PROVIDER REIMBURSEMENT REVIEW BOARD DECISION

ON THE RECORD
2011-D31

PROVIDER –
George Washington University Hospital
Washington, D.C.

Provider No.: 09-0001

vs.

INTERMEDIARY –
Blue Cross Blue Shield Association/
CareFirst of Maryland, Inc. and
Highmark Medicare Services

DATE OF HEARING –
May 25, 2010

Cost Reporting Period Ended -
December 31, 1999

CASE NO.: 04-0848

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ISSUE:

Whether the Intermediary's adjustments of the Provider's bad debts, because they were written off while they remained at an outside collection agency, were appropriate.

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 (FI) and Medicare administrative contractors (MAC). 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, 1395kk-1; 42 C.F.R. §§ 413.20 and 413.24.

Cost reports are required from providers on an annual basis 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. The 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 issuance 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. § 413.80(a).[2] In order to ensure that the 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 that remain unpaid are reimbursable. 42 C.F.R. § 413.80(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.

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

[2] Subsequently redesignated to 42 C.F.R. § 413.89 at 69 FR 49254, Aug. 11, 2004.

(4) Sound business judgment established that there was no likelihood of recovery at any time in the future.

42 C.F.R. § 413.80(e).

The Medicare bad debt requirements are also interpreted 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. § 413.80(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.)
>
> 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 charging bad debts and bad debt recoveries are addressed in 42 C.F.R. § 413.80(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. 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 still pending at an outside collection agency.

STATEMENT OF THE CASE AND PROCEDURAL HISTORY:

George Washington University Hospital (Provider) is a teaching hospital located in Washington D.C. On July 22, 1997, Universal Health Services, Inc. (UHS) purchased an 80 percent interest in the Provider from George Washington University (GWU), with GWU retaining 20 percent ownership. UHS is a for-profit hospital chain located in King of Prussia, Pennsylvania, and operates facilities throughout the country. CareFirst of Maryland, Inc. was the intermediary for this appeal. Highmark Medicare Services (Intermediary) has since assumed the responsibility for the Provider.

On March 1, 2003, the Provider filed an appeal with the PRRB for its fiscal year ended (FYE) December 31, 1999, naming six issues in dispute that encompassed ten Intermediary adjustments from the NPR dated September 10, 2003. On June 4, 2008, the parties submitted a partial administrative resolution to the Board in which five of the six issues under appeal were either resolved or withdrawn. Reimbursement for bad debts is the sole remaining issue to be adjudicated by the Board.[3]

It is UHS' policy that after providers have made reasonable collection efforts and accounts are determined to be uncollectible, all unpaid accounts are sent to an outside collection agency except when legally prohibited, or when payment at a future date is probable, or when the balance is less than collection agency minimums.[4] Upon satisfaction of these conditions, the accounts are written off as bad debts.[5] The Intermediary disallowed the bad debts that were referred to a collection agency on the basis that collection efforts were ongoing and the bad debts were not yet deemed worthless. The Provider estimates the reimbursement amount in dispute to be $30,896.[6]

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[3] *See* joint request for hearing on the record dated December 17, 2008. Bad debts reimbursement is identified as Issue No. 2 within the parties' position papers.

[4] *See* Provider's Bad Debt Write-Off Policy at Exhibit P-6-C-1.

[5] *Id.*

[6] Exhibit I-2.

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 Edward A. Moore of Universal Health Services, Inc. The Intermediary was represented by Arthur E. Peabody, Jr., Esquire, of Blue Cross Blue Shield Association.

PROVIDER'S CONTENTIONS:

The Provider contends that it adhered to the regulatory requirements and manual provisions outlined at 42 C.F.R. § 413.80(e) and PRM-1, Chapter 3, in claiming its bad debts and providing the necessary supporting documents. It states that return of an account from a collection agency is not one of the four criteria for an allowable bad debt. The Provider argues that it performs a reasonable in-house collection effort for at least 120 days following the first bill to the patient, thereby fulfilling the presumption of noncollectibility at PRM-1 § 310.2.

The Provider states it is not required to forward its uncollected accounts to an outside collection agency to qualify them as uncollectible. Its policy is to forward all uncollected accounts to outside agencies to ensure consistency of treatment across all payor sources and because there is no cost to the Provider unless a recovery is made. The Provider further indicates that it has properly accounted for subsequent bad debt recoveries against current bad debt listings.

The Provider also contends that the Intermediary's reliance on an audit guideline to deny reimbursement for accounts simply because they are pending at an outside collection agency violates the Bad Debt Moratorium. The Provider cites *Foothill Hosp. – Morris L. Johnston Mem. v. Leavitt*, 558 F.Supp.2d 1, 11 (D.D.C. 2008).[7]

INTERMEDIARY'S CONTENTIONS:

The Intermediary contends 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 criterion at 42 C.F.R. 413.80(e)(3) that a bad debt be "actually uncollectible" when claimed as worthless. Therefore, the Intermediary contends that the Provider's claim for Medicare reimbursement is premature in accordance with 42 C.F.R. § 413.80(f), arguing that such claims cannot be made until the accounts are returned from the collection agency as uncollectible and all collection efforts cease. The Intermediary did not address the applicability of the Bad Debt 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.

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

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. §413.80(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 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.

PRM 15-1 § 310.2 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. The Board is unable to reconcile the Intermediary's position with PRM 15-1 § 310.2.

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 that 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. Moreover, the Provider argues and the Board concurs 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. Thus, 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 a collection agency after the 120-day collection activity period has ended is the Medicare Intermediary Manual (MIM). The MIM addresses the audit procedures and steps that 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 Board finds that the term "uncollectible," within the meaning of the regulation, means that no payments have been received or are expected to be made on an account based upon the provider's experience and sound business judgment. The mere "active" status of an account with an outside collection agency does not automatically constitute proof of value or collectibility.

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 business processes and the regulations that the Board is entrusted to enforce. Providers may not control the decision-making processes 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, that the Provider promptly request the return of accounts assigned to an outside collection agency, despite the possibility of eventual collection. 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 substituting the CMS Administrator's interpretation 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 Hosp. – 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 debt. 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, any reliance on *Battle Creek Health System v. Leavitt*, 498 F.3d 401 (6th Cir. 2007) and *Mesquite Community Hospital v. Leavitt*, 2008 WL 4148970 (N.D. Tex/ Sep. 5, 2008) is misplaced because neither the district courts nor the appellate court in these cases addressed the applicability of the Moratorium.[8] On the contrary, *Foothill* clearly holds that the presumption of collectibility violates the Moratorium.[9]

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 still remained at an outside collection agency. The Intermediary's adjustments are reversed.

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[8] 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.

[9] 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.

BOARD MEMBERS PARTICIPATING:

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

FOR THE BOARD:

Yvette C. Hayes
Acting Chairperson

DATE: May 27, 2011