CENTERS FOR MEDICARE AND MEDICAID SERVICES

Decision of the Administrator

In the case of:	**Claim for:**
St. John Health 2004-2005 Bad Debt Moratorium CIRP Group Hall Render 2005-2006 Bad Debt Moratorium Group **Provider**	**Provider Reimbursement Determination for Cost Reporting Periods Ending: 2004-2006**
vs.	**Review of:**
BlueCross BlueShield Association/ Highmark Medicare Services Wisconsin Physicians Service **Intermediary**	**PRRB Dec. No. 2014-D19** **Dated: August 27, 2014**

This case is before the Administrator, Centers for Medicare & Medicaid Services (CMS), for review of the decision of the Provider Reimbursement Review Board (Board). The review is during the 60-day period set forth in §1878(f) (1) of the Social Security Act (Act), as amended, 42 U.S.C. §1395oo (f)). The parties were notified of the Administrator's intention to review the Board's decision. The Providers submitted comments, requesting affirmation of the Board's decision. The Intermediary submitted comments requesting reversal of the Board's decision. Accordingly, this case is now before the Administrator for final administrative review.

ISSUE AND THE BOARD'S DECISION

The issue is whether the Intermediary properly disallowed the Providers' bad debts solely on the ground that accounts related to such bad debts were still pending at outside collection agencies.

The Board, reversing the Intermediary's adjustment, held that the Intermediary improperly disallowed the Providers' bad debts in this case. The Board found that that the Providers properly claimed uncollectible Medicare accounts as bad debts even though those accounts were still held at a collection agency. The Board determined that the Providers had a bad debt policy and procedure wherein the

Providers utilized in-house collection efforts together with external referral of accounts to an outside collection agency. If the Providers determined that the account was uncollectible after completion of the in-house collection efforts for a period of 120 days, the Providers wrote-off the uncollected amount as a bad debt, but still referred the account to an outside collection agency where it remained unless eventually collected. The Board noted the Intermediary's argument that the referral to the outside collection agency had the affect of extending the collection effort and, thus, the debts were not worthless when the Providers wrote them off. However, the Board found there is no explicit requirement that collection efforts must cease before accounts can be deemed uncollectible. The Board concluded that, the practice of the Providers of writing-off uncollected accounts after 120 days as bad debts, and then still referring those accounts to an outside collection agency, is allowed by and is consistent with Medicare law and policy. The Board referred the decision of the District Court of the District of Columbia in *Foothill Hospital-Morris L. Johnston Memorial v. Leavitt*[1] in support of its decision. The Board also found that CMS' policy applying the presumption of collectability to any bad debt held at an outside collection agency violates of the bad debt moratorium.[2]

Further, the Board noted that, if a provider recovers amounts previously allowed as bad debts, the reimbursable costs in the period of recovery are reduced by the amounts recovered and, such recovery will, to the benefit of the program, reduce allowable bad debts in the period of recovery. The Board determined that the term "uncollectible" within the meaning of the regulatory provision means no payments have been received or are expected to be made on an account based on the experience of the provider and its sound business judgment. The mere "active" status of an account with an outside collection agency does not automatically constitute proof of collectability. A presumption of collectability arising from an account's "open" or "active" status at an outside collection agency is contrary to the reality of the collection business processes and the regulatory provision at 42 C.F.R. §413.89(e). As providers do not control the decision-making processes of outside collection agencies, an account that is actually worthless and uncollectible could languish as an open or active account with an outside collection agency on an indefinite basis should Providers fail to continue to pursue collection efforts.

---

[1] *See Foothill Hospital vs. Leavitt* 558 F.Supp. 2d 1 (D.D.C. 2008).

[2] Omnibus Budget Reconciliation Act of 1987, Pub.L. No. 100-203, § 4008(c), 101 Stat. 1330-55, as amended by the Technical Miscellaneous Revenue Act of 1988, Pub.L. No. 100-647, § 8402, 102 Stat. 3798, and as further amended by the Omnibus Budget Reconciliation Act of 1989, Pub.L. No. 101-239, § 6023, 103 Stat. 2176 (*reprinted in* 42 U.S.C. §1395f).

SUMMARY OF COMMENTS

The Intermediary commented, requesting reversal of the Board's decision. The Intermediary argued that by placing the debts at a collection agency and by not requesting their return prior to placing them on a cost report, the Providers have demonstrated that the debts were not yet deemed worthless and as such there was some likelihood of a recovery. Because the debts were not worthless when placed on the respective cost reports, the Providers cannot meet the criteria at 42 C.F.R. §413.89(e)(3) and (4).

The Providers commented, requesting affirmation of the Board's decision. The Providers argued that the Board correctly determined, based on Foothill[3], that CMS' policy was contrary the bad debt moratorium. The Provider stated that the intermediary in prior years had allowed bad debt claim reimbursement even when accounts were pending at an outside collection agency. Even under a narrow view of the bad debt moratorium focusing on prior experience of the Providers with their intermediary, the bad debt moratorium would still prohibit the adjustments in this case. The presumption of collectability did not exist prior to its placement in the 1989 Medicare Reimbursement Manual. The Provider also argued that a clarification memorandum dated June 11, 1990, prohibiting accounts pending at an outside collection agency to be claimed as bad debts was issued three years after the institution of the bad debt moratorium.[4] Because the presumption of collectability did not exist prior to August 1, 1987, the Board correctly determined that the bad debt moratorium prohibits this presumption from being applied to the Providers in this case. Finally, the Providers asserted that there is no explicit requirement that accounts pending at an outside collection agency have to be returned for those accounts to be claimed as bad debts under the bad debt regulatory criteria. [5]

DISCUSSION

---

[3] See note 7 supra.

[4] See, Providers' Pos. Paper (Oct. 6, 2008), Provider Exhibit No. P-20.

[5] The Centers of Medicare (CM) also commented requesting Administrator review in this case. However, as the Provider pointed out, the comments were one day late. Accordingly, the Administrator did not consider them, nor have they been included in the record. The CM comments were not ex parte, on their face, as they indicated on the original copies that a copy was provided to all parties. In addition, if the parties did not receive a copy from CM, due to oversight, any inadvertent ex parte communication was cured when the Administrator also attached a pdf copy in an email to the parties as a courtesy.

The entire record, which was furnished by the Board, has been examined, including all correspondence, position papers, and exhibits. The Administrator has reviewed the Board's decision. All comments received timely are included in the record and have been considered.

Section 1861(v)(1)(A) of the Social Security Act requires that providers of services to Medicare beneficiaries are to be reimbursed the reasonable cost of those services. Reasonable cost is defined as the "cost actually incurred, excluding there from part of the incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included …" Id. This component of Medicare law and policy does not specifically address the determination of reasonable cost, but authorizes the Secretary to promulgate regulations and principles to be applied in determining reasonable costs. One of the underlying principles set forth in the Act is that Medicare shall not pay for costs incurred by non-Medicare beneficiaries, and vice-versa. Medicare prohibits cross-subsidization of costs. These reasonable cost principles are reflected and further explained in the regulations. The regulations at 42 C.F.R. §413.9(c) provides that the determination of reasonable cost must be based on costs related to the care of Medicare beneficiaries.

In addition section 1815(a) of the Act states:

> (a) The Secretary shall periodically determine the amount which should be paid under this part to each provider of services with respect to the services furnished by it, and the provider of services shall be paid, at such time or times as the Secretary believes appropriate …, from the Federal Hospital Insurance Trust Fund, the amounts so determined, with necessary adjustments on account of previously made overpayments or underpayments; except that no such payments shall be made to any provider unless it has furnished such information as the Secretary may request in order to determine the amounts due such provider under this part for the period with respect to which the amounts are being paid or any prior period.

Consistent with section 1815(a) of the Social Security Act, the Secretary has implemented a number of Medicare documentation regulations, including those at 42 CFR §§413.9, 413.20 and 413.24, which require, *inter alia*, that a provider

furnish contemporaneous, auditable, and verifiable documentation in support of a claim for payment.[6]

Relevant to this case, the regulation at 42 C.F.R. §413.89(a) specifically provides that bad debts are reductions in revenues and are not included in allowable costs.[7] However, the regulatory provision at 42 C.F.R. §413.89(a) further provides that bad debts attributable to the deductible and coinsurance amounts of Medicare beneficiaries are reimbursed under the Medicare program.

Generally, bad debts are defined at 42 C.F.R. §413.89(b)(1) as "Amounts considered to be uncollectible from accounts and notes receivable that were created or acquired in providing services." Furthermore, "Accounts receivable" and "notes receivable" are designations for claims arising from the furnishing of services, and are collectible in money in the relatively near future. The regulatory provision at 42 CFR § 413.89(d) states that payment for deductibles and coinsurance amounts are the responsibility of the beneficiaries. However, recognizing the reasonable costs principle at Section 1861(v)(1)(A) of the Act which prohibits cross subsidization, the regulation at 42 CFR 413.89 states that the inability of providers to collect deductibles and coinsurance amounts from the Medicare beneficiaries could result in part of the costs of Medicare covered services being borne by individuals who are not beneficiaries. Therefore, to prevent such cross-subsidization, Medicare reimburses providers for allowable bad debts. Consequently, providers may receive reimbursement for Medicare bad debt, if they meet all of the criteria set forth in 42 C.F.R. §413.89(e).

> A bad debt 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.
> <u>3) The debt was actually uncollectible when claimed as worthless.</u>
> <u>4) Sound business judgment established that there was no likelihood of recovery at any time in the future.</u>[8] (Emphasis added).

In addition, 42 CFR 413.89(f) provides that:

---

[6] The Administrative Procedure Act provides that the proponent of any action has the burden of proof. 5 U.S.C. §556(d).
[7] Formerly designated as 42 C.F.R. §413.80.
[8] *See also* Section 308 of the PRM.

> (f) Charging of bad debts and bad debt recoveries. <u>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</u>. 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. (Emphasis added.)

The Provider Reimbursement Manual (PRM) provides guidance in implementing the regulations. Relevant to the issue in this case, section 310 of the Manual states:

> 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.

Section 310.A of the Manual further explains:

> 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 practice may include using or threatening to use court action to obtain payment.

A provider is required to demonstrate that it has completed collection efforts for comparable Medicare and non-Medicare accounts, including outside collection, before claiming Medicare debts as worthless. The PRM basically reflects the view that a means of measuring the reasonableness of a hospital's efforts to collect Medicare accounts is to compare them to the action the hospital takes when its own money, rather than the government's is at stake. The foregoing similar collection effort requirement must be met separate from section 310.2 of the PRM, which provides that:

> 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.

Section 314 explains the accounting period for bad debts and states that:

> Uncollectible deductibles and coinsurance amounts are recognized as allowable bad debts in the reporting period in which the debts are determined to be worthless. Allowable bad debts must be related to specific amounts which have been determined to be uncollectible. Since bad debts are uncollectible accounts receivable and notes receivable, the provider should have the usual accounts receivable records-ledger cards and source documents to support its claim for a bad debt for each account included. Examples of the types of information to be retained may include, but are not limited to, the beneficiary's name and health insurance number; admission/discharge dates for Part A bills and dates of services for Part B bills; date of bills; date of write-off; and a breakdown of the uncollectible amount by deductible and coinsurance amounts. This proposed list is illustrative and not obligatory.(Emphasis added.)

Section 316 also explains the treatment of the recovery of bad debts stating that:

> Amounts included in allowable bad debts in a prior period might be recovered in a later reporting period. Treatment of such recoveries under the program is designed to achieve the same effect upon reimbursement as in the case where the amount was uncollectible. Where the provider was reimbursed by the program for bad debts for the reporting period in which the amount recovered was included in allowable bad debts, reimbursable costs in the period of recovery are reduced by the amounts recovered. However, such reductions in reimbursable costs should not exceed the bad debts reimbursed for the applicable prior period. Where the provider was not reimbursed by the program for bad debts for the reporting period in which the amount recovered was included in allowable bad debts, reimbursable costs in the period of recovery are not reduced.

Consistent with the Act, the Secretary has also issued guidelines for intermediaries to follow when auditing cost reports. The Intermediary Manual (CMS Pub 13-4) explains that Medicare bad debts for deductible and coinsurance are reimbursed as a pass-through cost. Since they have a direct dollar for dollar effect on

reimbursement, there is an incentive to claim bad debts before they become worthless. The Intermediary Manual (Pub 13-4) audit instructions for both IPPS and TEFRA audits set forth at sections 4198 and 4199, provide that:

> If the bad debt is written-off on the provider's books 121 days after the date of the bill and then turned over to a collection agency, the amount cannot be claimed as a Medicare bad debt on the date of the write-off. It can be claimed as a Medicare bad debt only after the collection agency completes its collection effort.[9]

---

[9] *See* Section 4198, Exhibit A-11, which addresses IPPS audits and section 4199 Exhibit B-11, which addresses TEFRA audits. While Transmittal No. 28 was issued September 1989, the Administrator finds that it was transmitting established policy, in particular with respect to IPPS and TEFRA pass-through reasonable cost reimbursement issues such as bad debts. The Transmittal No. 28 was transmitting new policy with respect to some IPPS issues. For example, regarding the "effective date" of the transmittal, the transmittal states that for "New Policy", the "Effective Date" was "For Prospective Payment System (PPS) cost report audits performed after 10/12/89", and does not refer to cost reporting periods. Consistent with that, the IPPS Exhibit A shows certain "new policies" to be implemented for IPPS cost reporting periods beginning on or after January 1985. The transmittal also was transmitting established policy. The transmittal explicitly stated that the IPPS Exhibits "identify the most significant *and or recurring issues*..... Included in these Guidelines are reimbursement issues directly affecting PPS payments", while TEFRA audits (Section 4199 p 2-75) stated: "These exhibits represent areas where significant and *recurring adjustments often exists*."

Notably, the TEFRA bad debts audit guidelines are identical to the IPPS bad debt pass through reasonable cost audit guidelines and the transmittal states "Section 4199, TEFRA Review Guidelines—Various exhibits are updated or clarified in accordance with reimbursement principles. Audit in accordance with the quality standards in section 4112." (Moreover, many hospital complexes are paid under IPPS but have TEFRA units both of which may have bad debts.) Section 4117 in addressing TEFRA Review Guidelines, specifically references the time periods for applying TEFRA Exhibits A (Section 4199-Exhbit A-p 3-76) and TEFRA Exhibits B 2-77, et seq.. Section 4117 explains that the TEFRA review guidelines shown in TEFRA Exhibit B are provided as mandated review areas "which you must address in the review of the first year TEFRA cost reporting period. …During other TEFRA years, you have flexibility in audit areas."

Transmittal No 19, dated September 1985 added pages 2-31-2-42 involving Section 4118 "Prospective Payment System (PPS) Hospital Audit Guidelines." Transmittal

In sum, at the close of each fiscal year, the provider prepares a report showing its costs and the percentage of those costs allocated to Medicare services. The provider, after using reasonable collection efforts, may claim Medicare bad debts in the cost report during "the accounting period in which the accounts are deemed to be worthless." The cost report serves as the basis for the provider's total allowable Medicare reimbursement. The provider files the report with a fiscal intermediary under contract with the Secretary. The intermediary audits certain aspects of the cost report (which may vary year to year on focus and detail of audit) and issues a written "notice of program reimbursement" which determines the total amount reimbursable payable to the provider for Medicare services during the reporting period. 42 CFR §405.1803.

Relevant to certain Medicare bad debt claims, section 4008(c) of the Omnibus Reconciliation Act of 1987 (OBRA),"[10] as amended by the section 8402 of the Technical and Miscellaneous Revenue Act of 1988, and section 6023 of OBRA 1989 imposed a "moratorium" on changes to the Medicare bad debt policy in effect on August 1, 1987, as applied to hospitals. Specifically, the moratorium states, in part that:

> In making payments to hospitals under [the Medicare Program], 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 [the Medicare program] to providers of service for reasonable costs relating to unrecovered costs associated with unpaid deductible and coinsurance amounts incurred under [the Medicare program] (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 <u>if a fiscal intermediary, in accordance with the rules in effect as of August 1, 1987</u>, 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

---

No 19 dated February 1987 (Rev 19) revised section 4118, 4198 Exhibits and 4199 Exhibits. Transmittal No. 19 removed section 4118.2 (*see* Provider Exhibit 19.)

[10] *See* Pub. L. No. 100-203.

> the basis of an expectation of a change in the hospital's collection policy. (Emphasis added.)

In addition, the Conference Report accompanying the 1988 legislative amendment states that, "the conferees do not intend to preclude the Secretary from disallowing bad debt payments based on the regulations, PRRB decisions, manuals, and issuances in effect prior to August 1, 1987."

CMS issued additional guidance, by a Joint Signature Memorandum dated May 2, 2009, to clarify longstanding policy concerning reimbursement for a Medicare bad debt while the account is at a collection agency. As a result of this instruction, Medicare contractors are required to disallow Medicare bad debts for accounts at a collection agency where the contractor may heretofore have allowed those bad debts in the past based at least in part on interpretation of language contained in the OBRA 1987. The guidance again emphasized that the longstanding policy of Medicare is that in no case is an unpaid Medicare account that is "in collection", including a collection agency, an allowable bad debt under the regulations. To the extent any Intermediary might have allowed Medicare bad debts for an account at a collection agency, then the application of the policy was not in accordance with the "rules in effect" as of August 1, 1987."[11]

In this case, the issue is whether the Intermediary properly denied reimbursement for unpaid Medicare beneficiaries' coinsurance and deductible amounts claimed after 120 days from the date the first bill was mailed but which were still remaining at an outside collection agency.

The Intermediary denied the claims which were still active with the collection agency. The Administrator agrees with the Intermediary's disallowance of the bad debts in this case on that basis. Section 310.2 of the PRM permits a debt unpaid for more than 120 days from the date the first bill is mailed to the beneficiary to be deemed uncollectible. However, the Administrator notes that the language of that section implies discretionary rather than mandatory application of the presumption,

---

[11] This issuance was also in response to a May 2, 1990 CMS memorandum clarifying bad debt policy related to accounts at a collection agency. The memorandum properly articulated Medicare longstanding policy that when an account is in collection, a provider cannot have determined the debt to be collectible and cannot have established that there is no likelihood of recovery. However, in light of the Moratorium, the memorandum erroneously stated that it may have been reasonable for an intermediary to interpret that such claims were allowable prior to 1987. That analysis failed to consider that such an interpretation would not have been in accord with the rules in effect as of August 1, 1987.

i.e., the debt "may" rather than "shall" be deemed uncollectible. More importantly, that provision must be read consistent with the regulation and manual provisions and thus cannot absolve the Providers from meeting the general regulatory reasonable collection requirements or the specific reasonable collection requirements in the PRM. To meet the requirements embodied at 42 C.F.R. §413.89(e)(2) through (4), a provider must engage in a reasonable collection effort and must demonstrate that the debts were uncollectible when claimed as worthless and that sound business judgment evidences no likelihood of recovery at any point in the future. CMS policy has reasonably held that when a provider sends uncollected amounts to a collection agency, the provider cannot establish reasonable collection efforts have been made, the debt was actually uncollectible when claimed as worthless and that there is no likelihood of recovery.

Further, since Medicare bad debts have a direct dollar for dollar effect on reimbursement, there is an incentive to claim bad debts before they become worthless. If a provider continues to attempt collection of a debt, either through in-house or a collection agency, it is reasonable to conclude that the provider still considers that debt to have value and that it is not worthless. Thus, the Administrator finds it reasonable to expect a provider to demonstrate that it has completed its collection effort, including outside collection, before claiming debts as worthless.

The Administrator also notes that section 316 of PRM provides only an instruction, in the event that a Medicare bad debt is subsequently recovered, for reporting such revenue and its reimbursement effect. This is a provision to prevent double dipping by the Provider at the expense of the Program. The Administrator finds that the language of the manual section in no way infers that the Medicare program expects or even anticipates, providers to continue to pursue collection activities after claiming Medicare bad debts on their cost reports. The fact a debt recovered will be offset does not replace the reasonable collection effort requirement. If a provider deems a debt uncollectible after reasonable collection efforts, and, thus worthless, a provider would not be expected to pursue further collection activities. However, if a provider does continue to pursue collection activities, clearly it does not believe the debt to be worthless. The Board suggested this provision makes harmless any premature claiming of unpaid amounts as bad debts, as later collected amounts are offset. However, once the debt is allowed there is no longer any incentive to continue to make collection efforts. Consequently, the Administrator concludes that, under longstanding Medicare law and policy, if a Provider continues collection efforts at an outside collection agency, then the Provider has not complied with the regulatory criteria set forth at 42 C.F.R. §413.89(e)(3) and (4) and the provisions of Chapter 3 of the PRM.

Finally, the Administrator disagrees with the conclusions of the Board that the Bad Debt Moratorium was applicable in this case. First, CMS has always required that a provider demonstrate that its collection efforts were reasonable and, therefore, there has been no change in CMS policy.[12] Moreover, CMS has always required similar treatment between unpaid Medicare and non-Medicare claims and that if a provider sends unpaid non-Medicare debts to a collection agency, it must send Medicare unpaid coinsurance and deductibles of comparable amounts. In such instances, the Medicare unpaid amounts may not be claimed until collection activity has ceased for both the Medicare and comparable non Medicare amounts. Implicit in that requirement is that the bad debts cannot be claimed until collection efforts have ceased for all comparable amounts, for both Medicare and non-Medicare.[13] To suggest that, as long as the Provider conforms to this requirement of sending both Medicare and non-Medicare accounts to collection agency, it can immediately claim the Medicare debts while collection activities continue nullifies the effects, intent and purpose of section 310.A. It would be meaningless to require similar treatment, while concurrently allowing the provider to write-off the unpaid coinsurance and deductibles while the accounts are sill at the collection agency. Thus, the issue presented in this case is as a logical result of applying the policy set forth in section 310.A of the PRM.[14]

---

[12] For example, in *Humana Hospital*, PRRB Dec. No 92-D41 (FYE 1987), the Administrator reversed the Board's bad debt allowance, where the provider had claimed bad debts at 120 days, sent all bad debts at first to a collection agency but later only had the Medicare debts returned and non-Medicare bad debts sent to a second collection agency. *University Hospital*, PRRB Dec. No. 95-D43 (FYE 1987); *Hennepin County Medical Center*, PRRB Dec. No. 93-D83 (FYE 12/31/1987).

[13] As the court recognized in *University Hospital*, 120 F.3 rd 1145 (11 th Cir. 1997), PRM section 310.2 "does not come into effect unless the provider has complied with PRM section 310 in treating identically all Medicare and non-Medicare accounts *and has ceased collection efforts* with regard to all accounts after 120 days." (Emphasis added.)

[14] The provides in *El Centro Regional Medical Center v. Leavitt*, Case No. 07cv 1182 WQH (PCL), (S.D. Cal Nov. 24, 2008), also recognized this relationship when it argued: "Plaintiff asserts that the Secretary's requirement that non-Medicare bad debts must be returned from a collection agency in order for the provider to obtain reimbursement for its Medicare bad debts is contrary to the law, regulations, and Manual provisions that govern Medicare reimbursement. Plaintiff further asserts that if the Secretary's intent is that the adjudication in this case be considered part of an ongoing policy that Medicare bad debts can never be recovered when comparable non-Medicare bad debts remain at an outside collection agency, the decision is invalid as a violation of the notice and comment requirements of the Administrative Procedure Act and the Medicare program."

To the extent that any Administrator decision cannot be distinguished and has expressed policy that deviated from the existing policy stated above, it was erroneous and contrary to the moratorium and the rules in effect on August 1, 1987.[15]

Moreover, to invoke a further analysis under the moratorium criteria, a provider must demonstrate that its policy was to claim payment for these same types of bad debts and that prior to August 1, 1987, the Intermediary had in fact explicitly accepted that policy. This must be done consistent with Medicare documentation rules, which requires verifiable, auditable documentation contemporaneous with the pre-1987 conduct. Hence, declarations or testimony, alone, of the hospital's bad debts policy/practice and the intermediary's acceptance therein, would not be sufficient evidence to support a further analysis of whether the moratorium applies. Past cases that were decided on the moratorium issue relied upon extensive evidence provided by pre-August 1, 1987 contemporaneous hospital bad debt policy manuals, pre-August 1, 1987 dated notices of program reimbursements, audit adjustments and evidence of the degree of the intermediary's "investigation and audit" of cost reports prior to August 1, 1987. While a stipulation was submitted in this case, a stipulation cannot be binding if it might allow payment contrary to the law. In this case, a general stipulation alone is not sufficient to meet the complex evidentiary and legal

[15] See, e.g., *Methodist Hospital of Dyersburg*, PRRB Dec. No 200-D56 (FYE 1992); *Scotland Memorial Hospital*, PRRB Dec. No 84-D174, was factually different and involved a 1981 cost year when legal threats against beneficiaries were not thought to be allowed. The Administrator also recognizes an Administrator decision involving some facts treated contrary to this policy in *Lourdes Hospital*, PRRB Dec Nos. 95-D58, 95-D59, 95-D60. In *Lourdes*, the provider explained, that during the periods under appeals collection efforts ceased and the claims at issue were never in fact collected; "[t]herefore, even if the Board adopts the Intermediary's interpretation of the manual instruction, the provider argues that it should be reimbursed its costs in the subsequent cost reporting period for those Medicare debts which were never collected." In essence, the provider was arguing that if a revised bad debt list were provided applying the rules in effect the amounts would have been allowable in the periods being jointly appealed. Also of note, the Intermediary, inter alia, used a ratio method, (because of the lack of accurate provider data on recoveries), that estimated the recovery amounts to be applied and resulted in higher amounts being offset, in certain instances, than the amount originally claimed on the cost report and also included the amounts disallowed. Consequently, Lourdes provided unique facts involving multiple consolidated cost years and anomalous recovery amount determinations.

standards that would require payment under the moratorium.[16] Consequently, were it necessary to decide the case based upon the resolution of this issue, a remand would be needed for further fact finding.[17] However, in this instance, even assuming, *arguendo*, that a provider showed that it had a policy and practice of claiming unpaid Medicare accounts while still pending at the collection agency and that the Intermediary had accepted explicitly this treatment of unpaid coinsurance and deductible amounts prior to the institution of the bad debt Moratorium, the bad debt Moratorium still does not require payment in this case. The bad debt Moratorium applies only if an intermediary's prior acceptance of a provider's bad debt policy was "in accordance with the rules in effect as of August 1, 1987." Because the long-standing policy of the Medicare program is to not reimburse accounts held at an outside collection agency, the Moratorium prohibition would not apply.

Consequently, the Administrator finds that the Providers claimed the unpaid Medicare coinsurance and deductible amounts as bad debts while still pending at the collection agencies and concludes that, under longstanding Medicare law and policy, if a Provider continues collection efforts at an outside collection agency, then the Provider has not complied with the regulatory criteria set forth at 42 C.F.R. §413.89(e)(3) and (4) and the provisions of Chapter 3 of the PRM.

---

[16] See Stipulation Paragraph No. 21 "In the Providers' 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."

[17] See, e.g., Intermediary Comments, dated October 2, 2014, raising issues with the underlying facts regarding this Stipulation Paragraph 21 regarding the Providers' past bad debt policy, practice and the level of the Intermediary "acceptance" of the practice, including the level of audits, etc.

DECISION

The Board's decision is reversed in accordance with the foregoing opinion.

THIS CONSTITUTES THE FINAL ADMINISTRATIVE DECISION OF THE SECRETARY OF HEALTH AND HUMAN SERVICES

Date: 10/23/14 /s/

Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services