PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2014-D19

PROVIDERS –
St. John Health 2004-2005 Bad Debt Moratorium CIRP Group
Hall Render 2005-2006 Bad Debt Moratorium Group

PROVIDER NOs.: Various
See Appendix I

vs.

INTERMEDIARY –
National Government Services, Inc./Wisconsin Physicians Service/ Blue Cross and Blue Shield Association

DATE OF HEARING –
June 28, 2012

Cost Reporting Periods Ended -
See Appendix I

CASE NOs.: 09-1065GC; 09-2172G

INDEX

ISSUE:

Whether 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.[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.

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[1] Transcript ("Tr.") at 5-6.
[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 § 302.1defines 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
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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 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,[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:

The providers involved in these two group appeals include St. John Hospital and Medical Center (Michigan) for the fiscal years ending ("FYEs") June 30, 2004 and June 30, 2005; Lahey Clinic Medical Center (Illinois) for FYEs September 30, 2005 and September 30, 2006; and Evanston Hospital (Massachusetts) for FYE September 30. 2006.[13] These providers will be herein referred to collectively as the "Providers." The Providers' designated intermediary during the time at issue was National Government Services, Inc. ("Intermediary").

For the cost report periods at issue the Intermediary 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. §§ 405.1835-405.1841.

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

STIPULATIONS:

The parties stipulated to the following pertinent facts:

14. For all of the fiscal years and claims at issue in these appeals, it was the Providers' practice to claim a Medicare patient account as bad debt only after reasonable collection efforts have been made for at least 120 days.
15. For all of the fiscal years and claims at issue in these appeals, Providers made reasonable collection efforts for more than 120 days prior to writing the debts off and reporting them on the Medicare cost report.
16. For the Providers' fiscal years ending 2004, 2005, and 2006 the Medicare appealed cost reports, included claims for these bad debts.
17. The Providers' Fiscal Intermediary issued NPRs disallowing the bad debts claimed by the Providers for the fiscal years at issue in these

[12] Reprinted at 42 U.S.C. § 1395f note entitled "Continuation of Bad Debt Recognition for Hospital Services."
[13] Appendix I provides a listing of the providers and the relevant fiscal years by group appeal.

appeals. The Providers then transferred those bad debt claims related to accounts not returned from the collection agency to these group appeals.

18. The Fiscal Intermediary asserts that Medicare bad debts may not be claimed for accounts that remain at an outside collection agency.
19. The Providers' claims for reimbursement of the bad debts at issue in these appeals were denied solely because the debts were still the subject of collection efforts at outside collection agencies.
20. The Providers' bad debt claims were allowed even though they were referred to outside collection agencies in all prior fiscal years since 1987.
21. In the Provider's fiscal years prior to the years at issue in these appeals, the Fiscal Intermediary/MAC had allowed the Providers' bad debt claims that have been referred to outside collection agencies, because it interpreted the Bad Debt Moratorium as prohibiting it from disallowing bad debt claims, because such claims were allowed under Medicare program guidance in 1987, when the Bad Debt Moratorium became effective.
22. The Fiscal Intermediary/MAC now believes that its prior interpretation of the bad debt was incorrect.
23. The Fiscal Intermediary/MAC's current interpretation is contrary to its prior interpretation of the applicability of the Bad Debt Moratorium to bad debt claims like those presented in these appeals.[14]

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 this issue is the same as what was presented in *Foothill Hosp. v. Leavitt*, 558 F. Supp. 2d 1 (D.D.C. 2008) (*"Foothill"*) and subsequent Board decisions.[15] The Providers request that the Board rule consistent with those decisions.

The Providers assert the policies CMS and the Intermediary rely upon to disallow these claims changed after August 1, 1987, in violation of the Bad Debt Moratorium. The Providers give the following three examples of these changed policies: (1) the Medicare Intermediary Manual, CMS Pub. No. 13, Part 4 ("MIM 13-4"), § 4198; (2) the May 2, 2008 CMS joint signature

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[14] Stipulations at ¶¶ 14-23 (June 27, 2012). The Parties also submitted supplemental stipulations dated August 30, 2012 where they agreed to the amount in controversy for the Providers in these appeals. *See:* Provider's Post-Hearing Brief, Exhibit P-26 at 0226.

[15] *See Universal Health Servs., Inc. v. Blue Cross Blue Shield Ass'n,* PRRB Dec. No. 2011-D30 (May 27, 2011), *rev'd,* CMS Administrator Dec. (July 26, 2011); *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); *Lakeland Reg'l Med. Ctr. v. Blue Cross Blue Shield Ass'n,* PRRB Dec. No. 2012-D3 (Dec. 14, 2011), *rev'd,* CMS Administrator Dec. (Feb. 16, 2012); Tr. at 11-12, 16-17.

memorandum ("2008 Memorandum");[16] and (3) the MLN Matters New Flash No. SE0824 (April 2008) ("April 2008 MLN Matters").[17]

The Providers note inconsistencies in treatment of the issue in controversy by both the CMS Administrator and the Intermediary. The Providers agree with the Court's findings in *Foothill* showing that, in *Lourdes Hosp. v. Blue Cross and Blue Shield Ass'n* ("*Lourdes*"),[18] the CMS Administrator reversed the Board and approved of a Medicare provider's bad debt claims even though an outside collection agency was still working the delinquent accounts.[19] The Providers point to stipulations that show the Intermediary has allowed reimbursement of the Providers' bad debt claims that had been referred to an outside collection agencies for many years prior to and after the enactment of the Bad Debt Moratorium.[20]

The Providers' assert their collection efforts met all requirements and guidance in effect prior to the enactment of the Bad Debt Moratorium. The Providers focus their arguments on the controversy surrounding the use of collection agencies. The Providers explain that PRM 15-1 § 310 requires providers to undertake reasonable collection efforts, which are "similar to the effort the provider puts forth to collect comparable amounts from non-Medicare patients." At minimum, § 310 requires that a bill be issued timely to the party responsible for the patient's personal financial obligations, and that various "other actions" are taken in order to qualify as a "genuine" effort to collect. Sub-parts A and B of PRM 15-1 § 310 offer additional instruction on how the provider has options to utilize a collection agency, if it has such a relationship, to establish a reasonable collection effort (sub-part A), and what and how the collection effort may be documented by the provider (sub-part B). The Provider asserts that if a collection agency is used, PRM 15-1 § 310.1 provides requirements for reconciling any amounts that may be collected subsequent to the initial bill. Finally, PRM 15-1 § 310.2 creates a presumption of uncollectibility for debts that have remained unpaid for greater than 120 days, provided reasonable and customary attempts to collect have been made.

The Providers argue that it is not necessary for a provider who engages a collection agency for uncollected debts to utilize those services in order to meet 42 C.F.R. § 413.89(e)(2). The Providers believe sub-part A of PRM 15-1 § 310 merely explains that reasonable collection efforts "*may* include the use of a collection agency in addition to or in lieu of subsequent [collection activities]."[21] Nothing in sub-part A creates a presumption or requirement that, solely because a provider engages the services of a collection agency, that providers must now utilize those services before being deemed to have undertaken a "reasonable collection effort." Sub-part A instructs providers that the use of a collection agency may serve as part of (*i.e.*, in addition to) or all of (*i.e.*, in lieu of) the "other actions" described in the main paragraph of PRM 15-1 § 310, which are necessary to establish the provider's reasonable collection efforts.

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[16] Providers Exhibit P-21 (copy of the 2008 Memorandum).
[17] Providers Exhibit P-22 (copy of April 2008 MLN Matters). *See* Provider's Final Position Paper at 9-12; Provider's Post-Hearing Brief at 5-10.
[18] CMS Administrator Dec. (Oct. 25, 1995), *modifying*, PRRB Dec. Nos. 1995-D58, 1995-D59 and 1995-D60, (Aug. 31, 1995).
[19] *Foothill* 588 F. Supp. 2d at 6. *See also* Providers Exhibit P-18 (copy of CMS Administrator decision in *Lourdes*).
[20] Stipulation at ¶¶ 20, 21. *See also* Provider's Final Position Paper at 4-7; Provider's Post-Hearing Brief at 3-5.
[21] (Emphasis added.)

The Providers believe that if sub-part A were intended to establish this presumption, it would conflict with the guidance of PRM 15-1 § 310.1. The word choice and structure of the first sentence of § 310.1 reinforces this interpretation. The language, "...and the reasonable collection effort described in § 310 is applied," would serve no purpose in the sentence if the services of a collection agency were not able to be separated from the process of undertaking a "reasonable collection effort." The plain meaning of this sentence necessarily contemplates a scenario where a provider utilizes a collection agency after (a collection agency could not logically provider series before) it has undertaken a "reasonable collection effort." Therefore, the Providers assert the only way to read sub-part A in a way that does not conflict with § 310.1 is to interpret sub-part A such that a provider may engage a collection agency for uncollected charges, but it may also satisfy the requirements of a reasonable collection effort prior to the collection agency's involvement.

Finally, the Providers argue that PRM § 310.2 goes on to state that after 120 days of reasonable collection efforts, the debt may be deemed uncollectible. The Parties have stipulated the Providers pursued reasonable collection efforts for a minimum of 120 days[22] and, thus, satisfied its obligations before seeking reimbursement for the bad debt.[23]

INTERMEDIARY'S CONTENTIONS:

The Intermediary argues that the regulatory language at 42 C.F.R. § 413.89(e) is dispositive of the issue and prevents the Providers from claiming the bad debts while still at a collection agency. Specifically, the Intermediary asserts the Providers failed to meet § 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.[24] The Intermediary contends that the Providers cannot meet the regulatory requirement when collection efforts are continuing at the collection agency.

The Intermediary contends the Providers cannot rely on the PRM 15-1 § 310.2 safe harbor of collection efforts greater than 120 days because the Providers had not completed their collection efforts. The Intermediary believes this section eliminates the need for a provider to establish that each account was "actually uncollectible" with "no likelihood of collection at any time in the future" when reasonable collection efforts stop after more than 120 days. Since the Providers in this group appeal were trying to collect the debts through the use of a collection agency, they cannot claim the safe harbor under § 310.2 or claim they have met the criteria of § 413.89(e) because by their own actions the hospitals clearly believed the accounts had value and that there was still a possibility of collection.

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. The Intermediary relied on the 2008 Memorandum that CMS issued to remind

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[22] Stipulation ¶15.
[23] *See* Provider's Final Position Paper at 7-9.
[24] Intermediary's Final Position Paper, March 7, 2012 at 7.

Intermediaries of the longstanding CMS policy not to allow bad debt claims for accounts still at a collection agency.[25]

The Intermediary notes the 1990 Memorandum also reiterated the CMS policy position that "until a provider's reasonable collection effort has been completed, including both in-house efforts and the use of a collection agency, a Medicare bad debt may not be reimbursed as uncollectible." However, the 1990 Memorandum recognized that many providers had been claiming bad debts while an account was at a collection agency and that some intermediaries had permitted them as an allowable bad debt thinking the Bad Debt Moratorium prohibited any change. The 1990 Memorandum went on to instruct intermediaries who had allowed such bad debt claims, to continue to do so under the terms of the Bad Debt Moratorium. The Intermediary asserts this instruction was reversed through the 2008 Memorandum that stated, "any instructions previously issued which allowed hospitals to claim Medicare bad debt for accounts at a collection agency based on a Medicare contractor's interpretation of the policy as of August 1, 1987, are incorrect. In no case is an unpaid Medicare account which is in collection, including at a collection agency, an allowable bad debt under the regulations."[26]

In *District Hospital Partners, L.P. v. Sebelius* in the U.S. District Court for the District of Columbia,[27] the Secretary acknowledges that it is possible to find inconsistent statements regarding application of the bad debt policy, including comments in the 1990 Memorandum. However, any such inconsistent statement does not establish an inconsistency in the Secretary's policy making position. The Secretary relies on the decision in *North Shore Inc. v. Bowen,* 832 F.2d 405, 413 (7th Cir. 1987)(*"North Shore")* holding that the fact that the Secretary's "minions" have expressed differing views on an issue does not make the Secretary's ultimate policy on that issue invalid and merely reflects the "Department of Health and Human Services is a mammoth bureaucracy with seemingly endless layers of internal review, and reasonable people disagree" as to the meaning of a regulation. Further, the 1990 Memorandum as well as the 2008 Memorandum make it clear that CMS has interpreted the regulations to mean that a provider who continues to pursue collection at an outside collection agency has not determined that the account is worthless with no likelihood of collection at any time in the future, as a result, accounts pending at collection agencies cannot be claimed as Medicare bad debts.[28]

Finally, the Intermediary disagrees with the reliance of the Court in *Foothill* on the 1985 Hospital Audit Program[29] as support for a change in policy regarding claiming Medicare bad debts still at a collection agency. The Intermediary believes the sections of the 1985 Hospital Audit Program discussed by the Court relate to directing the auditor to ensure that Medicare and non-Medicare accounts are handled similarly. The 1985 Hospital Audit Program does not give specific instructions as to when an account is considered uncollectible and cannot be construed to mean that the Secretary believed accounts at a collection agency were uncollectible.[30]

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[25] *See*: Intermediary's Post Hearing Brief dated August 31, 2012 at 3. (The Intermediary referred to its Post-Hearing Brief as the "MAC's Final Position Paper" in its cover letter dated August 31, 2012. Hereinafter, it will be cited as "Intermediary's Post Hearing Brief.")

[26] *Id.*, at 4.

[27] 932 F. Supp. 2d 194 (D.D.C. 2013).

[28] *See*: Intermediary's Post-Hearing Brief, at 4-5.

[29] Intermediary Exhibit I-6.

[30] *See* Intermediary Post-Hearing Brief at 2-6.

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 Providers solely because the bad debts remained at the collection agency were improper based upon the Bad Debt Moratorium.

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.[31]

The Board finds that both prongs of the Bad Debt Moratorium are relevant to this case. Accordingly, the Board has divided its discussion based on each prong of the Bad Debt Moratorium.

FIRST PRONG OF THE BAD DEBT MORATORIUM

The first prong of the Bad Debt Moratorium prohibits changes to the bad debt policy in effect on August 1, 1987. Accordingly, the Board must review the bad debt policy that was in effect on August 1, 1987.[32]

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

[31] *See District Hosp. Partners, L.P v. Sebelius*, 932 F. Supp. 2d 194, 198 (2013).
[32] The Board's decision regarding the first prong of the Bad Debt Moratorium 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-D13 (July 1, 2014).

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.[33]

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 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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[33] *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).

> 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.[34]

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.[35]

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

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

[35] 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 49 and accompanying text (discussing the relevance of § 310.1 in interpreting the rest of § 310).

accounts. This requirement is memorialized in the CMS Form 339 which is submitted with the as-filed cost report.[36]

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.[37] 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.[38]

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.[39] In this regard, the Board notes that maintaining a written bad debt collection policy is consistent with 42 C.F.R.

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

[37] *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 in the Provider Reimbursement Manual, HCFA Pub. 15-1"); MIM 13-4, Ch. 5, § 4499 Exhibit 1 at § 1 (stating that "The Audit Program was developed to assist an intermediary or CPA firm in determining if the correct amount of reimbursement was made to the provider for the cost report being audited. Also, the audit program was designed so that an intermediary or CPA [firm] could express an opinion as to whether or not the provider is adhering to Medicare Reimbursement Principles as explained in the Provider Reimbursement Manual, HCFA Pub. 15-1."); MIM 13-4, Ch. 5, § 4499 Exhibit 21 at ¶¶ 21.01, 21.05(A)(1) (as revised by MIM 13-4, Ch. 5, Transmittal 16 (Dec. 1985)) (stating in § 21.01 "the scope of an audit of the balance sheet accounts for Medicare purposes is dependent upon the. . . effectiveness of the internal controls" and in § 21.05 "[r]eview the provider's 'bad debt' 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).

[38] 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").

[39] *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).

§§ 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"[40] for more than 120 days prior to writing off a bad debt.

The Board finds that the plain language of the Presumption of Noncollectibility does not create an automatic presumption after the passage of 120 days. Rather, it is 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).[41] Rather, in order to

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[40] (Emphasis added.)

[41] 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.

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."[42] 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."[43]

Based on the above analysis, the Board finds that the policy of not allowing providers to claim bad debts until they are returned from a collection agency is consistent with the regulations and Manual sections in effect on August 1, 1987. Therefore, the 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 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.[44]

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[42] 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).

[43] 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.

[44] *See* Provider Exhibits P-15, P-16, P-17.

The Board recognizes that the Provider's 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 Provider must treat Medicare and non-Medicare accounts equally, the Provider's decision to incorporate use of a collection agency into its customary collection efforts for non-Medicare accounts necessarily means that the collection agency activities get incorporated into the "reasonable collection effort" standard for Medicare accounts. 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 Provider 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."[45]

The Board recognizes that some of the Providers are located in the U.S. Circuit Courts of Appeals for the Sixth and Seventh 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.

The 1999 Seventh Circuit decision in *Mount Sinai Hosp. Med. Ctr. v. Shalala*[46] 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.[47] 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.[48] 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*,[49] 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.[50] 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

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[45] PRM 15-1 § 310.2 (emphasis added).
[46] 196 F.3d 703 (7th Cir. 1999).
[47] *Id.* at 708.
[48] *See id.* at 710-11.
[49] 498 F.3d 401 (2007).
[50] *Id.* at 411.

be claimed as reimbursable.[51] The Board finds nothing in the Medicare Bad Debt Audit 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.[52]

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

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[51] 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.

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

> 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.[53]

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.[54]

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*")[55] 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

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[53] (Emphasis added.)

[54] 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.

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

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*.[56]

Subsequent to the *Foothill* decision, the D.C. District Court upheld the Administrator's finding in *Lakeland Reg'l Health Sys. v. Sebelius*[57] 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."[58] In particular, the D.C. District Court notes the following:

> The Secretary's Policy is encompassed by 42 C.F.R. § 413.89(e), which expressly provides that a debt is not reimbursable unless it is "actually uncollectible when claimed as worthless" and "[s]ound business judgment established that there was no likelihood of recovery at any time in the future." Where, as here, an outside collection agency continues collection efforts on behalf of a provider, these criteria cannot be met.... After all, what provider exercising sound business judgment would spend his precious resources on the fool's errand of pursuing an uncollectible debt with no likelihood of future recovery? By prohibiting double-recovery, PRM § 316 eliminates any incentive a provider might conceivably have to simultaneously pursue collection from a beneficiary and reimbursement from CMS.[59]

In upholding the Secretary's policy on the use of collection agencies, the D.C. District Court found that the policy did not violate the Bad Debt Moratorium because it "is reflected in the agency's pre- and post-Moratorium interpretive guidance." In this regard, similar to the Board, the D.C. District Court looked to the 1985 guidelines for the Hospital Audit Program as evidence of this policy in effect prior to the Bad Debt Moratorium.[60]

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

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[56] 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.

[57] 958 F. Supp. 2d 1 (D.D.C. 2013).

[58] *Id.* at 7.

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

[60] 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").

interpretation is reasonable under the rules and regulations as they existed prior to August 1, 1987 rules and regulations.[61]

SECOND PRONG OF THE BAD DEBT MORATORIUM

The Board finds the evidence in this case shows the Intermediary violated the second prong of the Bad Debt Moratorium. The second prong states:

> The Secretary may not require a hospital to change its bad debt collection policy if a fiscal intermediary, in accordance with the rules in effect as of August 1, 1987, with respect to criteria for indigency determination procedures, record keeping, and determining whether to refer a claim to an external collection 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.[62]

The parties have stipulated: "In the Provider's fiscal years prior to the years at issue in these appeals, the Fiscal Intermediary/MAC had allowed the Providers' bad debt claims that have been referred to outside collection agencies, *because it interpreted the Bad Debt Moratorium as prohibiting it from disallowing bad debt claims, because such claims were allowed under Medicare program guidance in 1987,* when the Bad Debt Moratorium became effective."[63]

The Board notes that this is exactly the scenario explained in the June 11, 1990 HCFA Memorandum to Regional Administrators as allowable under the Bad Debt Moratorium since, "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 an customary attempt to collect the bill for at least 120 days *even though* the claim has been referred to a collection agency."[64] The Board is aware that CMS reversed this interpretation in the May 2, 2008 CMS Joint Signature Memorandum stating:

> [W]e have determined that any instructions previously issued which allowed hospitals to claim Medicare bad debt for accounts at a collection agency based on a Medicare contractor's interpretation of the policy as of August 1, 1987, are incorrect. In no case is an unpaid Medicare account which is in collection, including at a collection agency, an allowable bad debt under the regulations.[65]

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[61] 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.

[62] *supra*, note 12

[63] Stipulation ¶ 21 (emphasis added).

[64] Provider Exhibit P-20 at 0198.

[65] Provider Exhibit P-21 at 0201.

The Board notes neither the June 11, 1990 HCFA Memorandum to Regional Administrators nor the May 2, 2008 CMS Joint Signature Memorandum are to be used to set policy.[66] Notwithstanding, the Board finds the June 11, 1990 HCFA Memorandum to Regional Administrators the better interpretation of the Bad Debt Moratorium. This finding is based upon the June 11, 1990 HCFA Memorandum being contemporaneous with the writing of the statute and that it was signed by both the Director of the CMS Bureau of Policy Development and the Director of the CMS Bureau of Program Operations. In contrast, the May 2, 2008 CMS Joint Signature Memorandum was written 18 years later and was signed by the Director of the CMS Chronic Care Policy Group and the Director of the CMS Medicare Contractor Management Group.

The Board notes that the Eighth Circuit decision in *Hennepin* found the June 11, 1990 HCFA Memorandum to Regional Administrators consistent with the Bad Debt Moratorium stating:

> We conclude on this analysis that Congress intended the moratorium to apply only where a provider was in compliance with rules existing on August 1, 1987, as embodied in the regulation, the PRM, and PRRB decisions. The Secretary may not retroactively apply a more stringent interpretation of those existing rule, *nor may she or an intermediary reopen a notice of program reimbursement if the intermediary's interpretation of the existing rules leading to the issuance of the notice was reasonable and based on sufficient information.* FN6 . . .
>
> FN6 Preventing disallowance under the moratorium when an intermediary has accepted a provider's policy based on a reasonable interpretation of the rules in existence on August 1, 1987 is consistent both with the moratorium and the Secretary's interpretation of it. HCFA Memorandum to Regional Administrators, HCFA Clarification of Bad Debt Policy (June 11, 1990) reprinted in Medicare & Medicaid Guide (CCH) p 38,623.[67]

In conclusion, the Board finds that, while the Intermediary's interpretation of the rules and regulations is allowable under the first part of the moratorium, the Intermediary violated the second portion of the moratorium by not continuing to allow the Providers' bad debts based upon the Intermediary's reasonable interpretation of the rules and regulations as of August 1, 1987.

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[66] CMS instructions on the use of JSMs and Technical Direction Letters ("TDLs") specify that JSMs/TDLs are used by CMS to communicate internally with its contractors and, thus, are not issued to the general public. "JSMs/TDLs are typically used to communicate information to ... [CMS contractors] that does not warrant a contractor manual instruction." A JSM/TDL is appropriate for a contract award announcement, an emergency alert, and/or a one-time request for information. CMS "cannot use a JSM/TDL ... [to c]onvey new instructions; or [p]rovide clarification of existing requirements that impact contractor operations" but rather "[i]n these situations, submit a manual instruction through the formal Change Management/Change Request (CR) process." *See* CMS Division of Change & Operations Management of CMS/CMM/Medicare Contractor Management Group, *About Joint Signature Memorandums (JSMs) and Technical Direction Letters (TDLs)*, §§ 1 - 2.2 (May 2010) (only available on the CMS Intranet).

[67] *Hennepin County Medical Center v. Shalala*, 81 F.3d 743, 751 (8th Cir. 1996), ¶47 and fn6 (Emphasis added).

DECISION AND ORDER:

The Intermediary improperly 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 has previously through a reasonable interpretation of the rules and regulations allowed bad debts that were transferred to a collection agency prior to August 1, 1987 and therefore that interpretation is mandated under the Bad Debt Moratorium. The Intermediary's adjustments are reversed.

BOARD MEMBERS PARTICIPATING:

Michael W. Harty
John Gary Bowers, C.P.A.
Clayton J. Nix, Esq.
L. Sue Andersen, Esq.

FOR THE BOARD:

Michael W. Harty
Chairman

DATE: AUG 27 2014

APPENDIX I

Case No.: *09-1065GC*

Sched. of Prov. #	Provider No.	Provider Name	FYE	Intermediary
1	23-0165	St. John Hospital & Medical Center	06/30/2004	NGS
2	23-0165	St. John Hospital & Medical Center	06/30/2005	NGS

Case No.: *09-2172G*

Sched. of Prov. #	Provider No.	Provider Name	FYE	Intermediary
1	22-0171	Lahey Clinic Medical Center	09/30/2005	NGS
2	14-0010	Evanston Hospital	09/30/2006	NGS
3	22-0171	Lahey Clinic Medical Center	09/30/2006	NGS