PUBLICATION

The Bad Debt Moratorium Requires a Flexible Approach to Evaluating "Reasonable Collection Efforts" [Ober|Kaler]

October 28, 2015

On September 10, 2015, District Judge Randolph D. Moss of the U.S. District Court for the District of Columbia issued an opinion in *Mountain States Health Alliance v. Burwell* [PDF] (*Mountain States*) involving Section 310 of the Provider Reimbursement Manual (PRM), which requires that Medicare providers engage in "reasonable collection efforts" before declaring unpaid deductibles and copayments as uncollectible "bad debt."

In that case, the Secretary of Health and Human Services (Secretary) denied Mountain States Health Alliance (Alliance), as the owner of two acute care hospitals (Providers), the bad debt claimed on cost reports for the periods ending June 30, 2004 and June 30, 2005. According to the Secretary, the Providers treated the Medicare and non-Medicare accounts differently in their efforts to collect the debt, despite that PRM 310.A requires that where a collection agency is used, all uncollected patient charges of like amount shall be referred to a collection agency without regard to the fact that the patient was a Medicare or non-Medicare patient. The court remanded the case to the Provider Reimbursement Review Board (Board) with instructions that it apply a more flexible approach to evaluating "reasonable collection efforts."

Under the governing regulations, if providers wish to claim Medicare bad debt, they must demonstrate that: (1) the debt was related to covered services and derived from deductible and coinsurance amounts; (2) they undertook reasonable collection efforts; (3) the debt was uncollectible when claimed as worthless; and (4) sound business judgment established that there was no likelihood of recovery of the debt at any time in the future. 42 C.F.R. § 413.89. The regulations do not define "reasonable collection efforts," but the PRM guides providers to some extent. Indeed, PRM 310.A requires that where a collection agency is used, all uncollected patient charges of like amount shall be referred to a collection agency without regard to the fact that the patient was a Medicare or non-Medicare patient. Providers are otherwise left with some degree of discretion in their reasonable collection efforts and their sound business judgment. Moreover, in 1987, Congress enacted a law, known as the "Bad Debt Moratorium," to freeze the Secretary's Medicare bad debt policies in place, including PRM 310 and the Secretary's interpretation thereof. The law prevents the Secretary from making any changes in policy already in effect on August 1, 1987, with respect to payment for bad debt, including the criteria in place for what constitutes a provider's "reasonable collection efforts."

In *Mountain States*, "fiscal intermediaries" (FIs) evaluated the annual cost reports for FYs 2004 and 2005 under the Secretary's regulations and informal guidance such as the PRM. The FIs determined that the Providers' practices in collecting debt for 2004 and 2005, although thorough, were unreasonable because, despite treating Medicare and non-Medicare debt similarly for approximately one year in their collection efforts, the Providers' policies treated such debt differently after one year.

Specifically, the Providers engaged in in-house debt collection efforts without distinguishing between Medicare and non-Medicare patients for a period of six months. If those efforts failed, the Providers then referred those debts to a primary debt collection agency for six months, again without distinguishing between classes of patients. However, if the debt still remained uncollected after an additional six months at the primary collection agency, the Providers then declared the Medicare accounts uncollectible, yet sent the non-Medicare accounts to a secondary collection agency to further attempt collection. Due to this disparate treatment of the Medicare

debt after one year of collection efforts, the FIs determined that the Providers did not engage in "reasonable collection efforts" and disallowed the bad debt.

The Alliance appealed on behalf of the Providers to the Board, which affirmed the FI's decision to disallow the debt. The Board found it key that the Providers "made a single global decision not to refer [Medicare] accounts to the secondary collection agency based on attributes believed by the Providers to generally exist across Medicare accounts as a whole," i.e. "that the Medicare population *on average* is retired and not gainfully employed, is not necessarily going to borrow money, is living off retirement and social security income, presents difficulty with regards to pursuing property liens and wage garnishments, and has no regard for a lower credit score." That global decision applicable to Medicare, as opposed to non-Medicare accounts, based on the Providers' business judgment, did not comply with the PRM 310.A requirement that such accounts be treated in a comparable way to establish a reasonable collection effort. The Board upheld the FI's decision and applied a rigid reading of the PRM to justify the decision. The Board's decision became the final decision of the Secretary.

On appeal to the District Court, the Alliance challenged the Secretary's interpretation of the regulatory requirement that if a provider refers non-Medicare debt to a secondary collection agency, it must also refer Medicare debt to a secondary collection agency, on several grounds: that the PRM is a legislative rule that should be been promulgated under notice and comment rulemaking; that PRM 310 was not listed in the Federal Register as required by statute; that the Secretary's policy departs from the policy in effect on August 1, 1987, in violation of the Bad Debt Moratorium; and that even if PRM 310 is valid, the disallowance of the Providers' bad debt was arbitrary and capricious.

The court found that PRM 310 was not a legislative rule. Analyzing a long line of cases in this area of administrative law, the court concluded that it was an interpretive rule that does not have the full force and effect of law and thus need not be promulgated using notice and comment rulemaking procedures of the Administrative Procedure Act. Further, the court was not persuaded that the Secretary was required to publish PRM 310 in the Federal Register.

As to the Secretary's policy violating the Bad Debt Moratorium, the court disagreed with the Board's rigid application of PRM 310. The court found that the Board's strict reading of the PRM reasonable collection requirement was not consistent with a more flexible approach in place before the Bad Debt Moratorium and therefore violated the Moratorium. Specifically, the Alliance argued that prior to the Bad Debt Moratorium, the requirement that a provider that refers debt to a collection agency do so equally for Medicare and non-Medicare accounts, was not treated by the Secretary as a hard-and-fast rule, but rather permitted the provider to make sound business decisions on a case-by-case basis with regard to possible disparate treatment of accounts. After the Moratorium, according to the Alliance, the policy shifted to a rigid application of the rule where the provider was unable to use its sound business judgment, as evidenced by the Board's reading of the rule, in violation of the Moratorium.

The Alliance relied on two Board decisions predating the Moratorium, *Reed City* and *St. Francis*, which concluded that reasonable collection efforts were undertaken even where the providers referred only non-Medicare debt to collection agencies. Specifically, in those cases, the providers had not referred Medicare bad debt to collection agencies because the prospect of recovery was negligible, as determined by their sound business judgment. The FIs in those cases disallowed the debt based on their more rigid reading of PRM 310's reasonable collection policy, but the Board allowed the debt anyway, evidencing a flexible policy in place prior to the Moratorium.

Undisputedly, the Secretary applied a more flexible standard prior to the Bad Debt Moratorium in evaluating reasonable collection efforts and the use of outside collection agencies, and so the Board was not permitted to

apply a rigid standard to the Alliance Providers after the Moratorium. The court remanded the decisions to the Board with instruction to apply a more flexible pre-Moratorium approach to evaluate the Providers' reasonable collection efforts despite the disparate treatment of Medicare and non-Medicare debt.

Ober|Kaler's Comments

The question remains whether the Providers in *Mountain States* will meet a more flexible, case-by-case approach to their reasonable collection efforts, where the Providers' business decisions to treat Medicare debt differently after one year applied across the board, for the most part. Whether the Board will accept this one-year cutoff as reasonable is unknown.

Notably, the Bad Debt Moratorium was repealed in 2012, effective for all cost reporting years beginning October 1, 2012 or later, so a change in CMS's position after that time may be harder to attack. But for audits of fiscal years during which the Moratorium still applied, *Mountain States* serves as a reminder that the CMS's rigid approach to bad debt for those years may be inappropriate, and an appeal has merit.