PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2014-D13

PROVIDERS –
CHS 2004-2006 Medicare Bad Debt- Passive Collection CIRP Groups

Provider Nos.: See Appendix I

vs.

INTERMEDIARY –
See Appendix I

DATE OF HEARING –
December 8, 2011

Cost Reporting Periods Ended -
See Appendix I

CASE NOs.: 08-0611GC; 08-0619GC and 08-0621GC

INDEX

ISSUE:

Whether the Intermediary's adjustments to remove the Medicare bad debts claimed by the Provider while the debts were still at the collection agency were proper.

MEDICARE STATUTORY AND REGULATORY BACKGROUND:

This is a dispute over the amount of Medicare reimbursement due a provider of medical services.

The Medicare program was established under Title XVIII of the Social Security Act, as amended ("Act"), to provide health insurance to eligible individuals. Title XVIII of the Act was codified at 42 U.S.C. Chapter 7, Subchapter XVIII. The Centers for Medicare & Medicaid Services ("CMS"), formerly the Health Care Financing Administration ("HCFA"),[1] is the operating component of the Department of Health and Human Services ("DHHS") charged with administering the Medicare program. CMS' payment and audit functions under the Medicare program are contracted to organizations known as fiscal intermediaries ("FIs") and Medicare administrative contractors ("MACs"). FIs and MACs[2] determine payment amounts due the providers under Medicare law, regulation and interpretative guidelines published by CMS.[3]

Providers are required to submit cost reports annually, with reporting periods based on the provider's accounting period. The cost reports show the costs incurred during the reporting period and the portion of those costs allocated to the Medicare program.[4] Each intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider and issues the provider a Notice of Program Reimbursement ("NPR").[5] A provider dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board ("Board") within 180 days of the receipt of the NPR.[6]

The regulations governing bad debt are located at 42 C.F.R. § 413.89.[7] Subsection (a) states the general rule that bad debts are deductions from revenue and are not to be included in allowable costs. However, in order to ensure that costs attributable to covered services furnished to Medicare beneficiaries are not borne by individuals who are not covered by the Medicare program, subsection (d) specifies that bad debts attributable to Medicare deductibles and coinsurance are reimbursable. Bad debts must meet the following criteria specified in subsection (e) to be considered 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.

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[1] In 2001, the agency name was changed from CMS to HCFA. For simplicity, this decision generally will use CMS to refer to the agency.
[2] FIs and MACs are hereinafter referred to as intermediaries.
[3] *See* 42 U.S.C. §§ 1395h and 1395kk-1; 42 C.F.R. §§ 413.20, 413.24.
[4] *See* 42 C.F.R. § 413.20.
[5] *See* 42 C.F.R. § 405.1803.
[6] *See* 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835-1837.
[7] Redesignated from 42 C.F.R. § 413.80 at 69 Fed. Reg. 49254 (Aug. 11, 2004).

(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.

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" or "Manual"). PRM 15-1 § 302.1 defines the term "bad debts" as follows:

> 302.1 Bad Debts.—Bad debts are amounts considered to be uncollectible from accounts and notes which are created or acquired in providing services. "Accounts receivable" and "notes receivable" are designations for claims arising from rendering services and are collectible in money in the relatively near future.

Similarly, PRM 15-1 § 302.2 defines the term "allowable bad debts" as follows:

> 302.2 Allowable Bad Debts.—Allowable bad debts are bad debts of the provider resulting from uncollectible deductibles and coinsurance amounts and meeting the criteria set forth in Section 308. Allowable bad debts must relate to specific deductibles and coinsurance amounts.

PRM 15-1 § 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 addresses the concept of "reasonable collection effort" as follows:

> 310. REASONABLE COLLECTION EFFORT
>
> To be considered a reasonable collection effort, a provider's effort to collect Medicare deductible and coinsurance amounts must be similar to the effort the provider puts forth to collect comparable amounts from non-Medicare patients. It must involve the issuance of a bill on or shortly after discharge or death of the beneficiary to the party responsible for the patient's personal financial obligations. It also includes other actions such as subsequent billings, collection letters and telephone calls or personal contacts with this party which constitute a genuine, rather than a token, collection effort. The provider's collection effort may include using or threatening to use court action to obtain payment. (See § 312 for indigent or medically indigent patients.)
>
> A. Collection Agencies. —A provider's collection effort may include the use of a collection agency in addition to or in lieu of subsequent billings, follow-up letters, telephone and personal contacts. Where a collection agency is used, Medicare expects the provider to refer all uncollected patient charges of like amount to the agency without regard to class of patient. The "like amount"

> requirement may include uncollected charges above a specified minimum amount. Therefore, if a provider refers to a collection agency its uncollected non-Medicare patient charges which in amount are comparable to the individual Medicare deductible and coinsurance amounts due the provider from its Medicare patient, Medicare requires the provider to also refer its uncollected Medicare deductible and coinsurance amounts to the collection agency. Where a collection agency is used, the agency's practices may include using or threatening to use court action to obtain payment.
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> 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.

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."

In § 4008(c) of the Omnibus Budget Reconciliation Act of 1987,[8] Congress enacted a noncodified statutory provision that became known as the "Bad Debt Moratorium." In 1988, in § 8402 of the Technical and Miscellaneous Revenue Act of 1988, Congress retroactively amended the Bad Debt Moratorium.[9] In 1989, in § 6023 of the Omnibus Budget Reconciliation Act of 1989, Congress again retroactively amended the Bad Debt Moratorium.[10] As a result of these subsequent changes, the Bad Debt Moratorium, as amended, reads:

> CONTINUATION OF BAD DEBT RECOGNITION FOR HOSPITAL SERVICES.— In making payments to hospitals under title XVIII of the Social Security Act, 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

[8] Pub. L. No. 100-203, 101 Stat. 1330, 1330-55 (1987).
[9] Pub. L. No. 100-647, 102 Stat. 3342, 3798 (1988).
[10] Pub. L. No. 101-239, 103 Stat. 2106, 2167 (1989).

> 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.[11]

The dispute in this case involves the Intermediary's denial of bad debt claims, specifically related to the presumption of noncollectibility for patient accounts that were pending at an outside collection agency.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

The Providers involved in these group appeals are owned by Community Health Systems, Inc. ("CHS"), Brentwood, Tennessee. During the fiscal years at issue some of the Providers were owned by Triad Hospitals, Inc. ("Triad"). CHS acquired the former Triad hospitals in 2007 and assumed the appeal rights for such hospitals. As a result, the former Triad hospitals were transferred into the CHS common issue related party ("CIRP") group. There are three years of CHS group appeals included in this case and Appendix I provides the Schedule of Providers for this appeal by calendar year ("CY") – CY 2004 involving six hospitals; CY 2005 involving 54 hospitals;[12] and CY 2006 involving 58 hospitals.[13]

For the cost reporting periods at issue, the relevant intermediaries assigned to the Providers (collectively referred to as the "Intermediary")[14] removed Medicare bad debts claimed because the Providers' debts were still at a collection agency. The Providers timely filed the group appeals with the Board and met the jurisdictional requirements of 42 C.F.R. §§ 405.1835-1841. The Providers were represented by Gregory N. Etzel, Esq., of King & Spalding, LLP. The Intermediary was represented by Byron Lamprecht of Wisconsin Physicians Service.

STIPULATIONS:

For each of the cases, the parties stipulated to the following pertinent facts:

3. All of the Medicare bad debts at issue for the Providers in the Appeal are related to covered services and derived from deductible and coinsurance amounts.

4. It was CHS's policy to actively pursue all debts for at least 120 days prior to writing them off as bad debt. There is no dispute regarding CHS's compliance with its policy for the debts at issue. *Reference:* Provider Exhibit 3.

5. Certain hospitals in the Appeal were owned by Triad Hospitals, Inc. during the fiscal year at issue, and were later acquired by CHS. It was the policy of Triad Hospitals, Inc. ("Triad") to actively pursue all bad debts for at least 120 days prior to writing

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[11] Reprinted at 42 U.S.C. § 1395f note entitled "Continuation of Bad Debt Recognition for Hospital Services."
[12] The original Schedule of Providers contained 63 providers; however, nine of these providers have been dismissed for lack of jurisdiction. *See* Appendix I (final Schedule of Providers).
[13] The original Schedule of Providers contained 59 providers; however, one of these providers has been dismissed for lack of jurisdiction. *See id.*
[14] The intermediary assigned to each provider is listed in the final Schedule of Providers at Appendix I.

them off as bad debt. There is no dispute regarding Triad's compliance with this policy for the debts at issue. *Reference:* Provider Exhibit 6.

6. Following the conclusion of at least 120 days of in-house collection activities, both CHS and Triad forwarded uncollected accounts to outside collection agencies, and wrote the accounts off as "bad debts."

7. To the extent that any amounts were recovered by the outside collection agencies, CHS and Triad offset claimed bad debts by amounts recovered, in accordance with section 316 of the Provider Reimbursement Manual.

8. The in-house collection efforts utilized by CHS and Triad (e.g., phone calls, letters, and other collection methods applied) were genuine collection efforts under the applicable Medicare regulatory guidance.

9. The Triad and CHS in-house collection efforts were similar for all patients, regardless of payor.

10. In October of 2002, the Intermediary reviewed CHS's collection practices and issued a letter stating the following in response to CHS's questions regarding its collection practices: "The implication that a bad debt would be after meeting the above requirements [requirements of CMS-[15-]1 Section 308] because the bad debt is written off and referred to a related party (PASI) is unfounded. The regulations state the provider can presume the debt uncollectable and write it off after 120 days, assuming they have made consistent collection efforts (Medicare vs. Non-Medicare/Private Pay) as noted above in CMS 15-1, section 308. The issue centers on the continuing bad debt collection efforts after the Bad Debt has been written off per the general ledger. The regulations do not state that a provider cannot continue collection efforts (with a related party of unrelated party) after being written off." *Reference:* Provider Exhibit 4.

11. In June of 2006, the Intermediary informed CHS that "the Medicare program will not reimburse deductible and coinsurance amount while they are being worked by a collection agency." *Reference:* Provider Exhibit 5.

12. The Providers concede that the bad debts at issue in this Appeal were claimed while such debts were being worked by an outside collection agency after more than 120 days of in house collection efforts.

13. The sole basis for the Intermediary's disallowance of the bad debts at issue is that the provider wrote the accounts off as worthless even though there was no evidence that the delinquent accounts were recalled by the provider or that the collection efforts ceased by the collection agency.

14. The parties agree that the Provider's Exhibits 1-9 (2005-2006), Exhibits 1-8 (2004) (to the Provider's August 31, 2011 Final Position Papers) and the Intermediary's Exhibits I-1 through I-4 (to the Intermediary's September 28, 2011 Final Position

Paper and supplemental submission on October 4, 2011) are true and correct copies, and that there is no dispute as to the authenticity of these exhibits.[15]

PROVIDERS' CONTENTIONS:

The Providers contend that the Bad Debt Moratorium prohibits the Intermediary from disallowing bad debts on the basis that they were at a collection agency when claimed because the bad debt policy in place in 1987 did not prohibit providers from claiming bad debts while the debts were at a collection agency. The Providers believe that this issue is the same as that presented in the 2008 decision of the federal district court for DC in *Foothill Hospital – Morris L. Johnston Memorial v. Leavitt* ("*Foothill*")[16] and in three subsequent Board decisions issued in 2011 and 2012 for *Universal Health Servs., Inc. v. BlueCross BlueShield Ass'n* ("*UHS*");[17] *George Washington Univ. Hosp. v. Blue Cross Blue Shield Ass'n* ("*GWU Hospital*");[18] and *Lakeland Reg. Med. Ctr. v. Blue Cross Blue Shield Ass'n* ("*Lakeland*").[19] The Providers request that the Board rule consistent with these four decisions.

Additionally, and in the alternative, the Providers contend that the bad debts at issue satisfied the plain language of the bad debt guidance in place during the fiscal year at issue. The parties have stipulated that the first two requirements of 42 C.F.R. § 413.89(e) have been met.[20] The Providers believe that it can meet the third and fourth requirements of the regulation even though the debts claimed remained at a collection agency at the time of write-off. The Providers believe that the Board has consistently ruled that, assuming that a provider engaged in reasonable collection activities on debts for at least 120 days prior to writing off these debts as bad debts, it is impermissible for an intermediary to disallow these bad debts on the sole basis that the debts remain at a collection agency at the time of the write-off.[21]

The Providers believe that the third prong of the bad debt regulation requiring a debt be "actually uncollectible when claimed as worthless" was also met.[22] The Providers relied on the PRM 15-1 manual section that further clarifies this regulatory provision – the presumption of noncollectibility delineated in PRM 15-1 § 310.2. The Providers note that the U.S. Court of Appeals for the Sixth Circuit ("Sixth Circuit") characterized the PRM which includes the presumption of noncollectibility as "the prototypical example of an interpretive rule issued by an agency to advise the public of the agency's construction of the statutes and rules which it

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[15] Stipulations at ¶¶ 3-14 (copies included at Provider Exhibits P-9 (2004 and 2006) and P-10 (2005)).
[16] 558 F. Supp. 2d 1 (D.D.C. 2008).
[17] PRRB Dec. No. 2011-D30 (May 27, 2011), *rev'd*, CMS Administrator Dec. (July 26, 2011).
[18] PRRB Dec. No. 2011-D31 (May 27, 2011), *rev'd*, CMS Administrator Dec. (July 26, 2011).
[19] PRRB Dec. No. 2012-D3 (Dec. 14, 2011), *rev'd*, CMS Administrator Dec. (Feb. 16, 2012).
[20] *Id.* at ¶¶ 3-5, 8, 13.
[21] *See, e.g., Battle Creek Health Sys. v. BlueCross BlueShield Ass'n,* PRRB Dec. No. 2004-D40 (Sept. 16, 2004), *aff'd*, CMS Administrator Dec. (Nov. 12, 2004); *Dameron Hosp. v. BlueCross BlueShield Ass'n,* PRRB Dec. No. 2006-D16 (Feb. 17, 2006), *rev'd*, CMS Administrator Dec. (Apr. 17, 2006); *Sutter Merced Med. Ctr. v. BlueCross BlueShield Ass'n,* PRRB Dec. No. 2006-D56 (Sept. 27, 2006), *rev'd*, CMS Administrator Dec. (Nov. 22, 2006); *Foothill Presbyterian Hosp. v. BlueCross BlueShield Ass'n,* PRRB Dec. No. 2007-D11 (Dec. 19, 2006), *rev'd*, CMS Administrator Dec. (Feb. 14, 2007); *Mesquite Comty. Hosp. v. BlueCross BlueShield Ass'n,* PRRB Dec. No. 2007-D18 (Feb. 16, 2007), *rev'd*, CMS Administrator Dec. (Apr. 18, 2007); *Sierra Nevada Mem'l Hosp. v. BlueCross BlueShield Ass'n,* PRRB Dec. No. 2007-D40 (May 31, 2007), *rev'd*, CMS Administrator Dec. (July 27, 2007). *See also* the Board decisions for *UHS, GWU Hospital and Lakeland, supra* notes 17, 18, and 19 respectively.
[22] 42 C.F.R. § 413.89(e)(3).

administers."[23] The Providers at both CHS and Triad formulated their bad debt collection policies based on the presumption of noncollectability, essentially implementing this PRM provision as its procedure.[24] Significantly, this PRM provision has been in effect for over 40 years, well before the Bad Debt Moratorium.[25] The Providers assert that they collaborated with the Intermediary in developing their bad debt policy and that the Intermediary specifically confirmed the adequacy of that policy.[26] The Providers relied on the Intermediary's assurances over the years.

The Providers argue that their bad debt collection policy is interested in finding the collections process that will maximize its overall debt recovery for all payers, not just meet the minimum requirement for the Medicare program.[27] The Providers assert that they continue in-house collections even after the minimum time (*i.e.*, 120 days) has passed until the business office manager personally reviews and signs off on each debt prior to writing off that debt.[28] The Providers are not involved with the debts after they are written-off unless there is a successful collection effort by the collection agency. When there is a collection after the account has been written off, the Providers offset the bad debts claimed in the current year by the amount recovered in accordance with PRM 15-1 § 316.[29]

Finally the Providers believe they met the fourth criteria for claiming bad debt because "sound business judgment established that there was no likelihood of recovery at any time in the future."[30] The Providers argue that the Intermediary is inappropriately changing the standard for claiming bad debts from "likelihood of recovery" to "some possibility of recovery."[31] The Providers explain each debt is worked individually and evaluated for its individual likelihood of collection.[32] The Providers argue that the fact that a collection agency, with its specialized knowledge and additional collection tools at its disposal, may see the aggregate pool of debts as having some potential value does not render the Providers' business judgment that a particular debt has no likelihood of future collection invalid or untrue.[33]

The Providers argue that the "longstanding" agency policy that bad debts cannot be "worthless" or "uncollectible" while they remain at a collection agency appears nowhere in the bad debt regulation or Medicare manuals directed toward providers. The Providers stress that the only CMS publication addressing the denial of a bad debt while a Medicare account is still at the collection agency after the 120-day collection activity period has ended is in cost report audit guidelines located in the Medicare Intermediary Manual, CMS Pub. No. 13, Part 4 ("MIM 13-

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[23] *See Clark Reg. Med. Ctr. v. U.S. Dept. of Health & Human Servs.*, 314 F.3d 241, 248 (6th Cir. 2002) (quoting *Shàlala v. Guernsey Memorial Hosp.*, 514 U.S. 87, 99 (1995)).
[24] *See* Provider Exhibits P-3 and P-6 (Case No. 08-0621GC) (copy or description of Providers' policies and procedures); Tr. at 54, 58.
[25] Providers' Post Hearing Brief at 20.
[26] *See* Provider Exhibit P-4 (Case No. 08-0621GC) (letter from Intermediary to CHS dated Oct. 8, 2002).
[27] Tr. at 63.
[28] *Id.* at 111-112, 120.
[29] Stipulations at ¶ 7.
[30] 42 C.F.R. § 413.89(e)(4).
[31] Providers' Post Hearing Brief at 24.
[32] Tr. at 120.
[33] *Id.*

4").[34] The Providers assert this MIM 13-4 audit policy does not override the plain language of the regulation as clarified by the PRM 15-1. The Providers believe that the application of the MIM 13-4 audit policy is in violation of § 553 of the Administrative Procedure Act. The Providers further assert that the MIM 13-4 audit policy is irrational as it punishes providers who have a more rigorous collection effort which includes collection agencies while allowing those who do not use collection agency to claim the bad debts immediately.

INTERMEDIARY'S CONTENTIONS:

The Intermediary states that the Provider's policy to write off an outstanding debt as uncollectible, while at the same time contracting with a collection agency to continue collection efforts, contradicts the bad debt criteria at 42 C.F.R. § 413.89(e)(3) and (4) that the debt was actually uncollectible when claimed and that sound business judgment established that there was no likelihood of recovery at any time in the future. The Intermediary argues that, by continuing its collection efforts, whether through the use of an outside collection agency or by internal methods, the Provider has indicated that the bad debts are not yet deemed worthless and that there is some likelihood of recovery. Therefore, the Intermediary contends that the bad debt write-offs at issue fail to meet two out of the four criteria for an allowable bad debt under 42 C.F.R. § 413.89(e).

The Intermediary argues that the disallowance of bad debts still being pursued by a collection agency was confirmed by the Administrator in *UHS* and *GWU*. The Intermediary asserts under similar circumstances, the Sixth Circuit affirmed the district court who in turn had affirmed the Administrator's 2004 decision in *Battle Creek Health System v. Blue Cross Blue Shield Association.* Moreover, in 2008 in *Mesquite Community Hospital v. Leavitt*,[35] the U.S. District court for the Northern District of Texas concluded that the Secretary's decision was neither arbitrary nor inconsistent with the governing regulations.[36]

The Intermediary further contends that the disallowance of bad debts still at a collection agency does not represent a change in policy that is prohibited by the Bad Debt Moratorium because the regulation at 42 C.F.R. § 413.89(e) is a longstanding policy that predates the Bad Debt Moratorium. The Intermediary finds it significant that the Providers' witness did not have direct knowledge of what was claimed by the Providers prior to the date of enactment of the Bad Debt Moratorium (*i.e.*, August 1, 1987)[37] or why CHS' bad debt policy which was formulated based upon the PRM 15-1 bad debt guidance excluded the two words "as worthless."[38]

The Intermediary argues that the Providers' witness admitted that the amount received back from the collection agency represented value to the Providers[39] and that this value indicated some

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[34] *See* MIM 13-4, Transmittal 28, § 4198, Exhibit A-11 (Sept. 1989) (copy included at Appendix G (Case No. 08-0621GC)).
[35] No. 3-07-CV-1093-BD, 2008 WL 4148970 (N.D. Tex. Sept. 5, 2008) (copy included at Intermediary Exhibit I-4 (Case No. 08-0621GC).
[36] *Id.*
[37] Tr. at 83.
[38] *See* Provider Exhibit P-3 at 2 (Case No. 08-0621GC) (CHS bad debt policy); Tr. at 84.
[39] Tr. at 86.

likelihood of recovery.[40] Furthermore, the Intermediary believes that the use of a related party collection agency is actually just the continued collection process by the Providers.[41] Therefore, the Intermediary concludes that the Providers have not complied with the regulatory criteria set forth at 42 C.F.R. § 413.89(e)(3) and (4) or the bad debt policy provisions of Chapter 3 of PRM 15-1.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After considering the Medicare law and program instructions, the evidence presented and the parties' contentions, the Board finds and concludes that the Intermediary's adjustments to remove the Medicare bad debts claimed by the Provider while the debts were still at the collection agency were proper.

The issue in this case is whether Providers' collection efforts complied with the rules and regulations for claiming Medicare bad debts and/or the Intermediary's disallowance of the Providers' bad debts claims, because the claims had been referred to an outside collection agency, should be reversed because the Intermediary's adjustments violate the Bad Debt Moratorium. At the outset, it is important to address the applicability and scope of the Bad Debt Moratorium. There are essentially two prongs to the Bad Debt Moratorium: (1) the first prong prohibits CMS from changing its bad debt policy in effect on August 1, 1987; and (2) the second prong is a hold harmless provision that prohibits CMS from requiring a provider to change its bad debt collection policy when the Intermediary had accepted that policy prior to August 1, 1987.[42]

The Board finds that only the first prong of the Bad Debt Moratorium is relevant to this case. The Board finds that the second prong is not relevant because the Providers have presented no evidence showing that the Intermediary violated the prohibition of the second prong. In this regard, the Board notes that the Providers' witness testified in the hearing that he had no knowledge as to what the Providers were reimbursed by the Intermediary prior to August 1, 1987.[43] Further, there is nothing in the record to document or confirm what the Provider's policy was prior to August 1, 1987. As the second prong is not relevant, this decision focuses solely on the first prong of the Bad Debt Moratorium which prohibits changes to the bad debt policy in effect on August 1, 1987.

The Medicare program reimburses providers for bad debts resulting from deductibles and coinsurance amounts which are uncollectible from Medicare beneficiaries. Pursuant to 42 C.F.R. § 413.89(e), bad debts must meet the following criteria to be allowable:

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

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[40] *Id.* at 103.

[41] The record indicates that the Provider referred uncollected debt to several collection agencies including Professional Account Services, Inc. (PASI) which was a subsidiary of CHS. *See:* Tr. at 19-20; Provider's Post Hearing Brief at 26, footnote 20.; and Intermediary's Post-Hearing Brief at 3.

[42] *See District Hosp. Partners, L.P v. Sebilius*, 932 F. Supp. 2d 194, 198 (2013).

[43] Tr. at 83.

(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.

Additional guidance on the bad debt criteria is located in Chapter 3 of PRM 15-1. 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 provider to "establish that reasonable collection efforts were made." The § 310 guidance in effect during the time period at issue was revised 1983 and, thus, was established prior to the Bad Debt Moratorium.[44]

The Providers' appeal centers on the meaning and application of § 310 and, in particular, the second subsection of § 310 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 a provider actually does for its collection efforts) and what may be "considered a reasonable collection effort":

> 310 REASONABLE COLLECTION EFFORT
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> ***To be considered a reasonable collection effort,*** *a provider's effort to collect* Medicare deductible and coinsurance amounts must be similar to the effort the provider puts forth to collect comparable amounts from non-Medicare patients. *It must involve* the issuance of a bill on or shortly after discharge or death of the beneficiary to the party responsible for the patient's personal financial obligations. *It also includes* other actions such as subsequent billings, collection letters and telephone calls or personal contacts with this party which constitute a genuine, rather than a token, collection effort. *The provider's collection effort may include* using or threatening to use court action to obtain payment. (See § 312 for indigent or medically indigent patients.)
>
> A. Collection Agencies. —*A provider's collection effort may include* the use of a collection agency in addition to or in lieu of subsequent billings, follow-up letters, telephone and personal contacts. Where a collection agency is used, Medicare expects the provider to refer all uncollected patient charges of like amount to the agency without regard to class of patient. The "like amount" requirement may include uncollected charges above a specified minimum amount. Therefore, if a provider refers to a collection agency its uncollected non-Medicare patient charges which in

[44] *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).

> 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.
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> 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.
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> 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.
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> 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.[45]

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 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 on how much and what types of actual "collection effort" it will expend to collect debts and what tools the provider will use as part of its actual "collection effort" including whether the provider will engage certain third parties referred to as "collection agencies" to assist them in that effort.

Finally, regardless of where the provider sets the bar for its actual "collection effort" § 310 specifies that, in order for a collection effort to be considered reasonable, the provider's actual "collection effort" for Medicare accounts must be similar to that used for non-Medicare accounts and that there is consistency in this treatment across Medicare and non-Medicare debts.[46]

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

[46] 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 65 and accompanying text (discussing the relevance of § 310.1 in interpreting the rest of § 310).

Thus, it is the Provider's business decision to develop what is its reasonable and customary collection effort for Medicare deductibles and coinsurance mediated only by the CMS' requirement that this effort be similar to and consistent with its efforts to collect comparable amounts of non-Medicare debt. The business decisions that a provider makes in setting its debt collection process and procedure are reflected in the provider's written debt collection policy. As part of the normal cost report audit process and procedure, intermediaries request a copy of the provider's written bad debt collection policy for handling Medicare and non-Medicare patient accounts. This requirement is memorialized in the CMS Form 339 which is submitted with the as-filed cost report.[47]

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.[48] Specifically, as part of the audit of a hospital, the hospital audit program required the intermediary 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.[49]

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

[48] *See* Medicare Intermediary Manual, Part 4, CMS Pub. No. 13-4 ("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"). This 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 int ehh 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' 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).

[49] 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").

Further, the hospital audit program is derived from 42 C.F.R. §§ 413.20 and 413.24 for the purpose of testing hospital internal controls and adherence to Medicare policies.[50] 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 maintained 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 costs data and not impair comparability, financial and statistical records should be maintained in a manner 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"[51] for more than 120 days prior to writing a bad debt off.

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 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."

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[50] *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). *See also supra* note 49.

[51] (Emphasis added.)

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).[52] 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 uncollectable and, therefore, worthless.

A close reading of the conditional clause in the Presumption of Noncollectibility (*i.e.*, "[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 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 sent to the patient for that debt. When the prepositional phrase, (*i.e.*, "[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."[53] Otherwise, the words "remains unpaid more than" would be rendered superfluous and would reduce the Presumption of Noncollectibility to simply meaning that, after 120 days of reasonable and customary collection attempts, a debt "may be deemed uncollectible."[54]

Based on the above, 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 Intermediary's disallowance of the bad debts at issue is not in conflict with the first prohibition of the Bad Debt Moratorium. The Board

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[52] The Board notes that the presumption uses the prefix "non" as it is referred to as the "presumption of noncollectibility) while the regulatory criteria uses the prefix "un" by referring to debts as "uncollectible." Both 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 presumption uses a weaker prefix with the presumption.

[53] 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).

[54] 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 6 months after the date of service and, accordingly, the provider asserted that the Presumption of Uncollectibility 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.

finds the Providers' chose to utilize a collection agency as part of their "customary collection effort." The fact that the Providers' wrote off the debts at issue prior to sending them to the collection agency does not mean that the Providers' use of the collection agency was not part of the Providers' actual and customary "collection effort." The Providers' policy and procedure specifically list the use of the collection agency as part of its collection effort and, through this referral, the Providers clearly expected and desired some portion of the referred bad debts to be collected.[55] Testimony at the hearing indicated that the Providers believed that the uncollected debt had "value" and that there remained some expectation or likelihood that at least some of the debt would be recovered.[56]

The Board recognizes that the Providers' decision to send bad debts to a collection agency 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, the Provider's decision to incorporate use of a collection agency into its customary collection efforts necessarily means that the collection agency activities get incorporated into the "reasonable collection effort" standard that the Providers must meet. Therefore, the Board finds the Providers' collection effort is not complete until the collection agency 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 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."[57]

The Board recognizes that a number of the Providers are located in the U.S. Circuit Courts of Appeals for the Sixth, Seventh, and Eleventh Circuits and that there are decisions in these circuits addressing bad debt issues similar to those before the Board. Accordingly, the Board reviewed these Circuit Court decisions to determine whether they are applicable.

In the 1997 decision for *University Health Servs. v. Health & Human Servs.*,[58] the Eleventh Circuit upheld the Secretary's interpretation of PRM 15-1 §§ 310 and 310.2 that "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 nonMedicare accounts and has ceased collection effort with regard to all accounts after 120 days." In particular, the Eleventh Circuit stated the following regarding the § 310 requirement to treat similarly Medicare and non-Medicare accounts:

> The undisputed purpose of this requirement is to ensure that a provider treat similarly those accounts for which the provider has no guarantor as those for which the government acts as guarantor. Compliance with this policy presumably prevents Medicare from being sued as a payor for unpaid bills that might yet be paid by the responsible party. We cannot conclude that the Secretary's interpretation of the PRM guidelines drafted pursuant to the

[55] *See:* Provider's Exhibit 3
[56] Tr. at 84-86; 102-104
[57] *Id.* (emphasis added).
[58] 120 F.3d 1145 (11th Cir. 1997), *cert. denied*, 524 U.S. 904 (1998).

> "reasonable collection effort" regulation is arbitrary, plainly erroneous, or inconsistent with Medicare policy.

The Eleventh Circuit did consider the first prong of the Bad Debt Moratorium in rendering this decision and found that the Secretary's interpretation and application of the PRM 15-1 guidelines were not barred by the Bad Debt Moratorium.[59] The Board's findings in this case regarding the Presumption of Noncollectibility are consistent with the Eleventh Circuit's decision.

Similarly, the 1999 Seventh Circuit decision in *Mount Sinai Hosp. Med. Ctr. v. Shalala*[60] upheld the Secretary's application of the PRM 15-1 § 310 requirement to treat Medicare and non-Medicare accounts alike. Specifically, the Court upheld the Secretary's finding that the provider violated this requirement when it referred non-Medicare accounts to an outside collection agency while failing to do the same with Medicare accounts and, accordingly, the provider failed to engage in reasonable collection efforts on Medicare accounts.[61] The Seventh Circuit did consider the first prong of the Bad Debt Moratorium in rendering this decision and determined that the Secretary did not violate that prong.[62] In applying the first prong of the Bad Debt Moratorium in this case, the Board's findings regarding the Presumption of Noncollectibility remain consistent with the Seventh Circuit's decision.

In the 2007 decision for *Battle Creek Health Sys. v. Leavitt*,[63] the Sixth Circuit upheld the Secretary's interpretation and application of the PRM 15-1 manual provisions addressing bad debts to require providers to discontinue collection efforts by collection agencies before seeking Medicare reimbursement of debts outstanding for more than 120 days.[64] Although the Sixth Circuit did not consider the Bad Debt Moratorium in rendering this decision, in its application of the first prong of the Bad Debt Moratorium, the Board's findings regarding the Presumption of Noncollectibility remain consistent with the Sixth Circuit's decision.

The Board disagrees with the District Court's findings in *Foothill* as it pertains to evidence of CMS policy prior to August 1, 1987 allowing Medicare bad debts still at a collection agency to be claimed as reimbursable.[65] The Board finds nothing in the Medicare Bad Debt Audit

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[59] *See id.* at 1152-1153.
[60] 196 F.3d 703 (7th Cir. 1999).
[61] *Id.* at 708.
[62] *See id.* at 710-11.
[63] 498 F.3d 401 (2007).
[64] *Id.* at 411.
[65] The Board also reviewed a similar bad debt case that the U.S. District Court for the District of Columbia recently issued – *District Hosp. Partners, L.P. v. Sebelius* ("*District Hospital*"), *932* F.Supp.2d 194 (D.D.C. 2013). In *District Hospital*, the court used the same bases as 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 noncollectability 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 noncollectability in section 310.2 applied to accounts that had been sent to collection agencies.

Program-1985 that indicates that CMS had a policy of allowing Medicare bad debts reimbursement while the debts were still at a collection agency. 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.[66]

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

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932 F. Supp. 2d at 205-206 (citations to court record omitted). The Board disagrees with this court 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] Section 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. *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). 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 noncollectability, the Administrator first had to 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 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.

[66] *Foothill*, 558 F. Supp. 2d at 10-11 (citation to record omitted).

> 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.[67]

The Board notes that section 15.04 addresses the allowability of collection agency fees and tracks PRM 15-1 § 310.1 by 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 the Board maintains, describing uncollectible bad debts *coming back from* the collection agency to the provider.[68]

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*")[69] 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 the case before the Board was that bad debts (both Medicare and non-Medicare) 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*.[70]

Subsequent to the *Foothill* decision, the D.C. District Court upheld the Administrator's finding in *Lakeland Reg'l Health Sys. v. Sebelius*[71] stating: "that it has always been the Secretary's policy

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[67] (Emphasis added.)

[68] 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*, CMS Administrator (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.

[69] PRRB Dec. Nos. 1995-D58, 1995-D59 and 1995-D60, (August 31, 1995)

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

[71] 958 F. Supp. 2d 1 (D.D.C. 2013).

that accounts pending at collection at agencies cannot be written off as bad debts until collection activity has terminated."[72] In particular, the 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.[73]

In upholding the Secretary's policy on the use of collection agencies, the D.C. Court found that that policy did not violate the Bad Debt Moratorium because it "is reflected in the agency's pre- and post-Moratorium interpretive guidance." In this regard, similar to the Board, the D.C. Court looked to the 1985 guidelines for the Hospital Audit Program as evidence of this policy in effect prior to the Bad Debt Moratorium.[74]

Finally, the Board recognizes that the related party collection agency issue as one that could separately impact the outcome in this case. However, based upon the Board's previous findings, the related party collection agency issue is moot and, accordingly, the Board does not reach this issue. Further, the Board finds that the related party collection agency issue is not the common question to be addressed in a group appeal.[75] Providers (CHS and Triad) had differing bad debt collection policies.[76] The facts may differ by bad debt account and provider. Therefore, the additional questions of fact and interpretation of law and regulation will not be addressed in this decision and the Board declines, at this time, to bifurcate the group based upon whether the provider used a related party collection agency.

In summary, the Board finds that the Intermediary's interpretation of the rules and regulations is allowable under the first prong of the Bad Debt Moratorium because the Intermediary's interpretation is reasonable under the rules and regulations as they existed prior to August 1,

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[72] *Id.* at 7.
[73] *Id.* at 7-8 (citations omitted).
[74] Specifically, the D.C. Court states: "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 tens ("*was* applied") precludes reimbursement prior to the application of reasonable collection effort." *Id.* at 8 (citations omitted and italics emphasis in original). *See also El Centro Reg'l Ctr. v. Leavitt*, No. 07CV1182 WQH (PCL), 2008 WL 5046057, at *7 (S.D. Cal. Nov. 24, 2008) (upholding the Administrator's interpretation of PRM 15-1 § 310 "as being applicable to both in house and outside collection efforts").
[75] 42 C.F.R. § 405.1837(a)(2) (2008).
[76] Provider Exhibits P-3 and P-6.

1987 rules and regulations.[77] Similarly, the Board finds that the Providers have not presented sufficient evidence to establish that the Intermediary violated the second prong of the Bad Debt Moratorium.

DECISION AND ORDER:

The Intermediary properly disallowed the Providers' claimed Medicare bad debts solely on the ground that accounts related to such bad debts were still pending at outside collection agencies. The Intermediary's adjustments are affirmed.

BOARD MEMBERS PARTICIPATING:

Michael W. Harty
John Gary Bowers, C.P.A.
Clayton J. Nix, Esq.
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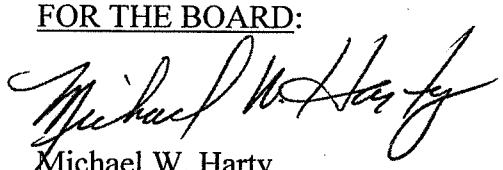
FOR THE BOARD:



Michael W. Harty
Chairman

DATE: JUL 01 2014

[77] 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 was issued subsequent to the Bad Debt Moratorium. Notwithstanding, the Board notes that its decision is consistent with these documents.

APPENDIX I

Case No.: *08-0621GC*

Sched. of Prov. #	Provider No.	Provider Name	FYE	Intermediary
1	15-0017	Lutheran Hospital of Indiana	06/30/2004	NGS
2	15-0075	Bluffton Regional Medical Center	09/30/2004	NGS
3	26-0074	Moberly Regional Medical Center	10/31/2004	WPS
4	42-0091	Carolina's Hospital System	06/30/2004	WPS
5	44-0189	Regional Hospital of Jackson	12/31/2004	WPS
6	45-0147	DeTar Hospital Navarro	09/30/2004	WPS

Case No.: *08-0619GC*

Sched. of Prov. #[78]	Provider No.	Provider Name	FYE	Intermediary
1	01-0009	Hartselle Medical Center	01/31/2005	WPS
3	01-0143	Woodland Community Hospital	09/03/2005	WPS
4	01-0150	LV Stabler Memorial Hospital	01/31/2005	WPS
5	02-0006	Mat-Su Regional Medical Center	05/31/2005	WPS
7	03-0101	Western Arizona Regional Medical Center	08/31/2005	WPS
8	04-0041	St. Mary's Regional Medical Center	08/31/2005	WPS
9	04-0078	National Park Medical Center	08/31/2005	WPS
10	04-0080	Harris Hospital	06/30/2005	WPS
11	04-0118	Northeast Medical Center	05/31/2005	WPS
12	05-0194	Watsonville Community Hospital	07/31/2005	WPS
13	10-0099	Lake Wales Medical Center	12/31/2005	WPS
14	14-0125	Gateway Regional Medical Center	12/31/2005	WPS
15	14-1342	Union County Hospital	12/31/2005	WPS
16	15-0017	Lutheran Hospital of Indiana	06/30/2005	NGS
17	15-0047	St. Joseph Medical Center	05/31/2005	Admina-Star
18	15-0075	Bluffton Regional Medical Center	09/30/2005	Admina-Star

[78] The providers numbered 2, 6, 42, 55, 58, 59, 61, 62 and 63 on the Schedule of Providers for Case Number 08-0619GC were intentionally omitted as the Board dismissed these providers for lack of jurisdiction.

Case No.: *08-0619GC (Continued)*

Sched. of Prov. #[79]	Provider No.	Provider Name	FYE	Intermediary
19	15-1318	Dukes Memorial Hospital	12/31/2005	WPS
20	18-0117	Parkway Regional Hospital	05/31/2005	WPS
21	18-0128	Three Rivers Medical Center	03/31/2005	WPS
22	18-0139	Kentucky River Medical Center	08/31/2005	WPS
23	26-0022	Northeast Regional Medical Center	05/31/2005	WPS
24	26-0074	Moberly Regional Medical Center	10/31/2005	WPS
25	32-0006	Eastern New Mexico Medical Center	05/31/2005	WPS
26	32-0014	Mimbres Memorial Hospital	03/31/2005	WPS
27	34-0133	Martin General Hospital	04/30/2005	WPS
28	36-0019	Barberton Citizens Hospital	12/31/2005	NGS
29	38-0020	McKenzie Willamette Medical Center	12/31/2005	WPS
30	38-0071	Willamette Valley Medical Center	12/31/2005	WPS
31	39-0072	Berwick Hospital Center	06/30/2005	WPS
32	39-0076	Brandywine Hospital	06/30/2005	WPS
33	42-0036	Springs Memorial	11/30/2005	WPS
34	42-0091	Carolina's Hospital System	06/30/2005	Palmetto GBA
35	44-0008	Henderson County Community Hospital	12/31/2005	WPS
36	44-0067	Lakeway Regional Hospital	05/31/2005	WPS
37	44-0072	Dyersburg Regional Medical Center	12/31/2005	WPS
38	44-0182	McKenzie Regional Hospital	12/31/2005	WPS
39	44-0189	Regional Hospital of Jackson	12/31/2005	WPS
40	45-0029	Laredo Medical Center	09/30/2005	WPS
41	45-0147	De Tar Hospital	09/30/2005	WPS
43	45-0165	South Texas Regional	06/30/2005	WPS
44	45-0192	Hill Regional Hospital	05/31/2005	WPS
45	45-0296	Cleveland Regional Medical Center	08/31/2005	WPS
46	45-0558	Abilene Regional Medical Center	08/31/2005	WPS
47	45-0596	Lake Granbury Hospital	11/30/2005	WPS
48	45-0653	Scenic Mountain Medical Center	12/31/2005	WPS
49	45-0702	Longview Regional Medical Center	12/31/2005	WPS
50	45-0743	Denton Community Hospital	03/31/2005	WPS
51	45-0830	Big Bend Regional Medical Center	09/30/2005	WPS
52	46-0014	Mountain West Medical Center	12/31/2005	WPS

[79] *Id.*

Case No.: *08-0619GC (Continued)*

Sched. of Prov. #[80]	Provider No.	Provider Name	FYE	Intermediary
53	49-0002	Russell County Medical Center	09/30/2005	WPS
54	49-0067	Southside Regional Medical Center	02/28/2005	WPS
56	49-0097	Southern Virginia Regional Medical Center	02/28/2005	WPS
57	51-0088	Plateau Medical Center	12/31/2005	WPS
60	32-0003	Alta Vista Regional Hospital	08/31/2005	WPS

Case No.: *08-0611GC*

Sched. of Prov. #[81]	Provider No.	Provider Name/Location	FYE	Intermediary
1	01-0009	Hartselle Medical Center	01/31/2006	WPS
2	01-0150	LV Stabler Memorial Hospital	01/31/2006	WPS
3	02-0006	Mat-Su Regional Medical Center	12/31/2006	WPS
4	03-0033	Payson Regional Medical Center	07/31/2006	WPS
5	03-0085	Northwest Medical Center	11/30/2006	WPS
6	03-0101	Western Arizona Regional Medical Center	08/31/2006	WPS
7	10-0099	Lake Wales Medical Center	12/31/2006	WPS
8	10-0122	North Okaloosa	03/31/2006	WPS
9	11-0189	Fannin Regional Hospital	12/31/2006	WPS
10	14-0125	Gateway Regional Medical Center	12/31/2006	WPS
11	14-1342	Union County Hospital	10/31/2006	WPS
12	14-1348	Red Bud Hospital	06/30/2006	WPS
13	15-0075	Bluffton Regional Medical Center	09/30/2006	NGS
14	15-0150	Dupont Hospital	03/31/2006	NGS
15	15-1318	Dukes Memorial Hospital	12/31/2006	NGS
16	18-0117	Parkway Regional Hospital	05/31/2006	WPS
17	18-0128	Three Rivers Medical Center	03/31/2006	WPS
18	18-0139	Kentucky River Medical Center	08/31/2006	WPS
19	19-0201	Women & Children's Hospital	05/31/2006	WPS

[80] *Id.*

[81] The provider numbered 33 on the Schedule of Providers for Case No. 08-0611GC was intentionally omitted as the Board dismissed this provider for lack of jurisdiction.

Case No.: *08-0611GC (Continued)*

Sched. of Prov. #[82]	Provider No.	Provider Name/Location	FYE	Intermediary
20	26-0022	Northeast Regional Medical Center	05/31/2006	WPS
21	26-0074	Moberly Regional Medical Center	10/31/2006	WPS
22	29-1307	Mesa View Regional Hospital	07/31/2006	WPS
23	31-0091	Memorial Hospital of Salem County	12/31/2006	WPS
24	32-0014	Mimbres Memorial Hospital	03/31/2006	WPS
25	32-0065	Lea Regional Hospital	12/31/2006	TrailBlazer
26	36-0019	Barberton Hospital	12/31/2006	NGS
27	36-0151	Affinity Medical Center	06/30/2006	NGS
28	37-0002	Woodward Regional Hospital	05/31/2006	WPS
29	37-0039	Claremore Regional Medical Center	10/31/2006	WPS
30	38-0020	McKenzie Willamette Hospital	12/31/2006	WPS
31	38-0071	Willamette Valley Medical Center	12/31/2006	WPS
32	39-0026	Chestnut Hill Hospital	06/30/2006	WPS
34	39-0076	Brandywine Hospital	06/30/2006	WPS
35	39-0084	Sunbury Community Hospital	06/30/2006	WPS
36	39-0127	Phoenixville Hospital	06/30/2006	WPS
37	39-0162	Easton Hospital	06/20/2006	WPS
38	42-0036	Springs Memorial Hospital	11/30/2006	WPS
39	44-0008	Henderson County Hospital	12/31/2006	WPS
40	44-0024	Bradley County Memorial Hospital	10/31/2006	WPS
41	44-0051	McNairy Regional Hospital	12/31/2006	WPS
42	44-0067	Lakeway Regional Hospital	05/31/2006	WPS
43	44-0182	McKenzie Regional Hospital	12/31/2006	WPS
44	44-0185	Cleveland Community Hospital	08/31/2006	WPS
45	45-0029	Laredo Medical Center	09/30/2006	WPS
46	45-0147	DeTar Hospital Navarro	09/30/2006	WPS
47	45-0165	South Texas Regional Medical Center	06/30/2006	WPS
48	45-0192	Hill Regional Hospital	05/31/2006	WPS
49	45-0299	College Station Medical Center	10/31/2006	WPS
50	45-0340	San Angelo Community Medical Center	08/31/2006	WPS
51	45-0447	Navarro Regional Hospital	12/31/2006	WPS
52	45-0596	Lake Granbury Hospital	11/30/2006	WPS
53	45-0702	Longview Regional Medical Center	12/31/2005	WPS

[82] *Id.*

Case No.: *08-0611GC (Continued)*

Sched. of Prov. #	Provider No.	Provider Name/Location	FYE	Intermediary
54	49-0067	Southside Regional Medical Center	02/28/2006	WPS
55	49-0092	Southampton Memorial	12/31/2006	WPS
56	49-0097	Southern Virginia Regional Medical Center	09/30/2006	WPS
57	51-0088	Plateau Medical Center	12/31/2006	WPS
58	53-0032	Evanston Hospital	04/30/2006	WPS
59	19-0164	Byrd Regional Medical Center	08/28/2007	WPS