PROVIDER REIMBURSEMENT REVIEW BOARD
HEARING DECISION

ON-THE-RECORD
99-D49

PROVIDER -Baystate Medical Center
Springfield, MA

Provider No. 22-0077

vs.

INTERMEDIARY -
Mutual of Omaha Insurance Company

DATE OF HEARING-
January 6, 1999

Cost Reporting Period Ended -
September 30, 1990

CASE NO. 93-1505

INDEX

ISSUE:

Was the Intermediary's disallowance of Medicare bad debts proper?

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Baystate Medical Center ("Provider") is a non-profit acute care teaching hospital located in Springfield, Massachusetts. It filed its Medicare cost report for the fiscal year ended September 30, 1990 ("FY 90") claiming reimbursement for Medicare bad debts. It used its credit and collection policy dated September 1984 to collect those bad debts. The Intermediary denied the Provider's claim for reimbursement of its Medicare bad debts because the Provider failed to use a collection agency to attempt to collect them. The Provider did use a collection agency to collect non-Medicare bad debts. The Provider claimed $451,587 of Medicare bad debts in FY 90. The Intermediary disallowed $342,855. The Medicare reimbursement in dispute is approximately $314,000. The Provider appealed these adjustments to the Provider Reimbursement Review Board ("Board"). The Provider's filing has met all of the jurisdictional requirements of 42 C.F.R. §§ 405.1835-.1841. The Provider was represented by Mark A. Borreliz, Esquire, of Choate, Hall & Stewart. The Intermediary was represented by Mr. Tom Bruce of Mutual of Omaha Insurance Company.

During FY 90, the billing and collection of payments from patients and third-party payors at the Provider were handled by its patient accounting department. In the case of inpatients, a bill was issued within seven to ten days following discharge. Over an ensuing period of at least 120 days, additional billing notices were mailed at 30-day intervals. The successive notices communicated progressively sterner messages demanding payment, with the final notice notifying the patient that nonpayment could result in the account being referred to an outside collection agency. In the case of outpatients, essentially the same procedures were followed, except that the initial bills were produced on a batch basis, with the result that they could follow the date of service by as long as 30 days. These automated processes were supplemented by individualized collection efforts, including clerical activity, collection activity, telephone calls, or correspondence back and forth with the patients. If those efforts were unsuccessful, the Provider referred its non-Medicare accounts of greater than $20, but not its Medicare accounts, to outside collection agencies. The non-referral policy for Medicare accounts came into existence in 1981 and 1982. At that time, the Provider found that its success in collecting Medicare accounts did not warrant the cost of referring the remainder to collection agencies. That policy was adhered to throughout the 1980s.

The Provider's credit and collection policies were routinely reviewed by the Intermediary throughout this time. Under their guidelines, which have been in existence since 1977, fiscal intermediaries were required to obtain the current credit and collection policy from a provider to ascertain any changes in the policy from year to year. The Intermediary also had to review the provider's bad debt logs, accounts receivables, and other files.

The Provider claimed Medicare bad debt costs on its Medicare cost reports for FY 82 through FY 86. All of these cost reports underwent audit activity (including field reviews and exit conferences) before August 1, 1987. Although the Intermediary made adjustments in different years partially disallowing the claimed bad debts, it never objected to the Provider's non-referral policy for Medicare accounts. The non-referral policy for Medicare accounts was expressly set out in the Provider's credit and collection policies during this time. Provider Exhibit 8 sets out the policy as it stood at the end of FY 84. Part IV.H.4 of the policy states:

> After final notice has been [sent] and 30 days have elapsed without response, the Collection Clerk will initiate collection procedures for write off to a collection agency.
>
> (Exception: Medicare coinsurance and deductible amounts. In these instances, the collection procedures will extend through 120 days including all previously described actions except referral to an outside collection agency. If follow-up reveals existence [sic] of Medicaid at any time prior to 120 days, the balance will be written off as a Medicare Bad Debt (Code 62) in accordance with Medicare regulations covering indigent patients.)

Id.

Similarly, Exhibit 7, an October 1985 description of the Provider's code 62, i.e., Medicare bad debts collection policy, states in paragraph 1:

> For all Medicare accounts where balances are attributable to deductible and coinsurance, normal collection procedures will be followed except that such accounts will not be referred to an outside collection agency.

Id.

During the audit of the Provider's FY 87 cost report, which took place in 1989, the Intermediary for the first time challenged the non-referral policy. For FY 90 the Intermediary disallowed almost all of the Provider's Medicare bad debt costs based on the Provider's referral policy. The policy was unchanged in this regard as shown by the credit and collection policy that was then in effect.

PROVIDER'S CONTENTIONS:

The Provider contends that under HCFA regulations, a Medicare bad debt is allowable where the following criteria are satisfied:

(1) The debt is related to covered services and derived from deductible and coinsurance amounts.

(2) The provider can establish that it made reasonable collection efforts.

(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.

42 C.F.R. § 413.80(e).

The Intermediary's dispute with the Provider's bad debt claims appears to relate to the second criterion. The Intermediary evidently believes that the Provider had an inconsistent bad debt collection policy and applied less than a reasonable collection effort in the case of Medicare patients. Program rules have never required, however, that Medicare and non-Medicare debt collection practices be identical. To the contrary, a provider's effort to collect Medicare coinsurance and deductible payments must merely be "similar" to the provider's efforts "to collect comparable amounts from non-Medicare patients." Provider Reimbursement Manual, HCFA Pub. 15-1 ("HCFA Pub.15-1") § 310. As has been previously recognized, a provider's effort to collect Medicare bad debts may qualify as reasonable though it stops short of outside collection agency activity, even if non-Medicare accounts are referred out. See e.g., St. Francis Hospital and Medical Center v. Blue Cross and Blue Shield Association, PRRB Dec. No. 86-D21, Nov. 12, 1985, Medicare and Medicaid Guide ("CCH") ¶ 35,302, aff'd, HCFA Admin. Dec., January 8, 1986, CCH ¶ 35,356; Reed City Hospital v. Blue Cross and Blue Shield Association, PRRB Dec. No. 86-D67, February 20, 1986, CCH ¶ 35,474.

The Provider argues that the Intermediary's present rejection of the Provider's bad debt policy, after having repeatedly accepted it for prior years, is statutorily barred. In § 6023 of the Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239 (Dec. 19, 1989), Congress expressly prohibited such conduct. Amending the moratorium it had imposed two years earlier on regulatory changes to the bad debt collection rules, Congress provided:

> 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 indigence 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.

Id.

The above prohibition is directly applicable to this case. The Intermediary, applying program rules in effect on August 1, 1987 with respect to collection agency referrals, accepted the Provider's bad debt collection policy before that date. It cannot now apply the same rules to declare the policy unacceptable. Harris County Hospital District v. Shalala, F. 863 Supp. 404 (S.D. Tex. 1994) stated that Section 6023 of OBRA 1989 prohibited a fiscal intermediary from disallowing a provider's indigence determination policy for years preceding August 1, 1987. University Health Services, Inc. v. Shalala, CV 193-180 (S.D. Ga., 1995), ruled that the Secretary could not use its 1990 interpretation of bad debt rules to deny recognition of Medicare bad debts because of a non-referral policy for many prior years under concededly ambiguous provisions of the HCFA manual. See also, Shalala v. St. Paul Ramsey Medical Center, 50 F. 3d 522 (8th Cir. 1995).

The Provider argues that applying the plain provisions of OBRA 1989 to the present case, the Intermediary's disallowance of the Provider's Medicare bad debts in FY 90 was improper and should be reversed. The Provider's claim for adjustments to its FY 90 cost report mirror precisely claims already argued by the Provider before the Board with respect to this same issue in Board Case Nos. 92-1842 and 92-1843. Accordingly, the Provider adopts and incorporates herein the full administrative record from each of those appeals including, but not limited to, its final position paper, the transcript of the live hearing held in these cases on March 6, 1996, and its post-hearing brief and exhibits.

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends that OBRA 89 does not apply to this case. The policies and procedures that the Intermediary has implemented on this Provider is the strict application of the Medicare Provider Reimbursement Manual ("Manual"), particularly the section on bad debts. The Intermediary must adhere to the Medicare law and regulations as well as Manual instructions. The Provider attempts to confuse the Board by asserting that the Intermediary did not make the adjustment in dispute in this matter in the past years. The Provider's assertions do not bear fruit; they have no substance. The record is very clear that the Intermediary during its FY 87 cost report review became aware of the Provider's collection policy. That policy violates HCFA Pub. 15-1 § 310. The Provider does not contest this. Provider Exhibit P-8 is clear evidence of the policy effective October 23, 1985, and that conflicts with the above Manual section. Moreover, the Provider later changed its credit and collection policy to be in conformance with the Provider Reimbursement Manual after the fiscal year in dispute.

The Intermediary notes that the Provider attempted to justify its position by citing an inappropriate portion of its credit and collection policy, Section H entitled Balances Due After Insurance. The Intermediary notes the general procedures for collection, as well as the Medicare procedures for collection, should also be considered.

After looking at the entire record, the Intermediary believes that the Provider has totally and absolutely failed to present a plausible argument. The Intermediary believes that the record clearly reflects that the Provider has taken a position which is totally untenable. The Provider could have come forward to the Board with evidence, if such existed, that would have supported its position and given the Board cause to deliberate over the adequacy of the Provider's documentation. The Provider has not come forward with such documentation, presumably because none exists.

CITATION OF LAW, REGULATIONS AND PROGRAM INSTRUCTIONS:

1. Law - Title XVIII of the Social Security Act:

§ 1861(v)(1)(A)	-	Reasonable Cost

2. Law - Omnibus Budget Reconciliation Act 1989:

§ 6023	-	Clarification of Continuation of August 1987 Hospital Bad Debt Recognition Policy

3. Regulations - 42 C.F.R.:

§§ 405.1835 - .1841	-	Board Jurisdiction
§ 413.80 et seq.	-	Bad Debts, Charity, and Courtesy Allowances

4. Program Instructions - Provider Reimbursement Manual, Part I (HCFA Pub. 15-1):

§ 310	-	Reasonable Collection Effort

5. Case Law:

Harris County Hospital District v. Shalala, 863 F. Supp. 404 (S.D. Tex. 1994), aff'd. 64 F. 3d 220 (5th Cir. 1995).

Reed City Hospital v. Blue Cross and Blue Shield Association, PRRB Dec No. 86-D67, February 20, 1986, CCH ¶35,474.

St. Francis Hospital and Medical Center v. Blue Cross and Blue Shield Association/ Kansas Hospital Service Association, Inc., PRRB Dec. No. 86-D21, November 12, 1985, Medicare & Medicaid Guide (CCH) ¶ 35,302, aff'd, HCFA Administrator, January 8, 1986, Medicare & Medicaid Guide (CCH) ¶ 35,356.

University Health Services, Inc. v. Shalala, 120 F. 3d 1145 (11 Cir. 1997) rev'd. CV 193-180 (S.D. Ga.,1995); rev'd HCFA Administrator , September 8, 1993, Medicare & Medicaid Guide (CCH) ¶ 41,763, rev'd, PRRB Dec. No. 93-D55, July 9, 1993, Medicare & Medicaid Guide (CCH) ¶ 41,586.

Hennepin County Medical Center v. Shalala, 81 F. 3d 743 (8th Cir. 1996)

Shalala v. St. Paul Ramsey, 50 F. 3d 522 (8th Cir. 1995).

FINDINGS OF FACT, CONCLUSION OF LAW AND DISCUSSION:

The majority of the Board, after considering the facts parties contentions, evidence submitted and court decisions finds and concludes that the Intermediary properly disallowed the Provider's claimed Medicare bad debts. The Provider did not consistently apply its bad debt policy to all patients. That did not meet the requirements of HCFA Pub. 15-1 § 310. The Board's decision is supported by the 8th and 11th U.S. Circuit Court Appeal, specifically Hennepin County Medical Center v. Shalala, 81 F. 3d 743 (8th Cir. 1996) and University Health Services Inc. v. Shalala, 120 F.3d 1145 (11Cir. 1997).

Those court decisions established:

- The appropriate administrative guidelines for bad debt reimbursement are found in HCFA Pub. 15-1 § 310.
- HCFA Pub. 15-1 §310 is a reasonable and consistent interpretation of the Medicare regulations regarding reimbursement of Medicare bad debts.
- The OBRA moratorium only applies where a provider was in compliance with rules existing on August 1, 1987 that were included in the Medicare regulations and program instructions.
- The disallowance of Medicare bad debts does not constitute a new substantive rule or a stiffer application of a pre-existing rule.
- The OBRA moratorium does not preclude the denial of the Provider's claim.

DECISION AND ORDER:

The Intermediary properly disallowed the Provider's claimed Medicare bad debts. The Intermediary's adjustments are affirmed.

BOARD MEMBERS PARTICIPATING:

Irvin W. Kues
James G. Sleep
Henry C. Wessman, Esq.
Martin W. Hoover, Jr., Esq. (Dissenting)
Charles R. Barker

Date of Decision: May 07, 1999

FOR THE BOARD:

Irvin W. Kues
Chairman

Dissenting Opinion of Martin W. Hoover. Jr.

I respectfully dissent:

The majority of the Board based its decision on the fact that the Provider did not consistently apply its bad debt policy to all patients even though this had been their policy for many years and unquestioned by the Intermediary. This finding and conclusion, according to the Board majority, did not meet the requirements of Provider Reimbursement Manual, Part I ("HCFA Pub. 15-1")
§ 310. I find there are two problems with the Board majority decision. First, from a merits viewpoint, this manual section requires that the Provider's effort to collect Medicare deductible and co-insurance amounts must be similar to the effort the provider puts forth to collect comparable amounts from non-Medicare patients. In my opinion, a requirement of consistent collection effort in not included in HCFA Pub. 15-1 § 310 language. The Health Care Financing Administration clarified HCFA Pub. 15-1 § 310 in 1990 to the effect that "similar" means " the same". This is an interpretation that was precluded by Section 6023 of the Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239 (1989) ("OBRA 89") Secondly, I agree with the Provider's contention that the Intermediary's current rejection of the Provider's established bad debt policy, after having accepted it for many prior years, is statutorily barred. In OBRA 89, Congress expressly prohibited such conduct. When amending the moratorium on regulatory changes to bad debt collection rules it had imposed two years earlier on regulatory changes to the bad debt collection rules, Congress provided that:

> 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 indigence determination procedures, recordkeeping, 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.

Id. at §6023.

The moratorium was originally intended to be a simple straight forward safe harbor. However, it has become an ultra complicated arena. For example, with regard to the moratorium, a question arises concerning the issue of "acceptance" of a provider's bad debt policies by the intermediary. In my opinion, the Provider's collection policies in this case have been accepted by the Intermediary prior to August 1, 1987 because the Intermediary

reimbursed the Medicare bad debts, after audit and without adjustment, for several prior years. Moreover; there was no evidence that new information not previously available was just discovered showing any non-compliance. The HCFA Administrator opined that acceptance must be affirmatively expressed and based on full, accurate information. This position is flawed because seldom does an intermediary "affirmatively" express any statement on any particular issue. To introduce the concept of analyzing what the intermediary did or said at the time of the audit will produce a hazardous quagmire. The typical expression of an acceptance is the issuance of a Notice of Program Reimbursement ("NPR"). The issuance of the NPR in prior years is the best objective method of indicating that full and accurate information was available and used in making the determination. Harris County Hospital District v. Shalala, 863 F. Supp. 404 (S. D. Tex. 1994)("Harris") held that an NPR evidences acceptance. Explicit affirmation of an acceptance contemplates that the acceptance must be: (1) expressly conferred upon the provider which is rarely done, and (2) is beyond the scope of the OBRA 89 provisions. The language of OBRA 89 does not support the Intermediary's position.

Although the United States Circuit Courts of appeal ("Circuits") are divided on this issue, the majority of the Board relied on Hennepin County Medical Center v. Shalala, 120 F.2d. 743 (8th Cir. 1996) ("Hennepin") and University Health Services Inc. V. Shalala, 120 F. 3d. 1145 (11 Cir 1997) ("University") as support for their decision which imposes the above referenced standard beyond the scope of OBRA 89. There is no precedent case in the first circuit where this Massachusetts provider is located. Therefore, the first Circuit may chart its own course or follow the 5th circuit where Harris held that an NPR constitutes acceptance.

Congress enacted the moratorium to preserve the bad debt rules, regulations and policies as they existed at August 1, 1987. The moratorium was to prevent the Health Care Financing Administration from retroactively applying new policy or new interpretations to existing bad debt policies and regulations. It is my opinion the University decision imposes a standard beyond the scope of OBRA 89 and renders such provisions meaningless and disregards Congress intent to preclude the retroactive application of previously accepted policies.

Martin W. Hoover, Jr., Esquire
Board Member