CENTERS FOR MEDICARE AND MEDICAID SERVICES
Decision of the Administrator

In the case of:	**Claim for:**
Maine Medical Center	**Medicare Reimbursement** **Cost Reporting Period(s) Ending:** **September 30, 2002 and** **September 30, 2003**
Provider	
vs.	
Blue Cross Blue Shield Association/ **National Government Services**	**Review of:** **PRRB Dec. No. 2013-D3** **Dated: November 29, 2012**
Intermediary	

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 Intermediary and the Provider commented. The parties were notified of the Administrator's intention to review the Board's decision. The Provider commented requesting the Administrator to affirm the Board's decision**.** The Intermediary and the Center for Medicare (CM) both commented requesting reversal of the Board's decision. Accordingly, the case is now before the Administrator for final administrative decision.

ISSUE AND BOARD'S DECISION

The issue is whether the Intermediary's exclusion of the crossover bad debts for cost reporting periods ending September 30, 2002 and September 30, 2003 due to a lack of documentation was proper.

The Board, reversing the Intermediary's adjustment, held that a review of the applicable regulations at 42 CFR §413.89(e) and program guidance at CMS Pub. 15-1 sections 308,

310, 312, 322 finds that neither the regulation nor the manual sections contained a requirement to bill the state Medicaid agency. The Board rejected the Intermediary's argument that the must bill policy, particularly the remittance advice requirement, was an absolute bar to Medicare recovery of a bad debt. The Board alleged that this provision is not identified in any statute or regulation, but only in the Joint Signature Memorandum 370, 08-03-04 ("JSM") and that a JSM is an inappropriate vehicle to set policy and is entitled to less deference than regulations and Manual instructions. Rather than the JSM, the Board determined that the PRM 15-2 at section 1102.3L is the policy in effect for the cost year at issue in this case and that section does not require a State Medicaid remittance advice and instead allows the provider to furnish other documentation for crossover claims where remittance advice is not available or possible. Thus, the Board held that where a provider can bill and the State is obligated to pay, the Provider must implement reasonable collection efforts, rather than a remittance advice, to obtain payment from the State under the PRM. The Board asserted that to read section §1102.3L as an absolute bar, regardless of the collection effort, would conflict with the statute and regulation.

The Board recognized that the court in *Community Hospital of the Monterey Peninsula v Thompson*[1] previously upheld the agency's must bill policy but that this case is distinguishable based on two key aspects. First the Board indicated that in *Monterrey Pennsylvania* there was a possibility of some payment from Medi-Cal whereas in this case there was, and still is, absolutely no possibility that the Maine Medicaid Program ("MaineCare") is liable from claims because since January 1, 1999 the State regulations eliminated payments for crossover claims. Secondly the Board noted that, unlike *Monterrey Pennsylvania*, the Trading Partner Agreement between MaineCare and Medicare was supposed to be compatible and the Provider, following the agreement instructions, actively pursued the remittance advices through MaineCare but through no fault of the Providers, the State's computer system failed and they were unable to obtain the remittance advices. The Board asserts that the unique circumstances of this case should excuse the Provider from the must bill/remittance advice requirement and instead use a reasonable collection effort policy. The Board held that the bad debts were actually uncollectible when the Provider claimed them as worthless and that sound business judgment established that there was no likelihood of recovery at any time in the future. Thus, the Board concluded, that the language in the PRM does not support the conclusion that uncollectibility must be established by a billing, the Intermediary improperly denied the Provider's claimed bad debts.

[1] 323 F.3d 782 (9th Cir. 2003).

SUMMARY OF COMMENTS

The Intermediary commented requesting that the Administrator reverse the Board's decision in this case. The Intermediary asserted that the Secretary's "must bill" policy, including the State remittance notice requirement, is necessary in order to generate the documentation maintained in the ordinary course of providers business that will support the crossover bad debt claims. Thus, the Intermediary stated that the Board's finding that the Provider met the requirements of a reasonable collection effort related to dual eligible beneficiaries, even though no Medicaid remittance advice existed to establish that the proper party had been billed and did not pay, violates Medicare regulations and CMS policy and should be reversed.

The Provider commented requesting that the Administrator affirm the Board's decision. The Provider alleged that its failure to produce a Medicaid remittance advice was through no fault of its own, and namely a malfunction by the State's Medicaid claims processing system. Accordingly, the Provider alleged that it should be considered a unique circumstance which prevents it from meeting the "must bill" policy criteria, i.e., the submission of a remittance advice for dual eligibles. The Provider asserted that, instead of the "must bill" policy, the Provider has met the requirements for a reasonable collection effort related to the dual eligible beneficiaries as required by 42 C.F.R. §413.89 and the manual instructions. Therefore, the Intermediary improperly denied the Provider's crossover claims solely on the basis for failure to produce a State Medicaid remittance advice.

CM commented asserting that the Board erroneously determined that the Provider has satisfied the regulatory and manual requirements to claim the crossover bad debts at issue. CM stated that in order to comply with 42 CFR 413.89(e)(3) and PRM section 322, Medicare requires a provider to document the State's liability for any cost sharing amounts related to unpaid Medicare deductible and insurance amounts for dual eligible beneficiaries. Accordingly, CM noted that a provider must make certain that no source, other than the patient, would be legally responsible for payment and in order to effectuate this requirement, a provider must submit a bill to its Medicare contractor who initiates the Medicaid crossover billing process with the State.

CM noted that the Board's assertion, that a JSM holds little weight and cannot be used to set policy, is flawed because the issuance of a JSM does not set policy, convey new instructions or provide clarification of existing requirements. Rather, the JSM simply reiterates instructions that have been previously issued. In this case, CMS used JSM-370 as means to reinforce the instructions from Change Request 2796. Change Request 2796

was issued following the Court's decision and instructions following *Monterrey Penninsula.* The JSM revised section 1102.3L of the PRM, Part II, requiring providers to submit, in part, the following: the patient's name, Medicare and Medicaid numbers, dates of services that correlate to the bad debt, and the remittance advice dates that will enable CMS' Medicare Administrative Contractor (also referred to in the past as the Medicare fiscal intermediary) to verify the authenticity of the Medicare patient and the related bad debt. CM asserted that, contrary to the Board's finding in this case, the Intermediary's reliance on JSM-370 and *Monterrey Peninsula* should be given considerable weight and is critical in conveying Medicare policy regarding the determination of the State's cost sharing liability.

CM pointed out that the Provider's reliance on the hold harmless provision does not apply in this case, because this provision applies only to providers who can establish that they followed the instructions for using an alternate form of documentation during cost reporting periods beginning prior to January 1, 2004. CM asserted that the record in this case confirmed that at no time prior to January 1, 2004, did the Provider follow the instruction set forth in section 1102.3L and submit other documentation, in lieu of the remittance advice. Therefore, the Provider is not entitled to protection under the hold harmless provision of JSM-370.

CM reasoned that due to the fact that a beneficiary's financial status may change quickly and that States maintain complex billing systems and documentation requirements unique to each State, it is the State's responsibility to determine its cost sharing liability. Neither a provider, nor CMS, are capable of making such liability determinations. Thus, the provider must submit a bill for a dual eligible beneficiary to its Medicare contractor to begin the Medicaid crossover billing process with the State and, thereafter, the State must process these crossover bills/claims to produce a remittance advice for each beneficiary to determine a patient's Medicaid status at the time of service and to also determine the State's liability for payment of Medicare deductible and coinsurance amounts. CM asserted that under 413.89(e)(3) and for the reasons provided in its comments, it is unacceptable for a provider to write off a Medicare dual eligible beneficiary bad debt as worthless without the State determining its share of liability.

CM acknowledged the anomaly that occurred in this case due to the State's computer system which resulted in MaineCare (the State Medicaid program) failing to process certain Medicare crossover claims. However CM asserted that the State had statutory requirement to process crossover claims, determine its liability for dual eligible beneficiaries and to provide the required remittance advice documentation to the provider. Accordingly, the Provider failed to meet reasonable collection effort requirements and the

Provider must seek a remedy from the State as a direct result of the State's shortcomings in failing to perform a statutorily mandated duty.

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.

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 fiscal intermediaries 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 (Emphasis added.)

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,[2] which provides that the determination of reasonable cost must be based on costs

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[2] The regulation at 42 CFR 413.1 explains that: "This part sets forth regulations governing Medicare payment for services furnished to beneficiaries." Paragraph (3) explains that: "Applicability. The payment principles and related policies set forth in this part are binding on CMS and its fiscal intermediaries, on the Provider Reimbursement Review Board, and on the entities listed in paragraph (a)(2) of this section. (b) Reasonable cost reimbursement. Except as provided under paragraphs (c) through (h) of this section, Medicare is generally required, under section 1814(b) of the Act (for services covered under Part A) and under section 1833(a)(2) of the Act (for services covered under Part B)

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.

Consistent with these reasonable cost principles and payment requirements, the regulatory provision at 42 CFR 413.89(a)[3] 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:

> *Requirements for Medicare*. 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. Uncollected revenue related to services furnished to beneficiaries of the program generally mean the provider has not recovered the cost of services covered by that revenue. <u>The failure of beneficiaries to pay the deductibles and coinsurance amounts could result in the related costs of covered services being borne by others. The costs attributable to the deductible and coinsurance amounts that remain unpaid are added to the Medicare share of allowable costs.</u> Bad debts arising from other sources are not an allowable cost. (Emphasis added.)

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to pay for services furnished by providers on the basis of reasonable costs as defined in section 1861(v) of the Act.…"

[3] Formerly designated at 42 CFR 413.80. The regulation addressing "Bad Debts, Charity, and Courtesy Allowances" was redesignated at 69 Fed. Reg. 49254 (August 11, 2004).

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.
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> 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.

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 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. (Emphasis added.)

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.) (Emphasis added.)

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 notes that:

> 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. (Emphasis added.)

For instances in which a State payment "ceiling" 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.

The patient's 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 its 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.

The Administrator, through adjudication, further addressed this policy in Community Hospital of the Monterey Peninsula, PRRB Dec. No. 2000-D80. As a result of that litigation, CMS issued a memorandum on August 10, 2004 regarding bad debts of dual-eligible beneficiaries.[4] The Joint Signature Memorandum (JSM-370) restated Medicare's longstanding bad debt policy that:

> [I]n 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.[5] The memorandum noted that in, Community Hospital of the Monterey Peninsula v. Thompson, supra, (2008), the Ninth Circuit upheld the must bill policy of the Secretary.[6] The memorandum also stated that regarding dual-eligible beneficiaries, 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

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[4] JSM 370 (Aug. 10, 2004). Intermediary Exhibit I-41.
[5] Id.
[6] Id., citing 323 F.3d 782.

and essentially pay nothing towards dual-eligible cost-sharing if the Medicaid rate is lower than what Medicare would pay for the service.[7] 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 the must bill policy.[8] The Ninth Circuit panel found that section 1102.3L was inconsistent with the Secretary's must –bill 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 effect 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-eligibles' co-pays and deductibles before claiming Medicare bad debts.[9]

The CMS JSM also provided a limited "hold harmless provision." This memorandum 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 1102.3L 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, 2004 and who relied on the previous language of section 1102.3L in providing documentation.[10]

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

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[7] Id.
[8] Id.
[9] See Change Request 2796, issued September 12, 2003.
[10] Id.

section 1102.3L of the PRM, Part II (Exhibit 5 to Form CMS-339)[11] 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.

In this case, the Provider is a voluntary not-for-profit general short term hospital located in Portland Maine. For the cost reporting periods at issue, the Provider claimed crossover bad debts for uncollected coinsurance and deductible amounts related to the care of dual eligibles. The Intermediary disallowed the crossover bad debts for which there were no State Medicaid remittance advices. As set forth in the stipulation,[12] the Provider stated that prior to July 1, 1999, MaineCare (the State Medicaid Program) paid some or all of the coinsurance and deductible amounts for Medicare/Medicaid crossover patients, as required by the State Plan. However, the Provider contended that effective July 1, 1999, the MaineCare program no longer paid "crossover claims". For the cost reporting periods, MaineCare and Medicare had a Trading Partner Agreement under which the MaineCare program provided electronic eligibility tables, updated monthly, and allowed the Medicare program to identify crossover patients and report them to MaineCare. The Provider stated that its crossover claims were submitted to MaineCare by the Intermediary, which provided an electronic tape of crossover claims directly to the MaineCare program on a weekly basis pursuant to the Agreement. The Provider explained that according to MaineCare, between November 1, 2001 and August 2003, an anomaly of unknown origin occurred wherein a large number of Medicare crossover claims from the Provider, which were apparently sent to MaineCare by the Medicare Intermediary, were never processed by MaineCare and a Medicaid remittance advice was never issued. The Provider stated that MaineCare claimed it has not been able to identify, retrieve and process those crossover claims, and cannot do so now. Thus, the Provider claimed it was unable to provide a MaineCare Remittance Statement because MaineCare cannot and has not provided them. The Intermediary maintained that the State Medicaid remittance advice

[11] Rev. 6 (April 2006)(changes originally issued pursuant to a Change Request 2796, issued September 12, 2003).

[12] Provider Exhibit P-28 (Case No. 06-1318); Provider Exhibit P-41 (Case No. 07-1386)(herein "Stipulation of Fact").

was required by CMS policy before the unpaid deductible and coinsurance amount can be claimed as a bad debt. The Provider maintained that, under these unique circumstances involved in this case, a State Medicaid remittance advice is not required and the Provider has submitted alternative evidence to support the claims as services to dual eligibles for which no payment is permitted under the State Medicaid plan.

After a review of the record and the applicable law and Medicare policy, the Administrator finds that the Provider failed to meet all the regulatory requirements and the Manual guidelines for reimbursement of the subject amounts as Medicare bad debts. The Administrator finds that, regardless of any omissions by the State to provide the Medicaid remittance advices, the Provider was required to bill for and produce the remittance advice before including crossover bad debt claims on its cost report. Accordingly, the failure to produce the Medicaid remittance advices represents a failure on the part of the Provider to meet the necessary criteria for Medicare payment of bad debts related to these claims and Intermediary was correct to deny the crossover bad debt claims for the cost years at issue.

In order to determine the State's liability and, likewise, the amount of coinsurance and deductible attributable to Medicare bad debt, the Provider is required to bill the State for these claims and receive a remittance advice. It is only through the State's records and claims system that the amount of any payment can be determined. This necessity is recognized by the statute at section 1903(r)(1) as it requires automated facilitation of cross-over claims between State Medicaid programs and the Medicare program for dual eligible patients. The policy requiring a provider to bill the State, 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 <u>remain unpaid</u> (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 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. 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 remittance advice issued 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.[13] The final decisions of the Secretary have consistently held that the bad debt regulation and the documentation requirements for payment set forth in the law and regulation require providers to bill the Medicaid programs for payment. 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 when the provider did not bill and receive a remittance advice from the State for its Medicaid patients.

The Provider points to Chapter III, Section 45 from the Maine Medicaid manual which states that "payments for crossover claims have been eliminated for dates of service on or after July 1, 1999"[14] to demonstrate that the State's obligation would be zero. However, the issue of the rate a State may pay is different from whether a State has a legal obligation to pay under Title XIX law as recognized, inter alia, in both the PRM 322 and the JSM-370. The must-bill policy concerning dual-eligible beneficiaries continues to be critical because States have a legal obligation to pay, but they may vary their rates in relation to the Medicare rate. Individual States administer their Medicaid programs differently and maintain billing and documentation requirements unique to each State program and a State's Medicaid program rates and payment obligations can change in different periods.[15]

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[13] *See, e.g.*, California Hospitals Crossover Bad Debts Group Appeal PRRB Dec. No. 2000- D80; *See also* California Hospitals at n.16 (listing cases). To the extent any CMS statements may be interpreted as being inconsistent with the "must bill" policy, such an interpretation would be contrary to the OBRA moratorium. In addition, the Ninth Circuit Court of Appeals decision in Community Hospital of Monterey Peninsula, discusses at length the various PRRB/Administrator decisions setting forth the must bill policy. One of the earliest cases was decided in 1993 and involved a 1987 cost year. *See Hospital de Area de Carolina*, Admin. Dec. No 93-D23.

[14] Exhibit 9-13, page 21

[15] For example, while the Provider asserts that zero State payment is owed for the years in this case, in contrast, as recently as November 7, 2011, the State of Maine Department of Health & Human Services acknowledged budget shortfalls for "co-insurance, deductible and co-payments for Medicare and MaineCare members who receive hospital services known as cross-over payments ($9.8 million)…"

The foregoing scenario set forth by the Provider was recognized in the JSM-370 in explaining the need for the Medicaid remittance advice, stating that:

> With respect to "dual-eligibles," Section 1905(p)(3) of the Social Security Act ("Act") imposes liability for cost sharing amounts for Qualified Medicare Beneficiaries on the States, though Section 1902(n)(2) allows the states to limit that amount to the Medicaid rate and essentially pay nothing toward dual eligibles' cost sharing if the Medicaid rate is lower than what Medicare would pay for the service. However, in 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 a beneficiary and can determine whether or not the State is liable for any portion thereof.

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. Thus, regardless of a State's rates, only through billing and receiving a State Medicaid Remittance advice can a provider demonstrate that a State is or is not liable for any portion thereof.

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 and receiving the remittance advice 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 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. As noted for the reasons set forth in CM's comments and various courts, the Board also incorrectly

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http://www.main.gov/tools/whatsnew/index.php?topic=DHS+Press+Releases&id=3182808V=article

dismissed the JSM 370 as a valid means of communicating established, longstanding policy.

In light of the foregoing, the Provider had not demonstrated that the bad debts claimed by the Provider were actually uncollectible and worthless when written off on the FYEs 2002 and 2003 cost reports. The Provider did not receive a remittance advice contemporaneous with the FYEs 2003 & 2004, as needed to meet the reasonable collection effort requirements of the regulation and manual provisions for the claims at issue in this case for the cost reporting period at issue. While 42 CFR 413.89 explains the criteria needed to be met to claim a bad debt, the regulation at 42 CFR 413.89(f) addresses the timing of when a bad debt can be claimed consistent with the general Medicare documentation requirements.[16] 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.

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[16] In addition to verifying the validity of the provider's bad debt, submission of the claim to the State and preservation of the remittance advice is an essential and required record keeping criteria for Medicare reimbursement. Under Section 1815 of the Act, no Medicare 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. 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 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. Here the Provider has not submitted claims to the State, received and "maintained" the required remittance advices contemporaneous with the cost reporting period and furnished such documents to the Intermediary, contrary to this principle. Further, any suggestion that amounts subsequently recovered can be offset in subsequent years, ignores the incentive to bill (and hence recover the bad debt) has been removed once Medicare prematurely pays the bad debt.

In accordance with section 314 of the PRM and 42 CFR 413.89(f), uncollectible Medicare deductible and coinsurance amounts are recognized, and only recognized, in the reporting period in which they are deemed worthless. As the court discussed in Palms of Pasadena v. Sullivan, 932 F.2d 982 (D.C. 1991), regarding when a bad debt may be claimed:

> Bad debts relating to Medicare patients can arise when these patients fail to pay their deductible or coinsurance despite the hospital's bona fide attempts at collection….If Medicare does not reimburse providers for these losses, this "could result in the related costs of covered services being borne by other than Medicare beneficiaries." … Medicare therefore steps in and compensates the provider for its losses, but it does so only after the Medicare patients' accounts actually become worthless…. Pursuant to this method, Medicare paid [the provider] a single amount for each bad debt relating to a Medicare patient, regardless of which hospital services gave rise to the debt.
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> The basic effect of these provisions is to bar providers from reporting bad debts on an accrual accounting basis. Rather, some bad debts-those arising from the failure of Medicare patients to pay their deductible or coinsurance amounts-are to be treated as if the provider were on a cash basis. That is, the provider reports (and is then reimbursed for) such Medicare bad debts only in the accounting period when the particular account receivable actually becomes worthless.[17]

These provisions, like that of 42 CFR 413.89(f), ensure the proper recovery of bad debts while safeguarding against double dipping, or duplicative recoveries. In addition, the period in which a bad debt is claimed can affect the amount of the bad debt to be allowed, either because of the offset of recovered debts, or the affect of certain new provisions affecting the percentage of bad debts which will be paid in a specific cost year.[18] Because the Provider has not submitted State issued remittance advices for these services contemporaneous with these FYs 2002 & 2003 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

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[17] Palms of Pasadena v. Sullivan, 932 F.2d 982, 983 (D.C. 1991). However, while Medicare reimbursement regulation requires health care providers to maintain standard financial records, it does not require the Secretary to make reimbursement determinations according to generally accepted accounting principles.

[18] See, e. g., 42 CFR 413.89(h)(2008).

third party, the State who is responsible for coinsurance and deductibles, the Provider has not shown that it has used reasonable collection efforts As the State has a legal obligation to process unpaid coinsurance deductibles and issue a remittance advice, the elements of the bad debts regulation are not met for the cost reporting periods. For the cost reporting periods during which contemporaneous remittance advices are received, bad debts may at that time be claimed for that cost reporting period if the criteria of 42 CFR 413.89 are otherwise met.

Finally, the Provider did not demonstrate it meets the criteria for the hold harmless provision set forth in JSM-370. The "hold harmless" policy found in the August 10, 2004 JSM-370, applies to a provider who has previously relied on alternative billing methods permitted under 1102.3L:

> This memorandum is to serve 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 1102.3L 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 allowable using other documentation in lieu of billing the state.
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> Intermediaries that required the provider to file a State Remittance Advice for cost reporting periods prior to January 1, 2004, may NOT reopen 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 issuance of this memorandum, relating to cost reporting periods before January 1, 2004, and who relied on the previous language of section 1102.3L in providing documentation. [19]

The Provider failed to demonstrate it relied on section 1102.3L and alternative documentation to support its crossover bad debt claims and, as a critical criteria, that the Intermediary accepted such documentation and made payment based upon such documentation for cost reporting periods beginning before January 1, 2004. For example, the documents submitted by the Provider to the Intermediary proposing alternative

[19] JSM 370 (Aug. 10, 2004). Intermediary Exhibit I-41.

documentation to support its bad debt claim is dated January 18, 2006.[20] The Provider incorrectly focuses on the cost years involved (beginning prior to January 1, 2004) and not on whether it can show reliance on section 1102.3L and that the Intermediary allowed payment based on alternative documentation for years beginning before January 1, 2004. Therefore, the "hold harmless" policy does not apply to the Provider in this case.

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 program is reasonably balancing the accuracy of the bad debt payment and the timing of when these bad debts can be paid 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 payor of last resort.

[20] See e.g. Provider's Exhibit P-20 in Provider's Final Position Paper. The Provider's letter was dated January 18, 2006, well after the date of the Change Request (September 2003) and the JSM-370 (August 2004). The Provider's letter to the Intermediary stated that: "[W]e have developed a method of identifying and documenting bad debt related to crossover claims that we believe satisfies the "must bill" policy, regardless of whether MaineCare is able to issue a remittance advice." The letter would indicate that this was the first time the Provider offered this alternative documentation and that the Intermediary had never accepted such documentation prior to this date. The record overall shows that the Provider offered no documentation that affirmatively demonstrated that the JSM-370 hold harmless provision was met in this case.

DECISION

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

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

Date: 1/28/13

/s/
Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services

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