes the growth in the HH patient population during this time is largely attributable to changes in technology (i.e. NxStg home hemodialysis) and increased nephrology physician support.*

As this brief discussion illustrates, based upon the most current information available in the spring of 2013, the home hemodialysis patient population was increasing at a significantly higher rate of growth than the peritoneal dialysis patient population or in-center patient population. It is BMA belief that the home hemodialysis patient population growth continues to out pace the peritoneal dialysis patient growth.

In the summer of 2014, the Division of Health Service Regulation / Medical Facilities Planning Branch tasked all dialysis providers with completion of the ESRD Data

Collection reports by September 12, 2014. Fresenius Medical Care, parent to BMA, complied with this requirement, and filed its reports for all Fresenius related facilities on September 11, 2014. The information from the Fresenius related facilities indicates that as of June 30, 2014 Fresenius related facilities were providing dialysis care and treatment for a total of 8,395 North Carolina ESRD patients. There were another 61 patients residing in other states who were also dialyzing at BMA facilities.

Within the TRC application, TRC indicates that the NC ESRD patient population is increasing at a rate of 3.17%. Assuming that this rate is accurate for the six months ended June 30, 2014, then the projected statewide ESRD population would have been approximately 15,820.85.

[15,574 X (.0317 / 12 X 6)] + 15,574 = 15,820.85, rounded to 15,821

Assuming the probable ESRD patient population for June 30, 2014 was 15,821, then BMA was providing care and treatment for 53.1% of the ESRD patients in our state. Based upon its service to more than half of the patients of the state, and based upon providing service to patients across the entirety of North Carolina, it is reasonable to suggest that the patient population of Fresenius related facilities is representative of the patient ESRD patient population of North Carolina.

Consider the following:

- BMA has calculated the estimated ESRD patient population of NC to be 15,820 patients as of June 30, 2014.
- Fresenius related facilities were providing dialysis care and treatment to 8,395 NC patients as of June 30, 2014.
- Fresenius related facilities were providing both in-center, home peritoneal dialysis care, and home hemodialysis care to patients of NC.
- Fresenius related facilities were providing treatment for 7,541 in-center dialysis patients.
- Fresenius related facilities were providing treatment for 635 peritoneal dialysis patients.
- Fresenius related facilities were providing treatment for 219 home hemodialysis patients.

From the above, one can determine that Fresenius related facilities were providing care and treatment to 854 home dialysis patients as of June 30, 2014.

- The peritoneal dialysis patient population of Fresenius related facilities was 635 patients or 74.36%.

- The home hemodialysis patient population of Fresenius related facilities was 219 patients or 25.64%.

BMA suggests that it is reasonable to conclude that the patient population of Fresenius related facilities is representative of the patient ESRD patient population across North Carolina. It is probable then that 25% of the future home patient population of Sampson County will be home hemodialysis patients and not peritoneal dialysis patients.

In fact, a review of the ESRD Data Collection reports filed by Fresenius on September 11, 2014 indicates that Fresenius related facilities were providing dialysis care and treatment for eight Sampson County home dialysis patients; two of those eight, 25%, were home hemodialysis patients.

In the TRC application for Sampson County Home dialysis, the applicant provides very limited data about the home patient population of the county. The applicant seems to go to great lengths to say the BMA served only one home dialysis patient at its FMC Roseboro facility. However, the applicant apparently failed to consult its own Exhibit #13, the DHSR / Medical Facilities Planning Section Patient Origin Report. BMA has reviewed that report and confirmed that of the 17 home patients reported as residing in Sampson County, Fresenius related facilities were serving seven of those patients.

The applicant has projected to serve seven Sampson County patients and two Duplin County patients in the first year of operations. However the applicant has provided letters of support from only five Sampson County patients. One must ask, where are the remaining two patients? Moreover, has the applicant made any allowance for home hemodialysis patient population?

The applicant included two letters from Duplin County patients but does not offer any specificity with regard to travel distance, but only suggests that Clinton is closer. With only two patients to research, the applicant could have provide more information such as an approximate mileage (not suggesting a patient residence address should have been provided).

The applicant has provided unreasonable suggestions about the population to be served and should be found non-conforming to CON Review Criterion 3.

2. To the extent that the applicant fails on Criterion 3, then the applicant should be found non-conforming to CON Review Criterion 5. If the projections of patients ot be served are unreasonable, then the projected revenues must also be unreasonable.

3. In addition to failures as discussed above, the applicant is also non—conforming to CON Review Criterion 18a.

   *(18a) The applicant **shall** demonstrate the expected effects of the proposed services on competition in the proposed service area, including how any enhanced competition will have a **positive impact** upon the cost effectiveness, quality, and access to the services proposed; and in the case of applications for services where competition between providers will not have a favorable impact on cost effectiveness, quality, and access to the services proposed, the applicant shall demonstrate that its application is for a service on which competition will not have a favorable impact.*
   [emphasis added by BMA]

   The Applicant has not provided any significant and relevant discussion with regard to the expected effects of the proposed services on competition in the proposed service area. In fact, the applicant has totally ignored the probable effects of competition in this area. Furthermore, enhanced competition in this area is more likely to have a detrimental impact upon the existing providers in the area, and will not have a positive impact upon the cost effectiveness, quality, and access to the services proposed.

4. The applicant has also indicated that it would write off the 20% required co-pay for Medicare patients (application, Page 59, 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 attached excerpts from CMS Billing Guidelines.

   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.

5. 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:

The TRC application to develop a freestanding peritoneal dialysis facility in Clinton, Sampson County, should be denied.

- The applicant has provided only five patient letters of support from Sampson County patients, representing that these are the basis for its projections, and then proposes to serve seven Sampson County patients in Operating Year 1.

- The applicant has proposed and unreasonable and unsupported annual change rate to project its patient population to be served.

- The applicant has based its financial projections on questionable patient projections. Therefore the financial projections are not credible.

- The applicant has not provided any analysis of the impact upon competition in the area. The applicant ignored the Sampson County home patient population served by BMA at its various locations.

- The application is not the best alternative for the ESRD patient population of the area. Its financial success can not be assured.

BMA suggests the application fails on multiple levels and should not be approved. The application fails to conform to CON Review Criteria 3, 4, 5, 6 and 18a.

For these reasons, the application should be denied.

Attachment: Excerpts from CMS Billing Guidelines

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 1862(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.)