PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2014-D30

PROVIDER –
HMA 2004-2006 Bad Debt Group Appeals

Provider Nos.: Appendix I

vs.

INTERMEDIARY-
Wisconsin Physicians Service/
Blue Cross and Blue Shield Association

DATES OF HEARINGS -
September 26, 2013 and
November 19, 2013

Cost Reporting Periods Ended –
FYEs 2004, 2005 and 2006

CASE NOs.: 07-2227GC; 07-2762GC;
and 08-1704GC

INDEX

ISSUE:

Whether the Intermediary properly disallowed the Providers' non-indigent debts for fiscal year ends 2004, 2005, and 2006, for not meeting all applicable regulatory requirements.

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

Providers are required to submit cost reports annually, with the reporting period based on the provider's accounting period. A cost report shows the costs incurred during the relevant reporting period and the portion of those costs allocated to the Medicare program.[4] Each intermediary reviews the cost report, determines the total amount of Medicare reimbursement due the provider and issues the provider a Notice of Program Reimbursement ("NPR").[5]

A provider may appeal an intermediary's final determination of total reimbursement (*i.e.*, the NPR) with the Provider Reimbursement Review Board ("Board") provided it meets the following conditions: (1) the provider must be dissatisfied with that final determination of the intermediary; (2) the amount in controversy is $10,000 or more for an individual appeal (or $50,000 for groups); and (3) the appeal must be filed with the Board within 180 days of the receipt of the final determination.[6]

The regulations governing bad debt are located at 42 C.F.R. § 413.89 (2004).[7] Subsection (a) states the general rule that bad debts are deductions from revenue and are not to be included in allowable costs. However, in order to ensure that costs attributable to covered services furnished to Medicare beneficiaries are not borne by individuals who are not covered by the Medicare program, subsection (d) specifies that bad debts attributable to Medicare deductibles and coinsurance are reimbursable as allowable costs. Bad debts must meet the following criteria specified in subsection (e) to be considered allowable:

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[1] In 2001, the agency name was changed from CMS to HCFA. For simplicity, this decision generally will use CMS to refer to the agency.
[2] FIs and MACs are hereinafter referred to as intermediaries.
[3] *See* 42 U.S.C. §§ 1395h and 1395kk-1; 42 C.F.R. §§ 413.20 and 413.24.
[4] *See* 42 C.F.R. § 413.20.
[5] *See* 42 C.F.R. § 405.1803.
[6] *See* 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835 - 405.1837.
[7] Redesignated from 42 C.F.R. § 413.80 at 69 Fed. Reg. 48916, 49254 (Aug. 11, 2004).

(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 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 the Medicare program. 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."

The proper accounting period for recording bad debts and bad debt recoveries is addressed in 42 C.F.R. § 413.89(f):

> The amounts uncollectible from specific beneficiaries are to be charged off as bad debts in the accounting period in which the accounts are deemed to be worthless. In some cases an amount previously written off as a bad debt and allocated to the program may be recovered in a subsequent accounting period; in such cases the income therefrom must be used to reduce the cost of beneficiary services for the period in which the collection is made.[8]

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

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[8] *See also* PRM 15-1 §§ 314, 316.
[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).

> for reasonable costs relating to unrecovered costs associated with unpaid deductible and coinsurance amounts incurred under such title (including criteria for what constitutes a reasonable collection effort, including criteria for indigency determination procedures, for record keeping, and for determining whether to refer a claim to an external collection agency.). The Secretary may not require a hospital to change its bad debt collection policy if a fiscal intermediary, in accordance with the rules in effect as of August 1, 1987, with respect to criteria for indigency determination procedures, record keeping, and determining whether to refer a claim to an external collection agency, has accepted such policy before that date, and the Secretary may not collect from the hospital on the basis of an expectation of a change in the hospital's collection policy.[12]

The dispute in this case involves the Intermediary's denial of bad debt claims, specifically related to the finding by the Intermediary that the Providers did not treat Medicare and non-Medicare debt collection similarly, in violation of Medicare regulations and policy located at 42 C.F.R. § 413.89(e) and PRM 15-1 § 310.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

These three group appeals involve short-term acute care hospitals in multiple states all owned and operated by Health Management Associates ("Providers" or "HMA").[13] The group appeals concern bad debts claimed in fiscal years ending in 2004, 2005, and 2006. For each of the fiscal years at issue, the Providers' designated intermediary, Wisconsin Physicians Service, f/k/a Mutual of Omaha Insurance Company ("Intermediary"), made adjustments to remove the bad debts at issue based on the Providers' use of a secondary collection agency for only their non-Medicare accounts.

The Providers timely appealed the Intermediary's determinations to the Board and met the jurisdictional requirements of 42 C.F.R. §§ 405.1835 – 405.1840. Specifically, HMA filed a request for a Common-Issue Related Party ("CIRP") appeal for each of the Providers in connection with the fiscal years at issue and then requested a transfer of these bad debt issues from the individual appeals to the CIRP appeal. The Board approved the request to establish a CIRP group appeals and the transfer of the individual appeals to these group appeals.

The Providers were represented by Joanne B. Erde, Esq., and Christopher L. Crosswhite, Esq., of Duane Morris LLP. The Intermediary was represented by Arthur E. Peabody, Jr., Esq., of the Blue Cross and Blue Shield Association.

PROVIDERS' CONTENTIONS:

The Providers contend that they satisfied all of the regulatory requirements for claiming bad debts contained in 42 C.F.R. § 413.89(e). The Providers argue they utilized extensive in-house collection efforts followed by collection efforts of three outside collection agencies ("OCAs").

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[12] Reprinted at 42 U.S.C. § 1395f note entitled "Continuation of Bad Debt Recognition for Hospital Services."
[13] *See* Appendix I for Summary of the Providers by CIRP.

The Providers assert that one of the three OCAs would continue collection efforts until the OCA determined that the accounts are uncollectible at which time the accounts would be returned to the Providers. When the uncollected Medicare and non-Medicare accounts were returned by the OCA, the Providers would determine that the accounts (both Medicare and non-Medicare) were uncollectable and that there was no likelihood of collection in the future and would write them off in their accounting records as bad debts based on the following activities of the OCAs:

1. Repeated review of the accounts to determine whether the debtors were bankrupt or deceased;
2. Repeated verification of both the debtors' addresses and phone numbers;
3. Issuance of numerous collection letters demanding payment;
4. Frequent phone calls at all times of the day and in the evening;
5. Reporting of the debts on the debtor's credit reports; and
6. Ruling out pursuit of legal action.

The Providers assert that they used similar collection efforts for Medicare and non-Medicare accounts during the collection process that involved the in-house and OCA efforts and ended when the accounts were returned from the OCAs and written off.[14]

Following the write-off process, the Providers elected to send their non-Medicare bad debts to a secondary collection agency ("SCA"). The Providers believe the activities of the SCA did not meet the criteria for and were not part of the Providers' "reasonable collection effort" as described in PRM 15-1 § 310. In this regard, the Providers maintain that the SCA activities neither were nor resembled an "active" collection effort as outlined in PRM 15-1 § 310. Rather, the SCA reported the debts on each debtor's credit report and took those steps necessary to comply with federal law prior to reporting the account to the credit bureau as delinquent.[15] The Providers assert that OIG reports confirm that a reasonable collection effort is measured by what happens before (rather than after) the write off of bad debts.[16] Likewise, the Providers argue CMS has no authority to limit a Provider's treatment of its unpaid non-Medicare accounts receivable once the reasonable collection effort is complete and the other requirements of 42 C.F.R. § 413.89(e) are met.[17]

Moreover, the Providers assert that the Presumption of Noncollectibility under PRM 15-1 § 310.2 is applicable because the Providers engaged in a reasonable collection effort well in excess of 120 days before sending the non-Medicare accounts to the SCA. The Provider maintains that, contrary to the Intermediary's position, nothing in PRM 15-1 supports requiring all collection efforts to cease before applying the presumption of noncollectibility.[18]

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[14] *See* Providers' Consolidated Post-Hearing Brief at 4-18.
[15] *See id.* at 26-31, 36-42. The Providers assert that the adequacy of the collection effort is supported by the following administrative decisions: *Lourdes Hosp. v. Blue Cross and Blue Shield Ass'n,* HCFA Administrator Dec. (Oct. 27, 1995), *rev'g,* PRRB Dec. No. 1995-58 (Aug. 31, 1995); *Scotland Mem'l Hosp. v. Blue Cross and Blue Shield Ass'n,* HCFA Administrator Dec. (Nov. 8, 1984), *aff'g,* PRRB Dec. No. 1984-D174 (Sept. 12, 1984) ("*Scotland*").
[16] *See* Provider Exhibits PC-30 at 11-12: PC-31 at 10-11.
[17] *See* Providers' Consolidated Post-Hearing Brief at 42- 44.
[18] *See id.* at 31-33.

Similarly, the Providers maintain that the SCA activities do not meet the regulatory requirement that bad debts "are collectible in money in the relatively near future."[19] By the time an account was transferred to the SCA, it had been many months after the services were rendered and, in all likelihood, an account would remain at the SCA for many years without any expectation that there would be any collection in the "relatively near future."[20]

The Providers maintain that, while they sent their unpaid non-Medicare accounts to the SCA, they believed that, based on sound business judgment, these accounts were uncollectible and there was no likelihood of collecting them in the future. The Providers maintain that they made this election to use an SCA for its non-Medicare accounts because: (1) the Providers did not have any other payment source for their non-Medicare bad debts; (2) there was no real cost to the Providers for sending them to an SCA; and (3) through the "warehousing" at the SCA, they might get lucky and the debtor would later have a life change where he/she could pay off the debt.[21]

The Providers' also argue that the Intermediary's actions violated the Bad Debt Moratorium in two ways. First, the Intermediary's reliance on the policy established in 1989 creating a "presumption of collectability" when an account is at a collection agency[22] is prohibited by the Bad Debt Moratorium because that policy was not in existence prior to August 1, 1987. In support of this argument, the Providers cite to 2013 decision of the U.S. District Court for the District of Columbia in *District Hosp. Partners LP v. Sebelius*.[23] Second, the Providers maintain the Bad Debt Moratorium precludes the Intermediary from disallowing the bad debts of those providers who have not changed their bad debt policies since August 1, 1987 and for whom the Intermediary had repeatedly audited the Providers' bad debt claims and allowed most of them.[24]

Even if the "presumption of collectability" policy does not violate the Bad Debt Moratorium, the Providers argue that the policy is inconsistent with regulations that require the exercise of "sound business judgment" rather than a ridged rule.[25] The Providers assert that the policy runs counter to the evidence and is arbitrary as it treats similarly-situated providers differently. Finally, the Providers believe that the policy which requires a Provider to recall its non-Medicare bad debts from an OCA after regulatory criteria are met violates the ban on cross-subsidization.[26]

INTERMEDIARY'S CONTENTIONS:

The Intermediary argues that while the Providers treated all accounts alike during its in-house and OCA efforts, it did not treat them all alike when, following these efforts, it only referred non-Medicare accounts to the SCA. The Intermediary notes that these decisions were made on a

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[19] 42 C.F.R. § 413.89(b)(1).
[20] *See* Providers' Consolidated Post-Hearing Brief at 36-42.
[21] *See id.* at 5, 19-22, 33-35.
[22] *See* Medicare Intermediary Manual, CMS Pub. No. 13-4 ("MIM 13-4"), Transmittal 28 (Sept. 1989) (revising MIM 13-4 § 4198) (copy included at Provider Exhibit PC-14).
[23] 932 F. Supp. 2d 194, 198 (D.D.C. 2013) (referenced in Providers' Consolidated Post-Hearing Brief at 31n.39).
[24] *See* Providers' Consolidated Post-Hearing Brief at 45-54.
[25] 42 C.F.R. §§ 413.89, 412.115(a). The Providers also cite to the HCFA Administrator's 1984 decision in *Scotland.*
[26] 42 U.S.C. § 1395x(v)(1)(A) and 42 C.F.R. § 413.89(d). *See* Providers' Post-Hearing Brief at 54-57.

global basis and not on the attributes of individual Medicare accounts. Therefore a reasonable collection effort was not made because the Providers did not treat Medicare and non-Medicare accounts of similar amounts alike.[27]

The Intermediary asserts the SCA engaged in genuine, legally regulated collection efforts. The Intermediary argues that the Providers' concept of "warehousing" is self-defined and unsupported by the record as not being a "collection process."[28] The Intermediary believes that the Providers' own witnesses' testimony confirm that the SCA engaged in collection activities such as updating addresses and zip codes, determining whether the debtor was bankrupt or deceased, making telephone calls for the purpose of collecting the debt and sending a letter warning "This is an effort to collect a debt."[29]

The Intermediary argues that the presumption of noncollectibility after 120 days contained in PRM 15-1 § 310.2 does not apply here because the Providers had not completed their collection efforts of the non-Medicare accounts. Indeed, the Intermediary asserts that there is a presumption of collectability whenever a debt is at a collection agency. Moreover, the fact that the Providers accepted collection proceeds from the SCA demonstrates that they "collected" the funds. The Intermediary concludes that: "Indeed, the collections demonstrate that the accounts had some value at some point in the future as a result of the providers' decision to refer them to a SCA."[30]

As to the Bad Debt Moratorium, the Intermediary asserts that the Providers fail to prove that the Intermediary accepted (much less reviewed) the alleged collection policy prior the August 1, 1987. The Intermediary further points out that the collection policy in question appears to require *both* Medicare *and* non-Medicare accounts be sent to the SCA as reflected in the following excerpt: "If no action is taken the system will generate a 978 adjustment for all non-Medicare accounts, 985 for Medicare accounts, and transmit the account to the secondary collection agency."[31] The Intermediary cites cases in the U.S. Courts of Appeal for the Sixth, Seventh, Eighth, and Eleventh Circuits that find the Intermediary's issuance of an NPR does not show acceptance of a policy prior to August 1, 1987 under the moratorium.[32] The Intermediary believes the regulatory and manual provisions barring dissimilar treatment of Medicare and non-Medicare bad debt collections predate the moratorium.

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[27] *See* Intermediary's Post Hearing Brief at 27.
[28] *Id.* at 13.
[29] Transcript ("Tr.") at 304- 305 and, 316 (Sept. 26, 2013); Intermediary's Post-Hearing Brief at 13-15. *See also* Provider Exhibit PC-20 (copies of letter issued by the SCA).
[30] *See* Intermediary's Post Hearing Brief at 11-13. In support of its interpretation of PRM 15-1 § 310.2, the Intermediary cites to the following Board decisions: *Mountain States Health Alliance 05 Bad Debt CIRP Group v. BlueCross Blue Shield Ass'n*, PRRB Dec. No. 2013-D06 (Mar. 4, 2013), *declined review*, CMS Administrator (Apr. 24, 2013); *Davie County Hosp. v. Blue Cross and Blue Shield Ass'n,* PRRB Dec. No. 1984-D89 (Mar. 22, 1984), *declined review,* HCFA Administrator (Apr. 18, 1984).
[31] *See* Intermediary's Post Hearing Brief at 15-16. Providers' Exhibits PC-1 at 18 (paragraph 8.8.4.6) and PC-28.
[32] *Detroit Receiving Hospital v. Shalala,* 194 .3d 1312 (6th Cir. 1999); *Mt. Sinai Hosp. Med. Ctr. v. Shalala,* 196 F.3d 703 (7th Cir. 1999); *Hennepin Cty. Med. Ctr. v. Shalala,* 81 F.3d 743 (8th Cir. 1996); *University Health Servs. v. Shalala,* 120 F.3d 220 (11th Cir. 1997).

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After considering the Medicare laws, regulations, program instructions, the evidence presented and the parties' contentions, the Board finds and concludes that the Intermediary's adjustments to remove Medicare bad debts from the Providers' cost reports were proper.

It is undisputed that the Providers treated Medicare accounts and non-Medicare accounts in a similar manner during in-house and primary collection agency efforts. The in-house collection efforts and primary collection agency efforts were expended for more than 120 days. After the in-house and primary outside collection agency efforts were expended, the Providers argue the collection process was complete and all accounts were written-off as bad debts. The Provider asserts that sending *only* the non-Medicare accounts to the SCA was not part of an ongoing collection process and, therefore, should not be used as a basis to disallow otherwise allowable Medicare bad debts.

The Board finds that the intent of the SCA was to collect additional amounts of accounts receivable by placing the non-Medicare accounts with the SCA who updates the patient's credit record, waiting for a potential "life event" to cause the patient to want pay the debt to clear the credit history.[33] The Board finds that the SCA did conduct active collection activities in the form of telephone calls and letters, along with the passive credit record update,[34] and that the SCA collection activities led to recoveries of patients accounts at a rate of 3.5 percent to 6.5 percent.[35] Therefore, the Board finds that the SCA was part of the Providers' customary collection process.

The Providers assert that they did not similarly place Medicare accounts to the SCA because the Providers believed that collection efforts were complete and that there was no likelihood of collecting Medicare accounts receivables under the "life event" logic.[36] As explained below, the Board finds that the dissimilar use of the SCA for non-Medicare versus Medicare patient accounts violates PRM 15-1 § 310 making the Providers' collection process unreasonable.

CMS promulgated regulations at 42 C.F.R. § 413.89(e) to specify the Medicare criteria for allowable bad debts. The criterion at issue in the case is requirement in § 413.89(e)(2) that "[t]he provider must be able to establish that reasonable collection efforts were made." In particular, this case involves the issue of how the use of collection agencies affects the reasonableness of a provider's collection efforts.

In PRM 15-1 § 310, CMS provides guidance on when collection efforts are "reasonable" and addresses the use of collections agencies. A key principle in § 310 for determining whether a provider's efforts to collect Medicare deductible and coinsurance amounts is "reasonable" is that such efforts are "similar" to the provider's efforts to collect "comparable" amounts from non-Medicare patients. As a result, the focus is on whether the provider expends "similar" efforts on "comparable amounts" regardless of patient type. In connection with the use of collection

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[33] *See:* Tr. at 302-314 (Sept. 26, 2013).
[34] *See* Tr. at 304- 305 and, 316 (Sept. 26, 2013); Provider Exhibit PC-20 (copies of letter issued by the SCA Stating "This is an attempt to collect a debt. . . . This is a communication from a debt collector.").
[35] *See* Providers' Consolidated Post Hearing Brief at 22; Provider Exhibit PC-10.
[36] Tr. at 310-311 (Sept. 26, 2013).

agencies, § 310 specifies that, if a provider uses a collection agency, a provider must refer all uncollected patient charges of "like amount" to the agency without regard to whether the patient is Medicare or non-Medicare.

The Board finds that the "similar" efforts requirement is applicable to this case. Based upon the Board's finding that the Providers' use of the SCA did constitute an attempt to make further actual collections on non-Medicare bad debt accounts, the Board concludes that the Providers' collection efforts on Medicare and non-Medicare patient accounts are similar up until the point when only certain active non-Medicare patient accounts are referred to a second collection agency.[37] The Board finds that the dissimilar use of the SCA for non-Medicare versus Medicare patient accounts violates PRM 15-1 § 310 making the Providers' collection process unreasonable. Similarly, the Board finds that the Presumption of Noncollectibility under PRM 15-1 § 310.2 is not applicable because this presumption by its terms is only applicable to a debt "after reasonable *and* customary attempts to collect a bill"[38] and the Providers had not conducted a reasonable collection effort due to the disparate treatment of Medicare and non-Medicare accounts. Further, the Providers had not completed their customary collection efforts because, on its face, the Providers' collection policy required *both* Medicare and non-Medicare accounts to be sent to the SCA as reflected in the following excerpt: "If no action is taken the system will generate a 978 adjustment for all non-Medicare accounts, 985 for Medicare accounts, and transmit the account to the secondary collection agency."[39]

Having found the Providers' sending of only non-Medicare bad debts to the SCA violates PRM 15-1 § 310, the Board turns to whether the Providers obtain relief under 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.[40]

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.

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[37] *See* Tr. at 75-80, 109-110, 112-116 (Sept. 26, 2013); Providers' Consolidated Post Hearing Brief at 4-6.
[38] (Emphasis added.)
[39] *See* Provider Exhibits PC-1 at 18 (¶ 8.8.4.6), PC-28.
[40] *See District Hosp. Partners, L.P v. Sebelius*, 932 F. Supp. 2d 194, 198 (D.D.C. 2013).

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.[41]

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

[41] *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).

> 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.
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> 310.1 Collection Fees.—*Where a provider utilizes the services of a collection agency and the reasonable collection effort described in § 310 is applied*, the fees the collection agency charges the provider are recognized as an allowable administrative cost of the provider.
>
> 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.[42]

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.[43]

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

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

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.[44]

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.[45] 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.

> [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 69 and accompanying text (discussing the relevance of the § 310.1 in interpreting the rest of § 310).

[44] *See* PRM 15-2, Ch. 11, § 1102.

[45] *See* Medicare Intermediary Manual, Part 4, CMS Pub. No. 13-4 ("MIM 13-4"), Ch. 5, § 4499 (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 (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 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).

> 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.[46]

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.[47] In this regard, the Board notes that maintaining a written bad debt collection policy is consistent with 42 C.F.R. §§ 413.20(a) and (d) and 413.24(c) to ensure adequate and sufficient cost information is maintained. Specifically, 42 C.F.R. § 413.20(a) specifies in pertinent part:

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

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

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

The Medicare program's expectation that the provider maintain a policy to memorialize the process for its actual "collection effort" is reflected in the use of the word "customary" in the Presumption of Noncollectibility delineated in PRM 15-1 § 310.2. In order to obtain the benefit of this presumption, a provider must follow its own policies for its "reasonable *and* customary attempts to collect"[48] for more than 120 days prior to writing off a bad debt.

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[46] 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").

[47] *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* 50.

[48] (Emphasis added.)

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).[49] 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."[50] 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."[51]

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[49] 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.

[50] 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).

[51] 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

Based on the above analysis, the Board finds that the policy of not allowing providers to claim bad debts because only non-Medicare accounts were being sent to the secondary 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 prong of the Bad Debt Moratorium. The Board finds the Providers chose to utilize the SCA as part of their "customary collection effort" for non-Medicare bad debt accounts and, as previously discussed, that the SCA did engage in *actual* collection efforts. The fact that the Providers wrote off the debts at issue prior to sending them to the SCA does not mean that the Providers' use of the SCA was not part of the Providers' actual *and* customary "collection effort." The Providers' policy and procedure specifically list the use of the SCA as part of its customary collection effort and, through this referral, the Providers clearly expected and desired some portion of the referred bad debts to be collected,"[52] The record further reflects that the SCA collection activities did result in meaningful collections as the net collection percentages for the SCA ranged from 3.5 percent to 6.5 percent.[53]

The Board recognizes that the Providers' decision to send only non-Medicare bad debts to the SCA 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 similarly, the Providers' decision to incorporate use of the SCA into its customary collection efforts for non-Medicare accounts means that the SCA activities must be incorporated into the "reasonable collection effort" standard being applied to the Providers for Medicare accounts for "like amounts." Therefore, the Board finds the Providers' collection practice does not meet the manual provision that states, "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."[54]

The Board recognizes that the Providers are located in numerous U.S. Circuit Courts of Appeals[55] and that there are decisions in these circuits addressing bad debt issues similar to those before the Board. Accordingly, the Board reviewed the bad debt decisions from the relevant Circuit Courts to determine whether they are applicable.

In the 1997 decision for *University Health Servs. V. Health & Human Servs.*,[56] the 11th Circuit upheld the Secretary's interpretation of PRM 15-1 §§ 310 and 310.2 that "PRM 310.2 [*i.e.*, the Presumption of Noncollectibility] does not come into effect unless the provider has complied with PRM § 310 in treating identically all Medicare and non-Medicare accounts and has ceased collection effort with regard to all accounts after 120 days." In particular, the 11th Circuit stated

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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.

[52] *See* Provider Exhibit PC-1 at 11, 18, 28, 43 (collection policies issued Mar. 1998 and Apr. 2006 showing how secondary collections are posted and how accounts are transmitted to the SCA). *See also* Tr. at 302-314 (Sept. 26, 2013.

[53] *See* Provider Exhibit PC-10; Tr. at 167-169.

[54] PRM 15-1 § 310.

[55] The Providers in this appeal are in the 3rd, 4th, 5th, 6th, 8th, 9th, 10th, and 11th Circuits. *See* Appendix I.

[56] 120 F.3d 1145 (11th Cir. 1997), *cert. denied*, 524 U.S. 904 (1998).

the following regarding the § 310 requirement to treat similarly Medicare and non-Medicare accounts:

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

The 11th Circuit did consider the 1st prong of the Bad Debt Moratorium in rendering this decision and found that the Secretary's interpretation and application of the PRM 15-1 guidelines were not barred by the Bad Debt Moratorium.[57] The Board's findings regarding the Presumption of Noncollectibility are consistent with the 11th Circuit's decision.

In the 2007 decision for *Battle Creek Health Sys. v. Leavitt*,[58] the 6th 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.[59] Although the 6th 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 6th Circuit's decision.

The Board disagrees with the D.C. Court's findings in *Foothill Hosp. v. Leavitt*[60] 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.[61] The Board finds nothing in the Medicare Bad Debt

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[57] *See id.* at 1152-1153.
[58] 498 F.3d 401 (2007).
[59] *Id.* at 411.
[60] 558 F. Supp. 2d 1 (D.D.C. 2008).
[61] 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. 9, 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

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.[62]

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.

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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.

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

> 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.[63]

The Board notes that 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 Board maintains, describing uncollectible bad debts *coming back from* the collection agency to the provider.[64]

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*")[65] 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 this case was that bad debts (both Medicare and nonMedicare) 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*.[66]

Subsequent to the *Foothill* decision, the D.C. District Court upheld the CMS Administrator's finding in *Lakeland Reg'l Health Sys. v. Sebelius*[67] 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."[68] In particular, the Court notes the following:

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[63] (Emphasis added.)

[64] The Board notes that, notwithstanding PRM 15-1 § 310.1, the Board historically has refused to limit the allowabilty 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 on what is needed to establish that a reasonable collection effort was made.

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

[66] 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.

[67] 958 F. Supp. 2d 1(D.D.C. 2013).

[68] *Id.* at 7.

> The Secretary's Policy is encompassed by 42 C.F.R. § 413.89e, 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.[69]

In upholding the Secretary's policy on the use of collection agencies, the 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 Court looked to the 1985 guidelines for the Hospital Audit Program as evidence of this policy in effect prior to the Bad Debt Moratorium.[70]

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.[71]

SECOND PRONG OF THE BAD DEBT MORATORIUM

The Board finds that none of the evidence in this case is sufficient to establish that 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

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

[70] 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 tense ("*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").

[71] 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.

> 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.[72]

The Board finds nothing in the record showing that the Intermediary approved the Providers' policy of only sending non-Medicare bad debt accounts to a secondary collection agency. The Board finds the earliest version of the Providers' accounts receivable policy in the record is dated March 1998 and states: "If no action is taken the system will generate a 978 adjustment for all non-Medicare accounts, 985 for Medicare accounts, and transmit the account to the secondary collection agency."[73] Thus, there is no evidence in the record of what the Providers' policy was prior to October 1, 1987. Even assuming *arguendo* that the March 1998 policy had been in effect prior to October 1, 1987, the Board finds nothing in this policy that would suggest *only* non-Medicare patients were sent to the secondary collection agency. The Board finds that the above excerpt confirms that both Medicare and non-Medicare accounts would have been transferred to the secondary collection agency prior to August 1, 1987 had this policy been in effect prior to October 1, 1987 and been followed.

Both the Providers and the Intermediary submitted audit workpapers to support past bad debt practices.[74] The Board finds nothing in these exhibits that supports the Providers' argument that the Intermediary had accepted the Providers' process of not sending non-Medicare accounts to a secondary collection agency prior to August 1, 1987 because none of the workpapers were dated prior to October 1, 1987. In fact, the earliest workpaper is from 1996. Further, the Board finds the workpapers only indicate either that the collection process was the same or that, if a difference was noted, the bad debts were disallowed.

DECISION AND ORDER:

The Intermediary properly disallowed the Providers' non-indigent debts for fiscal years ending in 2004, 2005, and 2006, for not meeting "similar" collection effort requirement within the reasonable collection effort requirements. 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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[72] *supra*, note 12
[73] Providers Exhibit PC-1 at 18, ¶8.8.4.6.
[74] Provider Exhibit PC-34 through PC-37; Intermediary Exhibit I-22, I-24.

FOR THE BOARD:

Michael W. Harty
Chairman

DATE: SEP 25 2014

Appendix I

SUMMARY OF THE PROVIDERS BY CIRP

MODEL FORM G: REVISED SCHEDULE OF PROVIDERS IN GROUP

Group Name: HMA 2004 Bad Debt Group Appeal **Page 1 of 2**

Representative: Joanne B. Erde, Esq., Duane Morris LLP **Date Prepared: 05/27/09**

Case Number (if known): 07-2227G

Issue: Whether the Intermediary erred in disallowing the Providers' Part A and Part B bad debts for services rendered to Medicare Beneficiaries.

	Provider Number	Provider Name/Location (city, county, state)	FYE	Intermediary	A Date of Final Determination	B Date of Appeal	C No. of Days	D Audit Adj. No.	E Amount of Reimbursement	F Original Case No.	G Date(s) of Add/ Transfer
1.	42-0010	Carolina Pines Regional Medical Center Hartsville, Darlington County, South Carolina	09/30/04	Mutual of Omaha Insurance Company	10/13/06	04/03/07	172	9, 12	$419,000	07-1683	06/27/07
2.	34-0129	Lake Norman Regional Medical Center Mooresville, Iredell County, North Carolina	09/30/04	Mutual of Omaha Insurance Company	09/22/06	03/13/07	172	15, 22	$585,000	07-1125	06/27/07
3.	39-0061	Lancaster Regional Medical Center Lancaster, Lancaster County, Pennsylvania	06/30/04	Mutual of Omaha Insurance Company	09/20/06	03/13/07	174	32	$227,000	07-1133	06/27/07

MODEL FORM G: REVISED SCHEDULE OF PROVIDERS IN GROUP

Group Name: HMA 2004 Bad Debt Group Appeal

Representative: Joanne B. Erde, Esq., Duane Morris LLP

Date Prepared: May 28, 2009

Case Number (if known): 07-2227G

Issue: Whether the Intermediary erred in disallowing the Providers' Part A and Part B bad debts for services rendered to Medicare Beneficiaries.

	Provider Number	Provider Name/Location (city, county, state)	FYE	Intermediary	A Date of Final Determination	B Date of Appeal	C No. of Days	D Audit Adj. No.	E Amount of Reimbursement	F Original Case No.	G Date(s) of Add/ Transfer
4.	18-0078	Paul B. Hall Regional Memorial Center Paintsville, Johnson County, Kentucky	09/30/04	Mutual of Omaha Insurance Company	09/01/06	02/26/07	178	12, 15	$182,000	07-0935	06/27/07
5.	25-0096	Rankin Medical Center Brandon, Rankin County, Mississippi	12/31/04	Mutual of Omaha Insurance Company	09/22/06	03/12/07	171	30	$105,000	07-1126	06/26/07 12/13/07
6.	51-0077	Williamson Memorial Hospital Williamson, Mingo County, West Virginia	09/30/04	Mutual of Omaha Insurance Company	08/23/06	02/16/07	176	15, 18	$270,000	07-0869	05/30/07 06/27/07

Group Name: HMA 2005 Bad Debt Group Appeal Page 1 of 9

Representative: Joanne B. Erde, Esq., Duane Morris LLP Date Prepared: 05/27/09

Case Number (if known): 07-2762G Issue: **Whether the Intermediary erred in disallowing the Providers' Part A and Part B bad debts for services rendered to Medicare Beneficiaries.**

	Provider Number	Provider Name/Location (city, county, state)	FYE	Intermediary	A Date of Final Determination	B Date of Appeal	C No. of Days	D Audit Adj. No.	E Amount of Reimbursement	F Original Case No.	G Date(s) of Add/ Transfer
1.	25-0007	Biloxi Regional Medical Center Biloxi, Harrison County, Mississippi	09/30/05	Mutual of Omaha Insurance Company	01/26/07	07/13/07	168	8	295,000	07-2390	09/11/07
2.	42-0010	Carolina Pines Regional Medical Center Hartsville, Darlington County, South Carolina	09/30/05	Mutual of Omaha Insurance Company	02/12/07	07/27/07	165	17, 22	515,000	07-2477	09/11/07
3.	LEFT BLANK INTENTIONALLY										
4.	10-0047	Charlotte Regional Medical Center Punta Gorda, Charlotte County, Florida	09/30/05	Mutual of Omaha Insurance Company	06/13/07	12/07/07	177	21, 24, 25, 33	381,000	08-0375	02/19/08
5.	34-0144	Davis Regional Medical Center Statesville, Iredell	09/30/05	Mutual of Omaha Insurance	03/12/07	08/13/07	154	33, 37, 38	280,000	07-2644	09/11/07 09/20/07

MODEL FORM G: SCHEDULE OF PROVIDERS IN GROUP

Group Name: HMA 2005 Bad Debt Group Appeal **Page 2 of 9**

Representative: Joanne B. Erde, Esq., Duane Morris LLP **Date Prepared:**

Case Number (if known): 07-2762G **Issue: Whether the Intermediary erred in disallowing the Providers' Part A and Part B bad debts for services rendered to Medicare Beneficiaries.**

Provider Number	Provider Name/Location (city, county, state)	FYE	Intermediary	A Date of Final Determination	B Date of Appeal	C No. of Days	D Audit Adj. No.	E Amount of Reimbursement	F Original Case No.	G Date(s) of Add/ Transfer
	County, North Carolina		Company							
6. 11-0075	East Georgia Regional Medical Center Statesboro, Bulloch County, Georgia	09/30/05	Mutual of Omaha Insurance Company	02/07/07	07/27/07	170	19, 21	381,000	07-2479	09/11/07
7. 34-0036	Franklin Regional Medical Center Louisberg, Franklin County, North Carolina	09/30/05	Mutual of Omaha Insurance Company	06/15/07	12/06/07	174	10, 14	261,000	08-0373	02/19/08
8. 34-0106	Hamlet Hospital Hamlet, Richmond County, North Carolina	09/30/05	Mutual of Omaha Insurance Company	08/24/07	02/15/08	175	11, 12, 15, 20, 23	601,000	08-1272	04/23/08

MODEL FORM G: SCHEDULE OF PROVIDERS IN GROUP

Group Name: HMA 2005 Bad Debt Group Appeal **Page 3 of 9**

Representative: Joanne B. Erde, Esq., Duane Morris LLP **Date Prepared:**

Case Number (if known): 07-2762G **Issue: Whether the Intermediary erred in disallowing the Providers' Part A and Part B bad debts for services rendered to Medicare Beneficiaries.**

	Provider Number	Provider Name/Location (city, county, state)	FYE	Intermediary	A Date of Final Determination	B Date of Appeal	C No. of Days	D Audit Adj. No.	E Amount of Reimbursement	F Original Case No.	G Date(s) of Add/ Transfer
9.	44-0144	Harton Regional Medical Center Tullahoma, Coffee County, Tennesse	05/31/05	Mutual of Omaha Insurance Company	09/21/07	03/06/08	167	34	198,000	08-1416	04/23/08
10.	10-0137	Heart of Florida Regional Medical Center Davenport, Polk County, Florida	06/30/05	Mutual of Omaha Insurance Company	09/11/07	02/26/08	168	23, 29	367,000	08-1222	03/31/08
11.	10-0049	Highlands Regional Medical Center Sebring, Highlands County, Florida	09/30/05	Mutual of Omaha Insurance Company	06/15/07	12/07/07	175	12, 17,	197,000	08-0372	02/19/08

MODEL FORM G: SCHEDULE OF PROVIDERS IN GROUP

Group Name: HMA 2005 Bad Debt Group Appeal **Page 4 of 9**

Representative: Joanne B. Erde, Esq., Duane Morris LLP **Date Prepared:**

Case Number (if known): 07-2762G **Issue: Whether the Intermediary erred in disallowing the Providers' Part A and Part B bad debts for services rendered to Medicare Beneficiaries.**

	Provider Number	Provider Name/Location (city, county, state)	FYE	Intermediary	A Date of Final Determination	B Date of Appeal	C No. of Days	D Audit Adj. No.	E Amount of Reimbursement	F Original Case No.	G Date(s) of Add/ Transfer
12.	34-0129	Lake Norman Regional Medical Center Mooresville, Iredell County, North Carolina	09/30/05	Mutual of Omaha Insurance Company	06/19/07	12/06/07	170	15, 18	219,000	08-0374	02/19/08
13.	39-0061	Lancaster Regional Medical Center Lancaster, Lancaster County, Pennsylvania	06/30/05	Mutual Omaha Insurance Company	03/12/07	08/13/07	154	48, 54, 55	309,000	07-2654	09/11/07 09/20/07
14.	49-0012	Lee Regional Medical Center Pennington Gap, Lee County, Virginia	09/30/05	Mutual of Omaha Insurance Company	06/15/07	11/01/07	139	12	120,000	08-0163	12/12/07
15.	10-0107	Lehigh Regional Medical Center Lehigh Arces, Lee County, Florida	12/31/05	Mutual of Omaha Insurance Company	09/13/07	03/06/08	175	12, 16	160,000	08-1422	04/23/08

MODEL FORM G: SCHEDULE OF PROVIDERS IN GROUP

Group Name: HMA 2005 Bad Debt Group Appeal **Page 5 of 9**

Representative: Joanne B. Erde, Esq., Duane Morris LLP **Date Prepared:**

Case Number (if known): 07-2762G **Issue: Whether the Intermediary erred in disallowing the Providers' Part A and Part B bad debts for services rendered to Medicare Beneficiaries.**

	Provider Number	Provider Name/Location (city, county, state)	FYE	Intermediary	A Date of Final Determination	B Date of Appeal	C No. of Days	D Audit Adj. No.	E Amount of Reimbursement	F Original Case No.	G Date(s) of Add/ Transfer
16.	10-0150	Lower Keys Medical Center Key West, Monroe County, Florida	09/30/05	Mutual of Omaha Insurance Company	08/27/07	02/15/08	172	11, 15	153,000	08-1273	04/23/08
17.	25-0038	Madison Regional Medical Center Canton, Madison County, Mississippi	12/30/05	Mutual of Omaha Insurance Company	08/30/07	02/15/08	169	16, 25	57,000	08-1271	04/23/08
18.	37-0014	Medical Center of Southeast Oklahoma Durant, Bryan County, Oklahoma	09/30/05	Mutual of Omaha Insurance Company	08/28/07	02/06/08	162	15, 24, 26	323,000	08-1207	03/31/08
19.	49-0027	Mountain View Regional Medical Center Norton, Norton City, Virginia	12/31/05	Mutual of Omaha Insurance Company	05/22/07	11/01/07	163	18, 21	55,000	08-0165	12/12/07

MODEL FORM G: SCHEDULE OF PROVIDERS IN GROUP

Group Name: HMA 2005 Bad Debt Group Appeal Page 6 of 9

Representative: Joanne B. Erde, Esq., Duane Morris LLP Date Prepared:

Case Number (if known): 07-2762G Issue: Whether the Intermediary erred in disallowing the Providers' Part A and Part B bad debts for services rendered to Medicare Beneficiaries.

	Provider Number	Provider Name/Location (city, county, state)	FYE	Intermediary	A Date of Final Determination	B Date of Appeal	C No. of Days	D Audit Adj. No.	E Amount of Reimbursement	F Original Case No.	G Date(s) of Add/ Transfer
20.	25-0122	Natchez Community Hospital Natchez, Adam County, Mississippi	09/30/05	Mutual Omaha Insurance Company	03/05/07	08/14/07	162	14, 16	230,000	07-2642	09/11/07 09/20/07
21.	25-0042	Northwest Mississippi Regional Medical Center Clarksdale, Coahoma County, Mississippi	12/31/05	Mutual Omaha Insurance Company	03/02/07	08/13/07	164	29, 30	254,000	07-2647	09/11/07 09/20/07
22.	18-0078	Paul B. Hall Regional Medical Center Paintsville, Johnson County, KY	09/30/05	Mutual Omaha Insurance Company	09/12/07	03/04/08	174	16, 23	241,000	08-1221	09/02/08
23.	25-0096	Rankin Medical Center Brandon, Rankin County, Mississippi	12/31/05	Mutual Omaha Insurance Company	05/29/07	11/01/07	156	25	109,000	08-0164	12/12/07

MODEL FORM G: SCHEDULE OF PROVIDERS IN GROUP

Group Name: HMA 2005 Bad Debt Group Appeal **Page 7 of 9**

Representative: Joanne B. Erde, Esq., Duane Morris LLP **Date Prepared:**

Case Number (if known): 07-2762G **Issue: Whether the Intermediary erred in disallowing the Providers' Part A and Part B bad debts for services rendered to Medicare Beneficiaries.**

	Provider Number	Provider Name/Location (city, county, state)	FYE	Intermediary	A Date of Final Determination	B Date of Appeal	C No. of Days	D Audit Adj. No.	E Amount of Reimbursement	F Original Case No.	G Date(s) of Add/ Transfer
24.	25-0138	River Oaks Hospital Jackson, Rankin County, MS	12/31/05	Mutual of Omaha Insurance Company	03/07/07	08/13/07	159	18	132,000	07-2648	09/11/07 09/20/07
25.	10-0124	Santa Rosa Medical Center Milton, Santa Rosa County, Florida	05/31/05	Mutual of Omaha Insurance Company	03/01/07	08/13/07	165	12	128,000	07-2640	09/11/07 09/17/07
26.	10-0217	Sebastian River Medical Center Sebastian, Indian River County, Florida	09/30/05	Mutual of Omaha Insurance Company	03/02/07	08/14/07	165	9	150,000	07-2643	09/11/07 09/20/07
27.	10-0249	Seven Rivers Regional Medical Center Crystal River, Citrus County, Florida	05/31/05	Mutual of Omaha Insurance Company	09/12/07	03/04/08	174	15, 19	243,000	08-1220	03/31/08

MODEL FORM G: SCHEDULE OF PROVIDERS IN GROUP

Group Name: HMA 2005 Bad Debt Group Appeal **Page 8 of 9**

Representative: Joanne B. Erde, Esq., Duane Morris LLP **Date Prepared:**

Case Number (if known): 07-2762G **Issue: Whether the Intermediary erred in disallowing the Providers' Part A and Part B bad debts for services rendered to Medicare Beneficiaries.**

	Provider Number	Provider Name/Location (city, county, state)	FYE	Intermediary	A Date of Final Determination	B Date of Appeal	C No. of Days	D Audit Adj. No.	E Amount of Reimbursement	F Original Case No.	G Date(s) of Add/ Transfer
28.	04-0021	Southwest Regional Medical Center Little Rock, Pulaski County, AR	12/31/05	Mutual of Omaha Insurance Company	09/14/07	03/06/08	174	18, 21, 25	136,000	08-1420	04/23/08
29.	01-0038	Stringfellow Memorial Hospital Anniston, Calhoun County, Alabama	06/30/05	Mutual of Omaha Insurance Company	08/02/07	01/21/08	172	16, 17, 20, 21	33,000	08-0689	02/25/08
30.	50-0037	Toppenish Community Hospital Toppenish, Yakima County, Washington	06/30/05	Mutual of Omaha Insurance Company	03/05/07	08/14/07	162	16	26,000	07-2641	09/11/07 09/20/07
31.	44-0193	University Medical Center Lebanon, Wilson County, TN	10/31/05	Mutual of Omaha Insurance Company	03/07/07	08/13/07	159	23, 25	158,000	07-2646	09/11/07 09/20/07

MODEL FORM G: SCHEDULE OF PROVIDERS IN GROUP

Group Name: HMA 2005 Bad Debt Group Appeal **Page 9 of 9**

Representative: Joanne B. Erde, Esq., Duane Morris LLP **Date Prepared:**

Case Number (if known): 07-2762G **Issue: Whether the Intermediary erred in disallowing the Providers' Part A and Part B bad debts for services rendered to Medicare Beneficiaries.**

	Provider Number	Provider Name/Location (city, county, state)	FYE	Intermediary	A Date of Final Determination	B Date of Appeal	C No. of Days	D Audit Adj. No.	E Amount of Reimbursement	F Original Case No.	G Date(s) of Add/ Transfer
32.	51-0077	Williamson Memorial Hospital Williamson, Mingo County, West Virginia	09/30/05	Mutual of Omaha Insurance Company	08/30/07	02/15/08	169	15, 17	274,000	08-1270	04/23/08

SCHEDULE OF PROVIDERS IN GROUP

Group Name: HMA 2006 Bad Debt Group Appeal

Representative: Duane Morris LLP

Date Prepared: October 29, 2009; Revised December 23, 2009

Case Number (if known): 08-1704G

Issue: Whether the Intermediary erred in disallowing the Providers' Part A and Part B bad debts for services rendered to Medicare Beneficiaries.

I					A	B	C	D	E	F	G
	Provider Number	Provider Name	Fiscal Year End	Intermediary	Date of Final Determination	Date of Hearing Request	No. of Days	Audit Adj. No.	Approx. Amount	Original Case No.	Date of Case Transfer
1.	11-0045	Barrow Regional Medical Center	12/31/06	Blue Cross and Blue Shield of Georgia	05/02/08	10/30/08	181	15, 17	90,969	09-0307	01/09/09
2.	10-0121	Bartow Regional Medical Center	03/31/06	Mutual of Omaha Insurance Company	09/20/07	03/06/08	168	9, 13	58,000	08-1419	03/31/08 04/23/08
3.	25-0007	Biloxi Regional Medical Center	09/30/06	Mutual of Omaha Insurance Company	02/05/08	07/18/08	164	26	267,000	08-2305	10/28/08
4.	10-0071	Brooksville Regional Medical Center	09/30/06	Mutual of Omaha Insurance Company	12/26/07	06/17/08	174	12, 15	185,000	08-2118	07/22/08

					A	B	C	D	E	F	G
	Provider Number	Provider Name	Fiscal Year End	Intermediary	Date of Final Determination	Date of Hearing Request	No. of Days	Audit Adj. No.	Approx. Amount	Original Case No.	Date of Case Transfer
5.		Left Blank Intentionally									
6.	42-0010	Carolina Pines Regional Medical Center	09/30/06	Mutual of Omaha Insurance Company	09/11/07	02/26/08	168	12, 15	433,000	08-1345	03/31/08 04/23/08
7.	25-0072	Central Mississippi Medical Center	03/31/06	Mutual of Omaha Insurance Company	08/29/07	02/15/08	170	35	466,000	08-1269	03/31/08 04/23/08
8.	42-0019	Chester Regional Medical Center	09/30/06	Wisconsin Physicians Service	02/04/08	07/18/08	165	22, 28	124,000	08-2299	10/28/08
9.	34-0144	Davis Regional Medical Center	09/30/06	Wisconsin Physicians Service	02/01/08	07/18/08	168	26, 31	184,000	08-2290	12/11/08
10.	11-0075	East Georgia Regional Medical Center	09/30/06	Mutual of Omaha Insurance Company	02/12/08	07/18/08	157	15, 22	221,000	08-2302	10/28/08
11.	10-0024	Fishermen's Hospital	09/30/06	Mutual of Omaha Insurance Company	01/18/08	07/10/08	174	12, 16	62,000	08-2358	10/28/08

					A	B	C	D	E	F	G
	Provider Number	Provider Name	Fiscal Year End	Intermediary	Date of Final Determination	Date of Hearing Request	No. of Days	Audit Adj. No.	Approx. Amount	Original Case No.	Date of Case Transfer
12.	34-0036	Franklin Regional Medical Center	09/30/06	Mutual of Omaha Insurance Company	02/19/08	07/18/08	150	9, 14	124,000	08-2301	10/28/08
13.	25-0025	Gilmore Regional Medical Center	12/31/06	Wisconson Physicians Service	03/28/08	09/19/08	175	13, 16	45,443	08-2841	09/19/08
14.	44-0144	Harton Regional Medical Center	05/31/06	Mutual of Omaha Insurance Company	09/17/07	03/06/08	171	10, 13	110,000	08-1415	03/31/08 04/23/08
15.	10-0137	Heart of Florida Regional Medical Center	06/30/06	Mutual of Omaha Insurance Company	09/18/07	03/06/08	170	10, 14	368,000	08-1413	03/31/08 04/23/08
16.	39-0068	Heart of Lancaster Regional Medical Center	06/30/06	Mutual of Omaha Insurance Company	08/16/07	01/23/08	160	8	103,000	08-0690	03/31/08
17.	10-0049	Highlands Regional Medical Center	09/30/06	Mutual of Omaha Insurance Company	02/07/08	07/18/08	162	13, 16	221,000	08-2303	10/28/08
18.	34-0129	Lake Norman Regional Medical Center	09/30/06	Wisconsin Physicians Service	03/13/08	09/04/08	175	13, 16	92,000	08-2836	09/04/08

	Provider Number	Provider Name	Fiscal Year End	Intermediary	A Date of Final Determination	B Date of Hearing Request	C No. of Days	D Audit Adj. No.	E Approx. Amount	F Original Case No.	G Date of Case Transfer
19.	39-0061	Lancaster Regional Medical Center	06/30/09	Wisconsin Physicians Service	05/09/08	11/03/08	178	39	149,676	09-0265	11/03/08
20.	10-0107	Lehigh Regional Medical Center	12/31/06	Wisconsin Physicians Service	04/30/08	10/14/08	167	12, 17	145,402	09-0077	10/14/08
21.	10-0150	Lower Keys Medical Center	09/30/06	Mutual of Omaha Insurance Company	02/22/08	07/18/08	147	21, 26, 36	160,000	08-2297	10/28/08
22.	25-0038	Madison Regional Medical Center	12/31/06	Mutual of Omaha Insurance Company	01/17/08	07/10/08	175	17	37,000	08-2357	10/28/08
23.	45-0031	Medical Center of Mesquite	03/31/06	TrailBlazer Health Enterprises, LLC	02/29/08	07/21/08	143	15, 17, 22	739,000	08-2310	10/17/08
24.	37-0014	Medical Center of SE Oklahoma	09/30/06	Mutual of Omaha Insurance Company	02/22/08	07/18/08	147	12, 20	208,000	08-2300	10/28/08
25.	45-0688	Mesquite Community Hospital	12/31/06	Wisconsin Physicians Service	03/20/08	09/11/08	175	18	386,000	08-2802	09/11/08

					A	B	C	D	E	F	G
	Provider Number	Provider Name	Fiscal Year End	Intermediary	Date of Final Determination	Date of Hearing Request	No. of Days	Audit Adj. No.	Approx. Amount	Original Case No.	Date of Case Transfer
26.	37-0094	Midwest City Regional Hospital	06/30/06	Mutual of Omaha Insurance Company	01/10/08	06/17/08	159	19, 23, 28	284,000	08-2115	07/22/08
27.	49-0027	Mountain View Regional Medical Center	12/31/06	Mutual of Omaha Insurance Company	02/22/08	07/18/08	147	16, 20	142,000	08-2298	10/28/08
28.		Left Blank Intentionally									
29.	25-0042	Northwest Mississippi Regional Medical Center	12/31/06	Wisconsin Physicians Service	05/08/2008	11/03/08	179	22	199,327	09-0264	11/03/08
30.	10-0211	Pasco Regional Medical Center	09/30/06	Wisconsin Physicians Service	08/01/08	01/09/09	161	13, 20	56,080	09-0577	01/09/09
31.	10-0077	Peace River Regional Medical Center	12/31/06	Wisconsin Physicians Service	04/25/08	10/14/08	172	17, 27	433,145	09-0081	10/14/08
32.	26-0119	Poplar Bluff Regional Medical Center	12/31/06	Wisconsin Physicians Service	10/14/08	03/30/09	166	20, 24, 25	283,218	09-1427	04/08/09

	Provider Number	Provider Name	Fiscal Year End	Intermediary	A Date of Final Determination	B Date of Hearing Request	C No. of Days	D Audit Adj. No.	E Approx. Amount	F Original Case No.	G Date of Case Transfer
33.	25-0096	Rankin Medical Center	12/31/06	Wisconsin Physicians Service	04/21/08	10/13/08	175	5,	176,359	09-0080	10/13/08
34.	25-0081	Riley Memorial Hospital	12/31/06	Wisconsin Physicians Service	03/20/08	09/11/08	175	16, 19, 26	219,000	08-2800	09/11/08
35.	01-0046	Riverview Regional Medical Center	06/30/06	Mutual of Omaha Insurance Company	05/01/07	10/22/07	174	3, 4, 18	390,000	08-0101	10/28/08
36.	10-0124	Santa Rosa Medical Center	05/31/06	Mutual of Omaha Insurance Company	09/21/07	03/11/08	172	16, 19	174,000	08-1392	03/31/08 04/23/08
37.	10-0217	Sebastian River Medical Center	09/30/06	Mutual of Omaha Insurance Company	02/22/08	07/18/08	147	10, 13	402,000	08-2296	10/28/08
38.	10-0249	Seven Rivers Regional Medical Center	05/31/06	Mutual of Omaha Insurance Company	09/18/07	03/06/08	170	16, 19, 25	288,000	08-1423	03/31/08 04/23/08
39.	04-0021	Southwest Regional Medical Center	12/31/06	Mutual of Omaha Insurance Company	05/08/08	11/03/08	179	20,25, 33	139,449	09-0263	01/09/09

					A	B	C	D	E	F	G
	Provider Number	Provider Name	Fiscal Year End	Intermediary	Date of Final Determination	Date of Hearing Request	No. of Days	Audit Adj. No.	Approx. Amount	Original Case No.	Date of Case Transfer
40.	01-0038	Stringfellow Memorial Hospital	06/30/06	Mutual of Omaha Insurance Company	08/22/07	02/09/08	171	11, 17	195,000	08-1206	03/31/08
41.	50-0037	Toppenish Community Hospital	06/30/06	Mutual of Omaha Insurance Company	10/19/07	04/01/08	165	16	18,000	08-1703	04/23/08
42.	26-0015	Twin Rivers Regional Medical Center	12/31/06	Wisconsin Physicians Service	05/19/08	11/06/08 11/12/08	171	19, 22, 28, 33	51,022		
43.	44-0193	University Medical Center	10/31/06	Wisconsin Physicians Service	03/04/08	08/13/08	162	24, 29, 45	117,000	08-2745	01/09/09
44.	10-0070	Venice Regional Medical Center	12/31/06	Mutual of Omaha Insurance Company	02/01/08	07/18/08	168	6	125,500	08-2307	10/28/08
45.	11-0046	Walton Regional Medical Center	09/30/06	Mutual of Omaha Insurance Company	02/06/08	07/18/08	163	15, 20	222,000	08-2304	10/28/08

					A	B	C	D	E	F	G
	Provider Number	Provider Name	Fiscal Year End	Intermediary	Date of Final Determination	Date of Hearing Request	No. of Days	Audit Adj. No.	Approx. Amount	Original Case No.	Date of Case Transfer
46.	51-0077	Williamson Memorial Hospital	09/30/06	Wisconsin Physicians Service	03/10/08	09/04/08	178	18	244,000	08-2837	09/04/08
47.	25-0136	Woman's Hospital at River Oaks	12/31/06	Wisconsin Physicians Service	03/19/08	09/10/08	175	14	20,000	08-2801	09/10/08
48.	50-0012	Yakima Regional Medical Center	06/30/06	Mutual of Omaha Insurance Company	11/21/07	05/02/08	163	1, 25, 26	135,000	08-1944	07/22/08