PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2014-D18

PROVIDERs –
Methodist Hospital-Southlake
Methodist Hospital-Northlake
Methodist Hospital, Inc.

PROVIDER NOs.: Various
See Appendix I

vs.

INTERMEDIARY –
Wisconsin Physicians Service/
BlueCross BlueShield Association

DATE OF HEARING -
January 15, 2014

Cost Reporting Periods Ended –
2000-2004

CASE NOs.: Various
See Appendix I

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ISSUE:

Whether the Medicare administrative contractor's disallowances of Methodist Hospital's bad debt claims should be reversed.[1]

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"),[2] 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[3] determine payment amounts due the providers under Medicare law, regulation and interpretative guidelines published by CMS.[4]

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.[5] 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").[6] 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.[7]

The regulations governing bad debt are located at 42 C.F.R. § 413.89.[8] 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.

[1] Transcript ("Tr.") at 6.
[2] In 2001, the agency name was changed from CMS to HCFA. For simplicity, this decision generally will use CMS to refer to the agency.
[3] FIs and MACs are hereinafter referred to as intermediaries.
[4] *See* 42 U.S.C. §§ 1395h and 1395kk-1; 42 C.F.R. §§ 413.20, 413.24.
[5] *See* 42 C.F.R. § 413.20.
[6] *See* 42 C.F.R. § 405.1803.
[7] *See* 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835-1837.
[8] Redesignated from 42 C.F.R. § 413.80 at 69 Fed. Reg. 48916, 49254 (Aug. 11, 2004).

(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 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.
>
> 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,[9] 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.[10] In 1989, in § 6023 of the Omnibus Budget Reconciliation Act of 1989, Congress again retroactively amended the Bad Debt Moratorium.[11] 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

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

> 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.[12]

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:

This case involves two related providers – Methodist Hospitals Southlake ("Southlake") and Methodist Hospitals Northlake ("Northlake"). Both of these Providers are located in or near Gary, Indiana. As of January 1, 2004, the two hospitals combined to form Methodist Hospitals, Inc. and have operated under one Medicare provider number since that time.[13] Collectively, Southlake, Northlake and Methodist Hospitals, Inc. will be referred to as "Providers" or "Methodist Hospitals." Each of the Providers had a fiscal year end of December 31st and the fiscal years ("FYs") at issue in this appeal are FYs 2000 to 2003 for Southlake and Northlake and FY 2004 for Methodist Hospitals, Inc.[14] During these FYs, the Providers' designated intermediary was Wisconsin Physicians Service ("Intermediary").

For the cost reporting periods at issue, the Intermediary removed Medicare bad debts claimed because the Providers wrote off debts while still at a secondary collection agency. The Providers timely filed the subject appeals with the Board and met the jurisdictional requirements of 42 C.F.R. §§ 405.1835-1841.

The Providers were represented by Daniel F. Miller, Esq., of Hall, Render, Killian, Heath & Lyman, P.C. The Intermediary was represented by Robin Sanders, Esq., of Blue Cross and Blue Shield Association.

STIPULATIONS:

The parties agreed to a stipulation of facts and they state in pertinent part:

> 3. The parties agree that the issue presented in these combined appeals is whether the MAC's disallowances of Methodist Hospital's bad debt claims should be reversed.

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[12] Reprinted at 42 U.S.C. § 1395f note entitled "Continuation of Bad Debt Recognition for Hospital Services."

[13] Tr. at 196-198.

[14] The Providers withdrew all of its claims for FY 1997 that are set forth in PRRB Case Nos. 01-0740 and 01-2657 for Southlake and Northlake respectively and for FY 1999 that are set forth in PRRB Case No. 03-0841 for Northlake. *See* Stipulation at ¶ 2; Supplemental Stipulations at ¶ 1. Further, the MAC agreed to withdraw the following objection to the Providers' bad debt claims set forth the Stipulations at ¶ 3(i) with respect to all the remaining fiscal years at issue in these combined appeals (*i.e.,* FYs 2000-2004): the Providers inconsistently pursued judicial collection actions against Medicare and non-Medicare patients. *See* Supplemental Stipulations at ¶ 2. *See*: Stipulation attached to Provider's Post Hearing Brief

The parties further agree that the sole bases upon which the MAC disallowed the bad debt claims in these combined appeals can be stated as follows. The MAC concluded that, based on information obtained as part of its review:

(i) With respect to all of the fiscal years at issue in these combined appeals, Methodist Hospitals inconsistently pursued judicial collection actions against Medicare and non-Medicare patients;

(ii) With respect to the 2000-2004 fiscal years at issue in these combined appeals, Methodist Hospitals referred all uncollected claims, for both Medicare covered and non-Medicare covered patients, to a secondary collection agency at the time the Medicare claims were written off and included on the Hospital's bad debt logs, but only after its internal collection procedures had been completed and after its primary outside collection agencies had concluded their efforts to collect the unpaid coinsurance and deductible amounts.

4. For all of the fiscal years and claims at issue in these appeals, it was Methodist Hospitals' practice to claim an unpaid Medicare patient account as bad debt only after collection efforts had been made for at least 120 days.

5. For all of Methodist Hospitals' fiscal years remaining at issue in this consolidated appeal, its Medicare cost reports included claims for these bad debts.

6. The MAC issued Notices of Program Reimbursement ("NPRs") for the fiscal years at issue in these appeals, disallowing the bad debts claimed by Methodist Hospitals for the reasons set forth in the audit work papers of the fiscal years at issue. Methodist Hospitals timely appealed all of the NPRs to the PRRB, in order to challenge the MAC's disallowance of the bad debts.

7. The MAC acknowledges that there are no jurisdictional impediments to the Board's consideration of Methodist Hospitals' appeals.[15]

The parties also agreed to the follow supplemental stipulations, in pertinent part:

2. With respect to the Methodist Hospitals' 2000-2004 fiscal years that remain pending before the Board, the MAC agrees to withdraw its objection to Methodist Hospitals' bad debt claims set forth in paragraph 3(i) of the parties' stipulation attached as Exhibit A, i.e., that with respect to all the fiscal years at issues in these combined appeals, Methodist Hospitals inconsistently pursued judicial collection actions against Medicare and non-Medicare patients.

3. Accordingly, with respect to the Methodist Hospitals' 2000-2004 fiscal years that remain pending before the Board, the sole basis upon which the MAC disallowed the bad debt claims at issue in these combined appeals is set forth in paragraph 3(ii) of the parties' stipulation attached as Exhibit A.

[15] Stipulation (Jan. 14, 2014).

4. All other matters set forth in the parties' stipulation attached hereto as Exhibit A remain in effect.

5. This supplemental stipulation is meant to further narrow the issues to be addressed in the Board's decision concerning Methodist Hospital appeals from the disallowance of bad debt claims for its 2000-2004 fiscal years that were the subject of the hearing the Board conducted on January 15, 2014.[16]

PROVIDERS' CONTENTIONS:

Beginning in July 1999 and continuing through FYs 2000 to 2004, the Providers began to utilize a secondary collection agency, for both Medicare and non-Medicare patients, after the Providers' internal efforts as well as the efforts of their primary collection agencies had been exhausted. The Providers would write off the unpaid Medicare accounts at the time those claims were referred to the secondary collection agency. The Providers contend its collection efforts fully comported with the Medicare program guidance applicable to bad debt collection activities.[17] Specifically, the Providers maintain that they pursued reasonable collection efforts for far more than 120 days and, thus, satisfied their obligations before seeking reimbursement for the bad debts at issue in these appeals. Accordingly, the Providers contend that, after pursuing reasonable collection efforts, the bad debts were properly presumed to be non-collectable. In fact, the Providers maintain that they went even further than necessary and did not write off the bad debts until they had been returned from the primary collection agency. At that point, substantial collection efforts had been pursued and the debts were deemed worthless, as sound business judgment established that there was no likelihood of future recovery.[18]

The Providers further contend that the Bad Debt Moratorium prohibits the Intermediary from disallowing the bad debt claims for FYs 2000-2004 based upon referral of all unpaid claims to the secondary outside collection agency because it is already settled as a matter of law that this limitation was not a CMS policy that was established prior to the enactment of the Bad Debt Moratorium. Moreover, if the Board concludes that, prior to the enactment of the Bad Debt Moratorium, the Intermediary had accepted the Providers' policy of writing off bad debt claims after pursuing internal collection efforts for at least 120 days, while then submitting them to an outside collection agency for follow-up, the Board must also reverse the bad debt audit adjustments for FYs 2000-2004 on this basis as well.

In numerous prior cases, providers have successfully challenged CMS' position that Medicare bad debt claims cannot be written off while pending with an outside collection agency after commercially-reasonable collection efforts have been pursued for a minimum of 120 days. An example is the bad debt appeal involving Foothill Presbyterian Hospital. In the Board's 2006

[16] Supplemental Stipulation (Mar. 5, 2014).
[17] The Providers note that the Intermediary does not dispute the fact that the Hospitals pursued collection activities in a commercially-reasonable manner for more than 120 days before any of the claims at issue were placed upon the Hospitals' Medicare bad debt logs. *See* Stipulation at ¶ 4.
[18] *See* Provider Combined Final Position Paper at 36-38.

decision in *Foothill Presbyterian Hosp. v. BlueCross BlueShield Ass'n* ("*Foothill*"),[19] the Board held that an adjustment disallowing bad debt claims because the Medicare provider referred the claims to an outside collection agency after pursuing its own collection activities for at least 120 days was a violation of the Bad Debt Moratorium.

The Board's unanimous decision in *Foothill* was reviewed and summarily reversed by the CMS Administrator, based upon the rationale that a debt is not worthless if a provider continues to pursue collection activities on the account through an outside collection agency.[20]

The provider appealed the Administrator's decision in *Foothill* to the U.S. District Court for the District of Columbia ("D.C. Court"). The D.C. Court agreed with the Board and rendered a decision favorable to the provider and explicitly held that the Bad Debt Moratorium precludes the Secretary, CMS and its agents from modifying DHHS' policies regarding bad debts on or after August 1, 1987.[21] Specifically, after an exhaustive review of the subsequent activities of DHHS, CMS and its agents regarding the bad debt policies that were implemented after August 1, 1987, the D.C. Court concluded that the Administrator's *Foothill* decision was based upon a change in policy in violation of the Bad Debt Moratorium. The D.C. Court noted that the CMS policies with respect to referrals to outside collection agencies had been inconsistent. In support of this finding, the D.C. Court cited to a prior 1995 decision of the CMS Administrator, *Lourdes Hospital v. Blue Cross and Blue Shield Ass'n* ("*Lourdes*")[22] wherein the Administrator approved a Medicare provider's bad debt claims even though an outside collection agency was still working on the delinquent accounts.[23]

In 2013, the D.C. Court reaffirmed its holding in *Foothill* that a bad debt could be deemed uncollectible even while collection efforts were continuing at an outside collection agency. Specifically, in *District Hosp. Partners, L.P. v. Sebelius* ("*District Hospital*"), the D.C. Court found that the presumption of collectability did not exist prior to 1987, and, therefore, the application of that policy to disallow the provider's bad debt claims pending at a collection agency violated the Bad Debt Moratorium's prohibition on DHHS changing its own bad debt policies.[24]

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[19] PRRB Dec. No. 2007-D11 (Dec. 19, 2006).

[20] CMS Administrator Dec. (Feb. 14, 2007), *rev'g*, PRRB Dec. No. 2007-D11 (Dec. 19, 2006).

[21] *Foothill Hosp.-Morris L. Johnston Mem. v. Leavitt*, 558 F. Supp. 2d 1 (D.D.C. 2008).

[22] CMS Administrator Dec. (Oct. 25, 1995), *rev'g*, PRRB Dec. No. 1995-D58 (Aug. 31, 1995).

[23] *See Foothill*, 558 F. Supp. 2d at 6. The Providers assert that the Administrator's decision in *Lourdes* demonstrates that eight years after the enactment of the Bad Debt Moratorium, the policy requiring bad debts be returned from a collection agency prior to being written off was not established even within the Agency itself. Further, the Court could have cited to another decision, *Methodist Hosp. of Dyersburg v. Blue Cross and Blue Shield Ass'n*, PRRB Dec. No. 2000-D56 (May 30, 2000), *declined review*, CMS Administrator (July 21, 2000), as another case wherein a provider was allowed to recover bad debt claims that were still pending at an outside collection agency. The Administrator allowed the Board's decision in *Methodist Hospital of Dyersburg* to stand, and it was issued nearly five years later than the Administrator's decision in *Lourdes*.

[24] 932 F. Supp. 2d 194 (D.D.C. 2013). The *District Hospital* decision upheld the Board's decision in *George Washington Univ. Hosp. v. Blue Cross Blue Shield Ass'n*, PRRB Dec. No. 2011-D31 (May 27, 2011), *rev'd*, CMS Administrator Dec. (July 26, 2011). Therein, the Board noted that, prior to writing off accounts as bad debt, the provider engaged in reasonable collection efforts until accounts were at least 120 days past due. The Board found that this policy was consistent with the Medicare regulations and program instructions. In its decision, the Board followed *Foothill* and found that CMS' current policy of presuming all accounts held at an outside collection agency do not qualify for bad debt reimbursement was a violation of the Bad Debt Moratorium.

During the time at issue, the audit guidelines for hospitals subject to IPPS located at Medicare Intermediary Manual, CMS Pub. No. 13, Part 4 ("MIM 13-4") § 4198 specified that an account must be returned from a collection agency before it can be claimed as a Medicare bad debt:

> If the bad debt is written- off on the providers' books 121 days after the date of the bill and then turned over to a collection agency, the amount cannot be claimed as a Medicare bad debt on the date of the write-off. It can be claimed as a Medicare bad debt only after the collection agency completes its collection effort.[25]

This provision was issued in 1989 after the enactment of the Bad Debt Moratorium and purports to create a presumption of collectability where a debt has been referred to a collection agency. The transmittal issuing this provision describes its application as "NEW POLICY-- EFFECTIVE DATE: For Prospective Payment System (PPS) cost report audits performed after 10/12/89."[26] However, the MIM 13-4 provision is in direct opposition to the presumption of uncollectability that has been embedded in the PRM 15-1 § 302.1 since prior to 1987, as discussed below. As the MIM 13-4 provision was adopted in 1989 and imposed a limitation that did not previously exist, it is invalid as a change in policy that occurred after the effective date of the Bad Debt Moratorium.

In fact, on June 11, 1990, shortly after revising MIM 13-4 § 4198 (and almost three years after the Bad Debt Moratorium was imposed), HCFA issued a joint-signature memorandum to all HCFA Regional Administrators to clarify Medicare bad debt policy. The Providers contend that the 1990 Memorandum contained a statement that flatly contradicts the Intermediary's contention that the policy set forth in the 1989 MIM provision was an existing policy in 1987. Specifically, the Providers contend that the 1990 Memorandum states: "However, the mere fact that a debt is referred to a collection agency after a provider's in-house collection effort is completed does not mean the debt is collectible."[27] Further, the 1990 Memorandum also states that:

> We believe that an intermediary could reasonably have interpreted the title of section 310.2, Presumption of Noncollectibility, to provide that an uncollectible account could be *presumed* to be a bad debt if the provider has made a reasonable and customary attempt to collect the bill for at least 120 days *even though* the claim has been referred to a collection agency. Such an interpretation is reasonable . . . .[28]

This demonstrates that CMS was aware that, where intermediaries were permitting providers' claims referred to a collection agency to be reimbursed as bad debts prior to the Bad Debt Moratorium, those intermediaries could not refuse to permit such claims based on CMS

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[25] MIM 13-4 § 4198 at Exhibit A-11 (copy included at Provider Exhibit P-60 at MH1175).
[26] MIM 13-4, Transmittal 28 (Sept. 1989) (copy included at Provider Exhibit P-60).
[27] *See* Provider Post-Hearing Brief at 20 (purportedly quoting the HFCA Memorandum issued June 11, 1990).
[28] (Emphasis in original).

directives issued long after the Moratorium's effective date. The Agency acknowledged that was true in 1990 and it remains true today. Indeed, in 1990 CMS conceded that doing so would constitute a change in policy and be a direct violation of the Bad Debt Moratorium.[29]

In support of its assertion that the 1990 Memorandum reflects policy that is contrary to the bad debt policy in effect as of August 1, 1987, the Providers point to several documents that predate the Bad Debt Moratorium. Specifically, the Providers point to the presumption of uncollectibility in PRM 15-1 § 310.2 and the Hospital Audit Program issued in December 1985 at MIM 13-4, Ch. 5, § 4499. In particular, the Providers point to the following discussion in the Hospital Audit Program of debts held by a collection agency as being "uncollectible":

> 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 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 the reviewing patient's file for copies of ht eagency's billing, follow-up letter and reports of telephone and personal contacts.
>
> 15.05 Obtain a list of prior year bad debts claimed and ascertain that the same bad debts have not been claimed in the current year. . . .
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> 15.07 Amounts included in allowable bad debts in a prior period could be recovered in a later period. The auditor should verify that recoveries of such bad debts are properly offset. To determine if bad debt recoveries were properly handled, perform the following

[29] *See* Provider Post-Hearing Brief at 20-21.

> steps: . . . .[30]

The Providers assert that the 1985 Hospital Audit Program confirms that CMS was well aware that hospitals' use of outside collection agencies would sometimes result in collection of claims previously written off and that it contains no prohibition against claiming the bad debts while the "uncollectible" claims were pending with the outside collection agency. Providers further assert that the plain language of the 1985 Hospital Audit Program allowed hospitals to use collection agencies to continue to pursue "uncollectible" Medicare claims, provided the claims were handled in a similar manner as that for non-Medicare claims.[31]

Nearly twenty years after the 1990 Memorandum, CMS issued another policy "clarification" in a joint-signature memorandum dated May 2, 2008 which was sent to all Fiscal Intermediaries and Medicare Administrative Contractors. This "clarification" is similar to the one issued earlier to providers as part of the MLN Matters News Flash No. SE0824 issued in April 2008 ("April 2008 MLN Matters").[32] The 2008 Memorandum stated:

> The purpose of this memorandum/letter is to clarify longstanding policy concerning reimbursement for a Medicare bad debt while the account is at a collection agency. As a result of this instruction, Medicare contractors (FIs and A/B MACs) are required to disallow Medicare bad debts for accounts at a collection agency where the contractors may heretofore have allowed those bad debts in the past based, at least in part, on interpretation of language contained in the Omnibus Budget Reconciliation Act of 1987 (OBRA of 1987).

Whatever CMS may have wished to be its "longstanding" bad debt reimbursement policy, the 2008 Memorandum flatly contradicts what is contained in the 1990 Memorandum discussed above, and is a transparent change in policy that is contrary to the Bad Debt Moratorium. Of course, the Agency also failed to address the intervening final decision in *Lourdes* which allowed providers' bad debt claims pending at outside collection agencies to be reimbursed.

The Administrative Procedure Act specifies that an Agency's substantive changes of regulations can only be made through notice and comment rule-making.[33] Thus, the Providers contend that, notwithstanding CMS's revisionist interpretation of provisions contained in its Manuals or its issuance of internally contradictory and redundant memoranda, its proclamations do not have the legal effect of a regulation, much less a statute, even in instance where a contract between CMS

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[30] MIM 13-4 § 4499 at Exhibit 15 (as revised by MIM 13-4, Ch. 5, Transmittal 16 (Dec. 1985)) (excerpt included at Provider Exhibit P-65).
[31] *See* Provider Post-Hearing Brief at 21-22.
[32] *See* Provider Exhibits P-62 at MH1204 (copy of May 2, 2008 Memorandum) and P-63 at MH1208 (copy of April 2008 MLN Matters).
[33] *See* 5 U.S.C. § 553.

and an entity, such as the Intermediary, requires that entity to comply with CMS guidance.[34] The new policy CMS proclaimed substantively changed the law without following the necessary rule-making process. More importantly, even if CMS had adopted the change through a rule-making process, regulations that conflict with a Congressional enactment, *i.e.*, the Bad Debt Moratorium, are contrary to law and cannot be upheld.[35]

INTERMEDIARY'S CONTENTIONS:

The Intermediary determined that the provider transferred the bad debts to a collection agency at the time of write-off. The transfer of these accounts to a collection agency indicates that the Providers have not deemed these debts as uncollectible or worthless. The Providers have continued its collection efforts through the collection agency. A debt cannot be deemed worthless until all collection efforts have ceased.[36]

As an initial matter, the continuation of its collection effort through a collection agency would indicate that the Providers did not consider these debts as worthless at the time of write-off for Medicare reimbursement purposes. The Providers have also failed to document the establishment that there was no likelihood of recovery at any time in the future at the time of write-off of these debts. With this, the Providers' Medicare bad debts for the years under appeal failed to meet two out of the four criterions for an allowable bad debt.[37]

Next, applicable case law in numerous forums, including court opinions, the Administrator's opinions, and prior PRRB decisions, supports the Intermediary's position in this case. The disallowance of bad debts being pursued by a collection agency was confirmed by the Administrator's 2004 decision in *Battle Creek Health System v. Blue Cross Blue Shield Ass'n*, ("*Battlecreek*").[38] In *Battle Creek*, the Board had decided in favor of the provider and ruled that the disallowance of the bad debts still at a collection agency was improper. The Administrator reversed this decision by concluding that the disallowance by the Intermediary was proper. The Administrator's decision was then subsequently upheld by both the U.S. District Court for the Western District of Michigan and the U.S. Court of Appeals for the Sixth Circuit.[39] In particular, the Sixth Circuit held as follows:

> We find the Secretary's interpretation of § 413.89(e) to be eminently reasonable. First, it conforms to the plain language of the regulation and PRM § 310.2. Plaintiffs' debts did not meet the criteria for reimbursement because the debts at issue were being serviced by a collection agency when claimed as worthless. The very fact that a collection agency was still attempting to collect the bad debts at issue indicates that these debts had not yet been

[34] *See Public Citizen v. U.S. Department of Health and Human Servs.*, 332 F.3d 654, 660-661 (D.D.C. 2003).
[35] *See* Provider Combined Final Position Paper at 31.
[36] Intermediary's Final Position Paper at 24.
[37] *Id.*, at 25
[38] CMS Administrator decision (Nov. 12, 2004), *rev'g*, PRRB Dec. No. 2004-D40 (Sept. 16, 2004).
[39] *See Battle Creek Health Systems v. Thompson*, 423 F. Supp. 2d 755 (W.D. Mich. 2006) (copy of opinion included at Intermediary Exhibit I-6); *Battle Creek Health System v. Leavitt*, 498 F.3d 401 (6th Cir. 2007) (copy of opinion included at Intermeidary Exhibt I-7).

> determined to be "actually uncollectible when claimed as worthless" and certainly contraindicates that "[s]ound business judgment established that there was no likelihood of recovery at any time in the future." 42 C.F.R. § 413.89(e)(3) and (4). These criteria cannot be met until the collection agency completes its collection effort and returns the debts to plaintiffs as uncollectible.[40]

Both the District Court and Sixth Circuit decisions support the Intermediary's position here — the Providers' continued attempts to collect through a collection agency demonstrates that the Providers did not consider the debts to be worthless at the time of write off and therefore, the debts are not allowable bad debts under the Medicare program. The Intermediary maintains that the Providers have not presented any persuasive arguments for why the Board should disregard this and other well-reasoned decisions upholding the Secretary's disallowance of the disputed bad debts.[41]

The Intermediary 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.[42] Therefore, the Bad Debt Moratorium does not alter the fact that, in order for the Providers to succeed in this case, they must establish that the bad debts at issue satisfy all of four of the requirements in § 413.89(e).

The Intermediary notes that the record is replete with admissions from the Providers and their secondary collection agency that the continued efforts to collect on the claimed bad debts are "very effective" and that the collection efforts result in recoveries.[43] Therefore, the Intermediary concludes that, based on the fact of these cases, regardless of the timing as to the specific policy statements by the Secretary regarding the disallowance of bad debts subject to continued collection efforts, the Providers' bad debts were properly disallowed because they failed to satisfy the "eminently reasonable" requirements of 42 C.F.R. § 413.89(e).[44]

The Intermediary further contends that the Secretary's specific policy regarding the disallowance of bad debts pending at collection agencies has been consistently applied since before the Bad Debt Moratorium. In support of this position, the Intermediary cites to the recent decision of the U.S. District Court for the District of Columbia, *Lakeland Reg'l Health Sys. v. Sebelius*, 958 F. Supp. 2d 1 (2013) ("*Lakeland Regional*"). In *Lakeland Regional*, the Court upheld the Secretary's policy regarding the disallowance of bad debts at a collection agency as both reasonable and appropriate and rejected the provider's arguments regarding the Bad Debt Moratorium. In making these holdings, the Court stated:

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[40] 498 F.3d at 411.

[41] *See Lakeland Reg'l Health Sys. v. Sebelius*, 958 F. Supp. 2d 1 (D.D.C. 2013); *Mesquite Cmty. Hosp. v. Leavitt*, No. 3-07-CV-1093-BD, 2008 WL 4148970 (N.D. Tex. Sept. 5, 2008). *See* Intermediary Post-Hearing Brief at 10-11.

[42] *See* 31 Fed. Reg. 14813 (Nov. 22, 1966).

[43] *See* Provider Exhibit P-5 at MH0119; Tr. at 109-112, 235-236.

[44] *k* Provider's Post Hearing Brief at 12.

> It is not, as plaintiff contends, fatal, *per se*, that the Secretary's Policy is not explicitly set forth in a pre-Moratorium writing. The interpretive guidance in place on August 1, 1987 'did not purport to be a comprehensive review of all conditions that might be placed on reimbursement of Medicare bad debts in the Secretary's enforcement of 42 C.F.R. § 413.89(e)."[45]

Accordingly, the Intermediary notes that the Court gave a detailed review of the procedures through which the Secretary implemented this particular policy and affirmed that "it has 'always' been the Secretary's policy that accounts pending at collection agencies cannot be written off as bad debts until collection has terminated."[46] The "substantial evidence" relied up by the Court included PRM 15-1 § 310.2, the 1985 Hospital Audit Program at MIM 13-4 § 4199, MIM 13-4 § 4199, the 1990 Memorandum, and the 2008 Memorandum.[47]

Finally, the Intermediary rejects the Providers' claims that the second prong of the Bad Debt Moratorium is relevant to this case. The second prong prohibits the Secretary from requiring a hospital to make changes involving a hospital's bad debt collection policy if an intermediary has accepted that hospital's policy prior to August 1, 1987. It is undisputed that the Providers did not begin utilizing a secondary collection agency until 1999 and did not begin claiming bad debts pending at those collection agencies until their FY 2000 cost report. Moreover, the Intermediary notes that it has consistently disallowed the Providers' bad debts remaining at a collection agency since the Providers began claiming such debts in 2000. Thus, the Intermediary concludes that the Providers cannot satisfy the second prong of the Bad Debt Moratorium.[48]

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.[49]

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

[45] 958 F. Supp. 2d at 8.
[46] *Id.* at 7.
[47] *See* Intermediary Post-Hearing Brief at 13-15.
[48] *See* Intermediary Post-Hearing Brief at 15-16.
[49] The Board's decision in this case is consistent with the decision it reached in *CHS 2004-2006 Medicare Bad Debt–Passive v. Blue Cross Blue Shield Ass'n*, PRRB Dec. No. 2014-13 (July 1, 2014).

bad debt collection policy when the Intermediary had accepted that policy prior to August 1, 1987.[50]

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. There is nothing in the record to document or confirm what the Provider's policy was prior to August 1, 1987. Indeed, the record demonstrates that the Providers did not begin using a secondary collection agency until 1999 at which point they began to write off accounts as bad debts prior to sending them to the secondary collection agency. 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.
(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.[51]

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
>
> ***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

[50] *See District Hosp. Partners, L.P v. Sebelius*, 932 F. Supp. 2d 194, 198 (2013).
[51] *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).

amounts from non-Medicare patients. *It must involve* the issuance of a bill on or shortly after discharge or death of the beneficiary to the party responsible for the patient's personal financial obligations. *It also includes* other actions such as subsequent billings, collection letters and telephone calls or personal contacts with this party which constitute a genuine, rather than a token, collection effort. *The provider's collection effort may include* using or threatening to use court action to obtain payment. (See § 312 for indigent or medically indigent patients.)

A. Collection Agencies. —*A provider's collection effort may include* the use of a collection agency in addition to or in lieu of subsequent billings, follow-up letters, telephone and personal contacts. Where a collection agency is used, Medicare expects the provider to refer all uncollected patient charges of like amount to the agency without regard to class of patient. The "like amount" requirement may include uncollected charges above a specified minimum amount. Therefore, if a provider refers to a collection agency its uncollected non-Medicare patient charges which in amount are comparable to the individual Medicare deductible and coinsurance amounts due the provider from its Medicare patient, Medicare requires the provider to also refer its uncollected Medicare deductible and coinsurance amounts to the collection agency. Where a collection agency is used, the agency's practices may include using or threatening to use court action to obtain payment.

B. Documentation Required. —*The provider's collection effort should be documented* in the patient's file by copies of the bill(s), follow-up letters, reports of telephone and personal contact, etc.

310.1 Collection Fees.—*Where a provider utilizes the services of a collection agency* *and* *the reasonable collection effort described in § 310 is applied*, the fees the collection agency charges the provider are recognized as an allowable administrative cost of the provider.

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.[52]

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

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

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.[53]

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.[54]

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.[55] Specifically, as part of the audit of a

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[53] 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 72 and accompanying text (discussing the relevance of § 310.1 in interpreting the rest of § 310).

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

[55] *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

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.[56]

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.[57] 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

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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).

[56] 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").

[57] *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 55.

> 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"[58] 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."

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).[59] 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."[60]

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[58] (Emphasis added.)

[59] 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.

[60] 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*

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."[61]

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 finds that 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.[62] 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.[63]

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."[64]

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).

[61] 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.

[62] *See* Provider Exhibit P-5 at MH0139-MH0141, MH0234-MH0236.

[63] *See, e.g.*, Tr. at 111-112.

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

The Board recognizes that a number of the Providers are located in the U.S. Circuit Court of Appeals for the Seventh Circuit and that this circuit addressed bad debt issues similar to those before the Board in the 1999 decision in *Mount Sinai Hosp. Med. Ctr. v. Shalala* ("*Mount Sinai*").[65] In *Mount Sinai*, the Seventh Circuit upheld the Secretary's application of the PRM 15-1 § 310 requirement to treat Medicare and non-Medicare accounts alike. Specifically, the Seventh Circuit 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.[66] 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.[67] 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.

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.[68] The Board finds nothing in the Medicare Bad Debt Audit Program-1985 that indicates that CMS had a policy of allowing Medicare bad debts

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[65] 196 F.3d 703 (7th Cir. 1999).

[66] *Id.* at 708.

[67] *See id.* at 710-11.

[68] 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.

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.

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.[69]

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

> 15.04 Where a provider utilizes the services of a collection agency, the provider need not refer all uncollected patient charges to the agency, but it may refer only uncollected charges above a specified minimum amount. *If reasonable collection effort was applied, fees the collection agency charges the provider are recognized as an allowable administrative cost of the provider. To determine the acceptability of collection agency services*, perform the following audit steps.
>
> A. Review provider contracts with the collection agency to determine that both Medicare and non-Medicare *uncollectible* amounts are handled in a similar manner.
>
> B. Determine that the patient's file is properly documented to substantiate the collection effort by reviewing the patient's file for copies of the agency's billing, follow-up letters and reports of telephone and personal contacts.
>
> C. Determine that the bad debt amounts recovered by the collection agency are properly recorded by verifying that the full amount collected is credited to the patient's account and the collection fee is charged to administrative expense.[70]

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

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

[70] (Emphasis added.)

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.[71]

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*")[72] 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*.[73]

Subsequent to the *Foothill* decision, the D.C. District Court upheld the Administrator's finding in *Lakeland Reg'l Health Sys. v. Sebelius*[74] stating: "that it has always been the Secretary's policy that accounts pending at collection at agencies cannot be written off as bad debts until collection activity has terminated."[75] 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

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[71] 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.

[72] CMS Administrator Dec. (Oct. 25, 1995), *modifying*, PRRB Dec. Nos. 1995-D58, 1995-D59 and 1995-D60, (Aug. 31, 1995).

[73] 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.

[74] 958 F. Supp. 2d 1 (D.D.C. 2013).

[75] *Id.* at 7.

> conceivably have to simultaneously pursue collection from a beneficiary and reimbursement from CMS.[76]

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.[77]

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, 1987 rules and regulations.[78] 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.
L. Sue Andersen, Esq.

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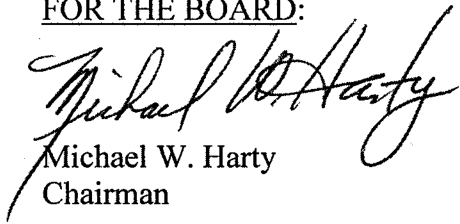
[76] *Id.* at 7-8 (citations omitted).

[77] 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").

[78] In reaching its decision, the Board relies on neither the June 11, 1990 Joint Signature Memorandum issued by HCFA Central to all HCFA Regional Administrators nor MIM 13-4, Transmittal 28, § 4198, Exhibit A-11 (Sept. 1989) as these documents were both issued subsequent to the Bad Debt Moratorium. Notwithstanding, the Board notes that its decision is consistent with these documents. Further, the Board notes that, contrary to the Providers' assertions, the 1990 Memorandum does *not* state that "the mere fact that a debt is referred to a collection agency after a provider's in-house collection effort is completed does not mean the debt is collectible." *Compare* Provider Post-Hearing Brief at 20 with the 1990 Memorandum.

FOR THE BOARD:



Michael W. Harty
Chairman

DATE: AUG 26 2014

Appendix I

PROVIDER NAME-PROVIDER NO.:	Methodist Hospital Southlake – 15-0132[79] PRRB Case No. 04-1350 – FYE 12/31/2000 PRRB Case No. 05-1139 – FYE 12/31/2001 PRRB Case No. 06-1473 – FYE 12/31/2002 PRRB Case No. 06-1477 – FYE 12/31/2003
PROVIDER NAME-PROVIDER NO.:	Methodist Hospital Northlake – 15-0002[80] PRRB Case No. 04-1348 – FYE 12/31/2000 PRRB Case No. 05-1185 – FYE 12/31/2001 PRRB Case No. 06-1353 – FYE 12/31/2002 PRRB Case No. 06-1303 – FYE 12/31/2003
PROVIDER NAME-PROVIDER NO.:	Methodist Hospitals, Inc. – 15-0002 PRRB Case No. 07-1344 – FYE 12/31/2004

[79] Case No. 01-0740 withdrawn. *See* Supplemental Stipulation at ¶ 1.
[80] Case Nos. 01-2657 and 03-0841 withdrawn. *See* Supplemental Stipulation at ¶ 1 and Stipulation at ¶ 2.