PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

2012-D3

PROVIDER –
Lakeland Regional Medical Center
St. Joseph, MI

Provider No.: 23-0021

vs.

INTERMEDIARY –
BlueCross BlueShield Association/
National Government Services, Inc.

DATE OF HEARING –
January 24, 2011

Cost Reporting Period Ended -
September 30, 2005

CASE NO.: 09-0957

INDEX

ISSUE:

Whether the Intermediary's disallowance of Medicare bad debts that had been referred to an outside collection agency was proper.

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 to provide health insurance to the aged and disabled. *See* 42 U.S.C. § 1395 *et seq*. The Centers for Medicare & Medicaid Services (CMS), formerly the Health Care Financing Administration (HCFA), 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[1] determine payment amounts due the providers under Medicare law, regulation and interpretative guidelines published by CMS. *See* 42 U.S.C. § 1395h and § 1395kk-1; 42 C.F.R. §§ 413.20 and 413.24.

Providers are required to submit cost reports annually, with reporting periods based on the provider's accounting year. The cost reports show the costs incurred during the fiscal year and the portion of those costs allocated to Medicare. *See* 42 C.F.R. § 413.20. 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). *See* 42 C.F.R. § 405.1803. A provider dissatisfied with the intermediary's final determination of total reimbursement may file an appeal with the Provider Reimbursement Review Board (Board) within 180 days of the receipt of the NPR. *See* 42 U.S.C. § 1395oo(a); 42 C.F.R. § 405.1835.

Bad debts are deductions from revenue and are not to be included in allowable costs. 42 C.F.R. § 413.89(a) (2004).[2] 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, bad debts attributable to Medicare deductibles and coinsurance are reimbursable. 42 C.F.R. § 413.89(d). Bad debts must meet the following criteria to be considered 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.

42 C.F.R. § 413.89(e).

[1] FIs and MACs are hereinafter referred to as intermediaries.

[2] Redesignated from 42 C.F.R. § 413.80 at 69 FR 49254, Aug. 11, 2004. *See* Exhibit P-2.

The Medicare bad debt requirements are also described in Chapter 3 of the Provider Reimbursement Manual, CMS Pub. 15, Part 1 ("PRM 15-1" or "Manual"). PRM 15-1 § 308 mirrors 42 C.F.R. § 413.89(e) in outlining the four main criteria that must be satisfied in order for bad debts to be reimbursable by Medicare. PRM 15-1 § 310 addresses the concept of "reasonable collection effort" as follows:

> 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 the "presumption of noncollectibility," providing 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."

The proper accounting period for recording bad debts and bad debt recoveries are 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.

See also PRM 15-1 §§ 314 and 316.

In § 4008 of the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987), Congress enacted what became known as the Bad Debt Moratorium:

> (c) CONTINUATION OF BAD DEBT RECOGNITION FOR HOSPITAL SERVICES.— In making payments to hospitals under title XVIII of the Social Security Act, the Secretary of Health and Human Services shall not make any change in the policy in effect on August 1, 1987, with respect to payment under title XVIII of the Social Security Act to providers of service for reasonable costs relating to unrecovered costs associated with unpaid deductible and coinsurance amounts incurred under such title (including criteria for what constitutes a reasonable collection effort).

OBRA 1987, Pub. L. No. 100-203, § 4008(c), 101 Stat. 1330, 1355 (1987) (reprinted in 42 U.S.C. § 1395f note). In 1988, Congress added the following language to the Bad Debt Moratorium:

> SEC. 8402. MAINTENANCE OF BAD DEBT COLLECTION POLICY. Effective as of the date of the enactment of the Omnibus Budget Reconciliation Act "42 USC 1395f note" of 1987, section 4008(c) of such Act is amended by inserting after "reasonable collection effort" the following: ", including criteria for indigency determination procedures, for record keeping, and for determining whether to refer a claim to an external collection agency."

Technical and Miscellaneous Revenue Act of 1988, Pub. L. No. 100-647, § 8402,102 Stat. 3342, 3798 (1988) (reprinted in 42 U.S.C. § 1395f note).

In 1989, Congress again retroactively amended the statute by adding the following:

> SEC. 6023. CLARIFICATION OF CONTINUATION OF AUGUST 1987 HOSPITAL BAD DEBT RECOGNITION POLICY. (a) IN GENERAL.— Section 4008(c) of the Omnibus Budget Reconciliation Act of 1987 is amended by adding at the end the following: "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."

Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, § 6023, 103 Stat. 2106, 2167 (1989) (reprinted in 42 U.S.C. § 1395f note).

The dispute in this case involves the Intermediary's denial of bad debt claims, specifically related to the presumption of noncollectibility for patient accounts that were pending at an outside collection agency.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

Lakeland Regional Medical Center (Provider) is a non-profit acute care hospital located in St. Joseph, Michigan. On August 28, 2007, National Government Services, Inc. (Intermediary) issued an original NPR for the Provider's fiscal year ended September 30, 2005. On September 15, 2008, the Intermediary issued a Notice of Correction of Program Reimbursement (Corrected NPR). In the Corrected NPR, the Intermediary disallowed all of the Provider's Medicare inpatient and outpatient non-crossover bad debts that had been referred to an outside collection agency.

The parties stipulated to the following pertinent facts: [3]

- The total amount in controversy is $434,785, consisting of:

  $218,557 – inpatient bad debt
  $216,228 – outpatient bad debt

  The Medicare impact of the adjustment is approximately $304,350.

- The Provider maintained a debt collection policy that incorporated the following procedures: an initial notification sent to the patient of the amount due at time of discharge; a minimum of three statements sent at intervals of twenty-one to thirty days; accounts are then referred to a pre-collection agency which then sends three collection letters at fourteen day intervals; accounts are then referred to a collection agency. The collection procedures do not differentiate between Medicare and Medicaid patient accounts. When properly applied to patient accounts, the Provider's debt collection policy represents a reasonable collection effort under Provider Reimbursement Manual, section 310.

The Provider timely appealed the Intermediary's determinations to the Board and met the jurisdictional requirements of 42 C.F.R. §§ 405.1835 – 405.1840. The Provider was represented by Chris Rossman, Esquire, and Jeffrey R. Bates, Esquire, of Foley & Lardner, LLP. The Intermediary was represented by James R. Grimes, Esquire, of Blue Cross Blue Shield Association.

[3] See Stipulation, ¶¶ 3-4.

PROVIDER'S CONTENTIONS:

The Provider contends that the bad debts for which it seeks Medicare reimbursement meet all of the requirements for allowability that are set forth in the Medicare regulations and the Provider Reimbursement Manual. The Provider argues that it engaged in substantial efforts to collect the amounts owed by both Medicare and non-Medicare patients. At the conclusion of such efforts, the Provider determined, based on its sound business judgment, that the debts were worthless with no likelihood of future recovery. The Provider argues that it relied upon the presumption of noncollectibility in PRM 15-1 § 310.2, that debts are not collectible, and therefore should be considered "worthless" when a provider engages in reasonable but ultimately unsuccessful collection activities for a period of at least 120 days. The Provider explains that the presumption of noncollectibility facilitates the efficient administration of a provider's reimbursement activities by avoiding the need to document the uncollectibility of each account on a case-by-case basis. The Provider asserts that PRM 15-1 § 310 provides guidance as to what constitutes a "reasonable collection effort" and indicates that the provider's collection effort should be documented in the patient's file, but points out that there is no requirement in the Medicare regulations or PRM provisions that a provider must cease its collection efforts before deeming debts uncollectible. Further, the Provider reasons that for the few cases where subsequent collections occur, the Medicare program is protected by virtue of the provision in PRM 15-1 § 316 that requires such collections to be offset against bad debts in the year of collection.

The Provider also contends that the Bad Debt Moratorium prohibits CMS and the Intermediary from disallowing Medicare bad debts that were referred to an outside collection agency. The Provider cites the decision in *Foothill Hospital – Morris L. Johnston Memorial v. Leavitt*, 558 F.Supp.2d 1 (D.D.C. 2008).[4] In *Foothill*, the District Court found that the Bad Debt Moratorium not only applies to an individual Medicare provider's policies, but also limits changes to the Secretary's own policy. The Court concluded that CMS' disallowance of bad debts that were at an outside collection agency constituted a change in CMS policy, and that this change in policy violated the Bad Debt Moratorium.

Finally, the Provider argues that *Battle Creek Health System v. Leavitt*, 498 F.3d 401 (6th Cir. 2007), upon which the Intermediary relies, was wrongly decided and is not controlling. The Provider references the *Foothill* Court's criticism of the 6th Circuit's decision in *Battle Creek*, and the resultant finding that CMS' reliance on *Battle Creek* was of limited value.[5]

INTERMEDIARY'S CONTENTIONS:

The Intermediary states that the Provider's policy to write off an outstanding debt as uncollectible, while at the same time contracting with a collection agency to continue collection efforts, contradicts the bad debt criteria at 42 C.F.R. § 413.89(e)(3) and (4) that the debt was actually uncollectible when claimed and that sound business judgment established that there was no likelihood of recovery at any time in the future. The Intermediary argues that by continuing its collection efforts, whether through the use of an outside collection agency or by internal

[4] *See* Exhibit P-4. The government appealed the *Foothill* decision but voluntarily withdrew its appeal. 2008 WL 4562209 (C.A.D.C.). As such, the District Court decision is now final.

[5] *See Foothill Hosp. v. Leavitt*, 558 F.Supp.2d 1, 6 (D.D.C. 2008) at Note 7.

methods, the Provider has indicated that the bad debt is not yet deemed worthless and there is some likelihood of recovery. Therefore, the Intermediary contends that the Provider's Medicare bad debt write-off for the current year fails to meet two out of the four criteria for an allowable bad debt under 42 C.F.R. § 413.89(e).

The Intermediary argues that the disallowance of bad debts still being pursued by a collection agency was confirmed by the Administrator in *Battle Creek Health System and Mercy General Health Partners v. Blue Cross Blue Shield Association/United Government Services, LLC*, Nov. 12, 2004.[6] The Administrator's decision in that case was upheld by both the U.S. District Court for the Western District of Michigan and the 6th Circuit Court of Appeals in *Battle Creek Health Systems v. Thompson,* 423 F.Supp.2d 755 (W.D. Mich. 2006) and *Battle Creek Health System v. Leavitt*, 498 F.3d 401 (6th Cir. 2007). In these cases, the courts found the Secretary's interpretation to be reasonable and conforming to the plain language of the regulation and PRM.

The Intermediary further contends that the disallowance of bad debts still at a collection agency does not represent a change in policy that is prohibited by the Moratorium because the regulation at 42 C.F.R. § 413.89(e) has been in effect since 1966 and therefore predates the Moratorium.

FINDINGS OF FACT, CONCLUSIONS OF LAW AND DISCUSSION:

After considering the Medicare law and program instructions, the evidence presented and the parties' contentions, the Board finds and concludes that the Provider properly claimed uncollectible Medicare accounts as bad debts even though the accounts were still held at a collection agency.

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.

The undisputed facts establish that the Provider's bad debt collection policies and procedures included both in-house collection efforts and referral of the accounts to an outside collection agency. If the Provider determined that the account was uncollectible after completion of its in-house collection efforts, the Provider wrote off the uncollected amount as a bad debt, but it still referred the debt to the collection agency where the accounts remained unless collected. The Intermediary does not challenge whether the bad debts claimed were related to covered services and derived from deductible and coinsurance amounts, the reasonableness of the Provider's collection effort, or that its policies applied to all bad debts without any distinction being made

[6] *See* Exhibit I-3.

between Medicare and non-Medicare accounts. However, the Intermediary asserts that the referral to the collection agency extended the collection effort and is inconsistent with the Provider's determination of worthlessness and potential for recovery.

The Board is unable to reconcile the Intermediary's position with PRM 15-1 § 310.2, which allows a provider to seek Medicare bad debt reimbursement for accounts that remain uncollected after a provider has engaged in reasonable and customary collection efforts for a period of at least 120 days. The Intermediary claims that the Provider must wait to claim a debt as uncollectible until either the collection agency returns the account to the Provider or the collection agency makes a determination that the account is worthless.

According to PRM 15-1 § 310.A, a provider's use of a collection agency may be in addition to or in lieu of collection efforts undertaken by the provider itself. That same section allows a presumption of noncollectibility after a provider's reasonable and customary attempts to collect the bill have failed and the debt remains unpaid for more than 120 days. Thus, the Board finds the Intermediary's argument that the Provider's use of an outside collection agency negates the presumption of noncollectibility, even if the debt remains unpaid after 120 days of reasonable collection effort, is without merit. The Board notes that when a provider, in a later reporting period, recovers amounts previously claimed as allowable bad debts, the provider's reimbursable costs in the period of recovery are reduced by the amounts recovered. Based on this Medicare program instruction, the Board finds that it is reasonable to infer that the Medicare program anticipates that providers may continue to pursue collection activities with respect to debts that have been deemed uncollectible for Medicare reimbursement purposes.

The Board also concurs with the Provider's contention that the Medicare regulations and program instructions do not support the Intermediary's decision to disallow the Provider's Medicare bad debts. The only CMS publication that addresses the denial of a bad debt while a Medicare account is still at the collection agency after the 120-day collection activity period has ended is the Medicare Intermediary Manual (MIM)[7] and a Medicare Learning Network (MLN) Matters article.[8] The MIM addresses the audit procedures and steps which intermediaries must use in performing their audits. However, this instruction, directed to intermediaries, goes beyond the requirements of the Medicare regulations and program instructions applicable to providers. The MLN article, issued in June 2008 to clarify CMS' bad debt policy related to accounts at a collection agency, includes a disclaimer that it "was prepared as a service to the public and is not intended to grant rights or impose obligations … It is not intended to take the place of either the written law or regulations."[9]

The Board finds that the term "uncollectible," within the context of the regulation, means that, based upon the provider's experience and sound business judgment, no payments have been received or are expected to be made on an account. The mere "active" status of an account with an outside collection agency does not automatically constitute proof of value or collectibility.

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[7] *See Universal Health Services, Inc., 2004 and 2005 Collection Agency Medicare Debt Appeal v. Blue Cross Blue Shield Ass'n/Wisconsin Physicians Serv. and Highmark Medicare Serv.*, PRRB Decision No. 2011-D30, May 27, 2011, at 6-7.
[8] *See* Exhibit I-8.
[9] *Id* at footnote.

A conclusive presumption of collectibility arising from an account's "open" or "active" status at a collection agency contradicts both the reality of the collection trade and the regulations that the Board is entrusted to enforce. Providers may not control the decision-making process of their outside collection agencies. Thus, an account that is actually worthless and uncollectible could languish as an "open" or "active" account with an outside collection agency indefinitely. Equally important, the position urged by the Intermediary would encourage, if not mandate, the Provider to promptly request the return of accounts assigned to an outside collection agency, despite the fact that utilizing a collection agency does not typically result in net costs for the Provider. Furthermore, CMS is not disadvantaged by this procedure, because if the Provider recovers funds from previously written off bad debts, such recovery will reduce allowable bad debts in the period of recovery.

The Board finds that the CMS Administrator's interpretation of the regulation requires undue efforts by providers in attempting to collect their bad debts, and such requirements do not foster program efficiency. Substituting CMS' requirements regarding bad debt collection policy for a provider's judgment based on its own operational experience and the nature of its bad debts, subjects providers to counter-productive burdens that are not required by the regulation. Additionally, the Board finds no explicit legal requirement that collection efforts must cease before accounts can be deemed uncollectible.

In addition, the Board finds that the U.S. District Court for the District of Columbia recently decided the precise question presented in this case related to the application of the Bad Debt Moratorium, and explicitly held that the presumption of collectibility violates the Moratorium. *Foothill Hospital – Morris L. Johnston Memorial v. Leavitt*, 558 F.Supp.2d 1, (D.D.C. 2008) ("the blanket prohibition against reimbursement while collection efforts are ongoing constitutes a change in policy, for this policy did not exist prior to the effective date of the Moratorium."). In *Foothill*, the Court first considered the "threshold question" of whether the Moratorium limits the Secretary's ability to change the Department's policies related to bad debts. The Court held:

> The original version of the Moratorium states that "the Secretary of Health and Human Services *shall not make any change in the policy* in effect on August 1, 1987." 42 U.S.C. § 1395f note (emphasis added). The plain meaning of this sentence is that the Secretary is prohibited from making any changes in the agency's bad debt policy as it existed as of August 1, 1987. Although the Moratorium was amended to incorporate a prohibition regarding the Secretary's ability to change an individual hospital's bad debt policy, there is nothing to suggest that this amendment was intended to change the meaning of the first sentence of the 1987 Moratorium with respect to the Secretary's bad debt collection policies. While defendant makes much of the use of the word "Clarification" in the 1989 amendment, arguing that it manifests an intent to clarify the original version rather than supplement it …, this "clarification" did not alter the first sentence of the 1987 Moratorium. If Congress had meant to correct some arguable ambiguity in the original text, it would have replaced or modified this language rather than simply adding to it. Instead, Congress chose to keep the original language in the first sentence intact, thereby prohibiting the Secretary from making changes to his pre-August 1987 bad debt policies, and it added a separate requirement in 1989

> prohibiting a fiscal intermediary from disallowing claims for bad debts for reasons pertaining to these specific elements of bad debt practices if it had approved such practices before August 1, 1987.

Id. at 5-6. Thus, it is clear that the Moratorium prevents CMS and the fiscal intermediaries from changing bad debt policy that was in effect prior to 1987, regardless of an individual hospital's practices. As such, the Intermediary's reliance on *Battle Creek Health System v. Leavitt*, 498 F.3d 401 (6th Cir. 2007) is misplaced because neither the district court nor the appellate court addressed the applicability of the Moratorium.[10] On the contrary, *Foothill* clearly holds that the presumption of collectibility violates the Moratorium.[11]

The Board concludes that the Provider's practice of writing off uncollected Medicare accounts after 120 days of reasonable collection effort, as allowed by PRM 15-1 § 310.2, and then sending them to a collection agency is consistent with the Medicare regulation and program instructions. Further, the Board finds that CMS' current policy of applying a presumption of collectibility to any bad debt held at an outside collection agency is a violation of the Bad Debt Moratorium.

DECISION AND ORDER:

The Intermediary improperly disallowed the Provider's claimed Medicare bad debts solely on the ground that accounts related to such bad debts were still pending at outside collection agencies. The Intermediary's adjustment is reversed.

BOARD MEMBERS PARTICIPATING:

Yvette C. Hayes
Keith E. Braganza, C.P.A.
John Gary Bowers, C.P.A.
Michael W. Harty

FOR THE BOARD:

Michael W. Harty
Chairman

DATE: December 14, 2011

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[10] The *Foothill* decision also noted that "the Battle Creek court was apparently unaware of its own contrary interpretation of the Moratorium as set forth in a 1999 unpublished opinion, where it concluded that the Moratorium contains two prohibitions, the first being that the Secretary cannot make any change in 'the policy in effect on August 1, 1987." *Detroit Receiving Hosp. v. Shalala*, No. 98-1429, 1999 WL 970277, at *12 (6th Cir. Oct. 15, 1999)." *Foothill*, 558 F.Supp.2d 1, 5 at Note 7.

[11] Because the *Foothill* Court based its opinion on a violation of the bad debt Moratorium, it did not consider the plaintiff's alternative argument that the Administrator's decision was arbitrary, capricious, and inconsistent with the governing statute and regulations. *Id.* at 11, Note 17.