PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

Hearing on the Record
2018-D18

PROVIDER –
Mountain States Health Alliance 05 Bad Debt – Passive Collection CIRP Group

Provider Nos.: 44-0176 and 44-0063

vs.

MEDICARE CONTRACTOR –
Cahaba Government Benefits Administrators, LLC

DATE OF HEARING -
November 22, 2016

Cost Reporting Periods Ended -
June 30, 2004; June 30, 2005

CASE NO.: 08-0105GC

INDEX

Page No.

ISSUE STATEMENT:

Whether the Providers engaged in "reasonable collection efforts" notwithstanding their differential treatment of Medicare and non-Medicare bad debt, in light of the *Reed City*[1] and *St. Francis*[2] Board decisions?

DECISION

After considering the Medicare law and regulations, the parties' contentions and the evidence submitted, the Provider Reimbursement Review Board ("Board") has applied the more flexible pre-moratorium approach as used in *Reed City* and *St. Francis* as directed on remand and finds that the Providers did not engage in "reasonable collection efforts." Therefore, the Medicare Contractor properly removed the bad debts from cost reporting periods ending June 30, 2004 and June 30, 2005.[3]

INTRODUCTION

This group appeal involves Johnson City Medical Center, an acute care hospital located in Johnson City, Tennessee and Indian Path Medical Center, an acute care hospital located in Kingsport, Tennessee (collectively referred to as "Providers"). Both Providers are owned by the same parent company, Mountain States Health Alliance ("Mountain States"). The Providers challenge the Medicare Contractor's removal of Medicare bad debts. The appeal is before the Board on remand from the U.S. District Court for the District of Columbia. The Providers were represented by Daniel J. Hettich, Esq., King & Spalding, LLP. The Medicare Contractor was represented by Peter Garasimchuk, Federal Specialized Services.

STATEMENT OF FACTS AND RELEVANT LAW

Medicare bad debts are unpaid costs attributable to the deductible and coinsurance amounts of Medicare beneficiaries.[4] Bad debts are reimbursable under the Medicare Program if they meet the following criteria:

> (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.[5]

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[1] *Reed City Hosp. v. BCBSA/BCBS of Mich.*, PRRB Dec. No. 86-D67 (Feb. 20, 1986).
[2] *St. Francis Hosp. & Med. Ctr. v. BCBSA/Kan. Hosp. Servs. Ass'n, Inc.*, PRRB Dec. No. 86-D21 (Nov. 12, 1985).
[3] *See* Schedule of Providers (attached) which lists the two Providers and the three FYEs at issue.
[4] 42 U.S.C. § 413.89(d).
[5] *See* 42 U.S.C. § 413.89(e).

The Provider Reimbursement Manual, CMS Pub. 15, Part 1 ("PRM 15-1") § 310 further interprets the concept of "reasonable collection efforts" in (2) above as follows:

> 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.)
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> 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 a "presumption of noncollectibility." Specifically, § 310.2 states 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."

Congress enacted several statutory provisions during the time period of 1987 through 1989 which have essentially "frozen" Medicare bad debt reimbursement policy as it was prior to August 1, 1987. These provisions known as the "Bad Debt Moratorium" ended on October 1, 2012.[6] The Bad Debt Moratorium prohibits the Secretary of the Department of Health and Human Services ("Secretary") from making any change in policy which was in effect on August 1, 1987, and it specifically states:

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[6] Pub.L. No. 112–96, tit. III, § 3201(d), 126 Stat. 192.

> …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 such title (including criteria for what constitutes a reasonable collection effort, including criteria…for determining whether to refer a claim to an external collection agency). The Secretary may not require a hospital to change its debt collection policy if a fiscal intermediary, in accordance with the rules in effect as of August 1, 1987, with respect to criteria for…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.[7]

In its initial decision in this case, *Mountain States Health Alliance 05 Bad Debt – Passive Collection CIRP Grp. v. BlueCross BlueShield Ass'n/Cahaba Gov't Benefits Adm'rs, LLC*,[8] the Board concluded that the Medicare Contractor properly removed certain Medicare bad debts from the Providers' cost reports. Its decision was based upon the Provider Reimbursement Manual ("PRM") 15-1 § 310 requirement that in order "[t]o 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."[9]

Specifically, the Board found that "[a]fter the in-house and primary outside collection agency efforts were expended, the Providers applied different collection efforts between Medicare and non-Medicare accounts."[10] The Board reasoned that the Providers' decision not to refer Medicare accounts to a secondary collection agency because it viewed these accounts on the whole difficult to collect while, at the same time, deciding not to refer certain non-Medicare accounts based on the specific attribute of each individual account such as bankruptcy, death, incarceration, or charitable status[11] did not comply with the regulatory requirements for a reasonable collection effort.[12] The Board further found in defining reasonable collection effort PRM § 310 "does not place at time limit (e.g. 360 days) on the requirement for expending "similar" efforts on "comparable" amounts to the extent a provider makes a business decision to continue collection efforts."[13]

The Providers subsequently filed suit in Federal District Court, which found that the regulatory "reasonable collection efforts" requirement does not "compel" the Board's interpretation.[14] The Court vacated the Board's decision, concluding that its inflexible interpretation of section 310 represented an impermissible change from the more flexible pre-Moratorium policy reflected in

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[7] Omnibus Budget Reconciliation Act of 1987 ("OBRA"), Pub.L. No. 100-203, tit. IV, §4008(c), 101 Stat. 1330 - 55, (reprinted in 42 U.S.C. § 1395f note).
[8] PRRB Dec. No. 2013-D6 (Mar. 4, 2013).
[9] *Id.* at 10.
[10] *Id.* at 8.
[11] *Id. See also* Administrative Record ("AR") at 12, 15, 81, 86, 95.
[12] PRRB Dec. No. 2013-D6 (Mar. 4, 2013) at 12.
[13] *Id.*
[14] *Mountain States Health Alliance v. Burwell*, 128 F. Supp.3d 195, 210 (2015).

the *Reed City* and *St. Francis* cases.[15] The Court pointed out that in both the *Reed City* and *St. Francis* cases the providers referred non-Medicare bad debt to collection agencies, but not Medicare bad debt. In both of these cases, the Board determined the Medicare Contractor should have allowed payment for these bad debts as the providers made "reasonable collection efforts."[16]

THE *REED CITY* CASE

In *Reed City Hosp. v. BCBSA/BCBS of Mich.*, PRRB Dec. No. 86-D67 (Feb. 20, 1986) ("*Reed City*"), the provider's collection policy included:

1) obtaining deposits from patients;
2) attempting to collect all deductibles at the time of admission;
3) evaluating patients' capability to pay;
4) determining Hill-Burton eligibility;
5) establishing procedures to collect billings within 90 days; and
6) sending unpaid accounts to a small claims court or a collection agency if not paid within 90 days.[17]

Only non-Medicare bad debts were sent to the collection agency, and the Medicare Contractor in that case denied reimbursement of Medicare bad debts based upon the "reasonable collection effort" requirement of PRM 15-1 § 310.

The record in *Reed City* includes documentation that the provider, after the audit, began forwarding its delinquent Medicare patient accounts to the collection agency with virtually insignificant results.[18]

Based on facts and uncontroverted evidence submitted in this case, the Board concluded that the provider's collection policies reflect that it maintained reasonable collection efforts on Medicare accounts deemed uncollectible…",[19] and the Board concluded that "[t]he [p]rovider's collection efforts are reasonable…"[20]

THE *ST. FRANCIS* CASE

In *St. Francis Hosp. & Med. Ctr. v. BCBSA/Kan. Hosp. Servs. Ass'n, Inc.*, PRRB Dec. No. 86-D21 (Nov. 12, 1985) ("*St. Francis*"), the provider's collection efforts for all accounts involved sending out a bill three (3) days after a patient was discharged, and every thirty (30) days thereafter for six (6) months. Thereafter, the Medicare accounts were written off and the non-Medicare accounts were turned over to a collection agency. The record shows St. Francis referred its FYE 1983 and 1984 Medicare accounts to a collection agency, but no amounts were

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[15] *Id at* 220.
[16] *Id.* at 218.
[17] *Reed City Hosp. v. BlueCross BlueShield Ass'n/BlueCross BlueShield of Mich.*, PRRB Dec. No. 86-D67 (Feb. 20, 1986) at 2.
[18] *Id.* at 1
[19] *Id.* at 4.
[20] *Id.*

recovered from Medicare beneficiaries for the 1983 fiscal year. The provider contended that these poor collection results justified its action for not referring FYEs 1980, 1981, and 1982 to a collection agency.

The Board found in *St. Francis* that substantial evidence demonstrated the provider's collection efforts for Medicare bad debts met the "reasonable collection efforts" requirement. The Board noted it was reasonable to write off bad debts when their pursuit would be too costly, and it accepted the zero recovery results of the collection agency for 1983 as proof that there was negligible likelihood of recovery for these Medicare bad debts.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

The Mountain States Providers claim they have engaged in "reasonable collection efforts" for these bad debts under the standards evidenced in the *Reed City* and *St. Francis* cases. The Providers contend that they referred their non-Medicare bad debt to secondary collection agencies, but claimed Medicare bad debt without referral because the prospect of recovery of the Medicare bad debt was negligible.[21]

The Providers argue that their collection efforts irrefutably exceeded the criteria for reasonable collection efforts established in *Reed City* and *St. Francis* and their efforts were therefore reasonable. They point out that they engaged in approximately 180 days of in-house collection efforts for both Medicare and non-Medicare accounts. Once in-house collection efforts were completed, the unpaid accounts were sent to an outside "primary" collection agency. The outside primary collection agency would continue pursuing the account until no payment was received for 180 days. There was no differentiation between Medicare and non-Medicare patient during this period.

At the end of 360 days of unsuccessful in-house and primary collection efforts, the collection agency deemed the debts uncollectible and returned to the Providers which then claimed them as bad debts. These returned, uncollectible accounts included Medicare accounts for which no payment had been received and as well as non-Medicare accounts such as bankruptcies, incarcerations, deaths, and charity status. Those debts which held future collection potential (debts for younger people whose financial ability to pay may be temporary) were forwarded to a secondary collection agency.[22]

The Providers state that their collection efforts were two to three times longer than those collection efforts established in *Reed City* and *St. Francis* and their efforts were therefore reasonable. Additionally, the Providers point out that they subjected their Medicare accounts to 180-days of outside collection efforts while the providers in *Reed* City and *St. Francis* did not utilize outside collection efforts at all for their Medicare accounts (noting that the Secretary in *St. Francis* found that using only in-house collection efforts was "reasonable").[23]

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[21] Providers' Brief Following Reopening of Appeal (July 18, 2016) at 1.
[22] *Id.* at 2-3.
[23] Providers' Brief Following Reopening of Appeal (July 18, 2016) at 7-8.

The Providers point to the *St. Francis* case (addressing 1980-1982 fiscal years), asserting that the Board found negligible likelihood of recovery of Medicare bad debts because outside collection agency efforts on accounts for 1983 did not recover any amounts. Likewise the Providers point out in *Reed City* the virtually insignificant results of collection agency efforts for later fiscal years corroborated a negligible recovery rate for Medicare bad debts. The Providers' in this appeal claim they are similar to *Reed City* and *St. Francis* because they submitted evidence from subsequent periods showing the continued pursuit of Medicare bad debts at a secondary collection agency would yield negligible results (less than three cents on the dollar).[24]

Finally, the Providers argue that the non-Medicare accounts that they sent to the secondary collection agency had balances of approximately $3000--six times larger than the average Medicare account balance of $514. Their ligation costs, they argue, were at least $187.50 plus attorney fees per account which demonstrates that the pursuit of the Medicare debt would "be too costly" to be worthwhile.[25]

In reviewing these cases the Board identified several distinguishing factors between the Mountain States case and aforementioned *Reed City* and *St. Francis* cases. First the Board in *Reed City* and *St. Francis* accepted the "insignificant" and "zero" collections in subsequent years as proof that use of a collection agency was ineffective and too costly for Medicare accounts. By contrast, the in Mountain State Providers collected over $246,000 related to Medicare accounts at the secondary collection agency.[26]

While Mountain States' witness testified that most Medicare patients' Social Security income is exempt from garnishment and that high litigation costs made it infeasible to pursue further collection through a secondary collection agency,[27] the evidence in the record shows the cost to collect the $246,000 of Medicare debts by the secondary collection agency was slightly over $100,000.[28] Therefore the Board finds that Mountain States has failed to prove that its secondary collection cost exceeds the amount collected on Medicare debt or that it is too costly to refer *any* Medicare debts.

Further, Mountain States' witness testified that the collection rate on a Medicare account as compared to a non-Medicare account is the same if not more.[29] It would be reasonable, therefore, that a provider would refer both Medicare and non-Medicare accounts of comparable value to the secondary collection agency as these accounts would all have the same likelihood of being collected. However, the record shows that the Provider has chosen not to refer Medicare accounts to the secondary collection agency at all.[30] PRM 15-1 § 310 does not allow a provider to base its debt collection activities on class of patient as these Providers have done.[31]

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[24] *Id.* at 9-10.
[25] *Id.* at 13.
[26] AR 99 and 168.
[27] AR 97.
[28] AR 99 and 168.
[29] AR 105.
[30] Providers Brief Following Reopening of Appeal at 3-4.
[31] Tr. at 133-136; AR 97.

The Board concludes even when applying the more flexible pre-moratorium approach the Mountain States Providers' debt collection procedure is not like that of the providers in *Reed City* or *St. Frances* as they did not engaged in reasonable collection efforts because their decision not to refer an account to the secondary collection agency was made based upon class of patient not on the likelihood that the account would be collected.

DECISION AND ORDER:

After considering the Medicare law and regulations, the parties' contentions and the evidence submitted, the Board finds, even when applying the more flexible pre-moratorium approach that was used in *Reed City* and *St. Francis,* the Providers did not engage in "reasonable collection efforts," and therefore the bad debts were properly removed by the Medicare Contractor.

BOARD MEMBERS PARTICIPATING:

L. Sue Andersen, Esq.
Charlotte F. Benson, CPA
Gregory Ziegler, CPA, CPC-A

FOR THE BOARD:

/s/
L. Sue Andersen, Esq.
Chairperson

DATE: January 26, 2018

Form G: Schedule of Providers in Group

Group Name: Mountain States Health Alliance 2005 Bad Debt-Passive Collection CIRP Group

Representative: Gregory N. Etzel

Date Prepared: 11/9/10[1]

Case No. 08-0105G

Issue: Bad Debt

#	Provider Number	Provider Name/Location (city, county, state)	FYE	Intermediary	A Date of Final Determ.	B Date of Appeal	C No. of Days	D Audit Adj. No.	E Amt. of Reimburse-ment	F Original Case No.	G Date(s) of Add/ Transfer
1	44-0176	Indian Path Medical Center, Kingsport, Sullivan County, Tennessee	6/30/05	Riverbend GBA	9/25/06	3/20/07	176	33, 38, 53, 56	$87,404	07-1659	10/22/07
2	44-0063	Johnson City Medical Center, Johnson City, Washington County, Tennessee	6/30/04	Riverbend GBA	9/29/06	3/20/07	172	40, 44, 51, 52	$332,419	07-1583	4/7/08
3	44-0063	Johnson City Medical Center, Johnson City, Washington County, Tennessee	6/30/05	Riverbend GBA	12/11/06	6/6/07	177	23	$294,279	07-2223	10/22/07

[1] This is an amended Schedule. The original Schedule was prepared and submitted on July 30, 2008.