PROVIDER REIMBURSEMENT REVIEW BOARD
DECISION
2023-D36

PROVIDER-
Memorial Hermann 2002-2012 Bad Debt Not Returned from Collection Agency CIRP Groups

Provider Nos.: Various

vs.

MEDICARE CONTRACTOR –
Novitas Solutions, Inc.

HEARING DATE –
February 27, 2020

Cost Reporting Periods Ended –
2002, 2004, 2007-2012

CASE NOs. 13-0583GC, 13-1710GC, 14-0584GC, 14-3382GC, 14-3963GC, 15-1816GC

INDEX

ISSUE:

Whether the Medicare Contractor's disallowance of Medicare Bad Debts claimed by the Providers for the fiscal years at issue, on the grounds that they had not been returned from a collection agency, was proper.[1]

DECISION:

After considering the Medicare law, regulations and program instructions, the arguments presented, and the evidence admitted, the Provider Reimbursement Review Board ("Board") finds that, for the fiscal years ("FYs") 2002, 2004, and 2007 through 2012, the Medicare Contractor properly disallowed the Medicare bad debts at issue claimed by the Providers because the bad debts remained at outside collection agencies ("OCAs") and that these disallowances did not violate the Bad Debt Moratorium. Accordingly, the Board affirms the Medicare Contractor's adjustments in these appeals.

INTRODUCTION:

The participants in these six (6) common issue related party ("CIRP") groups are each part of the Memorial Hermann Health System (hereinafter collectively "MHHS Providers") located in the greater metropolitan area for Houston, Texas.[2] The Medicare contractor[3] assigned to the MHHS Providers is Novitas Solutions, Inc. ("Medicare Contractor"[4]).

The MHHS Providers appealed cost reports from FYs 2007 through 2012 and are challenging the disallowances of Medicare bad debts made by the Medicare Contractor solely on the grounds that the accounts related to such bad debts were still pending at OCAs.[5] For FYs 2002 and 2004, there is only one MHHS Provider which had claimed bad debts still pending at an OCA on its as-filed FY 2002 and 2004 cost reports.[6] In contrast, for FYs 2007 through 2012, the MHHS Providers had self-disallowed the bad debts pending at the OCAs and protested the self-disallowance on their FY 2007-2012 as-filed cost reports.[7]

In each of these six (6) CIRP groups, the MHHS Providers timely requested a hearing before the Board and met the jurisdictional requirements on the OCA bad debt issue. Accordingly, the Board held a *consolidated* in-person hearing on February 27, 2020. Subsequent to the hearing, on September 18, 2020, the Secretary of Health and Human Services ("Secretary") issued the FY

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[1] Transcript ("Tr.") at 6.
[2] *See* Appendix B for a list of the MHHS Providers by CIRP group.
[3] CMS' payment and audit functions under the Medicare program were historically contracted to organizations known as fiscal intermediaries ("FIs") and these functions are now contracted with organizations known as Medicare administrative contractors ("MACs"). The term "Medicare contractor" refers to both FIs and MACs as appropriate.
[4] The Board's use of the "Medicare Contractor" is collective and refers not only to Novitas Solutions, Inc. but also to any prior Medicare contractors who were previously assigned to the MHHS Providers such as Blue Cross and Blue Shield of Texas and Trailblazers Health Enterprises, LLC. *See* Tr. at 198.
[5] Medicare Contractor's Consolidated Final Position Paper ("hereinafter Medicare Contractor's FPP") at 5 (Dec. 26, 2019); Providers' Consolidated Final Position Paper (hereinafter "Providers' FPP") at 7-8 (Nov. 22, 2019).
[6] Providers' FPP at 7-8; Schedule of Providers, Participant 2 at Tabs B, E and Participant 3 at Tabs B, E (Case No. 13-1710GC).
[7] Providers' FPP at 7-8.

2020 IPPS Final Rule finalizing certain *retroactive* revisions to the bad debt regulations[8] and the MHHS Providers specifically addressed the applicability of these retroactive bad debt regulations in their Post-Hearing Brief filed on May 3, 2021.[9] Concurrent with this decision, the Board issued a jurisdictional determination confirming the applicability of the *retroactive* bad debt regulations to the bad debts at issue and the Board's jurisdiction over that application. The MHHS Providers were represented by Stephanie Webster, Esq. of Ropes & Gray, LLP. The Medicare Contractor was represented by Edward Lau, Esq. of Federal Specialized Services, LLC.

STATEMENT OF FACTS:

The regulations governing bad debt are currently located at 42 C.F.R. § 413.89. Subsection (a) states the general rule that bad debts are deductions from revenue and are not to be included in allowable Medicare costs. However, subsection (d) allows reimbursement for bad debts attributable to Medicare deductibles and coinsurance in order to ensure that costs associated with care furnished to Medicare beneficiaries are "not . . . borne by individuals not covered by the Medicare program[.]" Subsection (e) addresses the criteria bad debts must meet in order to be allowable. These six (6) CIRP group cases involve a dispute about the application of the criteria in § 413.89(e) and the related interpretive manual provisions and whether the Medicare Contractor's application of this criteria violates the uncodified statutory provision known as the "Bad Debt Moratorium." Set forth below is an overview of this criteria, the Secretary's codification of certain "longstanding" policies into § 413.89(e), and the Bad Debt Moratorium.

A. The Bad Debts Regulation and Manual Instructions In Effect Prior to October 1, 2020

Prior to October 1, 2020, 42 C.F.R. § 413.89(e) stated the following criteria that bad debts must meet in order to be allowable:

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

These criteria have been longstanding; the Secretary established these criteria as part of the final rule published on November 22, 1966.[10]

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[8] 85 Fed. Reg. 58432, 58993-96 (Sept. 18, 2020).

[9] Providers' Post-Hearing Brief (hereinafter "Providers' PHB") at 13-14, 28-43 (May 3, 2021).

[10] In 1966, this criteria was initially established in subsection (e) of bad debt regulation at **20** C.F.R. § 405.420. 31 Fed. Reg. 14808, 14813 (Nov. 22, 1966). The bad debt regulation has had the following redesignations:

- In 1977, it was moved to Title 42 to 42 C.F.R. § 405.420. 42 Fed. Reg. 52826, 52826 (Sept. 30, 1977).
- In 1986, it was redesignated to 42 C.F.R. § 413.80. 51 Fed. Reg. 34790, 34790, 34813-34814 (Sept. 30, 1986).

Additional guidance on the Medicare bad debt requirements is located in Chapter 3 of the Provider Reimbursement Manual, CMS Pub. 15, Part 1 ("PRM 15-1"). PRM 15-1 § 308 mirrors 42 C.F.R. § 413.89(e) in outlining the four criteria that must be satisfied in order for bad debts to be eligible for reimbursement by Medicare. PRM 15-1 § 310 provides guidance as to what constitutes reasonable collection efforts. PRM 15-1 § 310.2 sets forth the "Presumption of Noncollectibility," providing that, "[i]f 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."

B. Retroactive Revisions to 42 C.F.R. § 413.89(e) To Codify Certain "Longstanding" Policies

In the FY 2021 IPPS proposed rule published on May 29, 2020, the Secretary proposed "codification of certain *longstanding* Medicare Bad Debt policies" into the bad debt regulation at 42 C.F.R. § 413.89.[11] Two changes relevant to this decision relate to: (1) when the Presumption of Noncollectibility applies; and (2) when accounts referred to an OCA may be written off as bad debts for purposes of Medicare reimbursement.[12]

With respect to the Presumption of Noncollectibility, the Secretary proposed to codify, *on a retrospective basis*, "our longstanding policy" that the 120-day clock to trigger application of the Presumption of Noncollectibility does not begin until no payment has been made for 120 days notwithstanding continued customary collection efforts:

> We are proposing to amend § 413.89(e)(2) by adding a new paragraph (e)(2)(i)(A)(5)(ii) to specify that when the provider receives a partial payment within the minimum 120-day required collection effort period, the provider must continue the collection effort and the day the partial payment is received is day one of the new collection period. For each subsequent partial payment received during a 120-day collection effort period, the provider must continue the collection effort and the day the subsequent partial payment is received is day one of the new collection period. The provider is permitted to end the collection effort at the end of a 120-day collection effort period when no payments have been received during those consecutive 120 days. *These revisions would be effective* ***for cost reporting periods beginning before***, on and after ***the effective date*** *of this rule* because we are proposing to clarify and codify *our longstanding policy* pertaining to the required 120-day collection effort.[13]

With respect to usage of OCAs, the Secretary proposed to codify, *on a retrospective basis*, "our longstanding policy" that, when a provider opts to use an OCA to pursue collection on accounts, the OCA's collection efforts on Medicare accounts must be similar to those for non-Medicare

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- In 2004, it was redesignated to 42 C.F.R. § 413.89. 69 Fed. Reg. 48916, 49254 (Aug. 11, 2004).

[11] 85 Fed. Reg. 32460, 32469 (May 29, 2020) (emphasis added).

[12] *Id.* at 32869-71.

[13] *Id.* at 32869 (emphasis added).

accounts in order to be considered "a reasonable collection effort" ***and*** such accounts cannot be written off and claimed as Medicare-reimbursable bad debts until they are returned from the OCA:

> We therefore are proposing to amend § 413.89(e)(2) by adding a new paragraph (e)(2)(i)(A) to specify that 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. *A provider's dissimilar debt collection practices for Medicare and non-Medicare patient accounts do* ***not*** *constitute a reasonable collection effort* to claim reimbursement from Medicare for a bad debt, *whether the collection effort from the provider is an in-house collection effort or* ***if the provider elects to refer bad debt accounts to a collection agency for an outside collection effort***. A provider may use a collection agency to perform a reasonable collection effort on its behalf. *The provider* ***must ensure*** *that the collection agency's collection effort is similar to the effort the collection agency puts forth to collect comparable amounts from non-Medicare patients*. The collection agency's collection effort can include subsequent billings, collection letters, and telephone calls or personal contacts with this party which constitute a genuine, rather than a token, collection effort. The collection agency's collection effort may include using or threatening to use court action to obtain payment. . . . ***Collection accounts that remain at a collection agency, for whatever reason, including accounts that are monitored passively by the collection agency, cannot be claimed by the provider as a Medicare bad debt***. When a collection agency obtains payment of an account receivable, the gross amount collected reduces the patient's account receivable by the same amount and must be credited to the patient's account. The collection fee deducted by the agency is charged to administrative costs.
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> *These revisions would be* ***effective for cost reporting periods beginning before***, on and after ***the effective date*** *of this rule* because we are clarifying and codifying *our longstanding policy*.[14]

On September 18, 2020, the Secretary issued the FY 2021 IPPS Final Rule finalizing the proposed *retroactive* codification of these "longstanding" policies regarding the Presumption of Noncollectibility and use of collection agencies.[15] In response to comments, the Secretary provided the following clarification on its *retroactive* codification of its policy on the Presumption of Noncollectibility:

> Longstanding Medicare bad debt policy regarding the presumption of noncollectibility, as set forth in the PRM § 310.2 supports a

[14] *Id.* at 32871 (emphasis added).
[15] 85 Fed. Reg. 58432, 58993-96 (Sept. 18, 2020).

continuous 120-day period without a payment as part of a reasonable collection effort. Section 310.2 states that "if, after 120 days, a payment is not received, the unpaid amount can be written off." We therefore have concluded that if, within the 120 days, a partial payment is received, the remaining uncollected amount cannot be written off to Medicare bad debt because the collection effort is active and ongoing by way of the response from the beneficiary submitting a payment. *Our longstanding position, asserted in court cases and legal documents over the years, is that if the provider continues to receive money, then the account is not a worthless account without value*. The account has some recovery value when payments continue to be received and therefore, it is appropriate for the provider to keep the account open for an additional collection period to attempt further collection efforts before presenting the unpaid amounts as a Medicare bad debt which is funded by the Medicare Trust Fund and comprised of taxpayer money. ***This longstanding bad debt policy*** *has existed in Medicare guidance, including the PRM, for decades, and providers and beneficiaries are familiar with and rely upon it. The clarification and codification of this longstanding Medicare bad debt policy into the regulations* ***with a retroactive effective date*** *does not affect prior transactions or impose additional duties or adverse consequences upon providers or beneficiaries, nor does it diminish rights of providers or beneficiaries*. The clarification and codification of this longstanding Medicare bad debt policy into the regulations with a retroactive effective date also serves an important public interest to assist providers and beneficiaries by avoiding confusion as to which longstanding policy should be applied for which cost reporting period, as might arise if the effective date was instead proposed for cost reporting periods beginning on or after the effective date of this rule. Failing to adopt the clarification and codification of longstanding Medicare bad debt policies with a retroactive effective date might lead some providers to believe that those policies did not apply to earlier cost reporting periods, and thus might cause confusion among some providers or cause others to resubmit previously submitted cost reports. The clarification and codification of longstanding Medicare bad debt policies into the regulations with a retroactive effective date serves the important public interest of promoting fairness and economy to providers by saving them the time and resources required for such resubmissions, and by saving government resources and funds from the taxpayer-funded Medicare Trust Fund that would be expended in review of cost report resubmissions. These considerations apply equally to all aspects of this final rule that we are finalizing with a retroactive effective date.

After consideration of the public comments we received, we are finalizing our proposal to amend § 413.89(e)(2) by adding a new paragraph (e)(2)(i)(A)(5)(i) to specify that a provider's reasonable

> collection effort requirement for a non-indigent beneficiary must also last at least 120 days after § 413.89(e)(2)(i)(A)(2) or (3) is met before being written off as uncollectible under paragraph § 413.89(e)(3). We are finalizing our proposal to amend § 413.89(e)(2) by adding a new paragraph (e)(2)(i)(A)(5)(ii), effective for cost reporting periods beginning before, on, and after the effective date of this rule [*i.e.*, October 1, 2021], to specify that a provider's reasonable collection effort requirement for a non-indigent beneficiary must also start a new 120-day collection period each time a payment is received within a 120-day collection period.[16]

Similarly, in response to comments, the Secretary provided the following clarification on its *retroactive* codification of its policy on the use of OCAs:

> The current Medicare bad debt regulation requires that to be allowable, a bad debt must be "actually uncollectible when claimed as worthless," and also that "sound business judgment established that there was no likelihood of recovery at any time in the future." § 413.89(e)(3) and (4). *It has been our* ***longstanding*** *policy that* ***an account that remains at a collection agency*** *has satisfied neither of these regulatory conditions, remains in a collection effort status, and thus cannot be claimed as a Medicare bad debt*. An account that remains at a collection agency still holds some value for the chance of a recovery and there is a possibility, a likelihood, of recovery while the account remains there. We have also reviewed the federal court decisions cited in some comments and do not agree that they prevent us from adopting the rules regarding similar collection efforts that we are finalizing.
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> A genuine, rather than a token, collection effort is based on the reasonableness of a provider's effort to collect the unpaid Medicare deductible and coinsurance amounts from the beneficiary or responsible party. It entails a serious and concerted effort by the provider to collect the unpaid debt. The provider's genuine, rather than token, collection effort has been addressed in PRM § 310 under the concept of "reasonable collection effort" as "also include[ing] 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." As we have asserted in the past in policy statements and proceedings, a genuine collection effort requires the provider to engage in prompt and continuous collection efforts, over at least 120 days, advising the beneficiary of the amounts to be collected,

[16] *Id.* at 58994.

> engaging in subsequent follow up and billing, *and may include the provider* ***engaging a collection agency***.[17]

Accordingly, the FY 2021 IPPS Final Rule *retroactively* revised 42 C.F.R. § 413.89(e) so that it reads, in pertinent part:

> (e) *Criteria for allowable bad debt.* A bad debt must meet the following criteria to be allowable:
>
> (1) The debt must be related to covered services and derived from deductible and coinsurance amounts.
>
> (2) The provider must be able to establish that reasonable collection efforts were made.
>
> (i) *Non-indigent beneficiary*. A non-indigent beneficiary is a beneficiary who has not been determined to be categorically or medically needy by a State Medicaid Agency to receive medical assistance from Medicaid, nor have they been determined to be indigent by the provider for Medicare bad debt purposes. To be considered a reasonable collection effort for nonindigent beneficiaries, all of the following are applicable:
>
> (A) A provider's collection effort **or the effort of a collection agency acting on the provider's behalf**, or both, to collect Medicare deductible or coinsurance amounts must consist of all of the following:
>
> (1) **Be similar to the collection effort put forth to collect comparable amounts from non-Medicare patients**.
>
> (2) For cost reporting periods beginning before October 1, 2020, involve the issuance of a bill to the beneficiary or the party responsible for the beneficiary's personal financial obligations on or shortly after discharge or death of the beneficiary.
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> ****
>
> (4) Include other actions such as subsequent billings, collection letters, and telephone calls, emails, text messages, or personal contacts with this party.
>
> (5)(i) Last at least 120 days after paragraph (e)(2)(i)(A)(2) . . . of this section is met before being written off as uncollectible under paragraph (e)(3) of this section.

[17] *Id.* at 58995-96.

(ii) **Start a new 120-day collection period <u>each time a payment is received</u> within a 120-day collection period**.

(6) **Maintaining** and, upon request, furnishing verifiable **<u>documentation</u>** to its contractor that includes all of the following:

(i) **The provider's <u>bad debt collection policy</u> which describes the collection process for Medicare and non-Medicare patients**.

(ii) The patient account history documents which show the dates of various collection actions such as the issuance of bills to the beneficiary, follow-up collection letters, reports of telephone calls and personal contact, etc.

(iii) The beneficiary's file with copies of the bill(s) and follow-up notices.

(B) A provider that uses a collection agency to perform its collection effort must do all of the following:

(1) Reduce the beneficiary's account receivable by the gross amount collected.

(2) Include any fee charged by the collection agency as an administrative cost.

(3) Before claiming the unpaid amounts as a Medicare bad debt, cease all collection efforts, including the collection agency efforts, and ensure that the collection accounts have been returned to the provider from the agency.

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(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.[18]

C. Bad Debt Moratorium

In § 4008(c) of the Omnibus Budget Reconciliation Act of 1987, Congress enacted a non-codified statutory provision that became known as the "Bad Debt Moratorium."[19] In § 8402 of

[18] *See id.* at 59024 (italics emphasis in original and bold and underline emphasis added.)
[19] Pub. L. No. 100-203, § 4008(c), 101 Stat. 1330, 1330-55 (1987).

the Technical and Miscellaneous Revenue Act of 1988, Congress retroactively amended the Bad Debt Moratorium.[20] In § 6023 of the Omnibus Budget Reconciliation Act of 1989, Congress again retroactively amended the Bad Debt Moratorium.[21] Finally, in § 3201(d) of the Middle Class Tax Relief and Job Creation Act of 2012, Congress amended the Bad Debt Moratorium to end it, effective for cost reporting periods beginning on or after October 1, 2012.[22] As a result of these serial amendments, the Bad Debt Moratorium reads:

> CONTINUATION OF BAD DEBT RECOGNITION FOR HOSPITAL SERVICES.— In making payments to hospitals under title XVIII of the Social Security Act [42 U.S.C. 1395 *et seq.*], the Secretary of Health and Human Services *shall not make any change in the policy in effect on August 1, 1987*, with respect to payment under title XVIII of the Social Security Act to providers of service for reasonable costs relating to unrecovered costs associated with unpaid deductible and coinsurance amounts incurred under such title (including criteria for what constitutes a reasonable collection effort, including criteria for indigency determination procedures, for record keeping, and for determining whether to refer a claim to an external collection agency). The Secretary *may not require a hospital to change its bad debt collection policy* ***if*** *a fiscal intermediary, in accordance with the rules in effect as of August 1, 1987*, ***with respect to criteria for indigency determination procedures, record keeping, and determining whether to refer a claim to an external collection agency***, *has accepted such policy before that date, and the Secretary may not collect from the hospital on the basis of an expectation of a change in the hospital's collection policy*. Effective for cost reporting periods beginning on or after October 1, 2012, the provisions of the previous two sentences shall not apply.[23]

Thus, the Bad Debt Moratorium has two separate and independent prongs: (1) CMS is prohibited from "mak[ing] any change in the [bad debt] policy in effect on August 1, 1987"; and (2) CMS is prohibited from requiring a provider to change its bad debt collection policy "if [a Medicare contractor], in accordance with the rules in effect as of August 1, 1987, . . . has accepted such policy before that date [*i.e.*, August 1, 1987]."[24]

D. Overview of the Facts

For the FYs 2007 through 2012, the Medicare Contractor adjusted to eliminate protested amounts for bad debts because the accounts were still at a collection agency and were presumed

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[20] Pub. L. No. 100-647, § 8402, 102 Stat. 3342, 3798 (1988).
[21] Pub. L. No. 101-239, § 6023, 103 Stat. 2106, 2167 (1989).
[22] Pub. L. No. 112-96, § 3201(d), 126 Stat. 156, 192-193 (2012).
[23] Reprinted at 42 U.S.C. § 1395f note entitled "Continuation of Bad Debt Recognition for Hospital Services." Though not relevant to the instant appeal, in 2012, the language was amended to include the following: "Effective for cost reporting periods beginning on or after October 1, 2012, the provisions of the previous two sentences shall not apply."
[24] *See District Hospital Partners v. Sebelius*, 932 F. Supp. 2d 194, 198 (D.D.C. 2013).

collectible.[25] For FYs 2002 and 2004, there is only one MHHS Provider and the Medicare Contractor appears to have disallowed certain bad debt claims because they were still at a collection agency and were presumed collectible.[26]

The MHHS Providers have alleged that the Medicare Contractor's disallowance of the bad debts at issue violated both prongs of the Bad Debt Moratorium for the years at issue. First, they claim that the disallowance violates the first prong because the Presumption of Noncollectibility at PRM 15-1 § 310.2 allowed the MHHS Providers to write off bad debts after 121 days of collection activity regardless of whether the bad debts were at an OCA.[27] Second, they assert that the disallowance violates the second prong because the Medicare Contractor had previously accepted the MHHS Providers' practice of writing off bad debts after 120 days regardless of whether accounts were returned from an OCA.[28]

DISCUSSION, FINDINGS OF FACT, CONCLUSIONS OF LAW:

The issue agreed to by the parties to these appeals is whether MHHS Providers' claimed Medicare bad debts for FYs 2002, 2004, and 2007-2012 pending at OCAs are allowable.[29] The MHHS Providers contend that patient accounts pending at OCAs are entitled to the Presumption of Noncollectibility – provided that the reasonable collection efforts required by PRM 15-1 § 310 were satisfied ***prior to*** sending the accounts to the OCAs. The MHHS Providers further contend that the CMS and Medicare Contractor policy denying reimbursement for accounts pending at OCAs violates the first and second prongs of the Bad Debt Moratorium because:

1. With respect to the first prong, it represents a prohibited change to CMS' bad debt policy as it existed on August 1, 1987; and

2. With respect to the second prong, it improperly required the MHHS Providers to change their bad debt practice that was established prior August 1, 1987.[30]

Thus, the Board's findings in these appeals address the Bad Debt Moratorium and the criteria necessary to be met before a provider's bad debt collection efforts comply with relevant rules and regulations for claiming Medicare bad debt.

At the outset, it is important to address the applicability and scope of the Bad Debt Moratorium. As noted above, there are two separate and independent prongs to the Bad Debt Moratorium: (1) CMS is prohibited from changing its bad debt policy that was in effect on August 1, 1987; and (2) CMS is prohibited from requiring a provider to change its bad debt collection policy when the Medicare Contractor had accepted that policy prior to August 1, 1987. The MHHS Providers have alleged that CMS violated both prongs. The Board will address each prong separately.

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[25] Providers' FPP at 7-8.
[26] *Id.*; Schedule of Providers, Participant 2 at Tabs B, E and Participant 3 at Tabs B, E (Case No. 13-1710GC).
[27] Providers' FPP at 1-2, 8-10.
[28] Providers' FPP at 11.
[29] Tr. at 6.
[30] Provider's PHB at 3-4, 21-25.

A. First Prong of the Bad Debt Moratorium – CMS's Bad Debt Policy

The first prong of the Bad Debt Moratorium prohibits changes to CMS' bad debt policy that was in effect on August 1, 1987. Accordingly, the Board must determine whether CMS' bad debt policy as it was applied to the MHHS Providers' Medicare bad debt pending with OCAs, is consistent with the policy that was in effect on August 1, 1987.

Pursuant to 42 C.F.R. § 405.1867, "[i]n exercising its authority to conduct proceedings under this subpart, the Board must comply with all the provisions of Title XVIII of the Act *and* ***regulations*** issued thereunder . . . ."[31] Here, it is clear that the Secretary's intent was merely to codify longstanding bad debt policies that existed prior to the Bad Debt Moratorium going into effect. Indeed, some of these policies are explicitly stated in PRM 15-1 as it existed prior to August 1, 1987. The following are examples of specific policies that existed in manual guidance prior to August 1, 1987 that the Secretary codified on a retrospective and prospective basis as part of the FY 2020 IPPS Final Rule:

Policy Area	Pre-August 1987 Manual Guidance	2020 Codification
Treating Medicare & Non-Medicare accounts similarly	PRM 15-1 § 310 specifies, in part: "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."	42 C.F.R. § 413.89(e)(2)(i)(A)(1) requires that collection efforts on nonindigent Medicare bad debts "[b]e similar to the collection effort put forth to collect comparable amounts from non-Medicare patients."
Requiring a written bad debt collections policy	Hospital Audit Program specifying: "The auditor should review the provider's policies and procedures to obtain an understanding of the method used to determine bad debts, bad debt collection effort and the method used to record the recovery of bad debts previously written off. After reviewing bad debt policies and procedures, the auditor should determine that only uncollectible deductible and coinsurance amounts are included in the calculation of reimbursable bad debts."[32]	42 C.F.R. § 413.89(e)(2)(i)(A)(6) requires "Maintaining and, upon request, furnishing verifiable documentation . . . of . . . (i) The provider's bad debt collection policy which describes the collection process for Medicare and non-Medicare patients"

Similarly, the Secretary codified his interpretation of the Presumption of Noncollectibility at PRM 15-1 § 310.2 into 42 C.F.R. § 413.89(e)(2)(i)(A)(5) which specifies that a provider's collection effort to collect a Medicare deductible or coinsurance amount must:

> (i) Last at least 120 days after paragraph (e)(2)(i)(A)(2) . . . of this section is met before being written off as uncollectible under paragraph (e)(3) of this section.

[31] (Emphasis added.)

[32] Medicare Intermediary Manual ("MIM") 13-4 ("MIM 13-4"), Ch. 5, § 4499, Exhibit 15 at § 15.01 (as revised by MIM 13-4, Ch. 5, Transmittal 16 (Dec. 1985)) (copy at Providers' FPP, Exhibit P-4). *See also* discussion *infra* in Appendix A providing additional bases for this policy.

> (ii) **Start a new 120-day collection period <u>each time a payment is received</u> within a 120-day collection period**.[33]

Similarly, the Secretary explained in the preamble to the 2020 IPPS final rule that he codified his "longstanding" policy that an account remaining with a collection agency fails to satisfy both 42 C.F.R. § 413.89(e)(3) and (4). This regulation specifies that, in order for a bad debt to be allowable: (a) the bad debt must be "actually uncollectible when claimed as worthless" (paragraph (3)); and (b) "sound business judgment established that there was no likelihood of recovery at any time in the future" (paragraph (4)).[34] In this discussion, the Secretary noted that PRM 15-1 § 310 specifically notes that a provider may outsource its "reasonable collection efforts" to a collection agency.[35] As a result, 42 C.F.R. § 413.89(e)(2)(i)(B) specifies:

> A provider that uses a collection agency to perform its collection effort must do all of the following:
>
> (1) Reduce the beneficiary's account receivable by the gross amount collected.
>
> (2) Include any fee charged by the collection agency as an administrative cost.
>
> (3) ***Before claiming the unpaid amounts*** as a Medicare bad debt, *cease all collection efforts****, including the collection agency efforts, and <u>ensure that the collection accounts have been returned to the provider from the agency</u>***.[36]

Here, 42 C.F.R. § 413.89(e)(2)(i)(B) plainly affirms the Medicare Contractor's disallowance of the MHHS Providers' Medicare debts at issue based on the fact that, when they were written off, they were still at a collection agency and were presumed to still be collectible. The Providers try to assert that the Presumption of Noncollectibility at PRM 15-1 § 310.2 supports their position.[37] However, the Secretary's codification of his longstanding interpretation of that provision at 42 C.F.R. § 413.89(e)(2)(i)(A)(5) confirms that, contrary to the MHHS Providers' position, this Presumption does *not* apply if collection efforts continue at an OCA (and are presumably still occurring if they remain at an OCA[38]). Indeed, the MHHS Providers acknowledge that the retroactive bad debt regulations both apply to and affirm the Medicare Contractor's disallowance of the bad debts at issue as illustrated by the following excerpts from the Providers' Post-Hearing Brief:

> Pertinent here, in its final rule issued on September 18, 2020, the agency added a new provision to the bad debt regulation providing

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[33] (Emphasis added.)
[34] 85 Fed. Reg. at 58995-96.
[35] *Id.*
[36] (Emphasis added.)
[37] *See, e.g.*, Providers' PHB at 1-2, 3, 6, 13, 16-19.
[38] Ex. P-2 states that the bad debt "listings have…been updated for Non-Medicare payments made after the cost report filing appeal was filed." This suggests that certain OCA collection efforts continued *after* the cost reports were filed.

that, "[t]o be considered a reasonable collection effort for non-indigent beneficiaries," "[a] provider that uses a collection agency to perform its collection effort must . . . [b]efore claiming the unpaid amounts as a Medicare bad debt, cease all collection efforts, including the collection agency efforts, and ensure that the collection accounts have been returned to the provider from the agency." 42 C.F.R. § 413.89(e)(2)(i). Another change provides that "deductible and coinsurance amounts uncollected from beneficiaries are to be written off and recognized as allowable bad debts in the cost reporting period in which the accounts are deemed to be worthless." 42 C.F.R. § 413.89(f).

. . . . [T]he agency gave the relevant amendments retroactive application, providing that they are "applicable to cost reporting periods *before*, on, and after October 1, 2020." 85 Fed. Reg. 58,432, 58,432 (Sept. 15, 2020) (emphasis added).

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The agency has attempted to bolster its position in this and other ongoing bad debt appeals by codifying its position through retroactive rulemaking after the hearing before the Board. . . . Second, by purporting to apply retroactively to cost years before the date of its promulgation, the new regulation violates the general prohibition on retroactive rulemaking under well-established precedent and the Medicare Act, qualifying for neither of two limited exceptions.

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Here, the retroactive application of the rule would *hurt*, not benefit, providers, especially the Providers in this appeal.

The agency's retroactive rule upsets hospitals' settled expectations regarding the procedures and policies that they faithfully followed, and contractors accepted, for decades with the expectation of receiving payment. Applying the new bad debt provision at issue here retroactively would be detrimental to hospitals and permit the agency to withhold bad debt reimbursement to which hospitals were entitled under preexisting policy and practice during relevant cost reporting years.

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Moreover, applying the regulation retroactively also threatens to hurt the Providers by forcing them—in light of the requirement to treat Medicare and non-Medicare accounts similarly—to pull back their non-Medicare accounts for the cost years at issue from collection agencies. It is not, and cannot be, in providers' or the

> public interest to deprive safety-net hospitals of an important source of revenue, especially now, in the wake of the COVID-19 pandemic and resulting declines in patient revenue.[39]

Even if the Secretary had not issued the retractive changes to the bad debt regulations, the Board would still uphold the Medicare Contractor's disallowance as explained at Appendix A. Similarly, the Board notes that, for FYs 2007 through 2012, ***none*** of the bad debts at issue were audited to confirm that they met other Medicare requirements because these bad debts were claimed as protested amounts and then disallowed by the Medicare Contractor because the claims were still at a collection agency and were presumed to still be collectible.[40] For FYs 2002 and 2004, there is only one MHHS Provider which had claimed bad debts still pending at an OCA on its as-filed FY 2002 and 2004 cost reports[41] and it is unclear to what extent these two (2) years were audited.[42] If the Medicare Contractor's disallowance of the bad debts at issue were reversed, these bad debts at issue would then need to be remanded to go through the normal audit process.[43]

B. The Second Prong of the Bad Debt Moratorium – MHHS Providers' Policy

The MHHS Providers contend that the Medicare Contractor's disallowance of the MHHS Providers' bad debt amounts at issue violates the second prong of the Bad Debt Moratorium. The second prong states:

> The Secretary may not require a hospital to change its bad debt collection policy if a fiscal intermediary, in accordance with the rules in effect as of August 1, 1987, with respect to criteria for indigency determination procedures, record keeping, and determining whether to refer a claim to an external collection

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[39] *Id.* at 13-14, 28, 33, 34 (footnote omitted at 14).

[40] Providers' FPP at 7-8. There is nothing in the record suggesting that the Medicare Contractor reviewed or audited any bad debt listing associated with the disallowed protested amounts relating to bad debts still at an OCA.

[41] Providers' FPP at 7-8; Schedule of Providers, Participants 2 & 3, each at Tabs B, E (Case No. 13-1710GC).

[42] There is no documentary evidence (*e.g*., the Medicare Contractor's audit workpapers documenting what it reviewed and what it found). Rather, there is only testimony. *See, e.g.,* Providers' PHB at 11 n.6 (stating: "For the two cost years at issue in this appeal for 2002 and 2004, the Medicare contractor initially disallowed the Providers' bad debt due to a lack of documentation. In the course of resolving those Providers' bad debt issues in their individual appeals, however, the MAC later refused to resolve several accounts, raising the changed policy."); Tr. at 115-18.

[43] For example, the audit process would review MHHS' written bad debt policies in effect during the relevant time period and audit the bad debt listings (likely by sampling) to confirm that the MHHS Providers complied with the relevant MHHS *written* bad debt collection policy, including as it relates to the use of OCAs and to treating Medicare and non-Medicare accounts of the comparable amounts similarly. Indeed, the Providers' PHB at 34 suggests that the MHHS Providers were not treating Medicare and non-Medicare bad debts of like amounts similarly as required by PRM 15-1 § 310: "Moreover, applying the regulation retroactively also threatens to hurt the Providers by forcing them—in light of the requirement to treat Medicare and non-Medicare accounts similarly—to pull back their non-Medicare accounts for the cost years at issue from collection agencies. It is not, and cannot be, in providers' or the public interest to deprive safety-net hospitals of an important source of revenue, especially now, in the wake of the COVID-19 pandemic and resulting declines in patient revenue." Further, while there is testimony to indicate why MHHS may have had disparate treatment, that was not reviewed or sufficiently established as being true. *See* Tr. at 84-87; *see also Univ. Health Servs. v. Health & Human Servs*., 120 F.3d 1145, 1149 (11th Cir. 1997), *cert. denied*, 524 U.S. 904 (1998) ("PRM 310.2 [i.e., the Presumption of Noncollectibility] does not come into effect *unless the provider has complied with PRM § 310 in treating* ***identically*** *all Medicare and non-Medicare accounts* and has ceased collection efforts with regard to all accounts after 120 days." (emphasis added)).

> agency, has accepted such policy before that date, and the Secretary may not collect from the hospital on the basis of an expectation of a change in the hospital's collection policy.[44]

For the reasons described below, the Board finds that the MHHS Providers have failed to meet their burdens of evidence and proof to establish by the preponderance of the evidence that they are entitled to have the second prong of the Bad Debt Moratorium applied to them for the bad debts at issue.[45]

First, as discussed both *supra* with the first prong and *infra* in Appendix A, it is clear that providers are required to maintain written bad debt collection policies that apply to Medicare and non-Medicare patients. However, the MHHS Providers have not entered into the record ***any*** written bad debt collection policies, whether from the years in question or that were in effect prior to August 1, 1987.[46] The sole evidence that the MHHS Providers entered is testimony from one witness who could *only* testify to the pre-1987 policy at ***one*** of the MHHS Providers (specifically only for Memorial City General Hospital)[47] and had ***no*** interaction or involvement with ***any*** of the other MHHS providers until either 1994 or 1997.[48] The witness further confirmed that his testimony is based *only* on his memory going back ***more than 30 years*** **(**as of the February 27, 2020 hearing).[49] More significantly,

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[44] *See supra* note 23 and accompanying text.

[45] *See* 42 C.F.R. § 405.1871(a)(3) (stating: "The decision must include findings of fact and conclusions of law regarding the Board's jurisdiction over each specific matter at issue (see § 405.1840(c)(1)), and whether the provider carried *its burden of production of evidence* ***and*** *burden of proof by establishing, by* ***a preponderance of the evidence***, that the provider is entitled to relief on the merits of the matter at issue." (emphasis added)).

[46] For example, the MHHS Providers' witness testified as follows:

> MR. LAU: Okay. Now, I know this is going back 33 years ago, but what was the providers Bad Debt policy back in 1987?
> THE WITNESS: In 1987, the policy was to work the account for 120 days after billing the patient when the remittance advice was received. And then turning the account to collection after it was written off to Bad Debt.
> MR. LAU: Okay. Was this a written policy?
> THE WITNESS: Yes, it was.
> MR. LAU: Okay, and is it anywhere in the record?
> THE WITNESS: No.

Tr. at 48-49. Further, neither party's exhibits include copies of any MHHS bad debt collection policies.

[47] *Id.* at 15-18.

[48] *Id.*(confirming that Memorial City was independent until 1994 when Memorial Health System took it over and then merged in 1997 with Memorial Hermann).

[49] The MHHS Providers' witness testified as follows:

> MR. LAU: Okay. So, your knowledge basically starts from 1985, then?
> THE WITNESS: Essentially when I was employed there, yes.
> MR. LAU: Okay do you -- are you aware of anything in the record that indicates what the Providers' Bad Debt policy was back in 1985 through 1987?
> THE WITNESS: No.
> MR. LAU: Okay, so we're going solely on your testimony today based on your memory going back 33 years ago?
> THE WITNESS: Yes.

Id. at 49-50. The Board recognizes that the witness testified that MHHS submitted a FOIA request to Novitas Solutions, Inc. ("Novitas") for copies of the MHHS Providers' pre-1987 bad debt collection policies that may have been maintained in their permanent file. *Id.* at 159-60. However, the record does not contain a copy of the alleged FOIA request nor the response received from Novitas. Moreover, the Providers' witness recognized that Novitas' predecessor, Trailblazer, may not have transferred all of their records to Novitas but did not indicate that any documentation requests were made of Trailblazer. *Id.* Finally, the Board notes that, even though Board has formal discovery processes at 42 C.F.R. § 405.1853(e), the MHHS Providers did not avail themselves of those processes. *See Id.* at 203-04.

the witness testified that the written pre-August 1, 1987 policy did ***not*** memorialize use of OCAs as part of the collection process and only memorialized the writing off of bad debts after 120 days of collection activities.[50] Indeed, the witness confirmed that there is nothing in the record that even indicates that the MHHS Providers actually used OCAs prior to August 1, 1987.[51] Accordingly, the Board gives no weight to the witnesses testimony about MHHS Providers' pre-1987 bad debt collection policies for OCAs (whether for the MHHS Providers collectively or individually).

Similarly, the MHHS Providers have not entered anything into the record to confirm that: (1) the Medicare Contractor had accepted the MHHS Providers' alleged *pre-August 1, 1987* bad debt collection policy to claim bad debts still pending with OCAs; or (2) MHHS Providers had submitted, *prior to August 1, 1987*, claims for bad debts pending with an OCA.[52] The fact that the MHHS Providers' witness testified that the alleged written *pre-August 1, 1987* bad debt collections policy did *not* reference use of an OCA reinforces why the lack of documentation is material.[53]

Finally, the record confirms that MHHS was not in existence until 1997 and, as such, there could ***not*** have been one overarching pre-August 1987 bad debt collection policy that was applied to all

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[50] The MHHS Providers' witness testified as follows:

> CHAIRMAN NIX: Thank you, I appreciate your patience with our questioning and I will be -- try to be as quick as possible. I just wanted to follow up on Ms. Turner's question about while we were talking about the policies. So as to the written policy and I'll sort of start back in the, I guess the pre-1987. In terms of the written policy, I understand and the written policy may be, you know, more verbose or less verbose than in terms of explaining what the actual operational policy is on a day to day basis. And but did the written policy state that after 120 said after doing X, Y, Z collection efforts, the bad debt would be written off?
> THE WITNESS: That's my understanding, yes.
> CHAIRMAN NIX: And did the policy, written policy refer to the collection agency piece?
> THE WITNESS: No.
> CHAIRMAN NIX: Okay.
> THE WITNESS: No. It only referred to what Memorial Hermann was responsible for doing.
> CHAIRMAN NIX: Okay. Okay. And in terms of prior to August 1, 1987, I know that you as I understand were hired I think September 30, 1985?
> THE WITNESS: '85, yes, sir.

Id. at 173-74. *See also id.* at 177-78:

> CHAIRMAN NIX: Okay. And, oh. And when -- so that was what you had described was at I guess Memorial City, that same written policy that you described earlier was the same at I guess the Memorial System when you went from Memorial City to Memorial System?
> THE WITNESS: They were very similar.
> CHAIRMAN NIX: Very similar and so essentially these are the steps you do for internal collection efforts and we write off 120 days and then there is no mention of collection agencies.
> THE WITNESS: Correct.
> CHAIRMAN NIX: Okay. And then the same thing with Memorial Hermann when it went from Memorial System to Memorial Hermann?
> THE WITNESS: Correct.

[51] *Id.* at 50.

[52] *Id*. at 50, 58-59.

[53] This highlights why the audit work papers for fiscal years 1995, 1997, and 2001 (Exs. P-8, P-9, and P-10) have little evidentiary value because there is no reference to OCAs, no indication that any of the bad debts involved OCAs, and no indication that the Medicare Contractor was aware of MHHS' use of OCAs as part of its customary bad debt collection process. Indeed, the Providers' witness testified that the pre-1987 policy made no mention of OCAs at all (*see supra* note 50) and, therefore, it is not verifiable that OCAs were part of the Providers' customary process at that time. Regardless, the audit workpapers for 1995, 1997, and 2001 would not be a sufficient basis to establish the pre-August 1, 1987 use of OCAs for all of the MHHS Providers.

MHHS Providers.[54] Similarly, the record suggests that ***none*** of the MHHS Providers were part of the same health care system in or around 1987.[55] As a result, it is clear that each of the participants in these groups would have had an individual written bad debt collection policy and that each participant's bad debt policy would have to be independently verified as meeting the second prong of the Bad Debt Moratorium. While the potential for factual and legal disparity between the participants would exist in connection with the second prong, no participant-by-participant verification exists in the record.[56]

Accordingly, based on the above, the Board finds that the second prong of the Bad Debt Moratorium is not applicable or relevant because the MHHS Providers have not presented sufficient evidence to establish, by a preponderance of the evidence, that the Medicare Contractor or CMS violated the prohibition of the second prong of the Bad Debt Moratorium. The Board decision is consistent with case law applying the second prong.[57]

DECISION:

After considering the Medicare law, regulations and program instructions, the arguments presented, and evidence admitted, the Board finds that the Medicare Contractor properly disallowed the Medicare bad debts protested by the MHHS Providers for the FYs 2002, 2004 and 2007 through 2012, because the bad debts remained at OCAs and that these disallowances did not violate the Bad Debt Moratorium. Accordingly, the Board affirms the Medicare Contractor's adjustments in these appeals.

Board Members Participating:

Clayton J. Nix, Esq.
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Kevin D. Smith, CPA

For the Board:

9/29/2023

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: PIV

[54] Tr. at 18.
[55] *See id.* at 18-21, 61-63, 99-101.
[56] The Board further notes that this is a group appeal and, per 42 C.F.R. § 405.1837(g) states: "A provider involved in a group appeal that also wishes to appeal a specific matter *that does not raise a factual or legal question* ***common*** *to each of the other providers in the group* must file a separate request for a single provider hearing in accordance with § 405.1811 or § 405.1835 of this subpart, or file a separate request for a hearing as part of a different group appeal under this section, as applicable."
[57] *See, e.g., Univ. Health Servs., Inc. v. Health & Human Servs*., 120 F.3d 1145, 1151-1155 (11th Cir. 1997), *cert. denied*, 524 U.S. 904 (1998); *Hennepin County Med. Ctr. v. Shalala*, 81 F.3d 743, 751 (8th Cir. 1996).

APPENDIX A

Alternative Ruling On The First Prong Of The Bad Debt Moratorium[58]

If the retroactive bad debt regulations at issue were not applicable to these cases, the Board would still find that CMS' policy of not allowing providers to claim bad debts until they are returned from a collection agency does not violate the first prong of the Bad Debt Moratorium because that policy is consistent with the regulations and Manual sections in effect *prior to* August 1, 1987.

The first prong of the Bad Debt Moratorium prohibits changes to CMS' bad debt policy in effect on August 1, 1987. Accordingly, the Board must determine whether CMS' bad debt policy that was applied to the MHHS Providers' Medicare bad debt pending with OCAs is consistent with the policy that was in effect on August 1, 1987.

As stated above, Chapter 3 of PRM 15-1 provides additional guidance for the requirements of 42 C.F.R. § 413.89(e). Section 308 mirrors 42 C.F.R. § 413.89(e) in outlining the four main criteria that must be satisfied in order for bad debts to be reimbursable by Medicare. PRM 15-1 § 310 provides additional guidance on how a provider can satisfy the second criterion that requires a provider to "establish that reasonable collection efforts were made." The § 310 guidance in effect during the time period at issue was revised in 1983 and, thus, was established prior to the Bad Debt Moratorium.[59]

The MHHS Providers' appeals centers on the meaning and application of § 310 and, in particular, the second subsection of § 310.2 addressing the "Presumption of Noncollectibility." In reading the § 310 guidance in its entirety, it is important to understand that the guidance recognizes and distinguishes between the provider's actual "collection effort" (*i.e*., what steps and procedures a provider actually takes as part of its collection efforts) and what may be "considered a reasonable collection effort":

> 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,

[58] This ruling is consistent with the Board's decision in *UHS 2006-2009 Medicare Bad Debts Sill at Agency CIRP Group v. Novitas Solutions, Inc.*, PRRB Dec. 2020-D20 (Aug. 31, 2020).

[59] *See* PRM 15-1, Transmittal 278 (Jan. 1983) (revising § 310). Subsequent to the time at issue, CMS revised PRM 15-1 Chapter 3 "to reflect updated references from HCFA to CMS, correction of typos, and replace Fiscal Intermediary with Contractor"). *See* PRM 15-1, Transmittal 435 (Mar. 2008).

> 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.
>
> ****
>
> 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.[60]

Significantly, § 310 makes clear that, in order for a debt collection policy to be reasonable, the provider must, at a minimum, issue a bill, as well as subsequent or follow-up bills, and collection letters which may or may not threaten a lawsuit. Section 310 also requires the provider to make telephone calls or other personal contacts and *may* include the use of a collection agency (*i.e.*, OCA) in lieu of any of the preceding efforts, or subsequent to its prior efforts to collect a bill. It is up to the provider to make a business decision as to how much and what types of actual "collection effort" it will expend to collect debts. The provider has numerous tools at its disposal as part of its actual "collection effort," including whether and when to engage OCAs to assist in its collection effort.

[60] (Italics emphasis added and underline in original.)

Regardless of the tools the provider selects for its actual "collection effort," § 310 specifies that, in order for a collection effort to be considered *reasonable*, the following two conditions must be met: (1) the provider's actual "collection effort" for Medicare accounts must be similar to that used for non-Medicare accounts; and (2) there is consistency in this treatment across Medicare and non-Medicare debts.[61]

Thus, it is the provider's business decision as to what process and tools it will adopt and use for its customary collection effort for Medicare deductibles and coinsurance and this is mediated by the Medicare requirement that those customary collection efforts be "reasonable," namely that the provider's collection efforts on Medicare bad debt be similar to and consistent with its efforts to collect comparable amounts of non-Medicare bad debt.

These business decisions that the provider makes in establishing its debt collection process and procedures must be reflected in the provider's written debt collection policy. As part of the normal cost report audit process and procedures, Medicare contractors request a copy of the provider's written bad debt collection policy for the handling of Medicare and non-Medicare patient accounts.[62] This requirement is memorialized in the CMS Form 339 which is submitted with the as-filed cost report.[63]

The hospital audit program in effect prior to the Bad Debt Moratorium confirms that the Medicare program expected hospitals to maintain and make available during audit a written bad debt collections policy at least since December 1985.[64] Specifically, as part of the audit of a

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[61] Prior to the Bad Debt Moratorium, CMS gave the following example of the § 310 requirement for similar treatment in the context of collection fees:

> [T]he allowability of collection fees has been clarified. *When a collection agency is used by a provider*, the collection fees are allowable costs *only if all uncollected charges of like amount, without regard to class of patient (Medicare or non-Medicare), are referred to a collection agency*.

PRM 15-1, Transmittal 210 (Sept. 1978) (emphasis added) (revising provisions addressing collection agency fees and moving those provisions from § 318 to § 310.1). *See also infra* note 87 and accompanying text (discussing the relevance of § 310.1 in interpreting the rest of § 310).

[62] *See* PRM 15-2, Ch. 11, § 1102 and Exhibit 1.

[63] *Id.*

[64] *See* MIM 13-4, Ch. 5, § 4499 Exhibits 1, 15, and 21 (as revised by MIM 13-4, Ch. 5, Transmittal 16 (Dec. 1985)) (stating, for example, in § 1.15 that ; "the auditor should request . . . [p]olicies and procedures relating to the determination and collection of bad debts"; in § 15.01 "[t]he auditor should review the provider's policies and procedures to obtain an understanding of the method used to determine bad debts, bad debt collection effort and the method used to record the recovery of bad debts previously written off"; and in § 21.05(A)(1) "[r]eview the provider's 'bad debt' policy and determine whether its application to both Medicare and other patients is consistent"). The hospital audit program was designed for use by both intermediaries and CPA firms to test the hospital's internal controls and adherence to Medicare policies. *See* MIM 13-4, Ch. 5, § 4402 (as revised by MIM 13-4, Ch. 5, Transmittal 16 (Dec. 1985)) (stating that "the audit program was designed so that an intermediary or CPA could express an opinion as to whether or not the provider is adhering to Medicare Reimbursement Principles as explained in the Provider Reimbursement Manual, HCFA Pub. 15-1"); MIM 13-4, Ch. 5, § 4499 Exhibit 1 at § 1 (stating that "The Audit Program was developed to assist an intermediary or CPA firm in determining if the correct amount of reimbursement was made to the provider for the cost report being audited. Also, the audit program was designed so that an intermediary or CPA [firm] could express an opinion as to whether or not the provider is adhering to Medicare Reimbursement Principles as explained in the Provider Reimbursement Manual, HCFA Pub. 15-1."); MIM 13-4, Ch. 5, § 4499 Exhibit 21 at ¶¶ 21.01, 21.05(A)(1) (as revised by MIM 13-4, Ch. 5, Transmittal 16 (Dec. 1985)) (stating in § 21.01 "the scope of an audit of the balance sheet accounts for Medicare purposes is dependent upon the. . . effectiveness of the internal controls" and in § 21.05 "[r]eview the provider's 'bad debt'

hospital, the hospital audit program required the Medicare Contractor to review the hospital's bad debt policy to test the hospital's internal controls and adherence to Medicare bad debt policies:

> 15.01 The Auditor should review the provider's policies and procedures to obtain an understanding of the method used to determine bad debts, bad debt collection effort and the method used to record the recovery of bad debts previously written off. After reviewing bad debt policies and procedures, the auditor should determine that only uncollectible deductible and coinsurance amounts are included in the calculation of *reimbursable* bad debts.[65]

Further, the hospital audit program is derived from providers' general records requirements in 42 C.F.R. §§ 413.20 and 413.24 for the purpose of testing hospital internal controls and adherence to Medicare policies.[66] In this regard, the Board notes that maintaining a written bad debt collection policy is consistent with 42 C.F.R. §§ 413.20(a) and (d) and 413.24(c) to ensure adequate and sufficient cost information is maintained. Specifically, 42 C.F.R. § 413.20(a) specifies in pertinent part:

> (a) *General*. The principles of cost reimbursement require that providers maintain sufficient financial records and statistical data for proper determination of costs payable under the program.

Similarly, 42 C.F.R. § 413.24(c) specifies in pertinent part:

> (c) *Adequacy of cost information*. Adequate cost information must be obtained from the provider's records to support payments made for services furnished to beneficiaries. The requirement of adequacy of data implies that the data be accurate and in sufficient detail to accomplish the purposes for which it is intended. Adequate data capable of being audited is consistent with good business concepts and effective and efficient management of any organization, whether it is operated for profit or on a nonprofit basis. It is a reasonable expectation on the part of any agency paying for services on a cost-reimbursement basis. In order to provide the required cost data and not impair comparability, financial and statistical records should be maintained in a manner

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policy and determine whether its application to both Medicare and other patients is consistent"). *See also*, *e.g*., *Buckeye Home Health Serv. Inc. v. Blue Cross of Central Ohio*, PRRB Dec. No. 1983-D108 (July 14, 1983), *review declined*, CMS Administrator (Sept. 1, 1983) (PRRB decision issued prior to the Bad Debt Moratorium where bad debts were disallowed due to the provider's failure to follow its bad debt collection policy).

[65] MIM 13-4, Ch. 5, § 4499, Exhibit 15 at § 15.01 (as revised by MIM 13-4, Ch. 5, Transmittal 16 (Dec. 1985)) (note that Chapter 5 is entitled "Hospital Audit Program") (emphasis added) (copy at Exhibit P-4).

[66] *See* MIM 13-4, Ch. 5, § 4499 Exhibit 1 at §§ 1, 1.04(B)(15), 1.15 (as revised by MIM 13-4, Ch. 5, Transmittal 16 (Dec. 1985)) (citing to 42 C.F.R. §§ 405.406, and 405.453 which were later relocated to 42 C.F.R. §§ 413.20 and 413.24 as authorities for the hospital audit program which includes among other things, review of the written bad debt collection policy).

> consistent from one period to another. However, a proper regard for consistency need not preclude a desirable change in accounting procedures if there is reason to effect such change.

The Medicare program's expectation that the provider maintain a policy to memorialize the process for its actual "collection effort" is reflected in the use of the word "customary" in the Presumption of Noncollectibility delineated in PRM 15-1 § 310.2. In order to obtain the benefit of this presumption, a provider must follow its own policies for its "reasonable *and* customary attempts to collect"[67] for more than 120 days prior to writing off a bad debt.

The Board finds that the plain language of the Presumption of Noncollectibility does not create an automatic presumption after the passage of 120 days. Rather, it is a discretionary presumption and does not foreclose the possibility that a debt may still be deemed collectible after 120 days as demonstrated by the use of the words "may be deemed."

In this regard, the Board notes that the Presumption of Noncollectibility does not excuse a provider from satisfying the other criteria specified in 42 C.F.R. § 413.89(e).[68] Rather, in order to satisfy the criteria of 42 C.F.R. § 413.89(e)(3), the provider must first determine that the debt is "uncollectible" by which it must exhaust what it has established as its reasonable and customary collection efforts. If a provider chooses to utilize a collection agency, these efforts must be exhausted before the debt can be determined to be uncollectible and, therefore, worthless.

A close reading of the conditional clause in the Presumption of Noncollectibility ("[i]f 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. . . .") confirms that a provider gets the benefit of the presumption for a debt only under certain circumstances. Specifically, a debt may be deemed uncollectible only if: (1) the provider has completed its customary collection attempts for that debt; (2) the actual collection attempts for the debt being claimed are "reasonable"; and (3) the collection attempts for the debt are completed more than 120 days from the date the first bill was sent to the patient for that debt. When the prepositional phrase, "[i]f after reasonable *and* customary attempts to collect a bill," is read in conjunction with the words "remains unpaid more than 120 days," it is clear that the prepositional phrase operates independent of the phrase "remains unpaid more than 120 days" and that the reasonable and customary attempts must be completed before a debt "may be deemed uncollectible."[69] Otherwise, the words "remains unpaid more than" would be rendered superfluous and would

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[67] PRM 15-1 § 310.2 (emphasis added).

[68] The Board notes that "presumption" is referenced only in the title of PRM 15-1 § 310.2 and uses the prefix "non": "Presumption of Noncollectibility." In contrast, the text of the manual provisions uses the prefix "un" when referring to debts as "uncollectible." Both of these prefixes generally mean not but the prefix "un" can be stronger than mere negativity and mean the opposite of or contrary to (*e.g*., compare the meaning of nonacademic to unacademic). *See* http://www.merriam-webster.com/dictionary/ (compare definitions of the prefix "un-" to the prefix "non-"); http://www.oxforddictionaries.com/us/definition/american_english/un-. As a result, the Board notes that it makes sense that the Agency adopted a weaker prefix with the presumption itself.

[69] The Board notes that, prior to the Bad Debt Moratorium, it was not uncommon for providers to have Medicare collection processes that ended in 120 days or less. *See, e.g*., *Wadsworth-Rittman Hosp. v. Blue Cross and Blue Shield Ass'n*, PRRB Dec. No. 1991-D85 (Sept. 26, 1991) (addressing 1986 cost reporting period); *King's Daughters' Hosp. v. Blue Cross and Blue Shield Ass'n*, PRRB Dec. No. 1991-D5 (Nov. 14, 1990), *review declined*, CMS Administrator (Dec. 26, 1990) (addressing 1984 cost reporting period).

reduce the Presumption of Noncollectibility to simply meaning that, after 120 days of reasonable and customary collection attempts, a debt "may be deemed uncollectible."[70] In summary, the Presumption of Noncollectibility does not excuse a provider from satisfying the other criteria specified in 42 C.F.R. § 413.89(e), nor does it create an automatic presumption of noncollectibility after the passage of 120 days. Rather, a provider must exhaust its reasonable and customary collection efforts, including the use of an OCA (if applicable) and more than 120 days must pass, before a debt can be deemed uncollectible.

Based on the above analysis, the Board finds that the policy of not allowing providers to claim bad debts until they are returned from a collection agency is consistent with the regulations and manual sections in effect on August 1, 1987. Therefore, the Medicare Contractor's disallowance of the bad debts at issue is not in conflict with the first prong or prohibition of the Bad Debt Moratorium. The Board finds that the MHHS Providers chose to utilize an OCA as part of their "customary collection effort." The fact that the MHHS Providers wrote off the debts at issue *prior to* sending them to an OCA does not mean that the MHHS Providers' use of an OCA was not part of the MHHS Providers' actual and customary "collection effort." While the record does not include a copy of the MHHS bad debt collection policy in effect during the years at issue,[71] the MHHS Providers state that their policy and procedure includes the use of an OCA as part of its collection effort and, through this referral, the MHHS Providers clearly expected and desired some portion of the referred bad debts to be collected.[72] Further, as discussed in *supra* note 50, the alleged pre-August 1, 1987 written collection policy (as recalled by the MHHS Providers' witness) did ***not*** refer to use of OCAs or explain OCAs fit into the then collections process. Therefore, it is clear that the MHHS written bad debt collections policy did change from the alleged pre-August 1, 1987 written policy to the current alleged written policy in effect during the years at issue,[73] which the MHHS Providers' witness represented does include and explain the use of OCAs in the bad debt collections process.

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[70] The Board's reading is consistent with the one Board decision issued prior to the Bad Debt Moratorium that considered the Presumption of Noncollectibility – *Davie Cty. Hosp. v. Blue Cross Blue Shield Ass'n*, PRRB Dec. No. 1984-D89 (Mar. 22, 1984) ("*Davie County*"). In *Davie County*, the provider did not write bad debts off until six months after the date of service and, accordingly, the provider asserted that the Presumption of Noncollectibility was applicable. The intermediary argued that the provider's collection efforts were unreasonable because: (1) "[t]he non-Medicare uncollectible accounts were referred to an outside collection agency for *further* collection attempts while the Medicare uncollectible accounts were not similarly referred, but were written off as bad debts" and the provider did not even make in-house telephone or letter-writing efforts comparable to those of the outside collection agency to collect the past-due Medicare accounts prior to writing them off and claiming them as bad debts. The Board did not apply the presumption, but rather found that the provider failed to establish that it had made reasonable collection efforts because, in deciding not to refer the Medicare accounts to the outside collection agency, the provider failed to establish that it used an acceptable in-house alternative to referral to a collection agency.

[71] As discussed in Section A of the decision, providing a copy of the ***written*** bad debt policy in effect during the relevant fiscal year is a necessary and integral part of Medicare's bad debt reimbursement audit and reimbursement processes and ensuring that Medicare and non-Medicare bad debt accounts are treated similarly. As the Board has other bases upon which to rule against the Providers, the Board need not address the fact that the record does not contain a copy of the bad debt policies in effect during the time periods at issue and how that fact affects the Providers' claims (*e.g.*, confirmation that MHHS' handling of the bad debts at issue complied with its ***written*** bad debt policies in effect during the time periods at issue).

[72] Tr. at 84-86.

[73] The Board again notes that the record does not contain a copy of MHHS' bad debt collection policy(ies) that was in effect during the years at issue.

The Board recognizes that the MHHS Providers' business decision to send bad debts to an OCA may have been above and beyond the *minimum* needed to establish a "reasonable collection effort." However, the Board notes that, because the providers must treat Medicare and non-Medicare accounts equally, a provider's decision to incorporate use of an OCA into its customary collection efforts for non-Medicare accounts necessarily means that the OCA activities get incorporated into the "reasonable collection effort" standard for Medicare accounts. Therefore, the Board finds that the MHHS Providers' collection effort is not complete until the OCA has completed its efforts or the account can be proven "worthless" with "no likelihood of recovery at any time in the future" by some other means. The MHHS Providers would not qualify under the "Presumption of Noncollectibility," even though the "debt remains unpaid more than 120 days from the date the first bill is mailed to the beneficiary" because this presumption only applies "*after* reasonable *and* customary attempts to collect a bill."[74] Indeed, while the record does not contain a copy of the MHHS bad debt collection policy in effect during the time periods at issue, it suggests that the MHHS Providers' ***written*** bad policy did not include the use of OCAs or the treatment of bad debts sent to an OCA, creating concerns about compliance with 42 C.F.R. §§ 413.20 and 24.[75]

The Board recognizes that some of the MHHS Providers are located in the U.S. Circuit Court of Appeal for the Eleventh Circuit and that there is a decision in this circuit addressing bad debt issues similar to those before the Board. Accordingly, the Board reviewed this Circuit Court decision to determine whether it is applicable to its analysis of Medicare bad debt policy and the associated first prong of the Bad Debt Moratorium.

In the 1997 decision, *Univ. Health Servs., Inc. v. Health & Human Servs*.,[76] the Eleventh Circuit found that "the Secretary's conclusion that [the provider] failed adequately to show that it had engaged in reasonable collection efforts based on sound business judgment *is supported* by substantial evidence."[77] In this regard, the Secretary had found that the provider had disparate treatment of Medicare and non-Medicare accounts because the provider wrote off as bad debt all delinquent accounts following 120 days of collection efforts and then referred *only* its non-Medicare accounts to an OCA.[78] The Eleventh Circuit also found that the first prong of the Bad Debt Moratorium was not triggered under this fact scenario.[79] While this case is not directly on point, the Board's findings remain consistent with this decision.

In its post-hearing brief,[80] the MHHS Providers urge the Board to follow the decisions of the District Court for the District of Columbia in the *District Hospital Partners* case (previously noted) and *Foothill Hosp.—Morris L. Johnston Mem'l v. Leavitt* ("*Foothill*"),[81] and ignore the more recent decisions of this same court in *Lakeland Reg'l Health Sys. v. Sebelius* ("*Lakeland*")[82] and *Community Health Sys., Inc. v. Burwell* ("*Community*").[83] However, the

[74] PRM 15-1 § 310.2 (emphasis added).
[75] *See supra* note 50.
[76] 120 F.3d 1145 (11th Cir. 1997), *cert. denied*, 524 U.S. 904 (1998).
[77] *Id.* at 1151 (emphasis added).
[78] *Id.* at 1150-1151.
[79] *Id.* at 1152-1153.
[80] Providers' PHB at 15-19.
[81] 558 F. Supp. 2d 1 (D.D.C. 2008).
[82] 958 F. Supp. 2d 1 (D.D.C. 2013).
[83] 113 F. Supp. 3d 197 (D.D.C. 2015).

Board disagrees with the District Court's findings in *Foothill* and *District Hospital Partners*. The Board finds nothing in the Medicare Bad Debt Audit Program from December 1985 indicating that CMS had a policy of allowing Medicare bad debts to be reimbursed while the debts were still at an OCA.[84]

The D.C. Court in *Foothill* discusses the 1985 guidance as follows:

> Not only is there a lack of support for defendant's current position, but several agency sources predating the Moratorium suggest that this new view is contrary to defendant's policy as of August 1, 1987. . . . Second, the Hospital Audit Program, dated December 1985, and found in the Intermediary Manual (Pub. HIM 13), uses the term "uncollectible" to refer to debts held by a collection agency.[85]

The following excerpt from the 1985 Hospital Audit Program shows the context in which the term "uncollectible" is used:

> 15.04 Where a provider utilizes the services of a collection agency, the provider need not refer all uncollected patient charges to the agency, but it may refer only uncollected charges above a specified minimum amount. *If reasonable collection effort was applied, fees the collection agency charges the provider are recognized as an allowable administrative cost of the provider*. *To determine the acceptability of collection agency services*, perform the following audit steps.
>
> A. Review provider contracts with the collection agency to determine that both Medicare and non-Medicare *uncollectible* amounts are handled in a similar manner.
>
> B. Determine that the patient's file is properly documented to substantiate the collection effort by reviewing the patient's file for copies of the agency's billing, follow-up letters and reports of telephone and personal contacts.
>
> C. Determine that the bad debt amounts recovered by the collection agency are properly recorded by verifying that the full amount collected is credited to the patient's account and the collection fee is charged to administrative expense.[86]

When examining the context of 1985 Hospital Audit Program, the Board notes that § 15.04 addresses the allowability of collection agency *fees* (and tracks PRM 15-1 § 310.1) by

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[84] MIM 13-4, Ch. 5, § 4499 Exhibits 1, 15, and 21 (as revised by MIM 13-4, Ch. 5, Transmittal 16 (Dec. 1985)) (excerpt of Exhibit 15 included at Ex. P-4).
[85] *Foothill*, 558 F. Supp. 2d at 10-11 (citation to record omitted).
[86] (Emphasis added) (excerpt at Exhibit P-4 at 6).

conditioning the allowability of collection agency *fees* on the collection agency first attempting reasonable collection efforts, a key element of which is the similar treatment of Medicare and non-Medicare debts of like amount. Section 15.04 focuses on the allowability of the collection agency *fees* as an administrative cost for services already performed and directs the auditor to review the provider contracts with the collection agency to ensure that the non-Medicare and Medicare uncollectible debts *returned* from the collection agency have been treated similarly in compliance with PRM 15-1 § 310. Thus, the Board maintains that the *Foothill* court misinterpreted § 15.04 as describing bad debts *going* ***to*** the collection agency as "uncollectible" rather than, as the Board has consistently held, describing uncollectible bad debts *coming back* ***from*** the collection agency to the provider.[87]

Further, contrary to the *Foothill* court, the Board finds the Administrator's decision in 1995 in *Lourdes Hospital v. Blue Cross and Blue Shield Association* ("*Lourdes*")[88] inconclusive as to CMS' policy related to debts that were still at a collection agency. In *Lourdes*, the Administrator reimbursed the provider for bad debts claimed less than 120 days from the first billing because, based on the evidence in the case, the provider established the bad debts were actually uncollectible. The provider's policy in *Lourdes* was that Medicare bad debts were written off prior to being sent to collection agency. The Administrator in its decision did not address this fact. Rather, the Administrator only focused on the provider establishing through evidence that the Medicare bad debts were actually uncollectible. Therefore, the Board draws no policy conclusions regarding the issue in this case from *Lourdes*.[89]

Similarly, the Board reviewed the decision in *District Hospital Partners*. In *District Hospital Partners*, the court used the same bases addressed in *Foothill* to make its ruling, except that it added the following reference to *Scotland Mem. Hosp. v. Blue Cross & Blue Shield Ass'n* ("*Scotland Memorial*"), Administrator Dec. (Nov. 8, 1984):

> Moreover, a pre-Moratorium Administrator decision, *Scotland Mem. Hosp. v. Blue Cross & Blue Shield Ass'n . . .*, directly contradicts the presumption of collectability. In *Scotland Memorial*, the Administrator noted that the presumption of noncollectibility established in PRM section 310.2 deserved "more weight than the subjective and unrealistic opinion of the provider's witness, who felt the bad debts were not uncollectible because she expected the collection agency to collect them." Thus, as of 1984, the presumption of noncollectibility in section 310.2 applied to accounts that had been sent to collection agencies.[90]

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[87] The Board notes that, notwithstanding PRM 15-1 § 310.1, the Board historically has refused to limit the allowability of collection agency fees to situations only where Medicare and non-Medicare accounts are both referred out to a collection agency. The Board's refusal to make this limitation predates the Bad Debt Moratorium. *See, e.g.*, *Mercy Hosp. of Laredo v. Blue Cross Ass'n*, PRRB Dec. No. 1982-D111 (June 29, 1982), *declined review*, Adm'r (July 27, 1982). However, this refusal to fully apply § 310.1 does ***not*** diminish the usefulness or import of § 310.1 in deciphering the construction and meaning of the PRM 15-1 provisions regarding what is needed to establish that a reasonable collection effort was made.

[88] Adm'r Dec. (Oct. 27, 1995), *modifying*, PRRB Dec. Nos. 1995-D58, 1995-D59 and 1995-D60, (Aug. 31, 1995).

[89] The *Foothill* court found that the "CMS Administrator's categorical stance" that bad debts at a collection agency could not be claimed until returned was in conflict with bad debts allowed in *Lourdes. See Foothill,* 558 F. Supp. 2d at 7 n.9.

[90] 932 F. Supp. 2d at 205-206 (citations to administrative record omitted).

The Board disagrees with this finding. As noted in the Administrator's *Scotland Memorial* decision "[t]he Medicare policy in effect during the cost year at issue set forth in [PRM 15-1] Sec. 310 . . . prohibited the use or threat of legal action to collect Medicare deductible and coinsurance amounts" and that "[t]his difference in permissible treatment of the different types of accounts prevented the providers from affording identical treatment to both Medicare and non-Medicare accounts." It was *this* prohibition that was the premise for not referring Medicare accounts to a collection agency, creating the difference in treatment of Medicare and non-Medicare accounts.[91] Upon this basis, the Administrator concluded that the Board acted reasonably in finding that the § 310 requirement for similar treatment of Medicare and non-Medicare accounts had been met. Thus, it is clear that, before applying the Presumption of Noncollectibility, the Administrator had to first determine whether the § 310 requirement for similar treatment had been met.

In connection with both the *District Hospital* case and the case at hand, PRM 15-1 § 310 (as revised by Transmittal 278) did not prohibit the use or threat of legal action to collect Medicare accounts and, accordingly, the Administrator's *Scotland Memorial* decision is not directly applicable or relevant because the justification in *Scotland Memorial* decision for treating Medicare accounts differently (*i.e*., the prohibition on threatening legal action for Medicare accounts) no longer exists. Notwithstanding, the principle in the Administrator's *Scotland Memorial* decision - that the § 310 requirement for similar treatment has to be met before the presumption can be applied – is still controlling.

Subsequent to the *Foothill* and *District Hospital Partners* decisions, the D.C. District Court upheld the Administrator's finding in *Lakeland*[92] stating: "it has always been the Secretary's policy that accounts pending at collection agencies cannot be written off as bad debts until collection activity has terminated."[93] In particular, the D.C. District Court notes the following:

> The Secretary's Policy is encompassed by 42 C.F.R. § 413.89(e), which expressly provides that a debt is not reimbursable unless it is "actually uncollectible when claimed as worthless" and "[s]ound business judgment established that there was no likelihood of recovery at any time in the future." Where, as here, an outside collection agency continues collection efforts on behalf of a provider, these criteria cannot be met. After all, what provider exercising sound business judgment would spend his precious resources on the fool's errand of pursuing an uncollectible debt with no likelihood of future recovery? By prohibiting double-recovery, PRM § 316 eliminates any incentive a provider might conceivably have to simultaneously pursue collection from a beneficiary and reimbursement from CMS.[94]

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[91] *See* PRM 15-1, Transmittal 278 (Jan. 1983) (revising § 310 "to eliminate the restriction against using or threatening court action to collect bad debts from Medicare beneficiaries" for cost reporting periods on or after January 1, 1983).
[92] 958 F. Supp. 2d 1 (D.D.C. 2013).
[93] *Id.* at 5.
[94] *Id.* (citations omitted).

In upholding the Secretary's policy on the use of collection agencies, the *Lakeland* court found that the policy did not violate the Bad Debt Moratorium because it "is reflected in the agency's pre- and post-Moratorium interpretive guidance."[95] In this regard, similar to the Board, the D.C. District Court used the 1985 guidelines for the Hospital Audit Program as evidence to support its finding that this policy was in effect prior to the Bad Debt Moratorium.[96]

Roughly two years after *Lakeland*, the D.C. District Court issued its decision in *Community* and, similar to *Lakeland*, upheld the Board's application of Medicare bad debt policy and the Presumption of Noncollectibility as laid out in this case, including that this application does not violate the first prong of the Bad Debt Moratorium.[97]

Based on the above analysis, the Board finds that the policy of not allowing providers to claim bad debts until they are returned from a collection agency is consistent with the regulations and Manual sections in effect prior to August 1, 1987.[98] Furthermore, careful review of the case law reveals no basis for the Board to reach a contrary conclusion now. Accordingly, the Board finds that the Medicare Contractor's disallowance of the MHHS Providers' protested bad debts is a permissible interpretation of the first prong of the Bad Debt Moratorium because it is reasonable and consistent with the rules and regulations as they existed prior to August 1, 1987.[99]

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In summary, a provider must complete or exhaust its reasonable and customary collection efforts, including the use of an OCA (if use of an OCA is incorporated into the customary collection process) and more than 120 days must pass, before a debt can be deemed uncollectible. In this case, the MHHS Providers chose to utilize OCAs as part of their customary bad debt collection effort during the fiscal years at issue. The fact that the MHHS Providers wrote off the debts at issue *prior to* sending them to the OCAs does not mean that the MHHS Providers' use of OCAs was not part of the MHHS Providers' customary collection effort.

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[95] *Id.* at 6.

[96] *Id.* Specifically, the D.C. Court stated: "The [1985 Hospital Audit Program] guidelines allow a provider to recoup fees paid to an outside collection agency 'as an allowable administrative cost' only '[i]f reasonable collection effort *was* applied.' The use of the past tense ('*was* applied') precludes reimbursement prior to the application of reasonable collection effort." *Id.* (citations omitted and italics emphasis in original). *See also El Centro Reg'l Med. Ctr. v. Leavitt*, 2008 WL 5046057 at *7 (S.D. Cal. 2008) (upholding the Administrator's interpretation of PRM 15-1 § 310 "as being applicable to both in house and outside collection efforts").

[97] 113 F. Supp. 3d at 217-18, 229.

[98] The Board further notes that the September 1989 audit guidelines essentially confirms the Agency's policy:

> After reasonable and customary attempts to collect the bill, the debt remaining unpaid more than 120 days from the date the first bill was mailed (unless the patient was deemed indigent). *If the Bad Debt is written-off* on the providers books 121 days after the date of the bill ***and then turned over to a collection agency***, the amount ***cannot*** *be claimed as a Medicare Bad Debt* on the date of the write-off. *It can be claimed as a Medicare Bad Debt* ***only after the collection agency completes its collection effort***.

MIM, Part 4, Transmittal 28 at Ex. A-11 (Sept. 1989) (emphasis added) (copy at Ex. P-5 at 27). As a minimum, the MHHS Providers' *stated* practice of writing off bad debts when sent to a collection agency is at direct odds with the above statement of the Agency's policy.

[99] In reaching its decision, the Board relies on neither the June 11, 1990 Joint Signature Memorandum issued by HCFA Central to all HCFA Regional Administrators nor MIM 13-4, Transmittal 28, § 4198, Exhibit A-11 (Sept. 1989) as these documents were both issued subsequent to the Bad Debt Moratorium. Notwithstanding, the Board notes that its decision is consistent with these documents.

Rather, and importantly, the MHHS Providers' *stated* policy and procedure includes the use of OCAs as part of their customary collection effort.[100]

The Board recognizes that a provider's decision to send bad debts to OCAs may be above and beyond the *minimum* needed to establish a "reasonable collection effort." However, because a provider must treat Medicare and non-Medicare accounts (of comparable amounts) similarly, a provider's business decision to incorporate the use of OCAs into its customary collection efforts for non-Medicare accounts necessarily means OCA activities must be incorporated into the "reasonable collection effort" standard for Medicare accounts – if the provider wishes to claim reimbursement for the Medicare accounts as bad debts. Therefore, in a case such as the one before the Board now, where a provider incorporates the use of OCAs in its customary collection efforts for non-Medicare accounts, the Board finds a provider's collection effort is not complete until the OCA has completed its efforts or the account can be proven "worthless" with "no likelihood of recovery at any time in the future" by some other means for the Medicare accounts.[101] Such a non-uniform collection policy would not qualify under the "Presumption of Noncollectibility," even though the "debt remains unpaid more than 120 days from the date the first bill is mailed to the beneficiary" because this presumption only applies "*after* reasonable *and* customary attempts to collect a bill."[102] Accordingly, the Board finds that these kinds of collection efforts did not satisfy the requirements for declaring Medicare bad debts uncollectible and, as a result, are not allowable Medicare costs.

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[100] The record does not contain a copy of the MHHS Providers' written bad debt collections policy. Rather, the only evidence presented is testimony and *only* as to ***one*** participant, Memorial City General Hospital. *See* Tr. at 59-60. Moreover, testimony also notes that there were changes made to the written policy during the fiscal years at issue (*see, e.g*., Tr. at 127) but the record does not contain copies of any MHHS policies.

[101] 42 C.F.R. § 413.89(e).

[102] PRM 15-1 § 310.2 (emphasis added).

APPENDIX B

Schedules of Providers

Schedule of Providers in Group

Group Name: Memorial Hermann 2008 Bad Debt Not Returned from Collection Agency Group Page No. 1 of 2

Representative Akin Gump Strauss Hauer & Feld LLP Date Prepared 6/26/2019

Case No: 13-0583GC Issue: The Disallowance of Bad Debt not returned from an outside collection agency.

Lead Intermediary: Novitas Solutions, Inc.

	Provider Number	Provider Name	Intermediary	FYE	A Date of Final Determination	B Date Hearing Rqst Filed	C No. of Days	D Audit Adj No.	E Amount of Reimbursement	F Original Case No.	G Date Add/ Transfer Filed
1	45-0068	Memorial Hermann - Texas Medical Center (Houston, Harris, TX)	Novitas Solutions, Inc.	6/30/2008	10/5/2012	4/2/2013	179	14, 17, 46	$205,050	Direct Add	4/2/2013
2	45-0184	Memorial Hermann Hospital System (Houston, Harris, TX)	Novitas Solutions, Inc.	6/30/2008	8/3/2012	1/30/2013	180	14	$307,303	Direct Add	1/30/2013
3	45-0610	Memorial Hermann Memorial City Medical Center (Houston, Harris, TX)	Novitas Solutions, Inc.	6/30/2008	8/3/2012	1/30/2013	180	9	$41,270	Direct Add	1/30/2013
4	45-0684	Memorial Hermann Northeast (Humble, Harris, TX)	Novitas Solutions, Inc.	12/31/2008	4/29/2013	10/23/2013	177	4, 8, 23	$32,914	Direct Add	10/23/2013

Schedule of Providers in Group

Group Name: Memorial Hermann 2008 Bad Debt Not Returned from Collection Agency Group Page No. 2 of 2

Representative Akin Gump Strauss Hauer & Feld LLP Date Prepared 6/26/2019

Case No: 13-0583GC Issue: The Disallowance of Bad Debt not returned from an outside collection agency.

Lead Intermediary: Novitas Solutions, Inc.

	Provider Number	Provider Name	Intermediary	FYE	A Date of Final Determination	B Date Hearing Rqst Filed	C No. of Days	D Audit Adj No.	E Amount of Reimbursement	F Original Case No.	G Date Add/ Transfer Filed
5	45-0847	Memorial Hermann Katy Hospital (Katy, Harris, TX)	Novitas Solutions, Inc.	12/31/2008	5/23/2013	11/15/2013	176	4	$179	Direct Add	11/15/2013
6	45-0848	Memorial Hermann Sugar Land Hospital (Sugarland, Fort Bend, TX)	Novitas Solutions, Inc.	9/30/2008	6/7/2013	11/26/2013	172	13	$5,966	Direct Add	11/26/2013
7	45-3025	Memorial Hermann TIRR (Houston, Harris, TX)	Novitas Solutions, Inc.	12/31/2008	6/3/2013	11/26/2013	176	15	$4,141	Direct Add	11/26/2013

Total Amount of Reimbursement: $596,823

Schedule of Providers in Group

Group Name: Memorial Hermann 2002, 2004, 2007 Bad Debt Not Returned From Collection Agency Group

Page No. 1 of 2

Representative Akin Gump Strauss Hauer & Feld LLP

Date Prepared 6/26/2019

Case No: 13-1710GC

Issue: The Disallowance of Bad Debt not returned from an outside collection agency.

Lead Intermediary: Novitas Solutions, Inc.

	Provider Number	Provider Name	Intermediary	FYE	A Date of Final Determination	B Date Hearing Rqst Filed	C No. of Days	D Audit Adj No.	E Amount of Reimbursement	F Original Case No.	G Date Add/ Transfer Filed
1	45-0068	Memorial Hermann - Texas Medical Center (Houston, Harris, TX)	Novitas Solutions, Inc.	6/30/2007	6/5/2009	12/2/2009	180	15	$207,498	10-0197	2/26/2016
2	45-0184	Memorial Hermann Hospital System (Houston, Harris, TX)	Novitas Solutions, Inc.	6/30/2002	10/21/2004	4/7/2005	168	9, 70	$318,147	05-1404	7/23/2018
3	45-0184	Memorial Hermann Hospital System (Houston, Harris, TX)	Novitas Solutions, Inc.	6/30/2004	9/6/2006	3/2/2007	177	60, 66	$69,294	07-1007	7/23/2018
4	45-0184	Memorial Hermann Hospital System (Houston, Harris, TX)	Novitas Solutions, Inc.	6/30/2007	9/11/2009	3/10/2010	180	11	$259,870	10-0749	7/23/2018
5	45-0847	Memorial Hermann Katy Hospital (Katy, Harris, TX)	Novitas Solutions, Inc.	12/31/2007	10/17/2012	4/12/2013	177	16, 17	$10,466	Direct Add	4/12/2013

Schedule of Providers in Group

Group Name: Memorial Hermann 2002, 2004, 2007 Bad Debt Not Returned From Collection Agency Group

Page No. 2 of 2

Representative Akin Gump Strauss Hauer & Feld LLP

Date Prepared 6/26/2019

Case No: 13-1710GC

Issue: The Disallowance of Bad Debt not returned from an outside collection agency.

Lead Intermediary: Novitas Solutions, Inc.

	Provider Number	Provider Name	Intermediary	FYE	A Date of Final Determination	B Date Hearing Rqst Filed	C No. of Days	D Audit Adj No.	E Amount of Reimbursement	F Original Case No.	G Date Add/ Transfer Filed
6	45-0848	Memorial Hermann Sugar Land Hospital (Sugarland, Fort Bend, TX)	Novitas Solutions, Inc.	9/30/2007	10/17/2012	4/12/2013	177	17	$8,231	Direct Add	4/12/2013
7	45-2072	Memorial Hermann Continuing Care Hospital (Houston, Harris, TX)	Novitas Solutions, Inc.	2/28/2007	8/28/2009	2/5/2010	161	11, 12	$29,696	10-0547	11/2/2015

Total Amount of Reimbursement: $903,202

Schedule of Providers in Group

Group Name: Memorial Hermann 2009 Bad Debt Not Returned From Collection Agency Group Page No. 1 of 2

Representative Akin Gump Strauss Hauer & Feld LLP Date Prepared 8/22/2019

Case No: 14-0584GC Issue: The Disallowance of Bad Debt not returned from an outside collection agency.

Lead Intermediary: Novitas Solutions, Inc.

	Provider Number	Provider Name	Intermediary	FYE	A Date of Final Determination	B Date Hearing Rqst Filed	C No. of Days	D Audit Adj No.	E Amount of Reimbursement	F Original Case No.	G Date Add/ Transfer Filed
1	45-0068	Memorial Hermann - Texas Medical Center (Houston, Harris, TX)	Novitas Solutions, Inc.	6/30/2009	6/7/2013	11/14/2013	160	4, 6, 7, 63	$216,992	Direct Add	11/14/2013
2	45-0184	Memorial Hermann Hospital System (Houston, Harris, TX)	Novitas Solutions, Inc.	6/30/2009	5/10/2013	11/6/2013	180	4, 12	$452,993	Direct Add	11/6/2013
3	45-0610	Memorial Hermann Memorial City Medical Center (Houston, Harris, TX)	Novitas Solutions, Inc.	6/30/2009	5/29/2013	11/14/2013	169	12, 16	$78,299	Direct Add	11/14/2013
4	45-0684	Memorial Hermann Northeast (Humble, Harris, TX)	Novitas Solutions, Inc.	12/31/2009	9/5/2013	2/25/2014	173	20	$198,635	Direct Add	2/25/2014

Schedule of Providers in Group

Group Name: Memorial Hermann 2009 Bad Debt Not Returned From Collection Agency Group Page No. 2 of 2

Representative Akin Gump Strauss Hauer & Feld LLP Date Prepared 8/22/2019

Case No: 14-0584GC Issue: The Disallowance of Bad Debt not returned from an outside collection agency.

Lead Intermediary: Novitas Solutions, Inc.

	Provider Number	Provider Name	Intermediary	FYE	A Date of Final Determination	B Date Hearing Rqst Filed	C No. of Days	D Audit Adj No.	E Amount of Reimbursement	F Original Case No.	G Date Add/ Transfer Filed
5	45-0847	Memorial Hermann Katy Hospital (Katy, Harris, TX)	Novitas Solutions, Inc.	12/31/2009	9/4/2013	2/25/2014	174	20, 25	$88,422	Direct Add	2/25/2014
6	45-0848	Memorial Hermann Sugar Land Hospital (Sugarland, Fort Bend, TX)	Novitas Solutions, Inc.	9/30/2009	7/30/2013	1/24/2014	178	16	$124,013	Direct Add	1/24/2014
7	45-3025	Memorial Hermann TIRR (Houston, Harris, TX)	Novitas Solutions, Inc.	12/31/2009	9/6/2013	2/25/2014	172	10, 16	$47,857	Direct Add	2/25/2014

Total Amount of Reimbursement: $1,207,211

Schedule of Providers in Group

Group Name: Memorial Hermann 2011 Bad Debt Not Returned From Collection Agency Group Page No. 1 of 2

Representative Akin Gump Strauss Hauer & Feld LLP Date Prepared 8/26/2019

Case No: 14-3382GC Issue: The Disallowance of Bad Debt not returned from an outside collection agency.

Lead Intermediary: Novitas Solutions, Inc.

	Provider Number	Provider Name	Intermediary	FYE	A Date of Final Determination	B Date Hearing Rqst Filed	C No. of Days	D Audit Adj No.	E Amount of Reimbursement	F Original Case No.	G Date Add/ Transfer Filed
1	45-0068	Memorial Hermann - Texas Medical Center (Houston, Harris, TX)	Novitas Solutions, Inc.	6/30/2011	2/27/2017	8/24/2017	178	56, 59, 60, 62, 65, 78, 81, 82, 83	$334,298	Direct Add	8/24/2017
2	45-0184	Memorial Hermann Hospital System (Houston, Harris, TX)	Novitas Solutions, Inc.	6/30/2011	11/5/2014	5/1/2015	177	30, 33, 35, 37	$344,224	Direct Add	5/1/2015
3	45-0610	Memorial Hermann Memorial City Medical Center (Houston, Harris, TX)	Novitas Solutions, Inc.	6/30/2011	10/2/2014	3/25/2015	174	17, 20	$82,263	Direct Add	3/25/2015
4	45-0684	Memorial Hermann Northeast (Humble, Harris, TX)	Novitas Solutions, Inc.	12/31/2011	5/8/2014	10/31/2014	176	12, 16	$90,394	Direct Add	10/31/2014

Schedule of Providers in Group

Group Name: Memorial Hermann 2011 Bad Debt Not Returned From Collection Agency Group Page No. 2 of 2

Representative Akin Gump Strauss Hauer & Feld LLP Date Prepared 8/26/2019

Case No: 14-3382GC Issue: The Disallowance of Bad Debt not returned from an outside collection agency.

Lead Intermediary: Novitas Solutions, Inc.

	Provider Number	Provider Name	Intermediary	FYE	A Date of Final Determination	B Date Hearing Rqst Filed	C No. of Days	D Audit Adj No.	E Amount of Reimbursement	F Original Case No.	G Date Add/ Transfer Filed
5	45-0847	Memorial Hermann Katy Hospital (Katy, Harris, TX)	Novitas Solutions, Inc.	12/31/2011	5/20/2015	11/13/2015	177	17, 21	$73,438	Direct Add	11/13/2015
6	45-0848	Memorial Hermann Sugar Land Hospital (Sugarland, Fort Bend, TX)	Novitas Solutions, Inc.	9/30/2011	2/7/2014	8/4/2014	178	12, 17	$20,644	Direct Add	8/4/2014
7	45-3025	Memorial Hermann TIRR (Houston, Harris, TX)	Novitas Solutions, Inc.	12/31/2011	2/14/2014	8/4/2014	171	10, 15	$49	Direct Add	8/4/2014
8	67-3038	Memorial Hermann Rehab Hospital Katy (Katy, Harris, TX)	Novitas Solutions, Inc.	9/30/2011	11/1/2013	4/30/2014	180	14	$6,056	Direct Add	4/30/2014

Total Amount of Reimbursement: $951,366

Schedule of Providers in Group

Group Name: Memorial Hermann 2010 Bad Debt Not Returned From Collection Agency Group Page No. 1 of 2

Representative Akin Gump Strauss Hauer & Feld LLP Date Prepared 8/22/2019

Case No: 14-3963GC Issue: The Disallowance of Bad Debt not returned from an outside collection agency.

Lead Intermediary: Novitas Solutions, Inc.

	Provider Number	Provider Name	Intermediary	FYE	A Date of Final Determination	B Date Hearing Rqst Filed	C No. of Days	D Audit Adj No.	E Amount of Reimbursement	F Original Case No.	G Date Add/ Transfer Filed
1	45-0068	Memorial Hermann - Texas Medical Center (Houston, Harris, TX)	Novitas Solutions, Inc.	6/30/2010	3/5/2015	8/28/2015	176	21, 26, 31, 43, 47	$120,273	Direct Add	8/28/2015
2	45-0184	Memorial Hermann Hospital System (Houston, Harris, TX)	Novitas Solutions, Inc.	6/30/2010	4/3/2014	9/30/2014	180	28, 30	$450,867	Direct Add	9/30/2014
3	45-0610	Memorial Hermann Memorial City Medical Center (Houston, Harris, TX)	Novitas Solutions, Inc.	6/30/2010	2/17/2014	8/18/2014	182	13, 14, 16	$57,593	Direct Add	8/18/2014
4	45-0684	Memorial Hermann Northeast (Humble, Harris, TX)	Novitas Solutions, Inc.	12/31/2010	2/24/2014	8/22/2014	179	15, 19	$466,047	Direct Add	8/22/2014

Schedule of Providers in Group

Group Name: Memorial Hermann 2010 Bad Debt Not Returned From Collection Agency Group Page No. 2 of 2

Representative Akin Gump Strauss Hauer & Feld LLP Date Prepared 8/22/2019

Case No: 14-3963GC Issue: The Disallowance of Bad Debt not returned from an outside collection agency.

Lead Intermediary: Novitas Solutions, Inc.

	Provider Number	Provider Name	Intermediary	FYE	A Date of Final Determination	B Date Hearing Rqst Filed	C No. of Days	D Audit Adj No.	E Amount of Reimbursement	F Original Case No.	G Date Add/ Transfer Filed
5	45-0847	Memorial Hermann Katy Hospital (Katy, Harris, TX)	Novitas Solutions, Inc.	12/31/2010	5/21/2015	11/12/2015	175	20, 22	$51,742	Direct Add	11/12/2015
6	45-0848	Memorial Hermann Sugar Land Hospital (Sugarland, Fort Bend, TX)	Novitas Solutions, Inc.	9/30/2010	10/23/2014	4/14/2015	173	24, 27	$14,166	Direct Add	4/14/2015
7	45-3025	Memorial Hermann TIRR (Houston, Harris, TX)	Novitas Solutions, Inc.	12/31/2010	7/1/2014	12/18/2014	170	12, 19	$13,817	Direct Add	12/18/2014

Total Amount of Reimbursement: $1,174,505

Schedule of Providers in Group

Group Name: Memorial Hermann 2012 Bad Debt Not Returned From Collection Agency Group Page No. 1 of 2

Representative Akin Gump Strauss Hauer & Feld LLP Date Prepared 8/26/2019

Case No: 15-1816GC Issue: The Disallowance of Bad Debt not returned from an outside collection agency.

Lead Intermediary: Novitas Solutions, Inc.

	Provider Number	Provider Name	Intermediary	FYE	A Date of Final Determination	B Date Hearing Rqst Filed	C No. of Days	D Audit Adj No.	E Amount of Reimbursement	F Original Case No.	G Date Add/ Transfer Filed
1	45-0068	Memorial Hermann - Texas Medical Center (Houston, Harris, TX)	Novitas Solutions, Inc.	6/30/2012	8/25/2017	2/21/2018	180	24, 28, 42	$143,672	Direct Add	2/21/2018
2	45-0184	Memorial Hermann Hospital System (Houston, Harris, TX)	Novitas Solutions, Inc.	6/30/2012	2/13/2015	7/29/2015	166	42	$271,291	Direct Add	7/29/2015
3	45-0610	Memorial Hermann Memorial City Medical Center (Houston, Harris, TX)	Novitas Solutions, Inc.	6/30/2012	10/17/2014	4/8/2015	173	4, 7	$60,990	Direct Add	4/8/2015
4	45-0684	Memorial Hermann Northeast (Humble, Harris, TX)	Novitas Solutions, Inc.	12/31/2012	4/7/2015	10/5/2015	181	11, 14, 15	$94,253	Direct Add	10/5/2015

Schedule of Providers in Group

Group Name: Memorial Hermann 2012 Bad Debt Not Returned From Collection Agency Group

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Representative Akin Gump Strauss Hauer & Feld LLP

Date Prepared 8/26/2019

Case No: 15-1816GC

Issue: The Disallowance of Bad Debt not returned from an outside collection agency.

Lead Intermediary: Novitas Solutions, Inc.

	Provider Number	Provider Name	Intermediary	FYE	A Date of Final Determination	B Date Hearing Rqst Filed	C No. of Days	D Audit Adj No.	E Amount of Reimbursement	F Original Case No.	G Date Add/ Transfer Filed
5	45-0847	Memorial Hermann Katy Hospital (Katy, Harris, TX)	Novitas Solutions, Inc.	12/31/2012	12/30/2014	6/25/2015	177	15, 16, 18, 19	$60,295	Direct Add	6/25/2015
6	45-0848	Memorial Hermann Sugar Land Hospital (Sugarland, Fort Bend, TX)	Novitas Solutions, Inc.	9/30/2012	9/18/2014	3/13/2015	176	10, 11, 15	$22,391	Direct Add	3/13/2015
7	45-3025	Memorial Hermann TIRR (Houston, Harris, TX)	Novitas Solutions, Inc.	12/31/2012	2/25/2015	8/21/2015	177	18	$15,470	Direct Add	8/21/2015
8	67-3038	Memorial Hermann Rehab Hospital Katy (Katy, Harris, TX)	Novitas Solutions, Inc.	9/30/2012	9/19/2014	3/13/2015	175	14	$4,468	Direct Add	3/13/2015

Total Amount of Reimbursement: $672,830