CENTERS FOR MEDICARE AND MEDICAID SERVICES
Decision of the Administrator

In the cases of:	**Claim for:**
Life Care Hospitals **Providers**	**Cost Reporting Period(s) Ending:** **Various**
vs.	
Novitas Solutions, Inc. and **Wisconsin Physicians Service** **Intermediary**	**Review of:** **PRRB Dec. No. 2016-D25** **Dated:September 28, 2016**

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 in § 1878(f) (1) of the Social Security Act (Act), as amended (42 USC 1395oo (f)). The parties were notified of the Administrator's intention to review the Board's decision. CMS' Center for Medicare (CM) commented, requesting a partial reversal of the Board's decision. The Medicare Administrative Contractor (MAC) commented requesting a partial reversal of the Board's decision. The Provider also commented requesting that the Board's decision be reversed in part. Accordingly, the case is now before the Administrator for final administrative decision.

ISSUE AND BOARD'S DECISION

The issue is whether the CMS "must-bill" policy applies to the Provider's dual eligible bad debts when the Provider does not participate in the Medicaid program.

The Board affirmed the MAC's dual-eligibility adjustment for those long term care hospitals (LTCH) located in Louisiana (LA) and Texas (TX), where the Providers could have been enrolled in the Medicaid program, but choose not to be enrolled in the Medicaid program. The Board reversed the MAC's adjustment for those Providers located in North Carolina (NC) and Pennsylvania (PA), where the State Medicaid program would not enroll long term care hospitals (LTCHs) in the Medicaid program. Therefore, the Board remanded those Providers located in NC and PA for a determination of the appropriate amount of dual eligible bad debt reimbursement relating to those State Medicaid programs.

SUMMARY OF COMMENTS

The Providers commented requesting that the Administrator reverse in part and affirm in part. The Providers requested that the Administrator affirm the part of the Board's decision that reversed the MAC's bad debt adjustment for Providers in States where the Medicaid program would not enroll LTCHs (NC and PA). The Administrator should reverse the portion of the Board's decision that affirmed the MAC's bad debt adjustments for the remaining Providers (LA and TX).[1]

The Providers contended that same issue was addressed in *Select Specialty '05 Medicare Dual Eligible Bad Debt Group*, PRRB Dec. No. 2010-D25, regarding five LTCH operated by Select Medical Corporation. The Board reversed the MAC's adjustment in that case in full and the Board's conclusions must be adopted here. The Providers pointed to the Court's review of that Board case in *Cove Associates Joint Venture v. Sebelius*, 848 F. Supp. 13 (D.D.C. 2013), on appeal and its summary of a "Catch-22" situation where providers are non-Medicaid participating providers. The Providers contended that the Court made a factual error when it remanded on the mistaken belief that the Select providers submitted sample bills to the State and the remand was for a determination on whether the providers were justified in relying on the agency's prior practice of not applying the must bill policy. The Providers contended that the Select providers submitted supporting documentation on remand confirming that in the applicable States, the State Medicaid program(s) did not have a mechanism and would not allow providers to bill Medicaid and receive a remittance advice for the applicable dates of service.

The Providers asserted that the Board was incorrect to rely on court cases that have been issued on the must-bill policy as no court has specifically addressed the issue raised here. Regarding the Providers in States that are allowed LTCH enrollment in Medicaid (LA and TX). the Providers referred to the controlling regulation and Provider Reimbursement Manual (PRM) sections 308, 301, 312 and 322 as to what constitutes a reasonable collection effort, with the focus on whether the Medicaid state program is legally responsible. In this instance, the State clearly would not pay because the Providers were not enrolled in the Medicaid program. This bears directly on whether the State had a legal responsibility to pay. The Providers were not legally recognized as parties that could submit bills to the State Medicaid program and the *States were not legally permitted to*

[1] The Providers requested that the Administrator modify the Board's decision to clarify that the MAC's bad debt adjustment are reversed for out-of-state beneficiaries The Administrator notes that this is outside of the scope of the Board's decision. (See Transcript of Oral Hearing (Tr.) at 240. (Board Chairman: "I just want to clarify for the record that the issue before the Board does not involve out-of-state Provider issues." Provider Witness: "That's correct. It's the Provider not participating in their state of residence.")

process or pay for the bills submitted by the Providers. Thus, all the Providers in this case are in a “Catch-22” situation.

Regarding the Providers located in LA and TX, there is no basis for the Board to uphold the bad debt adjustment for the Providers located in states in which they could have enrolled as LTCHs. The Administrator should reverse that part of the Board's decision. These Providers were also legally unable to bill the State Medicaid program. The Joint Signature Memorandum (JSM) and other sub-regulatory guidance, as the Board had earlier found, was not a vehicle to set policy and, regardless, in this case for these Providers the Stare was not legally responsible for paying the bad debts of Medicaid non-participating providers.

The JSM policy did not apply to non-Medicaid participating providers in this case as evidenced by the fact the Providers continued to receive payments based upon documentation other than Remittance Advices (RAs). Therefore, it was reasonable for the Providers to rely on the MACs practice of paying the bad debts at issue and exempting the Providers from the must-bill policy. The Community Hospital of Monterey Peninsula v. Thompson, 323 F.3d 1079 (9 th Cir. 2003) was issued five years before the adjustments in this case and, therefore, is not guidance on this issue. The Board's decision lost sight of the fact that a State's legal obligation to pay Medicare cost sharing amounts for dual eligible is triggered by both a State Medicaid plan requirement and a Medicaid participating provider. The Providers were not able to obtain RAs by submitting bills to the State. Accordingly, under the circumstances presented the Medicaid was not a responsible third party from whom the Providers were required to pursue collections.

Regarding Providers' dual eligible bad debts in States that did not allow LTCH enrollment in Medicaid (NC and PA), the Board correctly recognized that this situation was similar to the exceptions to the must bill policy that CMS recognized in the Monterey Peninsula case. One exception applies to community mental health centers (CMHC) and another exception applies to institutes for mental health diseases (IMHD), an exception based on the specific Medicaid polices toward these types of facilities that preclude Medicaid enrollment, claims processing, or reimbursement for services provided. Therefore, the Board properly reversed the MAC's dual eligible bad debts adjustment for the Providers located in States where LTCHs were not permitted to enroll in Medicaid. In these appeals, NC and PA did not allow LTCHs to enroll in Medicaid and the Board decision should be upheld.

The MAC commented requesting that the Administrator uphold the part of the Board's decision agreeing with the MAC's disallowance of bad debts where the Providers could be certified as Medicaid Providers but did not enroll, and reverse the part of the Board's decision in which the Board disagreed with, and remanded for recalculation, the MAC's disallowance of bad debts where the Providers could not be certified as Medicaid Providers. The MAC asserted that the Board's decision to remand the disallowances for recalculation appears to be based on a principle of equitable relief, a remedy not available

to the Board, contrary to statutory and regulatory requirements and the facts and circumstances of the issues presented. The MAC alleged that the Providers were required to bill the State Medicaid programs in order to comply with reasonable collection efforts for bad debt reimbursement. Accordingly, the MAC claimed that, because the Providers did not receive Remittance Advices (RAs) from Medicaid, the Providers did not fulfill reasonable collection efforts and, therefore, are not entitled to bad debt reimbursement so the Board incorrectly found in favor of some of the Providers on that issue.

The Centers for Medicare (CM) commented and requested that the Administrator uphold the Board's decision in reference to those Providers who were eligible to enroll in Medicaid but chose not to do so and reverse the Board's decision to remand to the MAC for recalculation of those bad debts for the Providers who alleged they were ineligible to enroll in the State Medicaid program. CM asserted that the Board incorrectly determined that the Providers in this case should be excepted from the "must-bill" policy because States would not enroll them due to their LTCH designation. Regardless, CM asserted that whether the States in question enrolled LTCHs or not, they were still contractually obligated to do so by statute.

Additionally, CM distinguished this case and from the alleged exceptions to the "must-bill" policy. First, CM denied that there is any exception to the policy. Second, even assuming an exception did exist, CM asserted that the facts in this case differ from those in cited submissions made in the district court brief in *Community Hospital of Monterey Peninsula v. Thompson*. CM stated that the circumstances alleged by the Board and the Providers as an exception instead represented a limited settlement agreement between CMHCs and the State of California which permits CMHCs in that State only to claim Medicare bad debt without billing the State first because CMHCs are not licensed by the state and IMDs are excluded from services under Medicaid.

Discussion

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 were received timely and are included in the record and have been considered.

Medicaid State Plans

Relevant to the issue involved in this case, two Federal programs, Medicaid and Medicare involve the provision of health care services to certain distinct patient populations. The Medicaid program is a cooperative Federal-State program that provides health care to indigent persons who are aged, blind or disabled or members of families with dependent children.[2] The program

[2] Section 1901 of the Social Security Act (Pub. Law 89-97).

is jointly financed by the Federal and State governments and administered by the States according to Federal guidelines. Medicaid, under Title XIX of the Act, establishes two eligibility groups for medical assistance: categorically needy and medically needy. Participating States are required to provide Medicaid coverage to the categorically needy.[3] The "categorically needy" are persons eligible for cash assistance under two Federal programs: Aid to Families with Dependent Children (AFDC) [42 USC 601 et seq.] and Supplemental Security Income or SSI [42 USC 1381, et seq.] Participating States may elect to provide for payments of medical services to those aged blind or disabled individuals known as "medically needy" whose incomes or resources, while exceeding the financial eligibility requirements for the categorically needy (such as an SSI recipient) are insufficient to pay for necessary medical care.[4]

In order to participate in the Medicaid program, a State must submit a plan for medical assistance to CMS for approval. The State plan must specify, inter alia, the categories of individuals who will receive medical assistance under the plan and the specific kinds of medical care and services that will be covered.[5] If the State plan is approved by CMS, under section 1903 of the Act, the State is thereafter eligible to receive matching payments from the Federal government based on a specified percentage (the Federal medical assistance percentage) of the amounts expended as medical assistance under the State plan.

Within broad Federal rules, States enjoy a measure of flexibility to determine "eligible groups, types and range of services, payment levels for services, and administrative and operating procedures.[6] However, the Medicaid statute sets forth a number of requirements, including income and resource limitations that apply to individuals who wish to receive medical assistance under the State plan. Individuals who do not meet the applicable requirements are not eligible for "medical assistance" under the State plan.

In particular, section 1901 of the Act sets forth that appropriations under that title are "[for the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish medical assistance on behalf of families with dependent children and of aged, blind or disabled individuals whose incomes and resources are insufficient to meet the costs of necessary medical services…." Section 1902 sets forth the criteria for State plan approval.[7] Section 1902(a)(10)(E)(i) of the Act requires Medicaid State plans to make "medical assistance available for medicare cost-sharing (as defined in section 1905(p)(3)) for qualified medicare beneficiaries…."

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[3] Section 1902(a) (10) of the Act.
[4] Section 1902(a) (1) (C) (i) of the Act.
[5] *Id.* §1902 *et seq.*, of the Act.
[6] *Id.*
[7] 42 C.F.R. §200.203 defining a State plan as "a comprehensive written commitment by a Medicaid agency submitted under section 1902(a) of the Act to administer or supervise the administration of a Medicaid plan in accordance with Federal requirement."

Notably, section 1905(a) states that for purposes of this title "the term 'medical assistance' means the payment of part or all of the costs" of the certain specified "care and medical services" and the identification of the individuals for whom such payment may be made. Sections 1905(p)(1) specifies that:

> The term "qualified medicare beneficiary" means an individual—
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> (A) who is entitled to hospital insurance benefits under part A of title XVIII (including an individual entitled to such benefits pursuant to an enrollment under section 1818, but not including an individual entitled to such benefits only pursuant to an enrollment under section 1818A),
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> (B) whose income (as determined under section 1612 for purposes of the supplemental security income program, except as provided in paragraph (2)(D)) does not exceed an income level established by the State consistent with paragraph (2), and
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> (C) whose resources (as determined under section 1613 for purposes of the supplemental security income program) do not exceed twice the maximum amount of resources that an individual may have and obtain benefits under that program or, effective beginning with January 1, 2010, whose resources (as so determined) do not exceed the maximum resource level applied for the year under subparagraph (D) of section 1860D-14(a)(3)(determined without regard to the life insurance policy exclusion provided under subparagraph (G) of such section) applicable to an individual or to the individual and the individual's spouse (as the case may be).

In addition, under section 1905(p)(3):

> The term "medicare cost-sharing" means (subject to section 1902(n)(2)) the following costs incurred with respect to a qualified medicare beneficiary, without regard to whether the costs incurred were for items and services for which medical assistance is otherwise available under the plan:
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> (A)(i) premiums under section 1818 or 1818A, and
> (ii) premiums under section 1839,
> (B) Coinsurance under title XVIII (including coinsurance described in section 1813).
> (C) Deductibles established under title XVIII (including those described in section 1813 and section 1833(b)).[104]
> (D) The difference between the amount that is paid under section 1833(a) and the amount that would be paid under such section if any reference to "80 percent" therein were deemed a reference to "100 percent".
> Such term also may include, at the option of a State, premiums for enrollment of a qualified medicare beneficiary with an eligible organization under section 1876.

Section 1902(n) provides that:

> (1) In the case of medical assistance furnished under this title for medicare cost-sharing respecting the furnishing of a service or item to a qualified medicare beneficiary, the State plan may provide payment in an amount with respect to the service or item that results in the sum of such payment amount and any amount of payment made under title XVIII with respect to the service or item exceeding the amount that is otherwise payable under the State plan for the item or service for eligible individuals who are not qualified medicare beneficiaries.
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> (2) In carrying out paragraph (1), a State is not required to provide any payment for any expenses incurred relating to payment for deductibles, coinsurance, or copayments for medicare cost—sharing to the extent that payment under title XVIII for the service would exceed the payment amount that otherwise would be made under the State plan under this title for such service if provided to an eligible recipient other than a medicare beneficiary.
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> (3) In the case in which a State's payment for medicare cost-sharing for a qualified medicare beneficiary with respect to an item or service is reduced or eliminated through the application of paragraph (2)—
> (A) for purposes of applying any limitation under title XVIII on the amount that the beneficiary may be billed or charged for the service, the amount of payment made under title XVIII plus the amount of payment (if any) under the State plan shall be considered to be payment in full for the service;
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> (B) the beneficiary shall not have any legal liability to make payment to a provider or to an organization described in section 1903(m)(1)(A) for the service; and
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> (C) any lawful sanction that may be imposed upon a provider or such an organization for excess charges under this title or title XVIII shall apply to the imposition of any charge imposed upon the individual in such case.
> This paragraph shall not be construed as preventing payment of any medicare cost—sharing by a medicare supplemental policy or an employer retiree health plan on behalf of an individual.

Medicare

The Medicare program primarily provides medical benefits to eligible persons over the age of 65, and consists of two parts: Part A, which provides reimbursement for inpatient hospital and related post-hospital, home health, and hospice care; and Part B, which is a supplementary voluntary insurance program for hospital outpatient services, physician services, and other services not covered under Part A.

Medicare providers are reimbursed by the Medicare program through Medicare administrative contractors (MACs) for Part A and carriers for Part B, under contract with

the Secretary. To be covered by Part B, a Medicare-eligible person must pay limited cost-sharing in the form of premiums, and deductible and coinsurance amounts. Where a Medicare beneficiary is also a Medicaid recipient, (i.e., "dually eligible"), a State Medicaid agency may enter into a buy-in agreement with the Secretary. Under such an agreement, the State enrolls the poorest Medicare beneficiaries, those eligible for Medicaid, in the Part B program by entering into an agreement with the Secretary and by paying the Medicare premiums and deductibles and coinsurance for its recipients as part of its Medicaid program.

Under Section 1861(v)(1)(a) of the Act, providers are to be reimbursed the reasonable cost of providing services to Medicare beneficiaries. That section defines "reasonable cost" as "the cost actually incurred, excluding therefrom any 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...." An underlying principle set forth in the Act is that Medicare shall not pay for costs incurred by non-Medicare beneficiaries, and vice-versa, i.e., Medicare prohibits cross-subsidization of costs. The section does not specifically address the determination of reasonable cost, but authorizes the Secretary to prescribe methods for determining reasonable cost, which are found in regulations, manuals, guidelines, and letters. With respect to such payments, section 1815 of the Act states that:

> 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 (but not less often than monthly) and prior to audit or settlement …..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.

In addition, consistent with the requirements of section 1815 of the Act, the regulation sets forth that providers are required to maintain contemporaneous auditable documentation to support the claimed costs for that period. The regulation at 42 CFR 413.20(a) states that the principles of cost reimbursement require that providers maintain sufficient financial records and statistical data for proper determination of costs payable under the program. The regulation at 42 CFR 413.24(a) also describes the characteristics of adequate cost data and cost finding, explaining that providers receiving payment on the basis of reimbursable cost must provide adequate cost data. This must be based on their financial and statistical records which must be capable of verification by qualified auditors. The cost data must be based on an approved method of cost finding and on the accrual basis of accounting. Generally, paragraph (b) explains that the term “accrual basis of accounting means that

revenue is reported in the period in which it is earned, regardless of when it is collected; and an expense is reported in the period in which it is incurred, regardless of when it is paid."

Along with the documentation requirements for payment, the regulations further explain the reasonable cost principles set forth in the Act. This principle is reflected at 42 CFR 413.9, which provides that the determination of reasonable cost must be based on costs actually incurred and related to the care of Medicare beneficiaries. Reasonable cost includes all necessary and proper costs incurred in furnishing the services, subject to principles relating to specific items of revenue and cost.

The provision in Medicare for payment of reasonable cost of services is intended to meet the actual costs, however widely they may vary from one institution to another. The regulation states that the objective is that under the methods of determining costs, the costs with respect to individuals covered by the program will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by the program. However, if the provider's costs include amounts not reimbursable under the program, those costs will not be allowed.

Unpaid Coinsurance and Deductibles

Consistent with these reasonable cost principles and payment requirements, the regulatory provision at 42 CFR 413.89(a) provides that bad debts, which are deductions in a provider's revenue, are generally not included as allowable costs under Medicare. The regulation at 42 CFR 413.89(b)(1) defines "bad debts" as "amounts considered to be uncollectible from accounts and notes receivable that were created or acquired in providing services. "Accounts receivable" and "notes receivable" are defined as designations for claims arising from the furnishing of services, and are collectable in money in the relatively near future. In particular, 42 CFR 413.89(d) explains that:

> Under Medicare, costs of covered services furnished beneficiaries are not to be borne by individuals not covered by the Medicare program, and conversely, cost of services provided for other than beneficiaries are not to be borne by the Medicare program.

The circumstances under which providers may be reimbursed for the bad debts derived from uncollectible deductibles and coinsurance amounts are set forth at paragraph (e). The regulation at 42 CFR 413.89(e) states that to be allowable, a bad debt must 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 there was no likelihood of recovery at any time in the future.[8]

To comply with section 42 CFR 413.89(e)(2), the Provider Reimbursement Manual or PRM provides further guidance with respect to the payment of bad debts. Section 310 of the PRM provides the criteria for meeting reasonable collection efforts. A reasonable collection effort, inter alia, includes:

> 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.... (See section 312 for indigent or medically indigent patients.)"

Moreover, Section 310.B states that the provider's collection effort is to be documented "in the patient's file by copies of the bill(s)...." Section 312 of the PRM explains that individuals who are Medicaid eligible as either categorically or medically needy may be automatically deemed indigent. However, section 312.C requires that:

> The provider must determine that no source other than the patient would be legally responsible for the patient's medical bills; e.g., title XIX, local welfare agency and guardian.... (Emphasis added.)

Finally, section 312 also states that:

> [O]nce indigence is determined, and the provider concludes that there had been no improvement in the beneficiary's financial condition, the debt may be deemed uncollectible without applying the §310 [reasonable collection effort] procedures. (See section 322 of the PRM for bad debts under State welfare programs.)

Relevant to this case, section 322 of the PRM provides that:

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[8] Further, 42 CFR 413.89(f) explains the charging of bad debts and bad debt recoveries: The amounts uncollectible from specific beneficiaries are to be charged off as bad debts <u>in the accounting period</u> <u>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.

> Where the State is obligated either by statute or under the terms of its plan to pay all, or any part of the Medicare deductible or coinsurance amounts, those amounts are not allowable as bad debts under Medicare. Any portion of such deductible or coinsurance amounts that the State is not obligated to pay can be included as a bad debt under Medicare provided that the requirements of §312 or, if applicable, §310 are met.

For instances in which a State payment "ceiling"[9] exists, section 322 of the PRM states:

> In some instances, the State has an obligation to pay, but either does not pay anything or pays only part of the deductible, or coinsurance because of a State payment "ceiling." For example, assume that a State pays a maximum of $42.50 per day for the SNF services and the provider's cost is $60.00 a day. The coinsurance is $32.50 a day so that Medicare pays $27.50 ($60.00 less $32.50). In this case, the State limits its payment towards the coinsurance to $15.00 ($42.50 less $27.50). In these situations, any portion of the deductible or coinsurance that the State does not pay that remains unpaid by the patient, can be included as a bad debt under Medicare, provided that the requirements of §312 are met. (Emphasis added.)

Section 322 of the PRM concludes by explaining that:

> If neither the title XIX plan, nor State or local law requires the welfare agency to pay the deductible and coinsurance amounts, there is no requirement that the State be responsible for these amounts. Therefore, any such amounts are includable in allowable bad debts provided that the requirements of §312, or if applicable, §310 are met. (Emphasis added.)

The patients' Medicaid status at the time of service should be used to determine their eligibility for Medicaid to satisfy the requirement of section 312. A patient's financial situation and Medicaid eligibility status may change over the course of a very short period of time. The State maintains the most accurate patient information to make the determination of a patient's Medicaid eligibility status at the time of service and, thus, to determine the State's cost sharing liability for unpaid Medicare deductibles and coinsurance. In addition, it is clear from section 322 of the PRM that the amount that can be claimed as bad debts is the amount the State "does not pay" which presumes that the State has been billed and the State had rendered a determination on such a claim.

[9] Relevant to this case, sections 1905(p)(1) and 1905(p)(3) of the Act requires State participation in payment of coinsurance and deductibles for QMBs although it may be limited, hence the situation referred to as a payment ceiling.

Reading the sections together, the Administrator concludes that, in situations where a State is liable for all or a portion of the deductible and coinsurance amounts, the State is the responsible party and is to be billed, and a determination made by the State in order to establish the amount of bad debts owed under Medicare. The above policy has been consistently articulated in the final decisions of the Secretary addressing this issue, since well before the cost year in this case.[10]

The policy requiring a provider to bill the State and receive a determination on that claim, where the State is obligated either by statute or under the terms of its plan to pay all, or any part of the Medicare deductible or coinsurance amounts, is consistent with the general statutory and regulatory provisions relating specifically to the payment of bad debts and generally to the payment of Medicare reimbursement. As reflected in 42 CFR 413.89(d)(1), the costs of Medicare deductible and coinsurance amounts which remain unpaid (i.e. were billed) may be included in allowable costs. In addition, paragraph (e) of that regulation requires, inter alia, a provider to establish that a reasonable collection effort was made and that by receiving a determination from the State, the debt was actually uncollectible when claimed. A fundamental requirement to demonstrate that an amount is, in fact, unpaid and uncollectible, is to bill the responsible party. Section 310 of the PRM generally requires a provider to issue a bill to the party responsible for the beneficiaries' payment. Section 312 of the PRM, while allowing a provider to deem a dually eligible patient indigent and claim the associated debt, first requires that no other party, including the State Medicaid program is responsible for payment, Section 322 of the PRM addresses the circumstances of dually eligible patients where there is a State payment ceiling. That section states that the "amount that the State does not pay" may be reimbursed as a Medicare bad debt. This language plainly requires that the provider bill the State as a prerequisite of payment of the claim by Medicare as a bad debt receive a determination on that claim and that the State make a determination on that claim.

Other controlling precedence and guidance for dual-eligible patients' unpaid coinsurance and deductibles are reflected in Administrator decisions and CMS policy pronouncements. The Administrator, through adjudication, addressed this policy in many cases including *Community Hospital of the Monterey Peninsula*, PRRB Dec. No. 2000-D80 (Oct. 31, 2000). As a result of that litigation, CMS issued a joint memorandum on August 10, 2004 regarding bad debts of dual-eligible beneficiaries. The Joint Signature Memorandum (JSM-370) restated Medicare's longstanding bad debt policy that:

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[10] *See, e.g., California Hospitals Crossover Bad Debts Group Appeal*, PRRB Dec. No. 2000-D80 (Oct. 31, 2000); *See also California Hospitals* at n.16 (listing cases). These decisions have denied payment when there is no documentation that actual collection efforts were made to obtain payments from the Medicaid authority before an account is considered uncollectible and worthless and when the provider did not bill the State for its Medicaid patients.

> [Iln those instances where the State owes none or only a portion of the dual eligible patient's deductible or co-pay, the unpaid liability for the bad debt is not reimbursable to the provider by Medicare until the provider bills the State, and the State refuses payment (with a State remittance advice). Even if the State Plan Amendment limits the liability to the Medicaid rate, by billing the state, a provider can verify the current dual-eligible status of the beneficiary and can determine whether or not the State is liable for any portion thereof. Thus, in order to meet the requirements for a reasonable collection effort with respect to deductible and coinsurance amounts owed by a dual-eligible beneficiary, the longstanding policy of Medicare is that a provider must bill the patient or entity legally responsible for such debt and receive a determination by the State on such a claim.

The memorandum noted that in *Community Hospital of Monterey Peninsula v. Thompson*, 323 F.3d 1079 (9th Cir. 2008), the Ninth Circuit upheld this policy of the Secretary. Section 1905(p)(3) of the Act imposes liability for cost sharing amounts for QMBs on the States through section 1902(n)(2) that allows the States to limit that amount to the Medicaid rate and essentially pay nothing towards dual-eligible cost sharing if the Medicaid rate is lower than what Medicare would pay for the service. Where the State owes none, or a portion of the dual-eligible deductible and coinsurance amounts, the unpaid liability for the bad debt is not reimbursable until the provider bills the State and the State refuses payment, all of which is demonstrated through a Remittance Advice. Importantly, the memorandum also indicated that, in November 1995, language was added to the PRM at section 1102.3L, which was inconsistent with this policy. The Ninth Circuit panel found that section 1102.3L was inconsistent with the Secretary's policy and also noted that, effective in August of 1987, Congress had imposed a moratorium on changes in bad debt reimbursement policies and, therefore, the Secretary lacked authority in November of 1995 to promulgate a change in policy. As a result of the Ninth Circuit decision, CMS changed the language in PRM—II Section 1102.3L to revert back to pre-1995 language, which requires providers to bill the individual States for dual-eligible co-pays and deductibles before claiming Medicare bad debts. The CMS JSM also provided a limited "hold harmless provision."[11]

[11] This memorandum also served as a directive to hold harmless providers that can demonstrate that they followed the instructions previously laid out at 1102.3L, for open cost reporting periods beginning prior to January 1, 2004. Intermediaries who followed the now-obsolete section 11102.3L instructions for cost reporting periods prior to January 1, 2004, may reimburse providers they service for dual eligible bad debts with respect to unsettled cost reports that were deemed allowed using other documentation in lieu of billing the State. Intermediaries that required the provider to file a State Remittance Advice for cost reporting periods prior to January 1, 2004 may not reopen the provider's cost reports to accept alternative documentation for such cost reporting periods. This hold harmless policy affects only those providers with cost reports that were open as of the date of the issuance of the memorandum relating to cost reporting periods before January 1,

In fulfilling the requirements of sections 312 and 322 of the PRM, Medicare requires a provider to bill the State and receive a remittance advice that documents the Medicaid status of the beneficiary at the time of service, and the State's liability for unpaid deductibles and coinsurance as determined and verified by the State. Accordingly, revised (to pre-1995 language) section 1102.3L of the PRM, Part II (Exhibit 5 to Form CMS-339) requires the submission of the following documentation:

> 1. Evidence that the patient is eligible for Medicaid, e.g., Medicaid card or I.D. number
> 2. Copies of bills for Medicare deductibles and coinsurance that were sent to the State Medicaid Agency.
> 3. Copies of the remittance advice from the State Medicaid Agency showing the amount of the provider's claim(s) for Medicare deductibles and coinsurance denied.[12]

While the policy at issue is referred to as the "must-bill" policy, the policy in fact requires a determination by the State on a filed claim. This policy concerning dual-eligible beneficiaries continues to be critical because individual States administer their Medical Assistance programs differently and maintain billing and documentation requirements unique to each State program. The State maintains the most current and accurate information to determine if the beneficiary is a QMB, at the time of service, and the State's liability for any unpaid QMB deductible and coinsurance amounts through the State's issuance of a remittance advice after being billed by the provider.

Consistent with the statute, regulation and PRM, a provider must bill the State and the State must process the bills or claims to produce a remittance advice for each beneficiary to determine their Medicaid status, at the time of service and the State's liability for unpaid Medicare deductible and coinsurance amounts. Thus, it is unacceptable for a provider to write-off a Medicare bad debt as worthless without first billing the State and receiving a determination from the State. Even in cases where the provider has calculated that the State has no liability for outstanding deductible and coinsurance amounts, the provider must bill the State and receive a remittance advice before claiming a bad debt as worthless because, as stated above, the State has the most current and accurate information to make a

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2004 and who relied on the previous language of section 1102.3L in providing documentation. The cost years in this case are all post-the hold harmless cost years. The relevance to the hold harmless provision in this case maybe whether it was applied for some of the Providers' prior cost years raised during the discussion of whether the MAC had made payments prior to 2008.

[12] *See* Change Request 2796, issued September 12, 2003

determination on the beneficiaries' status at the time of the services and to determine the State's cost sharing liability for all covered stays of dual eligible beneficiaries.[13]

During the cost reporting periods at issue, the Providers claimed Medicare bad debts on their cost reports for unpaid coinsurances and deductibles for beneficiaries who were also eligible for Medicaid benefits under the respective State's Medicaid program (i.e., dual eligible beneficiaries). The Intermediary disallowed all the bad debts based upon the "must bill" policy which requires the Provider to bill the State Medicaid program and obtain a remittance advice to support the Medicare claimed costs.

The Providers in this case are all commonly-owned by Life Care Management Services. For the fiscal years at issue (FYE 2005 through 2012), none of the Providers were enrolled in Medicaid. The Providers alleged they could not conform to the Must bill policy as they could not obtain Remittance Advices from the States in which they were located, LA, TX NC and PA. However, there are two types of situation under which the Providers did not bill and receive a remittance advice from the respective State in which they were located in this case. The first type of Provider was located in a State that allegedly would not recognize LTCHs and therefore would not enter into a provider agreement with a LTCH (NC and PA) and the other type of Provider was located in a State that would enter into an agreement with a LTCH, but the respective Provider chose not to enroll in the Medicaid program in that State (LA and TX).

LifeCare Hospitals of North Carolina and LifeCare Hospitals of Chester County are located in NC and PA respectively. A review of the record does not show documentation that these respective Providers attempted to enroll and received a denial from the respective State. The Providers' Exhibit P-54 shows a 2012 email from the LifeCare Hospitals regarding applications for two recently purchased hospitals to a PA State official, which stated that Life Care anticipated a denial letter from PA, but had discussed the possibility of enrolling for the limited purpose of processing cross-over claims. However, no denial letter was included in the record. The Providers witness pointed out that there was no legal impediment to enrolling in NC as they were certified and licensed as Hospitals. The Providers' witness offered testimony as to the extent of the efforts pursued to convince the State to enroll LTCHs in NC and PA for purposes of the cross-over claims, actions which were successful for years subsequent to this appeal. The Witness relayed that NC required no change in the law. (Tr. 179, 183) The Providers' witness did not indicate that a change of law was required in PA, but rather the critical point was convincing the State officials that recognizing LTCHs as a provider type would not adversely affect the State's Medicaid budget. (Tr. 124, 129.)

[13] One of the earliest Administrator decisions cases recognizing this policy was decided in 1993 and involved a 1987 cost year. See, *Hospital de Area de Carolina*, Admin. Dec. No. 93-D23.

LifeCare Hospitals of New Orleans and LifeCare Hospitals of Texas are located in LA and TX, respectively. The Providers chose not to pursue Medicaid enrollment in these States due to the low Medicaid reimbursement rates, as compared to Medicare reimbursement. (Tr. 66-69, 190, 191) LifeCare of New Orleans was adversely impacted by Hurricane Katrina and was closed in subsequent cost years. There was also some discussion at the Hearing as to whether LifeCare Hospitals of New Orleans had the benefit of the JSM hold harmless provision for cost years prior to 2004.

As of 2012, all of the Providers still operating were participating and enrolled in their respective State Medicaid plans. The Providers were submitting timely bills for their dually eligible patients' unpaid coinsurance and deductibles and receiving remittance advices from the State Medicaid programs in NC, PA, LA and TX.

After a review of the record and the applicable law and Medicare policy, the Administrator finds that the Providers failed to meet all the regulatory requirements and the Manual guidelines for reimbursement of the subject amounts as Medicare bad debts. The Providers failed to determine if the State was liable for any cost sharing amounts and, thus, the Providers failed to determine that the debt was actually uncollectible when claimed as worthless as required under 42 C.F.R 413.89(e) and Chapter Three of the PRM. Under the foregoing circumstances the Providers failure to obtain a remittance advice was not due to reliance on any affirmative action on the part of CMS but due either to the Providers' business decision not to enroll in the respective states Medicaid program, the failure to timely bill the State or the State's failure to act on the Providers' actions.

The non-Medicaid enrollment status of a provider does not change the legal responsibilities that result from the dual eligible status of a Medicare beneficiary for which a State may be liable for cost sharing amounts depending upon its Medicaid rate. For a certain group of Providers, the Board erroneously relied upon the "Catch-22" dicta introduced by the D.C. District Court in 2012 in Cove Associates. Jt. Venture. V. Sebelius,[14] in which the Court indicated that the Providers appear to be caught in an untenable position when they are required to comply with the "must-bill" policy and the State refuses to issue remittance advices. The Court further noted a reluctance to "place a stamp of approval on a policy that would put non-participating providers in the position of not being paid due to the delinquency of federally funded state programs."[15]

However, the State has a statutory obligation to determine its cost sharing liability concerning dual eligible beneficiaries, regardless of the Medicare-only participating status of the entity providing the services.[16] This legal responsibility is reflected in CMS' State

[14] 848 F. Supp. 2d 13 (D.D.C. 2012).
[15] *Id*, at 28.
[16] *See, e.g.*, section 1902(a)(10)(E) of the Act.

Medicare Manual (SMM), wherein it is set forth the state's statutory duty to determine its cost sharing liability. Section 3490.14(B) specifically provides that:

> [S]ubject to State law a provider has the right to accept a patient either as private pay only, as a QMB only, or (if the patient is both a QMB and Medicaid eligible) as a full Medicaid patient, but the provider must advise the patient, for payment purposes, how he/she is accepted. Medicaid payment of Medicare deductible and coinsurance amounts may be made only to Medicaid participating providers, even though a Medicare service may not be covered by the Medicaid State plan. A provider agreement necessary for participation for this purpose (e.g., for furnishing the services to the individual as a QMB) may be executed through the submission of a claim to the Medicaid agency requesting Medicaid payment for Medicare deductibles and noninsurance for QMBs.

Consequently, States must be able to process dual eligible beneficiary claims to determine the State's cost sharing liability. In instances where the State does not process a dual eligible claim, a Provider's remedy must be sought with the State.[17] If a State does not have the ability to process dual eligible beneficiary claims for all types of Medicare providers, then the State is out of compliance with the Federal statute and the state must be forced to comply.

The Providers in this case acknowledged that after reaching out and explaining the circumstances to NC and PA State officials, they were allowed to enroll in those States' Medicaid program in order to bill and receive RAs. In states where there was no alleged bar to enrolling, the States have subsequently enrolled and processed those Providers' claims. Where States are made aware of their duty and still refuse to enroll Providers for the purpose of billing and receiving remittance advices, or otherwise refuse to process non-enrolled providers' claims, then the appropriate course would be for the Providers to take legal action with their states. The CM pointed to a similar situation in Florida[18] where a provider successfully brought forth a case against the State Medicaid agency for failure to comply with the Federal statute to process claims for dual eligible beneficiaries so that the State could produce a remittance advices and determine its cost sharing liability. Thus, the Administrator finds that for non-Medicaid participating Providers, it is in many situations a business decision not to enroll in Medicaid and, regardless, that the State has a legal responsibility to process the claim for dually eligible patient claims for Medicare only providers. Finally, there is legal recourse available for Providers to require States to issue remittance advices. Accordingly, the "Catch-22" description is not an accurate description, nor an appropriate legal basis for the Board to allow an equitable payment to the Providers.

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[17] *See Alpha Comm. Mental Health Ctr. vs. Holly Benson, as Sect. of Health Care Admin.*, Case No. 2008 CA 004161 (2 Cir. 2010).
[18] *Id.*

Additionally, the Providers have not provided evidence to demonstrate that the CMS affirmatively misled the Providers that the must bill policy did not apply to them because they were non-Medicaid participants. The record shows that Providers were notified of the "must-bill" policy as early as October 1, 2004, pursuant to, among other things, the CMS Medicare Newsletter.[19] The Providers also contended they relied upon the post-moratorium changed cost reporting instructions of section 1102.3L of the PRM, Part II (Exhibit 5 to Form CMS-339), even though it was revised in 2003 to pre-moratorium language which similarly, does not distinguish between Medicaid and non-Medicaid participating providers.

The Providers' also alleged that the MAC had paid previous cost year claims that were allegedly submitted without State remittance advices and, accordingly, the Providers argued that this was evidence they were thus exempt from this requirement. Notably, there is no statement in the JSM, related PRM sections, or prior Administrator decisions (including multiple situations where providers have also claimed "impossibility")[20] distinguishing non-Medicaid participating hospitals from participating providers in the application of the policy. This is not surprising as a State has a legal responsibility for cost sharing for dually eligible even where a provider is Medicare participating only.

In addition, any allowance of bad debts without appropriate documentation as the Providers have alleged has happened in the past does not constitute an explicit or affirmative agency action on policy. As the MAC pointed out, it is not always possible to review every item of the cost report every year. For example, for the audit procedures being applied for a cost reporting periods at issue, the audit papers show a bad debt claim in excess of $50,000 being a factor in instituting a more detailed audit. The focus, scope and criteria for annual audits change from year to year. In addition, occasionally providers may receive payment for an undocumented claim but that does not relieve the provider of its responsibility to follow the rules and regulations of CMS. Such an error also does not demonstrate that CMS has abandoned or changed a policy. The PRM criteria that the State be required to make a determination on any debts owed before it may be claimed as a Medicare bad debt has been in place for years prior to these cost years. Under section 1815, payments shall not 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, consistent with the statute, the regulations require that providers maintain verifiable and supporting documents to justify their requests for payment under Medicare. The regulation at 42 CFR 413.20 provides that: "The principles of cost reimbursement require that providers maintain sufficient financial records and statistical data for provider determination of costs payable under the program….Essentially the methods of determining costs payable under Medicare

[19] *See* Intermediary Exhibit 1-7.

[20] *See e.g. Village Green Nursing Home, PRRB Dec. No*. 2000-D59, where Administrator upheld disallowance for bad debts.

involve making use of data available from the institution's basis accounts, as usually maintained…." As used in the context of the regulation at §413.20, "maintain" means that the provider is required to keep "contemporaneous" records and documentation throughout the cost year and to then make available those records to the intermediary in order to settle the cost report in the normal course of business.

The Board and Providers also relied upon a footnote in the Secretary's "Defendant's Memorandum in Reply to the Plaintiffs Opposition to Defendant's Motion for Summary Judgment"[21] in the District Court case of *Community Hosp. of Monterey Peninsula v. Thompson* as a basis for claiming there should exist an exception for these LTCHs to the must-bill policy. The Administrator notes that this brief was filed in reply to the Plaintiff's brief while the case was pending at the United States District Court, N.D. of California.[22] The District Court ruled against the Secretary on the must-bill policy at the District Court. However, on appeal, this case was overturned by the United States Court of Appeals, Ninth Circuit, and remanded to the District court in the Secretary's favor. CM has pointed out that the specific situation referenced within the footnote regarding CMCHs was a very limited settlement agreement between the Secretary and CMCHs located in the State of California located in California, which "are not licensed by the State and, therefore, have no Medi-Cal provider number"[23] Settlements are not admissible as evidence and would not be properly considered in this case. There is no evidence extraneous to this footnote of such a policy and in fact with respect to Community Mental Health Centers (CMCHs), the Administrator has upheld the must bill rule for such Providers in past cases.[24] Even assuming arguendo such a policy existed, in this instance the Providers are licensed by the State and hold their LTCH designation for purposes of exclusion from the Medicare Inpatient Prospective Payment System only. The second cited instance involved Institutions for Mental Diseases (IMDs) located in California, where the services were provided to individuals ages 22 to 64. The Federal statute and regulations precluded payment for services provided to patients of that age group in IMDs. The Federal law exclusion for payment is found at section 1905(a)(B) and prohibits "payments with respect to care or services for any individual who has not attained 65 years of age and who is a patient in an institution for mental disease except for inpatient psychiatric hospitals services for individuals under age 21." Thus, the Administrator finds that the footnote in the brief

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[21] Defendant's Memorandum in Reply to Plaintiffs' Opposition to Defendant's Motion for Summary Judgment at 9n.5, *Community Hosp. of Monterey Peninsula v. Thompson*, Case No. C-01-0142, 2001 WL 1256890 (N.D. Cal. Oct. 11, 2001) (copy included at Provider Exhibit P-27).

[22] *Community Hospital of Monterey Peninsula v. Thompson,* Case No. C-01-0142 (N.D. Cal. Oct. 11, 2001

[23] CMCHs have only been operating under Medicare conditions of participations implemented by CMS since 2014.

[24] *See, e.g., Royal Coast Rehabilitation Center,* PRRB Dec. 2000-D13, involving a CMHC.

in Community Hosp. does not create an exception to the must-bill policy for Medicare only participating LTCHs.

In light of the foregoing, the Providers have not demonstrated that the bad debts that were identified by the Provider was actually uncollectible and worthless. The Providers' assertions, that in some States the cost sharing liability would be zero, fails to recognize that States are in the best situation to make that determination and that States will always have some amount of cost sharing liability for beneficiaries' deductibles. Because the State has not issued remittance advices for these services contemporaneous with the cost reporting periods, the bad debts cannot be demonstrated as "actually uncollectible when claimed as worthless" and that "there is no likelihood of recovery at any time in the future" and that sound business judgment has established no likelihood of recovery in the future. In addition, as there is a third party, the State who is responsible for coinsurance and deductibles, the Provider has not shown that they have used reasonable collection efforts.

Notably, the Medicaid and Medicare programs are authorized by different provisions of the Social Security Act and financed under different mechanisms. The reasonable cost payment is made from the Medicare Trust Fund/Supplemental Medical Insurance, while Medicaid is a joint State and Federal program financed, inter alia, under State and Federal appropriations with its own separate and distinct rules and authorizations. Consequently, the remittance advices are critical as they document the proper payments that should be made from the respective programs. Moreover, a fundamental principle of the program is that payment be fair to the providers, the "contributors to the Medicare trust fund" and to other patients. In this instance the Medicare program is reasonably balancing the accuracy of the bad debt payment and the need to ensure the fiscal integrity of the Medicare funding, with the providers' claims for payment which can be made under two different program for which Medicare is the payer of last resort. As the State has a legal obligation to pay cost-sharing amount of the coinsurance and deductible and the State has not made a determination on these claims, the elements of the bad debts regulation are not met in this case.

Decision

The decision of the Board is modified in accordance with the foregoing opinion.

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

Date: 11/28/2016

/s/
Acting Principal Deputy Administrator
Centers for Medicare & Medicaid Services